EMpowering Pregnant women Affected by Trauma HistoRY: The EMPATHY study

by

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Research student declaration form

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Abstract

Over a quarter of pregnant women (~150,000) each year in the UK have suffered trauma such as domestic abuse, adverse childhood experiences, or sexual assault. These experiences can have a lasting effect on mental and physical health, and impact pregnancy and parenting. Despite this prevalence and the potential consequences, discussing prior trauma is not standard practice in maternity care in the United Kingdom. This critical participatory action research study aimed to address the research question: How can maternity services empower pregnant women affected by previous trauma to access support?

The study was underpinned by critical social theory and guided by a Research Collective comprising experts by experience, voluntary sector practitioners, and maternity care professionals. A systematic literature review and qualitative evidence synthesis was conducted which included 25 papers from 5 countries, representing the views of 1602 women and 286 healthcare professionals and experts from the voluntary sector. Interviews were then undertaken with women with lived experience of trauma (n=4), healthcare professionals (12), and voluntary sector experts (n=7).

Findings from the qualitative synthesis and interviews were reported separately and then integrated with insights from the Research Collective to develop an evidence-based framework of guiding principles for routine discussion of previous trauma in the perinatal period. The development process included a rigorous public consultation with 52 responses.

The framework contains 23 recommendations based on six core principles. Routine trauma discussion should be introduced as part of a system-wide change; maternity care providers should let women know previous trauma can affect their well-being and help them access support; trauma conversations need to be carried out sensitively, to build trust and relationships; staff must be provided with adequate training and support; trauma discussions should be tailored to local needs and services; and services should systematically assess the implementation and impact of routine trauma discussions and seek to continuously improve trauma pathways based on these insights.

The research marks a unique contribution to knowledge by offering a new model for trauma discussions, informed by meaningful engagement with trauma survivors and stakeholders. Further research is needed to determine whether implementation of the framework improves maternal and neonatal outcomes.

Publications and presentations resulting from this thesis

Peer reviewed journal publications

- Cull, J., Thomson, G., Downe, S., Fine, M. & Topalidou, A. (2023) ‘Views from women and maternity care professionals on routine discussion of previous trauma in the perinatal period: A qualitative evidence synthesis’, *PLoS ONE,* vol. 18, no. 5, pp. e0284119.

  A media report on this paper was reproduced in over 170 newspapers and websites in the UK and abroad, with an estimated reach of over 3.5 million individuals. The paper was also selected for inclusion as an NIHR Evidence Alert, which can be found at: https://evidence.nihr.ac.uk/alert/can-we-improve-discussions-with-pregnant-women-about-previous-trauma/

- Cull J., Thomson, G., Downe, S., Fine, M., Topalidou, A. (2024) ‘Should maternity care providers ask women about previous trauma, and how should they respond to disclosures? A synthesis of qualitative evidence’. *The Practising Midwife,* 27 (3), pp 24-28.

Professional and other publications

- Cull J. (2023), ‘The EMPATHY study: Empowering pregnant women affected by trauma HistorY’. *Institute of Health Visiting Website*. Available at: https://ihv.org.uk/news-and-views/voices/the-empathy-study-empowering-pregnant-women-affected-by-trauma-history/

- Cull, J., Thomson, G., Downe, S., Fine, M. & Topalidou, A. (2022) ‘Views from women and maternity care professionals on routine discussion of previous trauma in the perinatal period: A qualitative evidence synthesis’ (preprint), *medRxiv*, pp. 2022.10.25.22281395.

Peer reviewed conferences

- Cull J. (2024) Conference session - Trauma-informed Care. *Royal College of Midwives All Members Conference.* 8th-9th May, Liverpool, UK. *Invited speaker.*

- Cull J., Thomson, G., Downe, S., Fine, M., Topalidou, A. (2023) ‘EMpowering Pregnant women Affected by Trauma HistorY: the EMPATHY study’. *Poster presentation - National Institute for Health Research Academy Members Conference*, 10th-11th October, Leeds, UK.

- Cull J. (2023) ‘Supporting pregnant women who have suffered previous trauma: findings from interviews with women with lived experience of trauma, healthcare professionals, and voluntary sector experts’. *Oral presentation - International Confederation of Midwives Triennial Congress*, 11th-14th June, Bali, Indonesia.

- Cull J. (2023) ‘EMpowering Pregnant women Affected by Trauma HistorY: the EMPATHY study’. *Three Minute Thesis presentation - International Confederation of Midwives Triennial Congress*, 11th-14th June, Bali, Indonesia.

- Cull J. (2023) ‘Supporting pregnant women who have suffered previous trauma: findings from interviews with women with lived experience of trauma, healthcare professionals, and voluntary sector experts’. *Oral presentation - International Labour and Birth Research Conference*, 24th-26th April, Grange Over Sands, UK.

- Cull, J., Thomson, G., Downe, S., Fine, M., Topalidou, A. (2022) ‘Recognising and supporting women in the perinatal period who have experienced previous trauma: results from a systematic review and thematic synthesis’. *Poster presentation – International Marce Society for Perinatal Mental Health*, 21st-23rd September, online.

- Cull J. (2023) ‘EMpowering Pregnant women Affected by Trauma HistorY: the EMPATHY study’. *Three Minute Thesis presentation - University of Central Lancashire Three Minute Thesis event*, 16th May, Preston and online. *Awarded runner up prize.*

- Cull J. (2022) ‘EMpowering Pregnant women Affected by Trauma HistorY: the EMPATHY study’. *Oral presentation - Royal College of Midwives Education and Research Conference*, 23rd-24th March, Coventry, UK.

- Cull J. (2022) ‘Ensuring inclusivity in maternity trauma research’. *Poster presentation - Royal College of Midwives Education and Research Conference*, 23rd-24th March, Coventry, UK.

- Cull J. (2021) ‘Ensuring inclusivity in maternity trauma research’. Poster presentation - National Institute for Health Research Academy Members Conference, 23rd-24th November, Leeds, UK. Awarded Highly Commended.

Other presentations

- Cull J. (2023) ‘EMpowering Pregnant women Affected by Trauma HistorY: the EMPATHY study’. *International Trauma-informed Care Network Meeting*, 23rd November, online.

- Cull J. (2023) ‘Supporting pregnant women with histories of trauma: qualitative insights from women and care providers.’ *Oral presentation - Global Maternal and Infant Health Webinar*, 7th June, online.

- Cull J. (2023) ‘EMpowering Pregnant women Affected by Trauma HistorY: the EMPATHY study’. *North-West Regional Maternity*

Research Showcase and network planning event. 27th February, Manchester, UK.

- Cull J. (2022) ‘EMpowering Pregnant women Affected by Trauma HistorY: the EMPATHY study’. *Oral presentation - Global Maternal and Infant Health Webinar*, 2nd November, online.

- Cull J. (2021) EMpowering Pregnant women Affected by Trauma HistorY: the EMPATHY study. *Working with pregnancy in custody and the community; a trauma-informed approach,* 14th May, online.

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I dedicate this thesis to the memory of my dad, David Leslie Morrice, who loved to learn.

Glossary of terms and abbreviations

Terms

For the purposes of this study, trauma is defined as ‘an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual’s functioning and mental, physical, social, emotional or spiritual well-being’ (US Substance Abuse and Mental Health Service Administration: SAMHSA, 2014, p.7).

The term 'routine,' particularly when referring to discussions of previous trauma in the context of maternity services, implies that the topic is broached with all women, not just those whom healthcare professionals believe may have experienced trauma. Importantly, employing 'routine' in this manner does not diminish the importance of providing personalised care.

I have chosen to use the term ‘discussion’ as in ‘trauma discussion’ rather than ‘enquiry’ as discussion leaves open the possibility that trauma could be raised in a way that does not involve a direct question.

The term ‘survivor’ has been used in places, acknowledging that not all women who have experienced trauma resonate with this term. The terms ‘vulnerable’ and ‘marginalised’ have been used to describe groups who face heightened risks of experiencing poor health outcomes compared to the general population. This includes people living in areas of high deprivation, ethnic minority communities, and those who are socially excluded, such as refugees, the homeless, sex workers, and individuals in contact with the justice system (NHS England, 2024).

The choice of language within maternity care discourse, particularly regarding the designation 'woman', has become a focal point of debate and division (see e.g. Gribble et al., 2022). There have been calls for the use of desexed terms such as 'birthing people,' 'non-men,' or 'parent' to accommodate individuals who are biologically female but do not identify as women. This discourse holds particular relevance to the EMPATHY study due to evidence that transgender people are more likely than their cisgender counterparts to have suffered trauma (Flores et al., 2021). However, a wholesale change in maternity care language may be premature. Essential prevalence data regarding non-cisgender individuals in maternity care settings is lacking, and concerns have been raised about the clarity, accuracy, and unintended consequences of alternative terminology (Biggs, 2023; Garad et al., 2023; Gribble et al., 2022; Webb et al., 2023). Furthermore, the focus on gender-neutral language has been criticised for potentially erasing the term 'woman' and undermining women's rights (Munzer, 2021; Dahlen et al., 2021). In light of these complexities, a decision was made to use the term 'woman' throughout.

Abbreviations

ACE: Adverse Childhood Experience
CPAR: Critical participatory action research
EMPATHY: EMPowering Pregnant women Affected by Trauma HistorY
NHS: National Health Service
NIHR WOW National Institute for Health and Care Research Wellbeing of Women
PTSD: Post-traumatic stress disorder
UK: United Kingdom
US: United States

Chapter 1 Overview of the thesis

1.0 Introduction

This thesis presents findings from a critical participatory action research study which explores discussions of previous trauma within maternity care. The study is titled EMpowering Pregnant women Affected by Trauma HistorY, or EMPATHY. In this chapter, I describe the study context, research aims and objectives, theoretical framework for the study and my interest in this topic. Finally, an overview of the thesis is provided.

1.1 The research problem

Over a quarter of pregnant women (~150,000) each year in the United Kingdom (UK) have experienced significant trauma such as violence or sexual abuse in childhood or adulthood[1]. Data from the Office for National Statistics shows 24.8**%** of women suffered abuse before the age of 16, including physical, sexual, and emotional abuse and witnessing domestic abuse; 26.5% suffered sexual abuse since the age of 16 years; and 27% suffered domestic abuse since the age of 16 years (2020, 2023a, 2023a).

Exposure to trauma can have a severe and prolonged impact on mental health, physical health, and health seeking behaviours (Bellis et al., 2017; Bellis et al., 2019; Hughes et al., 2017). Internationally, preventing trauma and reducing its impact is a public health priority (Sara & Lappin, 2017). Some women who have experienced trauma will have recovered from their experiences at the time of pregnancy, while others begin the pregnancy with unresolved trauma which negatively affects their mental health and experience of parenting (Muzik et al., 2013; Seng et al., 2014). Women who have experienced trauma may find the perinatal period particularly challenging and find that aspects of maternity care, such as clinical

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[1] In 2022, the most recent year for which data were available, there were 605,479 live births and 2,433 stillbirths (Office for National Statistics, 2023c).

procedures, trigger memories of their previous abuse (Montgomery et al., 2015).

An increased understanding of the long-term effects of trauma exposure on both mother and baby has led to calls for universal screening within maternity care (Law et al., 2021). The American College of Obstetricians and Gynecologists recommend that maternity care providers screen all women for current and past trauma (2021). In the UK, whilst National Institute for Health and Care Excellence guidelines do not address routine enquiry about previous trauma, anecdotally several maternity hospitals have introduced it at the initial midwife appointment. However, concerns have also been raised that this could be re-traumatising for women (Ford et al., 2019), increase unnecessary or unwarranted safeguarding referrals (Underwood, 2020), or stigmatise women with a history of adverse events (Racine, Killam & Madigan, 2020).

It is evident that routinely discussing prior trauma with pregnant women requires careful consideration and sensitivity to ensure these conversations create value rather than cause harm. This study aimed to find out whether and how maternity care providers should raise the issue of previous trauma with women, what resources should be provided to women who have suffered trauma, and what training is required for maternity care professionals to sensitively carry out these discussions.

While the intervention developed in this study, a framework for discussing previous trauma, aims to support women coping with various forms of trauma, my primary focus has been on supporting women who have suffered abuse and violence. This emphasis arises from the recognition that women often suffer greatly after these experiences, but in many cases do not disclose to anyone or receive support (Jay et al., 2022). Although the focus has been on trauma experienced by childbearing women, I hope that future research will build on this work to include fathers and other non-birthing partners who have suffered trauma.

1.2 Research aim and objectives

The aim of this doctoral study was to work with key stakeholders to co-develop a trauma-informed intervention to address the research question *how can maternity services empower pregnant women affected by previous trauma to access support?*

The objectives were:

1. Review the literature around screening for trauma in maternity services, to establish the perspectives of women and clinicians on the acceptability, feasibility, and value of routine trauma discussions.
2. Explore key stakeholders' (women and professionals) views regarding enquiring about trauma histories in maternity services.
3. Develop an intervention for discussing trauma histories with women.
4. Explore the acceptability and feasibility of the intervention.

1.3 Theoretical framework of the study

The study was underpinned by a critical participatory action research (CPAR) approach, drawing on critical social theory to examine issues of power dynamics and injustices. CPAR studies actively engage with the affected community to enact tangible societal change (Fine & Torre, 2021). To facilitate this approach, I established a Research Collective of individuals with diverse expertise, including experts by experience, practitioners from voluntary organisations, and professionals in maternity care. The Research Collective first met in advance of submitting the doctoral funding application, ensuring their meaningful contribution to the study's conceptualisation and design from its inception.

1.4 Personal perspective on the topic

In this section, I offer insights into the motivations behind my study and my initial perspectives on engaging in trauma conversations. I am a midwife and at the time of beginning the study had been qualified for five years, having retrained in my mid-thirties from a previous career as a Chartered Accountant.

My interest in midwifery came not from an interest in childbirth, or babies, but from a commitment to empowering women. In my admission application to study midwifery, I stated my passion for ensuring every woman feels respected, capable, and confident, with a particular emphasis on supporting those facing additional challenges such as language barriers, disability, low literacy levels, or social issues. During my training, I found myself drawn to supporting women confronting significant emotional difficulties, including victims of domestic abuse and those at risk of losing custody of their children. This inclination led me to work in a hospital situated in a socioeconomically deprived area of London, where, due to its proximity to the Home Office, many of the women were seeking asylum in the UK.

My interest in supporting women who have suffered trauma was deepened by a poignant conversation with a nurse friend, who candidly shared her experiences of motherhood after growing up in a violent household. During pregnancy, she faced intrusive thoughts of harming her unborn child, but did not seek help out of fear that if she confided in her husband, he would leave her, and if she disclosed these feelings to her midwife, she would be referred to social services and her child would be taken into care. Our conversation stayed with me long after our encounter, highlighting the silent struggles endured by many women and the disconnect between their inner turmoil and outward appearances, which is often unnoticed by healthcare providers.

Reflecting on my clinical encounters, I began to contemplate whether women presenting with severe mental health challenges or exhibiting agitation may have a history of trauma. This curiosity led me to explore the rapidly growing field of trauma-informed care, where I discovered that maternity care providers in some regions of the United States and Australia routinely enquire about previous traumatic experiences (Flanagan et al, 2018; Mollart, Newing & Foureur, 2009). In my role as an hourly paid lecturer, I learned that at one of our local hospitals, midwives initiated discussions about previous trauma during booking appointments, a practice largely endorsed by students for its perceived benefits to women's well-being. However, delving deeper into how midwives typically responded to trauma disclosures - often involving referrals to safeguarding or mental health services - prompted critical reflection on how these discussions might be perceived by women. Martin-Baro’s (1996, p.28) provocative question resonated deeply:

> *‘Have we ever seriously asked what psychosocial processes look like from the point of view of the dominated instead of from that of the dominator?’*

These differing viewpoints led me to scrutinise my own biases and assumptions surrounding these discussions and their potential impact on women. My statement of positionality thus evolved: I was initially uncertain about the benefits of routine trauma discussion and was concerned that it may have unintended consequences, in particular for women from marginalised backgrounds or facing intersecting forms of discrimination. I feared disclosure could inadvertently exacerbate vulnerabilities, potentially leading to unwarranted or unwanted involvement from safeguarding or mental health services.

1.5 Research funding

The EMPATHY study was funded by a National Institute for Health Research Wellbeing of Women Doctoral Fellowship (grant number NIHR301525). The views expressed in this thesis are those of the author and not necessarily those of Wellbeing of Women, the NHS, the NIHR or the Department of Health and Social Care.

1.6 Structure of the thesis

The thesis is organised into eight chapters:

Chapter 1: Introduction

This chapter offers an overview of the study.

Chapter 2: Background to the study

Here, the potential lasting impact of trauma and the significance of the perinatal period as a uniquely powerful time to offer support are explored.

Routine trauma discussion is positioned as a foundational step towards developing trauma-informed care, but challenges in facilitating these discussions are identified.

Chapter 3: Systematic review and qualitative synthesis

The findings of a systematic review and qualitative evidence synthesis of views from women and maternity care providers views on routine discussion of previous trauma in the perinatal period are presented. The chapter provides an overview of the review methodology, the themes generated from the qualitative evidence, and research gaps to be addressed in the thesis.

Chapter 4: Theoretical framework and methodology

This chapter outlines the ontological and epistemological underpinnings of the study, describing the rationale behind using critical social theory as a theoretical foundation. The decision to employ a CPAR methodology and its application within the study context are described. Key study concepts are examined in detail.

Chapter 5: Interview methods

This chapter offers a comprehensive account of the methods used to conduct the study interviews. It includes participant recruitment, data collection methods, ethical considerations, and data analysis techniques. The influence of the underpinning key study concepts on study design and conduct is explored.

Chapter 6: Interview findings

Sociodemographic details of interview participants and reflections on the overlap between participant categories are discussed. Three key themes are presented: key elements of trauma discussions; strategies for raising the issue of previous trauma and responding to disclosures; and support requirements for staff engaged in trauma discussions.

Chapter 7: Development and evaluation of an evidence-based framework of guiding principles for routine discussion of previous trauma in the perinatal period

In this chapter I describe how insights from the interviews were integrated with the findings of the systematic review and qualitative synthesis to formulate a framework for routine discussion of previous trauma in the perinatal period. Details of a public consultation on the framework are also presented.

Chapter 8: Discussion and conclusions

This final chapter summarises the key findings of the study, underscores its unique contribution to knowledge, and situates these findings within the broader academic discourse. It evaluates the strengths and limitations of the study and provides recommendations for clinical practice, further research, and policy development. The chapter finishes with reflections and conclusions.

Chapter 2 Background to the study

2.0 Introduction

In the preceding chapter, I introduced the study and myself as the researcher, and outlined the structure of this thesis. This chapter serves to provide contextual background for the study. Drawing upon empirical evidence, the potential enduring impact of traumatic experiences on health and well-being is explored. The perinatal period is recognised as a critical juncture in which women who have suffered trauma may experience acute suffering. Attention is given for the potential for traumatic experiences to exacerbate health inequalities. I explore a framework for trauma-informed perinatal care. Finally, the potential benefits and challenges of routinely discussing previous trauma within maternity care are critically examined.

The purpose of the EMPATHY study is to develop an intervention for implementation in the UK; accordingly, evidence from high-income settings has been used where available due to the care provided being comparable.

2.1 The impact of trauma on health and well-being

The seminal Adverse Childhood Experience (ACE) study, in which 9,508 American adults were surveyed about their childhood experiences and current health, was the first to highlight the wide-ranging, long-lasting impact of trauma (Felitti et al., 1998). Participants were asked about seven categories of ACEs: psychological, physical, or sexual abuse; violence against mother; or living with household members who were mentally ill or suicidal, substance abusers, or ever imprisoned. The researchers found a strong and graded response between the number of categories of trauma suffered and every adult health risk behaviour and disease studied, including drug abuse, suicide attempts, heart disease and cancer.

The ACE study findings that traumatic experiences can have lasting negative impacts on physical, mental, and social health have been validated by a growing body of evidence. Physical or sexual violence can cause direct lasting damage including disabilities, chronic pain, unwanted pregnancies or miscarriage and traumatic brain injury (William et al., 2022; Valera & Kucyi, 2017). Trauma can also indirectly impact long-term physical health. In 2017, Hughes et al. carried out a systematic review and meta-analysis to establish the impact of multiple ACEs on health, which included 37 studies from 17 countries and a total of over 250,000 participants. Individuals with at least four types of adverse childhood experiences were at increased risk of respiratory disease cancer, diabetes and heart disease compared with individuals with none. Holman et al. (2016) proposed that the mechanisms linking trauma with long-term health conditions are not well understood but may include a combination of sustained stress, inflammation, and harmful behaviours such as substance misuse, smoking, and overeating.

The Adult Psychiatric Morbidity Survey, in which 7,400 adults in England were asked about their experiences of violence and abuse and their mental health, called attention to the profound effect of trauma on health and well-being (Scott et al., 2015). The survey found that violence and abuse were strongly and consistently linked with poor health, disability, and mental health disorders including depression, anxiety, psychosis, post-traumatic stress disorder (PTSD) and eating disorders. Participants were grouped into six different profiles based on their lifetime experience of abuse and violence. Respondents in the profile ‘extensive physical and sexual violence as adult and child’ were fifteen times more likely to attempt suicide than those in the profile ‘relatively little experience of abuse,’ and more than half of the first group had self-harmed. Some participants in the *Truth Project*, a listening study which took place as part of the Independent Inquiry into Child Sexual Abuse (Jay et al., 2022) said the abuse had shaped their whole life. Many described feeling on edge and unsafe at all times, and nearly a quarter suffered recurrent nightmares which affected their ability to sleep. Decades after the abuse, some were still haunted by memories and flashbacks. Feelings of guilt and lack of self-worth were common, as were difficulties in controlling emotions and disordered eating.

The systematic review and meta-analysis by Hughes et al. referred to above found that individuals with at least four types of ACEs were 10 times more likely to use intravenous drugs and seven times more likely to develop alcoholism than those with none (2017). London-based charity ‘One in Four’ carried out a project in which fourteen adults wrote about their experiences of childhood sexual abuse and addiction (2019). Some participants said they used alcohol or drugs to make life bearable. Others suffered loneliness, isolation, and an unmet need for connection, initially using drugs to give them the confidence to foster connections (One in Four, 2019). Participants in the *Truth Project* (Jay et al., 2022) raised similar issues of feeling that their experiences had destroyed their trust in others, affecting their ability to form and maintain friendships and relationships and preventing them from having a healthy and enjoyable sex life. Some described a pattern of abusive relationships which they felt was attributable to their early experiences *‘it was like you had a big sign on your head that said ‘prey’* (Jay et al., 2022, p.77).

2.2 Broader effects of trauma

Given the aforementioned statistics (see section 1.1), it is foreseeable that a history of trauma correlates with escalated healthcare costs and utilisation. Bellis et al. (2017) conducted a survey involving 7,414 adults in England and Wales. Participants were asked about ACEs and three types of healthcare usage over the preceding 12 months: visits to the General Practitioner, attendance at Accident and Emergency departments, and nights spent in hospital. The study found ACEs to be strongly predictive of heightened use across all three healthcare categories (Bellis et al., 2017). Additionally, studies indicate that women with a history of abuse are less likely to access preventative health care such as cervical screening, mammograms, and dental care as these can be reminiscent of abusive situations, potentially resulting in adverse long-term health consequences and increased healthcare costs (Razi et al., 2021; Alyce et al., 2022). A systematic review and meta-analysis published in the Lancet found that over a quarter of cases of anxiety and depression in Europe were attributable to ACEs, with researchers estimating the annual European cost of ill health stemming from childhood trauma to be $581 billion (Bellis et al., 2019).

Trauma can affect life chances through multiple mechanisms. Survivors of childhood maltreatment face an elevated risk of revictimisation in adulthood (Fereidooni, Daniels & Lommen, 2024). The UK charity 'One in Four' collected survivor narratives about the impact of childhood sexual abuse in their lives (2015). Participants described adverse effects on education, including missed school, concentration difficulties, and disrupted sleep patterns. Lower educational attainment can have long-term repercussions: Pinto Pereira, Li & Power (2017) analysed British birth cohort data including over 8,000 individuals aged 50, finding that child maltreatment correlated with poorer adult economic circumstances including prolonged sickness absence, unemployment, and financial instability. Nevertheless, for some individuals, abuse in childhood is linked to increased educational and career achievements, possibly as a coping strategy, or counteracting psychological impacts of abuse such as low self-esteem (Fisher et al., 2017).

In some cases, individuals may experience what is recognised as post-traumatic growth, even amidst the adverse effects of trauma. Tedeschi and Calhoun (2004) introduced this concept, defining it as *'positive psychological change experienced as a result of the struggle with highly challenging life circumstances'* (p.1). This growth may manifest as an enhanced appreciation of life, a greater sense of personal resilience, improved interpersonal relationships, strengthened spiritual convictions, and a reprioritisation of values. Echoing this sentiment, Thomson et al. (2022b, p.1153) note that adversity *'has the potential for new connections, growth and renewal'.* Post-traumatic growth was described by some participants in the *Truth Project*, who expressed pride in their inner strength, competence, and self-reliance (Jay et al., 2022). They believed their own experiences had increased their empathy for others, and many described how their own recovery had been helped by supporting others, for example as a therapist (Jay et al., 2022).

2.3 The perinatal period can be challenging

Women who have experienced previous trauma are at increased risk of both relapses of existing mental health disorders and the presentation of new mental illnesses during the perinatal period (Young-Wolff et al., 2019). Even those who have had long periods of stability and recovery can be disrupted at this time (Jay et al., 2022). The UK Confidential Enquiry into Maternal Deaths, which reviewed both maternal suicides and deaths of accidental causes in the perinatal period, notes that a history of trauma in childhood or adulthood was very frequent among the women who died, and concludes:

> *‘Where there is a history of significant mental health concerns and risk related to past trauma, including previous childhood abuse, it should be recognised that although there may be a period of relative stability during pregnancy, becoming a parent (particularly for the first time) can be associated with a marked worsening of mental state and increase in risk’* (Knight et al., 2022, p.34).

Trauma can be caused by maternity care and birth experiences, including birth trauma, pregnancy loss and the removal of a child into the care of social services (Thomson et al., 2021; Law et al., 2021). Birth can also cause the re-surfacing of previous trauma (O’Donovan et al., 2014). Women who do not remember their abuse or believe it is no longer relevant to their lives may be disturbed by unexpected flashbacks and the physical sensations of their body changing in pregnancy (Montgomery, Seng & Chang, 2021; Sobel et al., 2018). Women who have suffered sexual trauma may also find elements of maternity care, such as vaginal examinations, extremely distressing (Millar et al., 2021). This is a time when women often reflect on their own childhoods, which can be painful and upsetting (Law et al., 2021). A history of trauma can impact women’s confidence as mothers, and they may fear being overprotective or worry about harming their children (Montgomery, Seng & Chang, 2021). Some women face complex challenges, such as the abuser’s continued presence in their lives (LoGiudice & Beck, 2016).

The trauma history of a mother can affect her infant through multiple pathways. Maternal mental health impacts the emotional, social, and cognitive development of children, with the quality of early mother-infant attachments affecting the child's ability to form positive future relationships (Folger et al., 2018; Le-Scherban et al., 2018; Schickedanz et al., 2018). Sections 2.1 and 2.2 of this thesis demonstrate the association between abuse history and intimate partner violence and substance abuse as an adult: in pregnancy, these are health risk factors not only for the woman but her baby (Barrios et al., 2015; Frankenberger, Clements-Nolle & Yang, 2015). Maternal exposure to childhood trauma is also significantly associated with placental-foetal stress physiology, specifically placental corticotropin-releasing hormone (Moog et al., 2016). This can lead to prematurity, with children of mothers who have been exposed to multiple traumas being more likely to be born preterm and to be admitted to a neonatal unit (Miller et al., 2017). Moreover, women who have grown up in homes in which they were not safe or nurtured may find parenting more challenging (Greene et al., 2020).

2.4 Trauma contributes to health inequalities

As elucidated in section 1.1, an estimated one quarter of pregnant women in the UK each year have suffered trauma. However, trauma is not randomly distributed among pregnant women: some groups of women face additional risks of violence and abuse based on intersecting power structures including class, race, immigration status, sexuality, and whether they are living with a disability (Office for National Statistics, 2021b). While trauma occurs across the social spectrum, those in the lowest socioeconomic class face the greatest risk (World Health Organization, 2014). Women from Black or Black British and Mixed ethnic groups are significantly more likely to experience sexual assault than other ethnic groups, and disabled women are twice as likely as non-disabled women to suffer domestic abuse (Office for National Statistics, 2021b; SafeLives, 2017).

Vulnerable populations such as refugees, women who have contact with the criminal justice system or members of cultures with historical trauma, including minority ethnic groups, often have higher cumulative lifetime trauma exposures and consequent mental health problems, but are less likely to be offered or access treatment (Fair et al., 2020; Thomson et al., 2022a; Sperlich et al., 2017, Prady et al., 2016, Watson et al., 2019, Seng et al., 2011). The 2020 *Saving Lives, Improving Mothers' Care* report into maternal deaths in the UK concludes that women face a 'constellation of biases' based on belonging to a minority ethnic group, living in a deprived area, not speaking English, and other factors. Black women are four times as likely and Asian women are twice as likely to die when compared to White women in the perinatal period, and the highest stillbirth and neonatal mortality rates in the UK are among Black and Asian mothers living in the most deprived areas (Knight et al., 2020; Draper et al., 2022).

In their analysis of psychiatric interview data from 1,581 pregnant women in the US, Seng et al. (2011) observed that African American women, constituting 45% of the sample, exhibited a fourfold higher prevalence of current PTSD. This disparity was attributed to increased exposure to trauma, yet these women were less likely to be receiving treatment. Johnson-Agbakwu et al. (2014) found that 23% of 112 pregnant refugee women arriving in the US screened positive for PTSD, with half declining mental health services. A systematic review examining the perinatal mental healthcare experiences of ethnic minority women in the UK, conducted by Watson et al. (2019), echoed these findings. It revealed that despite a higher likelihood of experiencing mental health issues during pregnancy, women from ethnic minority backgrounds were less likely to access support. Contributing factors included a lack of awareness regarding perinatal mental health disorders among women, clinicians' failure to recognise symptoms, and a deficit of culturally appropriate services. Thomson et al. (2022a) conducted a mixed-method study on the maternity experiences of 104 minoritised ethnic women in North-West England. Their research uncovered a reluctance among participants to discuss mental health concerns, with only a minority feeling comfortable raising such issues with their midwife, despite a significant proportion reporting postnatal mental health worries.

These issues are discussed in more detail in chapter 4.

2.5 Pregnancy is a powerful time to offer support

The Royal College of Psychiatrists describes pregnancy and early motherhood as *'times of unparalleled contact with health services'* in which women at risk of mental illness can be identified and supported (2021, p.18). Detecting and treating perinatal mental health issues is a key public health goal outlined in the National Health Service (NHS) long-term plan, the National Maternity Review, and the Five Year Forward View for Mental Health (NHS England, 2019; 2016a; 2016b). Improving maternity care for women who have suffered abuse and violence is likely to contribute towards this goal and reduce health inequalities.

Parenthood can be a time of profound positive life changes. Chamberlain et al. (2019) carried out a qualitative systematic review and meta-synthesis of the pregnancy, birth and early postpartum experiences and views of parents with a history of childhood maltreatment. The review included 27 papers from five countries. The authors found that for many parents, pregnancy symbolised a fresh start, distinct from their past traumas. Mothers were motivated to care for themselves by adopting healthier lifestyles and distancing themselves from risky behaviours such as substance abuse. Several participants took considerable steps during this period to improve their futures, such as by finding secure work, returning to study, or securing stable housing. Pregnancy inspired new hopes and dreams for the future, including building healthy relationships and providing a safe and loving home for their new child. These findings echo the concept of post-traumatic growth described in section 2.2, emphasising relationships, values, and a renewed appreciation for life (Tedeschi and Calhoun, 2004).

2.6 A trauma-informed approach to care

Alongside research that attempts to determine the prevalence and impact of trauma have been efforts to define, implement and measure 'trauma-informed care', a model of service delivery which aims to develop an environment in which people who have experienced trauma feel safe and can build trust with their healthcare provider (Fenney, 2019). The NHS long term-plan (2019) commits to the development of trauma-informed mental health and youth justice systems, and the National Institute of Health and Care Excellence (NICE) has issued a recommendation for research studying the clinical and cost-effectiveness of trauma-informed care, noting that it:

> *'Could have a substantial impact on the experience of people with PTSD, reduce the length of hospital stays and outpatient visits [and] improve symptoms'* (2018a, p.150).

In 2014, the US Substance Abuse and Mental Health Services Administration (SAMHSA) published a seminal conceptual document which was used by the English, Welsh, and Scottish governments in developing their trauma-informed care guidance (Office for Health Improvement and Disparities, 2022; ACE Hub Wales, 2022; Scottish Government, 2021). The document proposes that there are four assumptions and six principles which are key to a trauma-informed approach.

The four assumptions are:
1. Everyone in the organisation realises the prevalence of trauma and its impact on behaviour, including its role in mental illness and substance use disorders.
2. Staff are able to recognise the signs of trauma, including by trauma screening and assessment.
3. The organisation responds by changing its policies and the language and behaviour of staff to take into consideration the experiences of trauma among service users and staff.
4. Active steps are taken to resist the re-traumatisation of clients and staff by ensuring psychological safety.

The six principles of a trauma-informed approach developed by SAMHSA are:

1. A sense of physical and psychological safety is prioritised for staff and the people they serve.
2. The organisation strives to develop trustworthiness and transparency.
3. The organisation facilitates peer support as a key vehicle for promoting recovery and healing.
4. Importance is placed on collaboration and mutuality with active levelling of power differentials between clients and staff, and between different staff groups.
5. The organisation promotes empowerment, voice, and choice, recognising the ability to heal from trauma and that staff facilitate rather than control this process.
6. The organisation recognises and addresses cultural, historical, and gender issues.

The SAMHSA guidance was built on and tailored to maternity services by a good practice guide commissioned by NHS England and NHS Improvement (Law et al., 2021). The guide combines primary research involving parents with lived experience of trauma and maternity staff and a review of evidence. The authors suggest that continuity of care is an additional key principle of trauma-informed perinatal care, because women are more likely to disclose previous trauma to known professionals, consistency enables healthcare professionals to better recognise deteriorating mental health, and this minimises the need for women to repeatedly share their experiences with different professionals. Women who receive continuity of care can build a relationship with their midwife, which promotes trust, respect, and improved outcomes (NHS England, 2016a). The guide also proposes five activities organisations should undertake to implement trauma-informed perinatal care: prioritisation by leadership and management; staff training; regular protected time for staff supervision to reduce vicarious trauma and burnout; co-production of services with individuals with lived experience of trauma; and evaluation of trauma-informed services to establish whether they improve experiences and outcomes for women and their families.

2.7 Routine discussion of previous trauma

Routine screening for trauma history is advocated by both SAMHSA and NHS England and NHS Improvement guidelines (SAMHSA, 2014; Law et al., 2021). The American College of Obstetricians and Gynecologists (2021) recommend that women's health providers screen for current and past abuse and assault. While National Institute for Health and Care Excellence guidelines in the UK do not address routine enquiry about previous trauma, anecdotal evidence suggests that some maternity hospitals have implemented this practice during initial midwife appointments.

Sperlich et al. (2017) propose that enquiring about women's history of traumatic events is a foundational step in establishing trauma-informed care. From an organisational perspective, such enquiries enable assessment of trauma prevalence, types, and priority needs in terms of care, interventions, and referrals (Sperlich et al., 2017). Asking women about traumatic experiences could also establish the need for audit or research at a local level, resulting in tailored services which meet the needs of the local population (Law et al., 2021). Moreover, discussing trauma offers an opportunity to educate pregnant women about its potential impact on health and well-being, reduce stigma, and signpost or refer to relevant resources such as substance abuse treatment or mental health services (Flanagan et al., 2018).

Furthermore, discussing previous trauma facilitates care planning to minimise the risk of women being re-traumatised and to improve their maternity care experiences (Millar et al., 2021). For instance, women who have suffered sexual assault may express concerns about vaginal examinations, birth, and breastfeeding (Sobel et al., 2018). Openly addressing these concerns may reassure them and enable midwives to offer practical support, such as assisting in birth plan development and providing dedicated support services. Women can also be signposted to supportive organisations and resources, such as the Pregnancy, Birth, and Parenting after Childhood Sexual Abuse e-resource (Montgomery, Seng & Chang, 2021). Additionally, providing information on helpful resources within the conversation could empower women who choose not to disclose their history to access support independently if desired (Law et al., 2021). Discussing trauma may also increase the likelihood of women disclosing their histories in future healthcare interactions (Sneddon, Wager & Allnock, 2016).

Evidence indicates that routine discussion of prior trauma is generally well-received by most women. For example, Flanagan et al. (2018) evaluated a four-month pilot of antenatal trauma screening within maternity services in Northern California. Women self-completed ACE and current resilience questionnaires and discussed them with their clinician, who provided a resource list which included support groups, parenting classes, and health education. The study involved 355 women, of whom 59% participated in a follow-up telephone survey. The majority (93%) of participants expressed comfort discussing trauma with their clinician, with over 85% agreeing that clinicians should broach this topic during pregnancy. Routine screening also appears likely to increase disclosure rates. Less than a quarter of 143 respondents in a study by Berry and Rutledge (2016) reported that they would volunteer information to their healthcare provider about past sexual assault experiences, but over 90% indicated they would respond truthfully to a direct question.

2.8 The challenges of routine trauma discussion

Addressing the challenges associated with routine trauma discussion is essential, as highlighted in section 1.1. Concerns have been raised regarding the potential for re-traumatisation of women (Ford et al., 2019), the risk of increased unnecessary or unwarranted safeguarding referrals (Underwood, 2020), and the potential for stigmatisation of women with adverse event histories (Racine, Killam & Madigan, 2020). This is a complex area, and in the UK has been introduced at Trust, rather than at national level, so implementation is inconsistent. Currently, there is no national guidance on conducting these discussions or responding to disclosures. Moreover, there is no validated trauma screening tool available to NHS staff, no standardised methodology (e.g., self-completion of questionnaire, face-to-face discussion) and a lack of consensus on how the information should be stored, shared and suitable actions should trauma be disclosed (Ford et al., 2019). While, as outlined above, both SAMHSA and NHS England and NHS Improvement guidance advocate for routine trauma screening, this is within a broader framework of service changes, including staff training, continuity of care, emotional support for staff, and service evaluation (SAMHSA, 2014; Law et al., 2021). However, the extent of implementation of these changes remains uncertain due to limited available evidence.

Although trauma screening is generally well received and holds potential benefits (see section 2.7), there is scant evidence demonstrating tangible improvements in experiences or outcomes for women and their babies. Ford et al. (2019) conducted a scoping review on routine enquiry into ACEs including 15 studies, 2 of which involved women in the perinatal period. The review highlighted a lack of studies measuring the impact and effectiveness of trauma screening, with none assessing how clinicians respond to disclosures, the impact on disclosure rates, or the resulting referrals. Consequently, it is challenging to gauge the true impact of trauma screening on the health and well-being of women and their babies.

It is evident that routinely discussing prior trauma with pregnant women requires careful consideration to ensure these conversations create value rather than cause harm.

2.9 Conclusion

In this chapter, I have demonstrated the prevalence and potential enduring impact of traumatic events on health and well-being. While any woman can suffer trauma, vulnerable populations are disproportionately affected yet face barriers to accessing support, suggesting that improving care in this area could help address health disparities. The perinatal period is a unique opportunity to help identify women who are experiencing the after-effects of trauma and guide them towards essential support services. However, the move towards routine discussion of previous trauma in maternity services is a complex area which demands careful deliberation to ensure the benefits outweigh any potential harms.

The subsequent chapter presents the findings of a qualitative synthesis of the views of women and maternity care providers on routine discussion of previous trauma in the perinatal period.

Chapter 3 Systematic review and qualitative synthesis

3.0 Introduction

The previous chapter highlighted the prevalence and impact of traumatic experiences and identified the importance of the perinatal period as a uniquely powerful time to offer support. Routine trauma discussion was positioned as an important first step in developing trauma-informed care, but numerous challenges of undertaking this sensitive discussion were identified, including the current organisation of maternity care.

In this chapter, I present the findings of a systematic review of qualitative research (qualitative evidence synthesis) to ascertain what is currently known about routine discussion of previous trauma within maternity care. The chapter provides an overview of the methodology, methods, and synthesised findings of the review. It also identifies the research gaps which will be addressed in this thesis.

3.1 Rationale for undertaking a systematic review

The purpose of my doctoral study is to develop an intervention for discussing trauma histories with women within maternity care. As a foundation for intervention development, it is important to discover what is already known about the topic through a review of existing literature (Fernandez et al., 2019). Khan (2011, p.xiv) describes a systematic review as *'a research article that identifies relevant studies, appraises their quality and summarises their results using a systematic methodology.'*

Systematic reviews need to be completely transparent about their methodology, so that the same review could be carried out by a different researcher with similar results (Shamseer et al., 2015). Bettany-Saltikov (2010) proposes that a protocol should be drafted before beginning the review, clarifying the review objectives, determining the inclusion and exclusion criteria, and explicitly stating the search strategy. The protocol should also include clear processes for selecting papers, evaluating study quality, and extracting information (Moher et al., 2015). Ultimately, the review should provide a comprehensive overview of what is known about the topic to identify gaps and direct future research (Fernandez et al., 2019).

My review was registered in PROSPERO with the reference number CRD42021247160 (Cull et al., 2021). Shamseer et al. (2015, p.5) propose that *'systematic review protocols are typically iterative; modifications to protocols before and during the review process are to be expected'*. In line with this recommendation, the PROSPERO protocol was updated to reflect changes made; the protocol and details of amendments made can be found at appendix 1. The review was informed by guidance produced by the Cochrane Effective Practice and Organisation of Care group on carrying out and reporting qualitative evidence syntheses (Glenton et al., 2021; Glenton et al. 2022a; Glenton et al., 2022b).

3.2 Aim of the review and review question

The aim was to systematically identify, appraise, and synthesise existing qualitative studies which explore the views of women and maternity care professionals on routine discussion of previous trauma in the perinatal period. The review question was 'What are the views of women and maternity care professionals on routine discussion of previous trauma in the perinatal period?

Prior to starting the review, I carried out a gap analysis in the Cochrane Library of Systematic Reviews and PROSPERO: no relevant previous systematic reviews were identified. Enhancing transparency in reporting the synthesis of qualitative research (ENTREQ) reporting guidance was used, supplemented by relevant aspects of Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA; Tong, et al., 2012, Page et al., 2021).

3.3 Methods

In this section, I describe the methods employed in the systematic review and qualitative synthesis, including the search strategy, data management, quality appraisal of studies, data synthesis, and assessment of confidence in the review findings.

3.3.1 Search strategy and selection criteria

Development of search strategy

As this was a qualitative review, the PEO framework (population, exposure, outcomes; Bettany-Saltikov, 2010) was used to help frame my review questions and to plan the search strategy. For my study, P = women in the perinatal period and maternity care professionals, E = routine trauma discussion within maternity care, and O = experiences, views, acceptability, feasibility, and values.

To determine the most appropriate search strategy, I reviewed key relevant papers I was already aware of. For each of these papers, I noted their title, the key words they had used, and terms used in the paper abstract, as a basis for my formal search strategy. However, when reviewing the key papers, I found two key problems. First, many alternative terms for trauma were used, including *complex trauma, adverse childhood experiences, adult survivors of child adverse events, exposure to violence, sexual abuse, rape, psychological trauma, child maltreatment, adversity,* and *childhood sexual abuse*. This highlighted the challenges of ensuring key studies were not missed.

Second, several papers which contained valuable information on routine trauma discussion in pregnancy had not specified ‘routine trauma discussion’ as a keyword or within the abstract. These papers tended to be focused more widely on improving perinatal care for women with previous traumatic experiences. For example, Montgomery, Seng & Chang (2021) used the keywords Childhood Sexual Abuse, Pregnancy, Birth, Parenthood, Co-production, E-resource. I was concerned that including a routine trauma discussion string (which could include enquiry, discussion, assessment, screening) would miss another tranche of useful papers. However, without including a trauma discussion string, my search for pregnancy, all trauma types and maternity care would return an unmanageable volume of hits.

The papers I was using to inform the strategy all referred to ‘trauma-informed’ in their keywords, title or abstract. I also examined other systematic reviews looking at aspects of trauma-informed care on PROSPERO to identify appropriate search terms. I ran pilot searches using this term on Medline and duplicated it using a variety of different terms such as trauma-sensitive, trauma-focused, and trauma-responsive. The MEDLINE search reaffirmed my findings that trauma-informed care is a niche field, with only 1,338 hits for the keywords ‘trauma informed’ or ‘trauma-informed’ as of 17.2.21. The alternative terms had very few hits and had always been used in addition to ‘trauma-informed’. I therefore decided to only use the search terms ‘trauma informed’ or ‘trauma-informed’ and hand select relevant papers that concerned the care of women in the perinatal period.

While searching for relevant papers, I also identified trauma screening tools, including the ACE-10 questionnaire. These tools were used as a prompt in the interview topic guide (see section 5.1).

Eligibility criteria

Only qualitative studies and qualitative aspects of mixed methods studies were included in the review. This was for two key reasons. First, while developing the search strategy, I noted that the volume of combined quantitative, qualitative, and mixed method papers was too great to meaningfully synthesise as part of a PhD, and within the timescales. Second, discussions of violence, abuse and other trauma are highly sensitive. It was crucial that the findings of the review would inform the later stage of my project – the development of a tool and method for routine trauma discussion. As qualitative studies offered insights into concerns, thoughts, and needs of both women who have experienced trauma, and maternity care professionals who will be raising the issue (recognising that maternity care professionals may themselves have experienced trauma), a qualitative approach was deemed more appropriate.

Inclusion and exclusion criteria for the review are detailed in Table 3.1. The phenomenon of interest was routine discussion of previous trauma in the perinatal period. Studies not based in a maternity setting, or which did not include women in the perinatal period (defined for this purpose as pregnancy and up to one year after birth) were excluded. The review was focused on psychological trauma: this could include all past trauma or specific types such as ACEs or sexual abuse but excluded studies involving participants solely exposed to physical trauma such as injuries. Only primary studies which were available in full and published in a peer-reviewed journal were eligible for inclusion. No limits on publication date were applied. Studies published in any language were eligible for inclusion in the review to limit language bias (Glenton et al., 2022b). I planned to initially translate titles and abstracts using open-source software (Google Translate). If necessary, full texts would be translated with the help of colleagues proficient in that language. Where an appropriate translator could not be accessed, the paper would be listed as ‘study awaiting classification’ to ensure transparency in the review process.

Table 3.1 Inclusion and exclusion criteria

Inclusion criteria	Exclusion criteria
Women in the perinatal period (pregnant to one year after birth)	Not women (e.g., men, children); women, but not in the perinatal period
Psychological trauma	Physical trauma, such as injury
Studies focused on routine trauma discussion within maternity services	Outside maternity services, or not focused on routine trauma discussion
Studies with a qualitative study design, which have collected and analysed the data using qualitative methods, or mixed methods studies where the qualitative findings can be extracted from the results	Quantitative studies; simple survey methodologies with no qualitative thematic analysis; mixed methods studies where the qualitative findings cannot be extracted from the results
No limits on publication language were applied	
Primary research	Secondary research, discussion articles, opinion or information pieces or commentaries, study protocols. theses, book chapters
Published in peer reviewed journal	
Papers which are available in full	Conference abstracts only
No limits on publication date were applied	

Search methods for identification of studies

A systematic search was undertaken in five databases – MEDLINE, CINAHL Plus, EMBASE, APA PsycInfo, and Global Index Medicus. Forward and backward citation tracking of studies to be included in the review, and key author searches were carried out as supplementary search strategies.

Selection of studies

Database results were imported to RefWorks reference management software. References were de-duplicated and then imported to Rayyan (www.Rayyan.ai), a web based systematic review data management software program. A second stage of de-duplication was carried out in Rayyan. My Director of Studies (GT) and I independently screened 20% of papers at title and abstract stage using Rayyan blind screening. The level of agreement was set at 95%. As we achieved 100% agreement, I then reviewed the remaining 80% of papers. The full text of all papers appearing to meet the inclusion criteria were then independently blind-screened by GT and I, and reasons for exclusion were recorded. Additional papers that I identified as relevant through citation tracking and key author searches were also assessed by GT. Any differences of opinion about inclusion were resolved through discussion.

3.3.2 Data extraction and management

I developed a standardised data extraction form using Excel and piloted it prior to beginning data collection. I used the form to record basic contextual and methodological information about each study, including bibliographic information, country of study, setting, study design, data collection, participants' characteristics, data analysis methods and key themes. To reduce bias and errors, GT independently extracted data from 20% of studies, and we compared results, resolving disagreements through dialogue.

3.3.3 Appraisal of the methodological quality of included studies

Quality appraisal has been defined as '*the process of carefully and systematically examining research evidence to judge its trustworthiness, its value and relevance in a particular context'* (Mhaskar et al., 2009, p.112). Garside (2014) argues that valuable theoretical insights may be gained even from studies which were conducted poorly, and Sandelowski (2015) notes that quality appraisal evaluates the *'stylized after-the-fact reconstruction of a study'* - the reporting of the study rather than the conduct of the study itself (p.89). Nevertheless, including flawed studies could result in a flawed synthesis, and it is now generally accepted that quality appraisal should be undertaken (Walsh and Downe, 2006; Munthe-Kaas et al., 2019). I therefore decided to assess the quality of each study eligible for inclusion and apply a minimum quality standard to ensure that the credibility or trustworthy of the review findings was not compromised (Glenton et al., 2022b).

I assessed the quality of each included paper using the Critical Appraisal Skills Programme (CASP) quality assessment checklist for qualitative studies (2018). This tool was chosen because it is the most commonly used by Cochrane authors for qualitative evidence syntheses, and by the World Health Organization for guideline processes (Noyes, et al., 2018a). The CASP checklist comprises 10 questions: 1 mark was allocated to each question if the criterion was met. The overall quality of each study was categorised as 'strong' (score 8-10/10; minimal methodological issues), 'adequate' (score 5-7/10; no major methodological issues) or 'weak' (0-4/10; major methodological issues). Studies scoring 'weak' were to be excluded on quality grounds. Garside (2014) suggest that more than one person should be involved in the assessment to bring a range of perspectives. We therefore decided that I would quality assess all papers, with GT independently assessing 20%. Where there was disagreement in any of the scores on the individual items of the quality appraisal checklist, these were discussed, and a consensus was reached through re-examination and discussion. Disagreements in ratings arising from individual items where there was insufficient information contained in the paper were rated as uncertain and not assigned a point. As suggested by Carroll and Booth (2015), I carried out *post hoc* sensitivity analyses to assess the impact on the review findings of excluding a study on quality grounds. Quality ratings contributed to the GRADE-CERQual assessments (described below).

3.3.4 Data synthesis

Data were synthesised thematically using the method developed by Thomas and Harden (2008). This approach to thematic synthesis was developed for reviews which aim to understand health issues from the perspectives and experiences of groups targeted by healthcare interventions, to address questions relating to intervention necessity, appropriateness and acceptability, and factors affecting implementation (Thomas and Harden, 2008). Findings from systematic reviews using thematic synthesis are intended to be directly applicable to intervention development and policy, as opposed to more conceptual or theoretical outputs (Barnett-Page and Thomas, 2009). As my review was focused on understanding women's and maternity care professional's views and / or experiences of routine discussion of previous trauma, and to inform development of an intervention, this method was a good fit. Further, this approach is suggested by the Cochrane Qualitative and Implementation Methods Group to be the most suitable for a qualitative synthesis (Noyes et al., 2018a).

In carrying out the synthesis, I drew on Thomas and Harden's paper (2008) and four well-cited studies which have used the approach: Clement et al. (2015), Bohren et al. (2015), Joseph-Williams, Elwyn & Edwards (2014), and Anderson et al. (2014). Thematic synthesis uses a three-stage approach (detailed below) and draws from grounded theory in using an inductive approach and 'constant comparison' method of generating themes (Barnett-Page and Thomas, 2009). I uploaded each paper to be included in the review onto MAXQDA, a software package that facilitates the organisation and analysis of qualitative data (www.maxqda.com). Using MAXQDA enabled me to experiment with different coding frameworks, easily moving codes between different hierarchical structures to find the best fit for the emerging themes and sub-themes. I began by reading each paper multiple times, until I had a detailed understanding of each study and had familiarised myself with the findings, and then used the three-stage approach as follows:

1. Inductive coding

First, the findings of each study were inductively coded on a line-by-line basis. I also checked the discussion section, and where relevant and appropriately backed up by data, I coded statements found there. At this stage I created preliminary codes that corresponded with the meaning and content of the text, for example ‘importance of language’ or ‘need adequate time and privacy’. As I coded each study, I created new codes as necessary. This detailed coding was a key process of translating findings between studies and the beginning of data synthesis. After coding all the relevant data in each paper, I reviewed all the text in each code to check the consistency of my interpretations and to determine whether more (or fewer) codes were needed.

2. Development of descriptive themes

The codes were then organised into related areas, constructing ‘descriptive’ themes (summaries of findings). For example, the codes ‘women felt unprepared’, ‘would have welcomed forewarning,’ and ‘felt singled out because of appearance’ became the descriptive theme ‘some women find routine trauma discussion invasive and unexpected’.

3. Generation of analytical themes

Finally, the descriptive themes were organised into analytical themes. Generating analytical themes involves ‘going beyond’ the findings of the primary studies to create new understandings and to directly address the review question: Thomas and Harden propose that this final stage is *‘the most difficult to describe and is, potentially, the most controversial, since it is dependent on the judgement and insights of the reviewers’* (2008, p.7). I looked for similarities and differences between the descriptive codes to start refining them and grouping into analytic themes. For example, the analytical theme ‘*you say it is confidential… but you are going to report me*’: the importance of trust’ comprised the following descriptive themes:

- Women fear judgement if they disclose their histories.
- Relationships are a critical prerequisite to trauma disclosure.
- The manner of the person asking and the environment are also important.
- If not handled sensitively, trauma discussion could affect future health care access and experiences.
- Some women will choose not to disclose previous trauma.

I shared, discussed, and refined the evolving codes, descriptive themes, and analytical themes with GT and the wider supervisory team throughout.

3.3.5 Assessment of confidence in the review findings

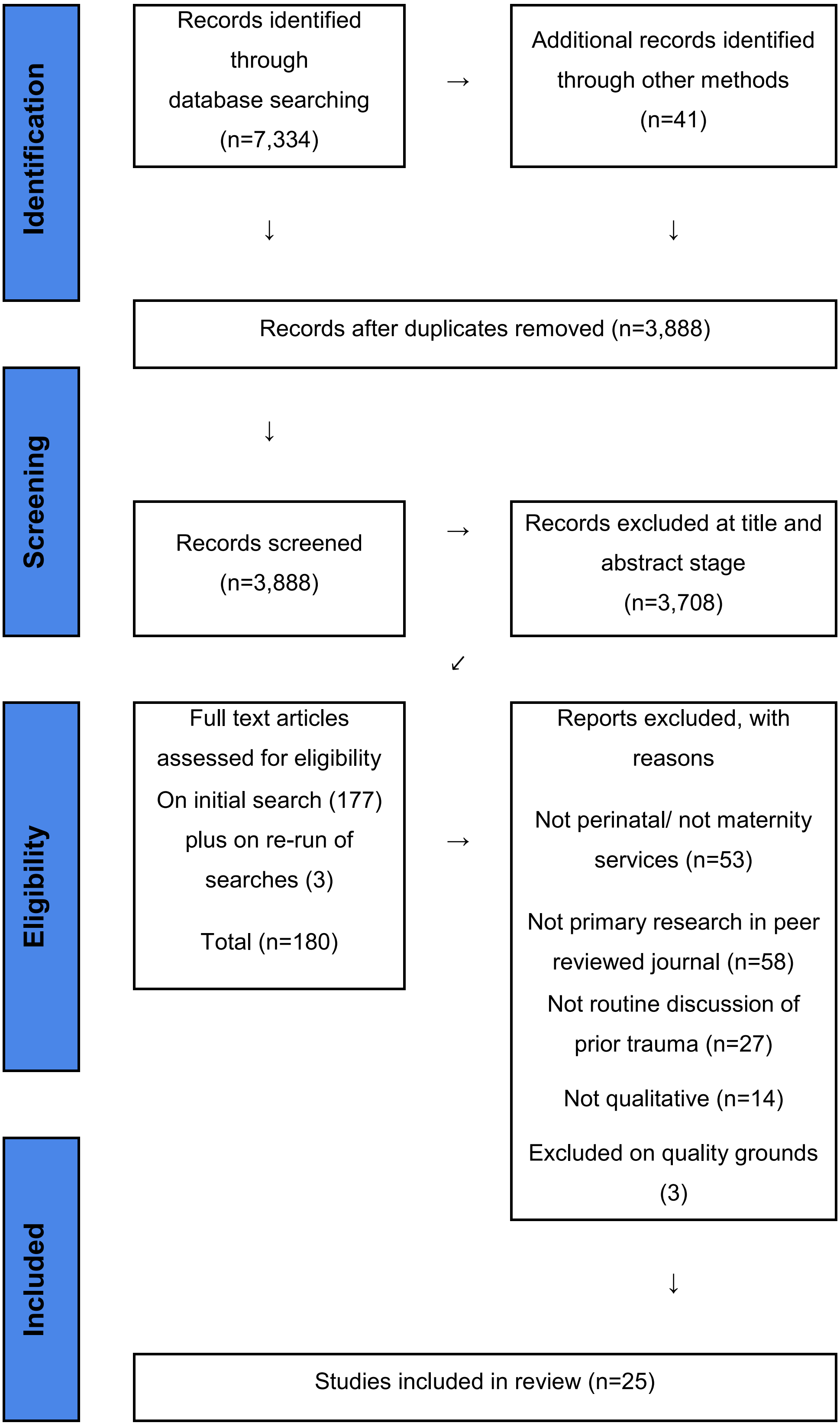
The GRADE 'Confidence in the Evidence from Reviews of Qualitative research' (GRADE-CERQual) approach was used to assess confidence in the synthesised findings (Lewin et al., 2018a; Lewin et al., 2018b; Munthe-Kaas et al., 2018; Colvin et al., 2018; Glenton et al., 2018; Noyes et al., 2018b). This approach facilitates a clear and transparent assessment of whether the findings from a qualitative synthesis accurately represent the phenomenon under investigation. Each summary of findings (descriptive theme) was evaluated in terms of methodological limitations, coherence, adequacy of data, and relevance. These assessments collectively contributed to an overall assessment of confidence in each finding. GRADE-CERQual was applied to descriptive themes because it was felt that this would yield more useful information than assessing confidence of the broader analytical themes. The summaries of findings and associated CERQual assessment of confidence were presented in an Evidence Profile and Summary of Qualitative Findings table (shown in the next section). The table was discussed and agreed between myself and GT.

3.4 Results of the search

Searches were conducted in July 2021. Results for each database can be found in appendix 2. Overall, 7,334 papers were identified from database searches, with a further 41 studies identified from backward and forward chaining and key author searches. Of the identified papers, 3,888 remained after removal of duplicates. After screening by title and abstract, full-text screening was carried out on 177 papers. Following quality appraisal, 24 papers met the criteria for inclusion in the review. The searches were repeated in April 2022 to identify any further papers that had been published; this resulted in three further papers for full text screening, of which one met inclusion criteria for the study (Preis et al., 2022). Of the papers, 71 were published in languages other than English, all of which were excluded at title /

abstract screening stage due to not meeting eligibility criteria. The PRISMA flow chart can be found at Figure 3.1.

Figure 3.1 PRISMA flow chart



Three papers were excluded due to quality (Matthey et al., 2005, Rollans et al., 2013a, and Rollans et al., 2016). Matthey et al. (2005) was a mixed methods study with limited methodological information detailed for the qualitative aspect. Rollans et al. (2013a) and Rollans et al. (2016) were part of a larger study, one paper of which was included in the review (Rollans et al., 2013b). These two papers gave limited methodological information, particularly with regards to analysis. Post hoc examination of the three excluded papers indicated that their inclusion in the review would not have altered the final themes. Rollans (2016) focused on the presence of partners in psychosocial assessment. Inclusion of this paper would have strengthened the GRADE-CERQual assessment of confidence in the finding 'partner presence is a barrier to trauma discussion'.

3.4.1 Description of the studies

The characteristics and quality of the 25 studies included in the review are summarised in Table 3.2. The included studies were published between 2001 and 2022[2]. In terms of study setting, 12 of the studies were carried out in Australia, nine in the United States, two in Sweden, and one each in England and Canada. Routine trauma discussion was explored from the perspective of women in thirteen of the papers, eight looked at the perspective of healthcare professionals, and the remaining four papers looked at both viewpoints. Most data were collected by individual interviews, focus groups and/or surveys. The studies represented the views of 1602 women and 286 healthcare professionals and experts from the voluntary sector.

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[2] The publication of the first relevant study in 2001 demonstrates the novelty of this area of knowledge.

Table 3.2 Characteristics of included studies

Study no.	Authors	Year	Country	Study design	Participants (number / type)	CASP Quality assessment rating	Focus of paper
1	Carlin, Atkinson and Marley	2019	Australia	Yarning - conversational process involving telling of stories and development of knowledge	15 Aboriginal women	Strong	Women's perspectives
2	Carlin et al.	2020	Australia	Health professionals - online survey or semi-structured interview. Aboriginal women - in depth interviews	18 health professionals 10 Aboriginal women	Strong	Women and care provider perspectives
3	Chamberlain et al.	2020	Australia	Stakeholder workshop	57 key stakeholders, with extensive experience working with Aboriginal families.	Strong	Women and care provider perspectives
4	Choi and Seng	2014	United States	Semi-structured telephone interviews	20 perinatal care providers	Strong	Care provider perspectives
5	Flanagan et al.	2018	United States	Childbearing women - ACE questionnaire plus telephone interview. Care providers - surveys and focus groups	210 childbearing women; 26 care providers	Adequate	Women and care provider perspectives
6	Gokhale et al.	2020	United States	Semi-structured interviews and completion of trauma history questionnaire	30 pregnant women	Strong	Women's perspectives
7	Kohlhoff et al.	2021	Australia	Focus groups and semi-structured interviews	Nine midwives, two obstetricians, and one nephrologist	Adequate	Care provider perspectives
8	Marley et al.	2017	Australia	Childbearing women - questionnaire. Care providers - questionnaire and follow-up interview	81 women; 9 study personnel	Adequate	Women and care provider perspectives

Study no.	Authors	Year	Country	Study design	Participants (number / type)	CASP Quality assessment rating	Focus of paper
9	Mendel, Sperlich, and Fava	2021	America	Semi structured interviews	99 first time mothers	Adequate	Women's perspectives
10	Millar et al.	2021	Canada	Questionnaire consisting of ACE-10 plus open- and closed-ended questions; semi-structured interviews	Questionnaire - 29 adolescent mothers Follow- up interview – 5 mothers	Strong	Women's perspectives
11	Mollart, Newing and Foureur	2009	Australia	Focus group interviews	18 midwives from 2 study sites	Strong	Care provider perspectives
12	Montgomery, Seng and Chang	2021	England	Focus groups, interviews, and an online survey	2 focus groups, 2 interviews, 29 responses to online survey	Strong	Women's perspectives
13	Mule et al.	2021	Australia	Open-ended question giving reason for non-disclosure of trauma history	161 childbearing women	Adequate	Women's perspectives
14	Olsen, Galloway and Guthman	2021	United States	Online survey with quantitative and open-ended questions	154 women	Strong	Women's perspectives
15	Reilly et al.	2020	Australia	Semi-structured interviews	3 midwives, 3 obstetricians, 2 managers, 1 mental health worker	Strong	Care provider perspectives
16	Rollans et al.	2013b	Australia	Qualitative ethnographic study – observation of antenatal and postnatal appointments plus face-to-face interviews.	34 observed antenatally; 20 of the same women who were observed during postnatal visit; 31 antenatal interviews, 29 postnatal interviews	Strong	Women's perspectives
17	Schmied et al.	2020	Australia	Survey before introduction of new psychosocial assessment, second survey following implementation; focus groups	First survey - 26 midwives, second survey - 27 midwives (9 midwives completed both). Focus groups - 16 midwives	Strong	Care provider perspectives
18	Seng et al.	2002	United States	Narrative interviews	15 childbearing women	Strong	Women's perspectives

Study no.	Authors	Year	Country	Study design	Participants (number / type)	CASP Quality assessment rating	Focus of paper
19	Sobel et al.	2018	America	Semi-structured interviews	20 women with history of sexual trauma; 10 without	Adequate	Women's perspectives
20	Stenson et al.	2001	Sweden	Open-ended written / telephone question about abuse screening in pregnancy	879 women	Adequate	Women's perspectives
21	Stenson, Sidenvall and Heimer	2005	Sweden	Focus groups	21 midwives in 5 focus groups	Adequate	Care provider perspectives
22	White, Danis and Gillece	2015	United States	Focus group	6 women	Strong	Women's perspectives
23	Willey et al.	2020a	Australia	Focus groups and semi-structured interviews	22 women who were refugees, 5 women who were migrants	Strong	Women's perspectives
24	Willey et al.	2020b	Australia	Focus group and semi-structured interviews	24 healthcare professionals	Strong	Care provider’s perspectives
25	Preis et al.	2022	United States	Focus groups and semi-structured interviews	22 healthcare professionals	Adequate	Care provider’s perspectives

3.4.2 Assessment of methodological strengths and limitations

Of the 25 included papers, sixteen were assessed as methodologically strong and nine as adequate. A lack of reflexivity was noted across most of the studies. Other common methodological weaknesses included insufficient information about data analysis, the lack of a clear statement of findings, and minimal discussion of ethical issues. The assessment of methodological strengths and limitations for each paper can be found at appendix 3.

3.4.3 Confidence in the review findings

Table 3.3 shows the summary of findings (descriptive themes) and CERQual rating for each summary of finding. The full CERQual assessments can be found at appendix 4. Confidence in most of the review findings was moderate or high, reflecting the quality and quantity of the studies included in the review. Each summary of finding was mapped to an analytical theme and these themes are discussed in the next section. All studies that met the inclusion criteria were from high-income countries. Because these findings were applicable to the UK, I did not downgrade the CERQual ratings for income status of the countries. However, the findings are not applicable to low- and middle- income countries.

Table 3.3 Summary of Findings (descriptive themes) and CERQual ratings

Summary of findings (descriptive theme)	**Relevant studies (study numbers as per Table 3.1)**	**CERQual assessment of confidence in the evidence**	**Analytical theme**
Women feel positively about routine trauma discussion	14 studies (1,2,6,8,10,12,13,14,16,18,19,20,22,24)	Low	*'I did not know how to say it, and no-one asked me'*: should maternity care providers ask women about previous trauma?
Some women find routine trauma discussion invasive and unexpected	8 studies (2,6,13,14,16, 20)	High	
Maternity care providers feel routine trauma discussion is valuable	11 studies (2,3,4,5,7,8,15,17,21,23,25)	Moderate	
Support for routine trauma discussion is contingent on adequate time and resources	16 studies (2,3,4,5,7,8,14,15,16,17,19,20,21,22,23,24)	High	
Women favour a broad, conversational approach to discussing trauma	5 studies (1,2,9,12,13)	Very low	*'A real Whitefella way to start'*: standardisation and tick-boxes in trauma discussion
Women who have suffered trauma want relationship-based care	6 studies (1,6,10,12,14,18)	Moderate	
Choice and control is important to women	6 studies (1,10,12,14,18,19)	High	
Women want further therapeutic support	7 studies (1,3,6,10,14,22,24)	Moderate	
Women fear judgement if they disclose their histories	12 studies (1,2,3,12,13,14,17, 18,19,20,22,24)	High	*'You say it is confidential… but you are going to report me'*: the importance of trust
Relationships are a critical prerequisite to trauma disclosure	13 studies (1,2,3,6,10,12,13,14,16,18,20,21,24)	High	
The manner of the person asking and the environment are also important	12 studies (1,2,3,6,8,13,14,16, 18,19,22,24)	High	
If not handled sensitively, trauma discussion could affect future health care access and experiences	3 studies (12,14,16)	Low	
Some women will choose not to disclose previous trauma	13 studies (2,3,4,6,10,12,13,14,16,17,18,19,24)	High	
Some women feel their previous experiences are irrelevant to their current pregnancy	7 studies (3,6,12,13,16,18,20)	Moderate	*'I'm not quite sure what is going on, but I feel really vulnerable'*: the intensity of the perinatal period
The perinatal period can be intense and challenging	10 studies (1,2,4,10,12,14,18, 19,20,24)	High	
Not all women were fully aware of the extent or impact of the trauma they had suffered	10 studies (1,2,3,4,6,12,13,14, 18,22)	High	

Summary of findings (descriptive theme)	**Relevant studies (study numbers as per Table 3.1)**	**CERQual assessment of confidence in the evidence**	**Analytical theme**
The perinatal period carries potential for healing and growth	7 studies (1,4,6,8,12,18,19)	Moderate	
Embedding trauma discussion in routine practice is challenging	7 studies (4,5,7,15,17,21,23)	Moderate	Challenges to embedding trauma discussion in routine practice
Partner presence can be a barrier to trauma discussion	2 studies (7,21)	Very low	
Women with limited English face additional challenges in discussing trauma	3 studies (16,23,24)	Low	
Hearing trauma disclosures can be distressing for maternity care providers	5 studies (4,7,8,11,21)	Low	*'You go home and it's playing on your mind as you're cooking'*: the impact on care providers of hearing trauma disclosures

3.5 Review findings

Six analytical themes were identified relating to women's and maternity care providers' views and experiences of routine trauma discussion. The first theme *'I did not know how to say it*, *and no-one asked me'* considers whether maternity care providers should ask women about previous trauma. *'A real Whitefella way to start'* explores standardised compared to more unstructured ways of asking about trauma. In the theme *'You say it is confidential… but you are going to report me'*, fear of judgement as a barrier to disclosure, and the importance of trust and relationships in trauma discussions is highlighted. The theme *'I'm not quite sure what is going on*, *but I feel really vulnerable'* calls attention to the intensity of the perinatal period, which is often challenging but also has the potential for healing and growth. '*Embedding trauma in routine practice'* explores barriers and facilitators to successful implementation. Finally, *'You go home and it's playing on your mind as you're cooking'* considers the impact on care providers of hearing trauma disclosures.

3.5.1 *'I did not know how to say it, and no-one asked me'*: should maternity care providers ask women about previous trauma?

This theme explores whether women and maternity care providers feel that routine trauma discussion should take place. Participants in 14 studies expressed that they felt routine trauma discussion is acceptable and worthwhile (Carlin, Atkinson & Marley, 2019; Carlin et al., 2020; Gokhale et al., 2020; Marley et al., 2017; Millar et al. 2021; Montgomery, Seng & Chang, 2021; Mule et al., 2021; Olsen, Galloway & Guthman, 2021; Rollans et al., 2013b; Seng et al., 2002; Sobel et al., 2018; Stenson et al., 2001; White, Danis & Gillece, 2016; Willey et al., 2020a). One of the participants in the study undertaken by Montgomery, Seng & Chang (2021) proposed:

'It might have just put a thought in my head, even if it wasn't something that I shared with anybody, it might have just put a thought in my head which might have been useful at some point' (p.9).

Some women felt it was difficult to broach the subject of previous trauma and would not have disclosed unless the clinician raised the issue:

'At the time, I could not and did not tell the healthcare professionals of my survivor status. I did not know how to say it, and no one asked me' (Montgomery, Seng & Chang, 2021, p.9).

The overall finding that women accepted routine trauma discussion masks several complexities and contradictions. In eight studies, women reported feeling unprepared for the discussion and found it intrusive (Carlin et al., 2020; Gokhale et al., 2020; Millar et al. 2021; Montgomery, Seng & Chang, 2021; Mule et al., 2021; Olsen, Galloway & Guthman, 2021; Rollans et al., 2013b; Stenson et al., 2001). This was reflected by a woman who was interviewed in the study by Millar et al. (2021):

'Like it doesn't feel good when you first meet someone, and they just start like trying to jump into your life. Like they know you. I hate that' (p.543).

Some participants spoke of how they would have welcomed forewarning of the discussion:

'I think they could have told me what they were going to ask before I even arrived for my appointment. I had no idea that was what was coming' (Rollans et al., 2013b, p.7).

In 11 studies, professionals reported that they felt routine trauma discussion was worthwhile (Carlin et al., 2020; Marley et al., 2017; Chamberlain et al., 2020; Choi and Seng, 2014; Flanagan et al., 2018; Kohlhoff et al., 2021; Preis et al., 2022; Reilly et al., 2020; Schmied et al., 2020; Stenson, Sidenvall & Heimer, 2005; Willey et al., 2020b). A clinician taking part in the study by Flanagan et al. (2018) reflected that while '*most of the time (the) screen is negative*', when finding the individual who had faced previous trauma, '*you're so glad you did'* (p.908). Participants in the study by Kohlkoff et al. (2021) felt there were three key benefits of routine trauma discussion: identify women at higher risk of mental health problems or family violence, increase referrals to appropriate support services, and provide support and education.

However, in seven studies, women felt that trauma discussions should only take place if care providers had enough time to respond to disclosures and could provide or refer into appropriate support (Carlin et al., 2020; Olsen, Galloway & Guthman, 2021; Rollans et al., 2013b; Sobel et al., 2018; Stenson et al., 2001; White, Danis & Gillece, 2016; Willey et al., 2020a). Having disclosed prior trauma, some women expected that they would be treated more sensitively and that other care providers would be aware of their history, and were aggravated when this wasn't the case (Rollans et al., 2013b; Sobel et al., 2018):

'Why don't they take the extra time just to read over [my file] and if they have any more questions about it then they can ask. If it's already there then why bother… it is really frustrating' (Rollans et al., 2013b, p.8).

Maternity care providers similarly spoke of their support for routine trauma discussion as contingent on having sufficient time and appropriate referral pathways (Carlin et al., 2020; Marley et al., 2017; Chamberlain et al., 2020; Choi and Seng, 2014; Flanagan et al., 2018; Kohlhoff et al., 2021; Reilly et al., 2020; Schmied et al., 2020; Stenson, Sidenvall & Heimer, 2005; Willey et al., 2020b). Without good quality support services, care providers were reluctant to discuss prior trauma, fearing this would open a ‘Pandora’s box’ of issues they were unable to deal with:

‘We see perinatal depression and anxiety but this is a continuum of social disadvantage and intergenerational trauma. We have super complicated patients with so many problems. Where do we fit mental health in where there are so few resources to respond properly?’ (Carlin et al., 2020, p.6).

3.5.2 *‘A real Whitefella way to start’:* standardisation and tick-boxes in trauma discussion

This theme explores how maternity care providers should raise the issue of previous trauma. Participants in several studies discussed limitations in the use of questionnaires to raise the issue of previous trauma (Carlin, Atkinson & Marley, 2019; Carlin et al., 2020; Mule et al., 2021; Chamberlain et al., 2020; Mendel, Sperlich & Fava, 2021). Participants suggested that closed questions (for example ‘in the last year, have you experienced…’) can prevent disclosures (Carlin, Atkinson & Marley, 2019; Mule et al., 2021). This Aboriginal participant in a study by Carlin, Atkinson & Marley (2019) proposed:

‘You talk about things because they are important to talk about not cause they happened one week ago! It is a real Whitefella way to start. It’s like you’re in or you’re out. You see that hey? Like what happens if it was a bit longer, then the lady might think ‘oh no, it’s not important, I won’t talk about that’ (p.7).

Mendel, Sperlich & Fava (2021) investigated the use of the ACE questionnaire (ACE-10) within maternity research. The researchers found that the questionnaire contains confusing and ambiguous questions, excludes important traumatic events in childhood (such as the death of a parent) and fails to ascertain the severity or duration of the traumatic experience. For example, one participant in the study had an ACE score of one out of ten but had suffered extensive abuse over 12 years of her childhood, resulting in seven miscarriages. The authors concluded that completion of the questionnaire might not give a true representation of the extent of trauma the woman has suffered.

Women who took part in the study by Carlin et al. (2020) felt that direct questions could cause women to disengage, and that broad, gentle questions were the best approach to ask about difficult experiences. The voluntary sector experts and healthcare professionals who participated in the study by Chamberlain et al. (2020) noted that direct questions about trauma can be problematic, because avoiding thinking about trauma experiences can be a way of coping. Instead, indirect methods of gentle communication were preferred, asked by:

*'Someone trusted - this sort of information will naturally become evident so the trusted person can gently empathise and draw attention to, as opposed to ask directly and abruptly' (*Chamberlain et al., 2020, p.9).

Another participant noted that clinicians should ask,

'Slowly, gently, and only where there is the possibility of being able to 'hold a space' and deal appropriately with the answer' (Chamberlain et al., 2020, p.10).

Carlin et al. (2020) explored clinicians' views of a questionnaire-based approach versus questionnaire plus narrative. Several participants reported that they only used the questionnaire, describing the narrative section as 'aspirational' due to time constraints and concerns that it positioned them as a counsellor. However, those who did use the narrative approach felt it enhanced rapport with women and that women understood the limits around the assistance they could provide:

'Generally I think women are keen to share some of their problems with us as nurses even though we cannot solve these issues as such but we can listen, we can advise them where to seek help and how we can assist as a support for some of their problems' (Carlin et al. 2020, p.7).

3.5.3 *'You say it is confidential… but you are going to report me'*: the importance of trust

This theme concerns the importance of trust and relationships to women who have suffered trauma. In twelve studies, fear of judgement was reported as a reason for non-disclosure (Carlin, Atkinson & Marley, 2019; Carlin et al., 2020; Montgomery, Seng & Chang, 2021; Mule et al., 2021; Olsen, Galloway & Guthman, 2021; Seng et al., 2002; Sobel et al., 2018; Stenson et al., 2001; White, Danis & Gillece, 2016;

Willey et al., 2020a; Chamberlain et al., 2020; Schmied et al., 2020). This included a general fear of being perceived as a bad parent, and specific concerns that their child would be removed from their care:

'You guys are bound by law [to report certain things]… You say it is confidential… but you are going to report me' (White, Danis & Gillece, 2016, p. 426).

Concerns about confidentiality were raised by participants in several studies, as was the misconception that the abused becomes the abuser. One mother stated:

'Speaking from personal experience, I felt at times that my past trauma was being used to assess the likelihood I would harm my own child, rather than as a means of identifying what support I might need as an individual' (Olsen, Galloway & Guthman, 2021, p.7).

Participants in 13 studies highlighted the importance of a trusting relationship, built through multiple encounters, as a prerequisite for trauma disclosure (Carlin, Atkinson & Marley, 2019; Carlin et al., 2020; Chamberlain et al. 2021; Gokhale et al., 2020; Millar et al. 2021; Montgomery, Seng & Chang, 2021; Mule et al., 2021; Olsen, Galloway & Guthman, 2021; Rollans et al., 2013b; Seng et al., 2002; Stenson et al., 2001; Stenson, Sidenvall & Heimer, 2005; Willey et al., 2020b). A mother from the study by Millar et al. undertaken in 2021 suggested:

'I think if I had a relationship, then yes [I would disclose trauma history]. But with the amount of time I was seeing them, no. 'Cause I was always seeing someone different' (p.542).

Participants in five studies proposed that trauma should not be discussed at the first appointment, but at a later appointment, enabling a relationship to be built first (Millar et al. 2021; Olsen, Galloway & Guthman, 2021; Stenson et al., 2001; Chamberlain et al., 2020; Stenson, Sidenvall & Heimer, 2005). This woman chose to disclose later in pregnancy:

'When she gave me the initial, you know, the history form… when I saw 'were you abused?' I said no. There was no way I was going to tell her' (Seng et al., 2002, p.366).

Although maternity care providers agreed that women were more likely to disclose prior trauma after a relationship with the care provider had been established, some felt it was appropriate to raise trauma at the first consultation, seeing this as the start of an ongoing conversation:

> *'If… they're not opening up… they'll go home and think about it and reflect on that and they may come back the next time and open up a bit more. It's just opening the door, isn't it?'* Schmied et al., 2020, p.8).

In twelve studies, participants described the importance of how the care provider asked about previous trauma (Carlin, Atkinson & Marley, 2019; Carlin et al., 2020; Gokhale et al., 2020; Marley et al., 2017; Mule et al., 2021; Olsen, Galloway & Guthman, 2021; Rollans et al., 2013b; Seng et al., 2002; Sobel et al., 2018; White, Danis & Gillece, 2016; Willey et al., 2020a; Chamberlain et al., 2020). Desired attributes consistently included kindness, friendliness, sensitivity, a non-judgemental attitude, respect, care, and compassion. One woman who took part in the study carried out by Sobel et al. (2018) expressed that *'I opened up to my midwife because I felt comfortable with her. That's it'* (p.1464). Conversely, a participant in the study by Seng et al. (2002) felt the need to change care provider, explaining:

> *'The doctor was kind of cold, not personable at all, and those feelings [emotional memory of being abused, shame, vulnerability, nakedness] would come back to me in his office, and I found myself crying at every visit'* (p.367).

For women with limited English, non-verbal signals like smiling and a relaxed manner were vital in inspiring trust:

> *'She make me like not scared because she smile a lot, her smiling and the way she spoke was really helpful'* (Rollans et al. 2013b, p.10).

Participants proposed that trauma discussions should be held in private, comfortable and welcoming surroundings (Gokhale et al., 2020; Olsen, Galloway & Guthman, 2021; White, Danis & Gillece, 2016; Chamberlain et al., 2020). The ideal combination of a trusted care provider and warm environment is summed up by a woman who took part in Gokhale et al.'s study (2020):

'The only way my health care providers can help me with my trauma is every time I come, make me feel like I'm at home. Make me feel comfortable. Make me feel safe and make me feel like I have nothing to worry about' (p.228).

Participants in three studies felt that if the conversation was handled badly, routine trauma discussion could impact upon future health care access and experiences (Montgomery, Seng & Chang, 2021; Olsen, Galloway & Guthman, 2021; Rollans et al., 2013b). One respondent to the survey carried out by Olsen, Galloway & Guthman (2021) proposed:

'If it isn't asked about in a sensitive way under the right circumstances, it could feel really intrusive or could be so upsetting or off-putting that someone could avoid needed health care entirely' (p.7).

Participants in thirteen studies reported that they would not disclose previous trauma to the healthcare professional looking after them, although not all studies explored the reasons for this (Carlin et al., 2020; Gokhale et al., 2020; Millar et al. 2021; Montgomery, Seng & Chang, 2021; Mule et al., 2021; Olsen, Galloway & Guthman, 2021; Rollans et al., 2013b; Seng et al., 2002; Sobel et al., 2018; Willey et al., 2020a; Chamberlain et al., 2020; Choi and Seng, 2014; Schmied et al., 2020). Mule et al. (2021) carried out a survey asking women whether they had chosen to fully disclose their histories during antenatal psychosocial assessment: 161 women responded that they had not and completed an open-ended question giving their reasons. The researchers found there were a range of reasons, including lack of trust of the person asking, fear of judgement, use of closed-ended questions and lack of time, but also simply privacy: they did not want to share this information. Similarly, a participant in the study by Olsen, Galloway & Guthman (2021) proposed that *'some people may not be ready'* (p.7) while a woman taking part in the study by Gokhale et al. (2020) suggested:

'It's not easy speaking up about situations like that and a lot of people don't because they don't feel comfortable or they don't feel like they could trust people enough to do that' (p.228).

This implies that even within a trusting relationship, some women who would benefit from support will choose not to share their histories. Accordingly, participants in the study by Seng et al. (2002) proposed that care providers should assume women are trauma survivors if they display signs or symptoms of trauma, irrespective of whether they have disclosed.

3.5.4 *'I'm not quite sure what is going on, but I feel really vulnerable'*: the intensity of the perinatal period

This theme explores experiences of the perinatal period for women who have suffered trauma. In seven of the studies, some participants reported feeling that there was no connection between their trauma histories and their current well-being and pregnancy (Gokhale et al., 2020; Montgomery, Seng & Chang, 2021; Mule et al., 2021; Rollans et al., 2013b; Seng et al., 2002; Stenson et al., 2001; Chamberlain et al., 2020):

'It's not really affecting me now… my main concern is getting through the pregnancy, not worrying about my past stuff' (Rollans et al., 2013b, p.8).

Some women wanted to focus on the pregnancy and a positive future and felt discussion of trauma could trigger distressing feelings. This was the case even when the perinatal period could be expected to bring up strong emotions, such as for this woman whose infant had been murdered:

'Cause when you come to the visit you want to hear stuff about your baby. You don't want to keep dwelling on this that happened in the past and you trying to have a happy moment' (Gokhale et al., 2020, p.227).

Some women had not foreseen that their pregnancy would be so difficult: *'it's hard to put into words because I'm not quite sure what is going on, but I feel really super vulnerable'* (Seng et al., 2002, p.363). Even women who appeared to be far along in recovery and living happy lives were often unprepared for the intensity of the perinatal period:

'I was really looking forward to the cuddling time with the baby and breastfeeding… I didn't expect this whole other ugliness' (Seng et al., 2002, p.367).

Women commonly felt a loss of control over their body, due both to the pregnancy and a sense of powerlessness within maternity care. Vaginal examinations, birth, or even seemingly benign clinical procedures such as blood pressure measurement caused flashbacks to abuse. Some women feared bodily exposure during labour and birth, with a participant in the study by Sobel et al. (2018) reporting:

'I was so concerned with being covered up… I would have been devastated [by a vaginal delivery]. I did not know how I was going to keep my clothes on and have a baby' (p.1464).

Until pregnancy, some women were not fully aware of the trauma they had suffered. Seng et al. (2002) explored this issue in detail through narrative interviews with 15 women who had suffered childhood sexual trauma and subsequently accessed maternity care. At the time of the pregnancy, four of the fifteen women had only a vague understanding that they had been subjected to abuse. Participants described indications in their thoughts and behaviour of the effects of trauma, such as fleeting flashbacks, suicidal intentions, and extreme promiscuity:

'I realized [later] there were pieces that had been floating around for a long time that I wouldn't acknowledge prior to [postpartum]' (p.363).

Because they had not fully admitted it to themselves, these women were not able to disclose the abuse to their healthcare providers:

'I knew early that I was not going to deliver vaginally. I knew in my head that I was not going there. So that piece I connected…I don't know that I drew a real direct line because of how vulnerable I felt. I wasn't probably ready to acknowledge that…So it was knowing and not knowing at the same time' (Seng et al., 2002, p.367).

Insights from participants alluded to the potential for post-traumatic growth in the perinatal period (Carlin, Atkinson & Marley, 2019; Seng et al., 2002; Sobel et al., 2018; Choi and Seng, 2014). However, this was not always an easy process, as described by this participant in the study by Seng et al. (2002):

'I kind of knew in some way it was affecting me, but I just couldn't connect the dots ever… but when I got pregnant it all just came out, came clear, and it was

hard, and I'm grateful… and I think it's going to help me grow past it and deal with it… but pregnancy is enough to deal with.' (p.367).

3.5.5 Embedding trauma discussions in routine practice

This theme investigates how trauma discussion can be introduced and explores barriers and facilitators to successful implementation. Care providers in four studies reported that they quickly adapted to routine trauma discussion, and found it feasible within their workloads (Flanagan et al., 2018; Schmied et al., 2020; Stenson, Sidenvall & Heimer, 2005; Willey et al., 2020b):

'I just think it's the initial getting used to… just even logging into it, and doing all of that was a hassle when I first started. It's 'Oh, this is all so hard.' But it's so simple now, because we're used to it… it's like anything… any tool that you use over and over again, it becomes more simple' (Willey et al., 2020b, p.e250).

Participants in seven studies discussed the challenges of ensuring all women are asked about prior trauma (Choi and Seng, 2014; Flanagan et al., 2018; Kohlhoff et al., 2021; Reilly et al., 2020; Schmied et al., 2020; Stenson, Sidenvall & Heimer, 2005; Willey et al., 2020b). Care providers taking part in studies by Choi and Seng (2014) and Stenson, Sidenvall & Heimer (2005) spoke of having preconceived notions of who might or might not have suffered trauma: '*If you have a feeling something isn't quite right*, *then it's easier*. *But just when you don't think…'* (Stenson, Sidenvall & Heimer, 2005, p.316). Participants in the study undertaken by Schmied et al. (2020) felt '*they're just not appropriate questions to ask'* (p.8) or avoided asking the question where a woman was felt to be *'keeping her distance'*. Describing a successful implementation of routine trauma discussion, this participant in Reilly et al.'s study (2020) proposed that key individuals were helpful in getting more reluctant staff on board:

'Even if you have people who are sceptical, if you are enthusiastic, and the clients get enthusiastic and really feel cared for, that automatically rolls over to the staff members that are sitting on the sidelines and saying 'I don't know if all this is necessary'… They start seeing that it is making a positive impact on people's lives…' (p.421).

Participants in the study by Stenson, Sidenvall & Heimer (2005) found it difficult to remember to raise the issue, resulting in some women not being asked about prior trauma. Documentation of abuse in hand-held notes could be a confidentiality risk, but several people taking part in the study suggested a check box in the records, to act as an aide memoire, and ensure the discussion is accorded the same importance as other issues (Stenson, Sidenvall & Heimer (2005). Participants in Kohlhoff's study (2021) proposed setting up a flag on the system to ensure effective information sharing among the maternity team.

Partner presence at appointments could influence the discussion of previous trauma (Choi and Seng, 2014; Kohlhoff et al., 2021; Preis et al., 2022; Stenson, Sidenvall & Heimer, 2005). This was felt by some participants in the study by Stenson, Sidenvall & Heimer (2005) to be a modern phenomenon, with one care provider proposing '*this generation of couples*, *the husband's there the whole time'* (p.3). Whilst a participant in Kohlhoff et al.'s study (2021) noted that '*pregnant women can be quite vulnerable and anxious*, *and it is good to have that support person with them'* (p.4), another pointed out:

'They're not going to be able to divulge anything while their partner's there, especially if their partner doesn't know about it, and sometimes that is the case' (p.4).

Trauma discussions were reported to be more difficult for women with limited English (Rollans et al., 2013b; Stenson, Sidenvall & Heimer, 2005; Willey et al., 2020b). Women often did not want to disclose sensitive issues through an interpreter, and where family members or partners were acting as interpreters, this provided a further barrier to disclosure. In the study by Stenson, Sidenvall & Heimer (2005), staff reported that partners were often asked to sit in the waiting room while this discussion took place: few partners insisted on being present, but the midwives sometimes felt in a difficult position where the woman had limited English:

'I would really prefer a professional interpreter but on most occasions the men say 'no'. They want to do the interpreting' (p.317).

3.5.6 'You go home and it's playing on your mind as you're cooking': the impact on care providers of hearing trauma disclosures

Hearing trauma disclosures could be challenging for care providers (Marley et al., 2017; Choi and Seng, 2014; Kohlhoff et al., 2021; Stenson, Sidenvall & Heimer, 2005; Mollart, Newing & Foureur, 2009). Mollart, Newing & Foureur (2009) explored this issue in detail in their Australian study in which they carried out focus groups with 18 midwives who undertook routine discussion of prior trauma. The midwife participants in the study reported that the cumulative, complex disclosures they heard affected them emotionally and impacted on their home and work life:

'You go home and it's playing on your mind as you're cooking. I don't know how long it usually goes on for, probably till you get that next bad case' (p.86).

Some participants in the study reported that they continued to think about trauma disclosures after work:

'Sometimes I've gone home and actually worried about people, then you've got to remember that they told me this today and they've been living with this for how long? Just keep telling yourself that' (p.86).

For some, this impacted on their family life:

'For me, I explode at home, I don't explode here [at work] because I know that no-one would put up with that kind of behaviour. But I do it to my kids, and that's not very good' (p.86).

Marley et al. (2017) interviewed healthcare providers about their experiences of routine trauma discussion with Aboriginal women in Western Australia. A participant in the study expressed: '*at the end of the day, it's hard not to want to neck a bottle of wine to cope with [hearing their stories]'* (p.8). The use of unhealthy coping strategies, such as excess alcohol, was echoed by a participant in Mollart, Newing & Foureur (2020):

'I can debrief 10, 20, 30 times, and the information is still with me, and I don't know where to channel that sometimes. Sometimes you channel that into things that are probably not appropriate' (p.85).

Participants in studies undertaken by Marley et al. (2017) and Mollart, Newing & Foureur (2009) felt clinical supervision is vital for midwives carrying out routine trauma discussion, and those with no access to supervision expressed resentment. However, not all care providers who were offered supervision chose to participate in it:

'The only way I know how to deal with it is I talk to colleagues… even though sometimes when you talk to colleagues, you know they're thinking about the booking-in they had, they're only half listening and you haven't actually been heard' (Mollart, Newing & Foureur, 2009, p.85).

Stenson, Sidenvall & Heimer (2005) was the only study to raise the issue of care providers who have experienced trauma themselves. The researchers carried out five focus groups with 21 midwives in Sweden to explore their views on discussing prior and current violence with women. The researchers noted that none of the participants spontaneously raised the issue. When the moderator brought it up '*several admitted that they had not considered the possibility that colleagues might have been subjected to abuse'* (p.316). The group discussed whether midwives could act professionally in this situation and concluded that they could, but it might be difficult if they are still in a violent relationship.

3.6 Gaps which the study will address

The review shows that there is a need for an acceptable and feasible intervention that enables women to remain in control of discussing their histories and accessing support, and that has clearly defined outcome measures to enable evaluation of its effectiveness. The findings also highlighted that it is critical that vulnerable populations (such as ethnic minority communities and those who are socially excluded) are involved in intervention design to ensure it is culturally acceptable and accessible to those most likely to benefit. Several gaps in the literature were highlighted, which will be addressed through the study:

- Most interventions have discussed trauma with women at their first antenatal appointment. However, given the importance of trust as a facilitator of disclosure, what is the optimum time to have this conversation?

- Both women who have suffered trauma and professionals support routine discussion of previous trauma only if there is adequate time to explore these often complex issues. Given the already busy antenatal schedule, how can sufficient time be ensured?
- Routine trauma discussions have generally used a questionnaire format to ask women about previous trauma, which the insights from this review suggest is not the most appropriate method. What format would be acceptable to women?
- There is a risk that discussing previous trauma with women could be re-traumatising for them. How can this risk be minimised?
- Are women's perceptions and experiences of routine trauma discussion and support after disclosure affected by characteristics such as class, ethnicity / race, and immigration status? How can trauma discussion be carried out so that the most vulnerable women feel comfortable to disclose if they would like to do so?
- Women with limited English face additional challenges in disclosing trauma, because they may not wish to share their histories with the interpreter or family member / friend interpreting for them. How can they best be supported?
- What training do maternity care professionals need to sensitively carry out discussions about previous trauma?
- The literature shows that it is emotionally difficult for care providers to listen to trauma disclosures. Although supervision was found to be helpful, some midwives chose not to access it. What is a helpful and acceptable model of supervision?
- No studies explored whether discussions of previous trauma might be more challenging for maternity care providers with personal experience in this area, or how they could be supported.
- Many studies found that some women will choose not to disclose, irrespective of how they are asked. How can these women be supported?

3.7 Conclusion

In this chapter, I presented the findings of a systematic review and synthesis of qualitative evidence to establish what is currently known about routine discussion of previous trauma within maternity care. The chapter provided insight into barriers and facilitators to care providers asking about previous trauma, and to women sharing their histories.

The review has identified gaps in the literature, which will be explored within the thesis and examined through the gathering of empirical data. This includes interviewing healthcare professionals, experts from the voluntary sector and women with lived experience of trauma to find out how trauma discussions should be conducted. The subsequent chapter presents the theoretical and methodological positioning of the study.

Chapter 4 Theoretical framework and methodology

4.0 Introduction

The previous chapter presented the findings of a qualitative synthesis of the views of women and maternity care providers on routine discussion of previous trauma in the perinatal period. I identified important unresolved issues, thus providing a rationale for the study.

In this chapter, I consider the foundational concepts, theories, and models which shaped my study approach. I begin by describing the study's ontological and epistemological frameworks, detailing the rationale for adopting the theoretical framework of critical social theory. I explore the philosophical underpinnings of critical social theory, focusing on intersectionality, a paradigm which is particularly relevant to the study's focus. I discuss my choice to use a CPAR methodology, outlining its key features and application within the study. I outline the creation of the Research Collective, the linchpin of CPAR, and their role in the study. Finally, I reflect on managing power dynamics within the Research Collective and analyse feedback from the group.

4.1 Ontological and epistemological framework

In this section, I explore the ontological and epistemological framework of the study, explaining my rationale for grounding the study in critical social theory and the ramifications of this decision.

Sociologist Douglas Porpora proposes that we each hold presuppositions that '*underlie and shape everything we do,'* suggesting that in order to effect radical changes in ourselves, society, and the world, we must scrutinise these beliefs (2015, p.1). Buried deep in our presuppositions, often unexamined, are our ontological and epistemological beliefs: what exists, and how do we know it exists? (Danermark, 2002). Ontologies and epistemologies also amalgamate to form research paradigms, which can be conceptualised along a continuum (Denscombe, 2021).

4.1.1 Positivism and social constructionism

On one end of the continuum is positivism, which uses a realist ontology and objectivist epistemology (Fryer, 2020). Positivists contend that there exists a singular, measurable reality that researchers can objectively observe (Robson and McCartan, 2016). Quantitative studies typically adhere to positivism, characterised by Kuhn (1996) as ‘problem solving’. Such studies have contributed valuable insights into the prevalence and impact of trauma. For instance, a systematic review by Hughes et al. in 2017 demonstrated a correlation between childhood trauma and heightened risks of mental and physical health issues. While these studies can illuminate potential effects of trauma at a population level, they offer limited insights on how to deliver optimal care to individual women.

Further, positivist research often assumes that components of health and illness can be isolated and evaluated (Alderson, 2021). Implicit in the design of the study carried out by Hughes et al. is the positivist presumption that individuals can be assigned into two distinct groups—those who have experienced traumatic events and those who have not. It further presumes that traumatic events can be neatly classified into predefined categories and that the severity of trauma can be quantified by tallying the number of ACEs. However, this perspective fails to capture the nuanced lived experiences of those who have undergone trauma (Lacey and Minnis, 2020). Furthermore, positivist research can establish causality between events, but not the mechanisms to explain how these events are linked (Fryer, 2020). Consequently, the study by Hughes et al. (2017) does little to explain how adversities in childhood affect health outcomes, which is key to developing effective interventions (Campbell, 2020).

Social constructionism, positioned at the opposite end of the continuum, uses a relativist ontology and subjectivist epistemology (Fryer, 2020). This philosophical outlook contends that reality is socially constructed: individuals interpret and attribute meaning based on their unique experiences, thus there exists no singular version of reality (Robson and McCartan, 2016). Social constructionists regard researcher objectivity as impossible, and advocate instead for researchers to reflexively consider how their involvement shapes the study (Burr, 2015). Typically aligned with qualitative methodologies, social constructionist research focuses on eliciting perspectives and experiences (Denscombe, 2021). To some extent, a social constructionist framework would be pertinent to this study, given the complex and individual nature of women's experiences with trauma, the subjective meanings they attribute to such events, and their responses, all of which are influenced by context (Finkelhor, 2018). However, Hekman (2010, p.3) points out the danger of such an approach in examining women's experiences:

> *'Feminists want to be able to be able to make statements about reality - that women are oppressed; that their social, economic, and political status is inferior to that of men; that they suffer sexual abuse at the hands of men. If everything is a linguistic construction, then these claims lose their meaning. They become only one more interpretation of an infinitely malleable reality.'*

While each woman's experience may be unique, significant commonalities likely exist in terms of the type of experience (e.g., rape), context (e.g., childhood abuse), and response (e.g., PTSD and anxiety). These shared experiences give the study meaning, as recognising similar types of experiences and responses enables consideration of the types of support that may be beneficial. Such commonalities would be overlooked if the study were grounded in social constructionism, thereby limiting its utility. Furthermore, I aim for my research to create positive changes in maternity care, necessitating an advancement from solely collecting experiences towards understand how care for women affected by trauma can be transformed.

4.1.2 Critical social theory

Critical social theory challenges traditional concepts of epistemology and ontology, arguing that both are subjective and socially constructed (Kincheloe and McLaren, 2011). Critical social theorists argue that knowledge and reality are shaped over time by social structures, including political, cultural, economic, ethnic, and gender structures (Paradis et al., 2020). Epistemological approaches in critical social theory question dominant narratives, seeking to uncover hidden assumptions and explore the subjective nature of knowledge production. Ontological perspectives within critical social theory seek to understand the underlying social structures and processes that shape individuals' lived experiences, highlighting the role of power relations, inequalities, and social hierarchies in shaping social reality (Paradis et al., 2020). Critical social theory provides a framework for understanding both the production of knowledge (epistemology) and the nature of reality (ontology) within society, offering insights into how power operates and shapes social dynamics (Illing, 2013).

Critical social theory is rooted in the pioneering work of Dr Karl Marx (Held, 1989). Marx (1818-1883) was both philosopher and activist: he declared, *‘the philosophers have only interpreted the world, in various ways; the point is to change it’* (Marx, 1845, p.3). Marx created a ‘grand narrative’; a social, political, and economic theory which reads history in terms of oppression and ensuing class struggles (Bohman, 2021). His seminal work, the Communist Manifesto, remains one of the most influential political texts of all time, sparking ongoing debate and controversies (Marx and Engels, 1848; Jones, Bradbury & Le Boutillier, 2018).

Marx contended that the underlying economic structure profoundly shapes every facet of society (Marx and Engels, 1848). He argued that the laws, politics, and culture of a society reflect the interests of the ruling class and perpetuate wealth disparities, a phenomenon known as cultural hegemony (Jones, Bradbury & Le Boutillier, 2018). He reasoned that participants in a capitalist society must first recognise its most powerful, often hidden, beliefs and values - its ideology - before they can liberate themselves from its grip (Anyon, 2011). His theories illuminate the ways in which capitalist economic relations engender alienation, powerlessness, and exploitation (Fromm, 2013). Building upon Marx's work, the Frankfurt School - a collective of leftist intellectuals affiliated with the Institute of Social Research at the University of Frankfurt - expanded Marxist economic analysis to encompass the political and social realms, pioneering the term ‘critical theory’ (Held, 1989). They sought to determine how society should be interpreted and how it can be radically transformed by blending Marxism with orthodox social science (Harrington, 2005).

Critical theories expose powerful, often concealed belief structures that significantly shape our lived experiences (Jones, Bradbury & Le Boutillier, 2018). These structures, termed ideologies, empower certain groups while oppressing others

(Held, 1989). Critical theories aim to bring to light ideologies that falsely justify oppression, thereby catalysing its ending (Bohman, 2021). Consequently, critical theories are emancipatory: as individuals recognise their oppression, they are partly liberated from it (Fromm, 2013). Critical social theorists aim to understand and ultimately address injustice at both individual and societal levels (Gough, McFadden & McDonald, 2013). As Patricia Hill Collins (2019, p3, p.4) articulates:

> *'Critical social theory sits in a sweet spot between critical analysis and social action… [it] both explains and criticises existing social inequality, with an eye toward creating possibilities for change'.*

The central question of my study - 'How can maternity services empower pregnant women affected by previous trauma to access support?' – underscores the importance of empowerment. Power dynamics and trauma are deeply interconnected: many traumatic experiences, such as childhood abuse, violence, racism, and birth trauma, involve significant power imbalances. To effectively address this research question, the theoretical framework must include an analysis of power structures and oppression, with a clear focus on social justice. Therefore, I argue that critical social theory is the most suitable framework for my study. In the following sections, I will explore the branches of critical social theory and explain my rationale for adopting an intersectional approach.

4.1.3 Branches of critical social theory

Critical social theory encompasses a vast body of conceptual work: Sloan proposes that *'the roots are in fact so deep and the branches so wide that no scholar can master all of critical theory'* (2009, p.306). Scholars have taken Karl Marx's critical theory and applied it to various power structures, such as sex and race. While Marxism focuses on class-based oppression within a capitalist system, feminism seeks to understand and address the oppression of women as a sex class within a patriarchal system, and critical race theory examines racial inequities, particularly within the legal system (Hall, 2019). Jahn (2021) argues that critical theories have made significant real-world impacts, influencing public perceptions of social issues, empowering social movements, and shaping governmental policies. He cites, for example, the pivotal role of queer studies in the repeal of the American military's

Don’t Ask, Don’t Tell policy, as well as feminist efforts that led to the recognition of rape as a war crime in the International Criminal Court (Jahn, 2021, p. 1281).

However, influential scholar-activists have highlighted the limitations of single-issue frameworks focused solely on race, gender, class, or sexuality, as they fail to account for the interplay of social constructs on power dynamics (Davis, 1982; Smith, 1998; Hill Collins, 1998; Mohanty, 2003; Matsuda, 1991). Smith (1998, p.xv) observes that *‘the ostensible dominance of one category masks both the operation of the others and the interconnections among them’*. Similarly, Hill Collins (1998, p.209) argues that race and economic class are:

> *‘Intertwined, mutually constructing, and intersecting categories… [they are] such tightly bundled constructs that one construct loses meaning without referencing the other.’*

As outlined in section 1.1, abuse and violence affect the lives of many women: such abuse is predominantly perpetrated by men (Office for National Statistics, 2021b). Feminism reframes male violence and abuse against women from an individual to a systemic issue: this change in perspective allows for the identification and exploration of misogynistic attitudes within the criminal justice system, education, and mass media (Bates 2016; Taylor, 2020). However, certain groups of women face heightened risk of abuse and violence based not only on their sex, but also from other intersecting factors such as socioeconomic class, race, immigration status, language proficiency, sexuality, and disability status, among others. For instance, socioeconomic status significantly influences the likelihood of experiencing abuse, with women earning less than £10,000 a year being three times more likely to be raped and six times more likely to suffer domestic violence than those earning over £50,000 a year (Cuthbertson, 2018, p.3). Additionally, racial disparities exist, as women from Black or Black British and Mixed ethnic groups are disproportionately more likely to experience sexual assault than other ethnic groups (Office for National Statistics, 2021b). Long et al. highlight how immigration status can compound women's vulnerability to violence:

> *‘Migrant and asylum-seeking women can be in an extremely isolated and precarious position and thus rendered particularly vulnerable to abuse. Women with*

insecure immigration status, women with no recourse to public funds, refugee and asylum-seeking women and women who are 'over-stayers' or cannot show that they are legally resident, are likely to face decreased - in some cases near impossible - access to support services, safety, and justice. The 'hostile' environment and well-founded fear of deportation or destitution can deter women with insecure status from reporting abuse' (2020, p.56).

Intersectionality offers a framework for recognising characteristics that influence how individuals are perceived and treated, shedding light on their interconnectedness and how they collectively shape advantages or disadvantages (Hankivsky, 2014). Using intersectionality allows me to overcome the limitations of single-issue critical social theories and better understand the interplay of social characteristics.

4.1.4 Intersectionality

Intersectionality integrates various critical theories, acknowledging that individuals can experience oppression or empowerment through overlapping power structures which magnify and reinforce each other, such as sex, class, race, ethnicity, sexuality, (dis)ability and weight (Romero, 2018). Intersectional critical social theory transcends singular identity categories to explore the web of influences contributing to social and health inequalities (Hankivsky and Christofferson, 2008).

Defined as *'the complex, cumulative way in which the effects of multiple forms of discrimination... combine, overlap, or intersect'* (Merriam-Webster, 2022), the term intersectionality was coined by Professor Kimberlé Crenshaw in 1989. Crenshaw's seminal work stemmed from a legal case involving five Black women at General Motors, who claimed the human resources practices at General Motors discriminated against them. They were unable to claim discrimination based on sex, because the company employed female secretaries, all of whom were White. Neither could they claim discrimination based on race, because the company employed African American mechanics, all of whom were male. There was no legal mechanism for them to claim discrimination based on being Black women, who were oppressed by an interaction of racist and sexist stereotypes (Crenshaw, 1989).

Crenshaw describes intersectionality as 'injustice squared', highlighting how characteristics like sex, race, and class intersect to compound vulnerability to oppression (2016). This perspective underscores the interconnected nature of identity and power dynamics, where individuals may face compounded forms of exclusion (Hill Collins and Bilge, 2020). Intersectionality evolves into a critical social theory when applied for social justice rather than solely explaining identities (Kelly et al., 2021).

While I adopt intersectionality to explore the complexities of routine trauma discussions, its application in research poses challenges, as noted by Hankivsky and Christofferson (2008). As a relatively new theory, there is a lack of consensus in how intersectionality should be applied and there can be a perception that it is non-viable (Rice, Harrison & Friedman, 2019). Conversely, leading intersectional social theorist Hill Collins contends that the richness and variety of intersectional projects is an asset rather than a liability (2019). Bowleg (2012, p.1270) proposes that researchers do not need to wait for a resolution to the methodological uncertainties of intersectionality to begin using it, but instead should adopt an ‘intersectionality-informed stance’. There are three key underlying theoretical principles of an intersectionality-informed stance: collaboration, social justice, and power (adapted from Hill Collins and Bilge, 2020). First, intersectional researchers should collaborate with groups most affected by injustice to gain understanding of interlocking and mutually reinforcing power dynamics (Matsuda, 1991). Second, critical social theory aims to highlight and dismantle social inequalities, so striving for social justice, or as Rice, Harrison & Friedman (2019, p.403) express it *‘a deeply held commitment to radical social transformation’* is a key goal of intersectional research. Third, intersectional projects should seek to unveil underlying power dynamics (Pihama, 1993).

I chose to use CPAR methodology because of its alignment with these core concepts of collaboration, social justice, and power. In the following sections, I define CPAR, explore its history and outline its core tenets of collaboration, social justice, and power as applied within my research.

4.2 Critical participatory action research

Critical participatory action research (CPAR) is conceptualised as ’a framework for engaging research with communities interested in documenting, challenging, and transforming conditions of social injustice’ (Fine and Torre, 2021, p.3). The ‘C’ in CPAR denotes the application of critical theories to scrutinise issues of power and injustice, while the ‘P’ symbolises the involvement of a diverse collective, including those most affected by the issues under investigation (Fine and Torre, 2021). The ‘A’ signifies the commitment to effecting tangible change in the world, and the ‘R’ underscores the imperative to conduct systematic investigation (Fine and Torre, 2021).

The origins of action research can be attributed to Kurt Lewin, a German psychologist affiliated with the Frankfurt School of Marxist intellectuals (see section 4.2.1), who introduced the term in English in a seminal 1946 paper (Lewin, 1946; Kemmis, McTaggart & Nixon, 2014). Lewin advocated for research that led to tangible changes, asserting that ‘*research that produces nothing but books will not suffice’* (1946, p.35). He proposed a cyclical process of planning, action, and reflection, collaborating closely with minority groups to address social issues (1946). The mechanics of action research, as conceptualised by Lewin, involve collaborative discussion and decision-making, action based on these discussions, review of the outcomes of the action, and then feedback into the ongoing cycle of discussion, action, and review (Zeller-Berkman, 2014). This iterative approach facilitates dynamic engagement with stakeholders, ensuring that research outcomes directly contribute to addressing social injustices (Kemmis, McTaggart & Nixon, 2015). Lewin's influence extended beyond his own contributions, significantly shaping the action research movement in North America (Zeller-Berkman, 2014).

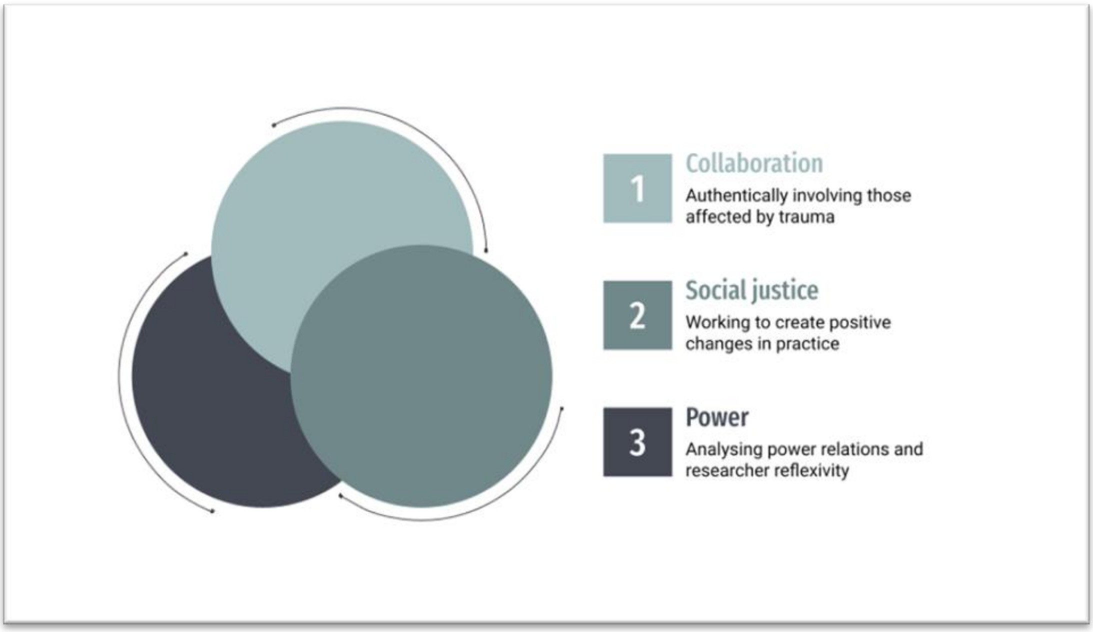
Concurrently, in Latin America, sociologist Orlando Fals-Borda championed a collaborative research movement aimed at merging 'people's knowledge' with 'scientific knowledge' to effect radical social change (Robles and Rappaport, 2018). Fals-Borda's approach integrated research with activism, aiming to achieve political change through collaboration with popular movements (Rappaport, 2020). CPAR builds upon the Lewin and Latin American lineages, incorporating critical theory with an intersectional lens to examine oppression based on gender, race, sexuality, disability, and indigeneity (Zeller-Berkman 2014, Torre et al., 2012). In 2009, contemporary PAR scholar-activists Michelle Fine and Maria Torre established the Public Science Project at the City, University of New York Graduate Center to provide a space for CPAR researchers (Zeller-Berkman, 2014). Studies undertaken at the Public Science Project are diverse, but each is focused on illuminating and ultimately transforming an area of social injustice. For example, the Morris Justice Project (Stoudt and Torre, 2014) brought together community members from South Bronx, New York with academics, activists and lawyers to document and challenge ‘stop and frisk’ policing tactics. Quantitative and qualitative data were collected using a resident survey, focus groups and interviews, and the researchers shared their findings using a range of creative techniques including film and community photo walls.

In the next section, I explore the fundamental theoretical principles of this study.

4.3 Underlying theoretical principles

In section 4.1.4, I identified collaboration, social justice, and power as underlying theoretical principles of the study, as depicted in Figure 4.1. Here, I describe how a CPAR approach aligns with these concepts and discuss their practical application within my study.

Figure 4.1 Underlying theoretical principles



1 **Collaboration**
Authentically involving those affected by trauma

2 **Social justice**
Working to create positive changes in practice

3 **Power**
Analysing power relations and researcher reflexivity

4.3.1 Collaboration

Hill Collins and Bilge (2020, p.68) assert that '*authentic understandings of social problems require the knowledge of those directly affected by them'.* CPAR studies are conducted collaboratively with those with lived experience of the issues under scrutiny, guiding decisions regarding research design, conduct, and dissemination (Fine and Torre, 2021). By working closely with those most impacted by social inequalities, CPAR studies aim *'to critically examine what is and to creatively imagine what could be'* (Fine and Torre, 2019, p.436). This approach aligns with the broader movement towards engaging service users directly in the research process, including its design, execution, and evaluation, to improve its relevance, quality, and impact (National Institute for Health Research, 2021).

The EMPATHY study has been supported by a 'Research Collective' comprising experts by experience, voluntary sector practitioners, and maternity care providers. In our first meeting, I asked the group what they would like to be named; 'Research Collective' resonated strongly among members, and they decided to keep that as their name. Detailed discussions on the involvement of the Research Collective are presented later in this chapter, and in chapters 5, 7, and 8.

4.3.2 Social justice

CPAR studies contribute to social justice by critically examining social structures to uncover their role in perpetuating inequities and by actively advocating for action to drive social change (Fine et al., 2003). Critical social theory not only seeks greater understanding but also strives for emancipation - liberation from social injustices (Kemmis, McTaggart & Nixon, 2015). Therefore, it is crucial that CPAR translates knowledge into social action, moving from critical enquiry to critical practice (Hill Collins and Bilge, 2020).

The EMPATHY study promotes social justice and equity through the adoption of an action research methodology, in which research findings have been translated into actionable policy recommendations (an evidence-based framework for trauma discussions) aimed at addressing systematic inequalities and promoting social justice within maternity care services. Furthermore, an intersectional lens has been applied to the research, as outlined in section 4.1.4, acknowledging the interconnected nature of various forms of oppression, such as race, class, and gender, and their impact on maternal health outcomes.

The study advances social justice through a participatory approach, with the Research Collective actively contributing to decision-making and the research process, including the development of a framework of guiding principles for trauma discussions. Communities affected by this research were further engaged through participation in interviews and the guideline consultation, ensuring that study outputs are culturally sensitive, acceptable, and accessible to diverse groups of women. Moreover, ethical considerations were carefully integrated to address power dynamics and ensure informed consent, as detailed in chapters 5 and 7. Finally, efforts will be made to disseminate research findings in accessible formats to a range of audiences, including policymakers, maternity care providers, community organisations, and affected communities themselves.

4.3.3 Power

Intersectionality illuminates how divisions such as race, class, and sex shape power relations that engender inequalities (Hill Collins and Bilge, 2020). CPAR is distinguished from other participatory action research approaches by its deliberate focus on questions of power and oppression. Fine and Torre (2021, p.10) propose that:

> *'CPAR signals a distinct way of thinking about who has knowledge, who holds expertise, and how new knowledge can be produced, across differences, when the perspective of those most impacted by injustice are privileged and fuelling movements for change are prioritised.'*

Acknowledging the impact of various forms of oppression, it is vital that the research includes input from a diverse range of women, including those who are typically excluded from knowledge production processes (Hankivsky, 2014). This study actively sought perspectives from women with diverse backgrounds and experiences, as well as representatives of voluntary service organisations supporting women with specific challenges. Participants included women from racial and ethnic minority groups, women who have experienced birth trauma, women seeking asylum in the UK, those affected by child removal into social care, and individuals involved with the criminal justice system. Engaging with these groups provided critical insights into how power dynamics have influenced and impacted their lives within the context of maternity care services. The challenges of mitigating power imbalances within the Research Collective are explored in section 4.4.

Self-reflexivity is also crucial in addressing power imbalances within research. Rice, Harrison & Friedman (2019, p. 415) propose that *'reflexivity disrupts power relations'* and can be transformative for both participants and researchers. Throughout this study, I maintained self-reflexivity through various practices:

- Keeping a reflexive journal to document personal biases, assumptions, and reflections on power dynamics encountered during data collection and analysis.
- Conducting a pre-understanding interview with my Director of Studies (GT) to acknowledge and examine my personal perspectives and positions of privilege.
- Engaging in regular supervisory sessions to critically reflect on power dynamics within the research process, seeking feedback and guidance.

- Seeking counselling during the latter half of the study, in which I further explored personal biases and power imbalances.

Section 5.6.3 offers reflections on how my social status may have influenced the research process and discusses the strategies I employed to address potential power imbalances.

4.4 The Research Collective

This section focuses on the pivotal role of the Research Collective in the study. I provide insights into the formation of the Research Collective and outline their contributions to the research. Additionally, I address the complexities around managing power dynamics within the group and present feedback gathered from members.

4.4.1 Creation of the Research Collective

I created a Research Collective to support the study, aiming to bring together an *'intentionally diverse… democratic space of inquiry'* (Torre, 2005, p.3). I reached out to people I knew or knew of who were working to support women who had suffered trauma: academics, healthcare professionals and representatives of voluntary sector organisations. I invited them to come along to the first Research Collective workshop, making it clear that no ongoing commitment was required. I also asked the voluntary sector organisation representatives if they could forward details of the workshop to women they had supported.

I advertised the workshop on social media with a flyer titled 'Improving maternity care for women who have had difficult experiences' which invited readers to 'Come along to this workshop and share your views on my proposed study' (appendix 5). I specified in the flyer that as the workshop was to be held online (via Microsoft Zoom), attendees had the option to join with or without their cameras activated. Additionally, I indicated that the session would not be recorded and that attendees could contribute their ideas about the project either verbally or through the chat function. Furthermore, I highlighted in bold on the flyer that participants would not be asked or expected to share their own experiences. The flyer stated that people who could not attend the workshop but were interested in finding out more could contact me separately. I spoke to everyone who expressed interest on a one-to-one basis prior to the workshop to briefly explain and seek feedback on the research topic and answer any questions.

I held the first Research Collective workshop online due to COVID restrictions. In my funding application, I included a budget to pay attendees at physical meetings £20, reimburse travel costs and provide refreshments. However, the online meeting went well and gave me the freedom to recruit Research Collective members nationally (including from Northern Ireland), rather than being restricted to locally, so I continued holding the workshops online. After the third workshop, a member emailed me to ask whether there was payment attached to being a part of the Research Collective. I had not seriously considered payment for attendance at online meetings, due to a combination of lack of consideration and feeling it would be difficult to organise.

I spoke with my Director of Studies and we arranged to reallocate the budget for in-person meetings to pay attendees at online workshops, including retrospective payment for workshop attendance. Initially some Research Collective members declined payment in shopping vouchers, but provided no reason. In later workshops I made it clear that this was included in the study budget and was funded not by me but by the funding body, and assumed people would accept the vouchers unless they told me otherwise. After a subsequent meeting, a woman who has sought asylum in the UK emailed me to say, *‘Thank you Jo for respecting and paying woman’s time its very meaningful.’*

4.4.2 Research Collective workshops

The Research Collective met six times: once before the study began, to provide feedback on the study application, and five times during the Fellowship period. The first four workshops were held online, using the platform Zoom, and lasted between 1.5 hours and 3 hours. The final workshop was held in person in London and lasted 4 hours including a shared lunch. The agenda typically included an overview of the study and the Research Collective’s role, ice-breaker activities, progress updates from the researcher, workshop objectives, and discussions on future steps. Additionally, a short break was incorporated into each session.

Each workshop included breakout sessions for smaller group discussions, and the fifth also included independent work, which was a review of the first draft of the framework of guiding principles for trauma discussions. Attendance ranged from eight to eleven members per workshop, with separate discussions arranged for those unable to attend due to scheduling conflicts. In total, 20 people were members of the Research Collective. Of the eight attendees at the first Research Collective workshop in July 2020, seven members remained involved throughout and attended the final workshop in March 2024. Each workshop included a diverse mix of experts, including those with lived experiences, representatives from voluntary organisations, and maternity care providers. GT participated in four workshops.

A summary of the main topics addressed in each workshop, along with key decisions and insights from the inaugural workshop, is provided below. Subsequent insights are elaborated upon in later sections (Chapters 5, 6, and 8). When conveying the perspectives of Research Collective members, I have endeavoured to fairly represent the views expressed, while acknowledging the diversity of viewpoints, as cautioned by Cahill (2004, p.282):

> *‘PAR recognizes and draws from situated knowledge and from lived experiences. It assumes that the subjects and agents of knowledge are multiple, heterogeneous, and contradictory. There is not an assumed consensus or a royal ‘we’ that erases differences.’*

The first workshop – July 2020

The inaugural workshop centred on the study’s broad topic and the Fellowship application. Members deliberated four key questions:

1. Identifying stakeholders for discussions on routine trauma.
2. Determining the preferred method of engagement (interviews vs. focus groups).
3. Selecting the mode of workshop delivery for future Research Collective workshops (Zoom, in-person, or a combination).
4. Naming the Research Collective.

The identified stakeholders guided the selection of expertise to be incorporated into the Research Collective and recruited as interview participants. Valuable insights were provided on the meaningful inclusion of marginalised women in the study. The decision was made to conduct individual interviews rather than focus groups, as this approach was deemed conducive to fostering open and candid dialogue. The group expressed a preference for continuing to meet on Zoom, and unanimously chose the name ‘Research Collective’. All members expressed the intent to continue their involvement in the study if the funding application was successful.

The second workshop – May 2021

Taking place shortly after the commencement of my Fellowship, this session focused on key aspects of methods for the study interviews. Building on the discussions of the first workshop, I solicited feedback on identifying the types of difficult experiences that warranted inclusion in the data collection, as well as the names of key organisations who provide support for individuals affected by such experiences. This discussion helped to provide targeted participant cohorts for the interviews. The Research Collective reviewed and refined the initial interview topic guide through structured breakout sessions and subsequent discussion. While the workshop attendees provided invaluable insights, time constraints necessitated scheduling an additional session to refine the topic guide.

The third workshop – Sept 2021

This supplementary workshop helped to improve the content, structure, and phrasing of the interview topic guide.

The fourth workshop – Oct 2022

In this workshop, the Research Collective discussed insights from the systematic review and emerging interview findings regarding training requirements of maternity care providers and optimal timings for trauma discussions.

The fifth workshop – March 2023

The workshop featured a presentation and discussion of initial interview findings. I then shared the first draft of the proposed research output: an evidence-based framework of guiding principles for routine trauma discussions. Members independently reviewed and provided feedback on the framework via Google Forms and as a group considered how the framework could be disseminated with maximum impact. Future research avenues were also discussed.

The sixth workshop – March 2024

In this workshop, the first held in person, I presented the outcomes of the guideline consultation process. During the session, the Research Collective divided into smaller groups to review and refine the framework, followed by a full group discussion to finalise amendments before publication. As this was our final workshop, I intended to ask members of the Research Collective to reflect on their involvement in the study, highlighting successes, identifying areas for improvement, and creating messages for researchers considering undertaking CPAR. Originally, the plan was to facilitate a reflective session for members to share insights and feedback in person, supplemented by an anonymous Google Form for any feedback members felt hesitant to share openly. However, due to time constraints, the reflective session was omitted, and participants were asked to complete the Google Form after the workshop instead.

In the subsequent sections, I reflect on managing power dynamics in the Research Collective and feedback received from the Research Collective.

4.4.3 Managing power dynamics in the Research Collective

Fine and Torre (2021, p.35) contend that CPAR researchers '*have an obligation to check the insidious influence of privilege, domination, and silencing within the research collective'.* Two experiences of managing power dynamics underscored these complexities.

During an icebreaker activity in the first workshop, the first person introduced themselves by job title as well as name, and subsequent Collective members did the same, creating the awkward situation that the experts by experience notably did not have a job title to share. This unintentional marginalisation of experts by experience was reflected in an email sent to me afterwards: '*I'm not a health professional, nor have I worked with women in any kind of professional supportive role, so I'm not able to help in the same capacity as many of the other brilliant women in the meeting today.'* This highlighted the need for me to establish clear guidelines for subsequent workshops. This was successful, but only to a certain extent; members continued to talk during the meetings in a way which clearly indicated their professional role or referenced their personal experiences.

The second challenge arose from the composition of breakout rooms, which in the first two workshops I divided based on professional roles versus lived experience. However, by the third workshop, most participants knew each other, and therefore I randomly split the breakout rooms, presuming everyone would feel able to contribute. A member contacted me afterwards to say she had found it difficult to contribute in the presence of healthcare professionals, particularly because she had suffered birth trauma which involved not being listened to by healthcare professionals. I implemented several measures to address this concern, including soliciting anonymous feedback after each workshop (described in the next section) and inviting more experts by experience to join the Research Collective to improve the balance with healthcare professionals and voluntary sector experts. I also reverted to splitting the breakout rooms into experts by experience and professionals / experts from the voluntary sector and asked the experts by experience to feedback to the main group first to ensure they had the opportunity to speak up. The member emailed me afterwards to say the changes helped to make her feel comfortable and more able to engage. Doing this did mean there was less opportunity for experts by experience and professionals to mix, and other experts by experience might have preferred to mix with other Collective members rather than always be in breakout room with the same people. However, as noted in the next section, members appeared to be satisfied with the workshops.

4.4.4 Feedback from the Research Collective

Following discussions with a member of the Research Collective (as detailed in section 4.4.3), anonymous feedback was collected via Google Forms after the fourth, fifth, and sixth workshops. Of the attendees, eight out of nine provided feedback for the fourth workshop, and six out of eight for the fifth workshop (excluding GT, who shared observations verbally). At the time of writing, six out of twelve Collective members have shared feedback on the final workshop. The complete feedback from the Research Collective is presented in full in Appendix 6; the following is an overview of the responses.

After the fourth and fifth workshops, participants were asked to rate several statements using a Likert scale, alongside offering free-text comments:

- The workshop had a clear purpose.
- I felt listened to and able to contribute.
- The workshop was an effective use of my time.
- As a group, we accomplished something in the workshop.

All participants in both workshops agreed the workshop had a clear purpose and they felt listened to and able to contribute. One attendee wrote '*Jo is excellent at ensuring everyone is able to speak.'* All agreed the workshop was an effective use of their time, with one noting, '*it felt like a very constructive session where all my time was effectively used.'* All agreed that the group accomplished something in the workshop, with one member commenting '*it feels like we are all working together for the same purpose.'*

I then asked a series of open-ended questions, asking members their key learnings, reflections on potential improvements to the workshop, and insights they would share with individuals considering joining the Research Collective. Responses were predominantly positive and have been categorised into four primary themes:
1. 'A very egalitarian space': Several members commented that the workshops were positive and inclusive, with one noting: *'All voices are welcomed, opinions valued and contributions considered: it's a very egalitarian space'* and another *'it's a really safe and welcoming environment.*'

2. Personal satisfaction: Members expressed personal benefits from their involvement, citing opportunities for sharing, learning, connecting with others, and being intellectually challenged. One member considered her involvement '*like a therapy for myself'.*

3. *Belief in impact:* Many members expressed confidence in the potential impact of the research on improving women's experiences in maternity care, indicating a sense of purpose and commitment to the project.

4. *Preference for face-to-face interaction*: Some Collective members felt that the first meeting would have been beneficial if it had been face-to-face (although this would have been impossible due to COVID restrictions) to build relationships. Following the fourth workshop, a suggestion was made for the final workshop to be in-person rather on Zoom, which gathered unexpected support from Collective members given the travel involved.

After the sixth workshop, participants were asked to share advice for other researchers considering a participatory approach. Participants stressed the importance of:

- Allowing sufficient time for relationship-building, as one participant highlighted, *'it's so important to have protected time to work on something as important as this […] it's worth spending the time to come together, make new relationships, build trust and listen deeply to each other.'*
- Setting clear guidelines at the outset was deemed crucial for ensuring everyone feels heard and respected. One participant recommended that researchers should be *'very clear about how the collective will work.'*
- Participants also emphasised the significance of inclusivity and creating a safe environment for engagement. Skilled facilitation was recognised as key to achieving this, with a participant commenting, *'The researcher needs to be skilled at making sure no one dominates and that everyone's voices are heard.'*
- Participants acknowledged the benefits of online meetings for accessibility but also highlighted the challenge of developing trust in virtual settings.

These insights can inform future research practices to enhance collaboration and engagement in similar projects.

4.5 Summary of theoretical framework and methodology

The study is underpinned by critical social theory. Critical social theories, which illuminate powerful and often hidden belief structures, incorporate an analysis of power structures and oppression and are orientated towards creating real world change. Critical theory has been applied to power structures such as sex, race, sexuality, and class, which has been influential in changing public perceptions of social issues. However, such single-issue frameworks fail to account for the impact of interacting social constructs such as race and sex.

Intersectionality brings critical social theories together to allow exploration of the effects of differing social characteristics on health and well-being. There are three components of intersectional research, which form the key concepts for my study: collaboration with those affected by the issue being studied; striving for social justice; and an analysis of power structures. CPAR, which prioritises participation with affected communities to deeply understand social issues with the aim of creating positive societal change, was chosen as my underpinning methodology due to its fit with an intersectional critical social theory approach.

4.6 Conclusion

In this chapter, I have discussed the key concepts, theories and models that underpin my study. I described the use of critical social theory as an ontological and epistemological framing and explained my rationale in choosing this approach. I outlined the key components of CPAR and explained how I applied this approach within the study. I then explored the creation of the Research Collective and their role in the study.

In the next chapter, I present details of methods used to conduct the study interviews, including participant recruitment, data collection methods, ethical considerations, and data analysis techniques.

Chapter 5 Interview methods

5.0 Introduction

In the preceding chapter, I outlined the theoretical and methodological foundations of the study. This included a discussion of the rationale behind adopting a CPAR methodology and its practical implementation throughout the research process.

In this chapter, a detailed account of the methods used to conduct the study interviews are given. I explain how participants were recruited, the interview process, and the subsequent analysis of interview data. Chapter 4 described how the theoretical frameworks of intersectionality and CPAR are underpinned by three underlying principles: collaboration, social justice, and empowerment. In this chapter, I explore how the study design and conduct was influenced by these principles. I describe the involvement of the Research Collective throughout and address ethical considerations, reflexivity, and the strategies employed to ensure the trustworthiness of the study.

5.1 Choosing methods, participant groups, and interview questions

This section outlines the rationale behind the empirical approach, the criteria employed for recruiting interview participants, and the development of the interview topic guide.

A qualitative approach was chosen to enable in-depth examination of various perspectives and viewpoints (Silverman, 2021). Qualitative studies aim to generate knowledge grounded in human experience, gaining nuanced insights into phenomena (Sandelowski, 2004; Leedy and Ormrod, 2015). Aligned with the principles of CPAR, as discussed in the preceding chapter, the study aims to examine issues that are relevant and meaningful to service users. In accord with the underlying theoretical principle of collaboration (see section 4.3), the Research Collective played a crucial role in shaping the study methods and interview questions, as described in section 4.4 and elaborated on below.

I asked the Research Collective who I should be talking with in order to understand how to empower pregnant women affected by trauma history to seek support. It was unanimously agreed that engaging with experts by experience, healthcare professionals, and voluntary sector organisations was imperative. Additionally, specific professions and trauma types were identified to ensure comprehensive representation. I also asked the Research Collective *how* I should talk with participants. Members of the Collective held different opinions about whether interviews or focus groups would be the most effective data collection method. While some felt that women might be more confident among peers, others noted that individuals can dominate focus groups. Further, as highlighted by others, with such a sensitive topic participants may be concerned about confidentiality and talk more freely on an individual basis (Blaxter, Hughes and Tight, 2010). Ultimately, one-to-one interviews were chosen, recognising the sensitivity of the topic and the importance of ensuring participant comfort and confidentiality.

In accordance with the guidance of Fine and Torre (2021), emphasising the pivotal role of the Research Collective in CPAR, the development of the interview guide was a collaborative effort. The Research Collective actively engaged in shaping and directing the study, providing invaluable insights into the content, sequence, and language of the questions. A pivotal debate within the Research Collective centred on the use of the term ‘trauma’ within the study. Members felt that using the word trauma can be an important part of recovery, as it allows women to both name their experience and recognise its magnitude but noted that not all women who have had difficult experiences with lasting impact recognise them as traumatic. Consequently, it was decided I should use this word judiciously, if at all, during interviews, but that the word trauma should be explicitly addressed in resources developed for women.

Within the group, there were differing viewpoints on how maternity care professionals should approach discussing trauma with women. One member, drawing from her experience with survivors of childhood sexual abuse, expressed concerns about direct questions, highlighting potential discomfort and the inability to ask a question which encompasses all distressing experiences. She suggested a more nuanced ‘prompt’ which allows women the opportunity to disclose their histories if they wished. However, two other members of the Research Collective, who primarily work with non-English speaking women, advocated for a simpler, more direct method due to language barriers and the need for clarity. To address this divergence, two decisions were made. First, participants would be asked their opinion on commonly used tools for raising the issue of previous trauma and provided with examples of conversational prompts as an alternative approach. Second, the interview guide would include a question specifically addressing trauma discussions with women with limited English proficiency, recognising language as a crucial determinant of health.

The interview guide was developed to include questions which were relevant to all participants, such *as 'When should maternity care providers inquire about difficult experiences?*' Additionally, questions tailored specifically to experts from the voluntary sector and healthcare professionals were included, such *as 'How can adequate time be allocated for these discussions?'* The Research Collective recommended the interview guide be shared with participants in advance to allow them time to reflect on the questions. The version disseminated to participants is provided in appendix 7. Appendix 8 features my annotated version of the guide, incorporating prompts to scaffold discussions during the interviews. A selection of trauma screening tools were used as prompts, including the ACE-10 questionnaire. These tools were identified while carrying out the systematic review (section 3.3.1). Ethical challenges around the use of this questionnaire are discussed in section 5.5.4.

5.2 Recruitment

In this section, I describe the strategies used to recruit interview participants, and the distinction and overlap between the Research Collective and interviewees. The recruitment process commenced after receiving ethical approval in February 2021. Ethical considerations are detailed in section 5.5.

I opted to recruit and interview healthcare professionals and voluntary sector experts before engaging with experts by experience. There were two main reasons for this approach. First, as an inexperienced interviewer, I believed that gaining practice in interviewing before tackling potentially more emotionally challenging interviews would be beneficial. Second, I felt that interviewing healthcare professionals and experts from the voluntary sector would enable me to identify potentially upsetting or sensitive topics that may arise, allowing me to prepare for navigating these effectively during subsequent interviews with experts by experience.

5.2.1 Recruiting maternity care professionals and voluntary sector practitioners

I sought to recruit maternity care professionals and personnel from voluntary sector organisations specialising in supporting women with histories of challenging experiences. My recruitment strategy aimed to ensure representation from various professions and diverse trauma experiences. The Research Collective highlighted that women with histories of child removal or involvement with the criminal justice system often have significant trauma but may be hesitant to disclose it to maternity care providers due to negative encounters with statutory services. They therefore recommended I include experts in these areas in the interview sample. Purposive sampling was considered the most suitable method, as it enabled me to ‘hone in on people or events which there are good grounds for believing will be critical for the research’. Denscombe (2021, p.79).

I began by recruiting through the clinical networks of myself and my supervisors, alongside contacts of the Research Collective. I reached out to professionals and experts working in this area to ask if they would like to be interviewed. Some participants had heard of my work through others and approached me. In one case, a participant came to an interview and brought a friend who works in the area and was interested in the topic, culminating in a spontaneous group interview. I monitored recruitment throughout to ensure diversity in professional representation and trauma types. I encountered difficulties recruiting an obstetrician or a General Practitioner, so I contacted the women’s health charity who co-fund my Fellowship (Wellbeing of Women) for support, which resulted in successful recruitment from these professional groups.

I initially considered interviewing members of the Research Collective. However, following discussions with my supervisors, I opted against this approach. This decision stemmed from the recognition that sharing personal interview findings and quotes within the Research Collective could potentially lead to distress or upset during subsequent workshops where these findings would be discussed. Additionally, this decision was in line with the study's underlying theoretical principle of equitable power distribution (refer to section 4.3). Separate engagement with the Research Collective also facilitated confirmability and credibility of the interview data. However, a healthcare professional and a voluntary sector expert were nominally in the Research Collective but were too busy to actively engage in the group. I therefore approached them to be interview participants.

5.2.2 Recruiting experts by experience

The recruitment of experts by experience was facilitated through collaboration with voluntary sector organisations dedicated to supporting women following previous trauma, including The Survivors Trust, Birth Trauma Association, Maternal Mental Health Alliance, and Pause. These organisations distributed a recruitment flyer (appendix 9) on my behalf, inviting interested women to contact me directly. This recruitment strategy sought to honour participants’ autonomy by removing the need for disclosure of personal experiences to establish eligibility, given the reasonable assumption that affiliation with these organisations implied prior trauma exposure. This approach resonated with the study’s overarching principle of empowerment, as described in section 4.3. Moreover, recruiting through these organisations meant participants had access to well-being support, reassuring me and satisfying ethical requirements (see section 5.5.1). The recruitment criteria stipulated that participants be over 18 years old and have previously accessed maternity services in the UK, with no time constraints on this.

Section 4.1.4 highlights how intersecting factors including proficiency in English can influence experiences of trauma and access to support. Despite efforts to recruit women with limited English proficiency, I was unsuccessful. I had hoped to recruit non-English speaking women through links with two organisations supporting women seeking asylum in the UK. However, one organisation failed to respond to recruitment requests, while the other was carrying out its own research and felt it would be too much of a burden for their service users to be involved in both. I informed each of the voluntary sector organisations who recruited on my behalf that I had money in the study budget to fund interpreting and translation for women who required this, but no women with limited English proficiency came forward. The implications of this for the study's underlying theoretical principle of social justice is discussed in section 8.2.2, and it is highlighted as a limitation in section 8.4.2.

5.2.3 Deciding to stop recruitment

I initially planned to interview around 15-20 healthcare professionals and voluntary sector experts, and 30 experts by experience. However, I realised after the first interview, which lasted over 90 minutes and was rich in insight, that this would result in an unmanageable amount of data. The first 23 participants covered the three types of participants I hoped to recruit: experts by experience, maternity care professionals and voluntary sector experts. Therefore, as these interviews included a range of maternity care professionals and trauma types that generated interesting data with new perspectives on trauma discussion, I decided to stop recruitment. Overall, I carried out 22 interviews (one with two participants as described in section 5.2). Of the 23 participants, 12 were maternity care professionals, six were experts from the voluntary sector and five were experts by experience.

5.3 Data collection

In this section, I discuss key aspects of data collection, including interview settings and method, engaging in reflexive dialogue with participants, and the transcription and secure storage of data.

5.3.1 Interview settings and method

Participants who lived within reasonable travelling distance from me were given the choice of an interview face-to-face at a location of their preference or remotely via Microsoft Teams. Participants from further afield were interviewed using Teams, which enabled me to recruit from across the UK. Offering both face-to-face and remote interview options and engaging with participants from diverse geographical locations ensured inclusivity and accessibility, promoting social justice within the research process in accordance with the underlying theoretical principles of the study (see section 4.3).

Interviews were conducted between March 2022 and January 2023. Of the 22 interviews, three were face-to-face: one was held in the participants' hospital office, one in a university boardroom, and one in my kitchen. All remaining interviews, including the group interview, were conducted via Microsoft Teams. I followed the Research Collective's recommendation to engage with experts by experience in advance of the interviews to establish trust. Embracing this approach, I engaged in pre-interview discussions with all participants whenever feasible, not only limited to experts by experience. This involved informal Teams discussions in which I introduced myself and my professional background, expressed my interest in the topic, and, for maternity care providers and experts from the voluntary sector, enquired about their work. As highlighted in section 5.5.1, I did not ask about personal trauma experiences during these conversations. The aim was to foster open dialogue and reduce power differentials, allowing participants to ask questions and engage on an equal footing.

While semi-structured interviews were generally conducted based on topic guides developed with the Research Collective (appendix 7), in line with the collaborative ethos of the study (section 4.3), I tailored each interview to the individual participant, by taking into account their expertise and perspectives. Rather than posing every question to all participants, I tailored discussions based on their experiences and responses, focusing on different areas of the topic guides. For instance, interviews with EV4 and EV5, who primarily work with women with limited English proficiency, centred largely on routine trauma discussions for this demographic. Similarly, during a pre-interview conversation, HP10 emphasised the importance of clinical supervision. Consequently, in our interview I focused on attaining her views on the best way to support staff conducting discussions about previous trauma.

While the semi-structured interview approach was predominantly employed, in certain instances, I adopted a more unstructured approach. For example, when interviewing a national expert in domestic abuse, who already held well-developed views on routine trauma discussion, I opted for a less structured format to allow for greater flexibility and depth in our discussion. In the initial interviews, the theme of active listening emerged prominently, with the fifth interviewee highlighting the value of ‘listening visits’ for women struggling with their mental health. Subsequent participants were therefore asked for their views on the prospect of additional ‘listening appointments’ within maternity care to address concerns related to previous trauma, mental health, or any other issues of significance. This approach aligns with the notion proposed by Hinton and Ryan (2020), who advocate for flexibility in topic guides to accommodate emerging themes and experiences.

Beginning with interviews of healthcare professionals and voluntary sector experts, as described in section 5.2, allowed me to refine my interviewing technique and anticipate potential challenges. This process familiarised me with the subject matter, increased my comfort level with interviewing, and boosted my preparedness for engaging with service users. Additionally, feedback from my Director of Studies on a subset of interviews further refined my approach to interviewing.

5.3.2 Reflective dialogue with participants

Hinton and Ryan (2020) argue that interviews are socially constructed, emphasising the influence of interactions between the researcher and interviewee. In alignment with the study’s emphasis on collaboration (section 4.3), I adopted a dialogical interviewing style, prioritising understanding and remaining receptive to the interviewee’s views while also encouraging participants to reflect critically on their perspectives. Dinkins (2005) describes this approach as ‘shared inquiry,’ in which the researcher and interviewee engage in reflective dialogue on emerging concepts. Here, I present two instances of dialogue during interviews that seemed to lead to shifts in perspectives.

Example 1: opening up critical dialogue

Near the beginning of an interview with a health visitor (interview HP4), the participant shared that she carries out routine trauma discussions at work, including questions about ACEs. She spoke about this practice positively and uncritically:

'It just opens up those conversations around trauma, to get that support in place whilst they are pregnant so that it is a really smooth transition when the baby is born'.

I asked how this is carried out, and whether she discusses trauma with all women attending the service. The participant responded that she only has these conversations with women deemed 'vulnerable' and described how women are identified as vulnerable:

'That's sort of down to us and the midwives to sort of think, right, do we think they need a more… you know to look into their social side of things'.

We carried on with the interview, and later I asked how care providers can make women comfortable to share their histories if they wish to do so. The participant responded, '*I suppose it is just being open and honest and letting them know that these are blanket questions that we ask all mums'.* I replied that I agreed that women would prefer not to be singled out; but that I wondered if perhaps they were?

She went on to speak about how previously all women were asked about ACEs at every contact and the challenges that arose from this:

'It sort of like split us really because there wasn't really any training on how you ask these questions and what do you do when these women disclose something and then you know you can't just leave, it was really, really difficult. So yes, so we don't ask everyone you are right, things have changed a little bit, we do just ask those questions on the pre-birth health assessment with those selected ladies.'

In the participant's response to the final interview question, regarding training requirements, her perspective appeared to have evolved into a more critical stance which recognised the challenges and unintended consequences of such discussions:

'I think we need training on how to ask these specific questions about trauma. We are just sort of told you need to be asking these questions but what are we asking, how are we asking, what are we going to do, you know it is not as easy as just saying have you suffered trauma, it is not as easy as that there is a lot more to it.

Do you ask them directly? Do you ask them indirectly? You know all of those things so yes. Training on how to ask those questions for sure.'

Example 2: evolving perspectives

In another instance, an obstetrician (HP12) initially held negative views regarding counselling for maternity care staff:

'I think there is possibly enough self-indulgence as there is at the moment (laughs). I mean all this bleating about doctors not getting paid enough, I am sorry you go to Morrisons and see people going to the till, emptying their purse and then putting food back, because they can't even buy provisions and we think we have got problems do we. Get real. We don't know we are bloody born…'

However, as the conversation unfolded, his perspective seemed to shift towards a deeper recognition of the emotional challenges inherent in maternity care work and the necessity of emotional support for staff members. Later in the interview, he spontaneously described a time when he became upset about a work event and started crying at a family Christmas meal:

'What we do has a big impact. But that is not negative, you know, crying is good it is not bad although it is a bit embarrassing (laughs) in front of your parents and the in-laws.'

He went on to talk about the cost of providing supervision: '*I think you are right but, I am not defeatist, but when you can't even afford bloody proper episiotomy scissors…'* and when challenged about the government's spending priorities, acknowledged that failure to provide supervision for healthcare workers was a political choice rather than an impossibility: *'it is about value isn't it. Undervalued workforce. And I mean women are marginalised in society and in healthcare. You know.'*

Not only did the participants' perspectives evolve during the interviews, but so did mine. In section 5.5.4, I describe an interview where I shared the ACE questionnaire with an expert by experience, which prompted emotional distress as she reflected on her childhood experiences. While it is understandable that a list of traumatic experiences could evoke distress in the recipient, what surprised me was the weight of responsibility I felt as the initiator of the discussion. Unlike my usual experiences of hearing distressing stories, this particular interview had a lasting impact on me. I attribute this to having instigated the discussion rather than it being a spontaneous disclosure by the participant. In a very real sense, I realised that I had caused the distress.

I was fortunate to have several advantages in managing this situation. First, I was able to remain on the call for an extended period, transitioning to lighter topics and later revisiting the issue to ensure the participant's well-being. This level of support and flexibility would not typically be feasible in a busy clinical setting such as a maternity care clinic. Additionally, I could check in with the participant afterwards and, as described in section 5.5.4, access funded counselling sessions that allowed me to process the impact of this discussion over several sessions. Unfortunately, such resources are often limited within the NHS and typically require assessment and waiting periods.

Having the time and space to explore the emotional implications of the questionnaire with the participant, rather than solely focusing on care plans and practicalities, was invaluable. Essentially, I had the luxury of time, space, and support to navigate the complexities of this emotional encounter and reflect on its impact on both myself and the participant. However, I am all too aware that maternity care providers asking about previous trauma within maternity care may experience similar upset and a sense of responsibility, without the necessary resources to support them through these challenges.

5.3.3 Transcribing and storing the data

All participants received consent forms in advance, in line with the principle of empowering participants. The consent process and form were discussed at the interview’s outset (see Appendices 10 and 12). Each consent statement was read aloud, and participants verbally confirmed their agreement to each, with their name and the date recorded. Participants who were interviewed face-to-face signed the consent form in my presence. I used a pre-prepared form to gather basic demographic data from all participants, including age category, self-described ethnic group, and self-described sex. Additionally, I requested information on job title and length of experience in the maternity care field from healthcare professionals and voluntary sector experts. For experts by experience, I requested their home postcode as a proxy for income, along with the number of children they had. The ethical considerations surrounding questions about obstetric history are explored in section 5.5.4.

Interviews conducted via Teams were video recorded with participant consent. Participants were given the option for audio recording only, but no participant chose this. In-person interviews were audio recorded using a PIN-protected, data-encrypted digital recorder. All study data were stored electronically. Hard copy data, such as consent and demographic forms from in-person interviews, were scanned, saved electronically, and then securely disposed of. Data were stored on a password-protected drive within the UCLan system and will be retained for five years from the study's conclusion.

I chose to utilise a professional transcription service to ensure accuracy and quality in the transcription process. Given the interviews' complexity, maintaining consistency and mitigating potential errors from self-transcription was paramount. Each transcript was thoroughly reviewed upon receipt to ensure accuracy and completeness. Any ambiguities or discrepancies were discussed with the transcriber. MAXQDA (a software program designed for storing and managing qualitative data sets) was employed for data analysis, facilitating focus on interpretive aspects while ensuring accessibility and manageability.

Non-verbal information, including pauses and disruptions, was included in the transcription. Interview recordings and transcripts were shared securely with the transcribing service via a secure file-sharing service. After thorough review and confirmation of completeness, the transcribing service deleted the original recordings and transcripts. Collaboration with university departments ensured compliance with GDPR and information security requirements. Personal or identifiable data were removed during transcription, with each participant assigned a unique code for labelling all documents. Consent recordings and demographic forms were stored separately from the main interview data.

5.4 Data analysis

In this section, I provide a detailed explanation of the analysis method employed, including my rationale for choosing reflexive thematic analysis. The role of the Research Collective in enriching the analysis process is explored. I illustrate how data were refined to enhance clarity and coherence, while preserving the essence of participants' perspectives.

5.4.1 Data analysis

Reflexive thematic analysis was employed to analyse the collected data. The interview topic guide was structured around thematic areas, such as the optimum timing for trauma discussions and what training is needed for maternity care providers carrying out trauma discussions, making thematic analysis a natural fit for data interpretation. Braun and Clarke (2006, p.79) define reflexive thematic analysis as '*a method for identifying, analysing and reporting patterns (themes) within data.'* Joffe (2011, p.10) notes that the ability to thematise meaning is used widely in qualitative research and '*forms the implicit basis of much other qualitative work.'* Braun and Clarke (2006) were pioneers in recognising thematic analysis as a distinct method and providing clear guidelines for its implementation.

Braun et al. (2019) consider that there are three main approaches to thematic analysis: coding reliability, codebook, and reflexive. Coding reliability and codebook approaches use standardised methods of coding, conceptualising researcher subjectivity as 'bias', and result in themes which are essentially summaries of participants' responses. Reflexive thematic analysis, conversely, calls for the researcher to draw on both explicit and implicit meaning in the data (Braun and Clarke, 2021a). In this approach, researchers play an active role in analysing and interpreting the data, generating codes rather than merely identifying them (Braun and Clarke, 2021b). Given the research question's emphasis on gaining rich and insightful perspectives from participants, a reflexive approach was deemed appropriate (Braun and Clarke, 2022). This approach allows for a nuanced exploration of participants’ views, facilitating the identification of underlying meanings and patterns within the data.

The thematic analysis followed Braun and Clarke’s six-step approach to qualitative data analysis, as depicted in Figure 5.1.

Table 5.1 Phases of thematic analysis

(Source: Braun and Clarke, 2006, p.87)

Phase	Description of the process
1. Familiarising yourself with your data	Transcribing (if necessary), reading and re-reading the data, and noting initial ideas.
2. Generating initial codes	Systematically coding interesting features across the entire dataset and collating relevant data for each code.
3. Searching for themes	Collating codes into potential themes and gathering data relevant to each theme, iteratively refining the process.
4. Reviewing themes	Checking the alignment of themes with coded extracts and the overall dataset, refining and adjusting themes as necessary.
5. Defining and naming themes	Refining theme specifics and generating clear definitions and names, often involving collaboration and discussion with the supervisory team.
6. Producing the report	Selecting compelling data extracts, finalising the analysis, and contextualising findings within the existing literature.

In the initial phase of familiarisation, each transcript was thoroughly reviewed to gain a deep understanding of the data. During the generation of initial codes, the entire dataset was systematically examined for relevant data, and tentative codes were created. This process involved multiple iterations to ensure consistency and accuracy in coding. During the third phase of searching for themes, codes were reviewed and grouped into broader patterns of meaning, with attention given to outliers. Alignment with coded extracts and the overall dataset was then assessed, and themes were refined accordingly. Braun and Clarke (2022) caution against viewing thematic analysis as a linear progression, emphasising the importance of revisiting earlier stages during this phase. It was often necessary to revisit and refine themes, which occasionally involved splitting, combining, or even discarding themes altogether to ensure the analysis captured the complexity and richness of the data. In the fifth phase, themes were described and named, with input from the supervisory team to enhance trustworthiness and mitigate personal biases. Finally, in producing the report, a thematic map was developed, and findings were contextualised within the existing literature.

5.4.3 Development of a framework of guiding principles for trauma discussions

During the analysis of interview findings, the decision was made to develop a framework of guiding principles for trauma discussions. At the outset of my PhD, I had envisaged creating a standardised national intervention or tool for raising the issue of previous trauma. However, the interviews highlighted the absence of a universally accepted approach to addressing previous trauma, indicating that a context specific approach was preferable. Additionally, the findings underscored that effective trauma discussions require a supportive surrounding environment, including confidentiality, sufficient time, and trust-building, showing the importance of focusing not only on the tool itself but also on the broader care environment. Consequently, it was decided to develop comprehensive and adaptable principles addressing all aspects of trauma discussions. This shift towards adaptable principles aligns with the study's aim to empower maternity care providers to tailor discussions to individual needs while respecting women's agency and autonomy. A more detailed exploration of the rationale for guideline development is provided in section 7.1.

5.4.4 Involvement of the Research Collective in interview data analysis

The engagement of the Research Collective played a pivotal role in enriching the analysis process, providing invaluable insights and perspectives. Their involvement in data analysis during both the fourth and fifth workshops (see section 4.4.2) enriched the depth and rigour of the analysis. The fourth workshop, held in October 2022, coincided with the completion of most interviews with maternity care providers and experts from the voluntary sector, prior to commencing interviews with experts by experience. During this workshop, an overview of emerging findings was presented, and the Research Collective provided feedback. Specifically, I sought their guidance on critical and complex aspects of the findings, such as determining appropriate training for maternity care providers regarding discussions on previous trauma and exploring the feasibility of implementing an additional appointment to discuss emotional well-being. The fifth workshop took place in March 2023, just after data collection had ended. At this workshop, the initial interview findings were shared, enabling the Research Collective to engage with the primary data and offer feedback. Members were invited to review the draft framework for routine trauma discussions, ensuring alignment with interview findings and identifying areas for refinement.

5.4.4 Polishing the transcripts

Data were refined to enhance the clarity and coherence of the analysis. I strove to preserve the essence of participants' points while eliminating extraneous detail and repetitions. This involved polishing the transcripts to ensure smooth flow without altering the intended meaning, including correcting grammar and removing filler words such as 'erm'. I used the convention … to indicate a pause, and […] to indicate a section of text which was removed from the quote for brevity. An example from the interview with HP10 illustrates this approach; the text highlighted in bold signifies the excerpt used in the 'polished' transcript.

Interviewer: '… in some trusts, they are already asking women if they suffered childhood sexual abuse. And it seems to me that a midwife who had been in that situation herself might find that conversation more difficult than someone else and might find it brings stuff up and I wondered what you thought about that, because it is really not explored in the literature'

Interviewee: 'Erm… **it makes me feel sick that we are going to put somebody in that situation.** You know and I have been there, and I continue to be there in services of erm… well we are going to do this now, well why, why are we going to do that, what are we going to do with it, what is the meaningfulness of it, and actually what about me, like what about me and like that is not what I signed up for you have just changed the rules of my job here, I don't know anything about you know I can see myself sat there thinking, well if you flipped it and said to me right [name] you are going to start asking about erm… birth, like I ask about birth experience are you are going to start talking about episiotomies or something and what grade tears people had, I would be like, right well you can't, you can't just dump that on me like I am going to need some CPD before I can't just open up those conversations, there is potential trauma there for that person which, and I don't have an understanding and competency around that. So I don't, you know you can't just dump a new topic on somebody and expect them to just run with it that's not fair. So from a professional point of view competency point of view, it is not ok like what do you actually know and understand about this topic theoretically, but also emotionally how the hell do you feel like are you alright, asking that. Is it triggering, cause **I can just see it now** like oh yes bump off sick, can't ask that question don't want to know or **somebody thinks yes**, **yes it will be alright, we will just ask this question and we will contain it, because they need to contain it maybe for themselves because they don't want to know the story that might unfold, but you can't control a client. You can't control the client going so have you experienced sexual trauma yes, well when I were 12 my dad raped me and somebody, you know whatever, you can't control that. And then you have got a traumatised staff member and then you have got a potentially doubly traumatised client, or worse case scenario they just get completely shut down and then the client never talks about that to another professional again** or they don't ask, oh no. **No. No. You can't just, no you can't.**

Here is the 'polished' transcript:

‘It makes me feel sick that we are going to put somebody in that situation […] I can just see it now […], somebody thinks yes, yes it will be alright, we will just ask this question and we will contain it, because they need to contain it maybe for themselves because they don’t want to know the story that might unfold, but you can’t control a client. You can’t control the client going so have you experienced sexual trauma yes, well when I were 12 my dad raped me and somebody, you know whatever, you can’t control that there is no control over that. And then you have got a traumatised staff member and a potentially doubly traumatised client, or worse case scenario they just get completely shut down and then the client never talks about that to another professional again […] No. No. You can’t just, no you can’t.’

5.5 Ethical considerations

The study received ethical approval from the University of Central Lancashire Health Ethics Review Panel in December 2021, reference number HEALTH 0220. As noted by Leedy and Ormrod (2015, p.120), ethical considerations in research typically revolve around protection from harm, voluntary and informed participation, right to privacy, and honesty with professional colleagues. The latter involves reporting findings transparently and crediting the work of others as appropriate, a principle upheld throughout this thesis.

In this section, I address the three remaining ethical areas: protection from harm, voluntary and informed participation, and right to privacy. Pertinent issues encountered during the study are discussed, alongside the measures implemented to mitigate associated risks. Additionally, two ethical dilemmas that emerged during the research are examined.

5.5.1 Protection from Harm

Leedy and Ormond (2015) propose that researchers should consider any harm or distress that might be caused to participants, but also potential benefits of taking part in the study.

As outlined in section 5.2, experts by experience were recruited through voluntary sector organisations specialised in supporting women who have undergone trauma.

Consequently, it was understood that these participants had suffered traumatic experiences. However, during interviews, participants were not questioned about their trauma histories or personal maternity care experiences, minimising potential distress. Recruiting through these organisations also ensured that participants had access to emotional support.

Questions related to trauma disclosures, as detailed in section 5.1, were carefully designed to minimise distress among participants. The participant information sheet (appendix 10) explicitly stated: *'If you feel that answering questions about these topics would be too distressing, we advise you not to take part. You can choose not to answer any question that you feel uncomfortable with.'* The information also included details of support services, including the organisation that informed them of the study (exclusive to experts by experience), the Samaritans, a mental health charity, a charity supporting survivors of sexual abuse, and their General Practitioner. In line with the underlying theoretical principle of power (see section 4.3), participants were reminded prior to the interview that all questions were optional, and they were free to stop the interview at any time and without giving a reason. After the interview, participants received a debrief email (appendix 11) reiterating support organisation details.

In line with the recommendations of Sweeney et al. (2022) concerning engagement with trauma survivors, I developed a distress protocol. In the event of a participant experiencing distress during the interview, my plan was to pause the session, allow time for emotional recovery, and jointly decide whether to continue. This protocol was activated in one instance during an interview with a midwife (HP11), where the participant articulated the emotional challenge of hearing trauma disclosures.

All participants received a modest financial incentive (£10 shopping voucher) for their participation. Additionally, interviewees expressed intangible benefits. Some participants found the interview process enjoyable, as indicated by comments such as: *'that has been very therapeutic'* (HP2); *'I have talked a lot and I have really enjoyed this interview'* (WLE2); and *'I have loved speaking to you, it has been* *absolutely wonderful'* (EV3). Others recognised the value of the study, with remarks such as: *'It will be magic if you can get some of this pushed into practice'* (EV3); and:

> *'I can see your passion for this, and I can see results that will benefit women, that will benefit a child because their mum was supported when she was pregnant, it has allowed that child to have a really good life'* (HP1).

One expert by experience expressed gratitude for the opportunity to contribute to the study, stating:

> *'I am really, really grateful someone is starting to do things about this, I wish I could take what someone did for me to everybody because I know what a difference it has made. I am just grateful, thanks for doing it.'* (WLE3).

5.5.2 Voluntary and informed participation

To uphold the principles of voluntary and informed participation, I employed various strategies aligned with the overarching concept of power (see section 4.4).

Recruiting through voluntary sector organisations, which disseminated a flyer on my behalf, ensured that women did not feel coerced into participation. All recruitment discussions occurred via email, further mitigating any perceived pressure. Prior to participation, all potential participants received comprehensive study documentation, including the study information sheet (appendix 10), consent form (appendix 12), and interview questions (appendix 7). This facilitated informed decision-making, enabling individuals to fully consider their involvement before committing. The information sheet outlined the study's aims, the voluntary nature of participation, procedures for withdrawal, and data storage protocols. Contact details for myself and GT were provided, allowing potential participants to seek clarification or ask questions. The post-interview debrief email (appendix 11) outlined the withdrawal process for interview data and repeated the contact details of myself and GT.

In alignment with the theoretical principle of power (section 4.3), I sought to empower participants to engage in the study with agency. Following guidance from the Research Collective (section 5.1), I provided interview questions in advance. This measure was designed to offer reassurance to participants, including both experts by experience and maternity care professionals potentially with traumatic backgrounds, that they would not be probed about their history of trauma. Additionally, receiving questions beforehand allowed participants to contemplate their responses, potentially leading to more articulate and comprehensive answers. Feedback from participants validated this approach, with one expressing: *‘Definitely. Because it gets you to think more in-depth’* (HP1), while another appreciated the opportunity to prepare: *‘I did have a look at the questions and I have written a couple of things down because I tend to go blank’* (HP4). At the outset of the interview, participants were asked to either sign a consent form (for face-to-face interviews) or provide verbal consent (for Teams interviews).

5.5.3 Right to privacy

To safeguard participant anonymity, careful efforts were made to ensure that, in reporting findings, individual responses could not be traced back to specific participants. Each interviewee was assigned a unique code number, which was used to label all documents instead of their names. These code numbers were entirely dissociated from participants' identities. Healthcare professional participants were designated as 'HP1’, ‘HP2,' and so forth, while individuals with lived experience of trauma were coded as 'WLE1’, ‘WLE2,' and experts from the voluntary sector as 'EV1’, ‘EV2,' and so on. All data were securely stored, with access restricted to authorised personnel. Certain demographic data were aggregated, and job titles were generalised to safeguard the identities of participants in unique or national roles.

In alignment with the core study principle of addressing power dynamics (section 4.3), particular attention was paid to empowering participants with lived experience of trauma and avoiding further harm. There was a concern that participants might disclose ongoing abusive relationships or past criminal activities, such as childhood sexual abuse, which had not been reported to authorities. Many survivors of abuse opt not to report such incidents to authorities, and removing this choice by reporting on their behalf could exacerbate feelings of disempowerment (Montgomery, Pope & Rogers, 2015). However, it was acknowledged that there might be instances where breaching confidentiality could be ethically justified.

Silverio et al. (2020) examined the ethical and legal considerations surrounding disclosures of childhood sexual abuse within a research context. The authors recommend that researchers adhere to participants' wishes regarding reporting such abuse to authorities. Breaching confidentiality should only be considered if there is clear evidence of current risk, and even then, researchers should first seek anonymous advice. I planned that in the event a participant disclosed criminal activity, I would discuss this with the relevant voluntary organisation and put together a co-ordinated response to report to the police, advising women accordingly. Anonymous consultation would be first be sought if necessary to determine whether the disclosed activity constituted a legal breach. The participant information sheet, disseminated to all potential interviewees, explicitly stated:

‘Confidentiality and full anonymity are assured, unless you tell us about any illegal activities or if you or anyone close to you are at risk of personal harm (in such instances, we will notify the voluntary service organisation who invited you to take part in this study for further follow-up).’

5.5.4 Ethical challenges arising during the interviews

In this section, I address ethical challenges encountered during the interview process.

Example 1: Sensitivity in demographic data collection

Initially, I asked experts by experience about the number of babies they had given birth to, inadvertently overlooking the potential emotional impact of this question for those who had experienced miscarriages, stillbirths, or child loss. During the second interview, as I shared my screen and read this question out, I began to register its potential sensitivity:

Me*: ‘I think I should I maybe change this next question, about how many babies you have given birth to. I wondered if it might be more sensitive to ask about pregnancies instead, what do you think?’*

Participant: ‘*Well it is funny, because I was looking at this question and reminded me of a question I had at the clinic, how many times you have been pregnant. It then* *goes down memory because I have given birth once and what happened to the others… I think either question can be upsetting.'*

I was grateful for the honesty and grace of this participant, and we talked together about the best way forward. We decided that asking the age of the participants youngest child would be more sensitive and I used this question in subsequent interviews.

Example 2: Reflection on inclusion of ACE questionnaire

During the first two interviews with experts by experience, I showed the ACE questionnaire (ACE-10) as an example of a tool which has been used to initiate trauma discussions in maternity care settings. However, one participant's reaction highlighted the emotional impact the questionnaire could cause, as she began to reflect on her own childhood:

Participant: *'Those are… it's hard looking at those questions. I can unfortunately answer yes to every single one of those. That's quite a, a thing you know. That is all I can say Jo sorry.'*

Later, the participant expressed: *'I know my body has reacted to seeing that form. I am fine, please don't think you have traumatised me, you haven't, it is just that the trauma is always there and it depends what can bring it to the surface.'*

This was an upsetting interview both for the participant and myself as I felt responsible for causing her painful reflections, and I explore this experience further in chapter 8. Notably, this was our second meeting, as we had run out of time in the first interview, and it may have been our familiarity which facilitated the depth of our conversation. I subsequently consulted with my supervisory team and decided to discontinue the use of the ACE questionnaire in study interviews. Instead, I would open the conversation more generally in an exploratory way, for example by asking participants *'What kind of questions should maternity care providers ask women?'* If I felt that more questions were needed to develop the participant's response, I would show the Antenatal Psychosocial Risk Questionnaire and Kimberly Mum's Mood Scale, which are less explicit than the ACE-10 (see appendix 13). After the interview I contacted the National Institute for Health Research (NIHR) to ask if I could use some of the funding for counselling to address the emotional impact of the interviews. They were willing to accommodate this, and I subsequently attended 11 counselling sessions. The NIHR also reported that in response to my request they are considering amending their Fellowship guidance notes to refer to the possibility of using funds for this purpose.

5.6 Trustworthiness

The legitimacy, or trustworthiness, of quantitative research is often assessed using the criteria of internal and external validity, reliability, and objectivity. Lincoln and Guba (1985) suggested that qualitative researchers should instead use the concepts of credibility, transferability, dependability, and confirmability. In this section, I talk about how I applied these concepts within the EMPATHY study.

5.6.1 Credibility

Credibility refers to the extent to which the findings accurately represent the participants' perspectives (Tobin and Begley, 2004). I employed various strategies to ensure that the findings were robust and reflective of the participants' experiences. I met with GT fortnightly and the wider supervisory team monthly, where we discussed the unfolding findings and talked through areas of interest and inconsistency. Additionally, engagement with the Research Collective, comprising experts in the field, offered a valuable platform for sense-checking of the data. The feedback received from the Research Collective was particularly affirming, with members expressing that the findings were rich, powerful, and resonated deeply with existing research on birth trauma and childhood sexual abuse, lending further credence to the robustness of the research outcomes.

Dissemination of the findings at international conferences, including the International Labour and Birth Research Conference and the International Confederation of Midwives Triennial Congress, provided opportunities for peer reflections. Further, presenting at smaller, more intimate settings, such as the Global Maternal and Infant Health Research webinar and the inaugural meeting of the North-West Maternity Research Network, enabled nuanced discussions with peers, allowing for deeper exploration of the research findings within professional networks. During my doctorate I developed teaching sessions on trauma-informed care for student midwives and qualified midwives undertaking an MSc in perinatal mental health. These teaching sessions helped me refine my ideas and to confirm the study findings.

This collaboration with the Research Collective, supervisors, and professional networks aligned with the underlying theoretical principle of collaboration (see section 4.3) and enhanced the credibility of the research by facilitating critical reflection and validation of findings.

5.6.2 Transferability

Transferability relates to the extent to which findings can be applied or transferred to other contexts or settings (Nowell et al., 2017). To enhance transferability, a deliberate approach was taken in participant selection, as outlined in section 5.2. This involved purposefully selecting a diverse range of participants, including maternity care providers from various professions, levels of experience, demographics, as well as voluntary sector practitioners and experts by experience representing different trauma types. This inclusive sampling strategy aimed to ensure that the findings are representative of a broader population. Moreover, the use of two data collection methods - interviews and a survey on the draft framework of guiding principles for trauma discussions (as described in Chapter 7) - facilitated a comprehensive understanding of the issue, further enhancing the transferability of the findings. Furthermore, engaging the Research Collective in reviewing the interview findings played a crucial role in confirming their applicability.

5.6.3 Dependability

Denscombe (2021) summarises dependability as whether similar findings would emerge if the research were replicated. In this study, dependability was reinforced through several approaches. A comprehensive account of research methods, including participant recruitment, data collection, and analysis, is provided in this chapter, enabling other researchers to evaluate replicability. Moreover, the maintenance of a detailed audit trail documenting key decisions and analytical processes enhances transparency.

Reflexivity, involving critical reflection of the researcher’s assumptions and biases, is integral to dependability (Nowell et al., 2017). Throughout this research, I maintained a reflexive stance to acknowledge and address potential biases. As summarised in section 4.3.3, this involved keeping a reflexive journal, conducting a pre-understandings interview with my Director of Studies, engaging in regular supervisory sessions, and seeking counselling during the latter half of the study to support self-awareness and mitigate potential biases. Feedback from my Director of Studies on a sample of interviews further aided reflexivity. The involvement of the Research Collective was instrumental in fostering my reflexive stance. By engaging the Research Collective in decisions regarding the study's framing, interview questions, participant selection, and data analysis (see section 4.4.2), the group played a crucial role in challenging my preconceived ideas and offering fresh perspectives. To optimise this process, I posed open-ended questions to the Research Collective, refraining from imposing my own ideas and instead actively listening to theirs. During workshops, I provided space for participants to engage with each other independently, including by abstaining from participating in breakout rooms. To assess the effectiveness of this approach, I solicited anonymous feedback after later Research Collective workshops, including asking whether members felt listened to and able to contribute (refer to section 4.4.4).

In addition to acknowledging and addressing potential biases through reflexivity, I carefully considered how my social status could influence the research process and employed strategies to mitigate potential power imbalances. Mann (2016) emphasises the significance of understanding one's social location as a researcher, which encompassed several key aspects in my case. As a White woman, a midwife, a native English speaker, and the lead researcher, each of these factors could be perceived as positions of power, shaping participants' perceptions of me during interviews. Being a midwife may have offered advantages in rapport-building with healthcare professionals, yet it could present challenges when interviewing experts by experience who may have had negative maternity care experiences (Rubin and Rubin, 2004). Moreover, the professional status associated with being a midwife carries certain societal assumptions and expectations, potentially leading to power imbalances and guarded responses from participants.

To navigate these dynamics, I adopted specific strategies during interviews. On the recommendation of the Research Collective (section 5.3.1), I conducted pre-interview meetings, where feasible, to establish familiarity and acknowledge the significance of relationships in data generation (Mann, 2016). Providing interview questions in advance was undertaken as a strategy to help empower participants and clarify that I would not ask about their personal experiences, emphasising instead a focus on their expertise and insights (section 5.5.2). In the interviews, I avoided formal clothing to promote a relaxed atmosphere and prioritised active listening, deferring to participants' expertise. I took care to demonstrate empathy and a non-judgemental approach during the interviews, ensuring I remained open and receptive and avoiding professional defensiveness in cases where maternity care providers were criticised. Field notes were collected during and after interviews, using a mind map function for immediate reflections. Reflections on upsetting experiences during the interviews are discussed in section 5.5.4.

5.6.4 Confirmability

Confirmability refers to the degree to which the findings are fair and unbiased (Denscombe 2021). Reflecting on the emerging findings with both my supervisory team and the Research Collective played a key role in enhancing confirmability. Additionally, employing reflexive measures such as the maintenance of field notes, as discussed in the previous section, helped mitigate the potential impact of my subjectivity on the findings. The presentation of findings in the subsequent chapter is supported by evidence to show that they are derived from the data. In these ways, I aimed to ensure that the findings were grounded in the participants' voices and experiences rather than being unduly influenced by my perspective.

Overall, by adhering to these principles of credibility, transferability, dependability, and confirmability, I sought to enhance the trustworthiness of the qualitative research conducted within the EMPATHY study.

5.7 Conclusion

This chapter detailed the methods employed for conducting the study interviews. I reflected on decisions made about the research process, which were guided by the principles of collaboration, social justice, and empowerment, rooted in the theoretical frameworks of intersectionality and CPAR that underpin this study. The subsequent chapter describes the findings from interviews with experts by experience, voluntary sector experts, and healthcare professionals.

Chapter 6 Interview findings

6.0 Introduction

In the previous chapter, I described the methods used to conduct the study interviews, including recruitment, data collection, and analysis. This chapter provides demographic information about the participants and the interview findings.

6.1 Participant information

In this section, demographic data about the participants is presented and discussed, and I reflect on the overlap between participant categories.

6.1.1 Demographic data

Of the 23 participants, 12 were maternity care providers, seven were voluntary sector practitioners and four were experts by experience. Summarised demographic data can be found in Table 6.1, and job titles for maternity care professional participants in Table 6.2.

To preserve participant anonymity, demographic data for maternity care providers and voluntary sector practitioners has been combined and some job titles have been slightly amended to make them more generic. Most professional participants were female (n=17), White (15), aged 31-45 (9) and lived in England (15). Practitioners from across a range of relevant professions were represented, including midwifery, obstetrics, perinatal mental health, health visiting, psychosexual therapy, psychiatry, children’s social care and general practice. The voluntary sector practitioners specialised in supporting women after domestic abuse, birth trauma, removal of children from care, seeking asylum, sexual violence, and female genital mutilation. Fifteen of the nineteen professionals and experts had over a decade of relevant experience.

All experts by experience were female (n=4), most were White (3), most were aged 31-45 (3) and all lived in England (4).

Table 6.1 Participant demographic data

	Experts by experience (n=4)	**Maternity care providers and experts from the voluntary sector (n=19)**
Sex		
Female	4	17
Male	0	2
Self-described ethnic category		
White, White British or White Other	3	15
Black African or African Black British	1	4
Age		
18-30	1	0
31-45	3	9
46-60	0	6
Over 60	0	4
Region		
England	4	15
Wales	0	2
Scotland	0	2

Table 6.2 Job titles - maternity care professional participants

(n=12)

	Job Title
1.	Clinical Matron / Specialist Midwife
2.	Specialist Midwife for Perinatal Mental Health
3.	Consultant Liaison Psychiatrist
4.	Health Visitor
5.	Clinical Lead for Perinatal Mental Health
6.	Clinical Lead for Perinatal Mental Health (prison setting)
7.	Team Manager, Children’s Social Care
8.	Professional Midwifery Advocate
9.	General Practitioner (retired)
10.	Psychosexual therapist
11.	Midwife - community and hospital
12.	Consultant Obstetrician and Gynaecologist

6.1.2 The blurred lines of participant categories

The categorisation of participants in the study proved to be more nuanced and overlapping than initially anticipated. Many maternity care professionals and voluntary sector practitioners shared their own experiences of trauma or that of their family members during the interviews. One of the voluntary sector practitioners is a qualified midwife with a wealth of experience supporting women in the criminal justice system. Furthermore, every expert by experience was actively involved in supporting women, either through local Maternity and Neonatal Voices Partnerships, working in a perinatal mental health charity, or expert by experience roles within mental health services. This blurring of participant categories was evident throughout the study, complicating the classification process.

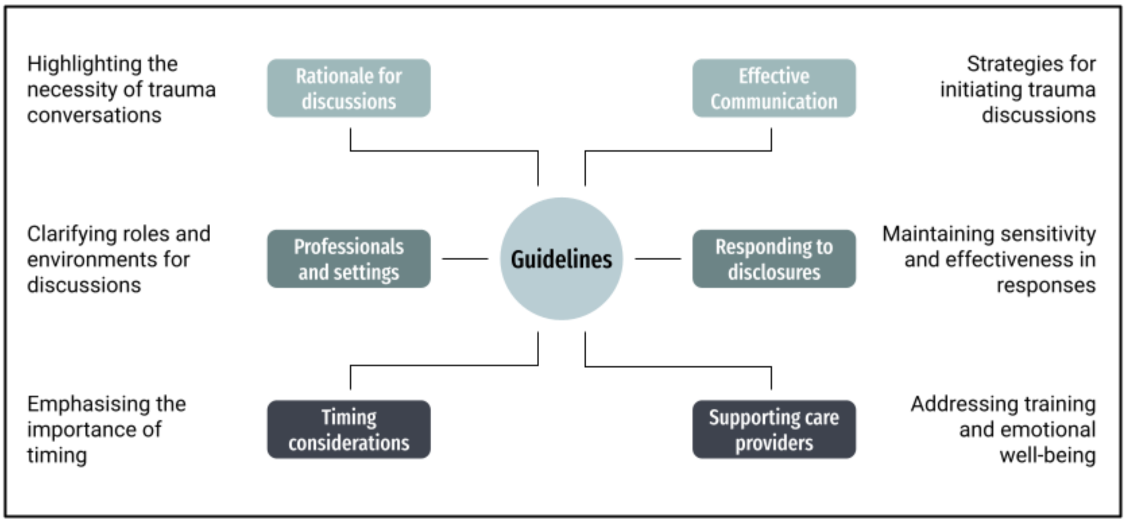
In some instances, it was challenging to determine the appropriate category for participants. For example, a qualified midwife who was no longer practising responded to the recruitment flyer aimed at experts by experience and asked to be included in this category. A voluntary sector practitioner invited a friend to join the interview, who shared relevant experiences both at work and personally; I classified her as a voluntary sector practitioner, but she could have equally been classified as an expert by experience. These overlapping participant categories underscore the complexity of trauma discussions and highlight the need for sensitivity and flexibility in research classification. The implications of care providers' own experiences of trauma are further explored in sections 6.8.5 and 8.3.3.

6.2 Overview of findings

In this section, I introduce six key themes derived from the interview findings. The first, *Rationale for discussions,* explores whether care providers should raise the issue of previous trauma with women, and what the potential benefits and disadvantages of doing so might be. In the second theme, *Professionals and settings,* I consider which professionals should carry out trauma discussions and the optimum setting for these conversations. The third theme, *Timing considerations*, examines when trauma discussions should be carried out. In the fourth theme, *Effective communication*, I share interviewee perspectives on finding the right language for trauma discussions, commonly used trauma discussion tools, and communication challenges. Maintaining sensitivity and effectiveness in responses is examined under the theme *Responding to disclosures.* The final theme, *Supporting care providers*, addresses the training and emotional well-being needs of professionals conducting trauma discussions.

As described in section 5.4.3, the interview findings highlighted the need for a framework of guiding principles to help maternity care providers navigate discussions of previous trauma. Each of the findings has fed into the development of such a framework, and this is shown in the thematic map at Figure 6.1. The framework is discussed in the subsequent chapter.

Figure 6.1 Thematic map of findings



6.3 Rationale for discussions

This theme explores the potential benefits and disadvantages of trauma discussions. I asked participants whether care providers should routinely raise the issue of previous trauma with women, and what the impact of doing so and providing subsequent support might be. Responses have been grouped into three sub-themes: *facilitate women's recovery from traumatic experiences, improve the quality of care provided*, and *potential for harm.*

6.3.1 Facilitate women's recovery from traumatic experiences

Participants underscored the profound impact of sensitively addressing trauma and providing post-disclosure support on women's healing from traumas. It was emphasised that 'healing' is not about erasing the memory of traumatic events, but about empowering women to reclaim agency over their lives and move forward with optimism. The perinatal period was identified as an optimum time for healing, provided appropriate support was given, with one interviewee describing it as *'an amazing opportunity and time to do this critical work'* (HP5).

Participants highlighted the interconnectedness of mental health and trauma experiences, suggesting that discussions surrounding these topics should be integrated. They argued that prioritising mental health discussions alongside physical health concerns would signal equal regard for both aspects of well-being within maternity care settings, with one participant expressing *'there is a huge emphasis on the physical and not so much on the mental health and well-being'* (HP5). An expert by experience talked of her trauma as *'very much here all the time, it is just a case of what level it is at'* (WLE2) and advocated for combining mental health and trauma discussions to facilitate healing. Several participants highlighted the critical link between trauma and suicide, arguing that without trauma discussions, care providers miss the opportunity to support women who may be extremely distressed. One expert by experience candidly expressed the potentially transformative impact of trauma discussions and support, commenting:

> *'I think it [talking about previous trauma and providing support] can make the difference between, it sounds dramatic but life and death. Literally. After my first birth I thought about ending my own life and this time I obviously don't anticipate that happening'* (WLE1).

Participants proposed that the significant life transition of the perinatal period can be particularly challenging for women who are also trying to come to terms with difficult experiences. Interviewees noted that women who have suffered trauma often face unexpected emotional distress or upsetting memories at this time, and care providers were felt to have an important role to play in educating women about the effects of trauma and preparing them for this possibility. Several participants felt that discussing trauma would lead women to feel their experiences were *'valued and relevant'* (EV2) and that simply having the opportunity to talk could be beneficial to women: *'they feel lighter, they feel like they share their burden, they feel like they can get better'* (EV4). This was echoed by a perinatal mental health specialist midwife who stated:

> *'A lot of my appointments the women will say 'I feel so much better because I have been listened to, I feel like a weight has been taken off my shoulder to somebody that is not in the family that I can just unload'. Now I didn't counsel, I didn't do anything fancy, I didn't do an extensive questionnaire or what have you, I just spoke to this woman and did my assessment and give her the time to express herself and that's what every woman should get'* (HP2).

If carried out sensitively, trauma discussions were felt to have the potential to greatly improve children's lives, *'interrupting that intergenerational transmission of trauma'* (HP5). A community advocate (EV5) eloquently expressed the potentially compounding effect of supporting trauma survivors: *'when you help that person you help them build the next generation'.* An expert by experience reflected on her challenging transition to motherhood and difficulty bonding with her baby. She believed that if women feel *'supported, seen and heard'* (WLE4) it could have *'a huge impact'* both for women and their infants. Another expert by experience agreed that supporting women after trauma could have far-reaching positive consequences*: 'you are shaping a parent to future proof their kids going through the same thing'* (WLE3). She added that the first step in improving babies' lives is a sensitive discussion of previous trauma: *'it is a really, really big task, but it starts with conversations.'*

Participants noted that fathers and other non-birthing parents may also be coming to terms with past trauma in the perinatal period. Interviewees proposed that care providers have a responsibility to support both parents, with some feeling they should ask partners about previous trauma and mental health. A perinatal mental health clinical lead (HP5) told me: *'midwife means with woman, and you have got to get rid of it, you have got to think family, take the whole family approach.'* Another participant spoke passionately about the importance of supporting fathers who have suffered sexual abuse, based on her personal experience of marriage to a survivor and her work on an anonymous helpline for survivors of sexual violence:

> *'They are really terrified but might even not have told their wives that they are survivors […] I have had no end of crying men saying to me, 'I am absolutely terrified of becoming a dad, how can I protect my unborn baby when I couldn't protect myself?' They also worry that if opening up about it someone is going to point their finger and say, 'oh that means you are going to be an abuser'* (EV6).

6.3.2 Improve the quality of care provided

Participants highlighted the potential for trauma discussions to enhance the quality of care provided to women during the perinatal period. By engaging in these discussions, clinicians can tailor their care to better meet the individual needs of women, thus fostering a more sensitive and supportive care environment. Interviewees felt that without understanding a woman's past trauma, care providers risk inadvertently causing further harm. A voluntary sector practitioner proposed that many women do not disclose because they have been failed and re-traumatised when they have attempted to seek help in the past, leading them to feel: *'what is the point. Nobody believes me'* (EV6). She told me her belief that when trauma survivors have a positive and respectful experience of disclosing trauma, they are more likely to seek medical help in future. Similarly, an expert by experience shared her belief that even where women choose not to disclose on this occasion, carrying out routine trauma discussions sensitively could facilitate trust and future disclosure: *'you have planted the seed of if I am ever ready I can. This is a safe space. This is a safe person'* (WLE2).

Moreover, participants underscored the economic benefits of implementing properly funded trauma discussions. Early intervention through trauma discussions can prevent crises from escalating, potentially saving resources in the long run. A psychiatrist participant argued that early trauma discussions are a good investment to pick up problems early and to ensure that women are given the support they need, pointing out *'that is better for her, but it is also actually a more efficient way to run the service'* (HP3). By investing in timely support, clinicians can mitigate the long-term impacts of trauma on women's mental health and well-being, ultimately benefiting not only the individual but also their families and society.

However, interviewees cautioned that trauma discussions will only be of value to women if used to improve care, rather than, as one participant said: *'just asked, recorded and then ignored…'* (EV7). It was felt that without appropriate protocols and referral pathways in place, trauma discussions risk being futile, potentially causing distress without offering meaningful support, as articulated by this participant: *'we shouldn't invite disclosure unless we can make a difference to that woman'* (EV1). Similarly, one interviewee argued that it is unethical to ask women about previous trauma as services cannot cope with existing demand: *'all you are going to do is possibly re-traumatise them, and not offer them anything helpful'* (HP9). A psychiatrist participant commented that asking questions about childhood experiences will identify many women who are no longer affected by their experiences, and even for those who are, there is not necessarily a great deal the care provider can do: *'you can't say 'oh right, well what we will do is undivorce your parents…'* (HP3).

6.3.3 Potential for Harm

Further, participants pointed out that trauma discussions could be damaging to women. Broader support services, and mental health services in particular, were viewed by some participants as inadequate, inconsistent, or not trauma-informed. A domestic abuse practitioner shared her belief that mental health services which fail to recognise that past trauma can be the cause of mental distress can be re-traumatising for women: *'she potentially is going to become medicalised, diagnosed and end up worse off than she started'* (EV1). It was noted that trauma conversations which are carried out insensitively could be very distressing: *'you could cause a lot of damage and leave the woman in a difficult place'* (EV2). Participants highlighted that direct questions about trauma could cause women to confront past experiences in an unanticipated and harmful way, as women may not have felt their experience was significant until this conversation: *'that may not have been a big deal to them then all of a sudden oh my god that was abuse'* (HP1).

Interviewees described the damage that could be caused by overzealous safeguarding responses to disclosures of previous trauma. One participant shared her experience of supporting women who have been pressured by healthcare professionals into reporting information to police against their will. She pointed out that without having perpetrator information, there is nothing meaningful for care providers to share with safeguarding teams, and that the police will be unlikely to pursue any conviction without a victim who is willing to press charges. She powerfully described how an unwanted safeguarding response could damage the trust between the maternity care provider and the woman: *'arse covered but to what end, you just ruined your relationship.'* (HP10). Similarly, a domestic abuse practitioner cautioned that trauma discussions could have catastrophic consequences for women:

'A good outcome is that that woman has a more positive experience of being pregnant and giving birth and the early time with her child, than she would have done without us asking. If the reality is that only 1 of 10 women who we ask has that outcome and 9 of them have disasters because suddenly social services are involved, and they are beholden to all sorts of systems and they are reporting to the police and they didn't really want to…' (EV1).

6.4 Professionals and settings

This theme explores the most suitable professionals and optimal environments for discussions about trauma. There are three sub-themes, *who should carry out trauma discussions?, continuity of care,* and *where to talk about trauma.*

6.4.1 Who should carry out trauma discussions?

When exploring who should conduct trauma discussions, most experts by experience and voluntary sector practitioners felt that women would be more comfortable disclosing previous trauma to a female clinician. Some participants explicitly stated that they would not disclose previous trauma to a male clinician. For example, when asked whether the gender of the person raising the issue of previous trauma matters, a health advocate and community consultant who were interviewed together replied: '*definitely, definitely a woman ((laughs)) yes we do not want a man,'* (EV5)*,* and: '*If it was me I would lie I wouldn't even open up to a man'* (EV4).

Various healthcare professionals involved in maternity care, including midwives, obstetricians, health visitors, and GPs, were suggested as suitable candidates for initiating trauma discussions. Midwives and health visitors were particularly favoured due to their frequent contact with women during pregnancy and the postnatal period. Some participants also acknowledged the value of support workers in facilitating disclosures. For example, a perinatal mental health clinical lead participant (HP5) shared her belief that women might be more likely to disclose trauma to a support worker than a clinician, seeing this as more of a peer-to-peer relationship: *'they are the unsung heroes, they do a lot of listening because people will for whatever reason maybe share more with them.*' However, she felt a professional may need to be involved in follow-up: *'if people aren't feeling so great it needs further exploration,* *and that’s where a midwife would be essential.’* The personal qualities of the clinician were deemed more important than their professional role, with kindness, empathy, and warmth highlighted as essential attributes for fostering trust and facilitating disclosures.

6.4.2 Continuity of care

Participants noted that for many women, multiple encounters are necessary before they feel safe enough to share their histories, with one emphasising the *‘enormous amount of weighing up that will go on before people trust and disclose’* (HP9). Continuity of care was seen as beneficial in this regard, allowing clinicians to establish strong rapport and create a psychologically safe environment for discussions:

> *‘It is such a personal and very intimate part of your life, it is not something you are ready to share with a complete stranger who says ‘oh hello I am your midwife, now tell me have you ever experienced trauma?*’ (EV6).

Nonetheless, some participants noted that even where continuity is not possible, clinicians can use kindness, compassion, and warmth to create a psychologically safe environment. One interviewee suggested *‘that initial warmth and that real interest in yourself is just as important as the relationship’* (WLE3).

6.4.3 Where to talk about trauma

Participants in the study highlighted the importance of providing a private and quiet space for discussing trauma, where women can speak without interruption. Many participants expressed concerns about discussing trauma in the clinical setting, due to its potential to inhibit disclosures. A perinatal mental health specialist midwife vividly described the lack of privacy in many clinical environments, saying her antenatal clinic was ‘*like Grand Central Station’* (HP2). Participants suggested that a more informal environment, with comfortable seating and refreshments, would be more conducive to sensitive discussions. For some women, clinical environments were reminiscent of previous negative experiences with statutory services. A community consultant shared her experience of many women being concerned about being secretly recorded in clinical settings, saying it would be better to ask about previous trauma in women’s homes or in the park: *‘because most people are cautious about the cameras’* (EV4). However, not all participants felt that the physical environment was paramount. One participant (HP7) stressed that the timing of the discussion is more critical than the location, highlighting the importance of being responsive to women's readiness to open up, rather than *'oh well I will give you an appointment in three weeks…’* It was suggested that there should be support available for women who become upset and need space to collect themselves after the appointment, in terms of both a private space and a staff member.

6.5 Timing considerations

Participant views on when to ask women about previous trauma have been grouped into four sub-themes: *preconditions for trauma discussions, talking about trauma more than once, the best time to start the conversation*, and *an additional appointment to discuss emotional health and well-being.*

6.5.1 Preconditions for trauma discussions

Several participants stressed that clinicians should initiate conversations about previous difficult experiences only when they can dedicate sufficient time to listen and respond to disclosures effectively. They highlighted the unpredictable nature of trauma discussions, acknowledging that some conversations may require considerable time. A midwife counsellor highlighted the challenge of this within a busy working day, commenting that when disclosures are complex or emotive: *‘you can’t say to the woman, my 60 minutes are up, out you go’* (HP8). The significance of trauma discussions for women, particularly if they have never shared their experiences before, was underscored by participants. An expert by experience commented that care providers need to provide sufficient space for these discussions *‘because you don’t know if this is the first time they have ever said that in their whole entire lives’* (WLE3). Another participant, drawing from experience supporting survivors of sexual violence, cautioned against initiating such discussions if there is not sufficient time available:

> *‘If you have got 2 minutes left and you say to somebody ‘so have you ever experienced sexual trauma?’, no, just don’t do it. Do it on a different occasion, think practically about it. Have you got the time to give the space?’* (HP10).

There was a consensus that asking about trauma should not occur in front of partners, who may be unaware of the woman's history. Additionally, participants noted that even young children being present could inhibit open discussion, with a specialist midwife noting: *'I do think as mums if your children are there you have to put that brave warrior face'* (HP1).

Participants also emphasised the importance of forewarning women about the upcoming discussion on previous trauma so they can prepare themselves and arrange for support if needed. One expert by experience shared the emotional impact of being asked probing questions without warning, echoing findings in section 6.3.3, '*it took me 3 days to get over that appointment'* (WLE2). Providing advance information about trauma discussions was seen as a way to show women they are valued and that their experiences will be taken seriously. Additionally, participants stressed the importance of informing women about the limits of confidentiality, with this seen as empowering to survivors and assisting in building rapport and trust. However, there were tensions regarding how to prepare women as, unless handled sensitively, this could induce anxiety; one participant mused that although it is important to forewarn about the discussion '*it is a difficult one, because you don't want to encourage women to disengage'* (HP2).

6.5.2 Talking about trauma more than once

Many participants advocated for discussing previous trauma and mental health multiple times in a 'light touch' way during the perinatal period, with several noting that it may take numerous appointments for women to feel safe enough to disclose, as described in 6.4.1. A voluntary sector practitioner suggested explicitly leaving open the possibility of future disclosures, enabling survivors to consider whether they would like to disclose later in the perinatal period, using wording like *'well if you change your mind and think of anything you can come back and let me know'* (EV6). Several participants suggested that some women might not be ready to seek support until after the birth of the baby, with a social worker proposing:

'As a female it can happen to you [abuse / violence] and you deal with it for you, but then when you bring a baby into the world suddenly you think 'oh my God,

how do I stop things happening to this baby?' and that's when you become kind of vulnerable and open to dealing with some of the things that you have just bottled up, because you want to make the world a better place for your baby' (HP7).

After women have disclosed trauma, it was felt to be important to give them the opportunity to discuss it again. A voluntary sector practitioner proposed that doing so helps to build relationships which are professional but also human, saying: *'if a friend told you they have been through a tough time you would say 'how are things going?'* (EV3). Another felt that raising the issue again helps develop trust and show that the clinician cares: *'people think 'oh has remembered, she is bothered', I think that is the way in'* (EV2). However, some interviewees cautioned that such an approach must be sensitive and in line with women's wishes, with one saying: *'you don't want to push, push, push'* (EV2) and another: *'if a woman says to you, 'I am fine I don't want to talk about it again', let's not keep bringing it up all the time'* (HP1).

Participants noted that irrespective of the sensitivity by which the issue of previous trauma is raised, and of the level of trust in the maternity care provider, women may choose not to disclose for various reasons, including lack of trust, fear of social services involvement, past negative experiences, stigma, or simply valuing privacy. An expert in supporting women after birth trauma speculated that women who are the most traumatised by their experiences will find it the most difficult to talk about them: *'very often if it is truly traumatic they will say no. Because they cannot disclose it, it is too emotionally difficult'* (EV3). It was therefore suggested that care providers *'shouldn't take a negative answer as gospel'* (HP9). It may be that raising the issue of trauma multiple times in pregnancy and / or providing continuity of carer (discussed in 6.4.1) mean that women feel more comfortable to disclose or are asked at a time when they need support. However, interviewees stressed the importance of providing independent access to support for women who may not feel comfortable disclosing. Furthermore, participants highlighted the need for clinicians to adopt a universal precautions approach, assuming that every woman may have experienced trauma and being sensitive to this possibility in their interactions.

6.5.3 The best time to start the conversation

In exploring the optimal timing to initiate discussions about trauma with women, several participants advocated for broaching the topic during the antenatal booking appointment, typically around 10 weeks gestation. They believed that initiating these conversations early would allow for timely support and prevent unnecessary delays. Participants recognised that women may not feel comfortable to share their experiences at the first appointment but felt that asking at this point would *'start the ball rolling,'* (HP7) demonstrating that these issues are important, and the care provider is willing to listen.

However, participants acknowledged the challenges associated with discussing trauma during the booking appointment[3]. Participants expressed frustration at the implementation of trauma discussions without additional time, as articulated by this interviewee: *'being squeezed in there, something that is already breaking but we are just going to put a little bit more on top, go on you can carry it'* (WLE2). They noted that the appointment is already crowded and lacks the necessary time and resources for in-depth conversations, with one interviewee remarking, *'it is almost impossible to do it [the booking appointment] without everybody being exhausted'* (HP9). Further, interviewees noted that by necessity the appointment consists mainly of closed questions and information-giving by the midwife, and it can be difficult to 'switch gears' to a more open and sensitive conversation. One participant expressed her unease at having to move on from an emotive disclosure to *'do you have a dentist, do you have a dog kind of thing'* (HP11).

Interviewees also noted that women are already asked a lot of *'quite intrusive'* (HP9) questions at booking, including about previous terminations, drug use, mental health problems, sexually transmitted diseases, and social services involvement, which could leave them feeling exposed and mean they lack the sense of safety necessary to disclose previous trauma. Participants noted the clinical environment of a booking appointment is not necessarily conducive to sensitive discussions, and the presence

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[3] The booking appointment typically takes place between 8 and 12 weeks of pregnancy and includes screening for physical and mental health problems, development of a perinatal care plan, and information on foetal development, health and nutrition, antenatal screening tests, and antenatal education.

of partners further complicates the dynamics of discussing trauma (section 6.4.2). Participants recognised the need to prepare women for these discussions and build a trusting relationship beforehand (see sections 6.4.1 and 6.5.1), which may be challenging to accomplish during the booking appointment. Overall, while initiating discussions about trauma early in pregnancy is advocated for, participants highlighted the practical challenges and limitations associated with doing so during the booking appointment.

6.5.4 An additional appointment to discuss emotional health and well-being

Based on the emerging data regarding the challenges of conducting sensitive trauma discussions during the booking appointment, I sought participants' views on having an additional antenatal appointment specifically focused on emotional health and well-being, including discussions about previous trauma. Participants from all categories responded positively to this idea, expressing: *‘I just got goosebumps just thinking how good that would be. Yes’* (EV4), *‘I think that’s brilliant’* (WLE4), and *‘I think it would be wonderful. And I think it would really do a lot to allay fears of women’* (EV6). A health advocate described it as a *‘great idea’* (EV5) and added: *‘even things that we don’t share with our husbands will come out, our worries, our fears.’*

Advantages of introducing an additional appointment for discussing emotional well-being and trauma were highlighted by participants. They suggested that such an appointment could alleviate the crowded schedule of the booking appointment, providing a protected space for meaningful conversations between the midwife and the woman. Participants favoured an unstructured, woman-led conversation format, akin to the 'listening visits' conducted by health visitors for women experiencing mental health challenges. One participant remarked, ‘*no paperwork, you just go along and you hear and connect. That is really powerful’* (EV3). Moreover, participants believed that an additional appointment could facilitate trust-building and relationship-building between the woman and the care provider. They speculated that women might be more inclined to disclose trauma during this second appointment, particularly if it involved the same care provider. Discussing trauma at the second appointment would allow the care provider to prepare women for the upcoming conversation. Furthermore, this would avoid overwhelming women during the initial appointment, which typically involves various medical procedures and enquiries.

Some participants suggested offering the appointment on a voluntary basis or on a needs-led basis, rather than making it a standard part of the antenatal care schedule. A children's social worker (HP7) proposed *'as long as it is voluntary so if somebody doesn't do it, it doesn't get classed as being a negative 'well they refused to do it.'* Participants noted that women may be sceptical about the purpose of the appointment, with a GP commenting that she felt it would be valuable *'provided women didn't see it as 'this is when they decide whether to refer me to social services'* (HP9).

Despite the perceived benefits, participants acknowledged the challenges of implementing an additional appointment within the constraints of overstretched and under-resourced maternity services. A voluntary sector practitioner remarked: *'yes oh that is gorgeous. I think that is a great idea. I don't know how you will get it through'* (EV7), while an obstetric consultant participant commented*: 'I think that is a brilliant idea […] that is dream world, ideal world kind of blue sky thinking'* (HP12). However, despite these challenges, participants viewed the idea as promising and worthy of consideration.

6.6 Effective communication

In this section, I explore the complexities of effectively communicating about trauma. There are two sub-themes in this section. In *communication challenges*, participants share insights into the obstacles encountered when addressing previous trauma. In *trauma discussion tools*, interviewees' perspectives on the effectiveness and appropriateness of tools commonly employed in trauma discussions are explored.

6.6.1 Communication challenges

Participants highlighted the complexities of discussing trauma, noting the need for sensitivity, clarity, and accuracy. Section 6.3.3 describes how trauma discussions can lead women to cause women to reconsider the significance of past experiences which they may previously have minimised. Similarly, interviewees observed that language commonly used in trauma discussions, such as ‘trauma’, ‘emotional abuse’, ‘sexual abuse,’ and ‘physical abuse’ may not resonate with women’s own perceptions of their experiences, potentially hindering disclosure. For instance, one participant explained that women may not feel they have been abused *‘but if you knew her history you would think she absolutely was’* (EV2). An expert by experience commented that some women may not yet be able to acknowledge the magnitude of their experiences, while others might be aware ‘*but feel really quite acutely ashamed’* (WLE4). Some groups of women, such as those who are autistic or have learning disabilities, were felt to face additional challenges in understanding and articulating their experiences. The use of explicit language was perceived to hinder conversations, potentially causing mothers to *‘completely shut off’* (HP4), while formal or academic terminology can be reminiscent of involvement with statutory services *‘if you ask them outright the word abuse can sometimes get their hackles up’* (HP6).

Participants universally felt that communication challenges are magnified for women with limited English proficiency. Even those with some proficiency in English may struggle to grasp complex information or subtle nuances. Furthermore, participants highlighted the lack of vocabulary in certain languages to describe mental health issues, making it challenging to discuss them sensitively. For instance, a midwife noted that her first language lacks specific terminology for mental health, simplifying it to terms like *‘crazy’* (HP1). Consistency in interpreters was deemed beneficial, with participants emphasising the importance of interpreter training in asking sensitive questions. However, opinions diverged regarding the preferred mode of interpretation. While some participants favoured telephone interpreters for their perceived intimacy, as only the clinician and woman are present in the room (HP1), others, like a perinatal mental health clinical lead in a prison setting, preferred in-person interpreters to avoid distractions and maintain focus (HP6).

Participants highlighted that not all women are literate in their native language. Therefore, simply translating questionnaires into a woman’s first language does not guarantee her understanding. Such situations may lead to misunderstandings of the questions or evoke feelings of embarrassment or shame in those unable to read or complete the questionnaire, despite it being in their primary language. Furthermore, a specialist midwife (HP1), discussing her experiences of caring for women who were seeking asylum, noted that women could unknowingly ask their abuser or neighbour to translate sensitive information. An expert by experience (EV4), fluent in English as a second language, considered that women prefer verbal communication over written forms, stating: *‘They’re just like I came here to be checked, I didn’t come here to fill out forms’* (EV4). The idea of translating questionnaires into audio format (Willey et al., 2020a) received positive feedback from participants, with one remarking, *‘an audio version that somebody could listen to on their phone, that is a brilliant idea’* (EV7). Moreover, participants highlighted that literacy challenges extend beyond women with limited English proficiency and underscored the importance of developing materials with low literacy levels in mind.

The stigma surrounding mental health in some cultures can further impede open discussions. A practicing midwife shared her experience of appointments in which *’the woman will look at the partner or the granny as if to say, ‘this is awful that you are even asking me this’* (HP11). She has found it impossible at times to overcome this stigma. In discussions with a community consultant and health advocate (EV4, EV5), it was highlighted that women from specific cultural backgrounds, such as the African community, may decline counselling due to a lack of understanding. One said: *‘they just know it is something on TV someone lying down, telling all their problems to a total stranger…’* (EV4) and the other added: *‘hypnotising them (laughs)’* (EV5). Despite these initial hesitations, both participants noted that women who eventually accept counselling often find it immensely beneficial, with one saying: *‘when they do it, they don’t want to leave, they are like, no, I need that’* (EV5). This underscores the transformative potential of mental health support, even in the face of cultural stigma and initial reluctance.

6.6.2 Trauma discussion tools

Participants were asked how care providers should initiate conversations about trauma, including their views on direct questions, questionnaires, and conversation starters. As a prompt, they were asked about specific tools, including the ACE questionnaire and the Antenatal Psychosocial Risk Questionnaire. These tools were identified during the systematic review process (section 3.3.1) and can be found in appendix 13. Not all participants were asked about these tools, as the interview approach was tailored to individual responses (section 5.3.1), and not all participants required prompts to engage in discussion. Additionally, following an interview with WLE2 (the 21st participant out of 23), I decided not to share the ACE questionnaire with subsequent participants to avoid potential distress (section 5.5.4). With the subsequent participant, WLE3, I introduced other tools for discussion but excluded the ACE questionnaire; however, she was familiar with it and shared her perspectives on it. The final participant, WLE4, provided comprehensive responses without the need for specific prompts or tools. Insights from responses are summarised below, although it should be noted that they are based on a limited number of respondents and should be tested in a larger sample.

Many participants expressed scepticism regarding the effectiveness of quantitative trauma and mental health screening tools. A voluntary sector practitioner (EV3) questioned their utility, highlighting that many women who die by suicide during the perinatal period have not been identified as needing support through such tools. Instead, she suggested *‘it is a relationship, listening, that will pick up far more of those than tick-boxes’* (EV3). It was felt that closed-ended questions in general may deter women from disclosing because of a fear of social services involvement, echoing findings from section 6.5.2. Further, a GP participant recalled experiences in a perinatal mental health service where women who had indicated significant issues in questionnaires were overlooked: *‘everything was positive including I want to kill myself, the self-harm one. Nobody got back to them’* (HP9). Some participants suggested employing multiple approaches to raise the issue of trauma during the perinatal period, as women may find it easier to write down than talk about their experiences, or alternatively may struggle with writing.

Antenatal Psychosocial Risk Questionnaire (ANRQ)

The ANRQ integrates mental health screening with questions about challenging life events, including *‘were you emotionally abused when you were growing up?’, ‘when* *you were growing up, did you feel your mother was emotionally supportive of you?'* and *'have you ever been physically or sexually abused?'* Views on the effectiveness and appropriateness of the questionnaire were mixed. Some participants acknowledged the clarity of the questions and one, an expert by experience, expressed appreciation for the acknowledgment of the profound influence of maternal relationships, remarking, *'you have seen the world a bit differently because you have not been raised by your mum…'* (WLE2) However, other participants questioned the utility of such detailed inquiries in the absence of clear pathways for intervention or support, reflecting participant comments in section 6.3.3. Further, several participants highlighted the potential for women to not recognise their experiences as abusive, reflecting comments in section 6.6.1, and some felt that the direct nature of the ANRQ questions could be perceived as intrusive, with descriptions including *'quite heavy'* (HP2), *'blunt'* (HP7) and *'more like child protection, you are looking if I am going to be a good mum'* (WLE3).

Kimberley Mum's Mood Scale (KMMS)

The KMMS combines a visual Likert scale depicting women's facial expressions ranging from happy to sad, adapted from the Edinburgh Postnatal Depression Scale, with an exploration of key domains of well-being, including childhood experiences and mental health. Participants overwhelmingly praised the KMMS. The visual Likert scale was described as *'colourful, visual, great,'* (HP1) *'good for if you have got young mums who maybe aren't that literate,'* (HP6) and *'this looks like a good helpful screening tool'* (HP12). Participants appreciated the warmth and humanity conveyed through the use of pictures, contrasting it favourably with conventional text-based questionnaires**.** Furthermore, participants commended the simplicity, clarity, and sensitivity of the discussion component of the KMMS, with one remarking *'it is simple but very, very effective'* (WLE2). They also valued the KMMS for providing a clear rationale for the discussion. The general, open conversational style of the KMMS was felt to be more conducive to fostering trust and eliciting honest responses than more direct inquiries about abuse.

Adverse Childhood Experiences questionnaire (ACE-10)

The ACE-10 contains questions such as *'Did an adult or person at least 5 years older than you ever touch or fondle you or have you touch their body in a sexual way? Or attempt or actually have oral, anal, or vaginal intercourse with you?'* Originally designed for research purposes, this questionnaire is increasingly used in clinical settings, including maternity care (Ford et al., 2019, Hardcastle and Bellis, 2019). Participants across all categories expressed strongly negative views about the questionnaire, critiquing its explicit language and its potential to re-traumatise women (see sections 6.6.1 and 6.3.3). Participants noted that many women may no longer be affected by childhood experiences, and furthermore, highlighted the absence of clear support pathways for women affected by events such as parental divorce or incarceration (see section 6.3.3). An expert by experience expressed a visceral emotional reaction to the questionnaire:

> *'It reminds you that you weren't looked after. You weren't taken care of. You know that as a child, you weren't parented, you weren't loved in the way that a child should be loved. What upsets me isn't the act of the abuse, it is the fact that I wasn't looked after and I didn't have that love and care and what that means as an adult'* (WLE2).

This powerful response underscores the deeply personal and potentially distressing nature of discussing ACEs, highlighting the importance of approaching such topics with sensitivity and empathy within clinical settings.

Trauma History Questionnaire

The Trauma History Questionnaire asks about previous traumatic experiences including crime, natural disasters, and sexual abuse. The overwhelming majority of participants were critical of the Trauma History questionnaire, feeling it to be excessively detailed and unsuitable for use in maternity services. Participants raised concerns about the appropriateness of the language used in the questionnaire, as articulated by a perinatal mental health specialist midwife (HP2), who stated, *'goodness me. I just don't like it, I just think that is very stark in a questionnaire.'*

Conversational prompts

As described in section 5.1, some members of the Research Collective expressed concerns about asking direct questions about previous trauma and suggested instead that maternity care providers use a more subtle ‘prompt’ to raise the issue of previous trauma. Participants were therefore shown two conversational prompts as alternative methods for initiating discussions about trauma. The first, developed by White, Danis and Gillece (2016), prompts women to reflect on whether they have experienced severe trauma or stress, providing examples for context. The second prompt, developed by Montgomery (2021), aims to prepare women for unexpected memories of past events during pregnancy. While conversational prompts were seen as helpful for clinicians, particularly those who may feel uncertain about broaching the topic of previous trauma, neither prompt was universally popular. Some participants liked that the White, Danis and Gillece prompt provided context for the enquiry, but others felt it too long and cumbersome for clinical use. Feedback on the Montgomery prompt was also mixed, with one participant commenting that it was straightforward, while one found it *‘a bit woolly’* (HP4) and another suggested *‘I suspect women wouldn’t know what you are on about really’* (HP3).

There was no one approach that everyone agreed with, and the wide range of views implies there may be no ‘right way’ to begin a trauma discussion. However, participants universally emphasised the importance of raising the issue of previous trauma in a meaningful way, encompassing genuine interest rather than a ‘tick-box’ feel, and a supportive attitude, as expressed by this community consultant: *‘we are on your side, we are here to support you’* (EV4). A women-led, empathetic approach was deemed essential for facilitating meaningful discussions about trauma.

6.7 Responding to disclosures

In this section, I consider how care providers should support women who disclose difficult previous experiences. Participant responses have been grouped into three sub-themes: *sensitive communication about disclosures; care planning;* and *documentation and information sharing.*

6.7.1 Sensitive communication about disclosures

Participants underscored the importance of sensitive communication when women disclose previous trauma, advocating for a patient-centred approach that prioritises active listening over intrusive questioning. A psychosexual therapist (HP10) emphasised the need for professionals to discern between genuine information-gathering and unnecessary curiosity, stating that they should *'understand the difference between your own nosiness versus what is actually needed.'* Echoing this sentiment, a voluntary sector practitioner who supports women seeking asylum (EV7) cautioned against probing questions such as 'were you raped?' or 'where is the father of your baby?' She asserted:

'I think it is really hard for people to fight their own curiosity and healthcare providers feel a certain sense of authority and permission to just ask whatever they want, whenever they want it. And, if there is a question that is not directly related to her care, and her baby's physical health in that moment, then it shouldn't be asked. So make your curiosity go to sleep. It is not your business' (EV7).

Participants highlighted the importance of the language used in responding to trauma disclosures, with one expert by experience noting, *'the smallest things they [healthcare professionals] say can sometimes have the biggest impact'* (WLE1). Conversely, some interviewees felt that healthcare providers should not worry excessively about which words to use, suggesting they should *'just be simple and straightforward'* (EV7) when discussing women's experiences. Several interviewees proposed that care providers should closely attend to the language used by women when describing their experiences and mirror their terminology accordingly. An expert by experience recounted a positive experience where she was asked if there were any words the care provider should avoid, underscoring the value of this approach (WLE2). Additionally, a domestic abuse practitioner (EV1) recommended using active rather than passive language, for instance saying, '*I am sorry somebody did that to you' instead of 'I am sorry that happened to you'*.

6.7.2 Care planning

Participants emphasised the importance of collaborative care planning between clinicians and women during the perinatal period. They highlighted the need for individualised plans that encompass birth planning, management of potential triggers (including triggering words or language), continuity of carer where feasible, and access to mental health support if this is or might become necessary. Additionally, some participants underscored the significance of supporting partners to effectively assist women during what can be a challenging time.

Building on these suggestions, an expert by experience proposed the introduction of a ‘trauma-informed care’ sticker on maternity notes, similar to those used to indicate conditions like gestational diabetes. This sticker would serve as a visual cue to staff, reminding them of the need for sensitive care and alerting them to the possibility that women may be experiencing difficulties (WLE1).

Opinions on peer support groups varied among participants. While some acknowledged the potential benefits of such groups for certain women, others recognised that not all individuals would find them helpful or enjoyable. A voluntary sector practitioner (EV3) highlighted that some women may feel uncomfortable or unwilling to participate in peer support groups, stating that some *‘would not be seen dead’* in such settings, while others *‘find the support of other women enormously helpful and make lifelong friends.’* Participants generally agreed that parentcraft, creative, or well-being-focused groups could be beneficial for women. However, a domestic abuse practitioner cautioned against trauma specialist groups being led by untrained staff, asserting that *‘a midwife being like 'oh I will start a group for all the traumatised women', that is a terrible idea’* (EV1). She emphasised the importance of ensuring that women from marginalised backgrounds feel welcome and supported in peer support groups.

6.8 Supporting care providers

In this section, I consider the support needed for staff carrying out trauma discussions. Participant responses have been grouped into five sub-themes: *staff training, the emotional impact of trauma discussions, supportive management, reflexive supervision, and the impact of care providers’ trauma.*

6.8.1 Staff training

Participants unanimously agreed on the necessity for comprehensive training in discussing previous trauma for maternity care providers, emphasising the importance of starting this training during undergraduate education. They highlighted that any staff member, including receptionists and clinical support staff, might observe signs of possible trauma such as impatience or anger, and recommended that all staff should be trained to recognise and communicate these observations to clinicians.

The suggested training curriculum encompassed understanding the prevalence and impact of trauma, including mechanisms of intergenerational transmission. Participants underscored the need for care providers to comprehend the potentially profound and enduring effects of childhood trauma. A children's social worker noted the potential for women have been sexually abused as children to be triggered in the perinatal period as they are troubled by how to protect their children: *'they have coped with it for so many years but the thought that their child may get sexually abused…'* (HP7).

Participants stressed the importance of recognising non-verbal cues indicating trauma or mental health struggles. Some experts by experience expressed frustration at care providers' failure to pick up on their distress, with one saying *'it was quite clear that I was distressed but they just didn't seem to realise'* (WLE1) and another who talked of care providers holding *'really outdated perceptions'* (WLE4) of mental health and trauma because women may appear to be: *'completely functioning people, but also be suffering incredibly deeply'* (WLE4).

Participants argued that interpersonal skills, centred on kindness, compassion, and building relationships, were essential for effective communication. Despite being considered fundamental, teaching these skills was acknowledged as challenging, particularly as some professionals may perceive maintaining professional distance as more credible. A GP advocated for the use of simulation with actors to enhance skills in sensitive conversation, describing it as transformative in improving her communication skills. Additionally, several participants proposed that training in fundamental counselling skills could help providers to support women who become upset during discussions of previous trauma.

6.8.2 The emotional impact of trauma discussions

Participants pointed out that by engaging in discussions about previous trauma, care providers may be confronted with profoundly distressing narratives. Multiple interviewees talked of the burden of hearing such stories, with one describing it as *‘heavy going’* (HP4) and another reflected on feeling *‘hopeless’* at times when helping women navigate their difficult pasts (HP8). The emotional impact may be particularly poignant for care providers who have endured similar experiences themselves. A midwife participant (HP11) cried during our interview when she reflected on the emotional burden of hearing women’s traumatic experiences. She revealed that hearing women's histories at times stirred memories of her own challenging childhood, leaving her feeling overwhelmed and *‘really full up with all of this stuff in my head’* (HP11). Participants suggested that awareness of the potential for hearing upsetting stories could mean care providers are reluctant to carry out discussions about previous trauma:

> *‘I don’t think that is coming from a lack of care, I think it is actually coming from a point of view of I don’t want to get to a stage where I have a nervous breakdown and can’t care for anyone…’* (HP12).

Moreover, participants cautioned against the potential harm caused by provider discomfort during disclosure, which could lead to interruptions and premature termination of conversations. This behaviour, while unintentional, could have devastating consequences, as articulated by a psychosexual therapist:

> *‘I spend so much of my time as a psychosexual therapist unpicking how clients have felt about being shut down by healthcare professionals, because they have been asked a question, but they haven’t been heard and listened to […] It is very likely to be about time restrictions, or it has triggered something in this professional. But your client shouldn’t have to carry that, your client just goes, oh I will never tell them again.’* (HP10).

6.8.3 Supportive management

Participants emphasised the essential role of supportive management for maternity care providers carrying out routine trauma discussions. A perinatal mental health specialist midwife highlighted the importance of managerial support in managing caseloads to ensure that emotionally challenging work is distributed evenly among the team, reflecting *'in my day that wasn't the case, I got all the substance misuse patients…'* (HP2). Furthermore, participants emphasised the vital role of managers in recognising and supporting staff who may have endured or are currently experiencing their own difficult life experiences, which could make trauma discussions particularly challenging. One participant (EV2) highlighted how staff might struggle not only in the immediate aftermath of difficult experiences but at other times such as the anniversary of a stillbirth, or delivering a baby which is given the same name as the child they lost. An expert from the voluntary sector described how life events which would be very difficult for anyone, such as the loss of a parent, can have *'other layers'* (EV6) for those who have suffered abuse.

Despite acknowledging the importance of supportive management, participants expressed concerns that many staff might not feel comfortable disclosing their own difficult experiences or subsequent mental health struggles to management. A voluntary sector practitioner shared experiences of supporting healthcare staff who were hesitant to disclose due to fears of career repercussions. Similarly, a therapist participant criticised the prevailing culture within the NHS that discourages vulnerability and prioritises stoicism, stating,

> *'Not wanting to be seen as weak or not able to cope, this ideology which is really strong in healthcare that you have just got to crack on with it, come on this is the job, pull up your pants, this is what you signed up for. It is not helpful, and it stops people from disclosing when the shit is hitting the fan for them'* (HP10).

Managers themselves voiced concerns that staff support services could be seen as punitive rather than supportive. For example, a perinatal mental health specialist midwife described a challenging situation where she was supporting a staff member known to be struggling with mental health issues and excessive drinking. She expressed apprehension about the response from the organisation, *'because I wouldn't necessarily say that HR would be supportive'* (HP2).

6.8.4 Reflexive supervision

The consensus among participants was that staff expected to engage in routine trauma discussions should receive regular reflexive supervision during working hours. Both group and individual supervision were deemed valuable and complementary. Participants advocated for supervision independent of the maternity team, as concerns over judgement and career progression could hinder open communication with managers (see section 6.8.3). An expert by experience denounced the expectation for staff to conduct these discussions without proper supervision as *'completely unfair and inappropriate'* (WLE4). Stressing the importance of mandatory supervision, a therapist (HP10) pointed out that many clinicians fail to recognise the potential for burnout. Without it being mandatory, she argued that staff who need support may not access it, remarking *'you don't know until you know how beneficial it is'* (HP10).

Participants asserted that reflexive supervision was essential for enabling care providers to conduct trauma discussions sensitively while maintaining boundaries to prevent burnout. Supervision also serves as a space for staff to cope with personal memories that these conversations may evoke. For example, a midwife with a difficult childhood shared her experiences of therapy over the last 18 months, saying, *'I have really needed that to cope with the stress of work and all of the different things that it has brought up for me'* (HP11). Notably, while she has found this necessary to continue at work, it is in her own time and at her own expense which raises issues of sustainability and fairness.

A psychosexual therapist warned of the risk of staff and women accessing maternity services being harmed by introducing routine trauma discussions in the absence of proper supervision:

> *'It makes me feel sick that we are going to put somebody in that situation […] I can just see it now […], somebody thinks yes, yes it will be alright, we will just ask this question and we will contain it, because they need to contain it maybe for*

themselves because they don't want to know the story that might unfold, but you can't control a client. You can't control the client going so have you experienced sexual trauma yes, well when I were 12 my dad raped me and somebody, you know whatever, you can't control that there is no control over that. And then you have got a traumatised staff member and a potentially doubly traumatised client, or worse case scenario they just get completely shut down and then the client never talks about that to another professional again […] No. No. *You can't just, no you can't.'* (HP10).

6.8.5 The impact of care providers' personal trauma

As noted in section 6.1.2, several participants from the 'maternity care professional' category disclosed previous personal trauma during our interviews. One participant spoke in detail about the impact of her personal experiences on her choice of career as a midwife and working life. Although this is slightly outside my study topic of routine discussion of previous trauma, her insights spotlight the potentially extensive impact of care providers' trauma, and I therefore explore them briefly here.

The participant, identified as WLE3, responded to the recruitment flyer aimed at experts by experience. Although she is a qualified midwife, she requested inclusion in the 'expert by experience' rather than 'professional' category. I did not explore this with her but felt this was part of a deliberate effort to disengage herself from midwifery. During our interview, she revealed that her decision to pursue midwifery was influenced by childhood adversity, but these experiences also rendered her more susceptible to mental health issues, ultimately leading to her departure from the profession.

She recounted the pressure faced by midwives, exacerbated by staffing shortages, which often deprived her of breaks and opportunities to decompress after distressing events due to the overwhelming workload: *'you are just like ok, I will just push that back, and I won't deal with that.'* She reflected that she found the intensity particularly difficult because of her previous experiences: *'as a healthcare professional who has experienced significant childhood traumas I cannot push* *myself that way, I become very unwell.'* She described putting extra pressure on herself to provide the best possible care*:*

> *'I think when you are a healthcare professional and you have been let down, you push yourself to try, you can't save the world, I know I can't do that, but if you are in my care, I am going to try my hardest to make everything ok…'*

However, this need to ensure women had a positive experience had a destructive impact on her well-being: *'I was constantly calling the ward saying 'what happened with her, is she ok, I can't sleep'.* She shared an experience of being present while a woman was treated roughly in labour and how distressing this was for her. Her suffering was compounded by feeling deeply alone and unable to explain why she was so upset: *'I could never be like 'to watch you push that woman's legs apart is really triggering to me. And I just sometimes can't deal with it.'* She felt that even if a senior midwife asked why she was distressed, they would be unlikely to have the sensitivity and understanding of the potentially long-term impact of trauma to be able to help her: *'she would probably be like 'OK why are you telling me your past (laughs).'* Finally, she described how painful it was to decide to stop practicing midwifery:

> *'I had to leave it. I wish I could have stayed […] we don't get to share enough what it feels like to walk away from a profession that was everything I am.'*

This experience underscores the potentially wide-ranging repercussions of personal adversity on maternity care providers and highlights the urgent need for adequate support systems to safeguard their well-being. Given the predominantly female composition of the workforce, it is plausible that a significant proportion of staff have themselves suffered trauma. This participant's experience suggests that, for some, their decision to work in this area may have been directly influenced by difficult experiences, potentially resulting in a higher prevalence of trauma among maternity care providers compared to the general population. The narrative shared by this interviewee suggests that some staff who have endured trauma may be re-traumatised in the workplace and lack the necessary support. This plausibly impacts staff engagement, sickness levels, and ultimately retention, thereby affecting the quality of care provided to women. This issue is explored further in chapter 8.

6.9 Conclusion

In this chapter, I presented insights gained from interviews with experts by experience, voluntary sector practitioners, and maternity care providers, encompassing six key themes: the rationale for trauma discussions, the role of professionals and optimum settings, timing considerations, effective communication strategies, responding to disclosures, and supporting care providers. Through these discussions, a comprehensive understanding of the complexities surrounding routine discussions of previous trauma in the perinatal period was gained.

In the next chapter, I describe the development and evaluation of a framework of guiding principles aimed at facilitating these discussions within perinatal care settings. Drawing upon the rich insights obtained from the systematic review, interviews, and the input of the Research Collective, the framework aims to provide practical recommendations for healthcare professionals to navigate the challenges associated with addressing previous trauma effectively. By translating the findings into actionable principles, this research seeks to contribute towards enhancing the quality of care provided to women during the perinatal period, thereby promoting their emotional well-being and overall health outcomes.

Chapter 7 Development and evaluation of an evidence-based framework of guiding principles for routine discussion of previous trauma in the perinatal period

7.0 Introduction

In the previous chapter, I presented findings from interviews with experts by experience, healthcare professionals, and voluntary sector practitioners. In this chapter, I describe how insights from the interviews were combined with the findings of the systematic review and qualitative synthesis to develop a framework for routine discussion of previous trauma in the perinatal period, which were refined through a public consultation.

7.1 Rationale for developing a framework for trauma discussions

Initially, I had envisaged developing a standardised national intervention for trauma discussions within the perinatal period. I expected that the intervention would include a structured methodology for engaging in trauma conversations, self-accessible information for women, and training for maternity care providers. The plan was to evaluate its acceptability and feasibility during the PhD, considering potential NHS implementation post-doctorate. However, the evolving insights from the systematic review, interviews, and Research Collective led to a shift towards developing adaptable principles for trauma discussions instead. Several factors contributed to this redirection, outlined as follows.

First, I expected that through my study I would identify the optimal methodology for trauma conversations and anticipated that this would be a pivotal element of the intervention. However, as explored in section 6.6.2, no one approach was universally acceptable. While participants acknowledged the potential benefits of a questionnaire approach to raising the issue of previous trauma, the commonly used questionnaires were felt to be of limited effectiveness and had the potential to be distressing and harmful to women. The Kimberley Mom’s Mood Scale was widely praised but was specifically developed for Aboriginal women living in Western Australia and could not be used in a UK setting without significant adaptations. A gap has emerged for a co-designed questionnaire, tailored to a UK context, but this was beyond the scope of my study.

Second, the EMPATHY study emphasised that an effective and sensitive trauma discussion involves more than simply employing an appropriate tool or methodology. Equally vital is creating an environment conducive to disclosure. This encompasses addressing concerns about confidentiality, ensuring sufficient time and an appropriate context for discussions, and establishing and maintaining a trusting relationship. The study also found that unspoken assumptions about the benefits of trauma discussions need scrutiny, and ways should be sought to measure their acceptability and usefulness. Practitioner-level data from my local area and findings from the EMPATHY interviews revealed that trauma discussions were often incorporated into care providers' responsibilities without adequate training, resources, or support. It was therefore felt to be important to develop a broad-ranging, foundational set of guiding principles outlining all aspects of effective and sensitive trauma discussions.

Third, no similar resources to the proposed framework exist. Existing guidance primarily focuses on enquiry and support for pregnant women in currently abusive situations, overlooking discussions about previous trauma (NICE, 2018b; Department of Health, 2017). Notably, the NHS England and NHS Improvement guide to trauma-informed perinatal care advises ‘early and respectful trauma screening and assessment for all’ but lacks specific directions on its implementation (Law et al., 2021, p.34).

Developing adaptable principles for trauma discussions, rather than implementing a standardised intervention, is also in alignment with the underlying theoretical principle of power (see section 4.3). Such an approach not only empowers maternity care providers to address the individual needs and circumstances of each woman but also recognises and reinforces women’s agency and autonomy within the discussion process, fostering collaboration and promoting more equitable and respectful interactions. Therefore, evidence from the systematic review and interviews were used to develop an evidence-based framework for routinely discussing previous trauma in the perinatal period, as detailed in the next sections.

The framework was initially referred to as guidelines in documents seeking feedback on its content. However, I later decided to refer to it as a framework or guidance rather than guidelines. This change acknowledges the early stage of the work, which is yet to be implemented, evaluated, and refined in practice.

7.2 Methods for development and evaluation of the framework

The Appraisal of Guidelines for Research and Evaluation II guidance was used to develop the framework (AGREE II; Brouwers et al., 2010; Brouwers, Kerkvliet and Spithoff, 2016). AGREE II is a widely accepted tool to inform the development, reporting, and evaluation of clinical practice guidelines (Scottish Intercollegiate Guidelines Network, 2019). The tool consists of six quality domains for guidelines, summarised as follows:

1. Scope and purpose: the guidelines should clearly define their aim, the relevant health questions, and the target population.
2. Stakeholder involvement: appropriate stakeholders, including intended users of the guideline, should be involved in their development.
3. Rigour of development: the process of collecting and synthesising evidence, formulating recommendations, and the plan for regular update of the guidelines should be stated.
4. Clarity of presentation: the recommendations should be clearly presented, specific, and unambiguous.
5. Applicability: guideline developers should consider probable barriers and facilitators to implementation, strategies to improve guideline uptake, and the resource implications of implementing the guidelines.
6. Editorial independence: the content of the guidelines should not be influenced by the views of the funding body or competing interests of guideline development group members.

In the sections below, I outline the development and refinement of the framework, categorised by these quality domains.

7.2.1 Scope and purpose

This domain concerns the overall aim of the guidance, the health questions addressed, and the target population (Brouwers et al., 2010).

The objectives of the framework are to:

1. Give clear guidance to maternity care providers on how to carry out sensitive and effective routine trauma discussions so they can identify and address the health and well-being needs of women in the perinatal period.
2. Identify the optimum service setting for trauma discussions so that service managers can ensure they are providing an appropriate environment and support for staff.
3. Describe training needs of maternity care providers relating to trauma discussions so that suitable undergraduate and postgraduate training can be provided.

The targeted patient population is women in the perinatal period who have suffered previous trauma. The guidance is aimed at maternity care providers, maternity service managers and those educating undergraduate maternity care providers. ‘Maternity care providers’ indicates those providing professional support to women in the perinatal period, including midwives, obstetricians, health visitors, general practitioners, and maternity support workers. The framework is designed to assist maternity care providers in recognising and supporting women who are suffering because of previous trauma. Further, it is expected that women who would benefit from additional support but are unwilling to disclose to their maternity care provider will be more likely to seek support and experience health benefits as a result.

7.2.2 Stakeholder involvement

This domain relates to the meaningful engagement of relevant stakeholders in the development of guidelines (Brouwers et al., 2010). Given the participatory nature of this study, stakeholder involvement was multifaceted and integrated throughout the entire process. This inclusive approach was critical to ensure that the framework effectively addresses the needs of marginalised communities, aligning with the study’s underlying theoretical principle of promoting social justice (see section 4.3).

The framework represents the culmination of the study, with the Research Collective engaged at various stages leading up to their development. Workshops held in July 2020 and May 2021 served to refine the study topic and identify areas of uncertainty and controversy surrounding routine trauma discussions, as detailed in section 4.4.2. These workshops played a pivotal role in clarifying the research aims and objectives (section 1.2), and in designing the review of existing evidence (chapter 3). In September 2021, another workshop convened to review the findings of the systematic review and to deliberate on important unresolved issues and gaps in the literature. These insights shaped the interview topic guides, detailed in section 5.1. Subsequently, in October 2022, a further workshop was held to discuss emerging interview findings and identify ongoing areas of ambiguity for exploration in the remaining interviews.

During our March 2023 workshop, I introduced the draft framework to the Research Collective. They were asked to review the guidance and provide feedback using Google Forms, a widely accessible platform praised by the Research Collective for its simplicity and user-friendliness. Google Forms also provides robust measures to protect data security, including data encryption, access control, and two-factor authentication (Google, 2023). The framework was reviewed and commented on by eleven members of the Research Collective, including three experts by experience, three voluntary sector experts, and five midwives.

Members of the Research Collective were asked to select from a multiple-choice question with the options ‘yes, very,’ ‘yes, somewhat,’ or ‘no’ to indicate whether they felt each recommendation was:

- Clear and understandable.
- Sensitively phrased.
- Important.
- Valuable to women who have suffered trauma.
- Acceptable to women, whether they have suffered trauma or not.
- Beneficial for women experiencing inequality and disadvantage.

They could also record a free text comment about each recommendation.

The feedback form also contained the following questions, with a free text response option:

- Do you feel these guidelines would be helpful to maternity care providers / service managers / student care provider educators? Please give reasons.
- Do you feel these guidelines are achievable in practice? Please give reasons.
- Do you feel that using these guidelines could result in harm? Please give reasons.
- Is there anything you would like to add?

Most of the comments were positive. All recommendations were deemed important and valuable by all members of the Research Collective, with one exception: one member expressed reservations about the importance of the recommendation that pathways should be designed with recognition of the additional difficulties women with limited English can face disclosing trauma, citing personal experiences with poorly translated information. I feel this comment shows agreement with the need to consider the needs of women with limited English, but a different perspective on how to achieve this.

Continuing discussions from previous sessions (see section 5.1), the Research Collective debated the use of the term 'trauma' in the framework. While acknowledging its role in facilitating healing for some women, it was noted that not all women categorise their experiences as traumatic, irrespective of their impact. This led to a suggestion to include the term ‘difficult experiences’ interchangeably with ‘traumatic experiences’ in the framework to cater to diverse preferences.

Feedback from the group was systematically incorporated into an improved draft for public consultation. This included a change in wording to refer to ‘maternity care providers’ rather than ‘midwives’ throughout, recognising that healthcare providers from a range of professions may carry out trauma discussions in the perinatal period. The language of several recommendations was clarified and small errors in the feedback form, such as a missing comment box, were resolved. No recommendations were added or removed, resulting in a draft for consultation comprising 22 recommendations.

In our workshop held in March 2024, the Research Collective reviewed and commented on the final draft of the framework.

7.2.3 Rigour of development

This domain concerns the process of gathering and synthesing evidence to formulate guideline recommendations (Brouwers et al., 2010).

The framework was developed using the following sources:

- Papers included in the EMPATHY study systematic review and qualitative synthesis (Cull et al., 2023).
- EMPATHY study interview findings (presented in chapter 6).
- The seminal conceptual document ‘SAMHSA’s concept of trauma and guidance for a trauma-informed approach’ (SAMHSA, 2014).
- The ‘Good practice guide to implementing trauma-informed care in the perinatal period’ commissioned by NHS England and NHS Improvement (Law et al., 2021).
- Insights from the Research Collective.

For some guideline recommendations, the evidence was clear and unambiguous. For example, the systematic review and qualitative synthesis found with high confidence that some women will choose not to disclose previous trauma (see section 3.4.3). This led directly to the recommendation *Women should be provided with information and support that they can access independently, without the need to disclose traumatic experiences to healthcare providers. Maternity care providers should address potential concerns about confidentiality, reassuring women that they cannot determine whether she has accessed online resources.*

In some cases, the evidence was more nuanced, and guideline recommendations were developed using a combination of evidence. For example, the systematic review found that women favour a broad, conversational approach to discussing trauma, but there was very low confidence in this finding (section 3.4.3). Participants in the interviews noted that direct questions about previous trauma could be clear to women and draw their attention to the significance of difficult experiences but could also be potentially re-traumatising. Considering the balance of potential benefits and risks, this evidence was combined to become the recommendation *Maternity care providers should only ask direct questions about difficult or traumatic previous experiences if there is a protocol and referral pathways in place and they have had training in how to ask and respond.*

7.2.4 Clarity of presentation

This domain specifies that the guideline recommendations should be specific, unambiguous and clearly presented (Brouwers et al., 2010).

The framework was assessed for clarity by the Research Collective, as described in 7.2.2, and through a public consultation, as detailed in the next section.

7.2.5 Applicability

This domain relates to the identification of potential barriers and facilitators to the implementation of guidelines, as well as strategies to improve the uptake of these guidelines (Brouwers et al., 2010).

After formulating and refining recommendations in collaboration with the Research Collective, as described in the preceding sections, a public consultation on the draft framework was conducted, in line with the study's underlying theoretical principle of collaboration (see section 4.3). The primary objective of this consultation was to ensure the guidance accurately reflected the needs and priorities of stakeholders, and were deemed relevant, practical, and effective. The aim was to gain insights into the practical challenges associated with implementation of the framework and to determine whether adjustments were necessary to enhance the likelihood of adoption. Details regarding the methods employed for the consultation are outlined below.

Recruitment

Recruitment for the consultation commenced on May 25, 2023, and concluded on September 10, 2023. Similar to the recruitment process for the study interviews (see

Section 5.2), recruitment for the public consultation evolved organically. Initially, I reached out to all the interview participants, offering them the opportunity to provide feedback on the framework. These participants brought a range of expertise, gained through personal experience, professional roles, or voluntary sector involvement, which were the diverse perspectives I aimed to engage. Their involvement also enabled them to review my interpretation of their interview responses, and how I had used this information to develop an evidence-based framework of guiding principles for trauma discussions.

In addition to interview participants, I contacted key voluntary sector organisations involved in supporting women after trauma, as well as professional contacts who had previously expressed interest in the study. The framework was shared in relevant professional groups, such as the UK Perinatal Mental Health Specialist Midwives Group, the Consultant Midwives' Forum, and the International Trauma-Informed Care Network. Furthermore, I promoted the guidance on my Twitter account on August 1, 2023. As of the time of writing this (October 17, 2023), the tweet garnered 5,555 views and although I did not ask people to share on my behalf, it received 28 retweets, including endorsements from influential accounts such as Sheena Byrom, a midwife with 26.6k followers, Dr Maeve O'Connell, a midwife with 14.2k followers, and The Birth Trauma Association, an organisation with 7.5k followers. In this period, I presented at several conferences and shared the Google Form link for attendees to take part in the consultation if they wished to do so. These conferences included the Global Maternal and Infant Health Research Webinar and the Internal Confederation of Midwives Triennial Congress (see preamble to this thesis).

Appropriate reminders were sent during the recruitment period. While most participants completed the consultation without issues, there was one instance where a respondent claimed to have submitted the questionnaire, but I did not receive it. After conducting a test consultation to confirm the functionality of Google Forms, I contacted the individual, who agreed to complete the questionnaire again but did not follow through.

Data collection

The public consultation was facilitated through Google Forms, chosen for its effectiveness in collecting feedback from the Research Collective. The feedback form included each of the 22 recommendations, allowing respondents to provide free-text comments on each recommendation individually. Additionally, respondents were asked for overall free-text comments on whether they felt the guidelines would be:

- Helpful to maternity care providers, service managers, and educators.
- Achievable to implement in practice.
- Valuable to women who had suffered trauma.
- Acceptable to women, regardless of trauma history.
- Beneficial to women facing inequality and disadvantage.
- Harmful.

Respondents were also invited to include any additional comments or suggestions. Additionally, participants were asked if they agreed to the anonymisation and use of collected information for subsequent research, presentations, and publications, as well as their willingness to be acknowledged in the published guidance. The consultation document is available in appendix 14.

Initially, I did not ask about respondents' professional expertise in this field. This was due to ethical concerns that participants might additionally disclose their own trauma histories and later regret doing so. I was aware that I had personal and professional relationships with many of the participants, creating uncertainty about how to best handle disclosures of personal trauma. Additionally, I felt that asking about professional or voluntary sector expertise might undervalue the opinions of lived experience respondents, echoing experiences from the initial Research Collective workshop (discussed in section 3.7). Nonetheless, as responses to the consultation accumulated, it became evident that participants possessed a wealth of experience that could enhance the credibility of the framework. To capture this valuable information, I added a final, optional free-text question as follows:
'We are keen to hear a range of perspectives on the guidelines. If you have professional experience in this area (for example, as a healthcare professional or working for a voluntary sector organisation) please give details below.'

Some minor revisions to the feedback form were made during the consultation period to improve clarity and rectify errors. I also added a note to the questionnaire preamble advising participants to read the guidance in full before providing feedback. These changes were made based on initial feedback from respondents, underscoring the importance of pilot consultations in future studies. When I began recruiting through Twitter on August 1, 2023, I recognised the need to provide context for those accessing the framework. I added a more extensive preamble about myself, the study, and the guidance to the questionnaire. I also included a hyperlink to the EMPATHY systematic review and qualitative synthesis paper.

Data analysis

Data from the consultations were exported to Google Sheets for initial analysis. Descriptive content analysis, a research method which aims to use data to build up a conceptual model, was used (Vaismoradi, Turunen and Bondas, 2013). The analysis took place in three phases, in line with guidance of Elo and Kyngäs (2008):

1. Preparation phase: I read through all the responses several times to become familiar with the data and obtain a sense of the dataset as a whole. I then decided on the unit of analysis: the basic unit of text to be classified during analysis. I decided the unit of analysis would be the responses to each survey question. Thus, all responses to question 1 would be analysed, then all responses to question 2, etc.
2. Organising phase: I grouped responses into tentative codes: for example, for the recommendation that maternity care professionals be provided with regular, independent counselling within paid working hours, tentative codes included ‘valuable,’ ‘essential,’ and ‘unfeasible.’ When this had been carried out for each survey question, I reviewed the analysis overall and ensured I had included all key points.
3. Reporting phase: the findings were reported using a narrative summary of the responses, supported by direct quotes to illustrate key points. When reporting participant responses, I focused on preserving the essence of the response while eliminating extra details, repetitions, and making necessary grammatical corrections.

In line with the ethical principle of the right to privacy (Leedy and Ormrod, 2015), I have written about the guideline consultation in such a way that the responses of individual participants cannot be identified.

7.2.6 Editorial independence

This domain relates to potential biased influences on the formulation of recommendations.

The views of the study funders, the National Institute for Health Research and Wellbeing of Women, did not influence the content of the framework. No members of the Research Collective had competing interests.

7.3 Findings from the guideline consultation

In this section, data about participants in the consultation is provided, and insights from the consultation are shared.

7.3.1 Participants

The consultation received 52 responses, comprising 7 interview participants (2 of whom were previous Research Collective members, as noted in section 5.2.1), 28 individuals personally approached based on their expertise or interest, and 17 recruited through various channels such as Twitter or conference presentations. As described in section 7.2.5, demographic information was not explicitly sought, but based on my familiarity with most participants, their names, and information shared during the consultation, 49 respondents were female, and 3 were male. Most participants were in the UK, with representation from other locations including Cameroon (n=1), the Netherlands (n=1), and Japan (n=1). All participants granted permission for the use of their responses in further research, and only one participant declined acknowledgment in the published guidance.

As detailed in section 7.2.5, participants were asked a free-text question about their professional experience in this field. In summary, the respondents exhibited diverse professional backgrounds, including:

- Voluntary sector representatives, including those linked with the Birth Trauma Association, For Baby's Sake, Birth Companions, and Birthrights.
- Obstetricians, midwives, and health visitors, many with expertise in supporting women with abuse histories.
- Specialists in maternal mental health and / or safeguarding, including in Mother and Baby Unit settings.
- Diverse professionals, including a commissioner, a social worker, a national advocate, and a clinical psychologist, a childbirth educator and a compassionate inquiry practitioner.
- Researchers dedicated to maternity care for survivors of sexual violence and abuse.
- Midwifery educators.
- Trauma survivors, some who also have academic or voluntary sector expertise or have supported their local Maternity Voices Partnership.

7.3.2 Feedback on the framework for trauma discussions

Feedback from consultation participants on individual recommendations is detailed in table 7.1. Of the 22 recommendations presented in the guideline consultation, 11 remained substantially unchanged, except for minor adjustments for clarity. The remaining 11 recommendations were revised based on feedback from the consultation. Additionally, a new recommendation was added, stating that maternity services should develop a comprehensive written policy for routine trauma discussions, including provisions for implementation, communication, staff training, supervision, evaluation, and review.

The following section presents a summary of participants' responses to open-ended questions about the framework, offering insights into their perceived value, feasibility, acceptability, potential impact on disadvantaged groups, and potential for harm.

Value of the framework

Most respondents viewed the guidance as valuable for women who had faced trauma, with comments such as *'absolutely invaluable'* (R9)*, 'there is much that is very important and valuable in these guidelines'* (R8), and *'I feel grateful to read* *these very well thought through and trauma sensitive directions to talk with our clients about difficult experiences'* (R25). Another participant suggested that if the framework was implemented *'there would be a dramatic shift in perinatal experiences and a lot less re-traumatisation'* (R41). The framework was seen as addressing an unmet need for care providers, service managers, and undergraduate educators, as while there is growing awareness of the importance of trauma-informed approaches *'there is much less available about what this means / looks like in practice'* (R9). The inclusion of clear recommendations for training maternity care providers was particularly welcomed. Moreover, one participant expressed interest in piloting the framework within the NHS trust where they are employed.

However, some respondents expressed reservations and suggested areas for improvement, such as expanding the scope of the framework to include commissioning services and integrating them with existing safeguarding and domestic abuse guidance and training. Respondents emphasised the need for sensitive implementation and adequate support pathways, and some felt that the framework should be expanded to include support for co-parents / partners who have suffered trauma. The difficulty of finding appropriate language to discuss trauma was also highlighted, with participant R41 noting that *'not everyone will identify as a trauma survivor'* although they may be describing symptoms of PTSD. A participant with expertise in sexual violence and maternity care described the guidance as *'excellent'* (R36) but recommended strengthening the survivor voice, including through empowering survivors to lead or co-deliver training. She asserted:

> *'I know this might seem unrealistic in a currently under-funded and over-stretched system, but survivors need to be instrumental to bringing about change - otherwise it is not a trauma-informed approach'* (R36).

Feasibility of implementation

Views were mixed among respondents as to whether the guidance could be successfully implemented. Some believed it would be straightforward, citing compatibility with existing mental health and emotional well-being questions. However, others highlighted challenges due to resource constraints and the demands on maternity services, expressed by one participant here, *'the NHS is tired,* *very very noisy with 'change' initiatives and nothing really changing'* (R28). While acknowledging the pressures on maternity services, some respondents returned to the importance of the work, emphasising that better care for women who have suffered trauma is essential. One participant said plainly: *'if they aren't [achievable] something has to change'* (R31). Others pointed out that changing practice is always challenging *'there will never be a [right] time'* (R9) and that it does not have to be an all or nothing approach: *'if even half the guidelines were implemented that would make a huge difference'* (R41).

Aligning trauma discussions with established workstreams on domestic abuse, safeguarding, and mental health was a suggested approach to make implementation more attainable, as these areas often have specialist maternity care teams, guidelines in place and a presence in mandatory training. *'Strong leadership'* (R34) and implementation champions were felt to be essential, with one participant suggesting that a funded coordinator post would make implementation more achievable (R50). Some respondents felt the framework could only be effective if combined with continuity of carer, which was described by one respondent as *'paramount'* (R52).

Acceptability

Participants believed that women would find the framework acceptable if provided with clear rationale for the discussion and it was handled sensitively. Even for those who had not suffered trauma, it was felt that trauma discussions could *'help women share all manner of concerns'* (R49), raise awareness and reduce stigma around trauma. Some participants shared their experiences of discussing trauma with women, noting that many responded with gratitude and understanding, even if they had not personally experienced trauma. Several respondents drew parallels between trauma discussions and routine enquiry for domestic abuse, noting that such discussions are generally acceptable and *'women are very supportive if they think it will help other women'* (R32).

Inequality and disadvantage

Most respondents believed that implementing the framework would benefit women facing inequality and disadvantage. They highlighted the complex relationship between trauma, inequality, and lack of support. For instance, one participant stated:

> *'Most definitely [the guidance would benefit women facing inequality and disadvantage] - as they have often suffered significant trauma, are more susceptible to traumas that arise with multiple disadvantage, and these could impact their current experiences of pregnancy, birth and mothering. They may also have less knowledge or access to places where they can find support'* (R40).

Recognising the impact of trauma on mental and physical health, respondents highlighted the potential for this guidance to improve care for vulnerable groups including women seeking asylum, individuals from ethnic minorities, and those facing socio-economic challenges. One participant suggested the approach proposed in the framework *'could be the most impactful way to challenge health inequalities and reach those people who do not have trust in the system'* (R9).

However, some respondents expressed reservations, citing barriers to disclosure within certain ethnic and socio-economic groups. As one participant noted, *'they are the ones least likely to disclose because of fears of consequences'* (R3). Participants highlighted the importance of addressing language barriers and stressed the necessity of cultural safety and ongoing anti-racist efforts to ensure the guidance effectively caters to all, particularly those from marginalised communities. Furthermore, several respondents proposed that the framework should use inclusive language to acknowledge individuals who are biologically female but do not identify as women, an issue discussed in the glossary of terms and abbreviations in the preamble to this thesis.

Potential for harm

Most participants felt the guidance itself was unlikely to cause harm, with comments including *'no more so than current fragmented care,'* (R19) *'far less than the harm caused when we don't know about previous trauma'* (R37) and *'more harm comes from women suffering guilt and blame for experiences that were not their fault'* (R5).

However, respondents expressed significant concern that the framework would be poorly implemented, as encapsulated by this participant: *'of course there are harms from disclosures if they are not managed well or if there is not sufficient time / corners are cut'* (R9). Concerns were raised that the guidance would be *'not delivered as intended and become a tick box exercise'* (R38) or be '*another document uploaded in a cloud that nobody looks at'* (R42), potentially raising unrealistic expectations for women and care providers. Many highlighted the risk of insufficient training leading to insensitive discussions or coercion, worsening women's experiences and preventing future disclosures. There were also concerns about inappropriate handling or recording of trauma disclosures, which might stigmatise women who have suffered trauma. Additionally, participants noted the potential to burden maternity care providers with additional responsibilities without adequate resources or support for women, resulting in low guideline uptake. Respondents stressed the importance of emotional support for staff dealing with such challenging situations.

7.4 Content of the framework of guiding principles

The framework begins with a preamble stating that procedures for trauma discussions should developed collaboratively with a diverse group of stakeholders, including experts by experience, maternal mental health services, voluntary sector organisations, and maternity care providers. The preamble underscores the importance of prioritising choice, control, and agency for women at all times.

The guidance contains 23 recommendations, rooted in six core principles:

1. Routine trauma discussion should be introduced as part of a system-wide change.
2. Maternity care providers should let women know previous trauma can affect their wellbeing, and help them access support.
3. Trauma discussions should be carried out sensitively, in a way that builds trust and relationships.
4. Staff should be given training and support to carry out routine trauma discussions.
5. Routine trauma discussions should be tailored to local needs and services.

6. Services should systematically assess the implementation and impact of routine trauma discussions and seek to continuously improve trauma pathways based on these insights.

The rationale for each recommendation, underpinning evidence base, and insights from the guideline consultation, are provided in table 7.1.

7.4.1 Preamble to the framework

Maternity care services should develop procedures for routine trauma discussions in close collaboration with a steering group comprising experts by experience, maternity care providers responsible for conducting trauma discussions, maternal mental health services, and local voluntary service organisations. The steering group should be intentionally inclusive and representative of various trauma types and member demographics.

To ensure that steering group members have adequate support, consideration should be given to recruiting experts by experience through voluntary service organisations. Participants in the steering group should receive compensation for their invaluable expertise and contributions. Feedback mechanisms, including anonymous options, should be implemented to foster open and inclusive communication within the group. The steering group should be meaningfully involved throughout the entire process of developing, implementing, and evaluating routine trauma discussions in maternity care.

The overarching principle of empowering women by promoting choice, control and agency over decisions relating to their care should be upheld at all times.

7.4.2 Principle 1. Routine trauma discussion should be introduced as part of a system-wide change

1. Maternity care services should develop a comprehensive written policy for routine trauma discussions, addressing the following key elements:

- Who, how, when, and where discussions will take place.
- Referral pathways.

- Communication strategy to prepare women for trauma discussions, ensure they understand the purpose and benefits, and inform them of available support resources.
- Strategies to ensure trauma discussions are culturally sensitive, equitable, and accessible. This includes addressing the needs of women with limited English proficiency or other communication needs and women who seek care later in pregnancy or have received limited maternity care.
- Format, content, and delivery plan for staff training, including provisions for ongoing training to maintain competency and awareness.
- Mechanisms for providing supervision and ongoing emotional support to staff involved in conducting trauma discussions.
- Procedures for evaluating and monitoring the impact and acceptability of routine trauma discussions, incorporating feedback from both women and staff.
- Identifying key individuals or teams responsible for implementing and overseeing the policy within maternity care services.
- A regular review schedule for the policy, to ensure it is responsive to emerging research, evolving practices, and feedback from stakeholders.

7.4.3 Principle 2. Maternity care providers should let women know previous trauma can affect their wellbeing, and help them access support

2. Maternity care providers should make women aware that previous difficult or traumatic experiences can affect their current wellbeing and experience of pregnancy and parenting.

3. Discussions about difficult experiences should be combined with discussions about mental health, because many troubling thoughts, feelings, and behaviours are attributable to previous experiences.

4. Maternity care providers should give women multiple ‘light-touch’ opportunities to talk about mental health concerns and previous difficult or traumatic experiences, because women may not feel comfortable disclosing or need support until later in the perinatal period.

5. Maternity care providers should only ask direct questions about difficult or traumatic previous experiences if there is a protocol and referral pathways in place and they have had training in how to ask and respond.

6. Women should be provided with information and support that they can access independently, without the need to disclose traumatic experiences to healthcare providers. Maternity care providers should address potential concerns about confidentiality, reassuring women that they cannot determine whether she has accessed online resources.

7. When women disclose previous difficult or traumatic experiences, maternity care providers should collaborate with them to develop a personalised plan of care for the perinatal period that prioritises choice, control, and individualised care. This plan could include:

- Clarifying birth preferences or wishes.
- Addressing potential triggers, with specialist psychological support if needed.
- Facilitating continuity of carer where feasible.
- Assisting in accessing mental health support if this would currently be, or might become, beneficial. In cases where women may not meet criteria for perinatal mental health services, exploring alternative support options such as third sector organisations or online resources is recommended.
- Providing information about additional support services, such as peer support, parentcraft groups, third-sector, community, or online resources.
- Offering information for women's partners on how to provide support during this time.

However, it is important to note that structured care plans may not be desired or beneficial for all women.

7.4.4 Principle 3. Trauma discussions should be carried out sensitively, in a way that builds trust and relationships

8. Women should be sensitively forewarned that the issue of previous trauma will be raised, providing them with the opportunity to prepare for the discussion and ensure they have adequate support in place. They should be informed that they can opt out of answering any questions about previous difficult experiences and told of the limits of confidentiality.

9. The issue of previous difficult or traumatic experiences should be raised when there is sufficient time for staff to listen and respond to disclosures, recognising that for women who do not feel listened to, these discussions can be re-traumatising. Where care providers cannot adequately respond to a disclosure due to time constraints, they should acknowledge the disclosure and schedule a follow-up appointment where they will be able to talk in more depth. Service managers should ensure appointments include additional time for trauma discussions and facilitate autonomy in arranging follow-up or additional appointments.

10. An additional antenatal appointment specifically focused on addressing women's social, emotional, and psychological well-being, including the opportunity to disclose any previous traumatic events if desired, should be provided. This appointment should adhere to the following criteria:

- Conducted in a private and undisturbed environment.
- Without the presence of a partner, acknowledging that some women may not have disclosed their traumatic experiences to their partners or that partners may have been involved in the experiences. However, if a woman prefers to include her partner or a trusted support person in the discussion, a follow-up appointment should be offered.
- Ensure there is a private space available and a dedicated staff member to provide support if a woman becomes upset during the conversation, allowing her the necessary time to gather herself.
- Ideally conducted by a female care provider, recognising that some women may not feel comfortable disclosing previous trauma to male staff.

All maternity care settings should prioritise allocating resources to facilitate this additional appointment. If an additional appointment is currently not feasible, services should consider how the above points can be integrated within existing maternity care appointments.

11. Where possible, the issue of previous difficult or traumatic experiences should be raised by a maternity care provider who is known to the woman, as many women will not disclose trauma without a trusting relationship.

12. Maternity care providers should collaborate with women to ensure documentation of trauma disclosures is sensitive and acceptable (while adhering to safeguarding requirements), recognising and advising women that maternity records may inadvertently be viewed by others, including partner and family. This approach aims to both prevent sharing of information without consent and reduce the potential for re-traumatisation by minimising the need for women to needlessly repeat their stories.

13. Maternity care providers should ask women's wishes about information sharing within the maternity team and with other services, and as far as possible follow these wishes.

7.4.5 Principle 4. Staff should be given training and support to carry out routine trauma discussions

14. Maternity care providers should undergo comprehensive training to sensitively conduct trauma discussions. This training must be collaboratively developed and delivered in partnership with experts by experience and specialist voluntary sector organisations, with due compensation for their invaluable expertise. Ongoing training, supervision, and support should be provided to staff to ensure sustained competence. The training curriculum should include the following key elements:

- Understanding the potential effects of trauma on mental and physical health, behaviour, wellbeing, and parenting across diverse population groups.
- Fundamental counselling skills, including active listening, employing open-ended questions, building confidence in asking about and responding to

disclosures of difficult experiences, and sensitively concluding difficult conversations.

- Recognising and sensitively supporting women who may have suffered trauma but choose not to disclose it.
- Local care pathways available for women who have suffered trauma.
- Appropriate documentation of trauma disclosures and safeguarding considerations.
- An evaluation so the effectiveness and acceptability of the training can be monitored.

Facilitators of the training must be mindful that attendees may reflect on personal experiences, potentially eliciting painful memories, and should consider strategies to support them.

15. All staff working in maternity care, including support staff such as healthcare assistants and receptionists, should receive role-appropriate training in supporting women who may have suffered trauma.

16. Staff training on routine trauma discussion and trauma-informed care should begin in the undergraduate period.

17. Maternity care providers should be provided with regular (e.g., monthly) counselling, within paid working hours, to help them manage the emotional impact of discussions about trauma, including any personal memories these conversations may evoke. The counselling should be confidential and provided by a qualified professional who is independent of service management.

7.4.6 Principle 5. Routine trauma discussions should be tailored to local needs and services

18. Consideration should be given to overcoming cultural, systemic, and societal barriers to trauma discussions. These barriers include:

- Shame, stigma, and silencing.
- Expectations about gender.

- Strong social taboos around discussing abuse, potentially leading to a lack of recognition of abusive experiences by women.
- Lack of awareness of mental health issues.
- Some languages lack specific vocabulary to describe mental health and may use terms that are stigmatising or derogatory (e.g., 'crazy').
- Mistrust of institutions, which may stem from prior experiences with statutory services.
- Fears that care providers will gossip or discuss their personal information without consent.
- Cultural bias and racism from care providers.
- Insecure immigration status, which can increase vulnerability to abuse and discourage disclosure of experiences.
- Sexual orientation and gender identity.

To ensure these barriers are considered and to provide an inclusive approach, the development of pathways and the design and delivery of training should incorporate input from individuals with various cultural backgrounds and lived experiences.

19. Pathways should be designed with recognition of the specific challenges faced by women with limited English proficiency or other communication difficulties when disclosing trauma. These challenges may include:

- Reluctance to disclose in the presence of an interpreter. It is essential to acknowledge and address potential barriers that interpreters might pose to open communication.
- Fear that interpreters will breach confidentiality and disclose sensitive information to others in the community. Strategies should be implemented to build trust and ensure interpreter confidentiality.
- Reluctance to disclose in the presence of partners, family, or friends who are acting as interpreters. It is crucial to discourage this practice, emphasising the importance of neutral and professional interpreters.
- Limited literacy in their own language can mean translated materials are not helpful and make women feel ashamed. Services should strive to provide accessible information such as audio translations of questionnaires and information leaflets.

- Difficulty understanding technical terms, written information, or subtle nuances even for women with good conversational English. Efforts should be made to communicate information in a clear, straightforward manner to ensure understanding across varying levels of English proficiency.
- Services should also consider how they can meet the needs of women who have other communication needs, including hearing difficulties, learning disabilities, neurodivergence, or low literacy.

20. Routine trauma discussion pathways should be tailored to local resources and services. Women should also be informed of national support organisations to ensure a minimum level of support for all women, regardless of location. It is important to acknowledge that some women prefer anonymous support options, such as telephone-based or national rather than local services, due to concerns about confidentiality and social encounters with support providers. Additionally, poverty should be recognised as a barrier to accessing support.

7.4.7 Principle 6. Services should systematically assess the implementation and impact of routine trauma discussions and seek to continuously improve trauma pathways based on these insights

21. While respecting women's individual rights to confidentiality and their choices regarding documentation of trauma disclosures in medical records, efforts should be made to measure the uptake and impact of routine trauma discussions. Collected data could include:

- Proportion of staff trained in conducting trauma discussions.
- Proportion of women asked about previous trauma.
- Basic sociodemographic information.
- Number of women who disclosed trauma and types of traumas disclosed.
- Changes in care resulting from trauma disclosures.
- Uptake of referrals made.
- Impact on related services such as referrals to mental health and addiction services.
- Impact of routine trauma discussion on outcomes such as health, quality of life and experience of parenting.

In analysing the data, both the overall dataset and specific results relating to marginalised groups and individuals from different cultural backgrounds should be considered to ensure inclusivity and representation of diverse voices.

22. Feedback should be sought at a local level from women using maternity services and staff regarding routine discussion of previous trauma. The aim of this feedback is to establish whether it is acceptable and helpful, and to identify unintended consequences, such as the risk of re-traumatisation for women or negative impact on staff wellbeing. To encourage open communication and constructive criticism, feedback collection should be anonymous. Services should collaborate with voluntary service organisations to develop strategies to seek feedback from marginalised populations. Responses should be analysed both as a whole, and separately for marginalised groups and different cultural backgrounds, to ensure trauma discussions are equitable.

23. While upholding women’s rights to confidentiality, maternity services should collaborate with each other to share findings and identify best practices. Findings should also be shared with the steering group, staff conducting trauma discussions, and local voluntary service organisations.

7.5 Underpinning evidence base

Table 7.1 presents the rationale for each recommendation, underpinning evidence base, and insights from the guideline consultation.

Table 7.1 Evidence base for the framework of guiding principles for routine trauma discussions in the perinatal period

Final recommendation and *rationale*	**Underpinning evidence (study numbers as per table 3.2)**	**Feedback from guideline consultation**
1. Maternity care services should develop a comprehensive written policy for routine trauma discussions, addressing the following key elements: ● Who, how, when, and where discussions will take place. ● Referral pathways. ● Communication strategy to prepare women for trauma discussions, ensure they understand the purpose and benefits, and inform them of available support resources. ● Strategies to ensure trauma discussions are culturally sensitive, equitable, and accessible. This includes addressing the needs of women with limited English proficiency or other communication needs and women who seek care later in pregnancy or have received limited maternity care. ● Format, content, and delivery plan for staff training, including provisions for ongoing training to maintain competency and awareness. ● Mechanisms for providing supervision and ongoing emotional support to staff involved in conducting trauma discussions. ● Procedures for evaluating and monitoring the impact and acceptability of routine	This recommendation consolidates the previously described evidence. NHS England and NHS Improvement advocate integrating trauma-informed care into organisational culture, policies, and practices, with input from experts by experience (Law et al., 2021). SAMHSA (2014) further recommends incorporating a trauma focus into policies and procedures.	Not applicable - this recommendation was added after the consultation.

trauma discussions, incorporating feedback from both women and staff. ● Identifying key individuals or teams responsible for implementing and overseeing the policy within maternity care services. ● A regular review schedule for the policy, to ensure it is responsive to emerging research, evolving practices, and feedback from stakeholders. *This recommendation aims to provide a structured framework for providing routine trauma discussions, ensuring consistency, clarity, and effectiveness in practice.*		
2. Maternity care providers should make women aware that previous difficult or traumatic experiences can affect their current wellbeing and experience of pregnancy and parenting. *Enables appropriate support to be put in place and prepares women for potential challenges that may arise during this critical period.*	NHS England and NHS Improvement advocate for providing women with information on the impact of prior trauma in the perinatal period, along with available support (Law et al., 2021). The EMPATHY study's systematic review and qualitative synthesis highlight the value of routine trauma discussions, as perceived by women and maternity care providers (1,2,3,4,5,6,7,8,10,12,13,14,15,16,17,18,19,20,21,22,23,24,25). Participants in the EMPATHY study interviews believed that carefully navigating discussions around trauma and providing effective support post-disclosure could prepare women for unexpected distress in the perinatal period and facilitate healing and growth. They highlighted the potential of trauma discussions to break the cycle of intergenerational trauma and tailor care to individual needs, while emphasising the economic benefits of well-funded interventions.	Participants proposed that trauma discussions can offer *'clarity, reassurance, and relief'* (R41) to survivors, while also normalising the effects of trauma on pregnancy, birth, and parenting experiences. However, participants stressed the need for sensitivity to avoid inducing anxiety or stigma and highlighted the importance of universally initiating trauma discussions without singling out women based on assumptions to prevent inadvertent stigmatisation. Furthermore, they advocated for a balanced approach that acknowledges the potential for healing during pregnancy, birth, and parenthood, while avoiding overemphasis on negative experiences that may disempower survivors.
3. Discussions about difficult experiences should be combined with discussions about mental health, because many troubling	SAMHSA (2014) and NHS England and NHS Improvement (Law et al., 2021) highlight the close	Participants stressed the significance of combining discussions about challenging past experiences with conversations on mental health, highlighting their interdependence. They

thoughts, feelings and behaviours are attributable to previous experiences. *Integrating these discussions could help establish a connection for women between previous traumas and ongoing mental health challenges.*	relationship between trauma and mental health problems. The EMPATHY study's systematic review found that some women were not fully aware of the extent or impact of the trauma they had suffered (1,2,3,4,6,12,13,14,18,22). Additionally, some women viewed their previous experiences as irrelevant to their current pregnancy (3,6,12,13,16,18,20). Most participants in the EMPATHY study interviews advocated for combining discussions about mental health and trauma. They believed that such integration could support women's healing and growth by acknowledging the ongoing impact of past experiences.	suggested that such dialogues might mitigate shame or stigma for women struggling with mental health issues. It was proposed that broaching either topic could facilitate disclosure of the other, noting that discussions about low mood could serve as a gateway for discussing traumatic experiences, and vice versa (R39). However, respondents cautioned against assuming a direct link between all challenging experiences and ongoing mental health issues. They stressed the need for sensitivity, highlighting that not all individuals facing mental health problems have suffered trauma, and that not all difficult experiences continue to affect well-being. Some participants expressed concerns about the lack of sustained support available for trauma survivors and the inadequacy of mental health services in responding to trauma. Others highlighted the necessity of clearly delineating role boundaries for maternity care providers and the need for improved training in this area.
4. Maternity care providers should give women multiple 'light-touch' opportunities to talk about mental health concerns and previous difficult or traumatic experiences, because women may not feel comfortable disclosing or need support until later in the perinatal period. *Providing multiple opportunities to discuss trauma gives women choice and control over when to discuss their experiences, addresses the challenge of trauma discussions being unexpected, and enables trust to be established with maternity care providers.*	The EMPATHY study's systematic review highlighted the significance of choice and control for women, indicating that a flexible approach to trauma discussions that accommodates women's preferences for when to talk about these experiences is consistent with their needs (1,10,12,14,18,19). Providing multiple opportunities for women to share their experiences can address the challenge that trauma discussions can be unexpected (2,6,13,14,16,20). Further, the review found that women may fear judgment if they disclose their histories, and giving them the chance to talk about difficult experiences later in pregnancy, when trust is established, may mitigate this fear (1,2,3,12,13,14,17,18,19,20,22,24). Additionally, the perinatal period can be unexpectedly challenging, making issues seemingly insignificant early in pregnancy more relevant later (1,2,4,10,12,14,18,19,20,24).	Participants unanimously supported offering multiple opportunities for discussions on mental health and trauma, believing these discussions would help *'make every contact count'* and reduce stigma surrounding trauma (R38). Empowering women to decide when to engage in these conversations, rather than restricting them to a single opportunity, was seen as essential. The idea of *'leaving a door open or planting a seed'* emerged, allowing women to reflect on their experiences and share when ready (R52). However, opinions varied on the term 'light-touch', with concerns about ambiguity and potential trivialisation of trauma. Participants stressed the need for clear language and tools for maternity care providers to facilitate these conversations effectively. They also highlighted the importance of ensuring that women perceive these 'light touches' as invitations to share their experiences rather than mere conversational points. Many participants observed that offering multiple opportunities to discuss past trauma allows time to foster trust between care

	EMPATHY study interview participants stressed the importance of a patient and gradual approach to trauma discussions, recognising that it may require multiple appointments for women to feel comfortable disclosing their experiences. They recommended that practitioners keep the possibility of future disclosures open, allowing survivors the necessary time and space to decide when and how to share their experiences. Additionally, participants suggested that some women might not be ready to seek support until after the birth of their baby.	providers and women. Continuity of care was highlighted as important for trust-building, allowing providers to "check in" at each visit and detect subtle changes in the woman's well-being (R30). However, some participants suggested that a new care provider might be better positioned to encourage disclosure due to different interpersonal dynamics.
5. Maternity care providers should only ask direct questions about difficult or traumatic previous experiences if there is a protocol and referral pathways in place and they have had training in how to ask and respond. *This recommendation aims to mitigate the risk of lasting harm through insensitive trauma discussions.*	Both SAMHSA (2014) and NHS England and NHS Improvement (Law et al., 2021) advise universal trauma screening. However, the evidence base does not indicate a clear 'right way' to raise the issue of previous trauma. The EMPATHY study systematic review found with very low confidence that women favour a broad, conversational approach to discussing trauma (1,2,9,12,13). Many participants in the EMPATHY study interviews questioned the effectiveness of quantitative trauma and mental health screening tools, feeling that a general, open style of conversation is more likely to elicit disclosure. Interviewees further proposed that closed-ended questions may deter women from disclosing because of a fear of social services involvement. It was also felt that direct questions could cause women to confront past experiences in an unanticipated and harmful way. The EMPATHY systematic review underscored the critical importance of allocating sufficient time and resources to support routine trauma discussions (2,3,4,5,7,8,14,15,16,17,19,20,21,22,23,24). This finding resonates with insights gained from the EMPATHY study interviews, in which participants stressed that the value of trauma discussions lies in improving care, cautioning against mere documentation without follow-through. The recommendation aligns with the NHS England and NHS Improvement guide to	Views on directly asking about previous trauma varied. Many agreed that direct questions should only be asked when care providers have received training and there is a structured protocol with established referral pathways, with one describing the *'potential for a woman's experience to be made worse if she is encouraged to share and then does not receive the care that she needs'* (R16). Some respondents felt that all care providers should be able to ask generic 'screening' questions, but detailed conversations about previous trauma should be handled by specially trained care providers. Others believed that maternity care providers already have the skills to conduct sensitive trauma discussions. They highlighted that *'the act of asking sensitively and hearing a disclosure can be incredibly powerful and healing in and of itself'* (R36), even in the absence of further support or referral. Concerns were raised regarding the absence of clear protocols in many areas, potentially hindering providers from initiating direct enquiries and consequently depriving women of essential support. Participants expressed concerns that care providers might use the lack of established referral pathways to avoid engaging in these conversations. The recommendation is a pragmatic compromise: while acknowledging that the lack of established procedures in some areas may result in women not being asked about previous trauma, potentially hindering their access to support, it aims to mitigate the risk of lasting harm through insensitive trauma discussions. The recommendation underscores the imperative of implementing protocols and training to ensure that all women

	implementing trauma-informed perinatal care, which emphasises the need for clear referral pathways for support relating to prior trauma (Law et al., 2021). SAMHSA (2014) advocates for a written policy or protocol for a trauma-informed approach for organisations, discouraging reliance on training workshops or individual leaders. Both SAMHSA (2014) and NHS England and NHS Improvement (Law et al., 2021) emphasise the importance of staff training in how to carry out trauma discussions. In the EMPATHY study systematic review, twelve studies highlighted the critical role of effective communication skills among maternity care providers in eliciting disclosure while minimising distress experienced by women (1,2,3,6,8,13,14,16,18,19,22,24). Furthermore, three studies included in the review found that if not handled sensitively, trauma discussions could affect future health care access and experiences (12,14,16). EMPATHY study interview participants argued that maternity care providers should receive training in sensitively conducting discussions about previous trauma. They highlighted the potential for harm to be caused by trauma discussions, through insensitivity, inadequate support for women, or overzealous safeguarding responses.	have an opportunity to discuss previous trauma and receive the support they need. Following the guideline consultation, the reference to a private setting was removed as this is covered in recommendation 9.
6. Women should be provided with information and support that they can access independently, without the need to disclose traumatic experiences to healthcare providers. Maternity care providers should address potential concerns about confidentiality, reassuring women that they cannot determine whether she has accessed online resources. *Providing access to information and support resources that do not necessitate disclosure empowers women to seek assistance on their*	Evidence from the systematic review indicates that many women choose not to disclose previous trauma due to various reasons, such as distrust of the person asking, fear of judgement, closed-ended questions, time constraints, and a desire for privacy (2,3,4,6,10,12,13,14,16,17,18,19,24). This underscores the importance of offering alternative avenues for accessing support to ensure that all women, regardless of their disclosure choices, can receive the assistance they may require.	Feedback from the EMPATHY guideline consultation overwhelmingly supported the importance of providing information and support to women without requiring disclosure of their experiences. Participants stressed that this approach could alleviate the burden of *'suffering in silence'* (R2) for women who feel unable to disclose and empower them to access support on their own terms. Recommendations included providing information in diverse formats and languages, co-designed with service users and specialist organisations, and disseminating it through various channels to ensure accessibility and visibility.

own terms, respecting their autonomy and privacy.	EMPATHY study interview participants emphasised the necessity of providing women with independent access to support, enabling them to seek help privately if they choose not to disclose their trauma histories. This recommendation aligns with NHS England and NHS Improvement guidelines, which advocate for providing all women with information on how prior trauma may impact them in the perinatal period, along with available support options (Law et al., 2021). Interview participants also highlighted the importance of adopting a universal precautions approach, wherein healthcare providers assume that all women may have experienced trauma and take steps to minimise the potential for re-traumatisation. This approach is endorsed by SAMHSA and NHS England and NHS Improvement guidance (SAMHSA, 2014; Law et al., 2021).	
7. When women disclose previous difficult or traumatic experiences, maternity care providers should collaborate with them to develop a personalised plan of care for the perinatal period that prioritises choice, control, and individualised care. This plan could include: • Clarifying birth preferences or wishes. • Addressing potential triggers, with specialist psychological support if needed. • Facilitating continuity of carer where feasible. • Assisting in accessing mental health support if this would currently be, or might become, beneficial. In cases where women may not meet criteria for perinatal mental health services, exploring alternative support options such as third sector organisations or online resources is recommended.	The recommendation is supported by findings from the EMPATHY systematic review, which highlighted the intense and challenging nature of the perinatal period, potentially triggering memories of past trauma (1,2,4,10,12,14,18,19,20,24). Additionally, the review revealed that some women who have experienced trauma desire therapeutic support during this time (1,3,6,10,14,22,24). Additionally, some women who have suffered trauma want relationship-based care (1,6,10,12,14,18). Moreover, the perinatal period holds potential for healing and growth (1,4,6,8,12,18,19). Feedback from EMPATHY study interview participants supported the value of creating a care plan, including information for partners on how to offer support during this period. They noted that some, but not all, women may find value in groups such as parentcraft or peer support groups. The recommendation aligns with guidance on trauma-informed perinatal care from NHS England and NHS	Consensus emerged among respondents on the importance of creating a comprehensive perinatal care plan subsequent to trauma disclosures. Participants underlined the need for a collaborative approach that grants women autonomy, control, and agency, acknowledging that not all survivors might wish for or benefit from a structured care plan. Participants recommended offering information about additional support services such as peer support, third-sector, community, or online resources. Recognising that many women might not meet the criteria for perinatal mental health services post-trauma, the suggestion was made for services to explore ways to cater to these individuals' needs. Participants advocated for using terms such as ‘birth preferences’ or ‘wishes’ instead of ‘plan’, extending the scope of plans beyond birth to encompass postnatal considerations and strategies for social support, and involving partners. Offering sample plans outlining potential triggers and practical adjustments was recommended, as well as providing specialist support for navigating complex discussions about triggers and management strategies. Ensuring these plans were respected

- Providing information about additional support services, such as peer support, parentcraft groups, third-sector, community, or online resources. - Offering information for women's partners on how to provide support during this time. However, it is important to note that structured care plans may not be desired or beneficial for all women. *This recommendation aims to ensure women are empowered to navigate the perinatal period with agency and support.*	Improvement (Law et al., 2021), which advises that all women should be supported to develop a personalised care and support plan.	and followed by care providers was felt to be crucial in preventing women from feeling *'violated and betrayed'* (R36). In response to the consultation feedback, the recommendation was refined to acknowledge that structured care plans may not be desired by all women, terminology was modified to 'birth preferences or wishes', support was included for women who do not meet the threshold for perinatal mental health services and guidance provided for helping partners support women.
8. Women should be sensitively forewarned that the issue of previous trauma will be raised, providing them with the opportunity to prepare for the discussion and ensure they have adequate support in place. They should be informed that they can opt out of answering any questions about previous difficult experiences and told of the limits of confidentiality. *Sensitively forewarning women about forthcoming trauma discussions, providing them with the choice to participate, and clearly delineating confidentiality boundaries fosters agency and empowerment.*	The EMPATHY systematic review identified that routine trauma discussions can be perceived as invasive and unexpected by some women (2,6,13,14,16, 20), with choice and control being vital components of their experiences (1,10,12,14,18,19). Moreover, studies within the review highlighted that insensitive handling of trauma discussions may impact future healthcare interactions (12,14,16). EMPATHY study interviewees emphasised the importance of forewarning women about forthcoming trauma discussions, allowing them to prepare and secure adequate support. While discussing confidentiality boundaries was felt to foster trust, concerns were raised that forewarning might induce anxiety, potentially leading to disengagement from care. Guidance from NHS England and NHS Improvement and SAMHSA underscores the importance of effective communication, empowering women to make informed decisions about their care (Law et al., 2021; SAMHSA, 2014).	Participants emphasised the need to prepare women for trauma discussions, offer them the choice to decline discussing their experiences, and clearly define confidentiality boundaries. While transparency, choice, and control were highlighted as essential aspects of trauma-informed care, concerns were raised about the potential anxiety induced by pre-warning and its impact on appointment attendance. Others argued that an 'opt-out' approach might inhibit further discussions. Some participants instead suggested a gentle approach, introducing sensitive topics during routine discussions to foster a safe and comfortable environment where women feel empowered to engage when they are ready. In response to consultation feedback, the recommendation was refined to explain the rationale for preparing women for trauma discussions and emphasise the importance of sensitivity in forewarning.

9. The issue of previous difficult or traumatic experiences should be raised when there is sufficient time for staff to listen and respond to disclosures, recognising that for women who do not feel listened to, these discussions can be re-traumatising. Where care providers cannot adequately respond to a disclosure due to time constraints, they should acknowledge the disclosure and schedule a follow-up appointment where they will be able to talk in more depth. Service managers should ensure appointments include additional time for trauma discussions and facilitate autonomy in arranging follow-up or additional appointments. *This recommendation aims to prevent harm from trauma discussions where women do not feel listened to, and ensure adequate support is provided for staff to conduct sensitive and effective conversations about trauma.*	The EMPATHY study's systematic review found with high confidence that support for routine trauma discussion is contingent on having adequate time for the discussion (2,3,4,5,7,8,14,15,16,17,19,20,21,22,23,24). Furthermore, studies included in the review found that mishandled trauma discussions could impact future health care access and experiences (12,14,16). Multiple participants in the EMPATHY study interviews stressed that clinicians should broach the topic of previous difficult experiences only when they can allocate sufficient time to listen and respond to disclosures. They highlighted the unpredictable nature of trauma conversations, with some discussions requiring significant time. Participants emphasised the profound significance of trauma conversations for women, especially if they have never shared these experiences before, and stressed the importance of providing sufficient space for such discussions. Guidance by NHS England and NHS Improvement (Law et al., 2021) states that services should facilitate disclosure by ensuring adequate time for women to discuss their needs.	Participants emphasised the need for staff to dedicate adequate time to listen and respond when women share previous difficult experiences. They highlighted that rushed or inattentive conversations could diminish the significance of these disclosures and erode trust in maternity care. One respondent expressed this, saying, *'it's insulting if someone asks you questions about abuse then doesn't have time to listen'* (R5). However, concerns were raised that this recommendation might be misused by care providers to avoid challenging conversations. Respondents suggested that when a care provider's workload prevents in-depth discussion, they should acknowledge the disclosure and schedule a follow-up appointment for a more thorough conversation. Participants stressed the role of management in ensuring staff have manageable workloads. The importance of continuity of carer was also highlighted, offering multiple opportunities for discussing trauma at more suitable times. One respondent proposed the idea of establishing a specialist midwife post or team to support women who have experienced trauma, expressing concerns about inadvertently re-traumatising women with well-meaning but under-resourced initiatives. In response to feedback from the consultation, the guideline was revised to address time constraints for staff responding to disclosures and emphasise service managers' responsibility to allocate sufficient time for trauma discussions.
10. An additional antenatal appointment specifically focused on addressing women's social, emotional, and psychological well-being, including the opportunity to disclose any previous traumatic events if desired, should be provided. This appointment should adhere to the following criteria: • Conducted in a private and undisturbed environment. • Without the presence of a partner, acknowledging that some women may not have disclosed their traumatic experiences to their partners or that	EMPATHY study participants identified challenges in discussing trauma during the booking appointment. They proposed that this appointment is already overcrowded and lacks sufficient time for meaningful conversations, mainly consisting of closed questions and information-giving by the maternity care provider, making it hard to transition to sensitive discussions. Interviewees proposed that the intrusive nature of questions asked during this appointment, including those about previous terminations, drug use, mental health, and social services involvement, can deter women from disclosing trauma. The EMPATHY study systematic review found that embedding trauma	Respondents generally agreed that trauma discussions should take place in a private and undisturbed environment. Views on partner presence varied, recognising partners as potential sources of support or, in some cases, of abuse, and they may not be aware of a woman's trauma history. A pragmatic proposal emerged suggesting that women should be given the choice of having a support person present. One advocate for this approach remarked, 'we wouldn't want to recreate an experience of feeling alone, exposed and vulnerable' (R48). Participants also recommended clarifying the nature of support for women who become distressed during these discussions. In response to feedback, the recommendation was amended to recognise women's preferences regarding partner involvement

partners may have been involved in the experiences. However, if a woman prefers to include her partner or a trusted support person in the discussion, a follow-up appointment should be offered. - Ensure there is a private space available and a dedicated staff member to provide support if a woman becomes upset during the conversation, allowing her the necessary time to gather herself. - Ideally conducted by a female care provider, recognising that some women may not feel comfortable disclosing previous trauma to male staff. All maternity care settings should prioritise allocating resources to facilitate this additional appointment. If an additional appointment is currently not feasible, services should consider how the above points can be integrated within existing maternity care appointments. *This approach aims to facilitate disclosure and prevent harm caused by insensitive trauma discussions.*	discussion in routine practice is challenging (4,5,7,15,17,21,23). Interview participants also observed that the clinical environment of a booking appointment is not conducive to sensitive discussions, and they proposed that discussing trauma in front of partners, who may be unaware of the woman's history, is not appropriate. Studies included in the EMPATHY systematic review recommended holding trauma discussions in private, comfortable, and welcoming surroundings (3,6,14,22) and highlighted partner presence as a barrier (7,21). NHS England and NHS Improvement (Law et al., 2021) proposed that services should consider the care environment's suitability for disclosure, including privacy and the presence of partners or family members. SAMHSA (2014) stressed the need for a safe, calm environment for trauma-informed care. EMPATHY study participants favoured an additional antenatal appointment focusing on emotional health and trauma discussions. They believed this could create a protected space for meaningful conversations, proposing an unstructured, woman-led format similar to 'listening visits' for mental health support. Moreover, participants believed that an additional appointment could facilitate trust and relationship-building between the woman and the care provider. They proposed that women might be more inclined to disclose trauma during this second appointment, particularly if it involved the same care provider. Discussing trauma at the second appointment would allow women to be prepared for the conversation, avoiding overwhelming them during the initial appointment, which typically involves various medical procedures and enquiries.	and outline support measures for those who become distressed during discussions. The recommendation was revised subsequent to the consultation to propose an additional appointment specifically focused on women's well-being, ideally conducted by a female care provider. Though not integrated into the guideline consultation, respondents indicated that these additions would be well-received. Guideline respondents identified challenges with addressing trauma during booking appointments, expressing concerns about the lack of a established trusting relationship at that stage, the risk of trauma discussions becoming perfunctory if included in this appointment, and the potential inadequacy of time to respond appropriately. Respondents noted that being cared for by exclusively female care providers is important to some women.

	Most EMPATHY study interview participants preferred female clinicians, citing personal comfort and trust as key factors. Some participants expressed directly that they would not disclose to a male clinician. SAMHSA (2014) advises that services provide gender-specific trauma screening, assessment, and treatment. NHS England and NHS Improvement (Law et al., 2021) state that services should offer the choice of female staff to enhance women's comfort and willingness to disclose trauma.	
11. Where possible, the issue of previous difficult or traumatic experiences should be raised by a maternity care provider who is known to the woman, as many women will not disclose trauma without a trusting relationship. *This approach aims to facilitate disclosure through creating trust.*	The systematic review and qualitative synthesis indicate with high confidence that for some women, relationships are a crucial factor in trauma disclosure (1,2,3,6,10,12,13,14,16,18,20,21,24). Six studies included in the review highlight that women who have suffered trauma prefer relationship-based care (1,6,10,12,14,18). EMPATHY study interview participants overwhelmingly expressed that women are more likely to share past experiences within the context of a trusting relationship. They noted that multiple encounters may be necessary before women feel comfortable enough to disclose their histories. However, participants also acknowledged that clinicians can use kindness, compassion, and warmth to establish a psychologically safe environment, even without continuity of care. NHS England and NHS Improvement (Law et al., 2021) advocate for continuity of carer to facilitate disclosure, recognise changes in mental health during the perinatal period, and reduce retraumatisation by minimising the need for repeated trauma disclosures to multiple practitioners.	Most participants supported the idea that maternity care providers known to the woman should initiate discussions about previous difficult or traumatic experiences. Respondents highlighted the importance of trust-building, particularly for women who have experienced domestic abuse, coercive control, or birth trauma. However, they also recognised that trust and rapport can be established even without prior meetings, with a respondent saying, *'you can feel comfortable disclosing to someone on a first meeting if they appear approachable, interested, and trustworthy'* (R5). Some participants cautioned that continuity of care does not guarantee a warm and trusting relationship. Training care providers in rapid relationship building was suggested as a valuable skill that would enhance all aspects of care, not just trauma discussions.

12. Maternity care providers should collaborate with women to ensure documentation of trauma disclosures is sensitive and acceptable (while adhering to safeguarding requirements), recognising and advising women that maternity records may inadvertently be viewed by others, including partner and family. This approach aims to both prevent sharing of information without consent and reduce the potential for re-traumatisation by minimising the need for women to needlessly repeat their stories. *This recommendation aims to foster trust between women and maternity care providers and to prevent harm resulting from insensitive handling of trauma disclosures.*	The systematic review and qualitative synthesis underscores the importance of choice and control for women (1,10,12,14,18,19). Additionally, three studies included in the review highlight that mishandling trauma discussions can impact future healthcare access and experiences (12,14,16). Participants in the EMPATHY study stressed the critical role of effective and sensitive documentation in building trusting relationships with women and delivering quality care. Concerns were raised about inadvertent disclosure of trauma information to others, which could have significant repercussions for women. Some women prefer their experiences not to be documented, Interviewees suggested care providers work with women to document notes, ensuring they retain autonomy over their information as far as possible. This recommendation aligns with guidance from NHS England and NHS Improvement and SAMHSA that women should be empowered to be involved and make decisions about their care (Law et al., 2021; SAMHSA, 2014).	Participants widely agreed on the importance of sensitive documentation, advocating for a collaborative approach where the woman and the care provider co-produce the record of their conversation. This ensures that the survivor's voice is heard and prevents the imposition of labels or interpretations that they may not agree with, such as categorising their experience as rape or domestic violence. However, concerns were raised about expecting emotionally distressed women to participate in the documentation process, suggesting that the onus should be on the provider to understand acceptable language and phrasing. Protective measures, such as keeping notes separate from routine records, were recommended to safeguard privacy and prevent access by controlling partners. Documentation of trauma disclosures proved to be a complex and nuanced area. Several participants recommended care providers should document a deliberately vague statement acknowledging the experience of trauma, with a focus on the plan of care. Furthermore, there were suggestions that women should have the autonomy to decide whether their trauma history is documented at all. One participant pointed out, *'often there is no reason for a disclosure of historical trauma to be documented, and it is critical that survivors feel ownership over their own narrative'* (R36). They expressed concerns that the absence of this autonomy could erode trust and deter survivors from seeking future services. However, it was noted that sensitive and comprehensive trauma documentation could potentially validate women's disclosures in future legal proceedings, highlighting a potential benefit of such documentation. Participants stressed the importance of handling trauma information sensitively. One respondent vividly expressed feeling *'exposed, ashamed, and angry that my joy in this pregnancy had been hijacked in such a cavalier way'* (R42) when a nurse in her second pregnancy referred to a rape she had disclosed in her first pregnancy in what she felt was a casual and dismissive manner.

13. Maternity care providers should ask women's wishes about information sharing within the maternity team and with other services, and as far as possible follow these wishes. *This recommendation is aimed at building trust between women and maternity care providers, improving communication among healthcare professionals, and mitigating harm resulting from insensitive handling of trauma disclosures.*	This recommendation is in line with findings from the systematic review and qualitative synthesis which emphasised the importance of choice and control to women (1,10,12,14,18,19). In the EMPATHY study interviews, effective and consensual information sharing emerged as crucial in establishing trust and delivering quality care. This involves good communication between professionals, minimising the need for women to repeat their experiences unnecessarily, and ensuring clarity and agreement on the recipients of shared information. Guidance from NHS England and NHS Improvement on trauma-informed perinatal care states that women should be empowered to make informed decisions about their care (Law et al., 2021).Similarly, SAMHSA guidance (2014) identifies empowerment as a fundamental principle of trauma-informed care.	The recommendation that care providers should ask women about their information sharing preferences received widespread support. Some participants believed it would help women appreciate the benefits of information sharing within the broader healthcare team, thereby contributing to optimal care provision. However, concerns were raised about safeguarding in cases where disclosure indicates potential risk of harm to the woman or her baby. Some participants suggested implementing a clear and upfront confidentiality statement before trauma discussions (addressed in recommendation 7). One participant (R43) deemed the phrase 'as far as possible' too vague and open to interpretation, potentially leading healthcare providers to disregard a women's wishes. Instead, they suggested aligning this recommendation with the legal requirements of safeguarding referrals: consent should always be sought from the individual before sharing their personal information with any other members of the maternity team and/or other services, unless disclosing such information would create a risk of further harm to them.
14. Maternity care providers should undergo comprehensive training to sensitively conduct trauma discussions. This training must be collaboratively developed and delivered in partnership with experts by experience and specialist voluntary sector organisations, with due compensation for their invaluable expertise. Ongoing training, supervision, and support should be provided to staff to ensure sustained competence. The training curriculum should include the following key elements: ● Understanding the potential effects of trauma on mental and physical health, behaviour, wellbeing, and parenting across diverse population groups. ● Fundamental counselling skills, including active listening, employing open-ended	Twelve studies included in the EMPATHY study systematic review highlighted the critical role of effective communication skills among maternity care providers in eliciting disclosure while minimising women's distress (1,2,3,6,8,13,14,16,18,19,22,24). Additionally, three studies included in the review found that mishandled trauma discussions could impact future healthcare access and experiences (12,14,16). Most EMPATHY study participants stressed the importance of interpersonal skills as a crucial training requirement. Guidance from SAMHSA and NHS England and NHS Improvement also emphasises the critical need for ongoing training on how to enquire and respond to disclosures (SAMHSA, 2014; Law et al., 2021).	The proposal that maternity care providers should receive training to conduct routine trauma discussions received widespread agreement, with one participant exclaiming, *'yes, yes, a thousand times yes.'* Respondent R48 highlighted the critical role of training by sharing a personal experience where a lack of training led to problematic interactions. She stressed, *'this is totally key I think - without training these questions can be awful.'* There was strong support for the involvement of survivors and specialist women-led organisations in developing and delivering this training, ensuring they are paid appropriately for their expertise. Several participants stressed the importance of ongoing training, supervision, and staff support to ensure the effectiveness of training. In response to feedback from the consultation, the recommendation was expanded to involve survivors and

questions, building confidence in asking about and responding to disclosures of difficult experiences, and sensitively concluding difficult conversations. ● Recognising and sensitively supporting women who may have suffered trauma but choose not to disclose it. ● Local care pathways available for women who have suffered trauma. ● Appropriate documentation of trauma disclosures and safeguarding considerations. ● An evaluation so the effectiveness and acceptability of the training can be monitored. Facilitators of the training must be mindful that attendees may reflect on personal experiences, potentially eliciting painful memories, and should consider strategies to support them. *This recommendation aims to equip care providers with the necessary skills to conduct sensitive and effective trauma discussions, thereby preventing harm caused by insensitive approaches.*	EMPATHY study interview participants recommended training clinicians to recognise non-verbal indications of trauma or mental health struggles, an idea echoed by SAMHSA and NHS England and NHS Improvement (SAMHSA, 2014; Law et al., 2021). The NHS England and NHS Improvement guide recommends involving experts by experience in reviewing training, evaluating training to identify potential improvements, and considering the possibility that staff may be reminded of their own life experiences during training (Law et al., 2021).	specialist organisations, consider staff emotional wellbeing, specify that ongoing training should be provided, and evaluate effectiveness and acceptability of training.
15. All staff working in maternity care, including support staff such as healthcare assistants and receptionists, should receive role-appropriate training in supporting women who may have suffered trauma. *Administrative and support staff play integral roles in the maternity care environment, directly influencing women's care and experiences.*	The SAMHSA guideline for trauma-informed care advises that all staff, including those providing direct care, supervisors, receptionists, and cleaning and maintenance staff, receive basic training on the impact of trauma and trauma-informed approaches (2014). The NHS England and NHS Improvement trauma-informed care guide (Law et al., 2021) echoes this, proposing that both clinical staff, including sonographers, and non-clinical staff, including catering staff, can support women to feel safe in the care environment. EMPATHY study interviewees highlighted that any member of staff may notice signs of possible previous trauma, including administrative staff, and recommended that all staff be	The recommendation that all staff working in maternity care, including support staff, receive role-appropriate training in supporting women who may have suffered trauma gathered broad support. Training for support staff, including healthcare assistants and receptionists, was deemed essential for adopting a trauma-informed approach. Participant emphasised that these personnel may encounter signs of trauma or be the first to receive disclosures. Participants highlighted the importance of starting trauma-informed care from the initial contact with maternity services, as it could enhance women's experiences and engagement with care.

	trained to recognise and communicate with clinicians about these observations.	
16. Staff training on routine trauma discussion and trauma-informed care should begin in the undergraduate period. *Student maternity care providers play integral roles in the maternity care environment, directly influencing women's care and experiences.*	EMPATHY interview participants advocated for training for maternity care providers to begin in the undergraduate period. This recommendation aligns with SAMSHA guidance (2014), which stipulates that all maternity services staff should undergo training in trauma impact and trauma-informed approaches. Additionally, NHS England and NHS Improvement guidance underscores the importance of ensuring that students and trainees feel adequately supported to deliver trauma-informed care (Law et al., 2021).	There was overwhelming consensus among participants that training on routine trauma discussions and trauma-informed care should commence during undergraduate education. Comments such as *'yes this needs strongly embedded in the midwifery curriculum'* (R8), 'AGREE AGREE AGREE' (R47) and *'100% it should be routine and standard'* (R11) showed strong agreement with this approach. Commencing training at this stage was viewed as a critical driver for systemic change and fostering a cultural shift towards trauma-informed care. Participants highlighted the importance of actively involving survivors and specialist women-led organisations in the development and delivery of this training, ensuring fair compensation for their valuable expertise.
17. Maternity care providers should be provided with regular (e.g., monthly) counselling, within paid working hours, to help them manage the emotional impact of discussions about trauma, including any personal memories these conversations may evoke. The counselling should be confidential and provided by a qualified professional who is independent of service management. *This recommendation is aimed at supporting the emotional well-being of maternity care providers, acknowledging the challenging nature of trauma discussions and their potential to evoke personal memories. By offering regular counselling sessions within paid working hours, it ensures accessibility and normalises seeking psychological support. The*	This recommendation is underpinned by four essential elements: provision of regular emotional support to staff; support provided within paid working hours; independence from service management; and engagement with a qualified professional. 1. *Provision of regular emotional support* The evidence consistently indicates provision of regular support is necessary for staff conducting trauma conversations. Five studies within the EMPATHY systematic review found that maternity care providers often find trauma disclosures distressing, impacting both their personal and professional lives (4,7,8,11,21). Clinical supervision was felt by participants to be vital for maternity care providers carrying out trauma discussions. EMPATHY study interviewees similarly talked of the burden of hearing upsetting stories of women's difficult lives and suggested that awareness of	The recommendation for regular, independent counselling during paid working hours for maternity care providers received strong endorsement. Respondents unanimously agreed on the necessity of emotional support for staff, highlighting its value with responses like *'this would be extremely valuable'* (R36), *'this is vital and not a nice-to-do'* (R14) and *'this is really important. I am so glad to see this'* (R37). They connected this support with improved care quality and staff retention. Participants highlighted the potential of routine trauma discussions to bring up personal memories and stressed the need to address this. They also recognised the possibility of vicarious trauma among staff, especially when supporting women through traumatic events. Participant R49 eloquently summed up the pressures on maternity staff and the imperative of providing support to maintain a healthy workforce: *'The impact of the work they do, their own lived experience, the stretched systems they work in, the responsibilities they hold and the extreme emotions they are*

requirement for confidentiality and independence from service management aims to create a safe space for staff to express themselves without fear of judgement or repercussion.	this may make providers reluctant to engage in discussions about previous trauma. Discomfort could also cause providers to interrupt women, causing further distress to women and preventing future disclosures. SAMHSA (2014) propose that protecting staff well-being is a key element of a trauma-informed approach. NHS England and NHS Improvement (Law et al., 2021) emphasise the importance of regular supervision to prevent secondary traumatic stress caused by hearing trauma histories. 2. *Within Paid Working Hours* Offering counselling sessions during paid working hours normalises seeking psychological support and ensures accessibility for all staff. Participants in the study carried out by Mollart, Newing and Foureur (2009) felt that clinical supervision is vital for care providers carrying out trauma discussions but noted that not all chose to access it. EMPATHY study interviewees pointed out that requiring an ‘opt-in’ to counselling will deter staff who fear this will portray them as weak or unable to cope. Interviewees further noted that some staff will not proactively seek support as they do not recognise the potential for burnout in their work. The majority of participants believed staff who are expected to carry out trauma discussions should be provided with regular reflexive supervision within working hours, making this a normal part of working life. This recommendation aligns with the NHS England and NHS Improvement guide to trauma-informed care, which states that protected time for supervision should be provided (Law et al., 2021). 3. *Independent of service management* EMPATHY study interviewees expressed that many staff do not feel able to seek support from within the service due to concerns about confidentiality, judgement, and career implications. Further, interviewees expressed that where distress is being caused by personal memories or experiences, staff may be unwilling to discuss this with a colleague. SAMHSA	*working with from one moment to the next - joy, fear, sadness, grief.......if we are going to develop, grow and sustain a healthy maternity workforce, this is essential.’* However, the feasibility of providing support within underfunded services was questioned by several participants, with comments including *'utopia indeed'* (R3) and *'while laudable, there are no resources to achieve this'* (R19). In contrast, others argued that staff support is an integral element of a trauma-informed approach and *‘cannot be seen as an added luxury’* (R9). Some suggested that informal peer support, supervision, or reflective practice would be suitable and cost-effective options. Group supervision was seen as helpful, but concerns were raised about potential dominance by strong personalities (R45). The wording of the recommendation was debated, with some suggesting that support should be optional rather than routine, and uncertainty expressed about the ideal frequency of support.

	(2014) also highlights the importance of supporting care providers affected by previous trauma. 4. *Professional support* EMPATHY study interview participants noted that trauma disclosures may evoke significant distress, necessitating professional support. While the NHS England and NHS Improvement guide suggests utilisation of Professional Midwifery Advocates for staff support, I do not endorse this approach (Law et al., 2021). PMAs are not trained counsellors or therapists, lack independence from service management, and their dual role - supporting midwives while safeguarding the public - precludes guaranteeing confidentiality (NHS England, 2017). The guide also suggests peer support, but I have not included this in the recommendation due to insufficient evidence and an absence of an established model for trauma-affected staff (Law et al., 2021).	
18. Consideration should be given to overcoming cultural, systemic, and societal barriers to trauma discussions. These barriers include: ● Shame, stigma, and silencing. ● Expectations about gender. ● Strong social taboos around discussing abuse, potentially leading to a lack of recognition of abusive experiences by women. ● Lack of awareness of mental health issues. ● Some languages lack specific vocabulary to describe mental health and may use terms that are stigmatising or derogatory (e.g., 'crazy'). ● Mistrust of institutions, which may stem from prior experiences with statutory services.	EMPATHY study interview participants highlighted the significant role of cultural factors as a barrier to discussions about trauma. Participants noted that some languages lack the necessary vocabulary to articulate mental health issues, making it challenging to engage in sensitive conversations about them. Additionally, participants pointed out that the stigma surrounding mental health problems in specific cultures can impede open and constructive discussions on trauma. SAMHSA's concept of trauma and guidance for a trauma-informed approach (2014) underscores the importance of addressing cultural, historical, and gender considerations as fundamental principles of a trauma-informed approach. Building on this perspective, Law et al. (2021) stress the crucial role of cultural sensitivity in trauma-informed perinatal care. They recommend that care providers actively collaborate with local community groups to gain insights into cultural barriers to trauma-informed care.	Participants widely acknowledged the importance of considering cultural barriers when discussing past trauma. Comments like *'this is crucial'* (R7), *'this is so important'* (R41), and *'excellent'* (R35) highlighted its significance. Participants particularly appreciated the inclusion of shame in these discussions. They suggested involving support workers and interpreters from diverse backgrounds in healthcare professional training. Recommendations were made to broaden the framework to include barriers faced by other groups, such as LGBTQIA+ individuals, women who have suffered FGM, and those with prior contact with statutory services. Participant R37 provided a valuable perspective, suggesting that terms like 'racism from care providers' and 'stigma' may be better framed as 'cultural, systemic, and societal barriers' to recognise the full range of obstacles. They also recommended adding 'silencing' to 'shame and stigma' to acknowledge that these are active processes that can keep survivors silent or silence them when they try to speak out.

● Fears that care providers will gossip or discuss their personal information without consent. ● Cultural bias and racism from care providers. ● Insecure immigration status, which can increase vulnerability to abuse and discourage disclosure of experiences. ● Sexual orientation and gender identity. To ensure these barriers are considered and to provide an inclusive approach, the development of pathways and the design and delivery of training should incorporate input from individuals with various cultural backgrounds and lived experiences. *This recommendation aims to facilitate trauma disclosure and mitigate harm caused by insensitive discussions, recognising the impact of cultural, systemic, and societal factors on individuals' ability to engage in open dialogue about trauma.*		As a result of feedback from the guideline consultation, the recommendation was amended to acknowledge sexual orientation and gender identity as barriers to trauma discussion and incorporate systematic and societal factors.
19. Pathways should be designed with recognition of the specific challenges faced by women with limited English proficiency or other communication difficulties when disclosing trauma. These challenges may include: ● Reluctance to disclose in the presence of an interpreter. It is essential to acknowledge and address potential barriers that interpreters might pose to open communication. ● Fear that the interpreter will breach confidentiality and disclose sensitive information to others in the community. Strategies should be implemented to build trust and ensure interpreter confidentiality. ● Reluctance to disclose in the presence of partners, family, or friends who are acting as interpreters. It is crucial to discourage	Studies included in the EMPATHY systematic review highlighted the difficulties faced by women with limited English proficiency in trauma discussions, citing interpreters as a barrier to disclosure (16,23,24). EMPATHY study interview participants universally felt that trauma discussions are more difficult for women with limited English. Participants highlighted that even women with good conversational English may struggle to understand complex information or pick up subtleties. Several participants noted that where possible it is beneficial to have consistency of interpreters and that interpreters would benefit from training in how to ask sensitive questions. Participants noted that not all women are literate in their first language, and therefore translating questionnaires into other languages might result in women not understanding the questions, possibly feeling ashamed, or inadvertently asking their	There was unanimous agreement on the importance of adapting trauma discussions for women with limited English proficiency. Participants stressed the need for time and resources to develop these pathways and highlighted limitations in referral services for women with limited English skills. The importance of ensuring continuity of interpreters whenever possible, in addition to the choice of using an interpreter or tools like Google Translate, was also highlighted. Participants pointed out the complexities when interpreters speak different dialects, often involving intersecting class and caste issues. Furthermore, the recommendation addresses the reluctance of some women to disclose previous trauma when family or friends act as interpreters. Several participants recommended the guidance should explicitly state not to use family members as interpreters, with one arguing *'there should be strong onus on the trust to recruit and train appropriate interpreters'* (R15). Respondents also spoke about the need to tailor support to different needs, including creating pathways and materials for

this practice, emphasising the importance of neutral and professional interpreters. ● Limited literacy in their own language can mean translated materials are not helpful and make women feel ashamed. Services should strive to provide accessible information such as audio translations of questionnaires and information leaflets. ● Difficulty understanding technical terms, written information, or subtle nuances even for women with good conversational English. Efforts should be made to communicate information in a clear, straightforward manner to ensure understanding across varying levels of English proficiency. ● Services should also consider how they can meet the needs of women who have other communication needs, including hearing difficulties, learning disabilities, neurodivergence, or low literacy. *This recommendation aims to address the barriers faced by women with limited English proficiency in discussing previous trauma.*	abuser or neighbour to translate for them, not realising the sensitivity of the information. The idea of questionnaires which were translated into audio, rather than written form, was popular with participants. Participants pointed out that lack of literacy is not only an issue for women with limited English, and materials should be written with this in mind. Law et al. (2021) advise services to consider the needs of individuals with language or literacy difficulties.	people who are neurodivergent, have learning disabilities, or are deaf. In response to feedback from the guideline consultation, this recommendation was expanded to provide detailed guidance on linguistic barriers and acknowledge other communication barriers including hearing difficulties, learning disabilities, neurodivergence, or low literacy.
20. Routine trauma discussion pathways should be tailored to local resources and services. Women should also be informed of national support organisations to ensure a minimum level of support for all women, regardless of location. It is important to acknowledge that some women prefer anonymous support options, such as telephone-based or national rather than local services, due to concerns about confidentiality and social encounters with support providers. Additionally, poverty should be recognised as a barrier to accessing support.	SAMHSA (2014) recommends services collaborate with community providers with expertise in delivering evidence-based trauma services. The NHS England and Improvement guide on trauma-informed care emphasises the importance of co-production of services with experts by experience, suggesting the engagement of voluntary service organisations and Maternity Voices Partnerships to aid in this (Law et al., 2021).	Respondents largely supported the recommendation that trauma discussions should be tailored to fit local resources and services, stressing the importance of care providers being informed about local support options and their accessibility. However, participants noted the need for a consistent level of support for all women, regardless of location, and noted that some women might prefer national rather than local support to maintain anonymity. Several participants highlighted the essential role of experts by experience and the voluntary sector, including respondent R9: *'Great to see inclusion of VCSE [Voluntary, Community and Social Enterprise] who play such a vital role and often have years of experience in this space. The impact of a good local knowledge of what's out there for women and*

This recommendation aims to leverage the expertise of voluntary sector organisations, involve experts by experience in service design, and ensure women are signposted to appropriate local and national support organisations.		*families is gold and integral to a holistic and relational model of care.'* In response to feedback from the guideline consultation, the recommendation was expanded to underscore the provision of a minimum level of support to all women and recognise poverty as a barrier to accessing support.
21. While respecting women's individual rights to confidentiality and their choices regarding documentation of trauma disclosures in medical records, efforts should be made to measure the uptake and impact of routine trauma discussions. Collected data could include: ● Proportion of staff trained in conducting trauma discussions. ● Proportion of women asked about previous trauma. ● Basic sociodemographic information. ● Number of women who disclosed trauma and types of traumas disclosed. ● Changes in care resulting from trauma disclosures. ● Uptake of referrals made. ● Impact on related services such as referrals to mental health and addiction services. ● Impact of routine trauma discussion on outcomes such as health, quality of life and experience of parenting. In analysing the data, both the overall dataset and specific results relating to marginalised groups and individuals from different cultural backgrounds should be considered to ensure inclusivity and representation of diverse voices.	SAMHSA (2014) advise that organisations should identify specific measures or indicators to gauge organisational progress towards achieving a trauma-informed approach, incorporating these metrics into quality assurance processes. NHS England and NHS Improvement (Law et al., 2021) highlight the importance of evaluating trauma-informed services to establish whether they improve women's experiences and outcomes. Proposed measures include changes in service user experiences of care, disclosure rates, and the implementation of trauma-informed approaches by staff.	Most respondents agreed on the importance of measuring trauma discussion effectiveness to understand if the care provided meets women's needs and support further funding. However, they acknowledged challenges in accurately assessing effectiveness. For example, Participant R15 suggested that a genuine measure would be a decrease in re-traumatisation rates, highlighting the complexity of evaluating the impact of these discussions. Participants stressed the significance of collaboration between services, frontline practitioners, experts by experience, and voluntary sector organisations to develop evaluation materials and mechanisms. Some suggested creating a national framework for implementation and evaluation that could be adapted locally. Additionally, they proposed having a dedicated staff member responsible for implementing and evaluating routine trauma discussions, along with a champion at the board level. In response to feedback from the guideline consultation, the recommendation was expanded to include the input of experts by experience and voluntary sector organisations in developing measures of effectiveness, and recommend the separate analysis of data relating to marginalised groups and women from different cultural backgrounds.

The recommendation aims to evaluate the impact of routine trauma discussions on maternity care provision and women's outcomes, enabling a comprehensive understanding of the intervention's effectiveness and driving quality improvement efforts.		
22. Feedback should be sought at a local level from women using maternity services and staff regarding routine discussion of previous trauma. The aim of this feedback is to establish whether it is acceptable and helpful, and to identify unintended consequences, such as the risk of re-traumatisation for women or negative impact on staff wellbeing. To encourage open communication and constructive criticism, feedback collection should be anonymous. Services should collaborate with voluntary service organisations to develop strategies to seek feedback from marginalised populations. Responses should be analysed both as a whole, and separately for marginalised groups and different cultural backgrounds, to ensure trauma discussions are equitable. *This recommendation aims to assess the acceptability and effectiveness of these discussions while identifying any unintended consequences, such as re-traumatisation of women or negative impacts on staff wellbeing.*	Several studies included in the EMPATHY systematic review showed that poorly managed trauma conversations can detrimentally affect women's subsequent engagement with healthcare services (12,14,16). Additionally, five studies in the review highlighted the emotional difficulties for maternity care providers hearing trauma disclosures (4,7,8,11,21). Participants in EMPATHY study interviews echoed concerns about the potential harm arising from insensitive trauma discussions, and the impact on staff of trauma conversations. To mitigate these risks, SAMHSA guidance (2014) recommends the development of processes for soliciting feedback from both service users and staff, ensuring anonymity and confidentiality to facilitate open communication and constructive criticism. In alignment with this, the NHS England and NHS Improvement guide by Law et al. (2021) advocates for the evaluation of trauma-informed services to determine whether such services effectively improve experiences and outcomes for women.	Respondents largely supported the collection of local feedback from women using maternity services and staff about routine trauma discussions, emphasising the importance of seamlessly integrating feedback collection into normal processes to prevent it becoming an additional burden. Several participants highlighted the need for trauma-informed methods when collecting local feedback to avoid re-traumatisation. They also mentioned that the cultural barriers to discussing trauma noted in recommendation 18 could deter some women from providing feedback, potentially affecting the data. To address these concerns, respondent R15 proposed that services collaborate with dedicated charities or community-based groups experienced in addressing trauma-related issues. As a result of feedback from the guideline consultation, the recommendation was expanded to assure anonymity for those providing feedback and consider marginalised populations in feedback collection and analysis.

23. While upholding women's rights to confidentiality, maternity services should collaborate with each other to share findings and identify best practices. Findings should also be shared with the steering group, staff conducting trauma discussions, and local voluntary service organisations. *This recommendation aims to promote continuous improvement of trauma discussions within maternity care services.*	The NHS England and NHS Improvement guide to implementing trauma-informed perinatal care (Law et al., 2021) advises commissioners and providers to consider how they can continually improve service design and delivery. Similarly, SAMHSA (2014) stresses the importance of quality improvement.	Respondents generally supported this recommendation, acknowledging its role in ongoing learning and the development of services. Participant R10 suggested that providing clear guidance on sharing findings while maintaining confidentiality, such as using composite narratives, would be beneficial. Additionally, participants proposed co-producing findings with survivors as a valuable approach.

7.6 Conclusion

In this chapter, I outlined the development and evaluation of an evidence-based framework for routine trauma discussions in the perinatal period. In the next chapter, I summarise the key findings of the study and offer final reflections and conclusions.

Chapter 8 Discussion and conclusions

8.0 Introduction

The preceding chapter described the development and evaluation of an evidence-based framework of guiding principles for routine trauma discussions in the perinatal period. In this chapter, I summarise the key findings of the study, reflecting on the integration of the underlying theoretical principles collaboration, social justice, and power, and their influence on the study. I go on to highlight the unique contributions to knowledge stemming from the study and situate these within the broader academic context. I critically evaluate the strengths and limitations of the study, offering recommendations for policy development, clinical practice, and further research. I finish the chapter by offering final reflections and conclusions.

8.1 Summary of findings

The study sought to address the research question outlined in section 1.2: *'How can maternity services empower pregnant women affected by previous trauma to access support?'* Employing a CPAR methodology, as discussed in chapter 4, enabled nuanced insights into conducting sensitive and effective trauma conversations to be collected. These insights were derived from a systematic review of qualitative evidence (chapter 3) and semi-structured interviews (chapters 5 and 6), culminating in the formulation of a framework for trauma discussions (chapter 7).

Key findings from this project highlight the importance of maternity care providers initiating discussions about previous trauma with women, explaining the potential enduring effects of such experiences and facilitating access to support services. Given the close interrelation between trauma and mental health, integrating discussions about both is beneficial. Providing multiple opportunities for women to express concerns or anxieties regarding trauma or mental health was considered to be crucial. Information and support should be provided irrespective of whether a disclosure has been made as some women will choose not to share their histories. Central to these conversations are trust and relationships, necessitating careful consideration in care provision. This encompasses preparatory measures such as informing women in advance about trauma discussions, allocating adequate time and ensuring a private, uninterrupted setting, striving for continuity of care where feasible, and maintaining sensitivity in documentation and information sharing.

Furthermore, the research underscores the necessity of comprehensive staff training, commencing at the undergraduate level. All staff in maternity care settings should receive role-appropriate training, including support staff such as healthcare assistants and receptionists, as they are well-positioned to recognise distressed women and may be the first to receive a disclosure. Recognising the emotional challenges inherent in supporting women who have suffered trauma, clinicians should receive regular, confidential counselling during paid working hours. The provision of routine counselling within working hours marks a significant cultural shift towards prioritising preventative care for staff well-being. Importantly, counselling services should be fully independent of service management to ensure staff feel comfortable sharing their struggles. Concerns about confidentiality, judgement, or career implications may otherwise deter staff from seeking support. Additionally, staff may be reluctant to disclose personal memories evoked by trauma conversations to colleagues, further underscoring the importance of confidential and independent counselling services.

Tailoring trauma discussions to local contexts and available resources emerged as another vital aspect. While individualisation is crucial, cultural barriers, such as gender expectations, must be navigated sensitively. Moreover, pathways for trauma discussions should be designed with consideration for the unique challenges faced by women with limited English proficiency, including reluctance to disclose in the presence of interpreters. Finally, the research advocates for ongoing evaluation of the effectiveness and acceptability of trauma discussions, with service providers encouraged to collaborate, share findings, and disseminate best practices.

8.2 Reflections on theoretical framework

In this section, I examine the study’s core concepts - collaboration, social justice, and power (section 4.3) - and their profound implications within the research.

8.2.1 Collaboration

In alignment with the CPAR approach, the study was supported from inception to dissemination by a Research Collective which included experts by experience, voluntary sector practitioners, and maternity care providers. In this section, I offer reflections on the engagement of the Research Collective and the challenges of conducting participatory research.

In section 4.4.3, I described two pivotal challenges encountered in navigating power dynamics within the Research Collective. First, despite concerted efforts to foster equality among all members, professionals often defaulted to their professional identities, while experts by experience frequently referenced their personal narratives. This underscores the enduring influence of social roles and identities, which can inadvertently reinforce power differentials and marginalise voices based on qualifications rather than lived realities. Second, even as the study progressed and familiarity within the group increased, one member expressed reluctance to speak up in front of healthcare professionals, citing past trauma of feeling unheard by them. This illustrates the profound impact of past experiences on engagement in research. These challenges offer valuable insights for future research projects, demonstrating the need for explicit strategies to address power dynamics within participatory research. These reflections echo the perspectives of Guishard (2009) and Fine et al. (2003), who caution against romanticising participatory action research and highlight the inherent challenges in fostering genuine collaboration.

Due to the COVID-19 pandemic, Research Collective workshops were initially held online. While this offered notable advantages, including convenience, accessibility for working parents, and the ability to engage participants from diverse geographic locations across the UK and Northern Ireland, it also presented challenges. Reflections from the Research Collective on the research process highlighted a preference for face-to-face interactions, emphasising the importance of in-person engagement in fostering trust and relationships (refer to section 4.4.4). This sentiment resonates with the findings of Wheeler et al. (2021), whose participatory study carried out in the same time period highlighted the difficulties associated with exclusively online interactions in establishing mutual understanding and conducive working relationships. In light of these insights, adopting a hybrid approach for future research, in which initial in-person meetings to lay the groundwork for rapport-building are followed by a blend of in-person and online meetings, is a promising strategy.

8.2.2 Social justice

CPAR seeks to advance social justice by not only deepening understanding but also instigating tangible improvements in practice (see section 4.2). The EMPATHY study contributes to social justice by offering practical guidance for conducting sensitive and effective trauma conversations.

Birthrights' (2022) inquiry into racial injustice and human rights within UK maternity care underscores the significant impact of linguistic and cultural barriers on the well-being of women and their infants. The report advocates for an individualised, person-centred approach to care, advocating for women to be empowered as active decision-makers in their care. Importantly, Birthrights' recommendations resonate with key principles outlined in the EMPATHY framework for trauma discussions, including fostering improved communication between women and their caregivers, undertaking meaningful co-production with women, and providing emotional support to staff members. The EMPATHY study translates these principles into actionable steps within trauma discussions.

I endeavoured to advance social justice by taking deliberate steps to ensure the inclusion of typically underrepresented groups within both the Research Collective and the data collection process. This inclusive approach aimed to ensure the study outputs are culturally sensitive, acceptable, and accessible to all groups of women. Several strategies were employed to foster inclusivity, including intentional diversification of both the interview sample and Research Collective to encompass a broad spectrum of trauma experiences and demographic profiles. Practical measures to facilitate participation included compensating interviewees and Research Collective members for their time, scheduling Research Collective workshops during school hours to accommodate childcare responsibilities, offering remote interview options using Teams, and using video conferencing for Research

Collective workshops. These efforts were designed to promote social justice and ensure the study's accessibility to individuals across the UK. This was successful to a certain extent. The study included a range of trauma experiences, including involvement with the criminal justice system and removal of children into care.

However, despite efforts, certain groups remained underrepresented. Although the study included Black African and Black British women, there was an absence of Asian women. This aligns with findings from the Care Quality Commission (2023), who highlight disparities in research participation among specific demographic groups, particularly individuals from ethnic minority backgrounds. This demonstrates the need for targeted inclusion efforts. While the Research Collective included one woman with English as a second language, efforts to recruit women with limited English proficiency for interviews were unsuccessful. Planned recruitment through links with two organisations who support women seeking asylum encountered obstacles, with one organisation failing to respond and the other engaged in its own research, deeming further involvement burdensome for their service users. I informed each of the voluntary sector organisations who recruited on my behalf of funding in the study’s budget for interpreting and translation support, but no women with limited English proficiency came forward. This limitation is acknowledged in section 8.4.2. Although there were challenges in achieving representation from women of diverse ethnic backgrounds and limited English proficiency in the interview sample, strategies for supporting these groups constitute essential components of the framework (see recommendation numbers 18 and 19).

8.2.3 Power

The foundational concept of seeking to overcome power differentials was realised throughout the study's execution and in the subsequent development of guidance derived from its findings, as detailed below. Additionally, researcher reflexivity, as explored in section 8.6, contributes significantly to the understanding of power dynamics.

Study conduct

Throughout the study, various strategies were implemented to address power dynamics and empower the Research Collective, interview participants, and contributors to the guideline consultation. In assembling the Research Collective, experts by experience were recruited through voluntary sector organisations. This approach not only ensured they had access to support but also alleviated the need for them to disclose personal experiences (see Chapter 4 for details). I made concerted efforts to manage group dynamics to ensure that all members felt valued and heard, which I discussed in section 8.2.1. Additionally, to facilitate open discussions within the Collective, I maintained a clear distinction between the interview participant sample and the Research Collective members. This separation aimed to enable Collective members to freely dissect interview findings without concerns of inadvertently offending any participant (see Section 5.1).

These actions align with the work of Vaughn and Jacquez (2020), who argue that the distinguishing feature of participatory research is empowering stakeholders in decision making, rather than the use of any particular research method or tool. While these efforts were aimed at minimising power differentials, Ross (2017) highlights the inherent limitations in research's potential to be empowering for participants. Ross notes that despite such efforts, the ultimate power remains with researchers, including decisions about what is included in the final write-up. Furthermore, opportunities for participant reflection and dissemination are largely controlled by researchers. This underscores the need for ongoing reflexivity and critical examination of power dynamics within research processes, ensuring that participants' voices and agency are truly respected and supported throughout the research journey.

Framework for trauma discussions

The guidance derived from the study's findings proposes practical measures aimed at empowering women within trauma discussions, aligning with a trauma-informed approach that recognises women as agents of their own situations (Sweeney et al., 2022). Central to these measures is the provision of agency to women in deciding whether and how much they wish to disclose about their experiences. Strategies such as providing advance notice of trauma discussions, offering opt-out options, and ensuring transparent information regarding confidentiality are key steps in this process.

The study found that women’s fear of being perceived as incapable of caring for their child acted as a barrier to disclosing their traumas. This finding resonates with existing research involving women who have suffered childhood sexual abuse (Montgomery, Pope, and Rogers, 2015) and removal of children into the care of social services (Pause, 2021). The study's findings also align with broader literature on perinatal mental health, where concerns about child protection involvement often prompt concealment or minimisation of mental health issues (National Childbirth Trust, 2017). Granting women autonomy over how their experiences are documented in their records, if at all, and with whom this information is shared, emerged as crucial factors in fostering empowerment.

Another critical aspect of empowerment is ensuring that women have control over the support they wish to access, if any. Despite improvements in specialist maternal mental health services, significant unmet needs persist, primarily due to geographical disparities and lengthy waiting lists (Maternal Mental Health Alliance, 2023). This study identified community-based, low-intensity treatments such as listening visits, peer support, or non-directive counselling as potentially beneficial for many women. However, existing mental health services often prioritise severe cases, neglecting women who may need or prefer less intense support (Royal College of Psychiatrists, 2021).

Importantly, the recommendation advocating for the universal provision of information about trauma resources removes the necessity for women to disclose their trauma to access support, thereby granting them power and control. As highlighted in a report by the Nuffield Foundation (Hood et al., 2020), children's social care services are more likely to intervene in families facing deprivation, with social disadvantage increasing the likelihood of children being subject to a child protection plan or removed into care. Linda Tuhiwai Smith (2012) cautions that what may appear to be 'paranoia' could, in fact, be local wisdom: women from certain population groups may legitimately worry that disclosing trauma could be used against them, and therefore may seek to access support confidentially.

8.3 Unique contribution to knowledge

In this section, I evaluate the significance and uniqueness of the study in three key areas: the development of a new model for trauma discussions, the use of the Adverse Childhood Experiences Questionnaire, and the exploration of trauma prevalence and its impact on maternity care providers.

8.3.1 Development of a new model for trauma discussions

Trauma discussions are commonly initiated using a questionnaire format which asks service users to tick a box of previous experiences, such as childhood sexual abuse or exposure to domestic violence (Ford et al., 2019). The EMPATHY study viewed trauma discussions from a much broader perspective, considering not only which tool should be used to initiate trauma discussions, but also the required staff training and support, presence of partners, documentation and evaluation and monitoring of routine trauma discussion.

Findings from the systematic review and qualitative synthesis and interviews were combined with insights from the Research Collective to develop a new model for trauma discussions, the evidence-based framework of guiding principles for routine discussion of previous trauma in the perinatal period. The draft framework was subject to a rigorous public consultation. The guidance is the first to explore and define the optimum context for trauma discussions and training needed for staff. In line with the critical social theory which underpins the study, the needs of women who are most likely to suffer as a result of poor-quality services, including those with limited English and facing cultural barriers to disclosure, are explicitly considered. While previous studies have acknowledged that some women will choose not to disclose previous trauma even if optimum conditions are in place (Cull et al., 2023), the model developed is the first to recommend that all women are given access to information and support, without necessitating disclosure, thus meeting their needs.

8.3.2 Use of the Adverse Childhood Experiences questionnaire

The EMPATHY study has contributed to the research base by highlighting the distressing nature of the ACE questionnaire for both service users and staff within maternity care settings. While the use of ACE measurement tools in healthcare contexts, including maternity care, has proliferated in recent years (Ford et al., 2019; Hardcastle and Bellis, 2021), concerns about the limitations and potential harms of this approach have been raised. Robert Anda, a researcher in the original ACE study, has cautioned against the use of ACE scores for individual risk prediction, pointing out that they were designed for population-level research rather than personalised health assessments (Anda, Porter & Brown, 2020).

Critics such as Lacey and Minnis (2020) have further noted several shortcomings of ACE scoring, including its inability to account for the nuanced nature of traumatic experiences, the lack of consideration of protective factors such as strong relationships, and the potential for further marginalisation of vulnerable populations. The focus on numerical scores overlooks the socio-political determinants of childhood trauma, such as poverty, leading Walsh (2020) to describe ACE scoring as a simplistic solution to complex social problems.

The study found that asking individuals about their ACE score can induce distress, potentially triggering shame, embarrassment, or memories of painful past experiences (see section 5.5.4). Pregnant women may worry about the impact of their traumatic experiences on the well-being of their unborn child, leading to increased anxiety and feelings of disempowerment. These interactions may themselves be traumatic (Walsh, 2020). Gentry and Paterson (2021) argued that there is a dearth of evidence supporting the routine implementation of ACE screening, citing a lack of clarity regarding effective interventions for those with positive ACE scores and uncertainty regarding the balance of benefits and harms associated with screening. Similarly, Finkelhor (2018) contends that ACE screening is ineffective at enabling healthcare providers to identify and address the needs of individuals affected by previous trauma. He concludes that the key challenge is how to use health care interactions to identify patients who are suffering from the effects of adverse childhoods and match them to effective services while minimising unnecessary costs and harms.

Moving forward, the woman-centred, compassionate approach advocated by the EMPATHY study holds promise in navigating these challenges. By prioritising open communication and empathy, healthcare providers can create an environment conducive to the identification of individuals affected by adverse childhood experiences while minimising potential harms. This approach aligns with Finkelhor's 2018 call to optimise health visits as opportunities for targeted interventions tailored to the unique needs of each person.

8.3.3 Prevalence and impact of trauma on maternity care providers

The study is the first to explore the impact of maternity care providers' own trauma on their working lives. I found that trauma discussions can be more difficult for care providers who themselves have suffered trauma, and that these prior experiences could have a profound and broad-ranging impact on their working life, from influencing their career choice to leaving the profession because of re-traumatisation and lack of support in the workplace.

The primarily female composition of the maternity care workforce raises the presumption that staff members have encountered trauma in alignment with national reported rates. Studies have indicated a prevalence of 46% for ACEs, 25% for domestic abuse, and 27% for sexual assault in the general female population (Hughes et al., 2020; Office for National Statistics, 2021a; Office for National Statistics, 2023b).

However, research indicates significantly higher incidences of domestic abuse, sexual violence, and ACEs among healthcare professionals compared to the general population (Dheensa et al., 2023; de Klerk, Gitsels and de Jonge, 2022; Mercer et al., 2023). A survey of 2,200 nurses, midwives, and healthcare assistants showed that 1 in 7 had suffered domestic abuse within the previous year, a rate three times higher than that of the general population (Cavell Trust, 2016). Another study by Leinweber et al. (2017) identified a 61% lifetime interpersonal trauma rate among

Australian midwives, correlating with a twofold risk of probable PTSD. Furthermore, studies have indicated that 18% of obstetricians and gynaecologists and 33% of midwives reported symptoms of PTSD following work-related trauma exposure. However, these studies did not account for the possibility of pre-existing or exacerbated PTSD due to personal trauma history (Slade et al., 2020; Sheen, Spiby & Slade, 2015).

No studies to date have examined domestic homicides of healthcare professionals (Dheensa et al., 2023), but a 10-year femicide census in the UK identified healthcare professionals as one of the most frequently reported occupations (Long et al., 2022). Additionally, data from the Office for National Statistics (2021c) reveals that the suicide rate among female nurses is 23% higher than that of other women. This significant disparity suggests profound distress, potentially linked to experiences of trauma.

The reasons behind the high prevalence of trauma among care providers remain unclear. It has been suggested that those who have experienced trauma may gravitate towards caregiving roles due to a heightened empathy and understanding towards others as a result of their experiences (Dheensa et al., 2023). An alternative explanation is that the inherent caring nature that draws individuals to healthcare roles might render them more susceptible to abuse (McGregor et al., 2016).

Trauma can affect maternity care providers’ performance and productivity through multiple avenues. Both physical and mental health issues, such as head or neck injuries, depression, and panic attacks, can impede concentration, undermine confidence in professional capability, and contribute to increased sickness rates (Dheensa et al., 2023). The extreme stress resulting from experiences of abuse can diminish the quality of work, leading to errors or an inability to be fully present for patients (Donovan et al., 2021). Healthcare providers who have been victims of abuse may face targeting by perpetrators within their workplace, as highlighted by the British Medical Association (2022). Further, the accumulation of past traumatic experiences significantly heightens the likelihood of developing PTSD after a current traumatic event, which strongly correlates with intent to leave the profession (Leinweber et al., 2017; Slade et al., 2020).

Survivors of trauma may find that supporting women who have faced similar experiences can evoke distressing memories (Donovan et al., 2021). Dheensa et al. (2023) found that workplace incivility or violence from patients can also trigger traumatic memories of abusive encounters. However, shared experiences of trauma can equip maternity care providers to better recognise clients who may have suffered trauma and provide empathetic and trauma-sensitive care (Donovan et al., 2021; de Klerk, Gitsels and de Jonge, 2022; Dheensa et al., 2023; Garrett, 2011).

Reports from the Royal College of Midwives (RCM, 2018) and the British Medical Association (BMA, 2022) illuminate the inconsistent support available for healthcare staff affected by abuse or violence. The BMA's findings revealed a concerning lack of comprehensive policies, with a third of trusts and boards lacking a domestic abuse policy for staff, while nearly half did not provide a designated confidential point of contact for staff members (p.6). The RCM report found that staff in training had even poorer access to support.

Both reports detail the unique challenges faced by healthcare professionals when attempting to access support services. This includes feelings of shame and inadequacy. Professionals frequently have concerns about confidentiality, such as the fear of encountering patients at domestic abuse support services. Further, healthcare professionals often face rigid working arrangements that fail to accommodate demands such as court cases and childcare responsibilities. These reports also identified pervasive stereotypes around domestic abuse victims which can lead to healthcare professionals being overlooked or not identified as potential victims themselves. An overarching concern expressed by healthcare providers was the fear of potential professional repercussions of disclosure, such as being perceived as less competent or referred to their professional regulatory body. Both reports describe a culture within healthcare services which can discourage disclosure (RCM, 2018; BMA, 2022).

The lack of specific evidence concerning trauma experiences among maternity care providers highlights a critical knowledge gap. Maternity care is characterised by unique emotional and physical demands that significantly differ from other healthcare sectors. Addressing this gap is crucial to understanding the experiences and needs of maternity care providers, which is essential for developing tailored strategies aimed at safeguarding their mental and physical well-being.

A fundamental culture shift is necessary to ensure staff access the available support. This shift entails a move from merely 'offering' support to those in need, towards embedding support as an integral and routine aspect of everyday working life, actively provided to all staff within working hours. This cultural transformation could significantly enhance the effectiveness of support initiatives.

8.4 Strengths and limitations of the study

In this section, I examine both the strengths and limitations of the doctoral study.

8.4.1 Strengths of the study

By concentrating on routine trauma discussions during the perinatal period, the study addresses a significant gap in existing literature. While understanding of the impact of adverse experiences on health across the lifespan is growing rapidly, there is a lack of clear guidance on the practical implementation of trauma-informed perinatal care. The study addresses this information gap.

The study employed a CPAR approach, engaging a diverse range of key stakeholders from inception to completion. This included input from the Research Collective who supported the study throughout; inclusion of the views of more than 1600 women and 250 healthcare professionals and experts from the voluntary sector in the systematic review and qualitative synthesis; study interviews; and public consultation on the draft framework. These stakeholders represented various professional types involved in delivering maternity care, diverse types of traumas and experts by experience from marginalised groups. This collaborative and broad-ranging perspective bolsters the validity and applicability of the framework for trauma discussions.

The study is grounded in a robust methodology that draws from empirical evidence obtained through the EMPATHY study's systematic review and interviews. The EMPATHY qualitative evidence is the first to integrate the perspectives of women and maternity care professionals on routine trauma discussions, ensuring a comprehensive understanding of the challenges and opportunities associated with trauma discussions. Rigorous search strategies and explicit measures to minimise bias, such as positionality and reflexivity, strengthen the reliability of the findings.

The study goes beyond merely identifying issues related to routine trauma discussions by offering practical solutions, underscoring a commitment to translating research findings into tangible measures. This amplifies the potential impact of the research on policy and practice. These strengths collectively contribute to the study’s credibility, relevance, and potential for meaningful impact in advancing trauma-informed care practices during the perinatal period.

8.4.2 Limitations of the study

While the study provides valuable insights into conducting effective and sensitive trauma discussions, several limitations affect the interpretation of the findings.

First, the study’s sample may not fully represent all relevant groups. The use of purposive sampling of maternity care providers, primarily through existing networks, introduced the potential for selection bias. The decision to conclude interview recruitment after 23 participants, driven by data richness and manageability concerns, may have excluded diverse perspectives that additional participants could have brought. As noted in section 8.2.2, despite efforts, challenges in recruiting women with limited English proficiency persisted. While attempts were made to mitigate sampling limitations, including seeking opinions through various channels (Research Collective, interviews, and guideline consultation), the study’s broader applicability could be limited which could affect the credibility of the findings.

Furthermore, members of the Research Collective, interview participants, and respondents to the guideline consultation were not asked about their personal trauma experiences. This raises the possibility that certain types of traumas were under- or overrepresented in the sample, potentially resulting in skewed findings. Although collaboration was sought through multiple avenues to reduce this risk, it remains a limitation. Additionally, concerns were raised regarding the environment for open discussion within the Research Collective, particularly in the presence of healthcare professionals. Despite efforts to encourage anonymous feedback from the fourth workshop and to adapt the workshop formats accordingly, it is possible that some members felt inhibited in sharing their views openly, affecting the richness of the data collected.

The absence of participants from Asian backgrounds in the interviews is noteworthy. Given the heightened risk of maternal and neonatal mortality or morbidity among women from Asian backgrounds (Knight et al., 2020), this represents a significant limitation, and future research should prioritise the inclusion of this demographic group and other underrepresented groups.

Lastly, the exclusion of quantitative studies from the systematic review may limit the comprehensiveness of the findings. Including quantitative studies could have provided additional depth and strengthened the overall conclusions and confidence of the review findings and the overall study. These limitations should be acknowledged when interpreting the findings and considered in the context of future research directions.

8.5 Implications for policy, practice, and research

This section outlines practical implications and recommendations derived from the study.

8.5.1 Implications for policy

The implications for policy stemming from this doctoral study are substantial, particularly in addressing the existing policy gap concerning routine trauma discussions within the UK maternity care system. The framework developed in this research offer an important evidence-based framework for conducting trauma conversations. The framework should be integrated into national guidance and allocated appropriate funding. This funding should encompass resources for staff training and delivery, as without adequate financial support, practical challenges such as financial constraints and understaffing may hinder the feasibility and widespread adoption of the guidance. Investing in implementation of this framework could yield long-term cost savings by facilitating earlier access to mental health support and potentially mitigating the intergenerational transmission of trauma, which has profound and enduring effects across the lifespan.

Furthermore, funding must extend to encompass appropriate supervision and support for staff involved in implementing the guidance. This support model should include independent, professional support services, as staff members may be hesitant to share personal experiences with colleagues they know, may require professional support, or may not recognise when their stress and burnout levels are escalating. By investing in comprehensive support structures, policymakers can help ensure the successful implementation and sustainability of trauma-informed practices within maternity care settings, ultimately leading to improved outcomes for both women and maternity care providers alike.

8.5.2 Implications for practice

The findings of the EMPATHY study carry significant implications for practice, which have been integrated into the framework for trauma discussions. Key implications include the need to introduce trauma discussions as part of a comprehensive system-wide change, conduct these discussions in a way that fosters trust and builds relationships between care providers and women, provide appropriate staff training and support, tailor discussions to local needs and services, and systematically evaluate the uptake and impact of trauma discussions. The study's systematic review underscores the reluctance of many women to disclose their histories to maternity care providers: a critical implication of this finding is the need for all women to be provided with independent access to support and resources.

The study identified a challenge in current practice, in that broaching the topic of prior trauma during the initial booking appointment is often ineffective. Many women hesitate to share their histories in the absence of a trusting relationship, and raising the issue at the first appointment means women are not prepared for the conversation and can find it intrusive and distressing. Partners are often present at this appointment and may be unaware of, or involved in, the trauma. Moreover, the structured nature of the booking appointment, primarily focused on medical history, does not facilitate the open and women-centric conversations necessary for addressing trauma.

A proposed solution to these challenges involves introducing an additional appointment dedicated to mental health and well-being, shortly after the initial booking appointment. This would ideally be with the same care provider to allow for the establishment of trust. Women could be prepared for this discussion at the booking appointment, so they can decide in advance whether they wish to share their histories and ensure they have appropriate support in place. Information on the potential impact of trauma and support which can be accessed independently could also be provided. This appointment aligns with the core trauma-informed principle of offering choice and control, and would provide women with an opportunity to lead trauma discussions in an unstructured and confidential setting.

Feedback from EMPATHY interview participants, including experts by experience, voluntary sector practitioners, and maternity care providers, strongly supports the concept of a separate antenatal appointment focused on emotional health and well-being. Anticipated benefits include demonstrating parity between physical and mental health, creating a safe space for women to share their histories, and potentially yielding cost savings by addressing problems at an earlier stage. This approach has therefore been integrated into the framework for trauma discussions.

8.5.3 Implications for research

The EMPATHY study interviews underscore the inadequacy of existing tools for broaching the topic of previous trauma. None of the currently available tools gained widespread acceptance, with some, such as the ACE questionnaire, deemed potentially harmful to women and jeopardising the relationship between care providers and women. The Kimberley Mum’s Mood Scale, which incorporates a visual Likert scale derived from the Edinburgh Postnatal Depression Scale alongside a discussion of key well-being domains including childhood experiences and mental health, emerged as the preferred tool among EMPATHY interview participants. While participants felt the scale was likely to be acceptable to women and effective in encouraging open conversations, its design for Aboriginal women in Western Australia necessitates substantial adaptation for UK use. Consequently, there is a pressing need for a culturally sensitive, co-designed tool, tailored to the UK context.

Further, the study revealed gaps in available information and resources for Trusts interested in implementing or having implemented routine trauma discussions. To prevent unnecessary duplication of work, the development of national materials, that can be locally adapted, is recommended. These materials should include a routine trauma discussion policy, a comprehensive training package for staff, and resources for women, including audio-based information for women with limited English proficiency. These materials should be developed and evaluated with the meaningful input of those who have experienced trauma, experts from the voluntary sector, and maternity care providers. The comprehensive development and evaluation of these materials would represent essential steps in advancing trauma-informed care practices during the perinatal period.

The study also sheds light on the impact of care providers' own trauma. The EMPATHY study interviews indicated that prior trauma can significantly influence career choice, work experiences, and retention rates. Further exploration of the prevalence and impact of trauma on maternity care providers is necessary to support their well-being and longevity within the profession.

8.6 Closing reflexive thoughts

In section 5.6.3 I detailed how I maintained a reflexive stance during the study to acknowledge and address potential biases. In this section, I reflect on the transformational process of conducting this research, both personally and academically. Through this process, I have gained profound insights into the complexities of trauma-informed perinatal care, experienced personal growth, and refreshed my resolve to work to improve maternity care.

One particular interview, in which showing the ACE questionnaire to a participant led her to reflect on her own childhood traumas, stands out. The interview is described in sections 5.44 and 8.2.3. Her poignant and articulate expression of the enduring impact of her difficult past left a lasting impression on me. This discussion took place during our second meeting, and I believe our established rapport facilitated its intimacy. This observation aligns with the proposal that an additional antenatal appointment to discuss trauma may be more effective (section 6.5.4) and the importance of providing multiple opportunities to broach the topic of trauma (section 6.5.2).

The emotional weight of this interview lingered, not only due to its distressing content but also because I felt a sense of responsibility as the person who had initiated the discussion. These sentiments were echoed in an interview with a community midwife, who cried when she recounted the emotional burden of hearing women's traumatic experiences during booking appointments (section 6.8.2). This highlights the inherent challenges in engaging with such sensitive topics and the essential need for support for staff. Recognising the emotional demands of my research, I sought support from the funders for my study – the National Institute for Health Research and Wellbeing of Women - who agreed to fund monthly counselling sessions for me. This invaluable resource provided a confidential space to navigate both study-related and personal challenges, reaffirming my determination to work towards improved staff well-being.

While my initial expectations were modest, I’m proud of the contributions my research has made to advancing the conversation around trauma-informed perinatal care. An article about the EMPATHY systematic review and qualitative synthesis reached millions of individuals, showing the relevance and urgency of this work. I had the privilege of presenting the work at high profile conferences including the International Labour and Birth Research Conference, the Royal College of Midwives Research and Education Conference, and the International Confederation of Midwives Triennial Congress. I was an invited speaker at the Royal College of

Midwives Main Conference 2024 and wrote a book chapter and various blogs during the doctoral period, further disseminating the key insights of my research.

None of this would have been possible without the study's supporters. The Research Collective, with their unwavering dedication and insightful contributions, played a pivotal role in shaping the study. Likewise, my supervisors provided invaluable mentorship, offering wisdom, encouragement, and the freedom to explore complex themes. Additionally, the maternity education team at Kingston University provided a nurturing environment for intellectual growth and critical reflection, allowing me the time and space to develop sessions on trauma-informed care which fostered the development of my ideas and arguments.

My background in Implementation and Improvement Science means I am acutely aware of the challenges of translating research findings into tangible changes in clinical practice. However, I remain optimistic about the potential of trauma-informed perinatal care to improve the lives of women, their children, and their families. I hope that this research will catalyse broader systemic changes that ripple out to positively impact future generations.

8.7 Conclusion

The EMPATHY study has illuminated critical aspects of trauma-informed perinatal care, offering valuable insights into the complexities and challenges faced by both women and maternity care providers. By focusing on routine trauma discussions during the perinatal period, the research addresses a significant gap in existing literature and provides practical solutions to improve the quality of care for women who have experienced trauma.

The study's strengths lie in its robust methodology, grounded in CPAR, and its collaborative approach involving a diverse range of stakeholders. The implications of this research extend beyond academia, with practical recommendations for policy development, practice improvement, and future research directions. Through the development of an evidence-based framework for routine trauma discussions, the study offers concrete steps towards creating a more empathetic and supportive maternity care environment. However, the challenges in improving care within overstretched and understaffed maternity services is acknowledged. There is a need for further research and ongoing efforts to address gaps in policy and practice.

It is hoped that the insights gained from this research will pave the way for a more empathetic and supportive approach to perinatal care, where every woman who is suffering because of trauma feels empowered to seek support.

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Appendix 1. PROSPERO protocol and details of amendments made to original protocol

What are the views of women and maternity care professionals on routine discussion of previous trauma in the perinatal period?' A qualitative evidence synthesis
Review methods were amended after registration. Please see the revision notes and previous versions for detail.

Citation
Joanne Cull, Gill Thomson, Soo Downe, Michelle Fine, Anastasia Topalidou. What are the views of women and maternity care professionals on routine discussion of previous trauma in the perinatal period?' A qualitative evidence synthesis. PROSPERO 2021 CRD42021247160 Available from: https://www.crd.york.ac.uk/prospero/display_record.php?ID=CRD42021247160

Review question [2 changes]
What are the views of women and maternity care professionals on routine discussion of previous trauma in the perinatal period?'

Searches [2 changes]
Sources that will be searched: electronic databases MEDLINE, PsycINFO, EMBASE and CINAHL and Global Index Medicus. Forward and backward citation tracking will also be carried out.
No limits, publication date or publication status restrictions will be applied. Studies published in any language were eligible for inclusion in the review.

Types of study to be included [2 changes]
Only qualitative studies and qualitative aspects of mixed methods studies were included in the review.

Condition or domain being studied [1 change]
The provision of care by maternity services to women in the perinatal period (pregnant or within 1 year after birth) who have experienced previous trauma.

Participants/population [1 change]
Women in the perinatal period (pregnant or within 1 year after birth) receiving maternity services; or maternity care providers providing these services.

Intervention(s), exposure(s) [1 change]
Routine discussion of previous trauma within maternity care. The discussion could include all past trauma or specific types e.g. adverse childhood experiences / sexual abuse.

Comparator(s)/control [1 change]
Routine discussion of previous trauma compared to no routine discussion in the comparator arm.

Context [1 change]
Studies not based in a maternity setting, or which did not include women in the perinatal period, were excluded.

Main outcome(s) [2 changes]
The views of women and maternity care professionals on routine discussion of previous trauma in the perinatal period

Additional outcome(s)
Not applicable.

Data extraction (selection and coding) [1 change]
Screening process
The search results from each database will be exported to RefWorks and duplicates will be removed. The results will be uploaded to Rayyan for screening and agreement within the review team. Studies will be reviewed by title and abstract and full text of the remaining studies will be reviewed to assess

suitability. The lead author will undertake all screening, and 20% (or until there is at least 95% agreement) of papers at title/abstract and all papers at full text stages will be assessed by a second reviewer. Any differences of opinion about inclusion will be resolved through discussion between the reviewers.

Data extraction

The following information will be extracted for each included study: bibliographic information, aim of study, country of study, setting, study design, data collection, participants' characteristics, data analysis methods and key themes.

Risk of bias (quality) assessment

The quality of each study will be assessed using the appropriate Critical Appraisal Skills Programme (CASP) checklist. Studies of low quality will be included only if they offer new or innovative insights not reported in studies of higher quality. The impact of methodological limitations of individual studies on the systematic review findings will be considered in the discussion section of the review.

Strategy for data synthesis

Thematic analysis will be carried out using the method developed by Thomas and Harden (2008). The findings will be analysed by the first author using a content qualitative descriptive and / or thematic analysis depending on the available data. Following initial analysis by the first author, the other authors will critique the coding and themes to enhance rigour and trustworthiness: the themes will be discussed and refined until consensus is achieved within the research team.

Analysis of subgroups or subsets
None planned, but may be considered dependent on what is identified.

Contact details for further information
Joanne Cull jcull@uclan.ac.uk

Organisational affiliation of the review
University of Central Lancashire

Review team members and their organisational affiliations [1 change]
Ms Joanne Cull. University of Central Lancashire
Professor Gill Thomson. University of Central Lancashire
Professor Soo Downe. University of Central Lancashire
Professor Michelle Fine. City, University of New York
Dr Anastasia Topalidou. University of Central Lancashire

Type and method of review [1 change]
Synthesis of qualitative studies, Systematic review

Anticipated or actual start date
01 March 2021

Anticipated completion date [1 change]
31 December 2022

Funding sources/sponsors

Joanne Cull is supported by a National Institute for Health Research Wellbeing of Women Doctoral Fellowship for this research project.
Grant number(s)
State the funder, grant or award number and the date of award
National Institute for Health Research and Wellbeing of Women, grant number NIHR301525, start date 1.5.21

Conflicts of interest

Language
English

Country
England

Stage of review
Review Completed not published

Subject index terms status
Subject indexing assigned by CRD

Subject index terms
Female; Humans; Narration; Parturition; Pregnancy; Social Support; Social Work

Date of registration in PROSPERO
13 April 2021

Date of first submission
10 April 2021

Stage of review at time of this submission [1 change]

Stage	**Started**	**Completed**
Preliminary searches	Yes	Yes
Piloting of the study selection process	Yes	Yes
Formal screening of search results against eligibility criteria	Yes	Yes
Data extraction	Yes	Yes
Risk of bias (quality) assessment	Yes	Yes
Data analysis	Yes	Yes

The record owner confirms that the information they have supplied for this submission is accurate and complete and they understand that deliberate provision of inaccurate information or omission of data may be construed as scientific misconduct.
The record owner confirms that they will update the status of the review when it is completed and will add publication details in due course.
Versions
13 April 2021
11 July 2022 Revision note:
Extend completion date. Remove Lesley Kay as review team member
19 July 2022 Revision note:
An initial scoping review found that the volume of included papers was going to be too great to synthesis in a manageable and meaningful way. I therefore changed the protocol as follows to address this issue: 1. I amended the review question to focus on routine discussion of previous trauma rather than more broadly trauma-informed care; 2. The study setting was restricted to maternity services, instead of health and social care services; 3. Initially, I planned to include all study types. I revised this to include only qualitative studies, and the qualitative aspects of mixed methods studies; 3. I excluded grey literature. The following changes were also made: - Amended anticipated completion date to 31.12.22 - Updated contact email address - Removed Lesley Kay from review team members - Amended data extraction (selection and coding) to reflect additional screening by second reviewer.

07 October 2022 Revision note:
1. Clarify review question and methodology.2. Include studies published in any language to limit language bias.3. Set criteria that only qualitative studies and the qualitative aspects of mixed methods studies are eligible for inclusion in the review. An initial scoping review showed that the volume of

combined quantitative, qualitative, and mixed method papers was too great to meaningfully synthesise. As qualitative studies offered insights into the concerns, thoughts, and needs of both women who have experienced trauma, and maternity care professionals who will be raising the issue (recognising that maternity care professionals may themselves have experienced trauma), a qualitative approach was deemed more appropriate. 4. Update review progress

Appendix 2. Database search results

Database: CINAHL Plus

Thursday, June 10, 2021 9:58:18 AM

#	Query	Limiters/Expanders	Last Run Via	Results
S1	trauma-informed OR trauma informed	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL Plus	1,495

Database: APA Psycinfo

Thursday, June 10, 2021 10:01:17 AM

#	Query	Limiters/Expanders	Last Run Via	Results
S1	trauma-informed OR trauma informed	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - APA PsycInfo	2,354

Database: MEDLINE

Thursday, June 10, 2021 10:02:13 AM

#	Query	Limiters/Expanders	Last Run Via	Results
S1	trauma-informed OR trauma informed	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - MEDLINE	1,539

Database: EMBASE

Database: Embase <1974 to 2021 June 09>

Search Strategy:

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1 (trauma-informed or trauma informed).af. (1778)

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Database: Global Index Medicus

World Health
Organization

Global Index Medicus

1. Search
2. (tw:(trauma-informed)) OR (tw:("trauma informed")) (168)

Appendix 3. Assessment of methodological strengths and limitations using CASP Qualitative checklist

Key: ✓= Yes; X= No; ?= Insufficient information to make assessment

	Validity					Description				Usefulness	
Study	**Aims**	**Methodology**	**Study design**	**Recruitment strategy**	**Data collection**	**Researcher bias**	**Ethics**	**Data analysis**	**Statement of findings**	**Value of research**	**Overall assessment**
1. Carlin, Atkinson and Marley, 2019	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Strong
2. Carlin et al., 2020	✓	✓	✓	✓	✓	?	✓	✓	X	✓	Strong
3. Chamberlain et al., 2020	✓	✓	✓	✓	✓	✓	✓	X	✓	✓	Strong
4. Choi and Seng, 2014	✓	✓	X	✓	✓	X	?	?	✓	✓	Adequate
5. Flanagan et al., 2018	✓	✓	✓	✓	✓	X	X	X	?	✓	Adequate
6. Gokhale et al., 2020	✓	✓	✓	✓	✓	X	✓	✓	✓	✓	Strong
7. Kohlhoff et al., 2021	✓	✓	✓	✓	✓	X	✓	X	X	✓	Adequate
8. Marley et al., 2017	✓	✓	✓	✓	X	?	✓	X	X	X	Adequate

	Validity					Description				Usefulness	
Study	**Aims**	**Methodology**	**Study design**	**Recruitment strategy**	**Data collection**	**Researcher bias**	**Ethics**	**Data analysis**	**Statement of findings**	**Value of research**	**Overall assessment**
9. Mendel, Sperlich, and Fava., 2021	✓	✓	✓	✓	?	?	✓	?	✓	✓	Adequate
10. Millar et al., 2021	✓	✓	✓	✓	✓	?	✓	✓	✓	✓	Strong
11. Mollart, Newing and Foureur, 2009	✓	✓	✓	✓	✓	✓	?	✓	✓	✓	Strong
12. Montgomery, Seng and Chang, 2021	✓	✓	✓	✓	✓	?	✓	✓	✓	✓	Strong
13. Mule et al., 2021	✓	✓	✓	✓	✓	X	✓	X	X	✓	Adequate
14. Olsen, Galloway and Guthman, 2021	✓	✓	✓	✓	✓	?	✓	?	✓	✓	Strong
15. Reilly et al., 2020	✓	✓	✓	✓	✓	?	✓	?	✓	✓	Strong
16. Rollans et al., 2013	✓	✓	✓	✓	✓	X	✓	✓	✓	✓	Strong

	Validity					Description				Usefulness	
Study	**Aims**	**Methodology**	**Study design**	**Recruitment strategy**	**Data collection**	**Researcher bias**	**Ethics**	**Data analysis**	**Statement of findings**	**Value of research**	**Overall assessment**
17. Schmied et al., 2020	✓	✓	✓	✓	✓	?	✓	✓	✓	✓	Strong
18. Seng et al., 2002	✓	✓	✓	✓	✓	?	✓	?	✓	✓	Strong
19. Sobel et al., 2018	✓	✓	?	?	✓	X	✓	X	✓	✓	Adequate
20. Stenson et al., 2001	✓	✓	✓	✓	X	✓	X	X	X	?	Adequate
21. Stenson, Sidenvall and Heimer, 2005	✓	✓	X	✓	✓	X	✓	✓	X	?	Adequate
22. White, Danis and Gillece, 2015	✓	✓	✓	✓	✓	?	?	✓	✓	✓	Strong
23. Willey et al., 2020a	✓	✓	✓	✓	✓	X	✓	✓	X	?	Strong
24. Willey et al., 2020b	✓	✓	✓	?	✓	✓	✓	✓	✓	✓	Strong
25. Preis et al., 2020	✓	✓	✓	X	✓	X	X	X	✓	?	Adequate

Appendix 4. Grade-CERQual assessments

Summary of findings (descriptive theme)	**Relevant studies (study numbers as per Table 3.2 Characteristics of included studies)**	**Methodological Limitations**	**Coherence**	**Adequacy**	**Relevance**	**CERQual assessment of confidence in the evidence**	**Explanation of CERQual assessment**
Women feel positively about routine trauma discussion	14 studies (1,2,6,8,10,12,13, 14,16,18,19,20,22 ,24)	*Moderate concerns:* methodological limitations in 4/14 underlying studies related to recruitment strategy, reflexivity, data collection and analysis, ethical issues, and unclear statement of findings	*Serious concerns:* this data is supported by findings from a large number of studies. However, it is contradicted by the finding that the discussion could be perceived as invasive and unexpected, and support for trauma discussion is dependent on adequate time and resources. This is an over-simplified description of women's views on trauma discussion.	*No or very minor concerns: the finding is supported by many studies, and explored with* sufficient richness	*No or very minor concerns:* finding is in accord with context of review question.	Low	Finding is supported by 14 studies, but there are serious concerns about coherence as the finding contradicts other findings, and four of the underlying studies have methodological limitations
Some women find routine trauma discussion invasive and unexpected	8 studies (2,6,13,14,16, 20)	*Moderate concerns:* methodological limitations in 2/8 underlying studies related to data collection and analysis, ethical issues, and unclear statement of findings	*No or very minor concerns:* this finding is coherent across a range of studies.	*No or very minor concerns:* this finding is well supported by details in the underlying studies.	*No or very minor concerns:* finding is in accord with context of review question.	High	Finding is supported by five studies, with rich data and no or very minor concerns about methodological limitations, coherence or relevance
Maternity care providers feel routine trauma discussion is valuable	11 studies (2,3,4,5,7,8,15,17, 21,23,25)	*Moderate concerns:* methodological limitations in 5/11 underlying studies related to recruitment strategy, reflexivity, ethics, data collection and analysis, research	*No or very minor concerns:* this finding is consistent and coherent across a range of studies.	*No or very minor concerns: the finding is supported by many studies, and explored with* sufficient richness	*No or very minor concerns:* finding is in accord with context of review question.	Moderate	Finding is supported by 11 studies, but there are concerns about methodological limitations in 5 of these studies.

		design and lack of clear statement of findings					
Support for routine trauma discussion is contingent on adequate time and resources	16 studies (2,3,4,5,7,8,14,15, 16,17,19,20,21,22 ,23,24)	*Minor concerns: methodological limitations in 6/16 underlying studies related to a variety of issues*	*Minor concerns:* to a certain extent this finding contradicts the finding that women felt positively about routine trauma discussion, as participants in several studies expressed unqualified support for the practice. However, these participants might reasonably have assumed that the discussion would only be initiated by a clinician who had adequate time, and that care would be tailored appropriately based on their response.	*No or very minor concerns: the finding is supported by many studies, and explored with* sufficient richness	*No or very minor concerns:* finding is in accord with context of review question.	High	Rated as high as supported by sixteen studies, and there are no or minor concerns about methodology, coherence, adequacy and relevance
Women favour a broad, conversational approach to discussing trauma	5 studies (1,2,9,12,13)	*Moderate concerns:* methodological limitations in2/5 underlying studies related to insufficient data analysis, little discussion of ethical issues, and unclear statement of findings	*Moderate concerns*: the only studies which directly asked women about their views of questionnaire versus conversational approaches were researching a particular tool (the Kimberley Mum's Mood Scale). In other studies women discussed general limitations of questionnaires.	Serious concerns: supported by five studies, with limited depth of data provided by most studies.	*No or very minor concerns:* finding is in accord with context of review question.	Very low	Finding is supported by only five studies, with moderate concerns about methodological limitations and coherence
Women who have suffered trauma want relationship-based care	6 studies (1,6,10,12,14,18)	*No or very minor concerns:* all underlying studies assessed as methodologically strong	*Minor concerns*: only six studies reported this finding, but it is consistent with the finding that relationships are critical to trauma disclosure.	*Minor concerns:* six studies report this finding, with rich data from some studies	*No or very minor concerns:* finding is in accord with context of review question.	Moderate	Finding is well supported by six studies, with no or very minor concerns about coherence, relevance, and methodological limitations
Choice and control is important to women	6 studies (1,10,12,14,18,19)	*Minor concerns:* methodological limitations in 1/6	*No or very minor concerns:* this finding is coherent across a range of studies.	*Minor concerns:* six studies report this finding, with rich	*No or very minor concerns:*	High	Finding is well supported by six studies, with no or very

		underlying studies relating to research design, recruitment strategy, reflexivity and data analysis		data from some studies	finding is in accord with context of review question.		minor concerns about coherence, relevance, and methodological limitations
Women want further therapeutic support	7 studies (1,3,6,10,14,22,24)	*No or very minor concerns:* all underlying studies assessed as methodologically strong	*Minor concerns:* reported by six studies	*Moderate concerns:* seven studies support this finding, with rich data from some studies.	*No or very minor concerns:* finding is in accord with context of review question.	Moderate	Finding is supported by six studies, with minor concerns about coherence
Women fear judgement if they disclose their histories	12 studies (1,2,3,12,13,14,17,18,19,20,22,24)	*Moderate concerns:* metholodological limitations in 3/12 underlying studies related to research design, recruitment strategy, ethics, data collection and analysis, and unclear statement of findings	*No or very minor concerns:* this finding is well supported by data from a wide range of studies.	*No or very minor concerns: the finding is supported by many studies, and explored with* sufficient richness	*No or very minor concerns:* finding is in accord with context of review question.	High	Finding is well supported by 12 studies, with no or very minor concerns about coherence, relevance, and methodological limitations
Relationships are a critical prerequisite to trauma disclosure	13 studies (1,2,3,6,10,12,13,14,16,18,20,21,24)	*Minor concerns:* metholodological limitations in 3/13 underlying studies related to research design, ethics, reflexivity, data analysis, and unclear statement of findings	*No or very minor concerns:* this finding is well supported by data from a wide range of studies.	*No or very minor concerns: the finding is supported by many studies, and explored with* sufficient richness	*No or very minor concerns:* finding is in accord with context of review question.	High	Finding is well supported by 13 studies, with no or very minor concerns about coherence, relevance, and methodological limitations
The manner of the person asking and the environment are also important	12 studies (1,2,3,6,8,13,14,16,18,19,22,24)	*Moderate concerns:* metholodological limitations in 3/12 underlying studies related to research design, recruitment strategy, ethics, data collection and analysis,	*No or very minor concerns:* this finding is well supported by data from a wide range of studies.	*No or very minor concerns: the finding is supported by many studies, and explored with* sufficient richness	*No or very minor concerns:* finding is in accord with context of review question.	High	Finding is well supported by 12 studies, with no or very minor concerns about coherence, relevance, and methodological limitations

		and unclear statement of findings					
If not handled sensitively, trauma discussion could affect future health care access and experiences	3 studies (12,14,16)	*No or very minor concerns:* all underlying studies assessed as methodologically strong	*Moderate concerns:* three studies reported this phenomenon, however it is difficult to validate it because few studies explored women's experiences of disclosing trauma and their feelings about the response to their disclosure.	*Moderate concerns: although* only three studies contributed to this finding, they were set in different countries (England, Australia and North America). This finding was discussed in passing rather than being a focus of any of the studies.	*No or very minor concerns:* finding is in accord with context of review question, although only three studies reported this finding they were in different countries which suggests it is relevant.	Low	Rated as low because this finding is supported by only three studies, and there are concerns about coherence
Some women will choose not to disclose previous trauma	13 studies (2,3,4,6,10,12,13,14,16,17,18,19,24)	*Minor concerns:* methodological limitations in 2/13 underlying studies relating to research design, recruitment strategy, reflexivity, insufficient data analysis and unclear statement of findings	*No or very minor concerns:* this finding is consistent and coherent across a range of studies.	*No or very minor concerns: the finding is supported by many studies, and explored with* sufficient richness	*No or very minor concerns:* finding is in accord with context of review question.	High	Finding is well supported, with no or minor concerns about coherence, relevance, and methodological limitations
Some women feel their previous experiences are irrelevant to their current pregnancy	7 studies (3,6,12,13,16,18,20)	*Moderate concerns:* methodological limitations in 2/7 underlying studies related to data collection, data analysis, ethical issues, and unclear statement of findings	*No or very minor concerns:* while this is not the case for all women, participants in seven studies reported that at the time of pregnancy they did not recognise the ongoing impact of their trauma.	*Moderate concerns:* the finding is supported by seven studies, with most providing rich data.	*No or very minor concerns:* finding is in accord with context of review question.	Moderate	Supported by seven studies, but there are concerns about methodological limitations for two of these studies

The perinatal period can be intense and challenging	10 studies (1,2,4,10,12,14,18,19,20,24)	*Moderate concerns: methodological limitations in 2/10 underlying studies related to research design, recruitment strategy, data collection, ethics, and data analysis*	*No or very minor concerns:* this finding is well supported by data from a wide range of studies.	*No or very minor concerns: the finding is supported by many studies, and explored with* sufficient richness	*No or very minor concerns:* finding is in accord with context of review question.	High	Finding is well supported by ten studies, with no or very minor concerns about coherence, relevance, and methodological limitations
Not all women were fully aware of the extent or impact of the trauma they had suffered	10 studies (1,2,3,4,6,12,13,14,18,22)	*No or very minor concerns:* methodological limitations in 1/10 underlying studies related to insufficient data analysis and unclear statement of findings	*No or very minor concerns:* this finding is coherent across a range of studies.	*No or very minor concerns: the finding is supported by many studies, and explored with* sufficient richness	*No or very minor concerns:* finding is in accord with context of review question.	High	Finding is well supported by ten studies, with no or very minor concerns about coherence, relevance, and methodological limitations
The perinatal period carries potential for healing and growth	7 studies (1,4,6,8,12,18,19)	*Moderate concerns: methodological limitations in 2/7 underlying studies related to data analysis, researcher bias and uncler statement of findings*	*Moderate concerns: seven studies reported this phenoment, but in each case it was tangential rather than the purpose of the study*	*Moderate concerns:* the finding is supported by seven studies, with some providing rich data.	*No or very minor concerns:* finding is in accord with context of review question.	Moderate	Supported by seven studies, but there are concerns about methodological limitations for two of these studies and the finding was tangential, rather than central to the purpose of the studies
Embedding trauma discussion in routine practice is challenging	7 studies (4,5,7,15,17,21,23)	*Moderate concerns: methodological limitations in 3/7 underlying studies related to research design, reflexivity, ethical issues, data analysis and lack of clear statement of findings*	*Minor concerns*: seven studies reported this finding, but it is consistent with the well-known phenomenon that consistent implementation of interventions with healthcare is difficult to achieve.	*Moderate concerns:* seven studies support this finding, with rich data from some studies.	*No or very minor concerns:* finding is in accord with context of review question.	Moderate	Finding is supported by seven studies, two of which have methodological limitations
Partner presence can be a barrier to trauma discussion	2 studies (7,21)	*Serious concerns:* both underlying studies have methodological	*Minor concerns:* the majority of studies did not look at the impact of partner presence	*Serious concerns:* only two studies	*Minor concerns:* while the	Very low	Finding is supported by only two studies, both of which have

		limitations, related to research design, reflexivity, data analysis, and lack of clear statement of findings	on routine trauma discussion. However, the finding is well supported by Kohlkoff et al. (2021) and Stenson, Sidenvall and Heimer (2005), who explored this issue in depth.	reported this finding.	finding is only supported by two studies, they are in different settings (Australia and Sweden), suggesting the finding has wider relevance		methodological limitations
Women with limited English face additional challenges in discussing trauma	3 studies (16,23,24)	*No or very minor concerns:* all underlying studies assessed as methodologically strong	*Minor concerns:* the majority of studies did not include women with limited English. However, this finding is well supported by Willey et al. (2020a) and Willey et al. (2020b), who explored this issue in depth.	*Serious concerns:* only three studies contributed to this finding: two papers explored the subject in depth, but they were by the same authors.	*Moderate concerns:* given that the finding comes from three studies which all took place in Australia, finding may not be relevant in other contexts.	Low	Rated as low as only supported by three studies
Hearing trauma disclosures can be distressing for maternity care providers	5 studies (4,7,8,11,21)	*Serious concerns: 3/5* underlying studies have methodological limitations, related to research design, reflexivity, data collection and analysis, and lack of clear statement of findings	*Moderate concerns:* while five studies made reference to this finding, only one explored it in detail so it is difficult to validate.	*Serious concerns:* finding is supported by five studies, only one of which explored the phenomenon in depth.	*No or very minor concerns:* finding is in accord with context of review question.	Low	Only five studies support this finding, and only one of those studies explored the phenomenon in depth. Three of the studies have methdological limitations.

Appendix 5. Research Collective recruitment flyer

Improving maternity care for women who have had difficult experiences

Come along to this workshop and share your views on my proposed study

Friday 24th July, 10:30-11:30am

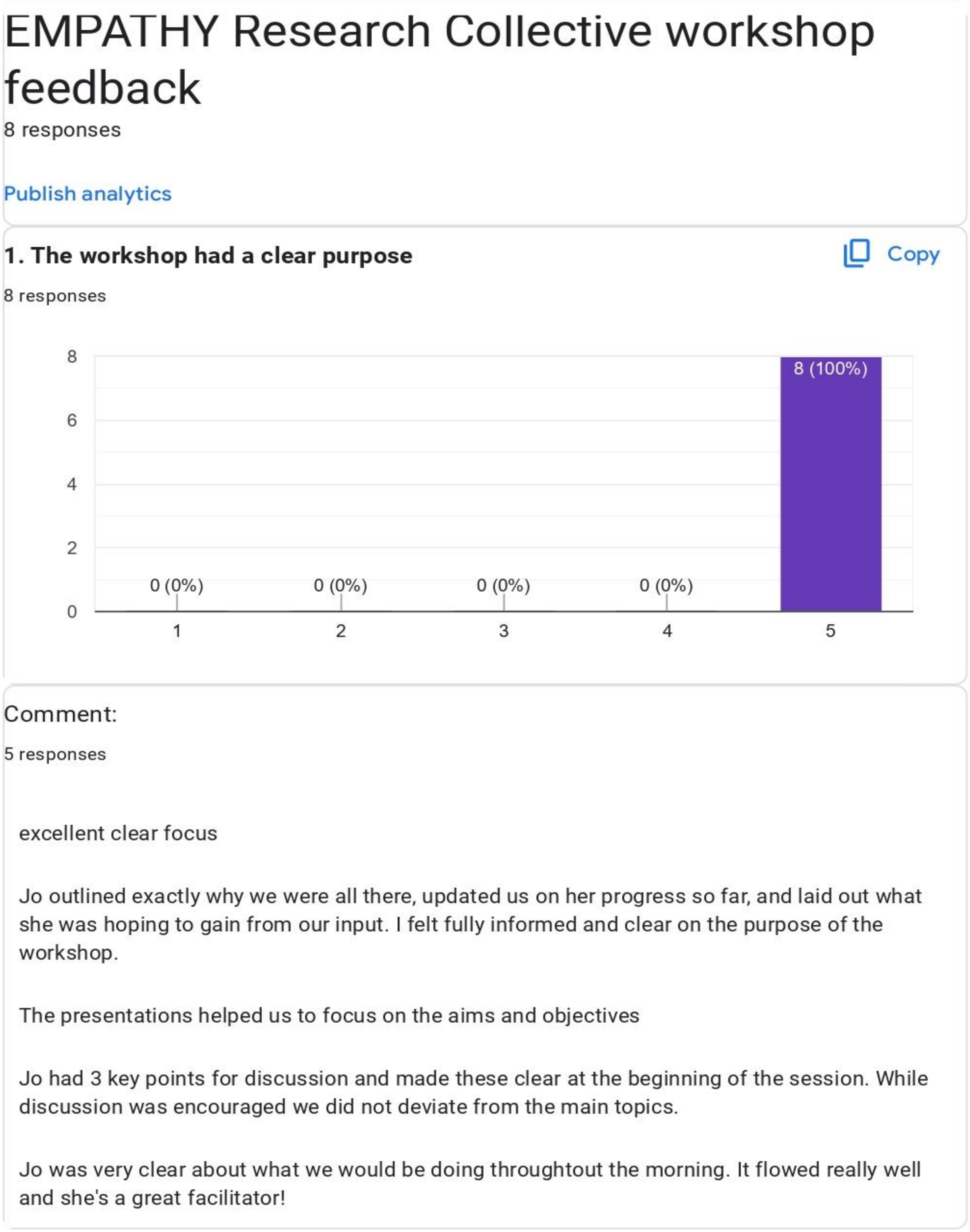
- *Take part with or without your video*
- *The meeting will not be recorded*
- *Share your ideas about the project - spoken or written*
- ***You will not be asked or expected to share your own experiences***

Zoom ID: 872 3795 7934 Password: 687249

If you can't come but would like to find out more, let me know at Joanne.Cull@nhs.net

Appendix 6. Feedback from Research Collective workshops

October 2022



EMPATHY Research Collective workshop feedback

8 responses

1. The workshop had a clear purpose

8 responses

Comment:

5 responses

excellent clear focus

Jo outlined exactly why we were all there, updated us on her progress so far, and laid out what she was hoping to gain from our input. I felt fully informed and clear on the purpose of the workshop.

The presentations helped us to focus on the aims and objectives

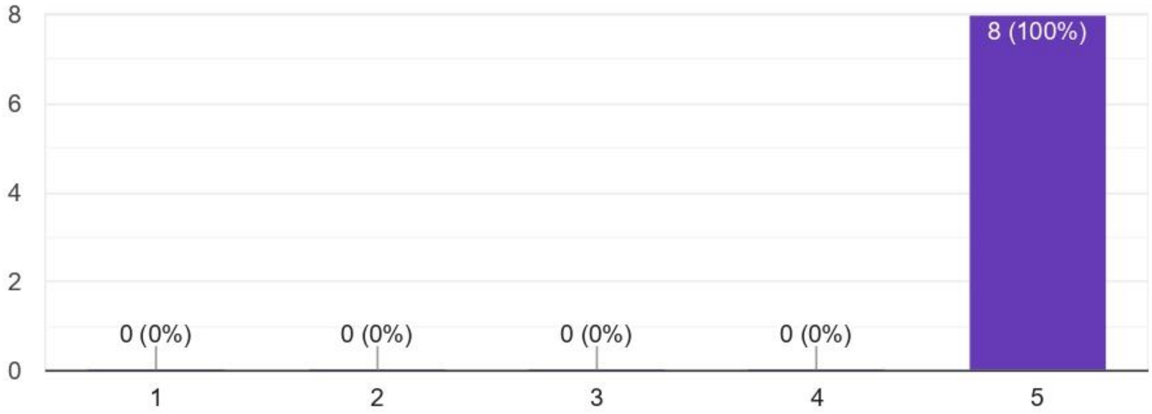
Jo had 3 key points for discussion and made these clear at the beginning of the session. While discussion was encouraged we did not deviate from the main topics.

Jo was very clear about what we would be doing throughtout the morning. It flowed really well and she's a great facilitator!

2. I felt listened to and able to contribute

Copy

8 responses



Comment:

5 responses

great opportunities for sharing ideas

Jo is excellent at ensuring everyone is able to speak and contribute constantly throughout the workshop, both in the main group and in breakout rooms.

Always v inclusive

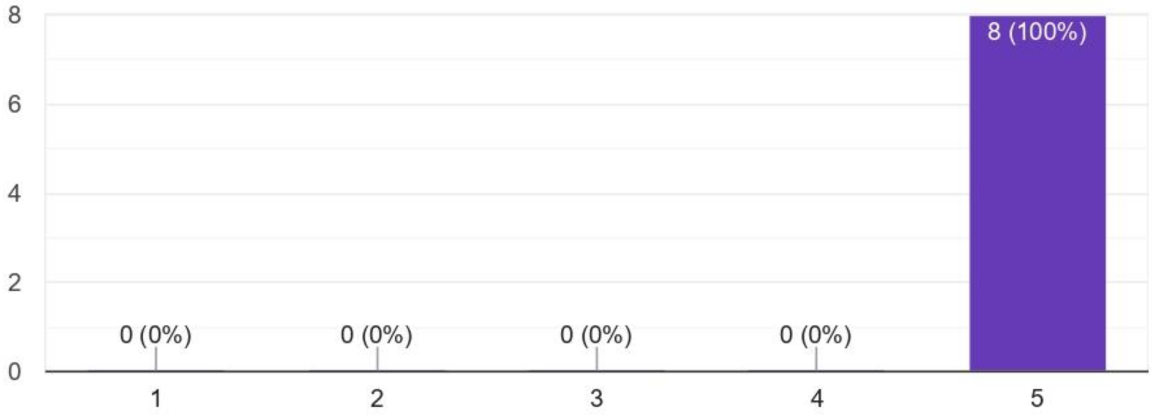
I felt a bit out of my depth at times (just personal, nothing to do with anyone else) but I felt listened to when I did speak and that some ideas I mentioned were useful.

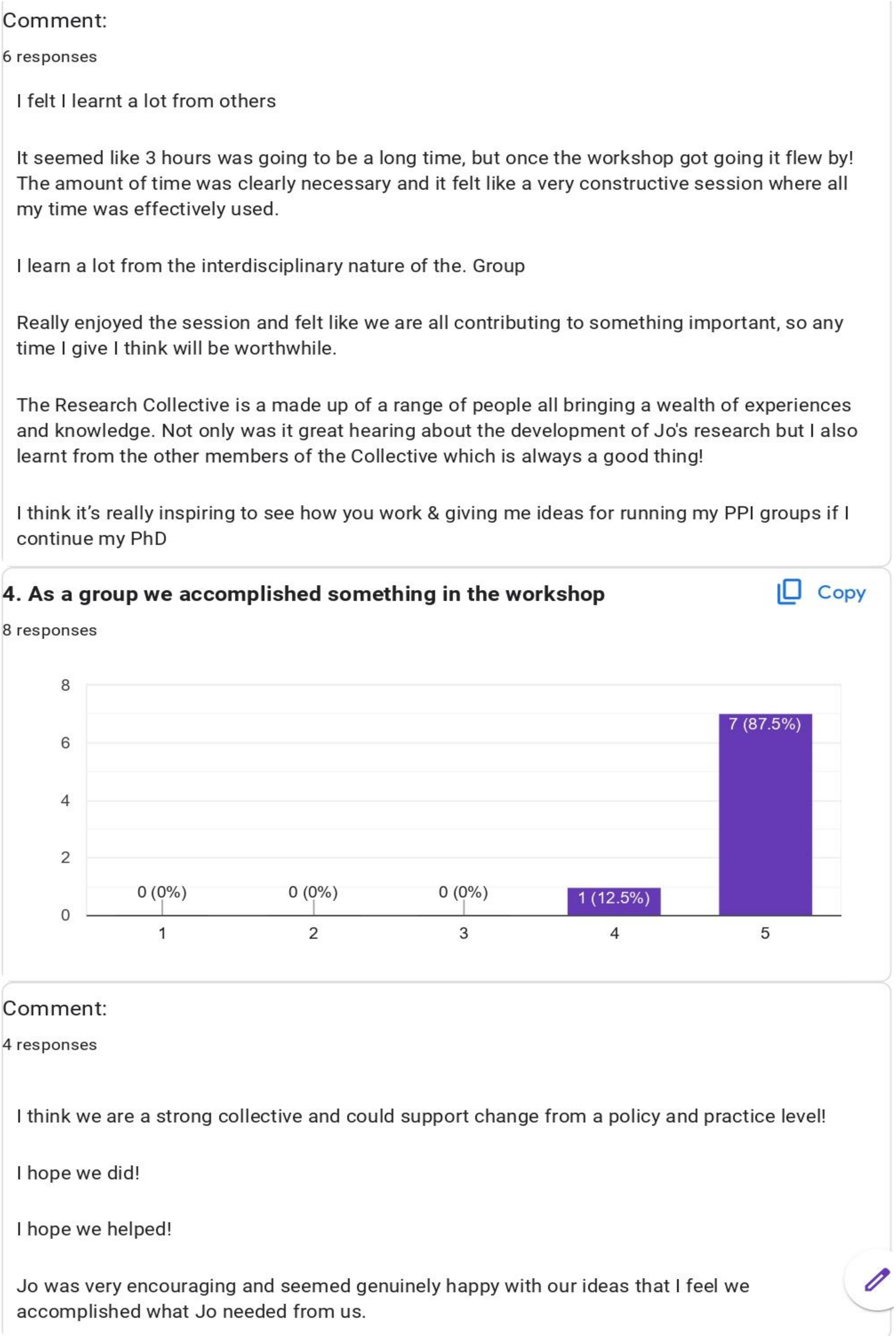
Jo aloowed plenty of opportunities for people to contribute

3. The workshop was an effective use of my time

Copy

8 responses





Comment:

6 responses

I felt I learnt a lot from others

It seemed like 3 hours was going to be a long time, but once the workshop got going it flew by! The amount of time was clearly necessary and it felt like a very constructive session where all my time was effectively used.

I learn a lot from the interdisciplinary nature of the. Group

Really enjoyed the session and felt like we are all contributing to something important, so any time I give I think will be worthwhile.

The Research Collective is a made up of a range of people all bringing a wealth of experiences and knowledge. Not only was it great hearing about the development of Jo's research but I also learnt from the other members of the Collective which is always a good thing!

I think it's really inspiring to see how you work & giving me ideas for running my PPI groups if I continue my PhD

4. As a group we accomplished something in the workshop

8 responses

Comment:

4 responses

I think we are a strong collective and could support change from a policy and practice level!

I hope we did!

I hope we helped!

Jo was very encouraging and seemed genuinely happy with our ideas that I feel we accomplished what Jo needed from us.

5. Please share one thing you learned during today's workshop

8 responses

I really like how you set us up as being equal and professionals AND women which often happens

There are many great ideas and research has produced a lot, but there are questions over resources available.

I have heard a lot of ideas that I didn't think before, but best thinking for a mother it to have time to heard and maybe from a group like this we did today

That the collective is really building up and there's a good mixture of people and experiences contributing.

Collaboration inspires creativity

I have been shocked about the disparity of care throughout the maternity journey. I knew it existed, but I have come away from the session feeling grateful for the care I did receive as many others are not so lucky, although that then does become a bit like imposter syndrome!

I learnt about some of the barriers of migrants when accessing care

Your facilitating skills are excellent and your lovely warmth & confidence. Although I already know that women with FGM need specialist support, I also am questioning whether we should treat them differently and label them as we do?

6. What would you change about today's workshop?

7 responses

Nothing

it's good to be often

Nothing!

Nothing

I can’t think of anything I would change. It was very good.

I think breakout rooms with 3 people is beret than 2. It’s just a bit too intense with only one other person with you

7. What would you say to someone thinking of joining the research collective?

7 responses

Excellent opportunity

It is a great opportunity to share, listen, learn, and be compassionately and intellectually challenged.

it is helpful for me and for the research it is like a therapy for myself

That it's a really safe and welcoming environment and feels like a place where you can make a difference and improve healthcare for others in the future.

All voices are welcomed, opinions valued and contributions considered: it’s a very egalitarian space

If you are someone in a healthcare setting who wants to improve the service you can do so through this collective, but also if you have experienced past trauma and feel able to join you can make a difference to pregnant people everywhere.

It’s really helpful to contribute to research as it’s ultimately helping women get better care

8. If you have attended previous workshops, please share any thoughts on what went well and what could be improved

5 responses

Both workshops have been really well facilitated

I really liked being paired up in breakout rooms with people with a more similar experience to myself. While I know all of the professionals involved are wonderful, empathetic people, it does feel a little easier to open up and share ideas and consider solutions with my peers, without worrying about perhaps being judged for lack of professional understanding when proposing solutions.

It would be great to meet face to face as I think there are quieter members of the group who could add valuable insight- this online nature of meetings isn’t conducive to letting people elaborate

This was my first session

You always do a great job. I’m v impressed

9. Is there anything you would like to add?

6 responses

This would be great in a seminar/workshop format with a mixture of research sharing and breakout sessions. If more people were to be able to access something like this, it would have an impact on its own.

the womans in the meeting are so amazing I am so pleased to be part of it

Just to thank Jo for the space and for ensuring that this research project is so considerate of so many people's experiences.

Jo is a wonderful, inspirational woman who will do great things!!!

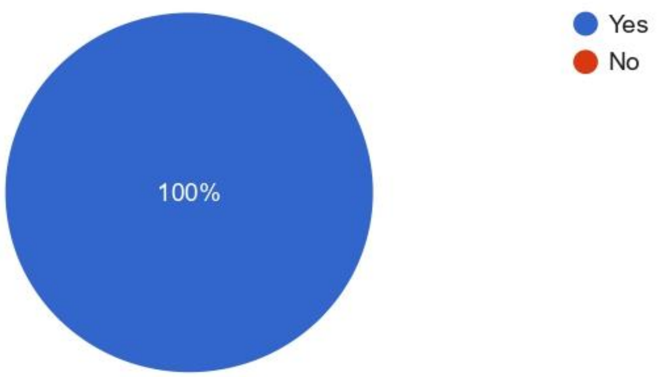
I am very grateful to be able to join Jo and the collective on this journey and look forward to reading/experiencing the end result.

No

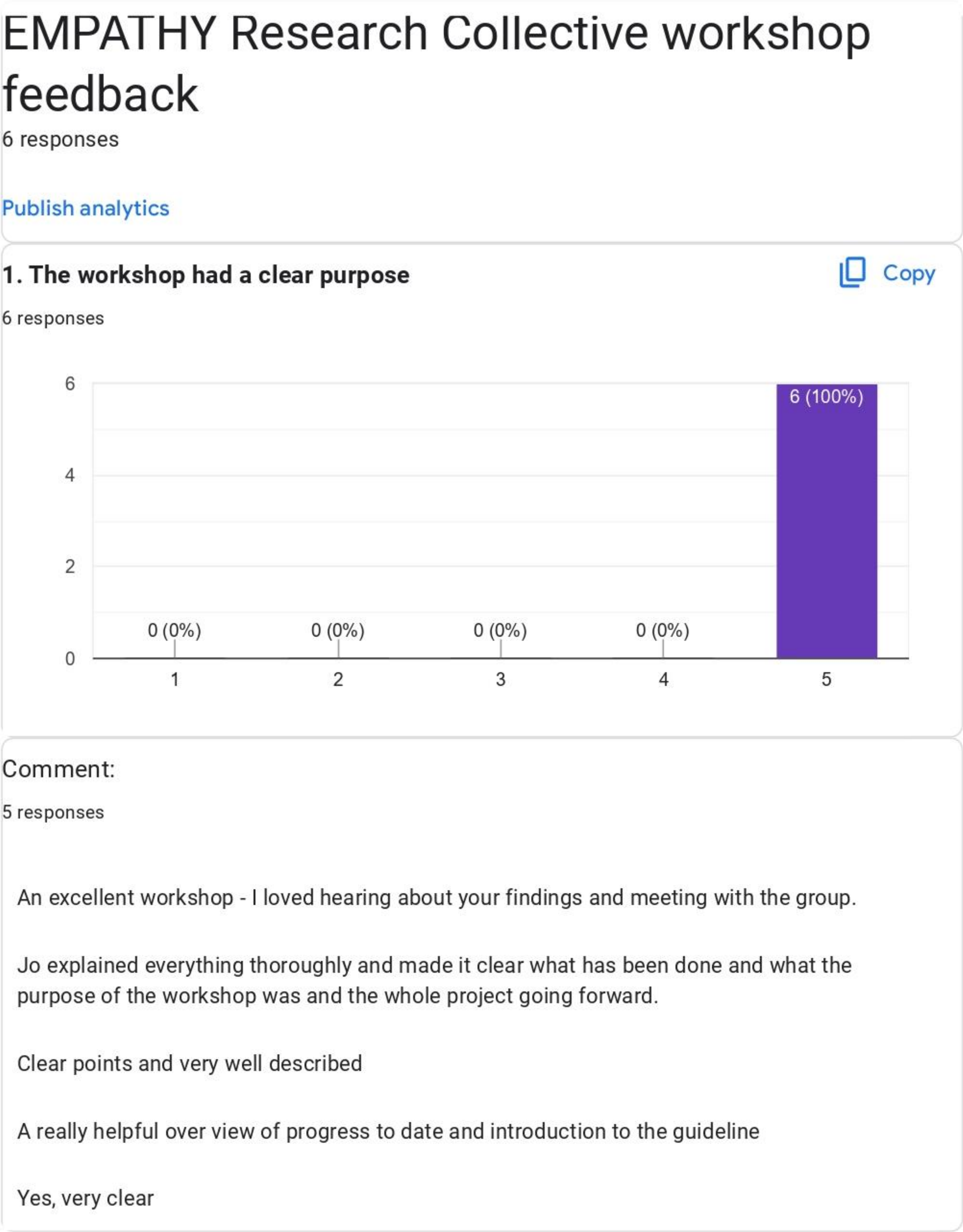
10. I agree that the information collected on this form can be anonymised and used for further research, presentations and publications

Copy

8 responses



March 2023



EMPATHY Research Collective workshop feedback

6 responses

1. The workshop had a clear purpose

6 responses

Comment:

5 responses

An excellent workshop - I loved hearing about your findings and meeting with the group.

Jo explained everything thoroughly and made it clear what has been done and what the purpose of the workshop was and the whole project going forward.

Clear points and very well described

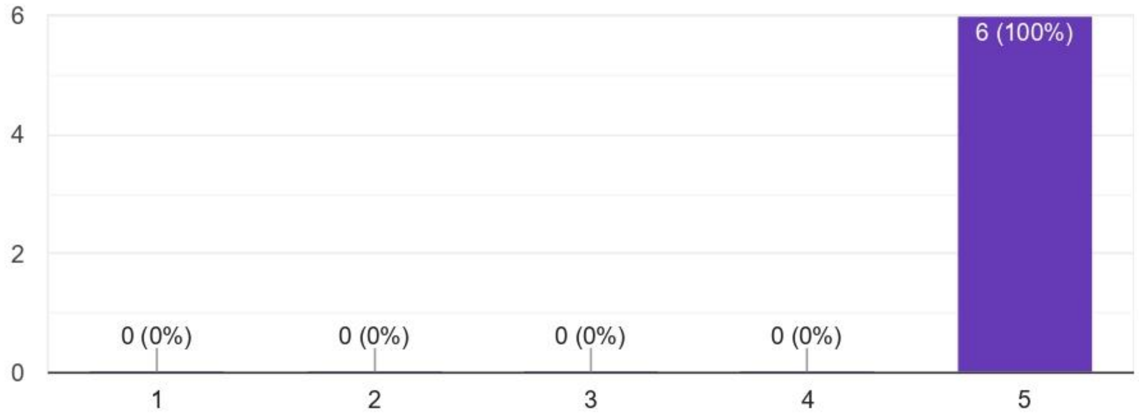
A really helpful over view of progress to date and introduction to the guideline

Yes, very clear

2. I felt listened to and able to contribute

Copy

6 responses



Comment:

5 responses

A lovely group of women

Jo makes room for everyone to speak and makes you feel very comfortable in voicing things.

I always feel listened and happy to be there

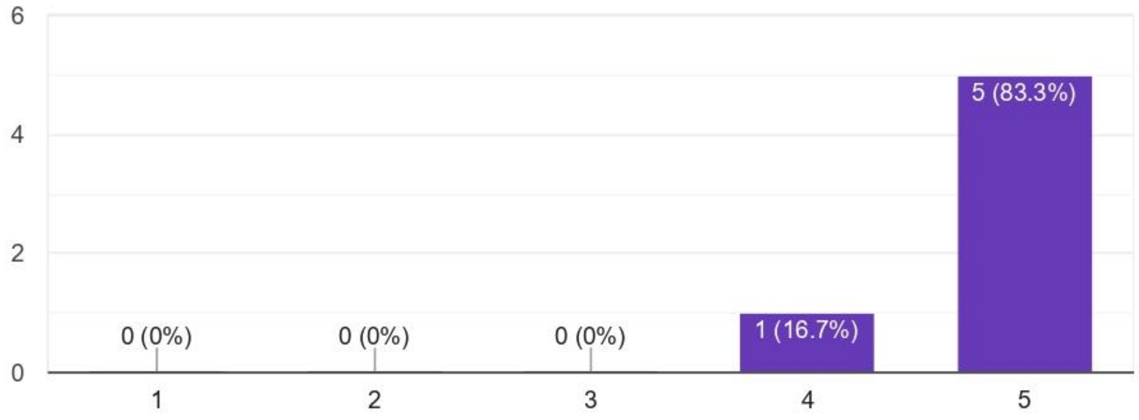
You always ensure everyone feels heard and usually give those who are maybe less likely to speak up the chance to talk first

Lovely to have that mix of break out spaces and in group discussion

3. The workshop was a good use of my time

Copy

6 responses



Comment:

5 responses

I learnt a lot and you gave me food for thought.

Absolutely, it genuinely feels as though we are going to make a real difference in maternity care with Jo's leadership and it's an honour to be involved.

I think as much as workshops as possible as easier to change what we think it is not relevant to our wishlist. So a definite yes

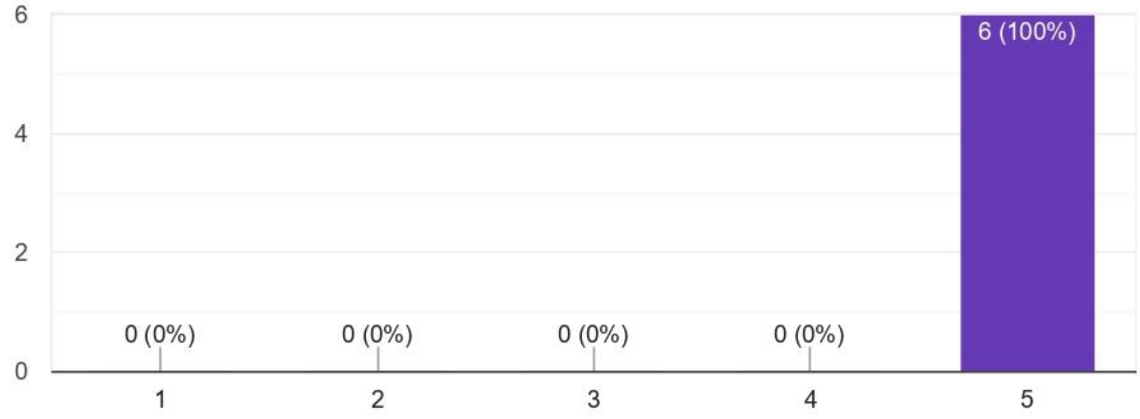
There are always competing demands but the time was used to good effect during the workshop and no time was wasted.

I found the session very thought provoking and I really valued hearing the interview insights, such rich quotes and deep sharing of experiences

4. As a group we accomplished something in the workshop

Copy

6 responses



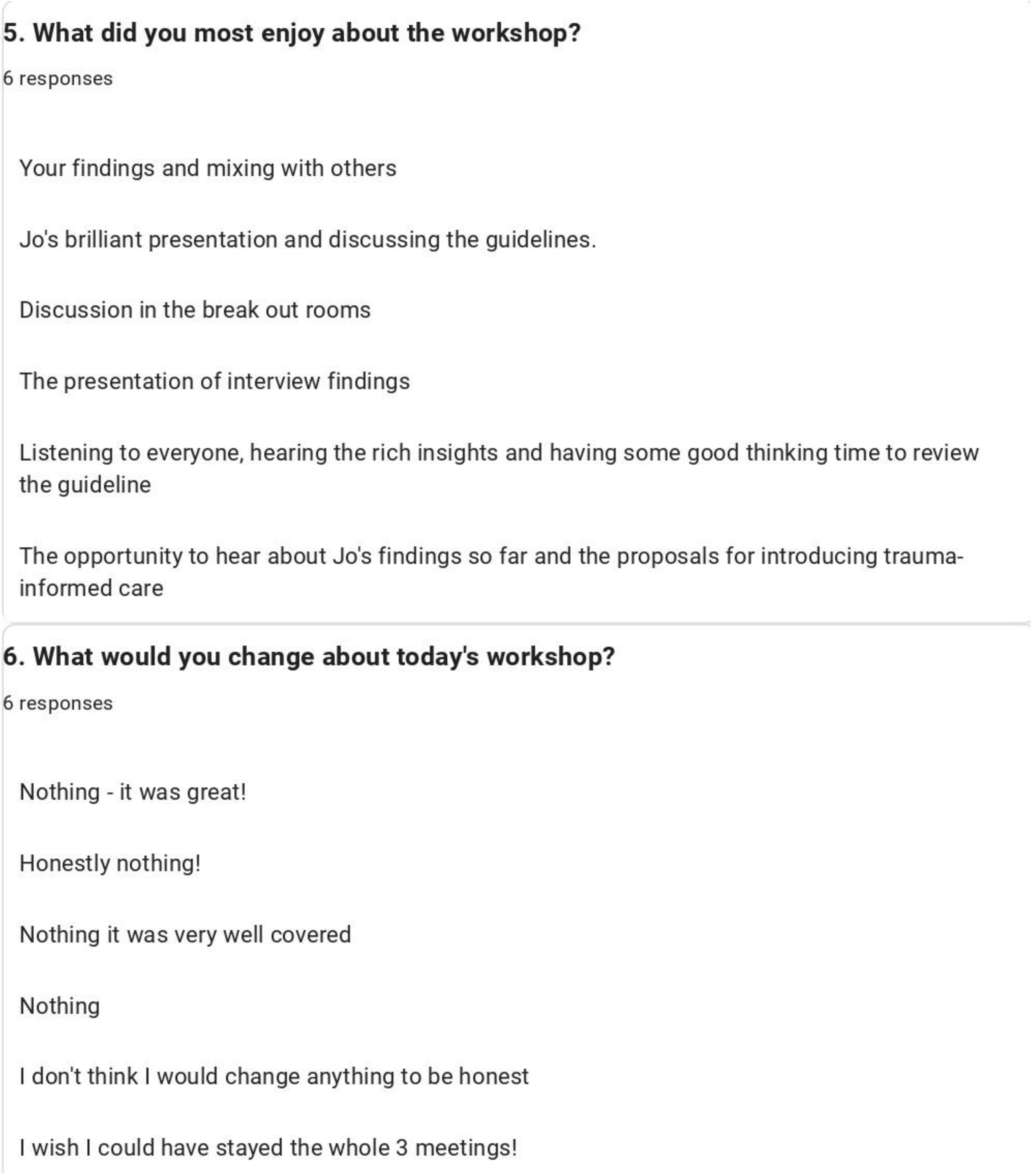
Comment:

3 responses

Definitely, we got to see what Jo has been up to and provide our thoughts and feelings for going forward. We accomplished seeing the project take another massive step forward and being active participants in this.

It feels like we are all working together for the same purpose and all have something to contribute

Yes, reviewing the guidelines and feeding back, and stimulating discussion about potential people/roles to consult for next steps and potential endorsements really interesting



5. What did you most enjoy about the workshop?

6 responses

Your findings and mixing with others

Jo's brilliant presentation and discussing the guidelines.

Discussion in the break out rooms

The presentation of interview findings

Listening to everyone, hearing the rich insights and having some good thinking time to review the guideline

The opportunity to hear about Jo's findings so far and the proposals for introducing trauma-informed care

6. What would you change about today's workshop?

6 responses

Nothing - it was great!

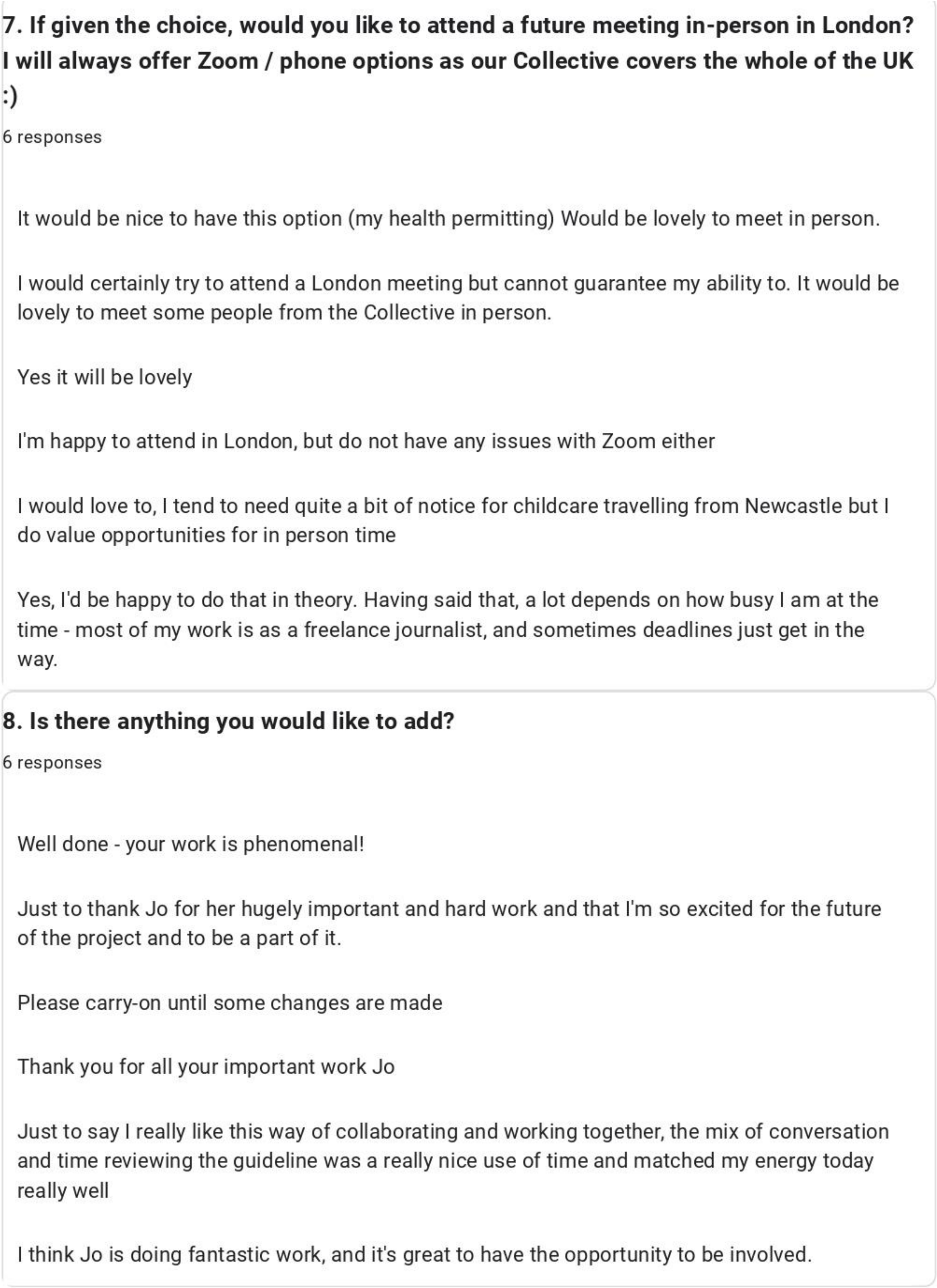
Honestly nothing!

Nothing it was very well covered

Nothing

I don't think I would change anything to be honest

I wish I could have stayed the whole 3 meetings!



7. If given the choice, would you like to attend a future meeting in-person in London? I will always offer Zoom / phone options as our Collective covers the whole of the UK :)

6 responses

It would be nice to have this option (my health permitting) Would be lovely to meet in person.

I would certainly try to attend a London meeting but cannot guarantee my ability to. It would be lovely to meet some people from the Collective in person.

Yes it will be lovely

I'm happy to attend in London, but do not have any issues with Zoom either

I would love to, I tend to need quite a bit of notice for childcare travelling from Newcastle but I do value opportunities for in person time

Yes, I'd be happy to do that in theory. Having said that, a lot depends on how busy I am at the time - most of my work is as a freelance journalist, and sometimes deadlines just get in the way.

8. Is there anything you would like to add?

6 responses

Well done - your work is phenomenal!

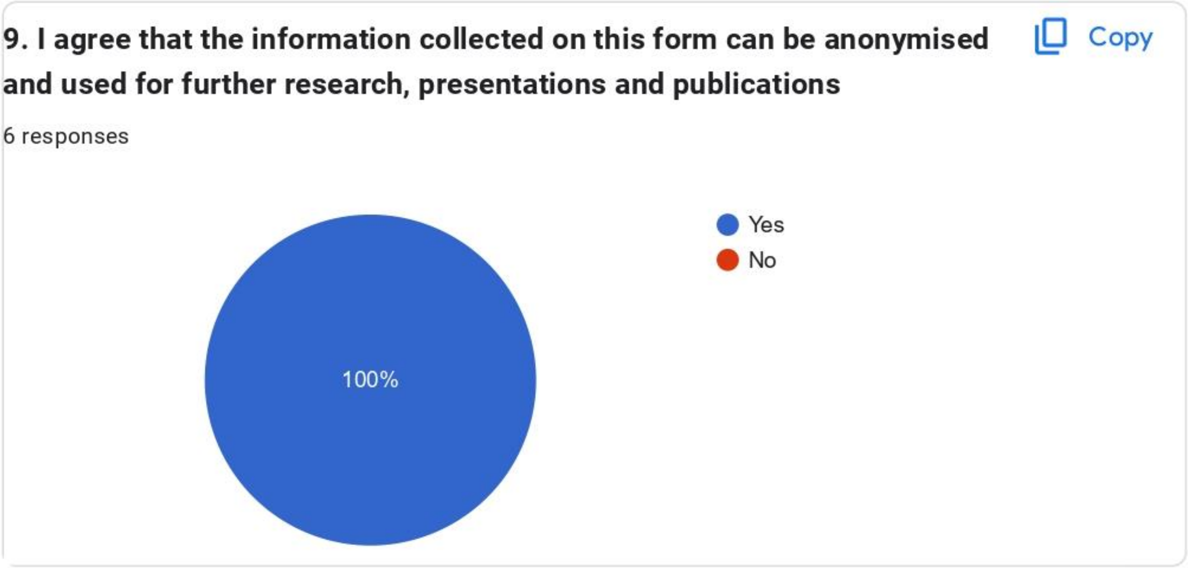
Just to thank Jo for her hugely important and hard work and that I'm so excited for the future of the project and to be a part of it.

Please carry-on until some changes are made

Thank you for all your important work Jo

Just to say I really like this way of collaborating and working together, the mix of conversation and time reviewing the guideline was a really nice use of time and matched my energy today really well

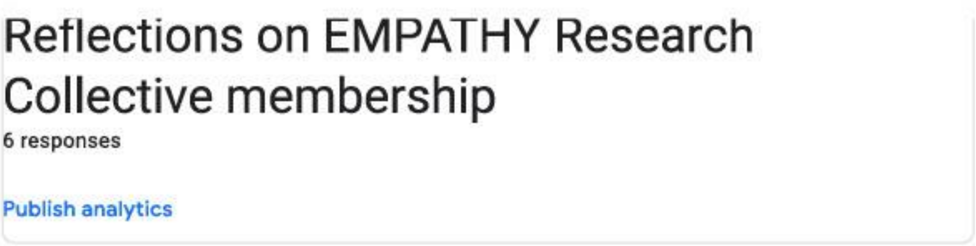
I think Jo is doing fantastic work, and it's great to have the opportunity to be involved.



9. I agree that the information collected on this form can be anonymised and used for further research, presentations and publications

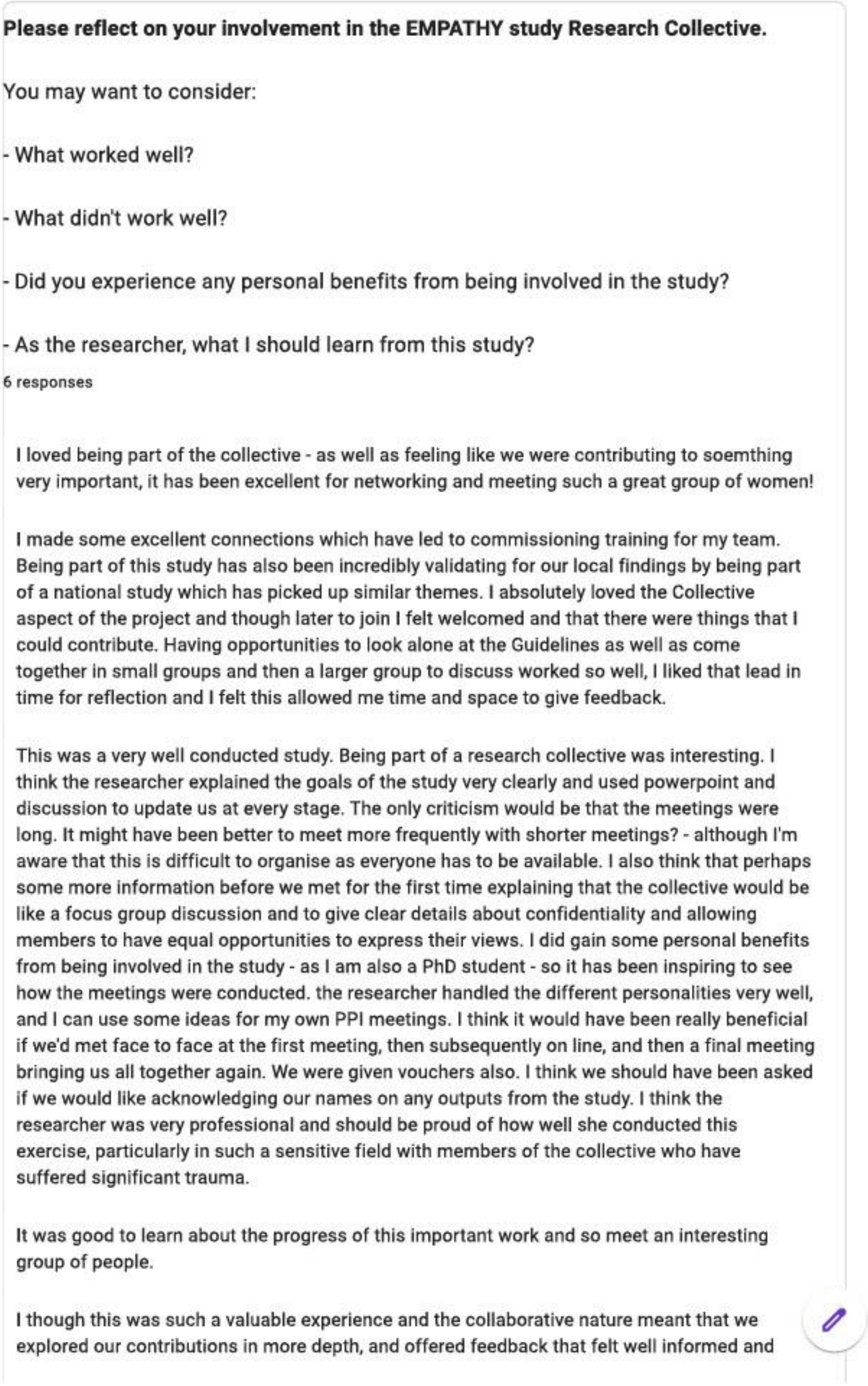
6 responses

March 2024 workshop



Reflections on EMPATHY Research Collective membership

6 responses



Please reflect on your involvement in the EMPATHY study Research Collective.

You may want to consider:

- What worked well?

- What didn't work well?

- Did you experience any personal benefits from being involved in the study?

- As the researcher, what I should learn from this study?

6 responses

I loved being part of the collective - as well as feeling like we were contributing to soemthing very important, it has been excellent for networking and meeting such a great group of women!

I made some excellent connections which have led to commissioning training for my team. Being part of this study has also been incredibly validating for our local findings by being part of a national study which has picked up similar themes. I absolutely loved the Collective aspect of the project and though later to join I felt welcomed and that there were things that I could contribute. Having opportunities to look alone at the Guidelines as well as come together in small groups and then a larger group to discuss worked so well, I liked that lead in time for reflection and I felt this allowed me time and space to give feedback.

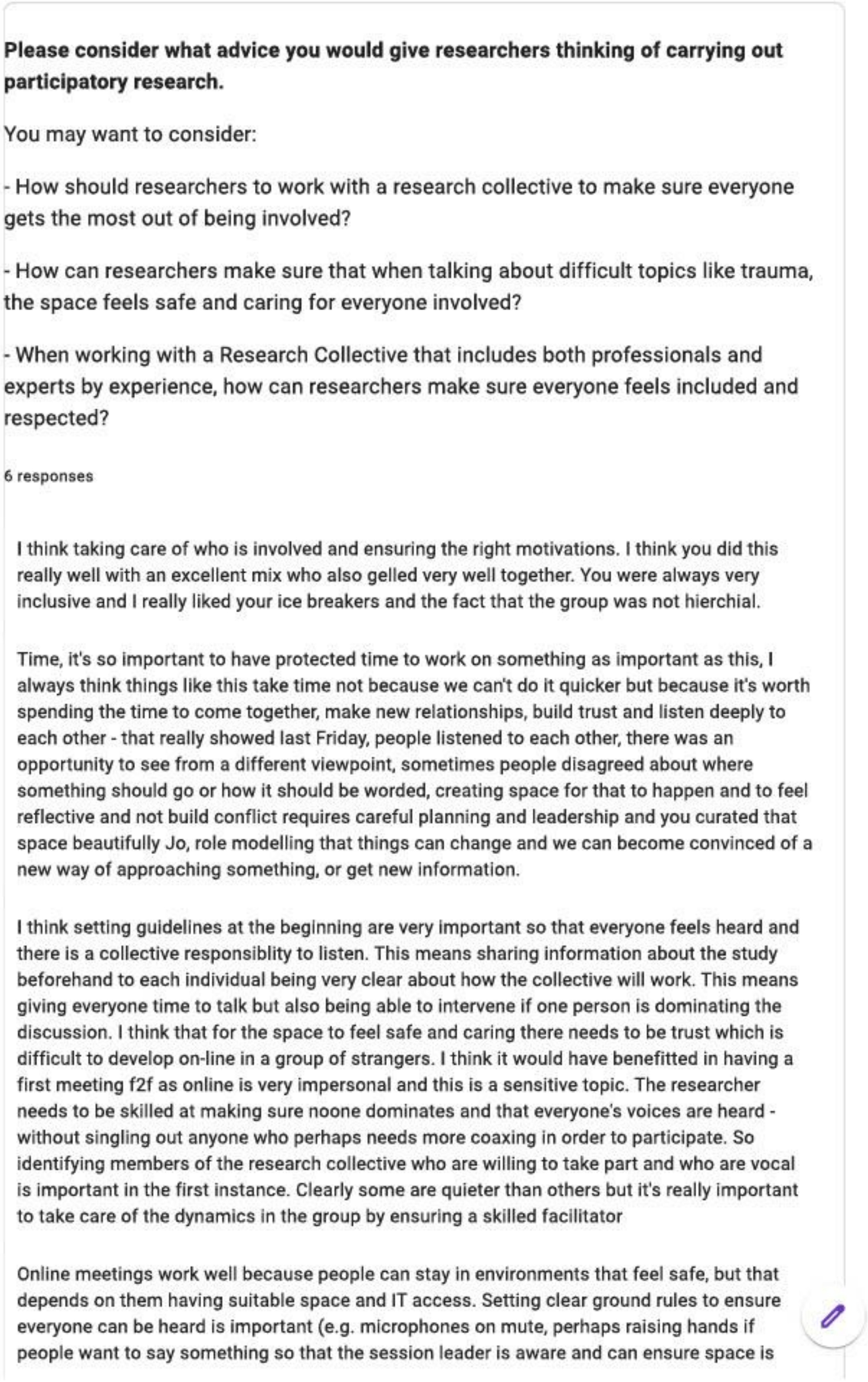
This was a very well conducted study. Being part of a research collective was interesting. I think the researcher explained the goals of the study very clearly and used powerpoint and discussion to update us at every stage. The only criticism would be that the meetings were long. It might have been better to meet more frequently with shorter meetings? - although I'm aware that this is difficult to organise as everyone has to be available. I also think that perhaps some more information before we met for the first time explaining that the collective would be like a focus group discussion and to give clear details about confidentiality and allowing members to have equal opportunities to express their views. I did gain some personal benefits from being involved in the study - as I am also a PhD student - so it has been inspiring to see how the meetings were conducted. the researcher handled the different personalities very well, and I can use some ideas for my own PPI meetings. I think it would have been really beneficial if we'd met face to face at the first meeting, then subsequently on line, and then a final meeting bringing us all together again. We were given vouchers also. I think we should have been asked if we would like acknowledging our names on any outputs from the study. I think the researcher was very professional and should be proud of how well she conducted this exercise, particularly in such a sensitive field with members of the collective who have suffered significant trauma.

It was good to learn about the progress of this important work and so meet an interesting group of people.

I though this was such a valuable experience and the collaborative nature meant that we explored our contributions in more depth, and offered feedback that felt well informed and

valuable, based on so much experience. It all worked well, there is nothing that I would change in this process. The researcher, Joanne Cull, held the group and all of the communications with clarity and compassion. We worked together well and did not stall. I would thoroughly recommend that more research is carried out in this way.

I thought it all worked very smoothly because Jo was both extremely thoughtful and extremely receptive to ideas and suggestions. It was a pleasure to work with someone who was so engaged with the topic she was studying, and who was genuinely interested in learning from others in the field. On a more practical level, Jo was very well-organised, and gave plenty of notice of meetings and did her best to organise them at convenient times. I think the main benefit I obtained from being involved in the study was the pleasure of watching someone take a collaborative approach to a research project and being willing to listen to others. It's certainly something I will take on board if I do research in future.



Please consider what advice you would give researchers thinking of carrying out participatory research.

You may want to consider:

- How should researchers to work with a research collective to make sure everyone gets the most out of being involved?

- How can researchers make sure that when talking about difficult topics like trauma, the space feels safe and caring for everyone involved?

- When working with a Research Collective that includes both professionals and experts by experience, how can researchers make sure everyone feels included and respected?

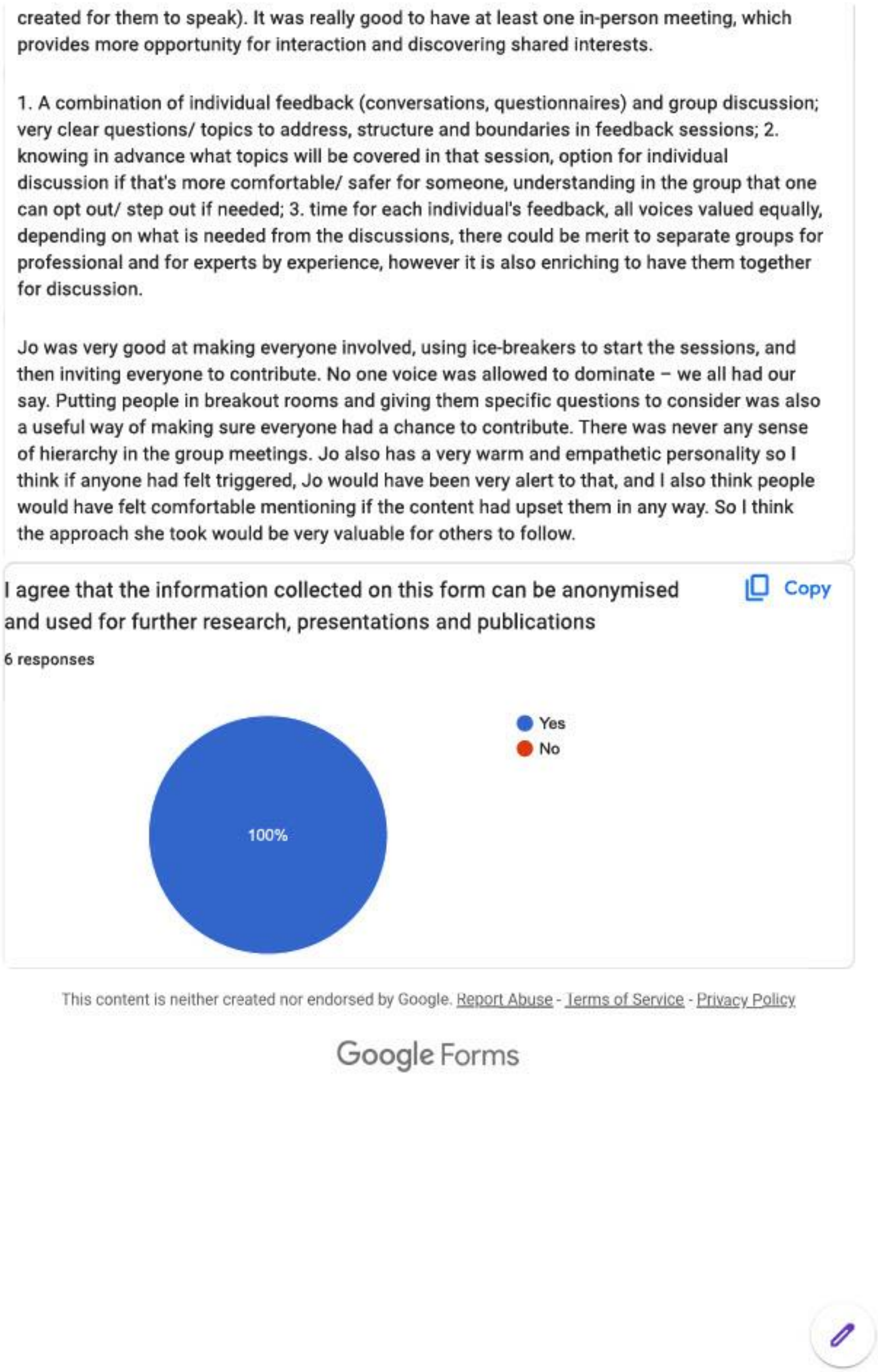
6 responses

I think taking care of who is involved and ensuring the right motivations. I think you did this really well with an excellent mix who also gelled very well together. You were always very inclusive and I really liked your ice breakers and the fact that the group was not hierchial.

Time, it's so important to have protected time to work on something as important as this, I always think things like this take time not because we can't do it quicker but because it's worth spending the time to come together, make new relationships, build trust and listen deeply to each other - that really showed last Friday, people listened to each other, there was an opportunity to see from a different viewpoint, sometimes people disagreed about where something should go or how it should be worded, creating space for that to happen and to feel reflective and not build conflict requires careful planning and leadership and you curated that space beautifully Jo, role modelling that things can change and we can become convinced of a new way of approaching something, or get new information.

I think setting guidelines at the beginning are very important so that everyone feels heard and there is a collective responsiblity to listen. This means sharing information about the study beforehand to each individual being very clear about how the collective will work. This means giving everyone time to talk but also being able to intervene if one person is dominating the discussion. I think that for the space to feel safe and caring there needs to be trust which is difficult to develop on-line in a group of strangers. I think it would have benefitted in having a first meeting f2f as online is very impersonal and this is a sensitive topic. The researcher needs to be skilled at making sure noone dominates and that everyone's voices are heard - without singling out anyone who perhaps needs more coaxing in order to participate. So identifying members of the research collective who are willing to take part and who are vocal is important in the first instance. Clearly some are quieter than others but it's really important to take care of the dynamics in the group by ensuring a skilled facilitator

Online meetings work well because people can stay in environments that feel safe, but that depends on them having suitable space and IT access. Setting clear ground rules to ensure everyone can be heard is important (e.g. microphones on mute, perhaps raising hands if people want to say something so that the session leader is aware and can ensure space is



created for them to speak). It was really good to have at least one in-person meeting, which provides more opportunity for interaction and discovering shared interests.

1. A combination of individual feedback (conversations, questionnaires) and group discussion; very clear questions/ topics to address, structure and boundaries in feedback sessions; 2. knowing in advance what topics will be covered in that session, option for individual discussion if that's more comfortable/ safer for someone, understanding in the group that one can opt out/ step out if needed; 3. time for each individual's feedback, all voices valued equally, depending on what is needed from the discussions, there could be merit to separate groups for professional and for experts by experience, however it is also enriching to have them together for discussion.

Jo was very good at making everyone involved, using ice-breakers to start the sessions, and then inviting everyone to contribute. No one voice was allowed to dominate – we all had our say. Putting people in breakout rooms and giving them specific questions to consider was also a useful way of making sure everyone had a chance to contribute. There was never any sense of hierarchy in the group meetings. Jo also has a very warm and empathetic personality so I think if anyone had felt triggered, Jo would have been very alert to that, and I also think people would have felt comfortable mentioning if the content had upset them in any way. So I think the approach she took would be very valuable for others to follow.

I agree that the information collected on this form can be anonymised and used for further research, presentations and publications

6 responses

Appendix 7. Interview topic guide

QUESTIONS FOR ALL INTERVIEWEES

HOW SHOULD MATERNITY CARE PROVIDERS ASK ABOUT DIFFICULT PAST EXPERIENCES?

- Do you think maternity care providers **should** ask pregnant women about difficult past experiences?
- **When** should maternity care providers ask about difficult experiences?
- **Who** should ask about difficult experiences?
- **Where** should these discussions take place?
- How can maternity care providers ensure that women who want to discuss their histories **feel comfortable** to do so?
- **How** should maternity care providers ask about difficult past experiences?
- How should maternity care providers **prepare women** for this conversation and let them know the purpose of the discussion?
- Are there any additional considerations when discussing trauma with **women who don't speak English as a first language**?
  Some of the **language used around difficult past experiences** may make these conversations harder for women. Are there any terms that you think maternity care providers should avoid?

HOW SHOULD MATERNITY CARE PROVIDERS RESPOND TO DISCLOSURES OF PREVIOUS TRAUMA?

- How should the information be **recorded and shared**?
- What **information and support** might women who have had difficult experiences find helpful?
- How can **maternity care be adapted** to help women who have had difficult experiences?
- What do you think should be included in **training for maternity care providers** around trauma-informed care?
- **What difference** do you think discussing prior trauma with women and providing support could make?

- Is there anything I haven't asked that you would **like to add**?

ADDITIONAL QUESTIONS FOR VOLUNTARY SECTOR EXPERTS AND HEALTHCARE PROFESSIONALS

- How can **adequate time be ensured** for these conversations to be meaningfully had within an overstretched and understaffed service?
- How can women who have experienced trauma be recognised through **verbal and non-verbal signals**?
- Trauma disclosures can be distressing to hear. How can **midwives' emotional wellbeing be protected**?

Appendix 8. Full interview guide with prompts

HOW SHOULD MATERNITY CARE PROVIDERS ASK ABOUT DIFFICULT PAST EXPERIENCES?

1. Do you think maternity care providers **should** ask pregnant women about difficult past experiences?

2. **When** should maternity care providers ask about difficult experiences?

PROMPTS:

- At booking?
- At a later routine appointment?
- At a separate appointment for this purpose?
- At multiple appointments?
- Is continuity of care / existing relationship important?

3. **Who** should ask about difficult experiences?

PROMPTS:

- Is professional background important (midwife / care assistant / obstetrician?)
- Is the gender of the person asking important?

4. **Where** should these discussions take place?

PROMPTS:

- Is this important?
- Home / clinic - hospital or community setting?
- What if partners / children are present?

5. How can maternity care providers ensure that women who want to discuss their histories **feel comfortable** to do so?

PROMPTS:

- How can the questions be asked sensitively?
- Should partners be excluded from part or all of an appointment to allow these issues to be discussed in private?
- For women who want to disclose their histories, what do you think would prevent them from doing so?

6. **How** should maternity care providers ask about difficult past experiences?

PROMPTS:

- How should the question be asked - direct question? General discussion? Questionnaire?
- Show examples:
  1. Antenatal Psychosocial Risk Questionnaire
  2. Kimberley Mum’s Mood Scale
  3. Hypothetical Prompt developed by White, Danis and Gillece
  4. Prompt developed by Montgomery (does not explicitly name abuse) ‘Sometimes pregnancy can trigger unexpected memories of things

that have happened to you or feelings that can take you by surprise. If that happens to you and you would like to talk about it, please let me know'.

- Complete through conversation with maternity care provider, or self-complete (on ipad or paper) then discuss with maternity care provider?
- Another option is to complete independently from maternity care, e.g. online tool which encourages women to seek support from healthcare provider but also provides links to relevant third sector agencies
- How can the questions be asked sensitively?

7. How should maternity care providers **prepare women** for this conversation and let them know the purpose of the discussion?

PROMPTS:

- What are the issues around confidentiality?
- Should we talk with women about potential negative implications of disclosures (for example, if children / self potentially at harm maternity care provider will need to share this information)?
- Should we talk with women about the potential positive implications of disclosure? To receive support and understanding, be offered adaptations to care, signpost or refer to services that might help in healing.

8. Are there any additional considerations when discussing trauma with **women who don't speak English as a first language**?
    - Challenges around use of interpreters
    - Looking back at methods of discussing trauma with women (e.g. Kimberley Mums Mood Scale), how easy would they be to understand for women with limited English?
    - Would women prefer to self-complete trauma checklist in own language?

9. Some of the **language used around difficult past experiences** may make these conversations harder for women. Are there any terms that you think maternity care providers should avoid?

PROMPTS

- Examples - victim / survivor
- Trauma / abuse / difficult experiences
- Maternity care providers have said that when they're talking about caring for women who have experienced trauma, they're not sure how to refer to them. For example, survivor moms. Do you have any thoughts about this?

HOW SHOULD MATERNITY CARE PROVIDERS RESPOND TO DISCLOSURES OF PREVIOUS TRAUMA?

10. How should the information be **recorded and shared**?

PROMPTS:

- Within the maternity team
- With wider support services e.g. Health Visitor, GP, neonatal team, perinatal mental health, safeguarding, third sector
- Consent for this
- Limits of confidentiality
- Electronic / hand-held record

11. What **information and support** might women who have had difficult experiences find helpful?

PROMPTS:

- For example mental health specialists / support from the voluntary sector

- Are there any other helpful resources you are aware of, for example books or websites?
- Do you think tailored small group antenatal classes for women who have had difficult experiences would be beneficial? (like Centering Pregnancy)
- How about peer or lay support groups?
- Or groups with more of a social focus, not explicitly about trauma but offering arts / movement / meditation?
- Using a friends and family diagram (genogram) - strengths based approaches to help women identify the sources of support in their lives and communities?
- Can you think of any services which aren't currently offered, but would be helpful to women?

12. How can **maternity care be adapted** to help women who have had difficult experiences?

PROMPTS:

- E.g. continuity of carer, limited vaginal examinations, elective caesarean section

13. What do you think should be included in **training for maternity care providers** around trauma-informed care?

PROMPTS:

- Training in communication skills to sensitively ask about previous trauma and respond to disclosures?
- Instances in which safeguarding procedures will, and will not, have to be followed, and how to discuss these with women.

14. **What difference** do you think discussing prior trauma with women and providing support could make?

- What matters to women?
- What should we be measuring?

15. Is there anything I haven't asked that you would **like to add**?

PROMPT

- Do you think specific conditions need to be in place before routine discussion of trauma is introduced?
- Was it helpful to receive the topic guide in advance?

ADDITIONAL QUESTIONS FOR HEALTHCARE PROFESSIONALS AND VOLUNTARY SECTOR EXPERTS ONLY

16. How can **adequate time be ensured** for these conversations to be meaningfully had within an overstretched and understaffed service?

17. How can women who have experienced trauma be recognised through **verbal and non-verbal signals**?

PROMPTS:

- How can care providers support women who they suspect are experiencing the effects of trauma, but have chosen not to disclose?

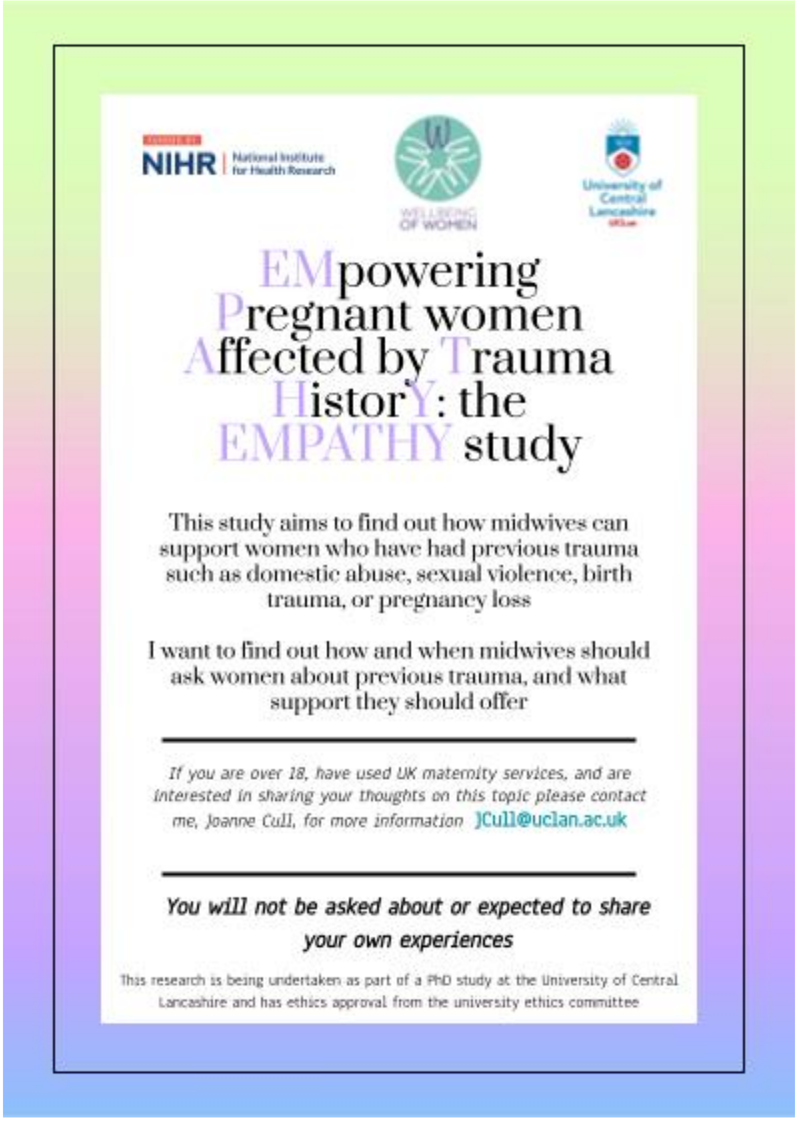
- Some providers have talked about 'universal precautions': assuming all women have experienced trauma as it is so prevalent. How do you think care providers can adjust their care to avoid causing distress to women who have had difficult past experiences?

18. Trauma disclosures can be distressing to hear. How can **midwives' emotional wellbeing be protected**?

PROMPTS:

- Supervision models -
  1. Who should provide the support - a midwife within the trust (Professional Midwifery Advocate) or a trained therapist?
  2. Should this be on an as-requested basis or with regular meetings (automatic supervision)?
- Midwives who have been, or are currently in, violent or abusive situations may find training around this issue distressing, and may find these conversations difficult. How can they best be supported?
- Should midwives be able to opt out of having these discussions? Some midwives may not have the personal resources to support women around these issues due to their own trauma.

Appendix 9. Recruitment flyer



NIHR | National Institute for Health Research

Wellbeing of Women

University of Central Lancashire

EMpowering
Pregnant women
Affected by Trauma
HistorY: the
EMPATHY study

This study aims to find out how midwives can support women who have had previous trauma such as domestic abuse, sexual violence, birth trauma, or pregnancy loss

I want to find out how and when midwives should ask women about previous trauma, and what support they should offer

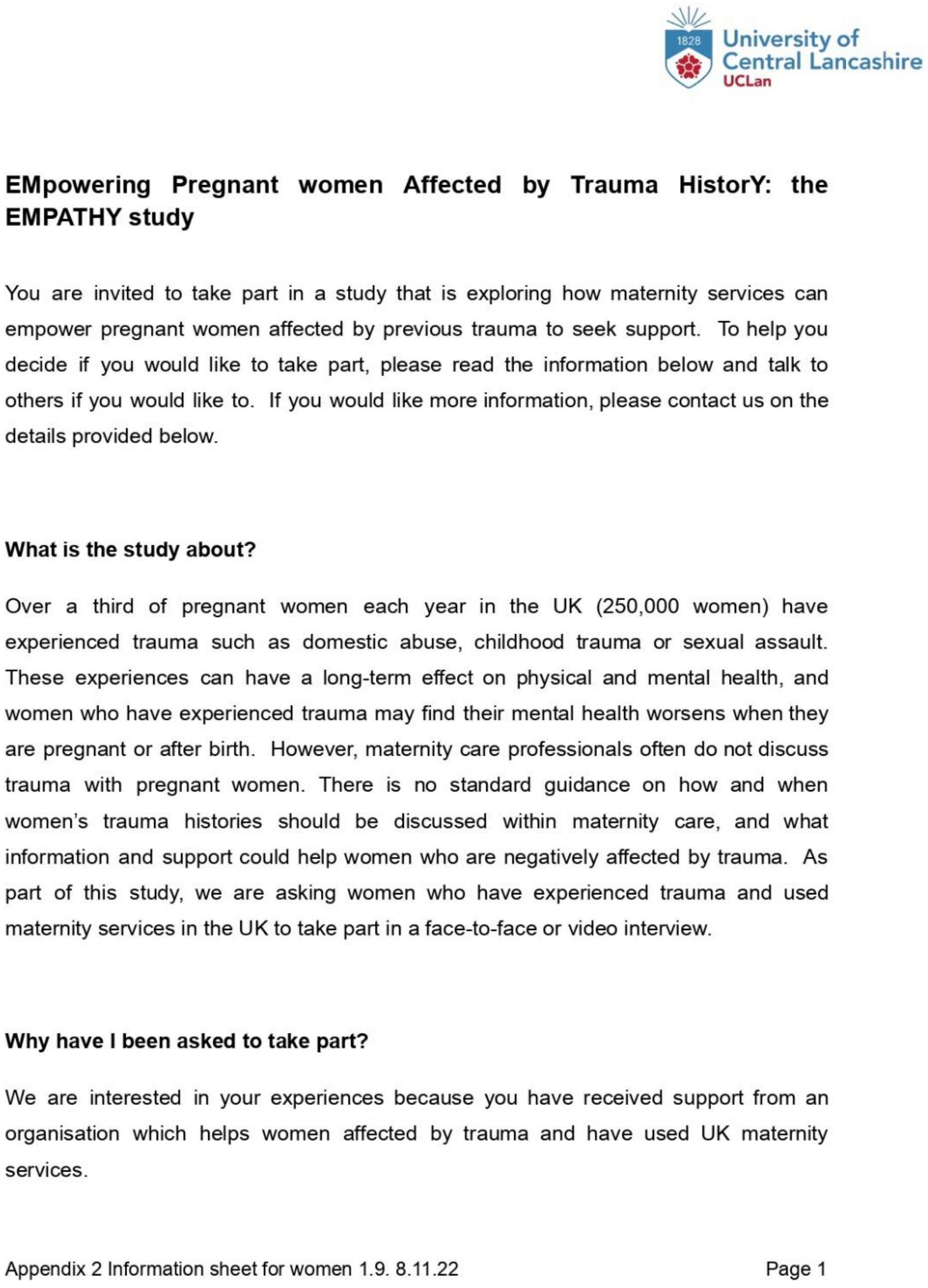
If you are over 18, have used UK maternity services, and are interested in sharing your thoughts on this topic please contact me, Joanne Cull, for more information JCull@uclan.ac.uk

You will not be asked about or expected to share your own experiences

This research is being undertaken as part of a PhD study at the University of Central Lancashire and has ethics approval from the university ethics committee

Appendix 10. Participant information sheets

Experts by Experience



University of Central Lancashire
UCLan

EMpowering Pregnant women Affected by Trauma HistorY: the EMPATHY study

You are invited to take part in a study that is exploring how maternity services can empower pregnant women affected by previous trauma to seek support. To help you decide if you would like to take part, please read the information below and talk to others if you would like to. If you would like more information, please contact us on the details provided below.

What is the study about?

Over a third of pregnant women each year in the UK (250,000 women) have experienced trauma such as domestic abuse, childhood trauma or sexual assault. These experiences can have a long-term effect on physical and mental health, and women who have experienced trauma may find their mental health worsens when they are pregnant or after birth. However, maternity care professionals often do not discuss trauma with pregnant women. There is no standard guidance on how and when women's trauma histories should be discussed within maternity care, and what information and support could help women who are negatively affected by trauma. As part of this study, we are asking women who have experienced trauma and used maternity services in the UK to take part in a face-to-face or video interview.

Why have I been asked to take part?

We are interested in your experiences because you have received support from an organisation which helps women affected by trauma and have used UK maternity services.

Appendix 2 Information sheet for women 1.9. 8.11.22 Page 1

No – it is entirely up to you if you want to take part or not. Even if you say yes now, you are still free to change your mind at any point and without giving a reason. During the interview you do not have to answer all the questions and can stop the interview at any time. Please contact us on the details below for further information.

What will happen if I want to stop taking part?

If you would like to remove your interview data from our study, please contact us within two weeks after the interview (see contact details below).

Can I have an interpreter for the interview?

We are happy to provide an interpreter. We can only provide an interpreter for face-to-face interviews, not on Microsoft Teams. The interpreter will not keep copies of any recordings or other details of what is said, and they will not be told any of your personal information (only your first name).

What are the benefits or risks to me taking part?

You may find it valuable to share your experience. The findings will help us to gain a more in-depth understanding of how women who have had traumatic experiences can be supported by maternity services. At the end of the interview, we will send you a £10 shopping voucher to thank you for taking part.

If you choose a face-to-face interview rather than an interview using Microsoft Teams, there is a potential increased risk of exposure to COVID-19, in spite of the mitigation actions detailed above.

If you feel that answering questions about maternity care for women who have experienced trauma would be too distressing, we advise you not to take part. You can choose not to answer any question that you feel uncomfortable with.

If you become distressed during the interview then it will be suspended to support you. You will be given a period of time to recover, and we will then decide together whether you would like to continue with the interview or not. Whether you continue or not, we will ensure that we do not leave the interview until you feel comfortable for us to do so.

Should you find the interview distressing, you can contact the following organisations for support:

- The organisation which informed you about the study
- The Samaritans (support for people having a difficult time). Website: www.samaritans.org Phone: 116 123
- Shout (free mental health text support). Text 'shout' to 85258
- The Survivors Trust (support for those who have experienced rape or sexual abuse). Website: www.thesurvivorstrust.org Phone: 08088 010818
- Your GP.

Who has reviewed this study?

This study has been approved by the Health ethics sub-committee at the University of Central Lancashire, with the reference HEALTH 0220.

Will my data be kept confidential?

Confidentiality and full anonymity are assured, unless you tell us about any illegal activities or if you or anyone close to you are at risk of personal harm (in such instances we will notify the voluntary service organisation who invited you to take part in this study for further follow-up).

How will my data be used?

The University processes personal data as part of its research and teaching activities in accordance with the lawful basis of 'public task', and in accordance with the University's purpose of "advancing education, learning and research for the public benefit". Under UK data protection legislation, the University acts as the Data Controller for personal data collected as part of the University's research. The University privacy notice for research participants can be found on the attached link https://www.uclan.ac.uk/data_protection/privacy-notice-research-participants.php

Further information on how your data will be used can be found in the table below.

How will my data be collected?	By taking part in one face-to face or remote video interview using Microsoft Teams.
How will my data be stored?	All data will be securely stored in password protected/encrypted computer files on the University's database. Microsoft Teams and Stream recordings will be deleted after the recordings are uploaded onto the University server.
Will my data be anonymised?	When the interviews are transcribed, we will remove any names/personal identifying information. When we use any of your quotes, we will use a pseudonym (fake name).
How long will my data be stored for?	We will destroy/delete your consent form / consent recording 5 years from the end of the study. We will keep the anonymised interview data indefinitely in line with the University Research Data Management Policy.
What measures are in place to	All data will be stored in password/encrypted computer files

protect the security and confidentiality of my data?	on the University's database. The interviews will be transcribed by a research assistant at the University. Your information will not be shared outside of the research team.
How will my data be used?	We will use anonymised quotes from the interviews in the thesis, journal publications, promotional material produced by the charity Wellbeing of Women (one of the study's funders) and for teaching and presentations but no personal information will be used, and you will not be able to be identified.
Who will have access to my data?	The research team, and CHE Secretarial Services, who are transcribing the interviews.
Will my data be archived for use in other research projects in the future?	If you agree to this, we will keep your fully anonymised interview transcripts for research, teaching and publication purposes in accordance with the University Research Data Management Policy.
How will my data be destroyed?	After the interviews, we will download the recording onto a computer and delete the interview off the recording device. Once a typed transcript of the interview has been produced, the audiovisual file will be deleted. Your personal data (e.g. contact details) will be destroyed at the end of the project, and the consent forms will be destroyed after five years.

What do I do if I want to take part?

Please email us on the contact details below within 10 days, and we will organise the interview to take place at a time and date to suit you.

Who has funded this study?

This study is part of Joanne Cull's doctoral research. Joanne's Doctoral Research Fellowship is funded by the National Institute for Health Research and Wellbeing of Women.

What if I am unhappy or there is a problem?

If you are unhappy, or if there is a problem, please feel free to let us know by contacting Professor Gill Thomson (Gthomson@uclan.ac.uk) and we will try to help. If you remain unhappy or have a complaint which you feel you cannot come to us with, then please contact the Research Governance Unit at OfficerForEthics@uclan.ac.uk.

The University aims to maintain the highest standards when processing your data. However, if you have any concerns about the way in which the University processes your personal data, it is important that you are aware of your right to lodge a complaint with the Information Commissioner's Office by calling 0303 123 1113.

If you feel the care you received from maternity services was poor or negligent, we advise you to contact the Patient Advice and Liaison Service of the hospital.

Research team

Joanne Cull, Doctoral Research Fellow, School of Community Health and Wellbeing, University of Central Lancashire, Preston. PR1 2HE. Tel: 01772 894578. JCull@uclan.ac.uk

Professor Gill Thomson, Professor in Perinatal Health, School of Community Health & Wellbeing, University of Central Lancashire, Preston. PR1 2HE. Tel: 01772 894578. GThomson@uclan.ac.uk

Voluntary sector experts and healthcare professionals

EMpowering Pregnant women Affected by Trauma HistorY: the EMPATHY study

You are invited to take part in a study that is exploring how maternity services can empower pregnant women affected by previous trauma to seek support. To help you decide if you would like to take part, please read the information below and talk to others if you would like to. If you would like more information, please contact us on the details provided below.

What is the study about?

Over a third of pregnant women each year in the UK (250,000 women) have experienced trauma such as domestic abuse, childhood trauma or sexual assault. These experiences can have a long term effect on physical and mental health, and women who have experienced trauma may find their mental health worsens when they are pregnant or after birth. However, maternity care professionals often do not discuss trauma with pregnant women. There is no standard guidance on how and when women's trauma histories should be discussed within maternity care, and what information and support could help women who are negatively affected by trauma. As part of this study, we would like to invite you to take part in a face-to-face or video interview to discuss your views.

Why have I been asked to take part?

We are interested in your views and experiences because you are an expert in supporting women who have experienced trauma.

What will the study involve?

To take part in an interview that will last approximately one hour. You can choose whether this is a face-to-face interview or remote video interview using Microsoft Teams. If you choose a Microsoft Teams interview, you can have your camera on or off during the interview.

We will ask about:

- Your experiences of discussing trauma with women;
- Your opinions on how and when maternity care professionals should discuss trauma with pregnant women;
- What factors you think would help a woman disclose trauma, or prevent her doing so;
- What services and resources could help women recover from traumatic experiences;
- How to improve maternity care for women who have experienced trauma.

We will also ask for some basic personal information, such as your role, length of service, and ethnic background, so that we can ensure the study includes a range of views.

If you take part in an interview the consent statements (see attached form) will be reviewed at the start and you will be asked to verbally agree to each statement and to provide your name and the date.

At the end of the interview, we will send you a £10 shopping voucher to thank you for taking part.

Do I have to take part?

No – it is entirely up to you if you want to take part or not. Even if you say yes now, you are still free to change your mind at any point and without giving a reason. During the interview you do not have to answer all the questions and can stop the interview at any time. Please contact us on the details below for further information.

What will happen if I want to stop taking part?

If you take part in an interview and would like to remove your interview data from our study, please contact us within two weeks after the interview (see contact details below).

What are the benefits or risks to me taking part?

Taking part will not have any direct benefits for you, but the findings will help us to gain a more in-depth understanding of how women who have had traumatic experiences can be supported by maternity services.

If you choose a face-to-face interview rather than an interview using Microsoft Teams, there is a potential increased risk of exposure to COVID-19, in spite of the mitigation actions detailed above.

Should you find the interview distressing, you can contact the following organisations for support:

- The Samaritans (support for people having a difficult time). Website: www.samaritans.org Phone: 116 123

- Shout (free mental health text support). Text ‘shout’ to 85258
- The Survivors Trust (support for those who have experienced rape or sexual abuse). Website: www.thesurvivorstrust.org Phone: 08088 010818
- Your GP.

Who has reviewed this study?

This study has been approved by the Health ethics sub-committee at the University of Central Lancashire [project number to be inserted].

How will my data be used?

The University processes personal data as part of its research and teaching activities in accordance with the lawful basis of ‘public task’, and in accordance with the University’s purpose of “advancing education, learning and research for the public benefit”. Under UK data protection legislation, the University acts as the Data Controller for personal data collected as part of the University’s research. The University privacy notice for research participants can be found on the attached link https://www.uclan.ac.uk/data_protection/privacy-notice-research-participants.php

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Will my data be anonymised?	When the interviews are transcribed, we will remove any names/personal identifying information. When we use any of your quotes, we will use a pseudonym (fake name).
How long will my data be stored for?	We will destroy/delete your consent form / consent recording 5 years from the end of the study. We will keep the anonymised interview data indefinitely in line with the University Research Data Management Policy.
What measures are in place to protect the security and confidentiality of my data?	All data will be stored in password/encrypted computer files on the University's database. The interviews will be transcribed by a research assistant at the University. Your information will not be shared outside of the research team.
How will my data be used?	We will use anonymised quotes from the interviews in the thesis, journal publications, promotional material produced by the charity Wellbeing of Women (one of the study's funders) and for teaching and presentations but no personal information will be used, and you will not be able to be identified.
Who will have access to my data?	The research team, and CHE Secretarial Services, who are transcribing the interviews.
Will my data be archived for use in other research projects in the future?	If you agree to this, we will keep your fully anonymised interview transcripts for research, teaching and publication purposes in accordance with the University Research Data Management Policy.
How will my data be destroyed?	After the interviews we will download the interview recording onto a computer and delete the interview from the recording device. Once a typed transcript of the interview has been produced, the audiovisual file will be deleted. Your personal

	data (e.g. contact details) will be destroyed at the end of the project, and the consent forms will be destroyed after five years.

What do I do if I want to take part?

Please email us on the contact details below within 10 days, and we will organise the interview to take place at a time and date to suit you.

Who has funded this study?

This study is part of Joanne Cull's doctoral research. Joanne's Doctoral Research Fellowship is funded by the National Institute for Health Research and Wellbeing of Women.

What if I am unhappy or there is a problem?

If you are unhappy, or if there is a problem, please feel free to let us know by contacting Professor Gill Thomson (Gthomson@uclan.ac.uk) and we will try to help. If you remain unhappy, or have a complaint which you feel you cannot come to us with, then please contact the Research Governance Unit at OfficerForEthics@uclan.ac.uk.

The University aims to maintain the highest standards when processing your data. However, if you have any concerns about the way in which the University processes your personal data, it is important that you are aware of your right to lodge a complaint with the Information Commissioner's Office by calling 0303 123 1113.

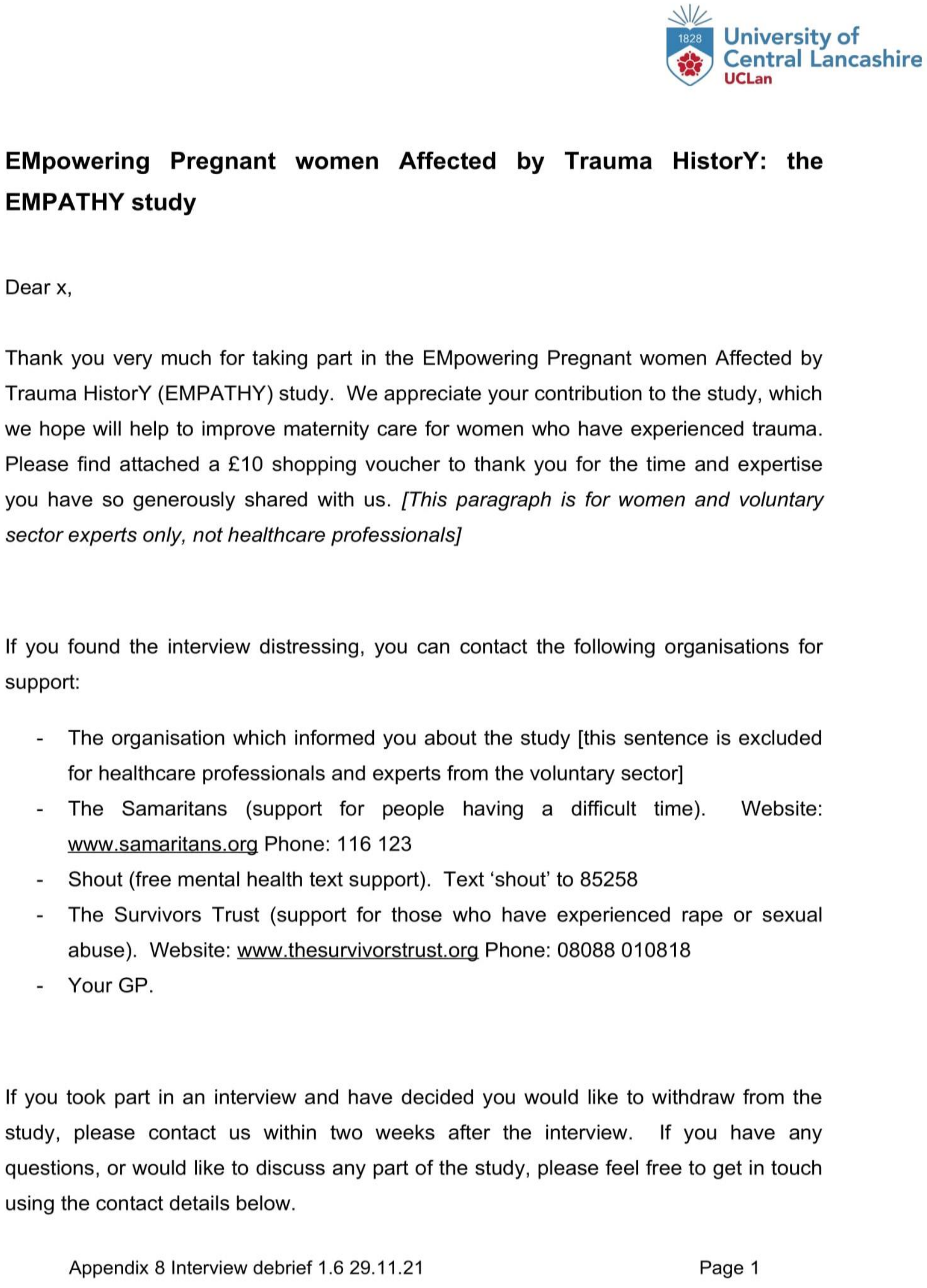
Research team

Joanne Cull, Doctoral Research Fellow, School of Community Health and Wellbeing, University of Central Lancashire, Preston. PR1 2HE. Tel: 01772 894578. JCull@uclan.ac.uk

Professor Gill Thomson, Professor in Perinatal Health, School of Community Health & Wellbeing, University of Central Lancashire, Preston. PR1 2HE. Tel: 01772 894578. GThomson@uclan.ac.uk

Thank you for taking the time to read this information sheet

Appendix 11. Debrief email



EMpowering Pregnant women Affected by Trauma HistorY: the EMPATHY study

Dear x,

Thank you very much for taking part in the EMpowering Pregnant women Affected by Trauma HistorY (EMPATHY) study. We appreciate your contribution to the study, which we hope will help to improve maternity care for women who have experienced trauma. Please find attached a £10 shopping voucher to thank you for the time and expertise you have so generously shared with us. *[This paragraph is for women and voluntary sector experts only, not healthcare professionals]*

If you found the interview distressing, you can contact the following organisations for support:

- The organisation which informed you about the study [this sentence is excluded for healthcare professionals and experts from the voluntary sector]
- The Samaritans (support for people having a difficult time). Website: www.samaritans.org Phone: 116 123
- Shout (free mental health text support). Text 'shout' to 85258
- The Survivors Trust (support for those who have experienced rape or sexual abuse). Website: www.thesurvivorstrust.org Phone: 08088 010818
- Your GP.

If you took part in an interview and have decided you would like to withdraw from the study, please contact us within two weeks after the interview. If you have any questions, or would like to discuss any part of the study, please feel free to get in touch using the contact details below.

With sincere thanks again,

Joanne Cull

Research team

Joanne Cull, Doctoral Research Fellow, School of Community Health and Wellbeing, University of Central Lancashire, Preston. PR1 2HE. Tel: 01772 894578. JCull@uclan.ac.uk

Professor Gill Thomson, Professor in Perinatal Health, School of Community Health & Wellbeing, University of Central Lancashire, Preston. PR1 2HE. Tel: 01772 894578. GThomson@uclan.ac.uk

Appendix 12. Consent forms

Experts by experience

EMpowering Pregnant women Affected by Trauma HistorY: the EMPATHY study

These statements will be read at the start of the interview, and you will be asked to verbally agree to each statement and to provide your name and date.

1. I have read and understood the information sheet [version 1.9, dated 8.11.22] and I have had the opportunity to ask questions.	
2. I understand that my participation is voluntary, and it is up to me whether I take part or not.	
3. I understand that I do not have to answer all the questions, and can stop the interview at any point, without giving a reason.	
4. I agree to the interview being recorded. I understand that the recording will be audiovisual, but that I can choose to have my camera off if I prefer.	
5. I understand that if I take part in an interview, I can ask for my data to be withdrawn from the study until two weeks after the interview, and if I do so, any of the data related to me will be destroyed.	
6. I understand that my participation will be anonymous and any details that might identify me will not be included in reports, publications or presentations produced from the study.	
7. I understand that all information I provide will be confidential unless I share anything that involves illegal activities, or I/someone close to me is at risk of personal harm – in such instances the research team will notify the voluntary service organisation who invited me to become involved in this study for further follow-up.	
8. I understand that if I choose a face-to-face interview rather than an interview using Microsoft Teams, there is a potential increased risk of exposure to COVID-19.	
9. I agree to take part in this study.	

I agree that my fully anonymised data (e.g. interview transcript) will be kept after the study has finished and may be used for teaching, further research/evaluation, presentations and publications and sharing with other people doing similar studies. It may also be used in promotional material produced by the charity Wellbeing of Women, one of the study's funders. I understand that no-one will be able to identify me directly from the information that is kept.
Yes ☐ No ☐

I would like an interpreter to be present for the interview. I understand that the interpreter will not retain copies of any recordings or other details of what is said, and they will not be told any personal information about me, only my first name.
Yes ☐ No ☐

Name of Participant

Date

Name of Researcher taking consent

Date

Voluntary sector experts and healthcare professionals

EMpowering Pregnant women Affected by Trauma HistorY: the EMPATHY study

These statements will be read at the start of the interview, and you will be asked to verbally agree to each statement and to provide your name and date.

1. I have read and understood the information sheet [version 1.9, 4.1.23] and I have had the opportunity to ask questions.	
2. I understand that my participation is voluntary, and it is up to me whether I take part or not.	
3. I understand that I do not have to answer all the questions, and can stop the interview at any point, without giving a reason.	
4. I agree to the interview being recorded. I understand that the recording will be audiovisual, but that I can choose to have my camera off if I prefer.	
5. I understand that if I take part in an interview, I can ask for my data to be withdrawn from the study until two weeks after the interview, and if I do so, any of the data related to me will be destroyed.	
6. I understand that my participation will be anonymous and any details that might identify me will not be included in reports, publications or presentations produced from the study.	
7. I understand that if I choose a face-to-face interview rather than an interview using Microsoft Teams, there is a potential increased risk of exposure to COVID-19.	
8. I agree to take part in this study.	

I agree that my fully anonymised data (e.g. interview transcript) will be kept after the study has finished and may be used for teaching, further research/evaluation, presentations and publications and sharing with other people doing similar studies. It may also be used in promotional material produced by the charity Wellbeing of Women, one of the study's funders. I understand that no-one will be able to identify me directly from the information that is kept.

Yes ☐ No ☐

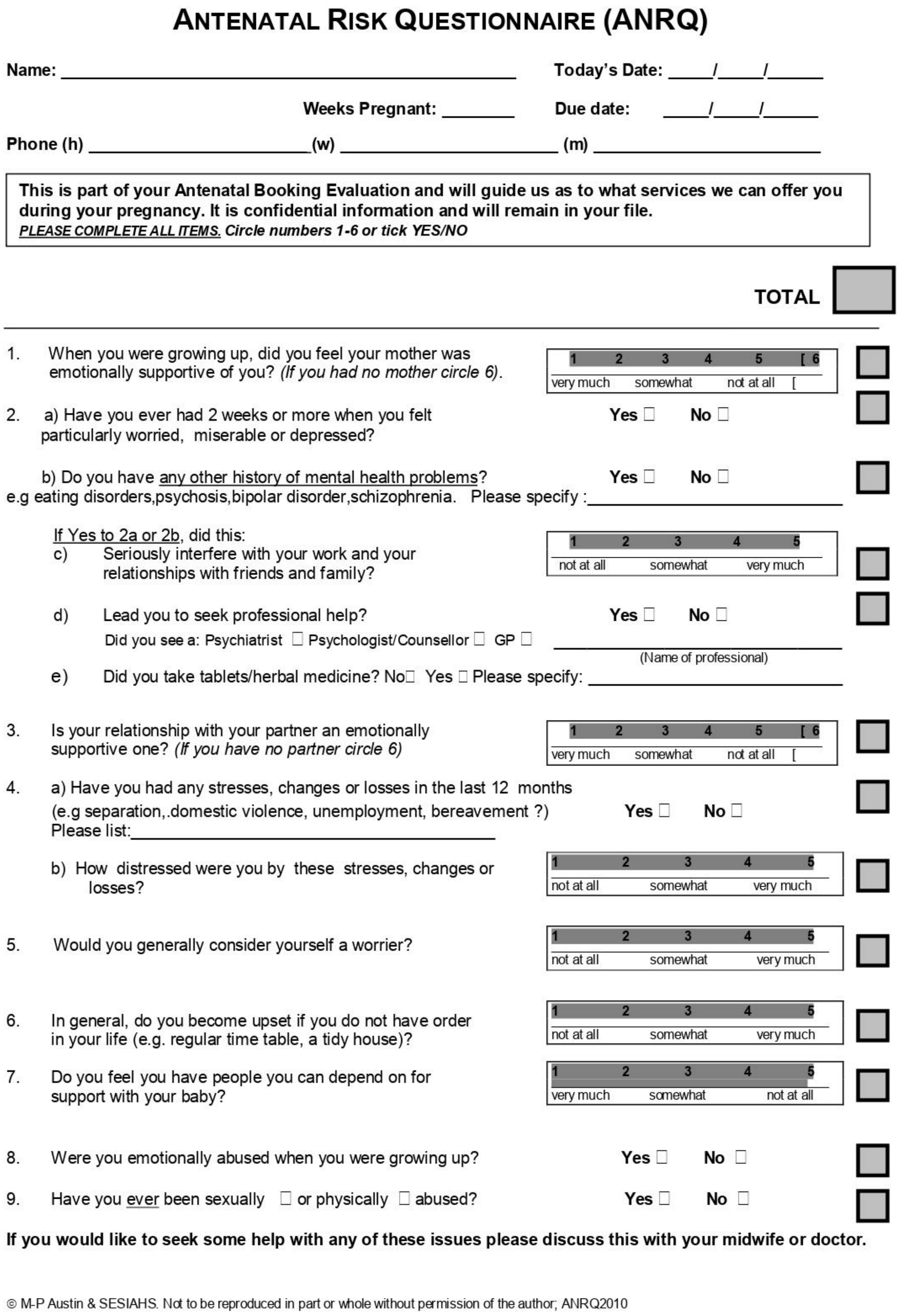
Name of Participant

Date

Name of Researcher taking consent

Date

Appendix 13. Trauma Discussion tools



ANTENATAL RISK QUESTIONNAIRE (ANRQ)

Name: ______________________________ **Today's Date:** ____/____/_____

Weeks Pregnant: ________ **Due date:** ____/____/_____

Phone (h) ____________________**(w)** ____________________ **(m)** ____________________

This is part of your Antenatal Booking Evaluation and will guide us as to what services we can offer you during your pregnancy. It is confidential information and will remain in your file.
***PLEASE COMPLETE ALL ITEMS.* Circle numbers 1-6 or tick YES/NO**

TOTAL ☐

1. When you were growing up, did you feel your mother was emotionally supportive of you? *(If you had no mother circle 6)*.
   1 2 3 4 5 [6 — very much somewhat not at all [☐

2. a) Have you ever had 2 weeks or more when you felt particularly worried, miserable or depressed? **Yes** ☐ **No** ☐ ☐

   b) Do you have any other history of mental health problems? **Yes** ☐ **No** ☐ ☐
   e.g eating disorders,psychosis,bipolar disorder,schizophrenia. Please specify :____________________

   If Yes to 2a or 2b, did this:
   c) Seriously interfere with your work and your relationships with friends and family?
   1 2 3 4 5 — not at all somewhat very much ☐

   d) Lead you to seek professional help? **Yes** ☐ **No** ☐ ☐
   Did you see a: Psychiatrist ☐ Psychologist/Counsellor ☐ GP ☐ ____________________ (Name of professional)

   e) Did you take tablets/herbal medicine? No☐ Yes ☐ Please specify: ____________________

3. Is your relationship with your partner an emotionally supportive one? *(If you have no partner circle 6)*
   1 2 3 4 5 [6 — very much somewhat not at all [☐

4. a) Have you had any stresses, changes or losses in the last 12 months (e.g separation,.domestic violence, unemployment, bereavement ?) **Yes** ☐ **No** ☐ ☐
   Please list:____________________

   b) How distressed were you by these stresses, changes or losses?
   1 2 3 4 5 — not at all somewhat very much ☐

5. Would you generally consider yourself a worrier?
   1 2 3 4 5 — not at all somewhat very much ☐

6. In general, do you become upset if you do not have order in your life (e.g. regular time table, a tidy house)?
   1 2 3 4 5 — not at all somewhat very much ☐

7. Do you feel you have people you can depend on for support with your baby?
   1 2 3 4 5 — very much somewhat not at all ☐

8. Were you emotionally abused when you were growing up? **Yes** ☐ **No** ☐ ☐

9. Have you ever been sexually ☐ or physically ☐ abused? **Yes** ☐ **No** ☐ ☐

If you would like to seek some help with any of these issues please discuss this with your midwife or doctor.

Kimberley Mum's Mood Scale Scoring Template

NAME:
DOB:
DATE:

Part 1 Instructions: Add up to determine total Part 1 score.
Any score > 0 in Question 10 requires further exploration.

					SCORE
1. I can sit down and have a good laugh	Yes, always 0	Yes, sometimes 1	No, not much 2	No, never 3	
2. I look forward for good things to happen	Yes, always 0	Yes, sometimes 1	No, not much 2	No, never 3	
3. I blame myself when things go wrong	Yes, always 3	Yes, sometimes 2	No, not much 1	No, never 0	
4. I worry too much and don't know why	Yes, always 3	Yes, sometimes 2	No, not much 1	No, never 0	
5. I feel frightened and shaky a lot	Yes, always 3	Yes, sometimes 2	No, not much 1	No, never 0	
6. I can't handle all the stress or I stress out	Yes, always 3	Yes, sometimes 2	No, not much 1	No, never 0	
7. I feel really no good, like no-one loves me	Yes, always 3	Yes, sometimes 2	No, not much 1	No, never 0	
8. I can't sleep because I am sad or think too much	Yes, always 3	Yes, sometimes 2	No, not much 1	No, never 0	
9. I am so sad I have been crying	Yes, always 3	Yes, sometimes 2	No, not much 1	No, never 0	
10. I think about doing something bad to myself or others	Yes, always 3	Yes, sometimes 2	No, not much 1	No, never 0	

For any response other than "No, never", ask exploring questions. E.g. Who do you think about doing something bad to? Can you tell me more about these feelings and thoughts you are having? When did you have these thoughts? Do you have a plan? What keeps you safe? Comments:

☐ Immediate concerns: Follow organisational policy or regional Suicide/Self Harm Protocols.
☐ If no immediate concerns, continue with KMMS Part 2.

TOTAL PART 1 SCORE

Kimberley Mum's Mood Scale Part 2

PART 1 SCORE:

NAME:
DOB:
DATE:

Refer to the KMMS Manual for information on how to facilitate the yarn, guidelines for administration, examples of enquiring/exploring questions for each psychosocial domain, how to determine overall risk, and options for follow-up actions.

EXPLORE THE WOMAN'S STORY, NOTING THE SITUATION AND HER PROTECTIVE AND RISK FACTORS

SUPPORT:

MAJOR STRESSORS:

SELF-ESTEEM / ANXIETY:

RELATIONSHIPS:

CHILDHOOD EXPERIENCES:

SUBSTANCE MISUSE:

SOCIAL, EMOTIONAL AND CULTURAL WELLBEING:

OVERALL RISK OF DEPRESSION AND/OR ANXIETY (PLEASE TICK)

Consider Part 1 score and the risk and protective factors identified during Part 2 in determining overall risk

LOW	Self-care recommended	☐
MODERATE	Clinical assessment within 1 week	☐
HIGH	Clinical assessment required within 48–72 hours	☐
IMMEDIATE CONCERNS	Clinical handover required immediately	☐

FOLLOW-UP ACTIONS: Explore relevant referrals, or next steps with the woman.

What’s Your ACE Score?

Prior to your 18th birthday:

1. Did a parent or other adult in the household often or very often… Swear at you, insult you, put you down, or humiliate you? -or- Act in a way that made you afraid that you might be physically hurt?
   No___ If Yes, enter 1 _____

2. Did a parent or other adult in the household often or very often… Push, grab, slap, or throw something at you? -or- Ever hit you so hard that you had marks or were injured?
   No___ If Yes, enter 1 _____

3. Did an adult or person at least 5 years older than you ever… Touch or fondle you or have you touch their body in a sexual way? -or- Attempt or actually have oral, anal, or vaginal intercourse with you?
   No___ If Yes, enter 1 _____

4. Did you often or very often feel that … No one in your family loved you or thought you were important or special? -or- Your family didn’t look out for each other, feel close to each other, or support each other?
   No___ If Yes, enter 1 _____

5. Did you often or very often feel that … You didn’t have enough to eat, had to wear dirty clothes, and had no one to protect you? -or- Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   No___ If Yes, enter 1 _____

6. Was a biological parent ever lost to you through divorce, abandonment, or other reason?
   No___ If Yes, enter 1 _____

7. Was your mother or stepmother:
   Often or very often pushed, grabbed, slapped, or had something thrown at her? -or- Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? -or- Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   No___ If Yes, enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?
   No___ If Yes, enter 1 _____

9. Was a household member depressed or mentally ill, or did a household member attempt suicide? No___ If Yes, enter 1 _____

10. Did a household member go to prison?
    No___ If Yes, enter 1 _____

Now add up your “Yes” answers: _________ This is your ACE Score

TRAUMA HISTORY QUESTIONNAIRE

The following is a series of questions about serious or traumatic life events. These types of events actually occur with some regularity, although we would like to believe they are rare, and they affect how people feel about, react to, and/or think about things subsequently. Knowing about the occurrence of such events, and reactions to them, will help us to develop programs for prevention, education, and other services. The questionnaire is divided into questions covering crime experiences, general disaster and trauma questions, and questions about physical and sexual experiences.

For each event, please indicate (circle) whether it happened and, if it did, the number of times and your approximate age when it happened (give your best guess if you are not sure). Also note the nature of your relationship to the person involved and the specific nature of the event, if appropriate.

Crime-Related Events		**Circle one**		***If you circled yes, please indicate***	
				Number of times	**Approximate age(s)**
1	Has anyone ever tried to take something directly from you by using force or the threat of force, such as a stick-up or mugging?	No	Yes		
2	Has anyone ever attempted to rob you or actually robbed you (i.e., stolen your personal belongings)?	No	Yes		
3	Has anyone ever attempted to or succeeded in breaking into your home when you were <u>not</u> there?	No	Yes		
4	Has anyone ever attempted to or succeed in breaking into your home while you <u>were</u> there?	No	Yes		
General Disaster and Trauma		**Circle one**		***If you circled yes, please indicate***	
				Number of times	**Approximate age(s)**
5	Have you ever had a serious accident at work, in a car, or somewhere else? (**<u>If yes</u>**, please specify below) ____	No	Yes		
6	Have you ever experienced a natural disaster such as a tornado, hurricane, flood or major earthquake, etc., where you felt you or your loved ones were in danger of death or injury? (**<u>If yes</u>**, please specify below) ____	No	Yes		

7	Have you ever experienced a "man-made" disaster such as a train crash, building collapse, bank robbery, fire, etc., where you felt you or your loved ones were in danger of death or injury? (**<u>If yes</u>**, please specify below) ____	No	Yes		
8	Have you ever been exposed to dangerous chemicals or radioactivity that might threaten your health?	No	Yes		
9	Have you ever been in any other situation in which you were seriously injured? (**<u>If yes</u>**, please specify below) ____	No	Yes		
10	Have you ever been in any other situation in which you feared you <u>might</u> be killed or seriously injured? (**<u>If yes</u>**, please specify below)	No	Yes		
11	Have you ever seen someone seriously injured or killed? (**<u>If yes</u>**, please specify who below) ____	No	Yes		
12	Have you ever seen dead bodies (other than at a funeral) or had to handle dead bodies for any reason? (**<u>If yes</u>**, please specify below)	No	Yes		
13	Have you ever had a close friend or family member murdered, or killed by a drunk driver? (**<u>If yes</u>**, please specify relationship [e.g., mother, grandson, etc.] below) ____	No	Yes		
14	Have you ever had a spouse, romantic partner, or child die? (**<u>If yes</u>**, please specify relationship below) ____	No	Yes		
15	Have you ever had a serious or life-threatening illness? (**<u>If yes</u>**, please specify below) ____	No	Yes		
16	Have you ever received news of a serious injury, life-threatening illness, or unexpected death of someone close to you? (**<u>If yes</u>**, please indicate below) ____	No	Yes		
17	Have you ever had to engage in combat while in military service in an official or unofficial war zone? (**<u>If yes</u>**, please indicate where below) ____	No	Yes		

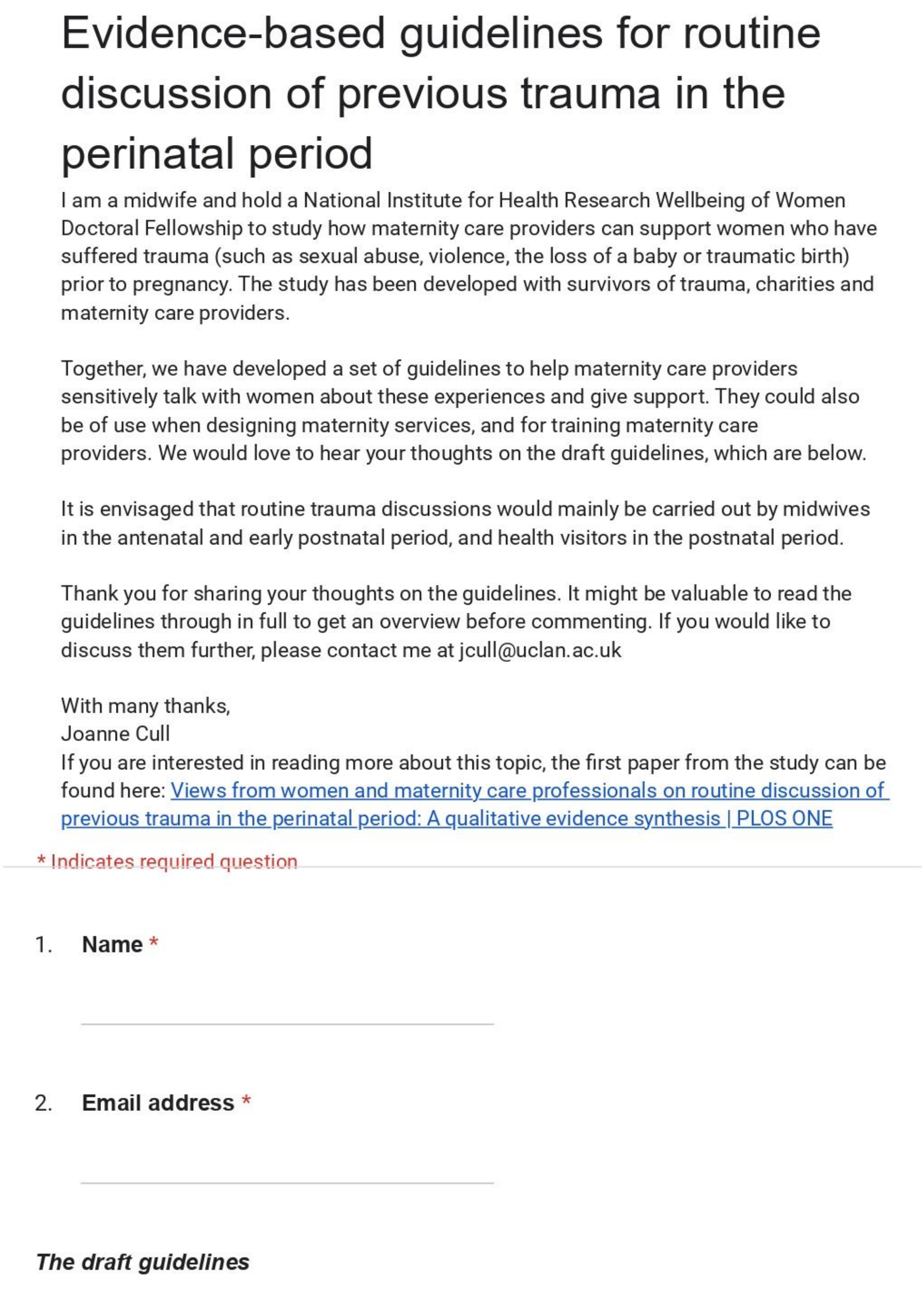
Physical and Sexual Experiences		**Circle one**		***If you circled yes, please indicate***	
				Repeated?	**Approximate age(s) and frequency**
18	Has anyone ever made you have intercourse or oral or anal sex against your will? (**If yes**, please indicate nature of relationship with person [e.g., stranger, friend, relative, parent, sibling] below)	No	Yes		
19	Has anyone ever touched private parts of your body, or made you touch theirs, under force or threat? (**If yes**, please indicate nature of relationship with person [e.g., stranger, friend, relative, parent, sibling] below)	No	Yes		
20	Other than incidents mentioned in Questions 18 and 19, have there been any other situations in which another person tried to force you to have an unwanted sexual contact?	No	Yes		
21	Has anyone, including family members or friends, ever attacked you with a gun, knife, or some other weapon?	No	Yes		
22	Has anyone, including family members or friends, ever attacked you without a weapon and seriously injured you?	No	Yes		
23	Has anyone in your family ever beaten, spanked, or pushed you hard enough to cause injury?	No	Yes		
24	Have you experienced any other extraordinarily stressful situation or event that is not covered above? (**If yes**, please specify below)	No	Yes		

Conversational prompts

‘We know that some stressful experiences can have an effect on pregnancy, even if they happened a long time ago. I ask everyone questions about past stress because sometimes there are things we can do to help with those effects on you and the baby. Have you had a severe trauma or stress in which you thought you or another person might die or experience serious harm? Examples include: physical attack, mugging, rape, severe car accidents, natural disasters, being diagnosed with a life threatening illness, or sexual abuse’ (White, Danis and Gillece, 2019).

‘Sometimes pregnancy can trigger unexpected memories of things that have happened to you or feelings that can take you by surprise. If that happens to you and you would like to talk about it, please let me know’ (Montgomery, 2021).

Appendix 14. Guideline consultation document



Evidence-based guidelines for routine discussion of previous trauma in the perinatal period

I am a midwife and hold a National Institute for Health Research Wellbeing of Women Doctoral Fellowship to study how maternity care providers can support women who have suffered trauma (such as sexual abuse, violence, the loss of a baby or traumatic birth) prior to pregnancy. The study has been developed with survivors of trauma, charities and maternity care providers.

Together, we have developed a set of guidelines to help maternity care providers sensitively talk with women about these experiences and give support. They could also be of use when designing maternity services, and for training maternity care providers. We would love to hear your thoughts on the draft guidelines, which are below.

It is envisaged that routine trauma discussions would mainly be carried out by midwives in the antenatal and early postnatal period, and health visitors in the postnatal period.

Thank you for sharing your thoughts on the guidelines. It might be valuable to read the guidelines through in full to get an overview before commenting. If you would like to discuss them further, please contact me at jcull@uclan.ac.uk

With many thanks,
Joanne Cull
If you are interested in reading more about this topic, the first paper from the study can be found here: Views from women and maternity care professionals on routine discussion of previous trauma in the perinatal period: A qualitative evidence synthesis | PLOS ONE

* Indicates required question

1. **Name** *

2. **Email address** *

The draft guidelines

3. 1. Maternity care providers should **make women aware** that previous difficult or traumatic experiences can affect their current wellbeing and experience of pregnancy and parenting

4. 2. Discussions about difficult experiences should be **combined with discussions about mental health**, because many troubling thoughts, feelings and behaviours are attributable to previous experiences

5. 3. Maternity care providers should give women **multiple 'light-touch' opportunities** to talk about mental health concerns and previous difficult or traumatic experiences, because women may not feel comfortable disclosing or need support until later in the perinatal period

6. 4. Maternity care providers should only ask **direct questions** about difficult or traumatic previous experiences if there is a protocol and referral pathways in place, they have had training in how to ask and respond, and are in a private setting

7. 5. Women should be provided with information and support which they can access **without having to disclose** they have suffered previous difficult or traumatic experiences, as many women will choose not to disclose their histories to health care providers

8. 6. When women disclose previous difficult or traumatic experiences, maternity care providers should work with them to develop a **plan of care** for the perinatal period, that could include:

   - creating a birth plan

   - management of possible triggers

   - provision of continuity of carer if possible

   - accessing mental health support if this would currently be, or might become, beneficial

9. 7. Women should be **forewarned** that the issue of previous trauma will be raised; that they can **opt out** of answering any question about previous difficult or traumatic experiences; and about the limits of **confidentiality**

10. 8. The issue of previous difficult or traumatic experiences should be raised when there is sufficient **time** for staff to listen and respond to disclosures, recognising that for women who do not feel listened to, these discussions can be re-traumatising

11. 9. Initial discussions about previous difficult or traumatic experiences should take place in a **private and undisturbed environment**, without partner presence. Support should be available for women who become upset during the conversation, including a private area they can use until they feel better

12. 10. Where possible, the issue of previous difficult or traumatic experiences should be raised by a maternity care provider who is **known to the woman**, because many women will not disclose trauma in the absence of a trusting relationship

13. 11. Maternity care providers should work with women to ensure **documentation** of trauma disclosures is sensitive and acceptable (within the limitations of safeguarding requirements), recognising and advising women that maternity records may inadvertently be viewed by others including partner and family

14. 12. Maternity care providers should ask women's wishes about **information sharing** within the maternity team and with other services, and as far as possible follow these wishes

15. 13. Maternity care providers should receive **training** to enable them to sensitively carry out routine trauma discussions. This training should include:

    - The potential impact of trauma on mental and physical health, behaviour, wellbeing, and parenting, in diverse population groups

    - Basic counselling skills including active listening, asking open-ended questions, confidence in asking about and responding to disclosures of difficult experiences, and sensitively closing difficult conversations

    - Recognising and sensitively supporting women who may have suffered trauma but have not chosen to disclose this

    - Local care pathways available for women who have suffered trauma

    - Documentation of trauma disclosures and safeguarding considerations

16. 14. **All staff** working in maternity care (including support staff such as healthcare assistants and receptionists) should receive role-appropriate training in supporting women who may have suffered trauma

17. 15. Staff training on routine trauma discussion and trauma-informed care should begin in the **undergraduate period**

18. 16. Maternity care providers should be provided with **regular (e.g. monthly) confidential counselling**, **provided within paid working hours.** The counselling should be independent of service management, with a qualified professional who can help them understand and deal with the emotional impact of routine trauma discussions, including coping with personal memories that these conversations may evoke

19. 17. Consideration should be given to **cultural barriers** in discussing previous difficult or traumatic experiences, which can include:

- Shame and stigma

- Expectations about gender

- Strong social taboos around discussing abuse, which means women may not recognise their experiences as abusive

- Lack of awareness of mental health issues

- Lack of vocabulary to describe mental health in some languages, or language which can be stigmatising e.g. ‘crazy’

- Mistrust of institutions

- Cultural bias and racism from care providers

- Insecure immigration status, which renders women more vulnerable to abuse and can deter them from disclosing their experiences

20. 18. Pathways should be designed with recognition of the additional difficulties **women with limited English** can face disclosing trauma, which may include:

- Reluctance to disclose in the presence of an interpreter

- Fear that interpreter will breach confidentiality and tell others in the community

- Reluctance to disclose in the presence of partner / family / friends who are acting as interpreter

- Lack of literacy in own language meaning translated materials are not helpful and can make women feel ashamed

- Even women with good conversational English may struggle to understand complex information or pick up subtleties

21. 19. Routine trauma discussion pathways should be **tailored** to local resources and services with the meaningful input of women with lived experience of trauma, frontline maternity care providers, and local voluntary service organisations

22. 20. While respecting women’s individual rights to confidentiality, ways should be sought to **measure the effectiveness** of routine trauma discussion, collecting data which could include:

- Proportion of staff trained in carrying out trauma discussions

- Proportion of women asked about previous trauma

- Basic sociodemographic information

- Number of women who disclosed trauma and trauma type

- Changes in care as a result of disclosure

- Uptake of referrals made

- Impact of routine trauma discussion on outcomes such as health, quality of life and experience of parenting

23. **21.** Feedback should be sought **at a local level from women using maternity services and staff** about routine discussion of previous trauma, to establish whether it is acceptable and helpful and identify unintended consequences (e.g. re-traumatisation of women / impact on staff wellbeing)

24. 22. While respecting women’s rights to confidentiality, maternity services should **share their findings and collaborate** to enable best practice to be identified and disseminated

General questions about the guidelines

25. Do you feel these guidelines would be **helpful** to maternity care providers / service managers / student care provider educators? Please give reasons

26. Do you feel these guidelines are **achievable** to implement in practice? Please give reasons

27. Do you feel that implementing these guidelines would be **valuable** to women who have suffered trauma? Please give reasons

28. Do you feel that implementing these guidelines would be **acceptable** to women, whether or not they have suffered trauma? Please give reasons

29. Do you feel that implementing these guidelines would be beneficial to women experiencing **inequality and disadvantage**? Please give reasons

30. Do you feel that using these guidelines could result in **harm?** Please give reasons

31. Is there anything you would like to **add**?

32. I agree that the information collected on this form can be anonymised and used for further research, presentations and publications

Mark only one oval.

○ Yes
○ No

33. I am happy to be acknowledged in the published guidelines, using the name I have given above

Mark only one oval.

○ Yes
○ No

34. We are keen to hear a range of perspectives on the guidelines. If you have professional experience in this area (for example, as a healthcare professional or working for a voluntary sector organisation) please give details below