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# TRAUMA INFORMED CARE IN MIDWIFERY

Mixed Methods Evaluation of Trauma-Informed Approach to Care (TIAC) Knowledge and Practices in Midwifery/ Perinatal Settings in Ireland.

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The thesis has been prepared according to the regulations of Dundalk Institute of Technology and has not been submitted in whole or in part for an award in this or any other institution.

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**Abbreviations:**

**ACE:** Adverse Childhood Experiences
**AMP:** Advanced Midwife Practitioner
**CLU:** Consultant Led Unit
**CMM:** Clinical Midwife Manager
**CMS:** Clinical Midwife Specialist
**CSA:** Childhood Sexual Abuse
**CTG:** Cardiotocography
**DKIT:** Dundalk Institute of Technology
**EPDS:** Edinburgh Postnatal Depression Scale
**GDPR:** General Data Protection Regulation
**HSE:** Health Service Executive
**INMO:** Irish Nurses and Midwives Organisation
**MBRRACE:** Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries
**MDT:** Multi-disciplinary Team
**MIA:** Midwives Association
**MLU:** Midwifery Led Unit
**NMBI:** Nursing and Midwifery Board of Ireland
**OSCE:** Objective Structured Clinical Exam
**PTSD:** Post Traumatic Stress Disorder
**RAMP:** Registered Advanced Midwife Practitioner
**RCM:** Royal College of Midwives
**RM:** Registered Midwife
**ROI:** Republic of Ireland
**SAMHSA:** Substance and Mental Health Services Administration
**SVD:** Spontaneous Vaginal Delivery
**TIAC:** Trauma Informed Approach to Care
**TIC:** Trauma Informed Care

**TUTF:** Technologies University Transformation Fund

**VE:** Vaginal Examination

**WHO:** World Health Organisation

*This thesis uses the terms Trauma Informed Approach to Care (TIAC) and Trauma Informed Care (TIC) interchangeably.

## Abstract

**Background / Aim**: The potentially adverse impacts of past trauma on the childbearing population are consistently highlighted in the UK and Irish confidential enquires into maternal deaths and long term morbidity (Knight et al. 2022). Knight et al (2022) reported that many post-natal suicides were remarkable in their absence of a pre-existing formal mental health diagnosis, but notable for the presence of a history of prior trauma.

**Methodology:** A sequential mixed methods explanatory study design was utilised which progressed in two phases, the first of which surveyed 197 Irish-based Registered Midwives (RM) using a trauma informed care scale by King et al (2019) to measure their knowledge and practice of trauma informed care. The second phase interviewed 18 RMs, who had self-selected from Phase 1, in five online focus groups. Ethical approval was granted by the DkIT School of Health and Science Research Ethics Committee.

**Findings:** This first phase of the study revealed that very few participants had ever received training on trauma informed care and, the majority of the few that had such training, had sourced it themselves. While objectively measured knowledge of TIC was good, self-appraised knowledge of TIC was poor. Respondents reported TIC to be the exception rather than norm within their practice, and their practice of self-care was poor. Respondents positively welcomed further education related to implementing TIC. Findings from focus groups revealed a fragmented perception of TIC within participants practice areas. Participants acknowledged the potential for all to experience, and the potentially enduring impact of trauma. Participants recognised the importance of compassion, kindness and empathy, and expressed a strong desire to progress the learning and to excel in the provision of trauma informed care. Participants described systemic barriers, and identified continuity, personalised care, and structured pastoral and peer support as key enablers, to the implementation of trauma informed perinatal care.

**Conclusion:** The study illuminates the everyday reality of midwives efforts to provide empathetic, effective, compassionate and individualised care, despite systemic, and sometimes personal, challenges. The findings suggest that enhanced TIC education, and structured trauma informed supports would support midwives in more effectively meeting the challenges encountered in everyday practice, and advancing their expressed desire to provide trauma informed services of excellence.

Beyond extending the existing body of knowledge, particularly in an Irish context, the study makes recommendations regarding trauma informed knowledge and practices which have the potential to enhance the perinatal care experience for both ‘cared for’ and ‘carer’

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# Chapter One
# Background and Context

## Introduction

Psychological trauma is a widespread, harmful and costly public health problem that has been 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 has lasting adverse effects on the individuals functioning and mental, physical, social, emotional, or spiritual wellbeing*" (SAMHSA 2014, pp.7). with SAMHSA noting that anyone can be affected by trauma at any time across the lifespan. (SAMHSA 2014, pp.7).

The impact that past trauma can have on the childbearing population is repeatedly highlighted in the UK and Ireland Confidential enquires into maternal deaths and morbidity referred to as Mothers and Babies: Reducing risk through audit and confidential enquire (MBRRACE). The recent MBRRACE report (Knight et al. 2022) recognised that very few women who died by suicide in 2020 had a formal mental health diagnosis, but significant numbers had a history of trauma. These authors recommended that perinatal services commit to embedding a C model, recognising the importance of trauma history and advocating professional sensitivity when enquiring about underlying trauma events. This report is significant in underlining the link between trauma and maternal mental health and trauma, stressing the importance of TIC for all.

The World Health Organisation (WHO) reports that a significant number of children globally experience forms of physical, emotional, sexual abuse or neglect (WHO 2022). These reports are notable considering that child sexual abuse (CSA) may cause the greatest negative long-term effects among childbearing women (Lev-wiesel et al. 2019).

A seminal study by Rhodes and Hutchinson in 1994, established that disturbing memories of abuse may be provoked during the birthing experience, and through touch, causing dissociation and feelings of fear, panic and powerlessness that may be very powerful for survivors of CSA (Rhodes and Hutchinson 1994).

It is also important to note that many aspects of childbearing may produce more positive feelings and transformation following previous trauma. For example, it has been asserted that breastfeeding and motherhood may provide some survivors with a sense of reclaiming their bodies and sexual identities, ultimately achieving a healing effect from trauma (Klingelhafer 2007; Wood and Van Esterik 2010).

This places a large emphasis on the unique position of the midwife in minimising the potential harm and maximising the remedial potential during the maternal health experience by providing individualised, client centred, compassionate care which is trauma sensitive and beneficial to both women and midwives (Kirkham 2010).

The degree to which midwives are prepared to meet this challenge is uncertain, especially so in an Irish context with the notable paucity of clinical and research attention to the issue of TIC within Irish maternal care services.

This study will go some way in addressing this deficit utilising a sequential mixed methods study design involving two phases within one regional Irish maternal health service. The first phase quantitively investigates the awareness and knowledge and practice of TIC, and the second phase qualitatively explores how this dimension of practice might be enhanced in a focus group study with practicing midwives.

The following chapter provides a review of literature. Chapter 3 presents the methodology and design of the study, chapters 4 and 5 present the data collection and analysis. The final chapter summarises and synthesizes the findings from both strands of the study, and concludes with some recommendations informed by the study findings.

# Chapter Two
# Literature Review

## Introduction

The purpose of a literature review is to show why the current study is needed and where it fits in to the overall body of knowledge on the phenomenon being researched (Parahoo 1997).

There are many types of literature reviews that can be carried out. This study was literature review is a narrative literature review. A narrative review attempts to summarize or synthesize what has been written on a particular topic but does not seek generalization or cumulative knowledge from what is reviewed. Instead, the review team often undertakes the task of accumulating and synthesizing the literature to demonstrate the value of a particular point of view (Paré and Kitsiou 2017).

Within the context of this study the aim of the literature review is to define and delineate how 'Trauma Informed Approach to care (TIAC) and Trauma informed care practices within Midwifery/ Perinatal Settings' are examined and explored within the literature.

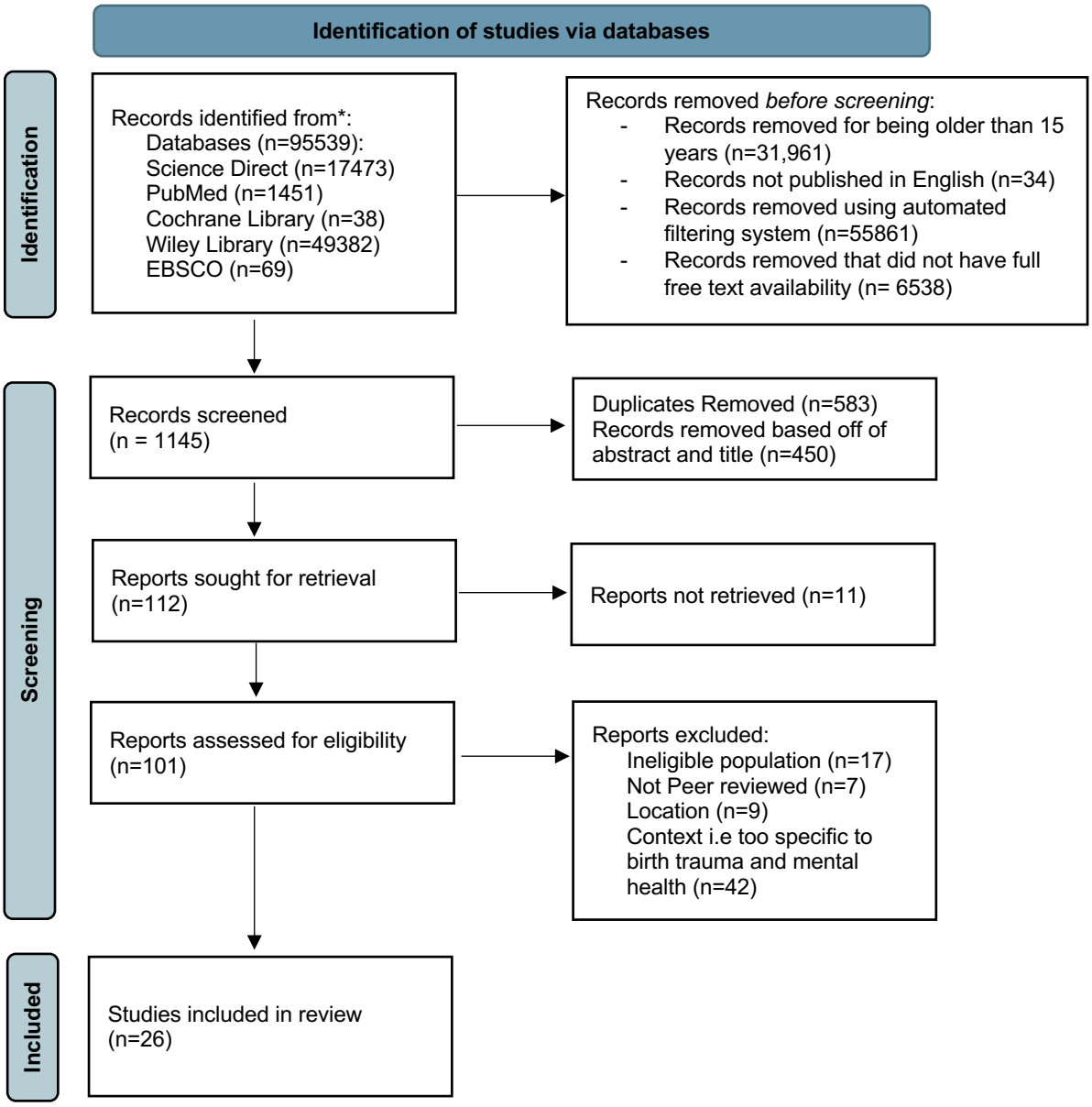
## Search Strategy

A comprehensive search strategy was developed to identify relevant literature for this MSc research study. To ascertain the most pertinent literature available and narratively report on current evidence, the author undertook an electronic search of the following databases; PubMed, EBSCO, Cochrane database, Science Direct and Wiley Library. Using a combination of Medical Subject Headings (MeSH), subject headings and keywords. Key search terms included: 'trauma-informed care', 'maternity services', 'trauma', 'perinatal mental health', 'trauma informed approach', 'midwifery' and 'pregnancy'. Boolean features were employed to refine the search, using combinations such as **AND** to connect major concepts (e.g.

‘trauma-informed care’ AND ‘maternity services’) and **OR** to include synonyms and related terms (e.g. ‘Trauma informed care’ OR ‘Trauma informed approach’).

The initial search yielded 1,451 results from PubMed, 69 from EBSCO, 17,473 from Science Direct, 38 from Cochrane database and 49,382 from Wiley Library, totalling 95,539 records. After removing duplicates, the remaining articles were screened in stages. First, search results were filtered to suit exclusion criteria; studies over 15 years old were excluded and studies not published in English were excluded. This led to 1,145 studies to be reviewed. Titles and abstracts were reviewed to exclude studies not related to trauma-informed care in the context of maternity care. This led to 112 articles for full-text review. Full-text articles were assessed against inclusion criteria: studies had to focus on trauma-informed approaches within maternity or perinatal services. Studies were excluded if they were over 15 years old, were not in English, not peer-reviewed, or lacked relevance to the research question.

Following this rigorous screening process, Twenty-six studies met the quality appraisal criteria for this literature review, with a summary of these studies presented in Appendix A. Four main themes were identified within the literature including ‘Education Needs’; ‘Standardized care may be substandard care’; ‘Future Directions for TIAC’; and ‘Shame- the Emerging Understanding of Trauma Informed Care’, with each of these themes discussed in the subsections below.


Identification of studies via databases
Identification
Records identified from*:
Databases (n=95539):
Science Direct (n=17473)
PubMed (n=1451)
Cochrane Library (n=38)
Wiley Library (n=49382)
EBSCO (n=69)
Records removed *before screening*:
- Records removed for being older than 15 years (n=31,961)
- Records not published in English (n=34)
- Records removed using automated filtering system (n=55861)
- Records removed that did not have full free text availability (n= 6538)
Screening
Records screened
(n = 1145)
Duplicates Removed (n=583)
Records removed based off of abstract and title (n=450)
Reports sought for retrieval
(n=112)
Reports not retrieved (n=11)
Reports assessed for eligibility
(n=101)
Reports excluded:
Ineligible population (n=17)
Not Peer reviewed (n=7)
Location (n=9)
Context i.e too specific to birth trauma and mental health (n=42)
Included
Studies included in review
(n=26)

## 2.1 Education Needs

*"On-going training on trauma is essential in the development of a trauma informed system" (SAMHSA 2014, p.13).*

Trauma informed care only began to become recognised and established in the late 1990s early 2000s (Wilson et al. 2013). As a result, it is a relatively new concept in terms of perinatal healthcare. The theme of education explores the current knowledge among healthcare professionals in relation to TIAC and the ways they implement it in practice. Stokes et al. (2017) recognised the unique position that Nurses hold in advancing trauma informed care. As there was limited research exploring nurses' knowledge of TIC, Stokes et al. (2017) explored nurses' knowledge and experiences related to TIC. They conducted semi-structed interviews with nurses to gain a deeper understanding. Data was analysed using constant comparison (Glaser and Strauss 1994). This approach is based off the principles of grounded theory so may not be the best approach for data analysis, however it has been used in qualitative descriptive work also (Paille and Mucchielli 2003). The authors findings highlighted that the nurses in the study were unfamiliar with the terminology of TIC and that there is a complex dynamic of the nurse patient interaction in the context of trauma. Stokes et al (2017) revealed that there is a possibility for (re)traumatization to occur for both the patient and the nurse and that previous trauma may perpetuate more trauma, through the patient-nurse interaction. These results should be considered cautiously as qualitative research results are specific to the participants, in this case the nurses, so the findings cannot be generalised or transferred (Lockwood et al. 2015). However, this study, highlights a lack of knowledge on TIC and places emphasis on the fact that this is a relatively new area in the field of healthcare. Of interest, despite limited awareness of TIC, participants were able to describe the attributes of TIC and recognised how many of these elements are a fundamental part of nursing care.

An allied concept to ‘lifespan trauma’ is ‘birth trauma’. Birth trauma is distress experienced by the mother during or after childbirth, like trauma it can be physical, emotional or psychological (Beck 2004). In a seminal study carried out by Beck (2004) to describe the meaning of birth trauma, the author concluded that birth trauma lies in the eye of the beholder, meaning that clinicians cannot decide what is or isn’t viewed as birth trauma but that it is entirely based off of the mother perceptions of her own birth. A systematic review by Simpson and Catling (2016) included twenty-one studies that looked at birth trauma. The findings of the review found that women with previous mental health disorders were more likely to experience birth as a traumatic event, and that inferior quality care interactions with care providers also increased the likelihood of birth trauma. Simpson and Catling (2016) highlighted the importance of antenatal recognition of risk factors for developing trauma and recommend enhanced education for maternity care workers. Although this study explored birth trauma specifically, the authors recognised that a history of trauma has an impact on the birthing experience of the woman and thus a more trauma centred approach could optimise the woman’s entire perinatal experience.

The co-existence of previous trauma and poor mental health in the perinatal period has been highlighted by Blackmore et al. (2016). Blackmore et al. (2016) conducted a prospective longitudinal cohort study which examined the impact of trauma exposure and mood symptoms on obstetric birth outcomes on 358 women in the US. Birth outcomes for 139 women who had reported previous exposure to trauma were compared with those of 219 women who had not. The study involved interviewing the women during their pregnancy utilising questions from the Edinburgh Postnatal Depression Scale (EPDS; Cox et al. 1987) and the Penn State Worry Questionnaire (PSWQ; Miller et al. 1990), and the collection of detailed demographic medical, clinical and sociodemographic data from both interview and medical records. Quantitative analysis revealed that women with

antecedent trauma were more likely to have a history of depression, were younger at their first pregnancy, and had a higher number of previous pregnancies in comparison to those not exposed to trauma. Childhood trauma in mothers was found to increase the likelihood of low birth weight babies (Blackmore et al 2016).

Aligned to this knowledge, Noonan et al. (2018) conducted a cross sectional survey on midwives' knowledge, confidence, and attitudes in relation to perinatal mental health in Ireland. Although it's looking at a broad topic of perinatal mental health, TIC is an emerging concept within the area of mental health. The midwives in this survey indicated elevated levels of knowledge and confidence in identifying women who experience depression or anxiety but felt less confident in caring for these women. The authors noted there to be a huge desire amongst midwives to become more educated in this area. The sample in this study consisted of 157 midwives, recruited through non-probability sampling. The response rate of the survey was 36.7% which the authors deemed 'acceptable', however Fincham (2008) would recommend a higher response rate to improve validity.

This enthusiasm amongst care providers to know more was also documented by Choi and Seng (2015) who piloted a nurse-led interprofessional in-service training programme on trauma-informed perinatal care in the USA. The researchers used a single group, pre-test post-test study design that included forty-seven participants. The quantitative findings indicated a statistical improvement in both knowledge and skills when comparing the pre and post-test groups. The qualitative data showed that the participants found the training relevant but also wanted to know and learn more about TIC. These findings reveal that when healthcare professionals are educated about TIC, their practice improves as a result. A limitation to this study was that the surveys were a self-appraisal with no test questions, thus actual knowledge or behavioural changes could not be assessed. The authors recognise this limitation demonstrating a holistic understanding of the

area (Tigre-Moura 2017). Both studies (Noonan et al 2018; Choi and Seng 2015) identify that midwives would like to be more educated and more informed about perinatal mental health. TIC is a relatively new and evolving aspect of perinatal care that can improve and promote positive care interactions, these findings suggest that midwives may need further training to enhance their understanding and use of TIC.

More recently Emsley et al. (2022) undertook a qualitative study, comprising of a 24-document analysis and semi-structured interviews amongst eleven professionals from healthcare organisations in the UK. This study attempted to explore where the National Health Service in the UK is currently positioned with regard to TIC. Study participants recognised that there needs to be an increase in education among healthcare professionals around TIC. Inclusion of direct quotes from organisations were not included but would have enhanced study robustness if used (Lockwood et al. 2015). The authors recognise the limitations of eleven participants and advise that future research should include interviews with healthcare professionals and service users to give a more complete picture of the landscape of trauma informed approaches in the UK. Although the Irish landscape of TIC is not explored in this study, an allied study on perinatal mental health knowledge and practice in Ireland was carried out by Huschke et al (2020). This scoping review mapped the body of research on this topic from an Irish perspective The authors used tables to 'map' out the available qualitative and quantitative research. This data charting form was an excellent way to analyse and present the findings and was consistent with the research design. Similar to the findings of Simpson and Catling (2016), this study once again noted that a history of a previous trauma including mental health problems and a lack of social support were contributing factors to poor perinatal mental health outcomes among women in Ireland. Huschke et al. (2020) identified a significant lack of training and knowledge among frontline staff with respect to perinatal mental health. These

researchers looked towards explanations, suggesting that the Irish maternity system consists of low pay, understaffed wards, impossible workloads, and low morale. These findings by Huschke et al. (2020) can be generalised, as the WHO (2016) also found that these attributes exist globally. Huschke et al. (2020) findings have implications beyond academia, by offering an insight into policy and practice development through education.

Despite the significance of mental wellbeing within maternity care, the recommendations from multiple studies continue to advocate for more education in this area. Long et al. (2022) carried out an integrative review to identify and describe the nature and extent of trauma informed education provided for midwives and midwifery students. Their thorough search of the literature included 5 data bases, but only identified 3 studies, none of which were midwifery focused, and midwives only represented a small proportion of the participants. They concluded that, in general, midwives reported receiving no previous TIC education and lacked confidence to provide quality care to women with lived trauma. The midwives recognised TIC education as essential and relevant for providing quality practice. The studies chosen for the review lacked diversity as all three were carried out in the USA and two were carried out by the same authors. This lack of diversity limits the transferability of the findings. The review demonstrates the dearth of literature on trauma informed education for midwives and midwifery students.

Several other studies, such as Carroll et al. (2018), examine midwives' knowledge, confidence, and skills in perinatal mental health. Whilst not specific to TIC, this Irish study explored trauma and trauma histories under the umbrella of perinatal mental health, and was therefore chosen for inclusion in this review. Carroll et al. (2018) conducted surveys among midwives on several aspects of TIC such as skills in discussing trauma histories, sexual abuse, domestic violence and previous birth traumas. The authors concluded a more comprehensive approach is needed

to educate midwives. It was noted that midwives do not need to be experts on mental health but that they need the knowledge and skills necessary to identify women at risk.

More recently Cull et al. (2023) carried out a qualitative evidence synthesis to examine the views from women and maternity care professionals on routine discussion of previous trauma in the perinatal period. They included 25 research papers from five high-income countries. Their findings revealed that women accepted routine discussion of trauma history during the antenatal period but that care providers were reluctant to discuss this area as they feared they may be unable to deal with what the women told them i.e. lack of education in regards to how to discuss trauma, lack of knowledge on resources available. This finding is significant and highlights the importance of providing evidence-based education to midwives, to make them comfortable and confident in providing TIC to their clients.

Education is a compounding factor to the provision of TIC within maternity services (Huo et al. 2023). Articles from Ireland, UK, USA and more have concurred of its importance. This emerging theme of education guided the assessment of midwives current knowledge on trauma informed care within Ireland for this current study, as it had yet to be explored in depth. Education is at the core of the implementation and sustainability of a trauma-informed care framework in the maternity services (Hall et al 2021). Throughout this theme the dearth of knowledge and low confidence levels among midwives and healthcare professionals in delivering care that is trauma informed is recognised. The integration of trauma informed care into practice is limited due to the lack of structured, evidence based educational interventions (Huo et al 2023). There is a huge desire among midwives to expand their learning and enhance their ability to effectively support women with histories of trauma, this highlights not only the challenges at hand but the opportunities also (Long et al 2022). Education not only facilitates knowledge transfer but empowers

care providers to approach practice through a trauma informed lens. By introducing trauma informed care education to both student midwives and midwives through continuous professional development, there is a potential to make a culture shift towards a maternity care system that acknowledges the prevalence of trauma and strives to prevent re-traumatisation (Itani et al 2025).

## 2.2 Standardised care may be substandard care

*"The physical setting should support the collaborative aspects of trauma informed care" (SAMHSA 2014, p.13)*

It has been clearly documented in the research that education amongst midwives is a major influence on the standard of care offered to women in the maternity services (Hunter et al. 2017). Despite the availability of research that informs midwives of the need to educate themselves in the area of trauma/ PMH, the need to enhance the provision of education and training persists. However, there exists another issue which affects the availability of trauma support that midwives can provide. The research has noted that midwives often have large caseloads, short staffing and minimal time to spend with women (Oliver and Geraghty 2022). So even in areas where midwives are educated about TIC, they may be unable to put their skills to practice (Long et al. 2022). Not only can midwives come under pressure and feel challenged in providing optimum care due to these pressures, the Royal Collage of Midwives (RCM) (2015) also believe that women's knowledge of time constraints at appointments, prevents them from disclosing past issues.

A scoping review by Viverioros and Darling (2019) on the perceptions and barriers to accessing perinatal mental healthcare, revealed that 'lack of time' was a recurring barrier to optimal mental health care. Viverioros and Darling (2019) found that time affected both the midwife and the woman. They revealed that the women themselves had a distinct knowledge of the minimal time allocated for appointment and resulting in a decision not to disclose their full history (Viverioros and Darling 2019). They also noted that midwives felt they did not have enough time to successfully complete a mental health assessment on women. Other studies have reported similar clinical constraints (Jones et al. 2012; Edge 2010; Mivsek et al. 2008; Ross-Davie et al. 2006).

Time barriers were highlighted by participants in Stokes et al. (2017) study. Stokes et al. (2017) explored nurse's knowledge and experiences of TIC. The concept of time was found to be an important element in the provision of care in the context of trauma. Time was identified in two dimensions; lack of time to spend with the person, and an organizational timeline of expectations toward recovery and discharge.

Similarly, when Mule et al. (2022) examined why some women do not fully disclose their histories during the psychosocial assessment with their midwife, limited time was a significant factor. The authors gathered data from 1796 pregnant women in Australia. They analysed data using a mixed methods approach. In the initial survey 193 (11%) women reported they were not honest in the assessment. 161 women responded to the open-ended question asking their reason for not fully disclosing. Time issues presented itself as a theme in the findings as many women felt rushed and limited in what they could say by the lack of time and closed ended questions. This study highlights the important role of the midwife in 'setting the scene' and building trust and rapport with the woman to improve the disclosure at the psychosocial assessment which could ultimately influence the entirety of that woman's perinatal journey. Midwives need to approach all women in a trauma informed manner, as they will not know the unique experiences of the woman or the events which led her to her current point.

In a related study, Nagle and Farrelly (2018) explored women's views and experiences of having their mental health needs assessed. The mental health assessment usually occurs during the booking visit when the midwife first meets the woman. A part of the assessment involves gaining an insight to that woman's life, personal history, mental health history and the mental health history of her family. This was a qualitative study carried out in a large maternity hospital based in Co. Dublin in Ireland. Their sample consisted of 8 women who were interviewed

using semi-structured interviews, in the early postpartum period. Braun and Clarke (2006) thematic analysis was used to analyse their findings. The authors found that a lack of time was a huge influence on women disclosing/ not disclosing their mental health needs. This study is significantly relevant to the current proposed study, as it too was conducted in Ireland. It is acknowledged that part of providing a TIAC trauma screening, an assessment should be undertaken (SAMHSA 2014). Nagle and Farrelly (2018) recognise that the current system of care means both midwives and women are constrained by time so an effective assessment may not be completed, potentially infringing the provision of a trauma informed service.

The model of perinatal care provision in the Republic of Ireland (ROI) adopts a very standardised approach to care, where individual needs may appear secondary to service provision (Huschke et al. 2020). The National Maternity Strategy (Department of Health 2016) highlighted significant service deficits while making recommendations for improvement by 2026. In the current model, women are generally discharged from the hospital into the care of their general practitioner (GP) whom they attend at 2 and 6 weeks postpartum. In 2022, Hanon et al. undertook a prospective cohort study that investigated maternal mental health in Ireland in the first year postpartum. Their findings suggest that the current model of 6-week postpartum care is ineffective in detecting and providing support for women's mental health needs, resulting in long-term consequences for women and children. The inadequacies in the current system could leave women vulnerable to unaddressed mental health issues, particularly if they have experienced trauma during childbirth or have a history of trauma (Perera et al. 2023). A TIAC may emphasize ongoing, sensitive, and holistic support throughout the postpartum period, and may better recognise the need for more frequent and comprehensive mental health assessments (SAMHSA 2014; Benton et al. 2024).

On a more sombre note, Knight et al. (2022) reported that Mental ill-health in pregnancy and beyond is an increasing cause of maternal death; 40% of deaths within the year after pregnancy were from mental health causes, with maternal suicide remaining the leading cause of direct deaths in this period. These findings highlight the crucial need for comprehensive mental health support during pregnancy and postpartum, including recognition and support for previous trauma, in order to achieve a system that is fit for purpose.

It is clear from the current available evidence from the ROI, that the maternity system may be inadequate in the provision of TIAC. It has also been highlighted that there is a distinct absence of women's voices and their lived experiences within the evidence base, particularly those of women of colour, migrant women and ethnic minorities (Huschke et al. 2020).

A US based study by Muzik et al. (2013) revealed that care provision framed around peer support, group intervention, safe, comfortable and child-friendly integrated services, would be a powerful perinatal model for women who have experienced trauma. This study undertook qualitative semi-structed interviews with 52 mothers. This was a large sample size (n=52) with a diverse demographic, increasing the representation and generalisability of the findings. This powerful finding could be adopted and implemented within the Irish maternity service to enhance TIC provision.

Ways to enhance TIC were further explored by Sperlich et al (2017) who carried out a review to explore integrating TIC into maternity care practices in the USA. They list some of the trauma-specific perinatal interventions which have been introduced such as the Minding the baby programme (Sadler et al. 2013), Parents under Pressure (Barlow et al. 2013) and the Compassionate minds (Renshaw and Wrigley 2015). These are trauma-based programmes which are available to all

parents. Some of these programmes support parents up to two years postpartum. It is possible that Muzik et al. (2013) findings may have contributed to the development of these programmes. This review further illuminates the deficiencies of trauma-based/ informed services in Ireland. TIC involves recognizing the prevalence of trauma, understanding its impact on individuals, and integrating this knowledge into care practices to avoid re-traumatization (SAMHSA, 2014). For midwives in Ireland, adopting such practices could include implementing screening for trauma histories, offering referrals to trauma-specific interventions, and providing ongoing support tailored to the needs of women who have experienced trauma (Benton et al. 2024). The introduction of trauma-based programs in Ireland, similar to those in the US, may be a significant step forward in enhancing perinatal care and ensuring that PMH needs are more comprehensively addressed (Benton et al. 2024).

It is estimated that approximately half of all cases of perinatal depression and anxiety go undetected despite regular contact with health professionals in the antenatal and postnatal period (RCM 2023). A profound reason for this is women's' fear of disclosing their true feelings and symptoms due to a lack of trust in professionals and a fear of their infant being removed from their care (RCM 2015).

The benefits of TIAC are seen again by Racine et al. (2021) who retrospectively studied maternal-child health outcomes associated with TIC within one Switzerland prenatal setting. By analysing 601 medical records of low-risk women they reported that infants of mothers who received TIC were less likely to have a health risk at the birth.

Higgins et al. (2016) undertook a qualitative descriptive study exploring the experiences of support for women within the maternity services in Ireland, using face-to-face in depth interviews. Findings were analysed using inductive thematic

analysis. The study offered valuable insights to Irish maternity services in 2016 while highlighting the fragmentation of care in units that lack a specialist mental health service. A true strength of this study was the emotional care that the authors provided for the participants (Parahoo 1997). One of the themes that emerged from the findings was the feeling among women that they were misunderstood, particularly by midwives, who were sometimes sceptical of their ability to care for their infants due to their emotional distress. This sense of mistrust was particularly evident in the case of a woman who disclosed a history of childhood sexual abuse. She requested that no males be present during her birth, but the only way this could be accommodated was by scheduling a planned induction of labour during standard working hours. This rigid scheduling highlights the lack of flexibility in the system to meet the needs of women with a history of trauma, further underscoring the need for more individualized and TIAC. The study highlights the need for TIC underpinned by trustworthiness, transparency, empowerment, and choice (SAMHSA 2014). Incorporating TIC into maternity services within Ireland could address these gaps by tailoring care to the individual needs of women, particularly those with traumatic pasts. Waddell (2019) emphasises the importance of understanding each woman's unique experiences and needs. A TIAC could ensure that women feel understood, respected, and supported throughout their maternity care journey, addressing not only their physical health but their emotional and psychological well-being.

Allied to the need for enhanced trust in TIC, the findings of Higgins et al. (2016) are congruent with the findings of Mule et al. (2022) in understanding why some women do not fully disclose their history of trauma or mental health at their psychosocial assessment. Mule et al's. (2022) Australian study revealed that 99% of women expressed they felt comfortable with their psychological assessment but, only one in ten said they were completely honest during the assessment. The analysis addressed themes such as; lack of trust in the midwife and a fear of a

negative perception as potential causes for a lack of honesty. The robust sample consisted of 1796 women. A questionnaire was used to gather data two weeks post the psychological assessment. They had an open-ended question for participants to elaborate their reasons for non-disclosure. One-hundred-and-sixty-one (n=161) respondents answered this question, thematic analysis revealed there was a fear of negative perceptions from others, a lack of trust in their midwife, and issues with time and the mode of assessment. Data was collected within two weeks reducing the likelihood of recall bias. The alignment of the findings of Higgins et al. (2016) and Mule et al. (2022), highlight the challenges faced by women in disclosing their trauma or mental health history during perinatal psychosocial assessments. Both studies underscore the critical need for midwives to adopt TIAC practices.

By building trust, offering non-judgmental support, and creating safe environments, midwives can encourage open and honest communication, leading to better PMH outcomes. Implementing TIC may help mitigate the fears of negative perception and lack of trust that hinders full disclosure, ensuring that women receive the comprehensive care they need (Waddell 2019; SAMHSA 2014). Throughout this theme the model of midwifery care provision was examined. The current system operates under efficiency and consistency which appears to be resulting in women receiving substandard care, particularly for women experiencing complex psychosocial needs and trauma histories (de Boer et al 2022). Limited time, rigid protocols and the lack of continuity of care are all factors contributing to environments where trauma remains unnoticed, unspoken, undisclosed and unaddressed (Huo et al 2023). A trauma-informed approach to care framework is a key part to delivering a maternity service that recognises and responds to trauma (Long et al 2024). The introduction of a trauma-informed care framework is hindered by systemic constraints and an organisational culture that is remaining static (Emsley et al 2022). By standardising care, there is a risk of compromising

women's mental health, silencing their voices and overlooking their trauma histories. The integration of trauma informed care into maternity services is no longer an optional enhancement but rather an essential evolution towards care that is inclusive, responsive and impactful (Sperlich et al 2017). With the broadening recognition and understanding of maternal mental health and trauma histories, there is a need to prioritise trust, choice, empowerment and safety within maternity services (Moran et al 2023). If maternity services commit to a trauma informed framework only then will the needs of all women truly be met.

## 2.3 Future Directions for TIAC

TIC is recognised as "*a whole system organisational change process which seeks to embed theoretically coherent models of practice across diverse settings and roles, including child welfare, family support, justice, mental health and education*" (Bunting et al 2019, p.1). The concept emerged from the seminal work on adverse childhood experiences (ACE) in a US study conducted by Felitti et al. (1998) which was influential in the field of trauma and stimulated extensive further research on the topic.

The definition of a midwife is to be 'with woman' (Health Service Executive 2024). Throughout the authors exploration of the available literature, there was compelling evidence that the midwife is in a prime position to influence, support, and provide TIC and reduce the risk of possible re-traumatization. Tolan et al's (2022) commentary paper suggest when midwives relate to women in a way that emphases safety and a holistic trauma informed approach, then they can mitigate the risk of further harm and positively impact women. From the preceding evidence, it appears to be of the upmost importance that the midwife is aware of the distinctive role that she/he plays when caring for someone who has had a previous trauma in their life. The role of the midwife is to be sensitive and avoid re-traumatisation as, their work may need to be undertaken in extremely intimate circumstances (Rhodes and Hutchinson 1994). Examinations, conversations,, the language, assisting women with feeding, or birth positions are all examples of intimate scenarios. Any of these scenarios can be triggering to somebody who has experienced a trauma in the past (Gorfinkel et al. 2021).

Simpson and Catling (2016) confirmed that poor quality interactions with health care providers had a negative impact on women during their perinatal journey. Laubmann's (2021) detailed exploration of trauma's impact on women's

experiences during pregnancy and childbirth, as outlined in the experiences shared by doulas and the insights from Simkin and Klaus (2004), underscores the importance of adopting TIAC in midwifery practice. Laubmann (2021) offers ways in which the midwife can become trauma-sensitive, helping them to understand how childhood sexual abuse or a history of childhood trauma affects pregnancy, labour and birth. In doing so midwives may be able to identify possible signs and triggers which will ultimately help in building a link between the past and current concerns. Effective TIC involves not only acknowledging and understanding the impact of past traumas but also integrating this awareness into practice to support women holistically (Benton et al. 2024). Midwives and other caregivers must be prepared to work with trauma triggers sensitively, ensuring that all interactions are supportive and empowering (Isobel 2023). This approach emphasizes the importance of individualized care plans that respect and accommodate the emotional and psychological needs of women, ultimately contributing to positive birth experiences and better mental health outcomes.

The significant influence of the care provider is highlighted by Rollans et al. (2013). The authors carried out an observational study of 34 pregnant women and 18 midwives within two tertiary Australian hospitals. The researchers sat in the room while the midwife carried out a psychosocial assessment of the women in pregnancy. It was noted that the midwives' style in carrying out the assessment varied but that midwives were generally empathetic when exploring the women's issues. The process of the psychosocial assessment and depression screening is mandated as routine care in Australia. Researchers are obligated to avoid harm, known as non-maleficence however this was not explicitly detailed in their paper. The psychosocial assessment is quite a personal assessment and women may not always be honest, especially if they know they are being observed, however the researchers failed to note this as a limitation of their study. If the woman did not feel comfortable to disclose a past trauma because she was being observed,

this could have a knock-on effect on the rest of her pregnancy (Perera et al. 2023). Furthermore, if the women were not comfortable to fully disclose, then the researchers may not have been able to observe the midwife's practice in challenging circumstances. Interestingly, Mule et al. (2022) later looked at why women may not fully disclose at a psychosocial assessment. This study again was carried out in Australia and using a mixed methods approach. A lack of trust in the midwife was cited as one of the contributing factors. This places emphasis on the importance of building a relationship with the women before carrying out the assessment. The authors exemplary use of participant voice displays transparency in the results in this particular study (Lockwood et al. 2015). Another dynamic of the midwife-woman relationship is recognised by Millar et al. (2021) who sought to develop TIAC recommendations by gaining understanding of the pregnancy and childbirth experiences of adolescent mothers with a history of childhood trauma, they found that participants wanted to build a relationship with their care giver, they didn't want to keep re-telling their story to new carers indicating their desire for continuity of care.

Sperlich et al. (2017) undertook a similar review which explored the conceptual and practical issues when integrating TIC into maternity practice within the USA. They recognised that providing TIC as part of midwifery practice has the potential to prevent adverse outcomes, break intergenerational cycles of maltreatment and mental health disorders and change the mothers and child's life span trajectories into a positive direction. They conclude that the global community of midwives are ideally positioned to support each other in creating ways to mitigate problems stemming from childhood maltreatment and adversity with the women in their care. Subsequently, when Stokes et al. (2017) explored nurses' knowledge and experiences in relation to TIC they described the uniqueness of the patient-nurse relationship and the importance of this relationship in preventing re-traumatization. Both Sperlich et al. (2017) and Stokes et al. (2017) underscore the importance of

midwives adopting trauma-informed practices to create a supportive and empathetic environment that fosters trust and open communication. By embracing TIC principles, midwives may be better able to address the complex care needs of women who have experienced trauma, thereby improving overall care quality and supporting positive long-term outcomes for both mothers and their children.

The importance of system wide TIAC is highlighted by Zingaro (2012) who suggests that one of the main problems for healthcare workers in providing TIAC, is the struggle to hold on to a safe version of the world when they are consistently witnessing and hearing stories of trauma. It is important that a trauma informed programme recognizes that the team involved in the provision of TIC may have their own experiences of trauma, or may be unsafe in their own personal life, even when they are offering safety and support to others.

As previously discussed Stokes et al. (2017) explored nurses' knowledge and experiences related to TIC. The participants reflected on how trauma effects them describing it in two distinct forms: vicarious traumatization-where a nurse is left traumatized by the patient's story, and, direct traumatization, where the patient traumatizes the nurse by their actions. The participants depict how trauma perpetuates trauma. Stoke's et al (2017) findings exemplify the importance of acknowledging how trauma affects not only the patient but also health care providers and the health system as a whole. Stoke's et al (2017) suggest that research expand upon current practices of debriefing to establish ongoing opportunities for self-reflection.

Similarly, Mollart et al. (2009) explored the impact that conducting a structured antenatal psychosocial assessment has on the midwives' emotional wellbeing in Australia. Although this research study is dated, it was included as there was no later published research in this area. The findings revealed the negative impact the

psychosocial assessment may have on the midwife. The midwife may feel unsupported, frustrated, and stressed which often results in midwives resorting to unhealthy coping mechanisms. The study identifies the possible personal costs to the midwife who experiences repeated revelations of domestic violence, childhood trauma, drug/ alcohol use, depression, and other troubling issues. This qualitative study was carried out using focus groups. The researchers recommend that organisations need to implement training and support programmes for midwives in counselling skills, stress management and education on referral pathways. An earlier allied study; Mezy et al. (2003), carried out focus groups to examine midwives experience of routine enquiry about domestic violence in London. This study revealed that midwives' own experiences of domestic violence can impact the discussion, emphasising the importance of adequate support for midwives in the provision of TIC. More recently Haider (2024) acknowledged that female healthcare professionals are more likely to experience domestic abuse, this can be for a number of reasons such as the resilience associated with a medical role or personality traits of healthcare professionals, such as empathy and compassion, which may result in tolerating abusive relationships for longer. Haider (2024) recalls her personal experience of domestic abuse and the acts of human kindness, positive workplace culture and powerful conversations with colleagues that got her through the experience. This publication is of profound significance in understanding how healthcare professionals not only address the issues of past traumas, but how their own experiences can influence this also.

Another aspect of bearing witness to trauma was reported by Minooee et al. (2019) who carried out a scoping review examining the impact of birth trauma on clinical decisions by midwives. Their findings revealed that witnessing such trauma can lead to diminished self-confidence, increased hyper-vigilance, and defensive behaviour. The study also highlighted that while some midwives may struggle with the emotional aftermath, others find personal and professional growth through their

experiences. These findings highlight the significant impact trauma can have, not only on the individuals receiving care, but also on those providing it. These insights are crucial for understanding the need for TIC across all levels of perinatal service provision. By accessing adequate clinical supervision and support, midwives may better manage their responses to trauma, ensuring that their well-being is maintained and that they continue to provide compassionate, effective care (Bingham et al. 2023). This was the first study to explore the literature on the impact of birth trauma on decisions of midwives. The researchers used 40 studies in their review, almost all the studies were conducted in high resource countries so the findings may be transferrable to an Irish perspective (Parahoo 1997).

Ertan et al. (2021) echoes the importance of a TIAC within maternity service in their cross-sectional online survey of 916 mothers and 64 partners which examined the link between a history of trauma and birth outcomes. The study is notable for the inclusion of partners, who are rarely included in such research, albeit that their response rate was low. Correlational analysis, conducted separately for mothers and partners, suggested that among mothers, past traumatic experiences and distressing events during childbirth were significantly linked to difficulties with mother-infant bonding and postpartum depression. Interestingly partners who had experienced past traumatic events scored significantly higher on the City Birth Trauma Scale (Ayers et al. 2008) which measures assesses PTSD following childbirth, compared to partners who had not experienced past traumas.

Emerging evidence continues to highlight that exposure to trauma can have significant impact on healthcare workers. Patterson et al. (2018) lends further insight into the effects of trauma on midwives as she describes how the pressures from within the healthcare system leave no time to comfort women affected by traumatic events or allow midwives to take care of their own wellbeing. This can result in midwives withdrawing or switching off from women. Midwives may suppress their emotions and present a hardened demeanour, thus becoming less

empathic or compassionate towards women and no longer willing or able to enter intimate professional relationships with women. While this may protect midwives from further stress, the loss of empathy and compassion, alongside being fearful, may lead to compromised care that ignores women and instils fear in them (Patterson et al 2018). SAMHSA (2014) recognise the impact of vicarious trauma and advises that organizations must ensure that resources are in place to support staff with trauma histories and/or those experiencing significant secondary traumatic stress resulting from exposure to and working with individuals with complex trauma. Moving forward, integrating TIAC principles for both carers and service users will be essential to ensuring that midwifery practices remain empathetic and supportive, addressing the emotional needs of both the women they serve and themselves (McArthur et al 2015; SAMHSA 2014).

Exploration of the available literature reveals that a key aspect of TIC is integrating TIC into routine practice. For example, Sachdeva et al. (2022) carried out a comprehensive review of the literature exploring TIC in perinatal services. In their review Sachdeva et al. (2022) highlight the importance of screening for a trauma history. They note that trauma survivors may not disclose their past traumas out of fear, shame or feelings of helplessness. Recognition and acknowledgement of trauma by healthcare professionals empowers women to communicate their choices and exert control over their perinatal experiences ultimately decreasing the likelihood for traumatization and mitigation of trauma related symptoms. The literature review by Sachdeva et al. (2022) offers a relatively current stock-take of the evidence with trauma informed psychiatry.

The journey towards a more TIAC is offered by Millar et al. (2021) who carried out a mixed methods study on pregnancy and childbirth experiences and preferences of adolescent mothers with a history of childhood trauma in Canada. The aim of the study was to develop TIC practices. The quantitative component of the study uses a cross-sectional survey which revealed 79.3% of participants felt they should

be asked about their trauma history by the care provider, but only after getting to know them, while 51% felt discussing trauma at their first appointment/ meeting with the care provider was not appropriate. The qualitative aspect further elaborated on this, finding that the interviewees wanted their trauma to be acknowledged by the care provider, as they would not be inclined to initiate the conversation themselves. The mixed methods approach allowed the researcher to develop on initial quantitative findings. A limitation of the qualitative findings is that interviews were conducted over only 15–35-minute periods. It is difficult to comprehend how an interview can last less than 30 minutes, especially when only one interview is carried out per person. It can take a great length of time for the interviewer and the interviewee to exchange civilities and engage in conversation let alone allow in-dept discussions to occur (Parahoo 1997). The study does provide an understanding of the impact of childhood on birth experience adding to the overall body of research in the area. It was also important to include this study as there is a limited amount of quantitative data on TIC.

On the more severe end of the spectrum of mental health challenges, Campodonico et al. (2022) undertook a qualitative study exploring the perspectives of people with psychosis and the influence of traumatic experiences on psychotic symptoms and quality of life. This study was selected for inclusion as people who experience psychosis report higher rates of trauma history (De Vries et al. 2018) but may be more unlikely to disclose a trauma history (De Vries et al. 2019). This study gives maternity care providers an insight into the importance of being trauma informed. A key finding from this study was the significance given to discussing trauma. Through semi-structured interviews with 11 participants, lasting between 50-90 minutes, participants revealed that on many occasions they wished somebody had asked them about their difficult life events, this finding is concurrent with Millar et al. (2021).

Participants in Higgins et al. (2016) Irish qualitative study recognised the lack of time midwives had to engage in conversation. They also highlighted the importance of having a specialist service for women experiencing PMH difficulties. These findings highlight a critical gap in current maternity care provision that TIAC may address by ensuring that midwives have the time and resources to engage empathetically by providing access to specialist services for mental health support.

By adopting a TIAC, maternity services may better meet the emotional and psychological needs of women, ultimately improving care outcomes and supporting a more holistic approach to maternal health (SAMHSA 2014). However, a referral to the perinatal midwife specialist is usually only made if the problem is identified. Hanon et al. (2022) recognised this in their Irish quantitative prospective. They recommended that midwives should be attentive in identifying women's mental health and predisposing risk factors. Enhanced integration of TIAC into midwifery practice could address this issue by fostering a proactive, rather than reactive, approach to care. TIAC principles advocate for continuous support, emphasizing the importance of midwives being vigilant and sensitive to mental health and trauma-related risk factors.

A qualitative evidence synthesis involving 25 different research studies from various high-income countries exploring the views of women and maternity care workers on the routine discussion of previous trauma in the perinatal period, was undertaken by Cull et al. (2023). The authors acknowledge that discussion of previous trauma can be complex and may require careful consideration, sensitivity and time. They conclude that there is a need for a routine conversation about trauma but acknowledge that this can be hindered by a lack of time, and a lack of appropriate referral pathways. These findings introduce dilemmas within TIC; women want their trauma acknowledged but there may be lack of time for discussion, limited pathways for referral and support, resulting in women effected

by trauma remaining silenced potentially furthering the shame associated with that trauma (Benton et al. 2024; Mule et al. 2022; Stokes et al. 2017).

SAMHSA (2014) emphasizes that effective TIC requires integrating trauma screening and assessment into routine practice. The evidence illustrates the tension between the desire for trauma to be acknowledged and the systematic limitations that may prevent meaningful engagement with this issue. To address these dilemmas, it may be essential for maternity services to not only prioritize trauma-informed practices but ensure that adequate time and resources are allocated for trauma discussions and clear referral pathways are established. This may help in reducing the stigma and silence surrounding trauma, thereby enabling midwives to offer appropriate support and interventions. Trauma informed care is an evolving landscape in midwifery practice, it plays a critical role in supporting women throughout their perinatal journey (Isobel 2023). The research demonstrates that midwives are uniquely positioned to implement TIAC through the 'with-woman' relationship (Bradfield et al 2019). The implementation of a TIAC faces many challenges such as time limitations, lack of training, unclear referral pathways and the emotional impact on care providers (Huo et al 2023). The literature consistently reports on the importance of caring not only for the women attending the services but for the staff providing the service also (Cull et al 2023). It is important to recognise that healthcare providers may have experienced their own traumas in the past or can be effected by their work through vicarious trauma. (Long et al 2022). Moving into the future a TIAC must be embedded as a whole-system approach to change that addresses and offers support, education, equal access to trauma informed resources and reflective practice for everyone in the organisation. By integrating these system wide changes, the maternity services can respond to the complex psychological and emotional needs of all those within the organisation (Benton et al 2024).

## 2.4 Shame- The emerging understanding of Trauma Informed Care

*"Organizations need to actively move past cultural stereotypes and biases and recognise and address historical trauma"* (SAMHSA 2014, p.11).

Research has shown that people receiving care in mental health settings can experience feelings of shame and stigma because of their situations (Scheff and Mateo 2016; Jones and Crossley 2008). The perinatal period is a time when women have reported multiple opportunities to experience shame i.e. shame of their appearance (Fair et al. 2022), feeding choices (Jackson et al. 2022), birth outcomes or even their ambivalent emotions during their pregnancy (Pilkington and Bedford-Dyer 2021). Women who have survived a trauma have shown a strong association with trauma and shame (Mirabile et al. 2023). Trauma has been positioned as a significant public health issue. Shame is a key emotional after effect of trauma and emerging literature argues that health professionals may have 'failed to see the obvious' by neglecting to acknowledge the influence of shame on past trauma (Dolezal and Gibson 2022). Shame has also been recognised as a barrier in seeking help and reporting trauma (Sachdeva et al. 2022; Peeler et al. 2018; Muzik et al. 2013) which exemplifies its relevance when providing care to women disclosing trauma histories. *"Shame is the painful feeling defined as a fear of disconnection that there is something about you, if people know about or see it then you will not be worthy of their connection" (Brown 2012).* Often women have suppressed memories of trauma; pregnancy, labour and birth can stimulate those subconscious memories into the present time (Slavic 2023).

Byrom's (2015) exploration of the role of courage in overcoming shame and facilitating the disclosure of trauma or abuse is deeply connected to the principles of TIC. Byrom (2015) wrote a commentary as a follow-up to a book she earlier published alongside Soo Downe (Byrom, and Downe, 2015). In her 2015 commentary, Byrom emphasizes that midwives play a crucial role in establishing

a partnership with women that fosters the courage needed to address and break the silence surrounding their traumatic experiences. This perspective aligns with the core principles of TIAC, which advocate for creating safe, supportive, and empowering environments for individuals who have experienced trauma. The book *The Roar Behind the Silence* (Byrom and Downe 2015) underlines the importance of kindness, compassion, and respect in maternity care, advocating for an approach that not only recognizes but actively addresses the emotional and psychological needs of women. Byrom (2015) argues that when midwives engage with women in a manner that emphasizes understanding and respect, they help build the trust and courage necessary for women to confront and disclose their traumatic histories. This connection is vital, as trauma is often accompanied by profound feelings of shame, which can act as a significant barrier to seeking help or disclosing traumatic experiences. Shame, is a pervasive and powerful emotion that can prevent women from sharing their trauma, thereby hindering their ability to receive the care and support their need (Dolezal and Gibson 2022). Byrom's insights highlight that midwives, through compassionate and trauma-sensitive care, can help women overcome this shame. This process not only supports the women in their journey toward healing but also enhances the overall effectiveness of the care provided.

Allied to this, Dolezal and Gibson's (2022) exploration of shame-sensitive practice presents a compelling extension to the TIAC framework, highlighting a critical gap in how TIAC addresses the complex emotional landscape of shame. Their analysis argues that while TIAC effectively promotes safety, empowerment and support for those who have experienced trauma, it often overlooks the inescapable and devastating impact of shame. Their concept analysis, suggests that shame-sensitive practice should be integrated into the TIAC framework to better support individuals who are dealing with the aftermath of trauma. The authors argue that TIC, while essential, tends to focus on creating environments that are physically

and emotionally safe but may not sufficiently account for the internalized shame that trauma survivors often carry. This oversight can result in care practices that unintentionally reinforce feelings of shame, particularly in interactions characterized by power imbalances, such as those between healthcare providers and service users. Dolezal and Gibson's (2022) work suggests that to truly support trauma survivors, care providers need to move beyond simply being trauma-informed to also being shame-sensitive. This is a monumental study as it is the first to explore shame-sensitive practice alongside TIC, significantly bridging gaps in the research (Aromataris et al. 2015).

Shame was not only documented as a feeling associated with trauma among women attending maternity services. Kendall-Tackett and Beck (2022) carried out a comprehensive narrative and exploratory review looking at secondary traumatic stress and moral injury among maternity care providers. Shame was a common feeling that impacted maternity care providers. They experienced guilt and shame in the aftermath of caring for women who experience birth trauma. This shame often led to them losing faith in the system. Beck and Gable (2012) describe this as 'haunting shame' that leaves care providers wondering what they could have done differently. Kendall-Tackett and Beck (2022) concluded that work-related trauma can deeply affect maternity-care providers. If not addressed and practitioners are not supported, these events can lead to serious physical and mental health issues for providers and possibly impair the care they provide. Healing is possible for everyone affected by traumatic births, but the first step is acknowledging that these events occur and can directly affect staff. Moving forward, the mental health of all maternity care providers needs to be a priority. These findings starkly highlight the importance of implementing a TIAC maternity service not only for the benefits of the clients but for the care providers also.

By integrating shame-sensitive practices into TIAC, healthcare providers may more effectively address the complex emotional needs of trauma survivors and themselves. By incorporating shame-sensitive practices, TIAC can become a more comprehensive and effective framework for supporting individuals who have experienced trauma, ultimately leading to better health outcomes and more compassionate care. The integration of shame sensitive practises into the framework of trauma-informed care is vital to provide an empathetic and understanding service (Lambert et al 2017). Shame-sensitive practise broadens the lens from which we are currently looking through. It aligns with the key elements of trauma-informed practice through its promotion of empowerment and safe environments that are attuned to the hidden burdens of shame (Dolezal et al 2022). Embracing this practise approach ensures that trauma informed care encompasses healing, compassion and transformation for everyone involved from the cared for to the care provider (Kimberg and Wheeler 2019).

## Conclusion

Defining and delineating TIC can be challenging. There is a distinct gap in Irish literature on TIC, in particular, the knowledge and practices of TIAC among healthcare professionals in perinatal services. Although SAMHSA's concept of Trauma and Guidance for a TIAC was published in 2014 there is little evidence supporting its implementation within Irish health services.

Similar themes have arisen throughout the literature. Few studies have been carried out in Ireland that relate to TIC and no studies have explored how midwives are currently practising TIC or questioned what their knowledge is on TIC. In view of this the following research question has been identified:

'What are the current knowledge and practices related to a Trauma- Informed Approach to care in Midwifery/ Perinatal Settings in Ireland?'

It is recommended by Polit and Beck (2012) that the aims and objectives of a study are clearly identified.

**Aim**

The aim of this research study is to evaluate knowledge and practices related to TIAC within the Midwifery/ Perinatal settings in Ireland.

**Objectives**

The Objectives of this study are:

- To evaluate current *knowledge* related to TIAC within the midwifery/ perinatal settings in Ireland utilising a mixed methods approach
- Evaluate current *interventions* related to Trauma Informed Practices within Midwifery/ Perinatal settings in Ireland
- Develop recommendations to integrate a universal TIAC model within midwifery/ perinatal settings in Ireland

# Chapter Three

# Research Methodology

## Research Design

This chapter presents the methodology used in the current study and presents the philosophical foundation that inspired the choice of methodology. Justification for the research design of mixed methods explanatory sequential design is also presented. The sampling and recruitment process will be discussed in addition to explanation of the data collection process. The strengths and challenges related to the methodological choices will also be explored, while highlighting all the choices made to ensure validity, reliability and rigour within the study.

## Paradigmatic Considerations

Research methodology is often understood within the framework of a paradigm, a concept originally introduced by Thomas Kuhn in *The Structure of Scientific Revolutions* (Kuhn 1970). Kuhn's notion of a paradigm extends beyond a simple "school of thought" to encompass an entire worldview that fundamentally shapes the research process. According to Halcomb and Hickman (2015), a paradigm serves as a comprehensive perspective on phenomena that guides and informs methods of inquiry, thereby influencing the researcher's approach to selecting topics of study, choosing appropriate methods, and analysing and interpreting data. A research paradigm is composed of four interconnected components: ontology, epistemology, methodology, and method. Ontology concerns the nature of reality, addressing questions about what is real and how the world is perceived. Epistemology, on the other hand, focuses on the nature of knowledge, exploring the sources and validity of what is claimed as knowledge. Methodology involves the overall strategy or approach used to gather knowledge, while the method refers to the specific tools and techniques employed in data collection (Lincoln and Guba 1985).

These four components collectively form the foundation of any research paradigm, guiding researchers in their quest to answer specific research questions. As Parahoo (1997) points out, paradigms not only determine the types of phenomena that can be researched, but also the ways in which these phenomena are studied and understood. The ontological, epistemological, and methodological assumptions inherent in a paradigm shape the researcher's perspective and influence the design and execution of the study. The distinction between methodology and method is particularly important. While methodology refers to the broader strategy or rationale behind the research process, method pertains to the specific instruments or procedures used to collect data (Polgar and Thomas 2020). Methodology, therefore, plays a crucial role in guiding researchers as they navigate the complexities of their research questions. The selection of an appropriate methodology is not just a technical decision but a foundational one that impacts the integrity, interpretability, and clinical applicability of the research findings (Polit and Beck 2013).

Understanding these components is essential for researchers as they plan their studies. The choice of ontology, epistemology, methodology, and method must be carefully aligned with the research question to ensure that the study is rigorous and that the findings are meaningful. As Bunniss and Kelly (2010) emphasize, different paradigms offer various ways of conceptualizing and conducting research, each contributing uniquely to the construction of disciplinary knowledge. Therefore, the selection of the appropriate paradigm is a critical step in the research process, influencing not only the design of the study but also the relevance and utility of its results.

Qualitative and quantitative methods are two methodological approaches in research. Qualitative research is based in the interpretivist paradigm where understanding the human experience as it is lived is the emphasis of this type of research (Polit and Beck 2013), and that understanding is gained from a person's

experience or feelings (Polit and Beck 2014). It is the belief that the social world is actively constructed by human beings and that individuals are continuously involved in making sense of or interpreting social environments (Milburn et al. 1995). Counter to this. Quantitative research is derived from a positivist paradigm which is based on the belief that reality can be observed or measured (Mack 2010). Positivism seeks to find explanations in empirical data with the belief in the notion of cause and effect (Parahoo 1997). Data is used to explain and increase knowledge about the physical world that people are a part of. Ideally, precise measurements are obtained, in an objective manner, of each part of the subject, event or process (Cluett and Bluff 2000). Mixed methods research integrates qualitative and quantitative data within a single programme of investigation (Halcomb and Hickman 2015).

Pragmatism offers an alternative epistemological paradigm (Hall 2013). It refers to a worldview that focuses on ‘what works’ rather than what might be considered absolutely and objectively ‘true’ or ‘real’ (Weaver 2018). Early pragmatists rejected the idea that social inquiry using a single scientific method could access truths regarding the real world. These pragmatists declared that truth could be judged by its consequences. The pragmatic paradigm is useful for guiding research design, especially when a combination of different approaches is philosophically inconsistent (Hall 2013). Tashakkori and Teddlie (2003) suggest that at least 13 different authors embrace pragmatism as the optimal world view for mixed methods research. Pragmatism draws on many ideas, including employing ‘what works’, using diverse approaches, and valuing both subjective and objective knowledge (Creswell and Clark 2018). Pragmatism presents a radical departure from age-old philosophical arguments about the nature of reality and the possibility of truth. In this new worldview, knowledge consists of warranted assertions that result from taking action and experiencing the outcomes (Dewey 2008). most of the focus in mixed methods research traditionally was on practical, procedural

issues about how to combine the strengths of qualitative and quantitative methods rather than philosophical claims. Thus, for most of the researchers operating within the field of mixed methods research, the appeal of pragmatism was more about its practicality than in its broader philosophical basis (Morgan 2014). This study pursues the pragmatist paradigm to support its use of a mixed methods approach. Pragmatism emphasizes practical solutions and is flexible in its methodology (Hall 2013). Neither the qualitative nor the quantitative is prioritised, the pragmatist approach values both the subjective and the objective knowledge (Allemang et al 2022). In this study, the research question was complex, in order to address and gain knowledge on the research topic neither qualitative nor quantitative methods were prioritised, so it aligns best with the paradigm of pragmatism (Morgan 2014). Pragmatism is evident in the chosen method of recruitment and use of non-probability sampling which offered an assessable way to reach the relevant participants. In data collection pragmatism is seen through the combination of the online survey and the follow up online focus group interviews which connected with the participants who are predominately shift workers from different geographical areas and finally the integration of both descriptive statistics and Brau and Clarke's thematic analysis (2006) to analyse the data. These choices reflects a 'what works' approach and allow for the generation of meaningful, context bound and insightful through the strengths of qualitative and quantitative methods (Morgan 2014).

## Mixed Methods Research

Mixed methods research draws from multiple scientific traditions and disciplinary backgrounds. Mixed methods research is a type of research in which a researcher combines elements of both qualitative and quantitative research approaches (e.g. use of qualitative and quantitative viewpoints, data collection, analysis, inference techniques) for the broad purposes of enhancing breadth and depth of understanding and corroboration (Johnson et al 2007).

Begley (2008) believes by combining methods the depth and extent of a research study can be improved. Mixed methods research began in the early 1960's among anthropologists and sociologists. The term 'triangulation' was then coined. Triangulation is the use of two or more data sources, theoretical perspectives or methods in a research study to compare findings and hence achieve greater validity (Gerrish and Lacey 2006). Mixed methods differs in that it combines two paradigmatic outlooks by utilising both a qualitative and a quantitative approach. Moreover, these research approaches involve integration of the qualitative and quantitative results to provide an enhanced and comprehensive answer to a research question. Data integration, a process of systematically merging quantitative and qualitative data, can occur in numerous ways and at various levels during the study design, methods (data collection, data analysis), and reporting/data interpretation stages (Creswell and Clark 2018). During the emergence of mixed methods as a research method, several researchers found it challenging combining paradigms (Smith 1983; Creswell and Clark 2007). This led to the 'Paradigm debate period' that found scholars arguing whether or not qualitative and quantitative methods could be blended (Creswell and Clark 2007). This research study adopts a mixed methods design, which is rationalised "that neither qualitative nor quantitative methods are sufficient, by themselves, to capture data. When used in combination allow for a more robust analysis, taking the advantages and strengths from each" (Ivanoka et al 2006, p.3).

There are two primary considerations in the overall design of a mixed methods study which are, how the components will be integrated, and the timing as to when each component is carried out (Creswell 2013). These aspects define the fundamental relationship between the various components of the study. Research can be carried out concurrently or sequentially. In a concurrent research design both the qualitative and quantitative data are collected at roughly the same time, they are therefore independent from each other. One does not inform the other (Bell et al. 2022). In this study the data is collected in a sequential manner meaning that the quantitative date is collected first and used to then inform the qualitative data collected after it.

## Research Design

Figure 1.1

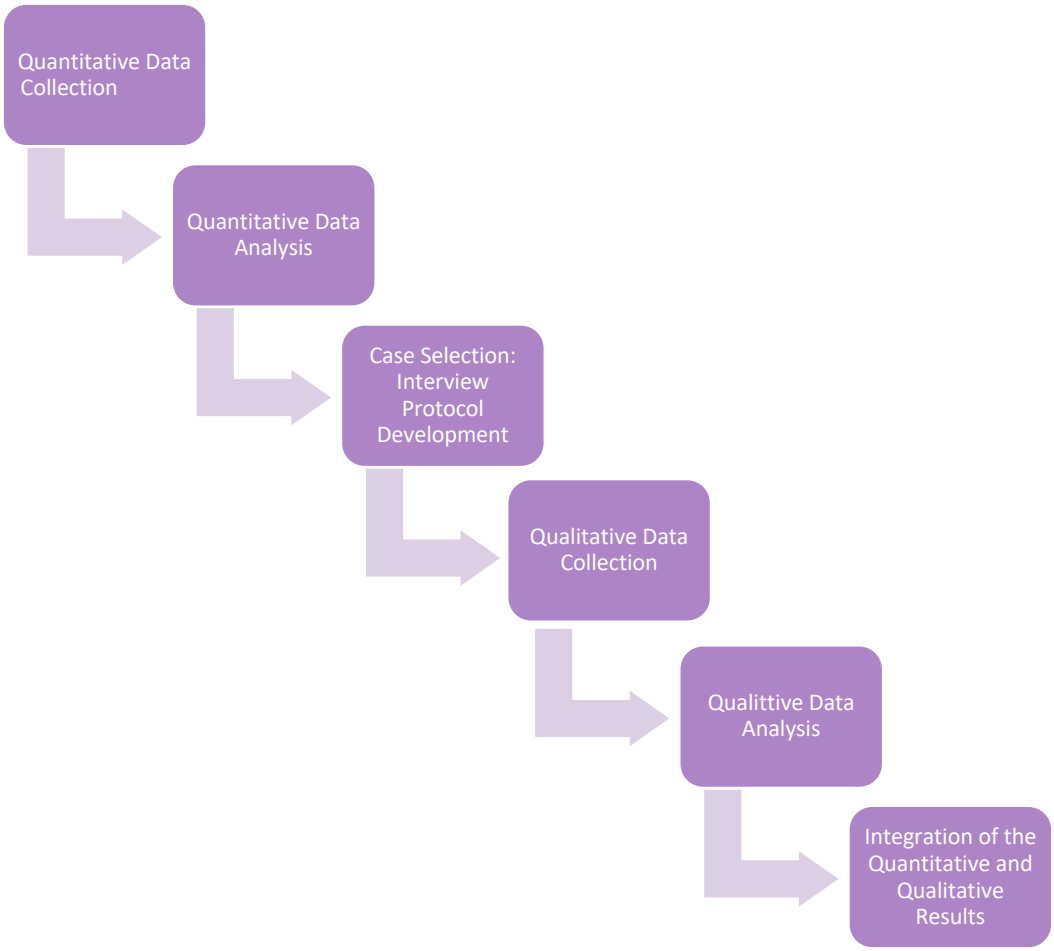
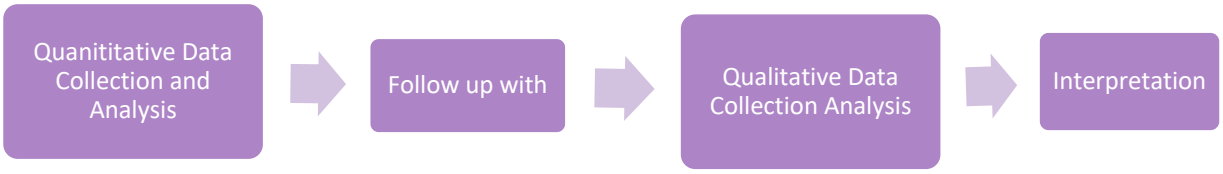



Diagram for use of Explanatory Design, figure adapted from Creswell and Clark 2007, p.121, Figure 4.4.

When utilising a sequential design, '*exploratory* sequential design' or '*explanatory* sequential design' can be selected. The selection is based on the research question, its aims and objectives. An exploratory sequential design is a mixed methods study design, where the quantitative phase of data collection and analysis follows the qualitative phase of data collection and analysis (Fetters et al. 2013). An explanatory design is typically chosen when the research team anticipates the quantitative measures will not be wholly sufficient to address the research question

(Creswell 2013). In an explanatory sequential design, the quantitative data is collected first and the qualitative data is collected later. An explanatory sequential design is highly popular among researchers (Ivankova et al. 2006). The data collection and analysis for the quantitative component is completed first, and may generate findings that are incomplete or difficult to interpret. The qualitative component is then implemented in order to generate further insights or clarification that may assist in explaining the quantitative findings. Explanatory designs may also be used when quantitative information is required in order to develop the sample for the qualitative phase. This approach, often uses a common sample e.g. a purposeful sample is drawn from the larger sample and used for the qualitative component. The data are integrated either through embedding or connecting. In this study the mixing of data occurs during the data collection stage. The researcher mixes the data by using an approach of connecting where the results from phase one build on to the collection of the data in phase two. Creswell and Clark (2007) explains that the connection occurs by using the results of phase one to shape the collection of data in phase two by specifying research questions, selecting participants, and developing data collection protocols or instruments. The explanatory sequential design occurs in two distinct phase (see Figure 1.2 below). The design commences with the collection and analysis of quantitative data, followed by the second phase of qualitative data collection and interpretation. The design of the second phase is based upon the findings of the first phase. On completion, the researcher must interpret how the qualitative findings further explain the initial quantitative data (Creswell and Clark 2007).

Figure 1.2




The explanatory sequential design, figure adapted from Creswell and Clark 2007, p.69, Figure 3.2.

A mixed methods explanatory sequential research design is used for this study.

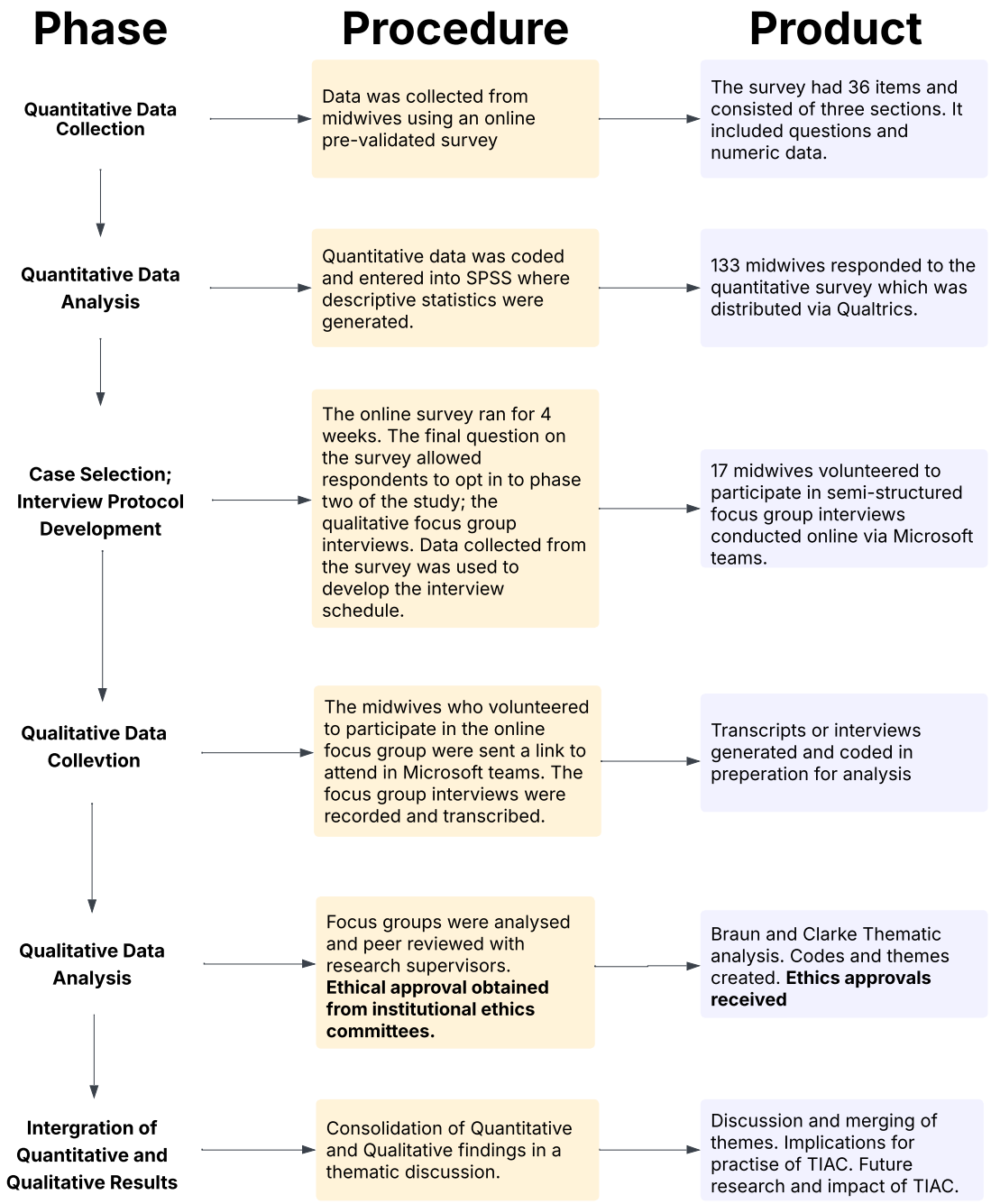
Phase one, the quantitative phase was conducted using a questionnaire and phase two, the qualitative phase was conducted using focus group interviews. Study participants were drawn from the Nursing and Midwifery board of Ireland (NMBI) registered midwives, currently practicing within perinatal healthcare settings in Ireland.

In sequential design, the issue arises as to whether the same or different participants need to be selected for the two phases of the project, and also if the number of participants will be the same or different for the two phases. In this particular study, phase one was quantitative and phase two was qualitative, so samples were unequal given that the nature of quantitative research is to generalise to a population, whereas the qualitative sample is used to provide an

in-depth understanding of a small group of people. Furthermore, since the two samples are not being directly compared as in concurrent designs, the sample sizes in a sequential design do not need to be of equal sizes (Creswell and Clark 2007) . The intent of an explanatory design is for the second phase of the study to help explain the first phase, therefore the data collection strategy is to select the same or a subset of the same participants from the initial, quantitative phase for the second follow-up qualitative phase (Ivankova et al. 2006).

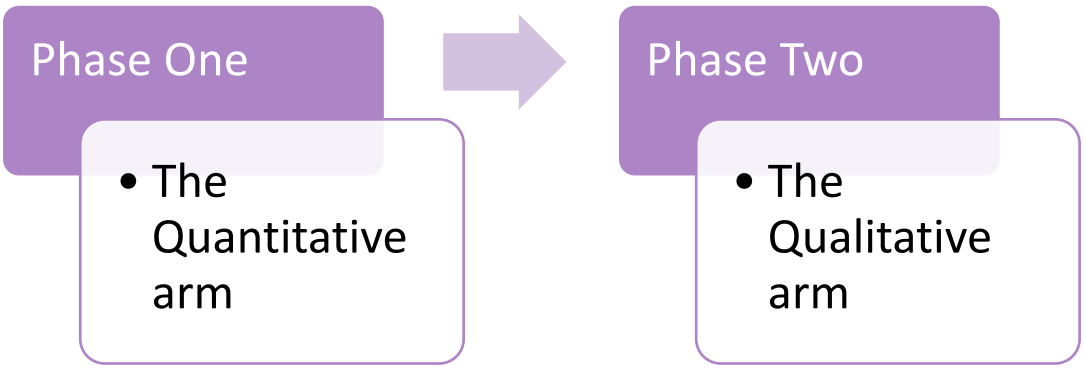
The advantages of an explanatory sequential design are widely identified in existing literature (McBride et al. 2019; Creswell 2005; Moghaddam et al. 2003; Creswell et al. 1996). Explanatory sequential design is straightforward to implement as the researcher conducts the two phases- quantitative, then qualitative,- separately, and collects only one type of data at a time, the final report is written with a quantitative section followed by a qualitative section, making it straightforward to write whilst providing delineation of dual informed data that will be further integrated at discussion (Creswell and Clark 2018). Creswell and Clark (2018) also identify some of the limitations associated with this design including the lengthy time it can take to carry out and complete the study as it is conducted in two separate phases. This also means that the participants must be available for a prolonged period of time, resources to collect and analyse the data may also be a challenge (Ivankova et al. 2006).

See the flowchart below for details on the full study design



**Research Methods**

Following an explanatory sequential research design, this study was conducted in two phases of investigation. Following discussion of the ethical considerations aligned to this study, data collection processes will be further discussed.




**Ethical Considerations**

Data from phase one was collected via Microsoft forms. No identifying information was attached to this dataset. If participants wished to volunteer for phase two, they were directed to an alternative link where contact details can be provided. This data was disaggregated from survey data.

Phase one data was stored in a password protected file on a password protected and encrypted laptop and only made available to the researcher and supervisors. Participants who volunteered for phase two were interviewed via online focus groups. The interviews were recorded and transcribed by the researcher. This data was stored in a password protected file on a password protected and encrypted laptop and only made available to the researcher and her supervisors. Information gathered in phase two was coded using pseudonyms to ensure confidentiality. The information gathered will be destroyed 6 months after the research study has

finished and findings have been published. This was explained in the participant's information email/ document. The study intends to do no harm to the participant and adhere to the DKIT/ NMBI ethical guidelines.

The researcher was aware of the risk to participant's wellbeing by asking them to consider and talk about events that they may have found traumatising. All participants were provided with information on how to access help or support if they needed this. All participants reported that they enjoyed the discussion and found it meaningful to reflect and talk about their experience.

The study will adhere to the NMBI Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives (NMBI, 2015) as follows:

*Respect for Persons/Autonomy*

Participants had the right to choose whether to participate in research study.

They received information outlining the nature of the study, including the likely risks and benefits, allowing them to make an informed choice/ give informed consent.

Participants had the right to withdraw from the study at any time with no consequences up to the point that the transcripts of the focus groups had been irrevocably pseudonymised during verbatim transcription, as beyond that point in the time the original audio recordings would have been deleted. However, participants were assured that beyond the point of transcription only pseudonyms were included, and it was not feasible to attribute any contributions to any individual person.

*Beneficence and Non-maleficence*

Participants had the right not to be harmed. The potential benefits of this study were balanced against potential risks to safeguard all contributors. In the unlikely event the study triggered emotional/ psychological upset, data collection would be

suspended, and participants would be supported and provided with the contact details of the Employee Assistance Programme which is available to all HSE employees free of charge.

*Justice*

Participants were treated fairly and equitably before, during and after the research study. There were no expectations about participation/ continued participation during the study period. All decisions made by participants were accepted without prejudice.

*Veracity*

Participants had the right to be told the truth and not to be deceived about any aspect of the research study. All aspects of this research project were explained by the researcher and all reasonable efforts were made to ensure the participants understand the implications of their participation throughout the study.

*Fidelity*

The researcher ensured that the participants understood the risks and benefits of participating in the study. Participant information document(s) were supplied to all contributors.

*Confidentiality*

The researcher ensured that anonymity was maintained in phase one by disaggregating volunteered contact details from the survey data. Confidentiality was maintained in phase two by assigning an identification number to each participant.

Careful consideration was given to achieving the research objective without any/ with minimal collection of personal data and/or the processing of data in such a way that prevented any ‘damage or distress’ to study participants.

The single caveat in this undertaking is the qualified confidentiality, which is explained to participants in the information provided, that an exception to absolute confidentiality if disclosures revealed a situation which placed others at risk to such an extent as to impose a duty-bound obligation on researchers and/or others present.

## Ethical Approval

Further information and the final ethics application (See Appendix B) was submitted on the 19/04/2023. Ethical approval was granted by Dundalk Institute of Technology ethics committee on the 03/05/2023. (See Appendix C)

## Phase One: Quantitative Data Collection

### *Population and Sampling for Phase One-*

One of the crucial tasks in designing a research project is to decide on the number and characteristics of the respondents who will be invited to take part in the study (Mesa 2016). A population can be defined as the total number of units from which data can potentially be collected (Parahoo 1997). In this study the population is the total number of registered midwives working in a client facing service in the ROI. The total number of registered midwives in client – facing roles appearing on the active register with NMBI is 3850 (NMBI 2022). It is not always possible to include the entire population in a study, not least because of costs and time involved. For this reason researchers select a proportion of the total number of potential respondents from whom to collect data . A proportion or subset of the population is known as the sample (Parahoo 1997). To calculate a sufficient sample size, a sample size generator was used to estimate this number (https://www.qualtrics.com/blog/calculating-sample-size/) yielding a 95% confidence with 5% margin of error giving a sample size of 350 participants based on the population size of 3850 (NMBI 2022).

A list of all the units of the target population provides the frame from which a sample is selected, a sample frame contains the same number of units as the target population (Parahoo 1997). There are some ready-made sample frames such as lists or registers. Due to General Data Protection Regulation (GDPR) (Government of Ireland, 2018) the contact details of midwives on the NMBI register could not be obtained. Midwives in the ROI can also practice in both the public and the private sector. With both of these issues the target population could have been challenging to access. However, a pragmatic approach to recruitment was adopted which will be further detailed below.

Non-Probability sampling is used when it is necessary to derive a sample from an unknown or hidden population (Procter and Allan 2006). As is the case in this study where it was not possible to obtain a comprehensive list of the study population, the researcher used a non-probability sampling scheme. Non-probability sampling schemes are commonly used in nursing research (Procter and Allan 2006). Non-Probabilistic/non-randomized social media volunteer sampling was employed in phase one to recruit respondents. This sampling approach has been advocated by Leighton et al. (2021) who deemed it both an effective and efficient way to recruit participants. Respondents from phase one were then asked to volunteer their consent for inclusion in phase two of the study.

***Recruitment for Phase One –***

Participants in phase one were recruited using non-probability sampling via social media. It has previously been noted that recruiting research participants from specific groups i.e. midwives, can be problematic (Browne 2002). Cleary-Holdforth (2020) previously demonstrated that studies carried out on midwives in the ROI may have low response rates. Cleary-Holdforth (2020) had a response rate of 22.3% while another study by O'Riordan et al. (2019) had a response rate of 7.2%

from midwives, and Smith et al. (2018) had a response rate of only 2.8% among midwives.

In order to recruit midwives via their workplace, the researcher would have had to gain ethical approval from each ethics committee or each hospital group totalling to 13 ethics applications including the ethics application to DKIT. Each ethics committee met at different times and most of them did not have availability for the project to be discussed in a timely manner. In addition, by accessing the midwives via their hospital based workplaces, this excluded midwives working in community settings or GP practices.

Non-probability sampling was a way of accessing this unique population due to the time restraints on the project (Elfil and Negida 2017). Recruiting participants through online advertisements emerged as the most viable option. A poster was designed and used to advertise the study online (Appendix F). Social networking sites have made it possible to conduct questionnaire research faster, cheaper, and with less assistance than alternative options (Bhutta 2021).

Non-Probability sampling was employed in phase one to recruit respondents. This sampling approach has been advocated by Leighton et al. (2021) who deemed it both an effective and efficient way to recruit participants. The purpose of this phase was to collect valid and reliable data from a subset of the population in order to inform in depth data gathering in phase two.

As previously mentioned, the Nursing and midwifery population in Ireland can be a challenging population to recruit for research. Bethel et al. (2021) identified these barriers to recruitment as questionnaire fatigue, hospital structures and institutional review boards as gatekeepers to accessing participants, and limited

generalizability of findings. To help counter this, social media presented an alternative and innovative way to recruit participants for this research. Social media platforms offer health researchers a wealth of opportunities for increasing the efficiency of recruitment efforts that is low-cost (Arigo et al. 2018).

The sample for phase one was recruited via midwifery specific accounts on established social media platforms (e.g. Twitter© etc.). Additionally, the following professional organisations hosted an invitation link to the study to enhance recruitment; NMBI, Irish Nurses and Midwives Organisation (INMO), The Midwives Association of Ireland (MAI) and Birth Rights Alliance. Respondents had to confirm that they were on the NMBI Live register of midwives before undertaking the questionnaire.

### *Data Collection Tool for Phase One*

For this quantitative phase of the research, an online questionnaire was chosen as the most appropriate data collection tool as it was the most efficient way of collecting data from a dispersed sample and it helped to ensure study robustness as it allows recruitment of a large sample (Van Quaquebeke et al 2022). The researcher sought permission to use a previously validated tool/ questionnaire to gather data (King et al. 2019) (Appendix E). Questionnaires are suitable where the researcher wants a broad overview of the phenomenon, and they can be used as a platform for further in-depth study (Kelley et al. 2003). Questionnaires are one of the most common methods of data collection in social and health research (Taherdost 2021). A questionnaire seeks written or verbal responses from people to a written set of questions or statements. It aligns with the quantitative approach as it is predetermined, standardised and structured (Parahoo 1997). A questionnaire also offers the possibility for the respondent to remain anonymous. From an informational perspective, they offer value in terms of the provision of evidence to inform policy, practice and education. Developing a questionnaire can be time-consuming and resource intensive, requiring much preparation time before the first question is phrased (Parahoo 2008). Murphy-Black (2006) recommends where possible, the use of previously validated questionnaires, that have been specifically designed and tested for the research purpose. The advantages of using an established questionnaire is that there should be published information about the validity and reliability of the questionnaire. Furthermore, using a validated tool in different healthcare settings allows for comparison across the sector. Disadvantages of a 'ready to go' questionnaire are that they may have copyright restrictions or charge a fee for their use (Boynton and Greenhalgh 2004).

Following a thorough search of the literature for appropriate and validated questionnaires, the researcher and research supervisors refined the final questionnaire (King et al, 2019, discussed below) for use in phase one of the study.

This choice was informed by the very recent publication of a robust systematic review of TIC Scales by Wathen et al. (2023). Wathen et al.'s 2023 review greatly enhanced both the currency and rigor of the final questionnaire choice. King et al.'s (2019) questionnaire was chosen as the quantitative data collection tool most fit for purpose. King et al.'s (2019) survey (Appendix D) was designed to identify gaps in trauma informed knowledge, attitudes and practices among healthcare professionals and further develop strategies to achieve a culture of trauma informed practice. Additional questions related to demographic data, and VAS (Visual Analogue Scale) questions related to opinions about integrating TIC into midwifery/perinatal settings in Ireland were included as additional questions. These questions did not impact on the established validity of the tool (see final questionnaire appendix H). VAS is a measurement instrument that attempts to measure a characteristic or attitude that ranges across a continuum of values and cannot easily be directly measured (Cebeci et al. 2021). Brazier and Ratcliffe (2017) believes VAS achieves high response rates and high levels of completion.

King et al.'s (2019) 'Knowledge, Attitudes and Practices of Trauma-Informed Practice Questionnaire' is a 36-item tool originally designed by Abdoh et al. (2017). The questionnaire is based on an extensive literature review carried out in 2017. Following this literature review, Abdoh et al. conducted face validity assessments of the tool with staff at their community centre and pilot-tested the tool with 17 multi-disciplinary specialist staff members. In a similar study two years later, King et al. (2019) adapted and modified the original questionnaire with permission from the authors. King et al. (2019) tested the reliability and validity of the adapted questionnaire by conducting content validity testing, construct validity assessments and internal consistency measures. Face validity was established by internal experts in the field of childhood adversity and trauma who reviewed each item to assess the degree to which it would measure the factors related to TIC. The construct validity testing assesses how well an instrument (this survey) covers all relevant parts of the construct it aims to measure (Knowledge, attitudes,

practices), in this study the tests carried out to establish this included chi-square test, the Bentler comparative fit index, (CFI), Tucker–Lewis index (TLI), and root mean square error of approximation (RMSEA). Akaike information criterion and Bayesian information criterion were also used to compare models.

Internal consistency measures whether several items that propose to measure the same general construct produce similar scores, King et al. (2019) calculated this using Cronbach's alpha for each factor which demonstrated overall acceptability. They finalised the questionnaire to a 21-item model. King et al. (2019) concluded that their now validated tool would allow organisations to identify gaps in the knowledge, attitude and practice among staff.

Supporting King et al.'s (2019) contentions, Wathen et al. (2023) carried out a robust scoping review which examined all available TIC measurement tools. Wathen et al. (2023) concluded that King et al.'s (2019) adapted questionnaire included questions that addressed all of the principles of TIC. Upon deciding to use the King et al. (2019) tool, the researcher sought and received permission from the author for its use, as recommended by Murphy-Black (2006) (Appendix E).

### *Pilot Study for Phase One*

#### Pilot Study

Before starting data collection, a pilot study should be carried out to appraise the data collection tool (In 2017). With a questionnaire, this can be carried out by giving the instrument/ tool to a smaller group of people with similar characteristics as the target sample. Hallberg (2008) recommends a sample size of at least 10-15 people for this pilot study. These people should be asked to respond to all questions, identifying those that may be difficult or ambiguous. They should also be asked to comment on readability, layout and clarity and whether they regard the questionnaire as being extensive, time-consuming or if they miss some questions that they would have expected to be included. If possible, the pilot group could, after having responded, discuss the content and the way the questionnaire is put together. Thereafter adjustments can be made.

The researcher carried out a pilot study with a group of undergraduate student midwives and a group of postgraduate student midwives in 2023. The total sample size for the pilot study was 34 (n=34). Following completion of the questionnaire, the researcher allowed time for feedback on the questionnaire and led the discussion using Bell's (1987) suggested questions i.e. Were the instructions clear?, How long did it take to complete?, Were the questions ambiguous?, Did you object to any questions, if so why? And Do you think any topic area has been omitted?. Piloting data collection tools identifies problems with the design or tools and allows them to be rectified before the main study (Malmqvist et al. 2019). If extensive alterations are needed a second pilot study is recommended (Wagstaff 2000). Feedback from the researcher's pilot study indicated that the survey was easy to understand, 'detailed enough to cover all aspects topic, clear and well laid out.

### *Distribution of Questionnaire for Phase One*

After finalising the data collection tool as outlined above, the researcher undertook social media/ online distribution. The hosting platform for the questionnaire was chosen as Qualtrics© as it enables the researcher to undertake data collection and feedback using a variety of distribution means. Qualtrics© allows researchers to create comprehensive and flexible survey designs. It accommodates a wide range of question types making it superior for data collection (Wang et al. 2021). Qualtrics© is also ideal for data management as it integrates seamlessly with SPSS for statistical analysis (Bryman 2016).

Once ethical approval was granted for this study (Appendix C), the researcher began recruitment of study participants as outlined above. A detailed written explanation of the study was included at the beginning of the questionnaire (Appendix I). Participants had to indicate that they had read the participant information (Appendix G) before proceeding to confirm consent to partake in the survey. This requirement gave the researcher permission to use data in a final report and further dissemination via publications/ conference presentations. If a participant had any queries in relation to the study, they could contact the researcher via a specific research study email address, or choose not to proceed. McGowan et al. (2018) support the use of online consent in self-test questionnaires where the study is uncomplicated and does not pose a high risk to participants such as was the case here.

## Phase Two: Qualitative Data Collection

### *Sample/Recruitment for Phase Two*

Creswell and Clarke (2007) suggest there are many ways of selecting participants from phase one of a mixed methods study to participate in phase two. In a mixed methods sequential explanatory design, data from phase one (quantitative), informs the interview schedules and data collection in phase two (qualitative). The questions in the qualitative interviews, probe the quantitative findings in much more depth (Creswell et al. 2008).

Sampling for phase two of this study was based on the principle of voluntariness. Volunteer sampling is where people volunteer to take part and are therefore self-selected. It is a sample of convenience over which the researcher has little control (Edgar and Maz 2017). The researcher is dependent on the sample volunteering to take part and this may prove challenging to recruitment (Parahoo 1997). On the other hand, Bhat (2019) suggests that volunteer sampling is inexpensive, has scope to provide rich, qualitative information and avoids sampling error which can occur when the sample is not representative of the prior population. In explanatory sequential research, the second phase should help explain the first phase, so the strategy would be to select the same or a subset of the participants from the initial quantitative phase for the second qualitative follow-up phase, allowing deeper understandings (Ivankova et al. 2006). To avoid bias, the researcher opened phase two to all members who participated in phase one and who wished to take part in phase two. Participants could opt to volunteer for phase two, receive more information or decline to participate. The volunteer link was disaggregated from responses to phase one and allowed participants to volunteer for phase two while keeping their questionnaire responses from phase one anonymous.

Since the sample in phase two was not being directly compared to the sample in phase one, as is the case in concurrent mixed methods designs, the sample sizes in sequential design do not need to be of equal sizes (Creswell and Clark 2007). Generally, qualitative studies use smaller samples than quantitative studies. Reporting on recommended sample size for focus groups can be limited (Carlsen and Glenton 2011). Curry and Nunez-Smith (2015) recommend a sample size for health research studies of 20-50 participants. For in-depth or semi-structured group interviews, four to five focus groups with 6-9 participants per focus group is advised (Krueger and Casey 2000). This number is considered small enough to allow for all members to participate, yet large enough to draw upon participants diverse experiences and perspectives. In this study, focus groups were hosted online to encourage participation and reduce costs for participants. There were a total of 5 focus groups made up of 3-5 participants. Smaller numbers are recommended in virtual focus groups due to the potential need to troubleshoot technological issues for participants, novelty of the process, and uncertainly on how interactions would proceed with too many participants on a virtual platform (Dos Santos et al. 2021).

### *Data Collection / Tool(s) for Phase Two*

For phase two of the research study- data was collected using online focus group interviews. Focus group interviewing is described by Powell and Single (1996) as a group of individuals selected and assembled by researchers to discuss and comment on the topic that is the subject of the research from personal experience. The main advantages of focus groups is that the researcher has the opportunity to observe group interaction on the topic (Joyce 2008). This interaction between people demonstrates both similarities and differences in the participants' opinions and experiences as opposed to the researcher drawing these conclusions when analysing individual interviews. Ethical considerations aligned to phase one were replicated for phase two (see page 50-54). Participants obtained information and

completed a consent form (Appendix J) prior to engaging in focus groups. This gave the researcher permission to use their data in a final report and further dissemination via publications/ conference presentations. Clarity seeking questions from participants were encouraged. All participants had a time interval of at least seven days between completing written informed consent and the conduct of the interview. Consent was re-affirmed verbally at the commencement of the focus group.

The focus group interview schedule was informed by the findings of phase one in keeping with the research design (Appendix M). The interviews were conducted using a semi-structured approach which means they are not as fixed as a structured interview, they allowed space for dialogue and for the participants to offer responses that are not predetermined (Jackson et al. 2008). They involved the use of topics and broad questions (Polit and Beck 2006).

Online focus groups are a group interview technique which are growing in popularity due to the busyness of people's lives and hectic work schedules (Joyce 2008). Participants in this study were actively working and from different parts of the country, online focus groups were much more convenient for participants. Dos Santos et al. (2021) found many benefits in using online focus groups, including flexibility for participants, psychological comfort, and participants could participate from any geographic location. Microsoft teams was used to undertake and transcribe the interviews. Microsoft teams is useful for hosting focus group interviews. It has various workflows which allowed the researcher to both host and record a meeting. It was possible to produce an automated written transcript from a recording that was downloaded with captions.

Once the interviews were completed, transcripts were systematically analysed using a thematic analysis approach as described by Braun and Clarke (2006) which is well suited to interviews which have been recorded in full. These findings will be reported upon in chapter 4.

## Data Storage

All research data was stored on the researchers own personal laptop which is password protected and only accessible to the researcher. Printed data was encrypted and stored in a locked cabinet, in a locked office within a restricted access area in DKIT, in line with the data protection legislation (Data Protection Commission 2024).

## Legitimacy/ Validity

*Quantitative Validity and Reliability*

Validity is the degree to which a tool/design measures what it is intended to (Cluett and Bluff 2000). Reliability refers to the consistency of a particular method in measuring or observing the same phenomena (Parahoo 1997). To enhance the reliability and validity of the quantitative phase of this study, the researcher chose to use a questionnaire/tool that had previously been tested and validated

The TIC Scale was validated by King et al. (2019). The authors carried out a face and content validity tests on the questionnaire by having internal experts in the field of trauma and childhood adversity review each item on the scale. See discussion on pages 60-63 for further details.

A recent scoping review (Wathen et al. 2023) examined all available measurement tools which look at TIC, identifying that Kings et al. (2019) tool was one of the only measurement tools that touched on all aspects of TIC. This scoping review

(Wathen et al. 2023) enhances the validity and reliability of the selected tool through their comparisons made with existing measurements.

### *Qualitative Rigour*

Rigour is the measure of strength of a qualitative research study in terms of adherence to procedures, accuracy and consistency (Gerrish and Lacey 2006). Qualitative rigor establishes and reports on trust or confidence in the findings of the study. Ensuring rigour in qualitative research is critical for establishing the trustworthiness and credibility of the findings (Ahmed 2024). Rigour in qualitative research is achieved through the careful application of several key criteria: credibility, transferability, dependability, and confirmability (Lincoln and Guba 1985). Credibility, is enhanced through techniques such as member checking, prolonged engagement, and triangulation (Shenton 2004). Transferability, refers to the extent to which findings can be applied to other contexts and is supported by providing thick descriptions that allow readers to make informed judgments about the applicability of the research (Morse 2015). Dependability, or the stability of data over time, is maintained through an audit trail that documents the research process in detail, ensuring that the study could be replicated under similar conditions (Nowell et al. 2017). Finally, confirmability, is the degree to which the findings were shaped by the respondents and not researcher bias. It is achieved through reflexive practices, such as maintaining a reflexive journal and engaging in peer debriefing (Korstjens and Moser 2018). By systematically addressing these criteria, qualitative researchers can enhance the rigour of their studies, thereby contributing to the credibility and trustworthiness of their findings.

Credibility:

Typically, focus groups have high face validity as a credible method of data collection that can directly capture the views of participants in response to the study

focus (Onwuegbuzie et al. 2009). To enhance the transparency the researcher chose to conduct the interviews using a semi-structured approach with an interview schedule which was informed by phase one of the study. The interview guide allows the discussion to remain organised, use prompts and allows the interviewer to give a certain amount of direction which enhances the transparency of the study (Goodman and Evans 2006).

Transferability:

Transferability implies that findings in present research study will be the same in a replicated study (Streubert and Carpenter 2011). The researcher maintained an audit trail to enhance the transferability as recommended by Ghafouri and Ofoghi (2018).

Dependability:

At the end of each focus group interview, the researcher summarised the issues and points discussed during the interview with participants to ensure they interpreted correctly what the participants were saying. This gave participants the opportunity to clarify any misunderstood information and to add anything they felt had been omitted ultimately enhancing the dependability of the study.

Confirmability:

Accuracy in transcription can threaten the consistency, to ensure accuracy in transcription the researcher is using Microsoft teams software which records and transcribes the focus group interviews verbatim. The researcher checked each line of the transcript against the recording for accuracy and made corrections and adjustments where necessary. Recoding's and transcripts were uploaded to a secure shared folder, accessible only by the researcher and researcher supervisors. As the researcher is a novice researcher, they gained experience in this software by participating in researcher studies previously to enhance their

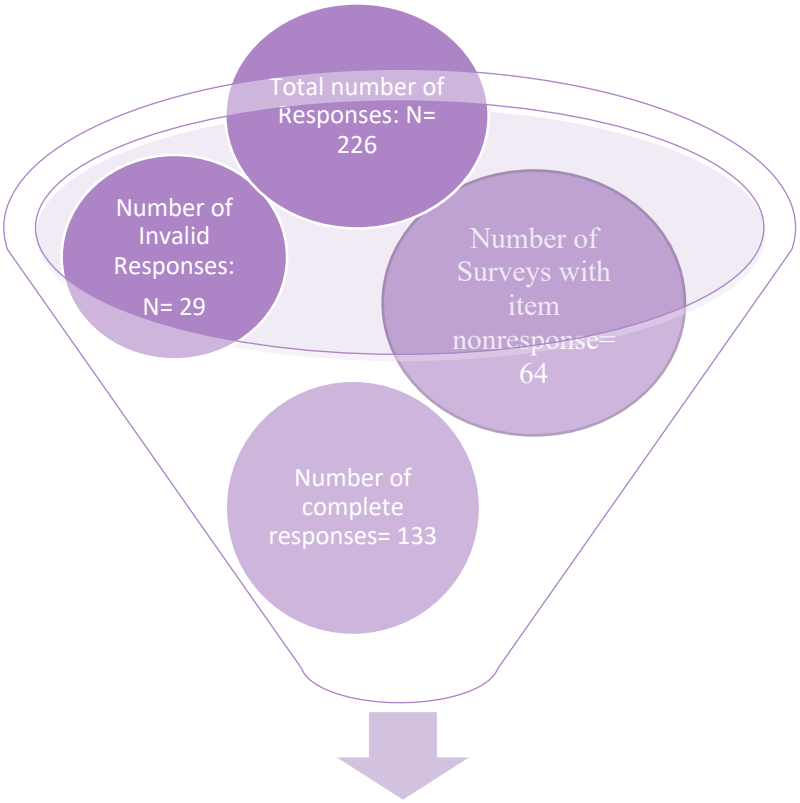
skills as recommend by Goodman and Evans (2006). All transcripts were reviewed for accuracy prior to analysis by the researcher supervisors.

# Chapter Four
# Data Analysis and Findings
# Quantitative Data

## Introduction

The quantitative strand of this study involved a survey among a non-probability convenience sample of midwives currently registered with the Irish national nursing/midwifery board. The data collection tool was the 36-item survey by King et al (2019) which measures Knowledge, Attitudes, and Practices of Trauma-Informed Practice. The TIAC survey was disseminated through targeted social media platforms over a four week period. Supplementary efforts to improve survey engagement and response rate included announcements at conferences, INMO journal notices and word of mouth

Over the four-week data collection period, 226 respondents undertook the survey. 29 of these were deemed invalid. The reasons for invalid survey responses was due to the respondents not completing the consent form or starting the survey but leaving every question blank (unit nonresponse). Sample size equated to 133 of fully completed surveys. However a further 64 respondents responded to some, but not all, survey questions- this is termed item nonresponse (Stasny 2001).




Number of Viable Responses:
N= 197

Responses were analysed using Statistical Package for the Social Sciences (SPSS) v.28.2 employing descriptive statistics. Findings from this analysis are presented in the sections below.

The first section presents demographic characteristics of respondents, and the second section presents descriptive statistics of responses for each of the variables in the survey including central tendency (range and mean) and variability (standard deviation). These measures report on the most common patterns of the analysed data set through the use of graphs, tables and discussion to help people understand the meaning of the analysed data (Hayes 2024).

**Respondent demographics**

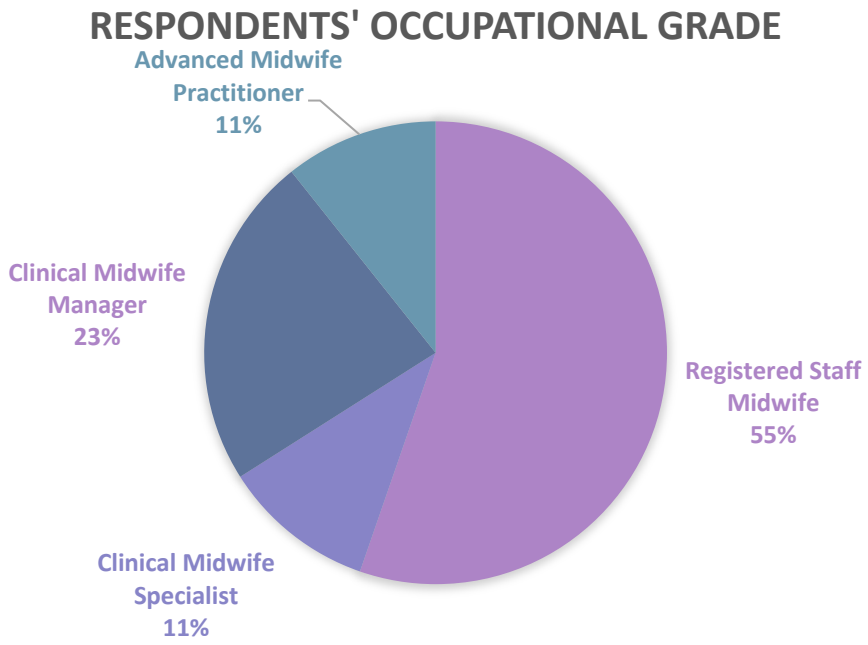
Question 1 asked respondents to describe their occupational role from among six pre-defined choices, with a free text option for 'other' responses. Of the 159 (80.7%) respondents who answered this question, over half 55.3% were Registered staff midwives (n=88), 23.3% (n=37) were clinical nurse manager III grades, and with clinical midwife specialists and advanced nurse practitioners each numbering representing 10.7% (n=17).

Table 1(a)

| RESPONDENTS' OCCUPATIONAL GRADE [N=159] | | |
|---|---|---|
| | % | n= |
| Registered Staff Midwife | 55.3 | 88 |
| Clinical Midwife Specialist | 10.7 | 17 |
| Clinical Midwife Manger | 23.3 | 37 |
| Advanced Midwife Practitioner | 10.7 | 17 |
| Total | 100% | 159 |

Registered staff midwife accounted for more than half of respondents (55.3%), while advanced midwife practitioners and clinical midwife specialist each accounted for approximately ten percent each (10.7%). Of the 37 Clinical midwife manager (CMM I, II, III) respondents, the majority (n=31) were involved in a direct care role

Figure i:


RESPONDENTS' OCCUPATIONAL GRADE
Advanced Midwife Practitioner 11%
Clinical Midwife Manager 23%
Registered Staff Midwife 55%
Clinical Midwife Specialist 11%

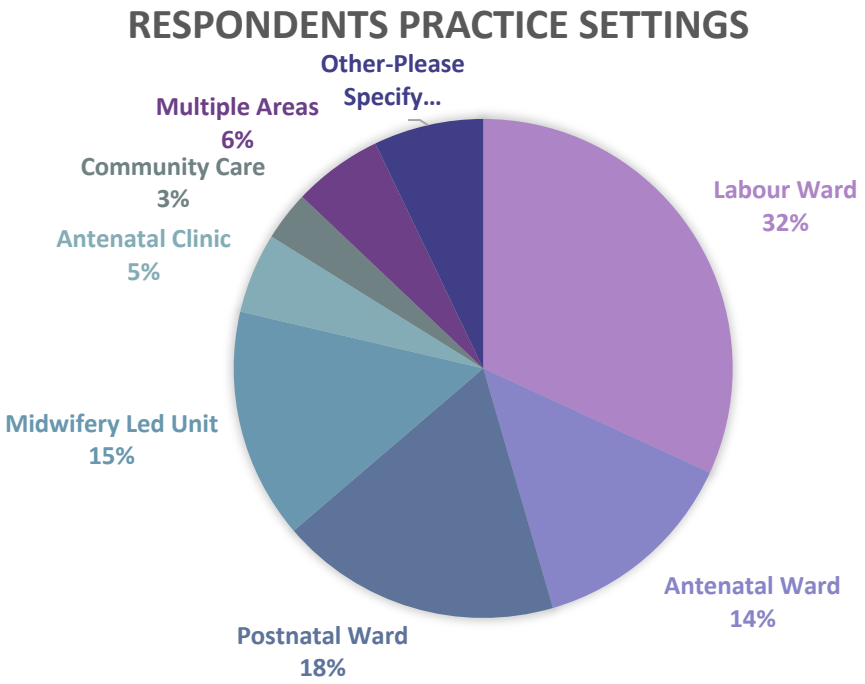
Question 2 asked respondents to describe their practice setting from among seven pre-defined choices, with a free text option for 'other' responses. Of the 154 (78.2%) of respondents who answered this question, almost one third 31.8% (n=49) worked in a labour setting, 18.2% (n=28) worked in a postnatal ward, 14.9% (n=23) worked in a midwifery led unit, and 13.6% (n=23) worked in an antenatal ward setting. The remainder worked in multiple areas 5.8% (n=9), in an antenatal clinic 5.2% (n=8), in community care 3.2% (n=5) and 7.% (n=11) in unspecified 'other' settings

Table 1(b)

| **RESPONDENTS' PRACTICE SETTING [N=154]** | | |
|---|---|---|
| | % | n= |
| Labour Ward | **31.8** | 49 |
| Antenatal Ward | **13.6** | 21 |
| Postnatal Ward | **18.2** | 28 |
| Midwifery Led Unit | **14.9** | 23 |
| Antenatal Clinic | **5.2** | 8 |
| Community Care | **3.2** | 5 |
| Multiple Areas | **5.8** | 9 |
| Other-Please Specify | **7.1** | 11 |
| Total | **100%** | 154 |

The large majority 78.6% (n=121) of respondents work in inpatient settings including, in order of frequency, labour wards, postnatal wards, midwifery led units and antenatal wards. The remaining 21.4% (n=33) work in non-ward other settings including, in order of frequency, multiple areas, antenatal clinics, community care. 11 respondents (7.1%) worked in unspecified 'other' settings

Figure ii:


RESPONDENTS PRACTICE SETTINGS
Other-Please Specify...
Multiple Areas 6%
Community Care 3%
Antenatal Clinic 5%
Midwifery Led Unit 15%
Postnatal Ward 18%
Antenatal Ward 14%
Labour Ward 32%

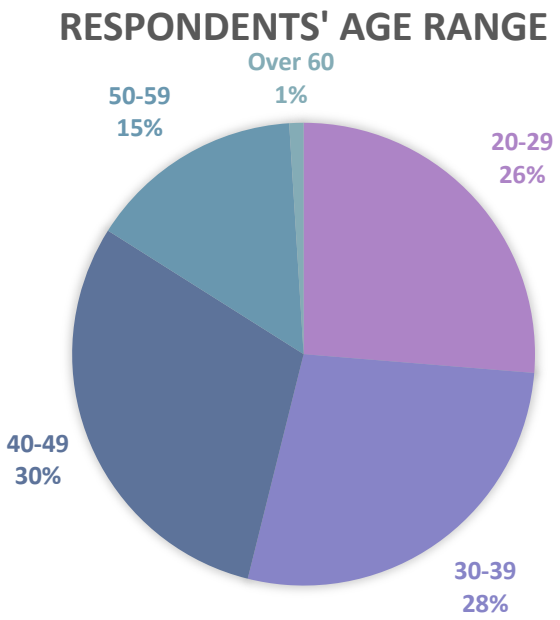
Question 3 asked respondents to select their age range from five pre-defined choices. Of the 159 (80.7%) respondents who answered this question, The majority of the sample falls within the 20-29 (n=42), 30-39 (n=44) and 40-49 (n=48) age range. Only 15.1% of the respondents were in the age 50-59 category (n=24), with the over 60 age range have only a single respondent (n=1)

Table 1(c)

| **RESPONDENTS' AGE RANGE [N=159]** | | |
|---|---|---|
| | **%** | **n=** |
| 20-29 | **26.4** | 42 |
| 30-39 | **27.7** | 44 |
| 40-49 | **30.2** | 48 |
| 50-59 | **15.1** | 24 |
| Over 60 | **.6** | 1 |
| **Total** | **100%** | 159 |

Based off the State of the register (NMBI, 2023) the 20-29 age range group may be over represented as they only make up 11.4% of the total workforce in the republic of Ireland. The over 60 age range is also under-represented as they make up a total of 12% of the work force. This could be to do with how the survey was disseminated online and advertised via social media etc.

Figure iii:


RESPONDENTS' AGE RANGE
Over 60
1%
50-59
15%
20-29
26%
40-49
30%
30-39
28%

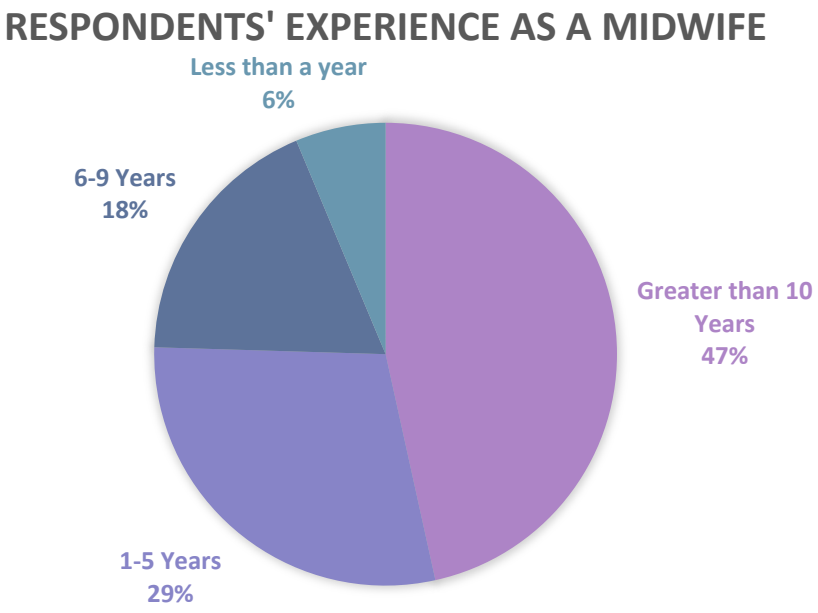
Question 4 asked respondents to describe their experience as a midwife, selecting from among five pre-defined choices of their length of experience in years Of the 159 (80.7%) of respondents who answered this question, almost half of the respondents 46.5% (n=74) had over 10 years' experience, 28.9% (n=46) had 1-5 years' experience, 18.2% (n=29) had 6-9 years' experience, and 6.3% (n=10) had less than a year's experience.

Table 1(d)

| **RESPONDENTS' EXPERIENCE [N=159]** | | |
|---|---|---|
| | % | n= |
| Less Than a Year | 6.3 | **10** |
| 1-5 Years | 28.9 | **46** |
| 6-9 Years | 18.2 | **29** |
| Greater than 10 years | 46.5 | **74** |
| Total | 100 | 159 |

The data indicates that a significant portion of midwives in the sample have extensive experience, with nearly half having more than 10 years of experience. This suggests a mature workforce with considerable expertise, despite the age profile reported earlier.

Figure iv:


RESPONDENTS' EXPERIENCE AS A MIDWIFE
Less than a year
6%
6-9 Years
18%
Greater than 10
Years
47%
1-5 Years
29%

Question 5 asked respondents to select their gender from among three pre-defined choices, with a free text option for 'other' responses. Of the 159 (80.7%) of respondents who answered this question, 98.7% (n=157) identified as female. 1.3% (n=2) identified as males and no one responded as other.

Table 1(e):

| **RESPONDENTS' GENDER [N=159]** | | |
|---|---|---|
| | % | n= |
| Female | **98.7** | 157 |
| Male | **1.3** | 2 |
| Other | **0** | 0 |
| Total | **100%** | 159 |

Females make up the majority of the workforce of midwives in the republic of Ireland. Males represent a total of 0.5% of the midwifery workforce (NMBI 2023) in making this a representative sample in terms of gender.

Question 6 asked respondents whether or not they had received training related to trauma informed approach to care pre-qualification as a midwife. Of the 158 (80.2%) respondents who answered this question, 89.2% said they had not received training pre-qualification (n=141) and 10.8% said that they had received training pre-qualification (n=17).

Table 1(f):

| **RESPONDENTS' THAT RECEIVED TIAC TRAINING PRE QUALIFICATION [N=159]** | | |
|---|---|---|
| | **%** | **n=** |
| Yes | **10.8** | 17 |
| No | **89.2** | 141 |
| **Total** | **100%** | 158 |

Question 7 asked respondents if they had received training on trauma informed approach to care since qualifying as a midwife from two pre-defined choices. Of the 148 (75.1%) of respondents who answered this question, 88.5% had not received training since qualifying (n=131). 11.5% had received training on TIAC since qualifying (n=17).

Table 1(g):

| **RESPONDENTS' RECEIVED TIAC TRAINING POST QUALIFICATION [N=148]** | | |
|---|---|---|
| | % | n= |
| Yes | **11.5** | 17 |
| No | **88.5** | 131 |
| Total | **100%** | 148 |

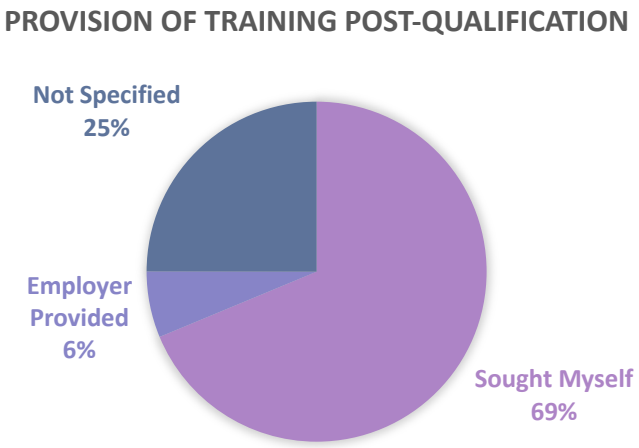
The respondents who answered yes were automatically brought to question 8 and those who selected no were bypassed from question 8 straight through to the next section on the questionnaire.

Question 8 asked respondents who answered yes for question 7, how the training they received was provided. Of the 16 (8.1%) respondents who answered this question, 68.8% had sought the training themselves (n=11). 6.3% received training that was provided by their employer (n=1).

Table 1(h):

| RESPONDENTS' PROVISION OF TIAC TRAINING WHEN QUALIFIED [N=16] | | |
|---|---|---|
| | % | n= |
| Sought Myself | **68.8** | 11 |
| Provided by Employer | **6.3** | 1 |
| Additional Training | **25%** | 4 |
| Total | **100%** | 16 |

Figure v:



This section presents participants responses to questions regarding the three variables of 'Knowledge' 'Attitude' and 'Practice' (King et al 2019). For each of these three variables the findings are presented in two formats. Initially, a table numerically presents the number of respondents, the range (minimum-maximum) of scores, the arithmetic mean, and the standard deviation among responses. These findings are then presented in a box plot, as an adjunct for simple visualization of the distribution of scores specific to each individual questions for each variable.

**Knowledge (Questions 9-14)**

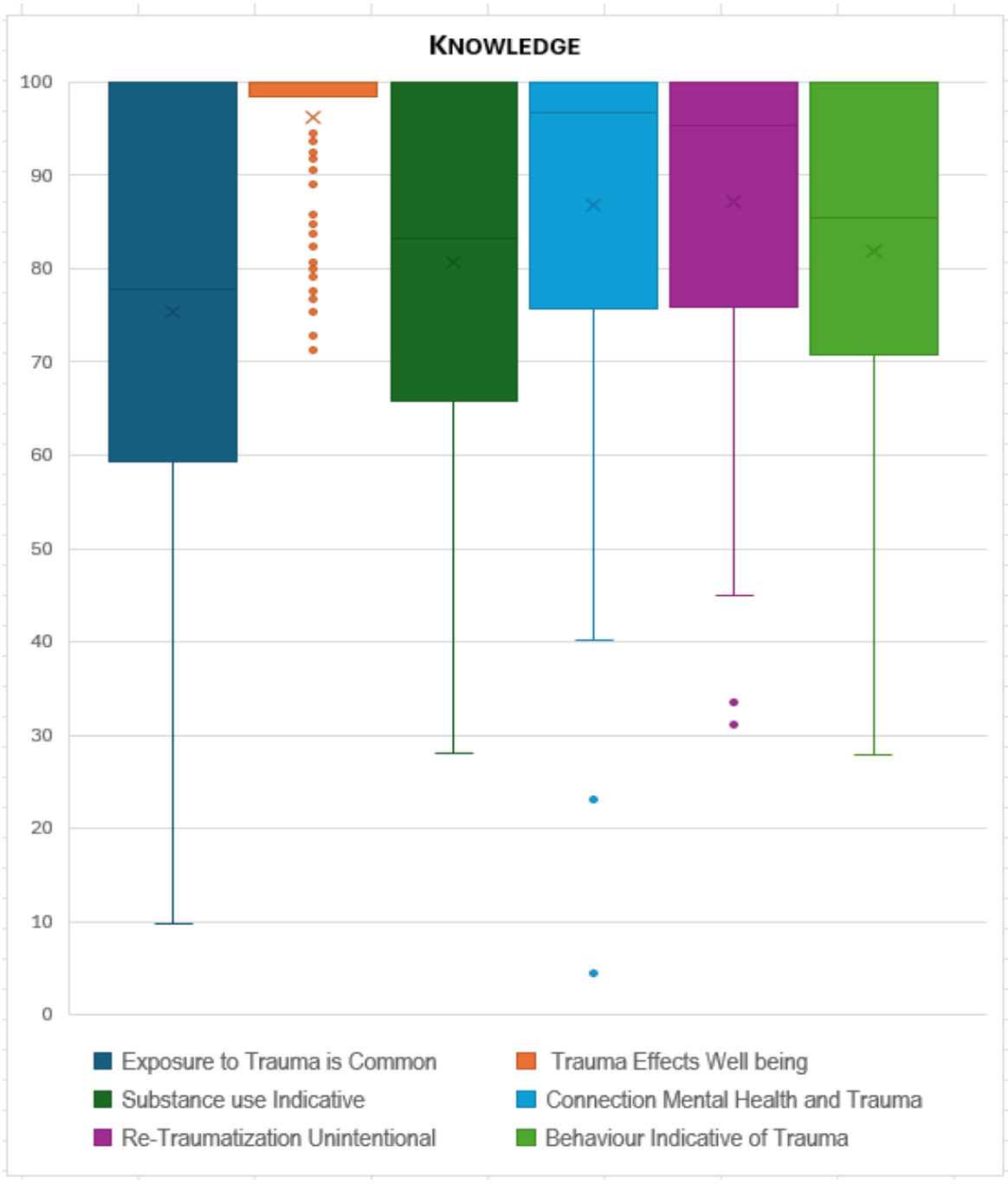
The first variable 'Knowledge' is composed of 6 questions (numbered 9-14). Each question requires respondents to rate their agreement/ disagreement with a specific knowledge related statement along a VAS between 0-100, with higher values indicating greater agreement/ knowledge. Of the 197 survey respondents between 141 (71.6%)- 142 (72.1%) completed the six constituent questions, and the range, mean and standard deviation of responses are summarised in table 2(a) below.

**Table 2(a) Knowledge**

| | N= | Minimum | Maximum | Mean | Std. Deviation |
|---|---|---|---|---|---|
| Trauma Exposure Common | 142 | 9.70 | 100.00 | 75.29 | 23.75 |
| Trauma Effects Wellbeing | 142 | 71.20 | 100.00 | 96.26 | 7.38 |
| Substance use Indicative of Trauma | 142 | 28.10 | 100.00 | 80.95 | 19.41 |
| Unintentional Re-traumatization possible | 141 | 31.10 | 100.00 | 87.28 | 16.48 |
| Trauma Mental Health Connection | 141 | 4.40 | 100.00 | 87.05 | 17.61 |
| Disturbing behaviour indicative of Trauma | 142 | 27.90 | 100.00 | 81.83 | 19.25 |

While the mean consistently demonstrated a high level of knowledge, figure demonstrates variance of responses for each of the six constituent questions.

Figure ix:



**Practice (Questions 15-20)**

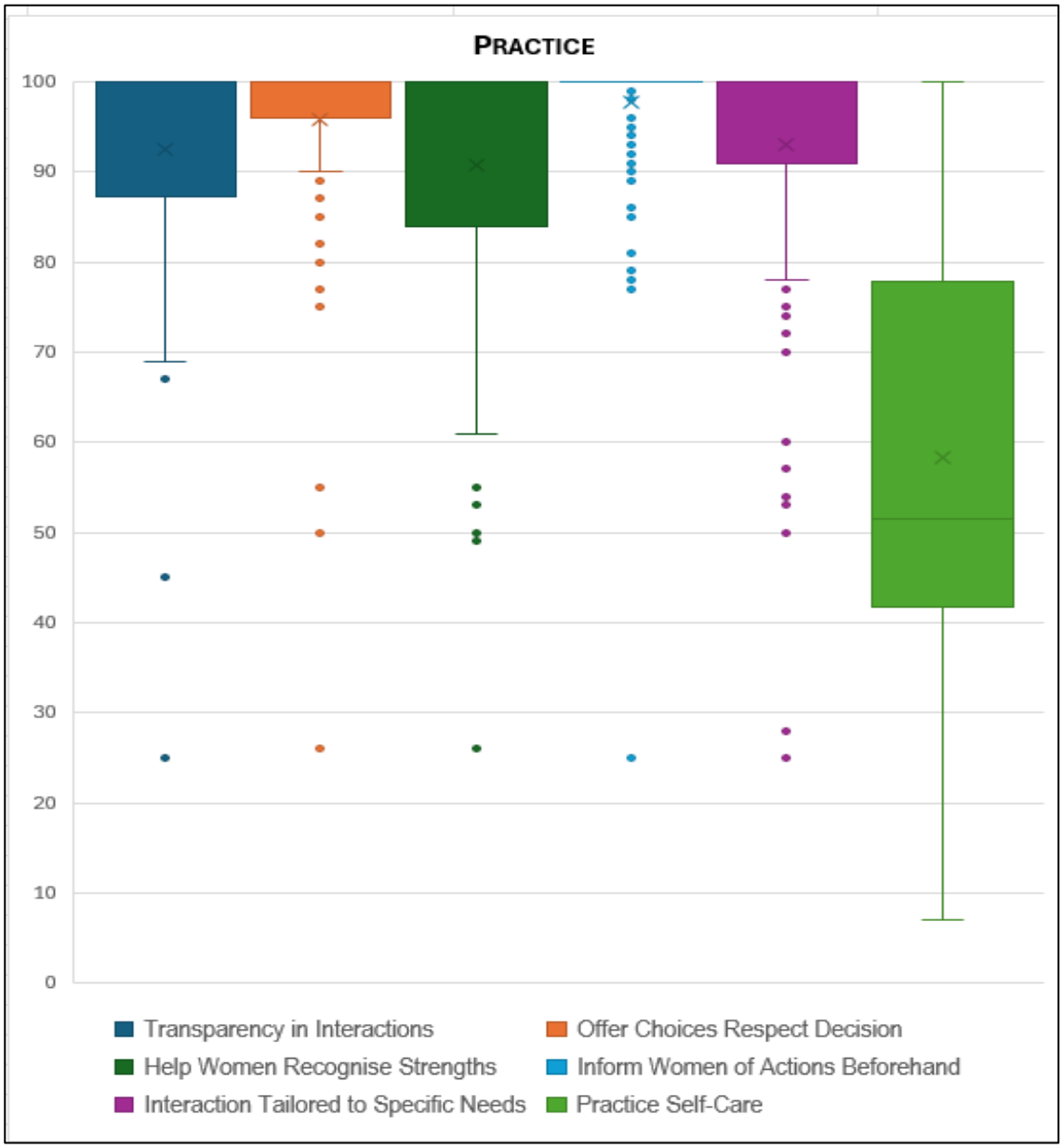
The second variable 'Practice' is composed of 6 questions (numbered 15-20). Each question requires respondents to rate their agreement/ disagreement with a specific TIAC related practice along a VAS between 0-100, with higher values indicating greater agreement/ knowledge. Of the 197 survey respondents 132 (67%) completed the six constituent questions, and the range, mean and standard deviation of responses are summarised in table 2(b) below.

**Table 2(b) Practice**

| | N | Minimum | Maximum | Mean | Std. Deviation |
|---|---|---|---|---|---|
| Transparency in all interactions | 132 | 25.00 | 100.00 | 92.45 | 11.8 |
| Offer choices and respect decision | 132 | 26.00 | 100.00 | 95.82 | 10.12 |
| Help women identify own strengths | 132 | 26.00 | 100.00 | 90.77 | 13.95 |
| Inform women of actions beforehand | 133 | 25.00 | 100.00 | 97.64 | 7.89 |
| Interactions client-specific and needs assessed | 132 | 25.00 | 100.00 | 92.97 | 14.73 |
| I practice self-care | 132 | 7.00 | 100.00 | 58.08 | 25.12 |

The findings indicate very high scores for five of the six indicators of practice component, with mean scores ranging between 90.77[Sd 13.95] and 97.63 [Sd 7.89]. The sole exception was the practice of self-care with a range on 7-100, a mean score of 58.28 [Sd 25.12].

Figure X:



**Attitudes (Questions 21-29)**

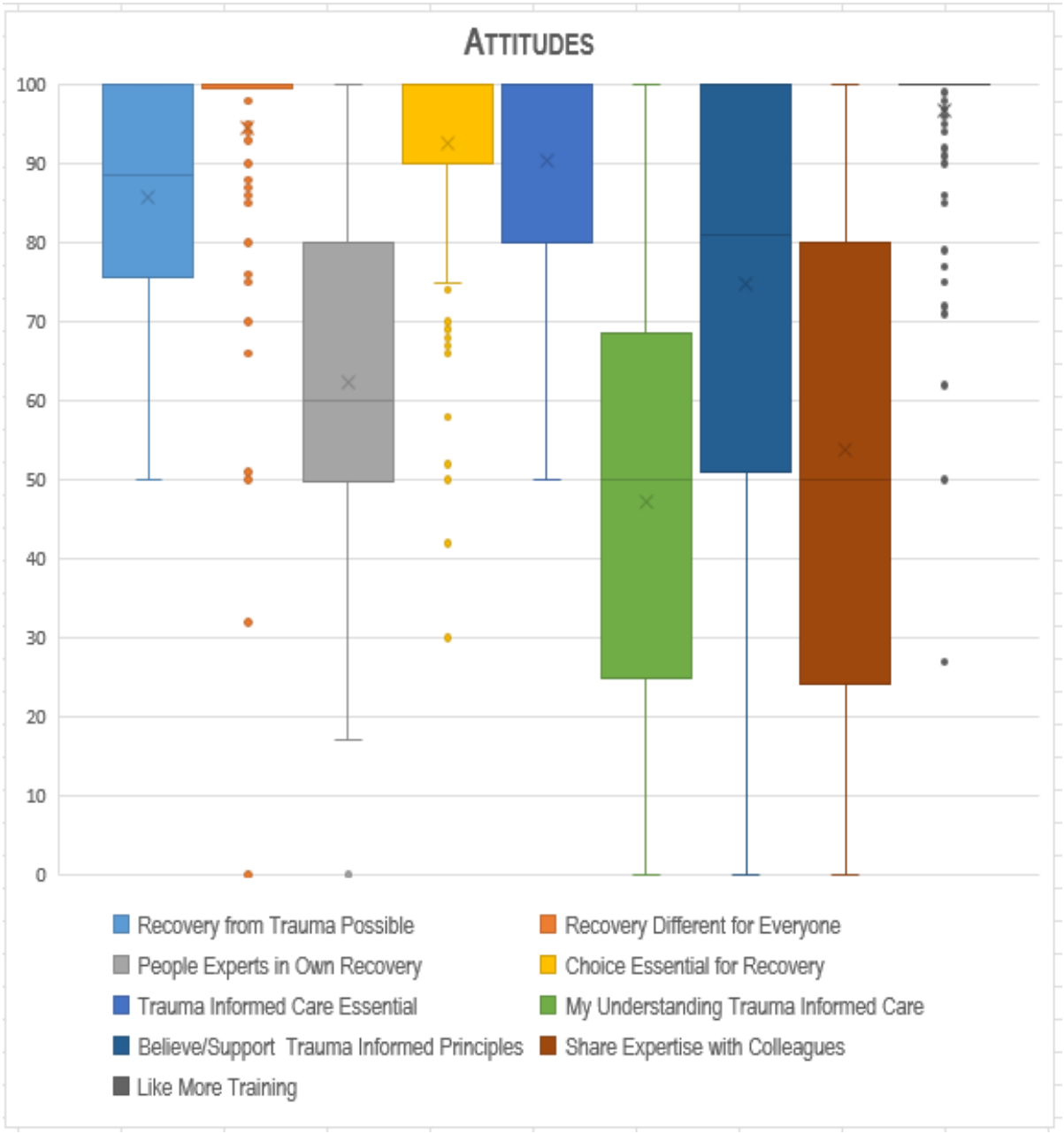
The third variable 'attitudes' is composed of 9 questions (numbered 21-29). Each question requires respondents to rate their agreement/ disagreement with a specific TIAC related attitude with higher values indicating greater positivity/affirmative attitudes. Of the 197 survey respondents between 123(62.43%)- 129(65.48%) completed the six constituent questions, and the range, mean and standard deviation of responses are summarised in table 2(c)

**Table 2 (c) Attitudes**

| | N | Minimum | Maximum | Mean | Std. Deviation |
|---|---|---|---|---|---|
| Recovery from trauma is possible | 129 | 50.00 | 100.00 | 85.67 | 14.57 |
| Paths to recovery differ for everyone | 129 | .00 | 100.00 | 94.48 | 13.84 |
| People are experts in their own recovery | 129 | .00 | 100.00 | 61.96 | 23.28 |
| Informed choice is essential in recovery | 129 | 30.00 | 100.00 | 92.44 | 13.97 |
| Trauma Informed Approach is essential | 128 | 50.00 | 100.00 | 90.42 | 13.41 |
| My understanding of Trauma Informed | 128 | .00 | 100.00 | 46.92 | 26.73 |
| Believe/ support the trauma principles | 127 | .00 | 100.00 | 74.48 | 28.83 |
| Share expertise/ collaborate with colleagues | 123 | .00 | 100.00 | 53.91 | 33.06 |
| Would like more training | 129 | 27.00 | 100.00 | 96.62 | 9.85 |

Respondents show strong agreement on fundamental principles of trauma-informed care, such as the paths to healing and the importance of informed choice. Respondents appear not to have a comprehensive understanding of TIAC principles as there is a low mean score (46.92) with a large standard deviation of 26.7.

Figure Xi:



## Opinions on the present and Future of TIAC (Questions 30-32)

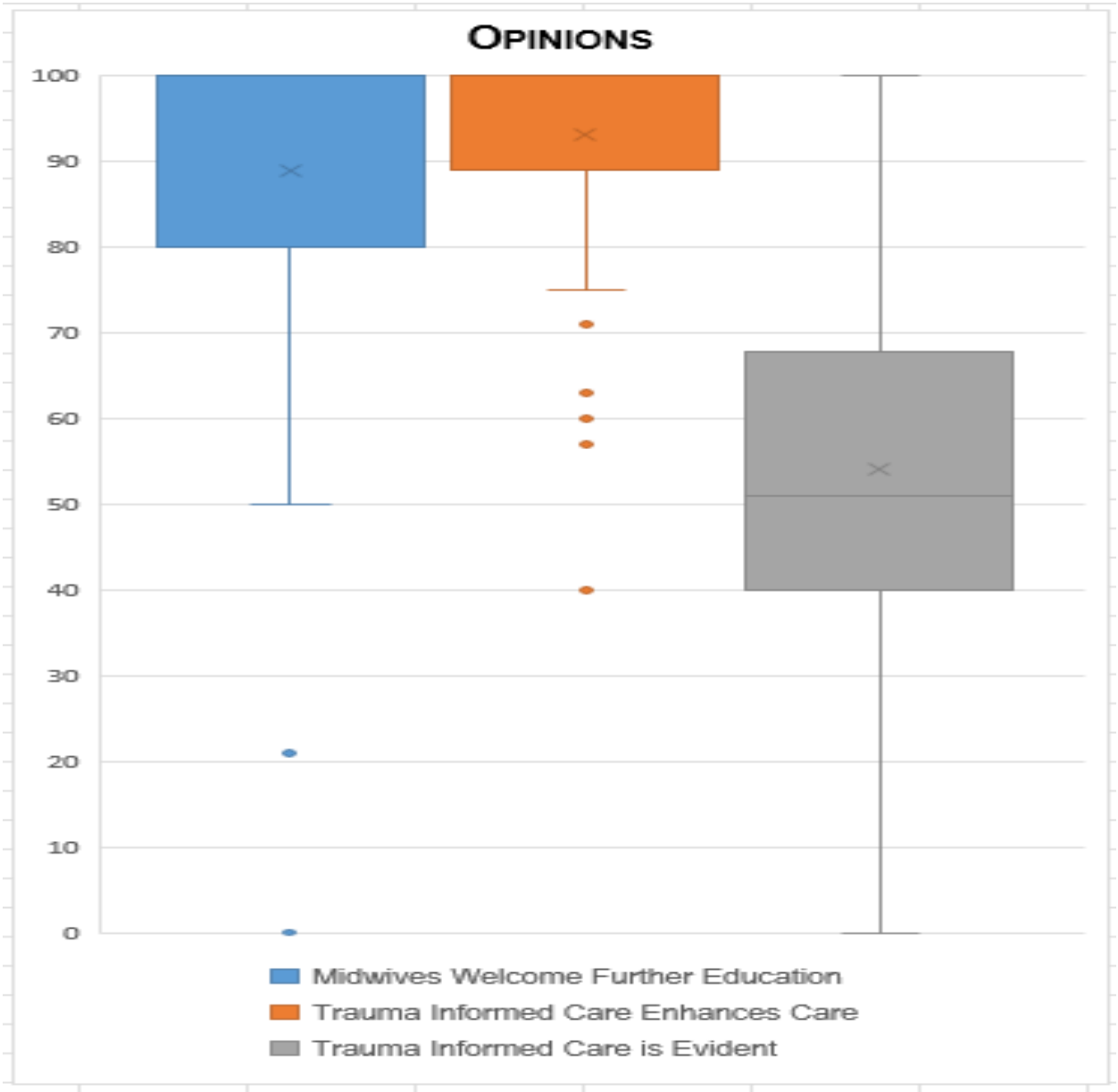
This final three questions were supplemental to the TIAC instrument and sought to measure respondents' opinions regarding the current implementation, and future directions of TIAC within their practice setting. Each of the three TIAC related questions asked respondents to rate their agreement with each statement on a 0-100 visual analogue scale with higher values indicating greater agreement with the statement, with a summary of findings presented in table 2(d) below.

**Table 2(d) Opinions on present and future of TIAC**

| | n= | Minimum | Maximum | Mean | Std. D |
|---|---|---|---|---|---|
| Midwives would welcome TIAC | 122 | .00 | 100.00 | 90.03 | 16.95 |
| Utilising TIAC will enhance care | 125 | 40.00 | 100.00 | 93 | 11.93 |
| TIAC practice is evident in my workplace | 115 | .00 | 100.00 | 51.66 | 22.18 |

The findings suggest a pattern of respondents rating ‘welcoming TIAC to practice’ and ‘believing that utilizing TIAC will enhance care’ as quite high as both have large mean scores and low standard deviations. The respondents show there is a lack of ‘TIAC being practiced within the workplace currently’ with a low mean score of 51.6.

Figure Xii:



**Opinions regarding implementing Trauma Informed Approach Care**

The final question invited respondents to provide their thoughts/opinions regarding the implementation of TIAC within the maternity services across the country. Sixty nine of the 197 respondents (34.01%) provided a total number of 69 open text comments. The comments were grouped and coded to find the most re-occurring comments (Appendix L). Support was consistently identified as one of the most re-occurring comments occurring 18/69 (26%), followed by adequate staffing which occurred 16/69 (23.1%), Adequate time 13/69 (18.8%) and then Education and training 11/69 (15.9%). See Table 3(a) below for the comments that were grouped and presented under the headings of realisation, recognise, response and resist re-traumatisation.

**Table 3(a)**

| | | |
|---|---|---|
| REALISATION | Support | (From colleagues/ management) |
| | Support | (for women) |
| | Self-Care at Work | |
| | | Interplay of Personal and Professional Trauma |
| RECOGNISE | Collaboration of the MDT | |
| | Midwives Ignored | |
| | Blame | |
| | Risk Management | for all staff |
| RESPONSE | Education and Training | |
| | Adequate Staffing | |
| | Continuity of Care | |
| | Adequate Time | |
| | Processes | Staffing Debriefs with Everyone in Care |
| | Environment | Infrastructure/ work Environment/ break rooms |
| RESIST RE-TRAUMATIZATION | Individualised/ collaboration with clients | woman centred care/ |
| | Dedicated Care Pathways | Structured |
| | Birth environment | Consultant led unit vs Midwifery Led Unit |
| | Birth options | CLU vs. MLU |
| | Procedures | Reduction in Vaginal Examinations |
| | Experience | |

**Summary:**

The findings from this quantitative analysis has addressed the key research question which is to evaluate the knowledge and practices of TIAC among midwives within the perinatal setting in Ireland. The findings from phase one reveal:

- 11.5% of respondents to the survey (n=23) had received training on TIAC
- Of this, 70% (n= 16) had sought the training themselves
- Knowledge related to trauma informed care was revealed to be good
- However self-appraised knowledge of trauma informed care was quite poor
- Self-appraised practice of self-care was also quite poor
- Participants welcomed the idea of further education related to implementing a trauma informed approach to care
- Support was consistently identified as one the key enablers for midwives in the delivery of TIAC, occurring 18/69 (26%), followed by adequate staffing which occurred 16/69 (23.1%), Adequate time 13/69 (18.8%) and then Education and training 11/69 (15.9%).

These findings have important implications for phase two of the study as they will be used in the development of the data collection tool for phase two of the research study. Based off the findings of phase one, the researcher developed an interview schedule to aid in the guidance of the focus group interviews (Appendix M).

# Chapter Five
# Data Analysis and Findings
# Qualitative Data

## Qualitative Findings

Data gathered from the survey from phase one, the quantitative phase, was used to inform phase two, the qualitative phase, focus groups. Semi-structured interviews were carried out using an interview guide with broad questions. The interview guide questions were derived from the findings of phase one to allow a more inadept exploration of these findings.

The email addresses of the participants from phase one who opted into phase two were extracted from the quantitative data. When focus groups are made up of different staff grades and authority levels, some employers may feel inhibited (HSENI 2009) because of this recommendation the researcher grouped participants based off staff grade i.e., staff midwives together, CMM's together, AMPS together etc. A timetable of focus group time slots was generated using Microsoft forms and a link to this was sent to each of the participants that opted into phase 2.

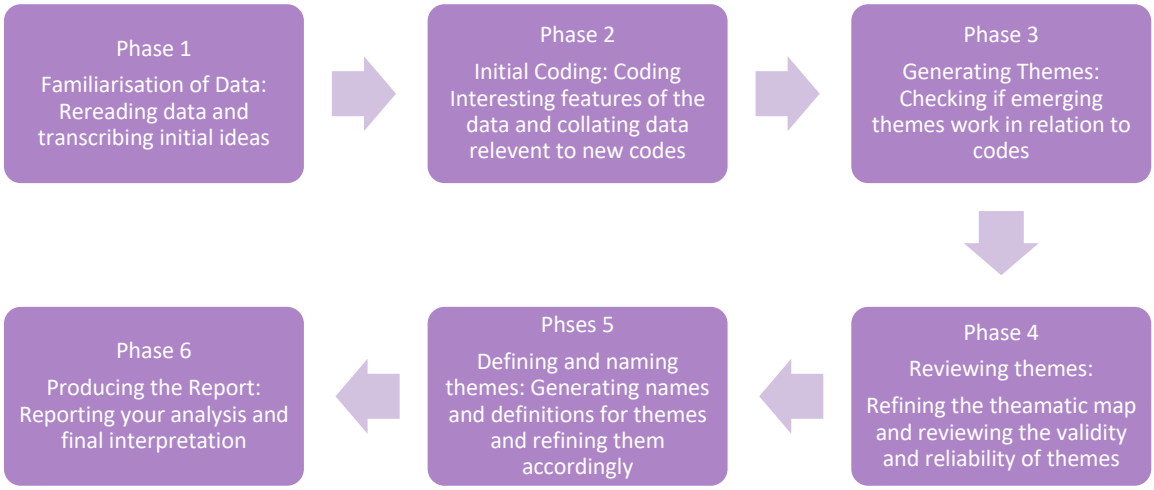
When they pressed on the link an opt-in/ opt-out form came up to ensure they wanted to continue with phase 2. They then selected a focus group time slot that suited their schedule. From this point once a group had 3-5 participant's the slot was closed and each of the participants in that slot were contacted to confirm their availability for their selected slot. They then received a link to the online Microsoft teams focus group. Focus group data was collected and transcribed using Microsoft teams as well as a recorder for back up of the data. The Microsoft teams transcripts were proof-read and cross-referenced with the recorded interviews by the researcher to ensure accuracy of the data. Any identifying information was removed and participants' confidentiality was maintained by the use of numerical identifiers not names i.e. P1, P2 etc.

There was a total of 18 participants in the focus group interviews. See table (4a) for demographic information on participants

4(A) Demographic Table- Qualitative Interviews

| **Demographics (n=18)** | | **Sample** |
|---|---|---|
| **Gender** | Female | 18 |
| | Male | 0 |
| | | |
| **Age Range** | 20-29 | 3 |
| | 30-39 | 5 |
| | 40-49 | 8 |
| | 50-59 | 2 |
| | Over 60 | 1 |
| | | |
| **Qualification** | Direct Entry Midwife | 7 |
| | Dual Qualified Midwife | 11 |
| | | |
| **Grade** | Registered Midwife | 10 |
| | Clinical Midwife Specialist | 3 |
| | Clinical Midwife Manager | 4 |
| | Advanced Midwife Practitioner | 2 |
| | | |
| **Experience** | Less than 1 year | 0 |
| | 1-5 years | 1 |
| | 6-10 years | 5 |
| | Greater than 10 years | 13 |
| | | |
| **Practice Setting** | Labour Ward | 3 |
| | Antenatal Ward | 1 |
| | Postnatal Ward | 3 |
| | Midwifery Led Unit | 4 |
| | Antenatal Clinic | 2 |
| | Community Care | 1 |
| | Multiple Areas | 4 |
| | Other | 1 |

Data was then analysed using Braun and Clarke (2006) thematic analysis. This method of thematic analysis follows six steps:




An illustration of Braun and Clarke's thematic analysis approach for developing themes from qualitative data. Adapted from Braun and Clarke (2006), p 87.

This approach was chosen as it has flexibility and rigour in identifying patterns of meaning across a data set.

Phase One: The process began with data familiarisation, where transcripts were read multiple times, and initial notes were made to capture early impressions.

Phase Two: Initial codes were generated inductively using a semantic coding approach to remain close to the participants' language and meanings. Coding decisions were carefully documented in a reflexive journal, which contributed to the development of an audit trail.

Phase Three: codes were examined for similarities, differences, and relationships, which informed the generation of preliminary themes.

Phases Four and Five: themes were reviewed, refined, and defined through iterative discussions between the research team to ensure internal coherence and distinctiveness.

Phase Six: involved producing a rich, analytic narrative that captured the essence of each theme in relation to the research questions. This audit trail ensured that the analysis was both credible and dependable, aligning with qualitative research standards (Nowell et al 2017).

The thematic analysis provided a nuanced understanding of participants' experiences, while also allowing space for complexity and contradictions within the data to emerge.

The thematic analysis (Appendix M) revealed four main key themes and 3 subthemes as follows:

1. Awareness, understanding and recognition of trauma
2. Education
3. Challenges in providing TIAC and a responsive maternity system
   Subtheme 1: System vs. Individual needs
   Subtheme 2: Personalised Care
   Subtheme 3: Continuity of Care
4. Interplay of Personal and Professional Trauma.

Each of these themes and subthemes will be further explored throughout this chapter using quotes from participants to support the findings.

**Theme One: Awareness, understanding and recognition of Trauma:**

Responses to questions under this theme explain participants' awareness, understanding and recognition of TIAC. The theme of awareness, understanding, and recognition of trauma reveals a moderately limited grasp of TIC among maternity service providers. Many participants acknowledged that TIC is not a central focus in their practice, often only becoming relevant when women disclose their trauma experiences.

Focus group discussions appeared to reveal largely fragmented understanding of TIC in the maternity services. Participants in the focus groups expressed modest understanding of the full scope of TIC within the maternity services.

*"I agree with the others that it's not front and centre of the care that we provide…I remember the term, talking about trauma when I was in college."-P6*

*"When we talk about trauma informed care, it's not something that's probably recognized in maternity care and definitely not really recognized among our obstetric colleagues."-P4*

Participants further revealed that TIC only became salient when women disclosed their trauma.

*"I have to admit, in my own practice I wouldn't have really thought about it that much until I came across women who disclosed trauma or and it had been mentioned in their notes."-P5*

*"If they have been big enough and brave enough to disclose you want to be able to help them you want to be able to give them the right advice you know."-P11*

Participants recognised that once trauma is disclosed, they can then act on it identifying a need for midwives to actually ask about a trauma history.

*“I do think we're very good at being aware of previous traumas and at minding the women who have disclosed their trauma to us.”-P9*

*“Maybe we're good at if somebody discloses a trauma or a trauma is very obvious, but I don't know that we’re good at asking.”-P7*

Each participant had individualised perceptions of trauma and TIC. For example, P3 highlighted the subjective nature of trauma, while P13 emphasised the importance of being aware of own body language and actions that may trigger discomfort, based on undisclosed prior traumas.

*"Everybody's own vision of trauma is different.”-P3*

*“It's being aware of language you would use and certain things you might do like body language, that may make somebody uncomfortable if they have certain experiences prior, that they may not have disclosed to you.”-P13*

P12 spoke about how care providers often explore maternity notes to try to gain a deeper understanding of individual contexts, but that often healthcare professionals will make assumptions about the woman based off of this information and that may influence their care

*“I think there's probably a certain amount of assumptions that people can make based on information they see on a page or how someone presents or what their own kind of understanding of different types of trauma might be.”-P12*

However, participants also highlighted the importance of being aware of trauma histories and speaking to women with compassion.

*'It's about being aware and being compassionate for them and speaking to them as best as you can.'-P3*

*'being aware that even coming into the hospital might be even traumatising.'-P3*

*'We don't know what's going on in people's personal lives or what has gone on…they're trying to deal with trauma then they're seeing it at work, it could be triggering things for them, that they're trying to deal with, I think there needs to be more awareness.'-P8*

*'Making an effort to understand that the woman in front of you may be in a specific situation, you have no idea what came before or what's going to come after the situation you're in at that moment. Being aware of body language that's used'.-P13*

*'If you're talking about trauma informed care you, they've obviously had a trauma before. They've been informed of it. They've probably had a debrief thing, but probably need more debriefing and obviously going forward, being very aware of that.'-P16*

*'But you're aware of their vulnerability because of the way their body language and your skills.'-P16*

The participants recognised that kindness, courtesy, and respect are fundamental human values and deemed them crucial in the delivery of TIC. These values are deeply intertwined with the core principles of midwifery and woman-centred care,

and align closely with the essential role of the midwife in providing compassionate, individualized care.

However, P11 lamented on the loss of kindness as a skill, emphasizing its importance.

*“There's no magic wand here. From my experience it's to be kind, that seems to be a lost skill…having courtesy and respect and being kind is a big thing. Time is a harder commodity to try and harness to give the women what they need.”-P11*

P14 and P7 echoed this sentiment linking kindness to effective communication, empathy and the core role of the midwife.

*“They kept saying like everything is your choice they were very, very kind. If you can give them the time and the respect and speak to them the way they deserve it can make a huge difference in the way they're going to reflect back on this (the experience)”-P14*

“*It's just being kind actually. If you are kind to somebody that means you're listening and you're being empathetic and you're giving them time, that's really all you have to do for most people to open up to you and people do people*”-P7

The use of the word kindness resonated with other participants throughout the focus groups. Kindness encapsulated other skills such as listening, empathy and giving time.

*“I think that for me it’s somebody that comes in and greets you kindly and is really empathetic.”-P9*

‘*Sometimes time is an issue, but more so it's the person and they may want to keep whatever they're feeling private or what they've gone through in the past, private. It's just about Informed consent as best you can. You know, it just comes down to that. Then I'm just going to be compassionate and empathetic to her*.’-P17

Another participant also recognised how lack of time could induce fear among women in the service

*‘I'm very disheartened with the service, to be honest. I feel really peeved off. I've had lots of people I know go through the service and they've had different negative outcomes, be it, they're not getting care that they thought they would get simple things like asking for paracetamol, but took four hours and then they're talking about, well, if I can't get paracetamol, what are they going to do for me when I'm in actual labour? And there's a fear there constantly. So they're going home and they feel like they haven't had proper care.’-P16*

Participants in the study frequently associated trauma with birth experience, indicating a somewhat narrow understanding of TIC that appeared to primarily focus on birth trauma. While birth trauma is important, some participants acknowledged that this perspective may overlook the other sources of trauma that can affect maternity care.

*"I acknowledge that probably 1/3 of women probably come out of their birth feeling traumatized.”-P4*

*“I think that that's probably one of the first ways that we can have address any trauma from developing further or developing in first place if it's birth related.”-P5*

*“They're coming to homebirth from a place of trauma and avoiding the hospital system and free-birth you know we're having 10-15 free births in every county.…these are women who trusted the system. First they came to the hospital with a previous birth because they trusted the hospital and they were let down by the system.”-P4*

*“I don’t think we’re good at preventing trauma, when you’re running into theatre with a woman on a bed are we actually aware of how traumatising that is going to be.”-P9*

*“You can see women who are really struggling with the birth that they've just had and midwives turn around and saying you had a great birth, you did so well there.”-P12*

*“When I hear trauma, I associate it with their births really, their birth has been traumatic for them and it's been a negative experience.”-P16*

*“I suppose for me, I would nearly put it all down to birth trauma simply because of where we work. When you think about it you see women coming in and they're carrying other traumas, and that might be leading them to maybe substance abuse or other different things as well, then they're carrying on through because of trauma that they've had in their life.”-P17*

*“When I was training, obviously we did cover bits about birth trauma, but I don't think it (trauma informed care) was really focused on.”-P18*

Participants stressed the need for involving a multidisciplinary approach to care and linking women with appropriate support services.

*'Involving all the multi-disciplinary team. Especially if there's any history of depression, anxiety and like that, you can link them with perinatal support in the hospital.'-P3*

*"…to actually provide a trauma informed service wherever we work, every single person on the team…who faces a woman or a family should have that knowledge and understanding…the damage is done by communication and usually by midwives and doctors...You can see women who are really struggling with the birth that they've just had and midwives turn around and say you had a great birth, you did so well there. I think there needs to be a huge amount more training and understanding around what trauma informed care is and how we all bring it in every single day.'-P12*

P12 looks at the missing piece in the puzzle of midwives practice of TIAC. This participant shares the belief that midwives may be afraid of discussing trauma and places an emphasis on the importance of have a specialised midwife/ team to care for both staff and the women which may break the barriers of fear.

*'We're saying what happened, as in the emergency section, but we're not actually asking what happened to you…No more than as a midwife, we're saying you were at a stillbirth and you did that, but how did that make you feel? We're missing that piece and I think we need to be using the word trauma, we are a bit afraid of saying it cause I'm putting an idea in someone's head that you're traumatized but it's still widely recognized and mental health and trauma are involved together, but they're actually quite separate and maybe, actually having a trauma midwife who's there for both staff and the women, but it's a huge role. I would like to see a trauma team set up and be and be using the word far more often.'-P7*

While participants recognised the importance of compassion, kindness and empathy there was a clear need for broader education and integration of trauma-informed knowledge and practices. The emphasis on birth trauma indicates a rather narrow view that should be expanded to encompass and acknowledge the impact of trauma across the lifespan. Furthermore the call for multidisciplinary collaboration and specialized roles may underline a need for systemic change to support both healthcare providers and clients in delivering care that is truly trauma-informed.

**Theme Two: Education**

Responses to questions under this theme emphasized the significant gap in education and training for midwives in TIAC. This knowledge deficit appears to have left many midwives feeling unprepared to adequately support and empower women who have experienced trauma. The participants noted that their current knowledge in this area largely stems from personal experience and exposure rather than formal education. The participants called for comprehensive educational initiatives, including workshops and training sessions, to better equip midwives with the knowledge and skills needed to address trauma in their practice. There was agreement that improving education in this area would not only enhance the care provided to women but also empower midwives to perform their roles with greater confidence and competence.

The participants in the focus groups underlined the critical need for comprehensive education and training for midwives in TIC, to ensure they can support and empower women effectively. Participants also identified the dearth of TIC education.

*"You know, would anybody have sat us down and said OK, so this is trauma informed care?"-P2*

*"I certainly never received any training in the area of how to prepare for trauma-informed care."-P5*

*"My own personal experience and exposure has been very little."-P6*

*"When I was training, obviously we did cover bits about birth trauma, but I don't think it (trauma informed care) was really focused on."-P18*

*"No, no, there's no education around it."-P3*

Further, participants recognised the value and importance of education in empowering midwives to provide a TIAC.

*"You talk about empowering women. You have to empower your midwives as well. 99% of these questions are asked by midwives…we are holding that space, and to expect us to do that without education."-P2*

*"I've encountered it with newer girls (midwives) They're like, I don't know what to say to this woman. Tell me what to say. How do I talk to her? And you know, if you've done it once or twice, you do pick up on things to say and the right way to say it. But even if you had a little bit of that included in your training or just as like a workshop or a study day. That somebody just sat down and said right, OK, well, this is the kind of language that we want you to use that women find beneficial, you know, rather than going into a situation where you're not entirely confident."-P18*

The participants highlighted that their existing knowledge and education TIC came from their exposure and clinical experience. There was a huge value placed of the individuals' soft skills. Soft skills in midwifery are interpersonal and communication abilities that enhance a midwife's capacity to provide compassionate, effective and holistic care to women (Shakespeare and Keleher 2007).

*"We just need to, value what women tell us now, it's the soft skills, it's that you listen, give the time, sit on the bed, ask the question, wait for an answer, and don't answering the question yourself. You know when there's a momentary pause, that comes with experience."-P4*

*"I think when you're a newly qualified midwife, it's hard enough to keep up with the actual conversation, Never mind the subtext underneath the conversation and*

*that's absolutely when I think you're at the most risk of not recognizing or maybe contributing to trauma…In my own practice, I try to use my own judgment."-P5*

One participant highlighted the wisdom that comes from experience. This coincides with Davison's (2021) discussion of midwives ways of knowing. Midwifery wisdom incorporates theoretical and embodied knowledge, clinical skills, deep listening, intuitive judgement, spiritual awareness and personal experience (Davison 2021).

*"You look back on their notes and think, oh, they had a one traction Kiwi or an episiotomy or an SVD on all fours. Like, what was traumatic about that? But you don't know, you know, you just have to go by what they're saying. I think that's just more learned experience. I think that's something that is difficult to teach like, reading of body language. It's just something that comes with time."-P18*

One participant decided to explore their understanding of the physical manifestations of trauma to optimise the care they provide. This may display a wider desire to learn and practice TIC.

*"…. I've been learning about somatic exercise and releasing trauma from your body, one of the places that we hold trauma is in our pelvis. I'm really mindful now that if I'm looking after a woman and asking her to go into that position of, bringing the feet up, letting the legs fall out to the side that actually she might have some trauma in her body that she's not recognized, that she has never acknowledged and it comes out at that point. That's me personally. That's where we tend to store our traumas in our pelvis."-P17*

P8 shared a journey of understanding that broadened from considering previous poor birth experiences to recognizing deeper, more diverse origins of trauma,

including childhood traumas and experiences of migrant women. This broadened awareness may display a need for more comprehensive support and education for clients and staff.

*‘I'm going to be really honest I had read up on this, I perceived it being if a woman had a poor experience, maybe on a previous pregnancy and poor outcome or difficult delivery or whatever, then on the next occasion we were supporting her. Until I went and read up a little bit about it.*

*“So I suppose I've realized now that it's more about trauma back from childhood or Post Traumatic stress disorder. You know, women coming now from these migrant countries that are bringing issues with them and then maybe staff themselves own personal experience is coming up through looking after women who've had different maybe childhood experiences of sexual abuse or whatever. I suppose it's being aware of it, screening for it and supporting the women and ourselves.’-P8*

Educating women on the importance of trauma disclosure was seen as fundamental to empower them and give them a voice.

*“We need to educate women to speak up.”-P4*

*“A big part of women's experiences, particularly when it comes to trauma, is their understanding of what's going on and for me, comes back to the education that they've had and information they've been given throughout their pregnancy.”-P6*

The need for improvements in education, knowledge and training provision within the maternity services appeared unequivocal .

*"A lot of our knowledge and what we're doing needs to be updated."-P12*

*"I would have always considered myself very trauma informed and the more reading I did about it, I realized that actually things I was doing or saying weren't necessarily helpful. I think it comes from a lack of training."-P13*

*"I think that in terms of education around trauma informed care, I'd like to see a really big emphasis on the language."-P13*

*"Better education pathways for when a woman does disclose domestic abuse and we do have a pathway to follow."-P3*

Participant 4 acknowledged the necessity of incorporating new evidence about TIC into practice. This statement encapsulates the commitment to improving care.

*"I think we know better now, we just need to try and do a little better. We can't ignore the evidence anymore."-P4*

**Theme three: Challenges in Providing Trauma Informed Approach to Care, Relationship-based Care, and a Responsive Maternity System**

Responses to questions under this theme explain the challenges that participants' face in the delivery of TIAC. The provision of TIAC in maternity services faces significant challenges, rooted in balancing systemic demands and individual needs. The focus group discussions highlighted several barriers, including staffing shortages, time constraints, and inconsistent care approaches, which may hinder midwives' ability to deliver personalized, TIC. The participants expressed frustration with these systemic issues, feeling that both they and their clients were unappreciated. The theme of challenges in providing TIAC was broken down into three subthemes:

- System vs. Individual needs
- Personalised Care
- Continuity of Care

**Subtheme 1: System vs. Individual Needs**

The emphasis on responding to the needs of the woman as opposed to those of the system, highlights the shift towards more individualized care. It may also suggest that healthcare systems could be more flexible and adaptive to meet the specific requirements of each woman. The participants in the study identified many challenges within current maternity services which were seen to hinder the delivery of TIC.

Staff shortages appeared to severely impact the quality of TIC provided by midwives as well as staff morale. As a result, participants appeared frustrated with the healthcare system as a whole, feeling themselves and their clients were unappreciated

*'Department of Health is about cost efficiency, they see this short term picture as opposed to the to the long term picture. You can't really value sitting on the bed or giving a woman an hour and a half appointment, or bringing her back an extra time. They don't see the value of that.'-P4*

*'I suppose it all comes back to staffing levels really, which I know there's no quick fix for that.'-P6*

*'M*y thing would be more staff, I could fix nearly everything if we'd more staff.'-P14

*'There's staffing levels, there's structure wise, there's all sorts of things that now impact on how you can get somebody to trust you enough that they would tell you that.'-P2*

The issues with staffing appeared to negatively impact on the time that midwives could spend with the women in their care. The chronic time pressures appeared to affect the quality of care provision.

*'I suppose the big thing is to listen if the women feel they're being listened to that's a big starting point and it's to have that time. But we're constantly pressed for time.'-P11*

*'If you don't have the time, you can say things without thinking of the effect you're going to have on the person. We're so understaffed and the women are coming with more complex physical needs and mental needs. You tie yourself up thinking, Did I give that woman the best care that I could?'-P14*

*'Women may not want to disclose because they'll see that the midwife, they're seeing is really busy and they don't want to bother them.'-P3*

The lack of staffing and time was viewed as inadequate for the women in the service.

*'I think that it's probably specific midwives on the ground trying to push the agenda and maybe not having time or not being supported enough to actually deliver the care that they want to. Unfortunately, to the detriment of women.'-P5*

*'You're looking after so many women and babies. You're thankful that you get through a day/ night shift without anything happening. You're lucky enough if you can support a breastfeeding mum. When you look at that working environment, how on earth are you supposed to then provide trauma informed care?'-P2*

A core value of being a midwife lies in advocating for women, and a lack of time appeared to inhibit this.

*'You don't have the time to advocate.'-P2*

One participant recalled a specific scenario in which care was impacted by lack of time.

*'I met a woman in the labour ward and she was traumatized by having had a vaginal examination that morning, I spent a little time talking through it, I was just passing through, so I passed that on to the midwife, and the CMM who were looking after her. They just nearly rolled their eyes and were like, alright, whatever, but it saddened me because I had given her the time, I'd recognize there was something not right there, but the staff on the floor didn't want to listen to it. They didn't have time to deal with it. They didn't have time to be able to sit down with that woman and see exactly what was going on and possibly amend what their plan for her would have been because they just didn't have the time to do it.'-P6*

In a different way, other participants recalled scenarios where time wasn't an issue and women appeared to feel able to disclose a trauma history.

*'When I think back now I probably wrote her off as a young one who wasn't really that proactive about her pregnancy, then at one particular appointment I had a lot of time to give her and she told me she couldn't engage because she was terrified of labour due to a history of a sexual assault. You're better off just tackling it before they walk in the door at the labour room.'-P12*

*‘I looked after a lady with a concealed pregnancy as a result of rape, I was lucky enough the ward was not busy that night and could sit and speak with her. She spoke for hours and cried for hours. I felt like if she didn't, if I had been really busy that night, I don't know what would have happened.’-P15*

The participants appeared to value practical support, such as staffing and resources to provide a TIAC, over symbolic gestures such as being offered a free ice-cream.

*‘We all understood that the gesture was well meant, but one day an ice cream van came in, we all got a free ice cream cone. But we were like just give me another midwife. We felt it was totally bizarre and there was a big thing about it on social media and you're like, what is it for or who is it for? Its not that we didn't welcome the ice cream, but it just seemed very kind of like a tick box saying, the band aid is on.’-P2*

Other challenges identified by participants included the lack of consensus surrounding approaches to care. This refers to the unity of the approach regarding the plan of care for the woman.

*‘If somebody was say, attending community midwifery and they disclosed domestic violence, somebody would say Ohh then we'd have to bring them in and get them under the care of the hospital. Like, why would you do that? You’re taking away their whole continuity? They're trust and you're going to put them into a system where they might only see a doctor every time they come for a visit and nobody will be checking in with them. We have a funny way of thinking of things sometimes.’-P2.*

*‘We should be using the same approach with every woman.’-P1*

*‘But now, they're coming to homebirth from a place of trauma and avoiding the hospital system and free-birth. We're having 10-15 free births in every county. These are women who trusted the system. First they came to the hospital with a previous birth because they trusted the hospital and they were let down by the system.’-P4*

*‘It would be lovely if everybody was singing from the same hymn sheet with the way that we approached care. At the moment that's not the kind of practice I'm seeing.’-P14*

Participants also felt that the inconsistency in information provided to women could lead to inadequate care.

*‘I think most women do feel safe, but they come across one person who tells them one thing and another person tells them something different. If we're not all singing the same song, then that will immediately put their guard up and they’ll feel unsafe.’-P10*

Cultural and language barriers was recognised as negatively impacting care provision. There was acknowledgement among participants that there may be different types of traumas experienced by migrant women that are unique and diverse.

*‘Women coming now from migrant countries are bringing individualised issues.’-P8*

*‘At the minute the amount of refugees coming in from Ukraine and what have you, they have been through so many traumas there that we would have absolutely no idea of.’-P3*

*‘Language barriers is huge and cultural differences and foreign nationals that don't speak English.’-P18*

The physical environment also appeared to impact on optimal service provision:

*‘I'd say environment and practical things like staffing and space, lack of private space, are all barriers to trauma informed care and supporting a woman through something like that.’-P2*

*‘If you're seeing them in their own house, they're way more comfortable telling you things.’-P3*

**Subtheme 2: Personalised Care**

This sub-theme underscores the importance of building trusting relationships between healthcare professionals and clients. Participants revealed that relationship-based care involves understanding the unique needs of each woman and responding to those needs rather than systemic protocols.

"Respond to the needs of the woman as opposed to the system."-P4

*“Make it as person centred as you can.”-P5*

Many participants referred to this as ‘Humanizing care’.

*"It's individualizing that experience and humanizing the whole thing."-P2*

*"We talk a lot about humanizing birth, we just don't do enough of that."-P2*

*"I think judgment is a really big thing...I treat every single woman exactly the same, whether she's 15 or 50.”-P9*

*“Sometimes time is an issue, but more so it's the person. Maybe they want to keep whatever they're feeling private or they've gone through in the past, private. So then it's about Informed consent as best you can. I'm just going to be compassionate and empathetic to her.”-P17*

*“I get a bit disheartened, if you can have one person coming back to a person who's had a tough time and just visiting them, I think they do appreciate it. They're actually not a number that people care about them.”-P16*

The impact of COVID-19 on human interactions was also identified as an impediment to optimal TIC.

*“During COVID we reverted to doing bookings on the telephone and all that kind of thing. I think it's sad that in 2023 lots of units haven't reverted back to one to one in person. I think trauma informed care is what you see. I think, you said that even when somebody comes in, you can feel it and you know from their body language. Not everybody's going to start crying, but you can see somethings going on and I think that's really missing now when a booking history is being done over the phone. We need to be making that connection at the very beginning.”-P2*

**Subtheme 3: Continuity of care**

Continuity of care emerged as essential for identifying and addressing trauma, allowing midwives to build trust and rapport with clients. Consistent support throughout pregnancy and childbirth appears to enable midwives to pick up on cues and provide personalized, TIC, reducing the risk of re-traumatization and ensuring women feel supported throughout their perinatal journey.

Participants identified continuity of care as a critical component for identifying and addressing trauma, as it allows midwives to get to know the woman, recognise prompts or changes in behaviour that allows the midwife to adjust and personalise care .

*'It's picking up on their queues or any previous history as well. That's the benefits of having that continuity you can, as midwives, pick up on things.'-P1*

*'If you have that continuity with a woman you should be in a better position to pick up any issues, we know very few women in Ireland are cared for within a continuity of care model and to me it's an awful shame.'-P6*

*"I recognize there is a need for obstetric led care, but there should be some sort of midwifery continuity provided through that, there is in many other places. It's something that is completely overlooked even in the maternity strategy...If we were able to get midwives seeing women, having that continuity, building relationships, we might be in a better position to be able to identify and deal with these things that are cropping up."-P6*

*'Continuity more than anything else, be it midwife-led or obstetric-led.'-P13*

*‘If there is continuity of care, it definitely makes a huge difference’.-P14*

Continuity of care was highlighted as essential for building trust and rapport with people. Midwives stressed the benefits of providing consistent support throughout pregnancy and childbirth, enabling the identification of trauma-related issues and fostering a therapeutic relationship.

*‘I think your relationship based care and the named health professional that you know. Asking the questions and identifying the needs of the women who are coming back to them and trust them. And having responsive maternity services.’-P4*

*‘We’re at an advantage for identifying those women because we build up such a rapport with them. You can have midwife-led care everywhere.’-P14*

*“People go private so they have continuity of care. It’s a huge thing we're still not providing women and it means so much. Sometimes you've got 5 or 6 minutes to try and build relationships before you do something really intimate with somebody that you would never ever do normally, and that's a big, big thing.”-P7*

Midwives advocated for sustained continuity of care to avoid re-traumatization and ensure women feel supported throughout their perinatal journey.

*‘I used to try and it's not always possible. When they'd (women) come in, they’d ask for me, so they didn't have to continually tell their story or whatever. That would be my thing, it would be to try give them continuity during their pregnancy.’-P2*

**Theme Four: The Interplay of Personal and Professional Trauma**

The questions under this theme explain participants' experiences and exposure to trauma within the workplace. The participants give insightful descriptions of scenarios that effected them. They display resilience in how they dealt with the scenarios and also the supports that assisted them. The focus group discussions demonstrated awareness among participants that trauma exists in everyone's life.

*"We all bring trauma, be it from a previous birth or from life, everybody has some sort of life trauma. It's being aware and to always consider there probably is some trauma in someone's life you know and to be mindful of that."-P1*

*'We're probably all traumatised in different ways, shapes and forms.'-P18*

One participant said that it was her own personal experience of trauma that led her to becoming a midwife, to strive for better care standards for others.

*'You do bring some of your own trauma into it (the job). I jokingly say why did I become a midwife? because of my birth, of what I experienced. I felt it could be better.'-P2.*

The impact of looking after women who experienced trauma or disclosed a trauma history appeared to have a substantive and sustained impact on the participants

*"A women I cared for experienced childhood sexual abuse. That actually impacted on me as well because I built a relationship with her and all these years later we're still friends. It was paving this pathway for her throughout her pregnancy."–P2*

The participants also described care encounters and clinical scenarios that deeply affected them. A compounding commonality amongst the participants was the lack of support offered to them or received by them when they were exposed to a traumatic experience.

*“I think sometimes we’re bad at recognising the trauma that we go through. I attend a psychiatrist and I spoke to her about a woman I had seen and couldn't find a heartbeat…I was six weeks pregnant at the time, she was horrified hearing the story...But we normalize it. Your coming out of it feeling fine mostly burying down… when I look back at all the loss, pain and all those horrible things that happen. It’s sad, they don't haunt us, but how much are we covering up? These things would haunt any other person for their life, because it’s not a natural experience to have to go through. As midwives we’re not very good at recognizing the significance of the situations. We brush them off.”-P9*

*“…something I will never forget is myself and the bereavement midwife held those babies till they died. They were both born and breathed. It was one of the most surreal experiences. It will never leave me. There's not really anything that anybody can do about it, it doesn't haunt me or anything, but it's something I will never forget.” P10*

*“I've never spoke to anybody about any of those traumatic dealings where you're beating yourself up about something.”-P15*

Participants described the importance of the relationships around them and how often they relied on their partners, parents or other family members to confide in, and debrief with after a difficult event.

*“If somethings really bugging me, I probably go to my husband, obviously not disclosing names around them. You would just be like, Oh my God, this happened and people respond like, oh, my God, you're going to go back in there tomorrow?”.-P15*

*“On the occasion that you come home and chat with your partner or your mom and tell them (about your day) confidentiality, obviously, but then they're like, Oh my God, like, how do you do that job? And that doesn't make you feel any worse but you realize how they're like, this is horrendous. How do you put up with this stuff? but you know the lovely job that being a midwife is. When laid bare to people, you can see how horrified they are at the stuff you deal with. I suppose it could be that could be a big deal. We say it’s okay, but you keep it with you.”-P14*

*“You know, as soon as you get home, you just go, OK, I'm home. That's it. I need to put this out of my head. But, after busy nights or whatever…I don’t want to leave the house. I don't want to do anything. I just want to lie in a hoop on the sofa. You carry so much of it yourself and then you're dreading going back in.”-P18*

One participant revealed the desensitisation effect of repeated exposure to traumatic birth events, revealing how they became ‘immune’ to how traumatising clinical interventions could be for clients.

*‘What’s major is when they come in, they feel so violated. I think we've just taken it as oh she just had a forceps, because we're so used to it. We become immune to it.’-P16*

There appeared to be a lack of support for midwives who worked with or observed traumatic events in the workplace. Many participants made reference to ‘*internalising their feelings’*.

*‘You give something of yourself and your story, while the main focus of course, is on her and her needs. I think we all internalize, otherwise, we couldn't do our job.’-P11*

*‘We have to box things off. Like you deliver a miscarriage and then you must go and put a CTG on acting like nothing has happened. I don't think our training makes us ready for it (dealing with trauma).’-P10*

*‘There are women that I remember from my very first placement as a student midwife that I won't forget. Then you think how many more women are going to be able to fit into my brain.’-P14*

*‘I'd love to be able to say that 'I'm great at leaving it all at the door’, but I think as midwives, nurses, caregivers were not very good at that.'-P13*

*‘When we were in college, one of the things that was drummed into us was you leave it at the door, you don't bring your troubles to work with you. You're here to look after that woman. It's not about you. It's about them. So, there is that still, the attitude, where it doesn't matter what's going on with you. But no, it does. If you know your colleagues well and feel like you can open up to them or they can open up to you, you're mindful that somebody's going through something. If you're working with them, maybe you're going to give them a bit more of a dig out or you're going to help them or you're going to make sure they get their breaks first. Unless somebody feels that they can tell you that, unless you have a good relationship with your colleague, you might not know that. But with college and with management it doesn't matter. It's nothing to do with work. Leave it at the door, collect it on your way out but while you're here, You're here to work’.-P17*

*‘I would agree with that.’-P18*

As a result of being exposed to other people’s traumatic experiences, midwives voiced their feelings about the care they provided, how they often second-guessed their care, worried about their performance, and often became overly self-critical.

*‘I know myself, coming home from a hard day, driving home in the car, you are constantly thinking What else could I done? you kind of beat yourself up going home in the car.’-P15*

*‘You tie yourself up thinking did I give that woman the best care that I could?’ –P14*

*“We go straight to blaming ourselves in many ways. Everyone goes home to something, a sick parent, a child with autism, a sleepless child, a breastfeeding toddler. You can't know what's going on.”-P4*

*“Can I keep her safe? It’s my responsibility to keep her safe?”-P2*

Peer support was seen as a key factor for midwives’ overall wellbeing and resilience in the working environment. Peer support is a core component of creating a supportive and empathetic work environment. It helps mitigate the impacts of trauma, enhances emotional resilience, and ensures that midwives feel supported and valued in their roles. By prioritizing and nurturing peer support, healthcare organizations can enhance the effectiveness of TIC and improve the overall work experience for their staff (SAMHSA 2014).

*‘I really think they are the backbone to midwifery support. It’s your colleagues that are standing beside you.’-P6*

*‘Having had stuff going on in my personal life and needing time off, I actually found most of the times I was accommodated without needing to ask and that was really appreciated and it tends to not be the manager of the department, but it your friends and colleagues doing rosters etc that looked after and minded you.’-P5*

‘I think we share these experiences with each other, on nights and that. A bit like a marriage, it’s part of being in a small unit, it’s important that you have that camaraderie and you do share these stories.’-P7

*“*We try to have each other's backs and look after each other and that's very important.”-P11

*“It is really at work that you do most of your offloading.”-P14*

Participants compared support from their peers with the limited support and understanding from management within the workplace.

*‘If your, just say, looking after miscarriages or IUD's, your colleagues will, ask Are you OK? your managers will try, where is possible, not to give you another woman after she has delivered. But I find from, higher u there's not very much. Unless it's been something particularly horrendous…It's just another day…I’ll go home, tell my husband, he’s like, what? And I’m like, yeah. It’s just another day, but he’s horrified.’-P18*

*‘As the management structure goes up, the lack of compassion there is...From my experience, there was very little compassion before I left, even afterwards. The higher you go, the less and less you care.’-P2*

*‘Sometimes as a midwife, you need time to depress before you can go into the next room and look after the next woman. But you just don't get it. It's hard, you must compartmentalize what's happened and deal with it later. If managers were more aware of that, but again it's time constraints, the system must keep moving.’-P3*

*‘The pressures of different departments and different jobs, when people are stressed and short staffed, they're not thinking of their fellow team members and what's going on in their lives, they’re just thinking of the current situation. We should be caring for each other.’-P1*

One participant recalled a difficult situation regarding a time when they felt a lack of support from management, and the troubled feelings that arose from that. She has consciously chosen to adopt a more empathetic and supportive approach towards students and newer staff in the workplace. She identifies herself as a "mother figure," someone who provides guidance and assistance rather than demanding or dictating tasks. Her empathy is driven by the negative experience she had, which motivates her to ensure that others don’t feel the same way she did. By being supportive and kind, she aims to create a more nurturing environment for those who are newer to the field, in contrast to the lack of support she experienced ultimately creating a trauma informed environment for the staff she works with.

*‘I was eight weeks pregnant, working in the labour ward, I had a normal delivery which ended up a PPH....I hadn't been relieved for break. They (management) were just saying you need to do the incident report forms. She said sure, that’s because you can't manage everything. That was wrong. And I always remember that. I think I'm very kind. When I see students coming along, I'll always support them. I'm not blowing my own trumpet here, I'm very much like a mother figure. I wouldn't be like do this do that. I'm not one of those old school people. I'll help*

*them, and I'll say do this it will make it better and easier on you. I'm very much empathetic with the newer staff coming through definitely because I hated the way I was made feel.'-P16*

One midwife compared a different management approach and the positive effect it had on her. In this scenario the manager's approach aligns with the principles of TIC which includes creating a safe, supportive environment and promoting empowerment.

*"I was lucky in my first few years as a midwife. I had this manager, she was amazing, just great. You never felt you couldn't go to her…She'd try and have monthly meetings and always made them positive. It gave time to find out how work was at that moment and is there any area where we're not doing right. I didn't appreciate her. It was only when I came under a different management style that I couldn't believe it…you would be scared going to her, and if you were newly qualified or something, you wouldn't feel comfortable, you'd be anxious.'-P2.*

Self-care does not appear to have been routinely practiced by the participants. This is of significant concern as it directly impacts both the wellbeing of the care-giver and the quality of care they provide.

*'I'm so busy taking care of everyone else. I'm probably the last one to be taken care of and I'm just so used to that. That's the way it is. I don't even know how to self-care.'-P1*

*'We really should look after ourselves better.'-P15*

There appears to be a disconnect between support offered in the workplace and the practical needs of healthcare providers. The statements highlight that while

some self-care initiatives, like meditation breaks, were introduced, they were not always well-received or effective due to the high-pressure, time-constrained environment in which healthcare professionals work.

*'I think there's some meditation breaks and stuff like that but again, I don't think it was that well responded to. People didn't have the time to go down and you're stressing constantly thinking, I have to go back.'-P1*

*'Relax or meditate and what you're not asking me is how my workspace is? what the environment is like? you know, the valid stuff that you have to say.'-P2*

*'I get a bit disheartened. If you can have one person like coming back to a person who's had a tough time and just visiting them, I think they do appreciate it. They're actually not a number.'-P16*

*"Focus on staff well-being, I think the better we are in ourselves, the better we can mind people. Unfortunately it does just fall to the wayside sometimes, like when the place is busy. It's not something that gets focused on like, we're all great at asking each other. Are you OK? You know, can I do anything? But how many people do you know that cry on the way home after their shifts? Lots of people, myself included. I've done it loads of times. It's not nice."-P18*

There was evidence of profound resilience among the participants. Resilience is the ability to adapt and cope in the face of adversity (Sisto et al 2019). It is vital for healthcare providers, especially those working in high-stress environments like midwifery. However, in TIC, it is equally important to recognize that resilience alone is not enough if underlying trauma and stress are not adequately addressed.

*‘In general, our workforce is quite junior, but how resilient I see them. I know trauma is probably there underneath somewhere. You're all saying you just carry on, but you'd wonder. What's going on underneath all that? Does it catch up on you eventually? We don't know what's going on in people's personal lives or what has gone on, they're also trying to deal with trauma, then they're seeing it at work, it could be triggering things for them, that they're trying to deal with, I think there needs to be more awareness.’-P8*

*‘We focus on that positive piece. That's what we do. That's how we keep going.’-P7.*

**Conclusion of findings from Phase Two**

Phase two of the study used online focus groups to gather data from midwives across the ROI with regards to their knowledge and experience of TIAC. A total of 18 midwives participated in this phase of the research across 5 focus groups. Data was analysed using Braun and Clarke (2006) thematic analysis. This method of thematic revealed four main themes: Awareness, understanding and recognition of trauma, Education, Challenges in providing TIAC and a responsive maternity system and The Interplay of Personal and Professional Trauma. There were also three subthemes identified under Challenges in providing TIAC which were: System vs. Individual needs, Personalised Care and Continuity of Care.

The main findings from phase two revealed that:

- Participants appeared to demonstrate a fragmented perception of TIC within maternity services.
- Participants recognised and articulated the importance of compassion, kindness and empathy across the perinatal care continuum.
- Participants have a strong desire to learn more about TIAC and want to enhance and excel in TIC provision.
- Participants can face systemic challenges which may impact the delivery of a trauma-informed service.
- Participants identified that continuity and personalised care would be key enablers of TIAC.
- Structured pastoral and peer support is important in sustaining TIAC.
- Participants acknowledged that everyone, including themselves and colleagues, can experience trauma, which can have a lasting impact.
- Participants demonstrated resilience and adaptation to the changing landscape of perinatal care.

The findings from phase one, the quantitative phase and from phase two, the qualitative phase will now be integrated throughout the discussion chapter.

# Chapter Six

# Discussion

## Introduction

The purpose of this research study was to evaluate knowledge and practices related to TIAC within the Midwifery/ Perinatal settings in Ireland.

The objectives were:

- To evaluate current *knowledge* related to TIAC within the midwifery/perinatal settings in Ireland utilising a mixed methods approach

- Evaluate current *interventions* related to trauma informed practices within midwifery/perinatal settings in Ireland

- Develop *recommendations* to integrate a universal TIAC model within midwifery/perinatal settings in Ireland

This chapter synthesizes the quantitative and qualitative findings from the study, integrating both datasets to provide a comprehensive understanding of TIAC within maternity services (Appendix N). The discussion highlights key themes that emerged from the data, explores the overlap and integration of findings from both phases of data collection, and situates these results within the broader literature.

The chapter will be framed by the three overarching themes that have emerged from data synthesis, within each theme there are three subthemes. These are:

**Education and Training**

1. Current Landscape on TIAC
2. How Knowledge is currently acquired
3. A Path Forward in education and training

**Working with Women**

1. Staff, Time and Infrastructure
2. Continuity of Care
3. Dedicated Care Pathway

**Working with Trauma- Minding Midwives**

1. Midwives exposure to trauma in the workplace
2. Midwives personal trauma
3. Need for improved support

## Education and Training

Education and training have been identified as key components of TIC. Under this theme, the following sub-themes scaffold existing understanding:

### 1. Current Landscape of TIAC

TIAC is increasingly recognized as essential in healthcare, particularly in maternity services (Benton et al. 2024). Evidence indicates that many healthcare professionals, including midwives, have not previously received TIAC education (Long et al. 2024; Long et al. 2022). Women with trauma histories frequently interact with healthcare services multiple times before encountering a professional knowledgeable in TIAC (Li et al. 2019; Stokes et al. 2017). Midwives have a unique opportunity to provide early TIAC during pregnancy, which can prevent re-traumatization, promote biopsychosocial well-being, and improve care satisfaction (Flanagan et al. 2018). However, while Choi and Seng (2015) and Cannon et al. (2020) have demonstrated potential to improve knowledge and skills with TIAC education, more rigorous and long-term studies are advocated by these authors to confirm sustained confidence in TIAC delivery.

Quantitative data from the current study, echoes the evidence from Li et al. (2019) and Stokes et al. (2017), revealing a significant gap in formal training on TIC among midwives. Almost 72% of respondents had not received any TIAC training before qualifying, and 66.5% had not received post-qualification training. This finding is stark, and may highlight a systemic issue in midwifery education and professional development programs with regard to the need for more comprehensive inclusion of TIAC within curricula. Qualitative data from focus groups further supported this finding, participants emphasized the critical need for comprehensive education in TIC throughout their training and career. Midwives expressed concerns that without formal training, they feel they’re not fully equipped to effectively support and empower women who have experienced trauma. These

concerns were acknowledged by midwives in previous studies (Long et al. 2022; Cannon et al. 2020; Flanagan et al. 2018; Choi and Seng 2015), where participants expressed a lack of knowledge and confidence to provide appropriate care for women with a trauma experience, whilst also revealing insufficiency of targeted TIAC education, during third-level education/post-graduation education in TIAC.

Of those midwives, in the current study, who had undertaken additional training in TIAC, nearly 70% sought it independently. Nevertheless, most participants demonstrated a deep knowledge about the effects of trauma on wellbeing, and the potential for re-traumatization, as indicated by high mean scores of 87-96% and low standard deviations in the quantitative findings related to this question (See Chapter 3 Section B Table 1) .

The participants display both personal and aesthetic knowledge (Carper 1978). Personal knowing enables the nurse to identify his/her responses, strengths and weaknesses in a situation and to be aware of the individual biases affecting the quality of the nurse-patient relationship (Rafii et al 2021). Aesthetic knowing is achieved through empathy, dynamic adaptation and understanding of the components as a whole as well as the recognition of specific cases rather than holism (Rafii et al 2021). However, despite this personal/aesthetic knowledge (Carper 1978), focus group discussions revealed a fragmented understanding of TIAC. Participants demonstrated confidence in discussing birth-related trauma but displayed more limited knowledge about the broader aspects of life-span trauma. This inconsistency may highlight a theory-practice gap, where theoretical knowledge may not fully translate into practical understandings. Evidence from the literature supports this contention, noting that training alone is insufficient without practical, context-specific implementation strategies (Fixsen et al. 2005). This finding may suggest a need for comprehensive training that bridges the gap between theory and real-world practice, enabling midwives to apply TIAC

principles more effectively within diverse scenarios. The study's quantitative data indicating limited formal training in TIAC, is corroborated by qualitative insights that emphasize the need for improved education among midwives. Further, the proactive nature of participants seeking independent training, supports the expressed need for accessible and structured training opportunities. This need aligns with recommendations from the National Children's Bureau (2021) regarding the importance of staff education in establishing a trauma-informed system. The National Children's Bureau is a UK based organisation that strives to improve the system that keeps children safe, secure and supported, they are currently working on delivering trauma-informed practice within the early child development sector in the UK. From a knowledge perspective, the quantitative findings of this study, indicate a robust understanding about the effects of trauma on personal well-being and also the potential for re-traumatization. This is evidenced by high mean scores and low standard deviations within the data from the knowledge question (Chapter 3 Section B Table 1), suggesting that TIAC knowledge level is consistently high across the surveyed sample. This could be interpreted as a potentially positive outcome of initiatives aimed at enhancing *awareness* and *understanding* of trauma and its impacts. Respondents to the questionnaire in phase one identified some of these initiatives that may be beneficial including; "Informal Sessions", "Debriefing sessions for all team members", "Short Videos on HSEland", "Reflection", "Discussion", "Drills", "Simulation Training" and a "Day course in trauma information relevant to maternity care". The finding supports the call for more targeted and comprehensive training in TIAC, to help equip healthcare professionals with the necessary knowledge to address trauma-related issues effectively (SAMHSA 2014).

It is important to note that many midwives repetitively referenced the importance of 'soft skills' such as listening, kindness and empathy as a means of providing TIC. These soft skills are core to the role of a midwife and have been set out previously by NMBI in The Practice Standards for Midwives (2022) which governs

midwives in Ireland. Similarly, Moloney and Gair (2015) found that midwives' empathy played a key role in creating a positive birth experience and that a lack of empathy and compassion contributed to birth trauma. While these soft skills enable midwives to create supportive and empathetic environments for trauma survivors, they do not inherently equip midwives with the specialized knowledge required to address trauma comprehensively (Long et al. 2024).

**2. How is Knowledge Currently Acquired**

Long et al. (2022) found that current knowledge acquisition in TIAC among midwives is primarily sought through short, interactive educational sessions, group discussions, and real-life scenario training. Participants in their study favoured these methods, highlighting the importance of pre-reading and videos to provide foundational knowledge. The use of virtual reality simulations and interactive technologies was recommended by these authors, to enhance practical skills in recognizing and responding to trauma-related behaviours. Long et al. (2022) suggest that there is variability in TIAC curriculums which are often developed in-house, leading to inconsistencies in knowledge and application of TIAC. TIAC is a relatively new concept that has been defined and adapted in various ways across different settings and populations, making it difficult to synthesize consistently (Berring et al. 2024).

Within the current study, focus group discussions provided a deeper insight into how midwives currently acquire knowledge and skills related to TIC. Participants highlighted that much of their understanding comes from clinical experience and exposure (personal/ ethical/ aesthetic knowing) (Carper 1978), rather than structured educational programs (empirical knowing). They placed significant value on the development of soft skills; empathy, active listening, and communication, which are crucial for delivering TIC. This qualitative insight aligns with the quantitative data in highlighting the existing gap in formal training, but also

adds nuance to understanding, by illustrating how midwives adapt to this gap through hands-on experience. Midwifery philosophy, emphasizes holistic, woman-centred care and the importance of building strong, empathetic relationships with women. Midwives work in partnership with women and use professional knowledge, skills and attitudes to competently support the woman and her baby (NMBI 2022). This core philosophy reflects a commitment to providing compassionate care despite systemic challenges. Midwifery protects and enhances the health of women and infants, which in turn protects and enhances the health and wellbeing of society (NMBI 2022).

### 3. The Path forward for Education and Training

There is growing awareness that there is a significant gap in formal TIAC education for midwives in Ireland, as highlighted by the data in this study. Participants in focus groups underscored the critical need for targeted, comprehensive TIAC education. They suggested various methods for delivering this training, including informal sessions, debriefing sessions, short videos, reflection, discussion, drills, simulation training, and day courses. Coleman (2024) investigated the use of continuing education sessions to increase health care providers' knowledge and readiness to implement TIAC into their practice. Health care providers' knowledge and comfort with TIAC was improved by the education sessions, endorsing the views of the midwives in this study. In addition to emphasising the need for more comprehensive TIAC training, midwives also suggested a variety of methods for delivering this education, from informal sessions and reflective practices to more structured approaches like simulation and continuing education courses. The existing literature (Long et al. 2024; Sperlich et al. 2017) supports these interventions, consistently demonstrating the positive impact of structured TIAC education on healthcare providers' knowledge, attitudes, and readiness to implement these principles into practice (Sperlich et al. 2017). This emphasises

the critical need for both formalised undergraduate and continuing education in TIAC, to ensure that midwives continue to be well-equipped to deliver TIAC.

The limited nature of formal training in TIAC, as evidenced by both quantitative and qualitative findings within this study, indicates an urgent need for a more structured approach to TIAC education. Midwifery curriculum may need to incorporate more comprehensive training on TIC to ensure all midwives have a foundational understanding before entering clinical practice. Aligned to this contention, Long et al. (2024) carried out an evaluation to determine if there was a significant difference in attitudes towards TIC between midwives who participated in a 2-day TIC education program and those who did not. The results suggested that midwives who participated in the 2-day TIC education program had significantly higher scores for positive attitudes towards TIC compared to those who did not partake in the program. This effect was sustained at 6 months highlighting the importance of formal training and the potential it has to optimise care delivery in the longer term. This is in contrast to the findings by Choi and Seng (2015) suggesting shorter, half day sessions as a preference for TIAC education. Expanding this consideration, Long et al. (2022) carried out an integrative review on TIC education for midwives, identifying five studies including Choi and Seng's (2015) study, and concluded that the majority of participants agreed that longer, more in-depth education involving reflective discussion was required. This recommendation, together with the findings of Long et al. (2024) may indicate that a 2-day workshop on TIC may be more successful and beneficial for midwives, further research is needed.

While formal education is crucial, the reliance on clinical experience suggests that on-the-job training and mentorship programs play a significant role in developing TIC skills (Morra et al. 2024; Snider et al. 2023). Hospitals and midwifery practices could consider implementing continuing professional development (CPD) opportunities focused on TIC knowledge and skills. In addition, clinical supervision

is well established as a mechanism to support clinicians who care for individuals with a lived experience of trauma, many of whom may also have their own previous experiences of trauma (SAMHSA 2014). The implementation of an ongoing clinical supervision programme for midwives may help to sustain attitudinal and behavioural changes as a result of TIAC education, and demonstrate an organisation's commitment to implementing a fully integrated, TIAC framework (Patterson et al. 2019; Seng 2015; SAMHSA 2014). Further, effective supervision in midwifery is crucial not only for reinforcing the provision of TIC, but also for fostering professional development, improving clinical skills, and ensuring high-quality care that meets both the emotional and physical needs of people (Hunter et al. 2019).

Regarding mechanisms to facilitate TIAC education and support, participants in this study suggested that online training or incorporation of a training module into a professional education platform such as HSEland, would be helpful. In support of these digital interventions, a Turkish study by Isbir and Yilmaz (2023), about online TIAC training, concluded that digital training can contribute to increased knowledge and skills among midwives and recurring training is needed for long-term attitudinal change. This underscores the importance of accessible, sustainable education and support to ensure full integration of TIAC into midwifery practice.

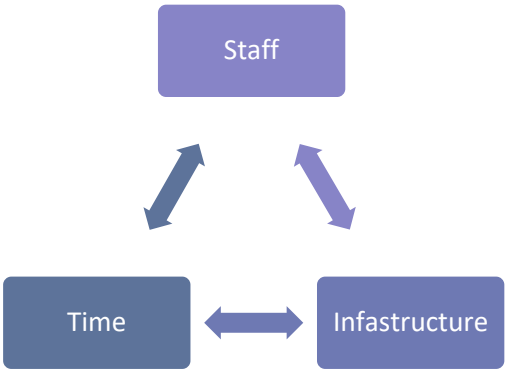
The value placed on soft skills by focus group participants, highlights the importance of integrating these skills into real world education and training programmes. Educational interventions should emphasize the development of interpersonal skills alongside theoretical knowledge (Sperlich et al. 2017). Simulation, Objective Structured Clinical Exam (OSCE), role play and reflective practice can be effective methods for enhancing these skills (Ronning and Bjorkly 2019). The benefit of reflective practice is shown by Law et al. (2021) who promote it as an important area of TIAC for practice improvement. A recent study by Lee et

al. (2023) with 17 medical students who used simulation-based training to practice conversations and interventions related to trauma, found that the participants confidence improved across multiple domains such as identifying and inquiring about trauma. The participants also felt more familiar with TIAC history taking and overall it was perceives as a beneficial educational tool. This novel approach may represent a feasible and effective means for educating about TIAC within acute care settings, like maternity services. Previous studies also found that midwives engage well with simulation based training, as it allows them to develop skills, link theory to practice and develop feelings of confidence in areas where they lacked exposure (Lendahls and Oscarsson 2017). Lee et al.'s (2023) study, in particular, may hold significant potential for changing the way midwives have been educated about TIC, enhancing knowledge, skills, and maternity care experiences.

In conclusion, the findings from both qualitative and quantitative research strongly advocate for the incorporation of comprehensive TIAC education into midwifery training. Formalized educational programs, supplemented by ongoing professional development opportunities, are essential for fostering the necessary skills and attitudes required for TIC. The evidence indicates that midwives who receive structured TIAC training not only develop a deeper understanding of trauma-related issues, but also maintain a positive attitude towards TIAC in their practice over time. As the demand for TIC continues to rise, it's imperative that midwifery education evolves to include these critical elements, ensuring all midwives are prepared to meet the complex needs of their clients with empathy, competence, and confidence.

## Working with women

### 1. Staff, Time and Infrastructure




The importance of adequate staffing in maternity services cannot be overstated, particularly in ensuring continuity of care (Powell et al. 2022). Improved staffing levels are essential for the physical and emotional needs of clients, enabling midwives to provide thorough, individualized care (Almorbaty et al. 2023; Turner et al. 2022). The ability of midwives to provide comprehensive, individualized support is often compromised by chronic understaffing, time constraints, and inadequate facilities (Almorbaty et al. 2023). These limitations not only impact the quality of care that women receive but also contribute to the frustration and burnout experienced by midwives (Suleiman-Martos et al. 2020). Moral distress occurs *'when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action'* (Addo et al 2020 p.1). Moral distress further exacerbates the shortage of midwives, which negatively affects birth experiences and birth outcomes, ultimately rendering it a public health issue (Rost et al 2024). Ensuring that midwives have the necessary resources, including sufficient staffing levels and suitable environments for care, is crucial for meeting the physical and emotional needs of both women and care providers (Almorbaty et al. 2023). This discussion explores the critical role of staffing, time, and facilities in the delivery of TIC and highlights the challenges and potential solutions for

improving care quality in midwifery. The quantitative data gathered from phase one reported that adequate staffing and adequate time were two of the most influential factors on the implementation of TIAC.

When midwives have more time to spend with individuals they are better able to address complex needs, discuss care plans in detail, and provide emotional support, all of which are essential components of TIC (Hunter and Warren 2014; Mollart et al. 2013). As one participant noted, "More staffing, allowing midwives to spend an adequate amount of time providing trauma-informed care" (P11). The lack of time at each antenatal and postnatal appointment is a common concern expressed by staff across maternity care systems (Matthew et al. 2022). In Matthew et al.'s (2022) study, staff expressed feeling that they frequently do not have enough time to spend with women to adequately address their needs or to discuss trauma, nor did they feel there was enough time to process what they experience as providers when caring for trauma-exposed individuals  Women also indicated a desire for time, noting that the best thing providers could do when asking someone about their trauma is to allow time for them to 'open up', which is not always logistically feasible (Matthew et al. 2022).

Participants in the current study emphasized that chronic understaffing significantly impacted the quality of care they are able to provide. Many midwives expressed frustration with the healthcare system, feelings of being undervalued and overburdened were cited quite often within focus groups. One participant noted, "*Department of Health is about cost efficiency, they see the short term picture as opposed to the long term picture"* (P4). This sentiment may reflect a broader issue, where the health system appears to prioritise operational efficiency over the quality of person care. This frustration is echoed by Doherty and O'Brien (2022) whose action research study explored Irish midwives understanding of burnout. In their study, frustration was a compounding theme. Midwives described a sense of frustration stemming from being unable to provide high-quality care and form

meaningful relationships, due to insufficient time (McInnes et al. 2020). This frustration appeared to originate from feeling undervalued and underappreciated within the Irish maternity care system. McGowan et al. (2023) also highlight the importance of creating a safe environment where staff know that necessary measures and policies are in place to keep them physically and emotionally safe as they work. Employees who feel safe at work are less likely to be depressed and more likely to be productive, and experience compassion. A study of social workers by Senreich et al. (2019) similarly reported that feeling valued at work usually translates to lower workplace stress and higher levels of satisfaction.

Likewise, within the current study, inadequate staffing and time pressures were seen as detrimental to the care women received. For instance, a participant recalled a situation where she felt a woman's trauma was not addressed due to staff being too busy: "*They didn't have time to deal with it. They didn't have time to be able to sit down with that woman and see exactly what was going on*" (P6). Similarly, another participant mentioned that complex needs are often unmet due to time constraints, affecting both the care offered to women, *"If you don't have the time, you can say things without thinking of the effect you're going to have on the person. We're so understaffed and the women are coming with more complex physical needs and mental needs. You tie yourself up thinking Oh, did I give that woman the best care I could?"* (P14) and midwives' ability to advocate effectively *"You don't have time to advocate"* (P2). The lack of time due to understaffing often results in rushed interactions, where important details about a woman's health and trauma history may be overlooked. This may lead to a failure in recognizing and addressing trauma, potentially exacerbating a woman's distress and negatively impacting her mental health (SAMHSA 2014). For example, one participant highlighted that, "*Women may not want to disclose because they'll see that the midwife they're seeing is really busy*" (P3). This sentiment may indicate that women might withhold important information if they perceive the midwife as being too rushed or overwhelmed. Supporting the need for adequate time and space, Cull et

al. (2023) highlight the need for unhurried trauma discussions, and advocate for them to only take place when the clinician has enough time to respond to disclosures and provide or refer onto appropriate support.

Physical environments and practical resources are also crucial for providing TIC. Midwives in the current study noted that having a private and comfortable space for consultations is essential, yet often lacking. For example, one participant mentioned, "*Staffing and space, you know, even the private space, they are all barriers to trauma-informed care*" (P2). The environment, along with sufficient staffing, significantly influences the ability to provide personalized and empathetic care (Beck et al. 2015). Involving individuals with lived trauma experience in the co-production of services is essential for improving care delivery. This includes influencing how services are commissioned and designed, and ensuring care providers acquire the skills, knowledge, and abilities necessary to support individuals effectively (Law et al. 2021).

The delivery of TIC within midwifery is deeply influenced by the availability of adequate staffing, time, and facilities (Huo et al. 2023). Addressing these challenges requires a commitment from healthcare systems to prioritise the well-being of both midwives and the people they care for. By improving staffing levels, ensuring sufficient time for each interaction, and enhancing the physical care environment, a more supportive, effective, and compassionate midwifery care environment would be created that better meets the needs of all involved.

## 2. Continuity of Care

Continuity of care is particularly important for building trust between women and their midwives, which is essential for TIC (Tafe et al., 2023; Benton et al., 2024). When women see the same midwife or team of midwives consistently, they are more likely to feel comfortable and safe, which facilitates the disclosure of sensitive information about past trauma. This continuity allows midwives to provide more personalized care and better supports women's mental and emotional health throughout their pregnancy and childbirth journey (Sheen et al. 2015). Continuity can help prevent re-traumatization by minimizing the need for women to repeatedly recount their traumatic experiences during follow-up appointments (Law et al. 2021). Trauma survivors often experience heightened anxiety and distress when recalling their trauma constantly (Law et al. 2021). Additionally, collaboratively documenting a woman's mental health history, well-being, and care plans, including decisions made with her and her significant others, is crucial for effective communication and continuity of care (Higgins et al. 2017). This aligns with the principles of TIC by promoting empowerment, continuity, and emotional safety. This process ensures that care is personalized and sensitive to the person's needs, helping to prevent re-traumatization (SAMHSA 2014).

Participants in the current study, underlined the benefits of continuity of care for trauma-informed approaches. Continuity of care was a reoccurring comment in the survey, deemed one of the key enablers that support midwives in the delivery of TIAC. The focus group interviews allowed for further exploration of this where one midwife stated, "*If you have that continuity with a woman you should be in a better position to be able to pick up any issues*"-P1. Another participant emphasized that continuity allows midwives to notice subtle cues and build a therapeutic relationship over time *"With Midwife-led care, we don't have to rush them through their appointments…They're coming to the same place… maybe not the same midwife at each appointment, but they've seen them in passing. Or, we might say*

*oh, my colleague was telling me she met you…There's a bit more of a report built with the women. They come in and feel that bit more comfortable to be able to say things that they might not necessarily have said otherwise"*-P14. This approach helps to provide consistent support throughout pregnancy and childbirth. It's essential for addressing trauma-related issues, as it creates a stable, trusting environment that enhances women's experience and helps in addressing mental health concerns (Sperlich et al. 2017). The benefits of continuity of care are evident in the participants' experiences. One midwife emphasized that consistent care helps in recognizing and responding to trauma-related issues more effectively, as it allows for the development of a deeper understanding of the woman's needs and *concerns "Having continuity of care throughout all of the care pathways, if we were able to get midwives seeing women having that continuity, building relationships, we might be in a better position to be able to identify and deal with these things that are cropping up"-P6.* Continuity in delivering high-quality care is recognized as an essential component of TIC (Benton et al. 2024). Continuity allows women, their families, and care providers to build trusting relationships during the perinatal period. Care providers who maintain consistent relationships are better positioned to detect long-term mental health changes that may require intervention (Sandall et al. 2016). Even if women do not actively volunteer information, ongoing interactions enable providers to observe signs of distress or changes in mental health that may require further exploration/ intervention (Cull et al. 2023). A consistent care-provider is more likely to build trust, so even if women are hesitant to share information voluntarily, the provider can gently probe and provide support (Sandall et al. 2016).

Lack of continuity can lead women to feeling unsafe and mistrustful of the care system (Grand-Guillaume-Perrenoud et al 2021). One participant noted that discrepancies in information provision can erode trust: *"If we're not all singing the same song, then that will immediately put their guard up and they will feel unsafe*" (P10). Ensuring that midwives can consistently follow through with the same

women throughout their care journey is pivotal for TIC as many women will not disclose their histories to a stranger in the absence of a trusting relationship (Cull et al. 2023). Similarly, one of the most frequent barriers to TIC is lack of continuity between clients and providers (Matthew et al. 2022). Participants in Matthews et al. (2022) noted that lack of continuity makes it difficult to form a trusting relationship within which trauma can be disclosed comfortably. Individuals expressed frustration at a lack of continuity and a desire to know providers better overtime. They expressed concern that if providers don't know their history and the context of their concerns or living situation, they will be judged, not helped. Trust is central to any relationship (O'Brien et al. 2021). A trusting relationship between a woman and her midwife is important for the emotional aspect of the birth experience. For example, in Leap et al.'s (2010) study, women linked trusting relationships with the way midwives shared information and discussed choice with them. Lewis et al. (2017) further explored the concept of trust and described it as an evolving concept that developed over time as a series of building blocks. The participants in this study (Lewis et al. 2017) described an initial trust associated with an expectation of assumed competence in the midwife, but this was then influenced by the developing relationship between midwife and mother. The concept of trust was interwoven with women's expression of a desire to develop a two-way relationship that included the midwife trusting the woman. Mirzaee and Dehghan's (2020) grounded theory study demonstrated how women used strategies to form "mutual effective interactions," "to build trust with their midwife. These studies demonstrate that trust is multifaceted and bi-directional between the midwife and the woman.

Continuity of care is essential for delivering trauma-informed midwifery care, as it fosters trust, enhances communication, and allows for a deeper understanding of each woman's unique needs. The consistent presence of a familiar caregiver helps to reduce anxiety, prevent re-traumatization, and ensure that mental health concerns are promptly addressed (Sandall et al. 2016). Conversely, the lack of

continuity can lead to mistrust, miscommunication, and missed opportunities to provide the comprehensive support that women need. To optimize TIC, it's vital to prioritize continuity, enabling midwives to build strong, therapeutic relationships that positively impact both the physical and emotional health of women throughout their care journey.

### 3. Dedicated Care Pathway and Team

Establishing a dedicated care pathway and specialized team for women who have experienced trauma are essential for providing targeted and effective support (Sperlich et al. 2017). Specialized roles such as perinatal mental health professionals and bereavement midwives are crucial for addressing the unique needs of trauma survivors. These roles ensure that women receive appropriate and timely mental health support, which is vital for their overall well-being (Creedy et al. 2017). In phase one of this current study, dedicated care pathways and specialised midwifery support was identified by survey respondent's as a key factor in preventing re-traumatisation. Phase two allowed for further elaboration of this in which the participants highlighted the importance of specialized support for referring women to: "*We had two midwives who were perinatal mental health midwife specialists...I was confident I had somewhere to send them [women who had experienced a traumatic birth]*"-P3. The RCM (2023) also recognise that specialist midwife roles are crucial to effective perinatal mental health care. Lambert and Gill-Emerson (2017) suggest formalising a trauma change team, to include former service users, who will drive the implementation of TIAC and allocate responsibility for the roll out of TIC requirements e.g.all policies, procedure and paperwork reviewed to ensure they incorporate TIAC principles in order to achieve a trauma informed service. This team would be the key drivers for education, training and policy development within the organisation. Huo et al. (2023) similarly recognised the importance of an 'implementation team' that would

seek regular service user feedback, and designing initiatives in collaboration with service users.

Continuity of care, combined with specialized support, helps create a safe and supportive environment for women (Bradford et al. 2022). Midwives within the current study also emphasized the need for a more cohesive approach to TIAC, where all staff are trained and aware of trauma-informed practices. As one participant suggested, "*Having a good mental health team or at least one continuity of carer as women may be more open to disclosing previous traumatic events*"-P7.

The importance of having a clear referral pathway and specialized support is mentioned throughout the current study. Immediate access to mental health support within maternity units is also critical, as it ensures that women can receive the help they need at the right time (Sambrook-Smith et al. 2019). Knowledge about referral processes for trauma survivors is a key feature of TIAC (Goldstein et al. 2024). Midwives need to be well-informed about how to refer women to appropriate support services, ensuring timely and effective care (Benton et al. 2024). This proactive support system ensures that women receive ongoing care tailored to their needs, fostering a trauma-informed environment (Mollart et al. 2013). However, it is not just about creating new policies and procedures, Harris and Fallot (2001) recommend that when an organisation has made a commitment to TIAC and has undergone some awareness training, management and staff should carefully review existing policies through a trauma lens and identify any policy or procedure that does not take cognisance of trauma theory and research, and amend them as required. This is particularly important when it comes to midwives recognising and responding to ‘triggering’ among women, which refers to the re-experiencing of trauma-related effects including flashbacks or physiological responses in response to cues directly or indirectly reminiscent of trauma (Isobel 2023). During perinatal care, triggering, can result in hypersensitivity, distress, sadness, fear, pain, anger and shame (Isobel 2023). It

can occur in healthcare settings due to the power differentials, lack of transparency of processes, screening/ assessment, the layout of the clinical setting and the busy or distracted clinicians (Hall and Hall 2013). Midwives providing care associated with birth can increase safety through vigilance of triggering trauma or re-traumatisation, as well as enhancing agency and control (Isobel 2023).

Improving staffing levels, providing more education and training, supporting staff, and ensuring adequate time for midwives to provide care are critical elements for implementing a trauma-informed approach in midwifery. Additionally, establishing dedicated care pathways and specialized teams for both staff and women enhances the quality of midwifery care. These measures collectively contribute to better mental health and well-being for midwives and improved care outcomes for women and their infants (Beck et al. 2015; Sheen et al. 2015; Hunter and Warren 2014; SAMHSA 2014). The impact of these factors on women in midwifery care can be profound. Adequate staffing and time allows for more thorough and empathetic care, which can significantly improve a woman's experience and outcomes during pregnancy and childbirth (Jin et al. 2022). Continuity of care builds trust and facilitates the disclosure of trauma, enabling midwives to provide more effective support (Sandall et al. 2024). Specialized care pathways ensure that women receive targeted help for their mental health needs, reducing the risk of re-traumatization and improving overall mental health outcomes (Beck et al. 2015; Hunter and Warren 2014). Women who receive TIC that is supported by adequate staffing, continuity, and specialized pathways are more likely to feel safe, supported, and understood. This holistic approach not only improves their immediate pregnancy and childbirth experience by reducing stress and anxiety (Harris and Fallot 2001), enhancing power and control through inclusion in decision making (SAMHSA 2014). It also contributes to their long-term mental and emotional well-being (Creedy et al. 2017; Sheen et al. 2015), by minimizing the risk of re-traumatization (Sperlich et al. 2017) and reducing the risk of PTSD in the future (Harris and Fallot 2001).

## Trauma in the Workplace- Minding Midwives

The role of the midwife can be inherently challenging. Midwives are often exposed to traumatic events in their daily work (Kerkman et al. 2019). From managing complex births to working with perinatal loss, the emotional and psychological toll on midwives can be profound (Bingham et al. 2023). This impact is further intensified when midwives have experienced personal trauma themselves, creating a complex interplay between personal and professional lives. Despite the resilience and dedication midwives demonstrate, the lack of adequate support systems can exacerbate the risk of burnout, secondary traumatic stress, and other mental health issues (Doherty and O'Brien, 2022). Addressing these challenges is crucial not only for the well-being of midwives but also for ensuring the delivery of high-quality care to women. This section of the discussion explores the multifaceted nature of trauma in the midwifery profession and emphasizes the urgent need for comprehensive support systems as highlighted by the participants in this study.

### 1. Midwives exposure to trauma in the workplace

Midwives often encounter traumatic events as part of their professional roles and this may, significantly impact their mental health and well-being (Guzzon et al. 2024; Kerkman et al. 2019). One participant shared a poignant experience: "*For me, something I will just never forget is me and the bereavement midwife held those babies till they died*" (P10). This illustrates the profound emotional toll that caring for bereaved parents and dealing with infant death can have on midwives. The emotional strain of these experiences is compounded by the close relationships midwives often form with their clients, leading to a deep personal investment in their care (Hunter and Warren 2014).

The psychological burden is further compounded by the necessity to sometimes quickly shift focus to the next person, often without adequate time to process these

traumatic experiences or support to process their emotions (Creedy et al. 2017). As one midwife mentioned, *"You help deliver a [miscarried baby] and then you have to go off and put a [fetal monitor] on and act like nothing has happened*" (P10). This rapid transition highlights the compartmentalization that midwives often must practice, potentially leading to cumulative stress and burnout (Sheen et al. 2015). Studies by Sheen et al. (2015) and Leinweber and Rowe (2010) indicate that the normalization of traumatic experiences within the healthcare environment contributes to emotional suppression among midwives. Midwives report that they often bottle their emotions to continue working effectively, which can result in long-term emotional suppression (Davies and Coldridge 2015). The lack of immediate/timely support, and the need to "box things off" to handle the next task, can further contribute to their emotional burden. This emotional burden is not always immediately recognized, potentially leading to long-term mental health issues such as burnout, anxiety, and depression (Mollart et al. 2013). Despite the resilience shown by midwives, there is a noticeable lack of institutional support to help them process and cope with these traumatic experiences (Kendall-Tackett and Beck 2022).

Previous research has explored the effects that caring for women who experience traumatic births can have on midwives. A systematic review carried out by Bingham et al. (2023) examined the phenomenon and concluded that midwives often feel shock, fear, responsibility, and powerlessness, which may contribute to some experiencing serious mental illness. Midwives also reported a shaken belief in the normal physiologic birth process which consequently led to more defensive practice. An earlier systematic review, carried out by Uddin et al. (2022) exploring the perceived impact of birth trauma witnessed by maternity health professionals, found that witnessing traumatic birth events was associated with profound emotional and physical impacts on maternity workers, signifying the importance of acknowledging and addressing this across the maternity workforce. Uddin et al. (2022) recommend that effective education and training, a supervisory network,

changes to practice and policy, and support and treatment, should be provided to assist and improve the outcomes and work-life of maternity workers who witness traumatic births. Similarly, within the current study, midwives wanted enhanced training and education, improved policies and optimised support for trauma exposure to enhance their trauma informed knowledge and care.

### 2. Midwives Personal Traumas

Midwives often enter the profession with their own personal traumas, which can influence their approach to care and heighten their emotional responses to workplace events (Leinweber and Rowe 2010). Personal experiences, such as traumatic births or significant life events, can motivate individuals to become healthcare professionals, driven by a desire to improve care standards (Leung et al. 2023). For example, one midwife noted, "*I jokingly say why did I become midwife because of my birth…because of what I experienced and I felt it could be better*"-P2. This comment highlights how personal trauma can shape career choices and professional motivations, which may impact understanding of trauma and care provided.

However, personal trauma can also make midwives more vulnerable to the emotional impacts of workplace trauma, creating a complex interplay between personal and professional experiences (Leinweber and Rowe 2010). These personal traumas can be re-triggered by similar experiences, exacerbating their emotional stress and leading to secondary traumatic stress (Sheen et al. 2015). Participants frequently acknowledged that everyone brings some form of trauma to their work, reflecting a shared understanding that trauma is a common human experience: "*We all bring trauma, be it from a previous birth or from life"*-P1. In the quantitative data there was a large standard deviation on the recognition that trauma is a common experience.

Participants in phase one identified that trauma effects wellbeing as this question had a low standard deviation. This was further explore in the focus groups through the lived experiences the participants shared of how trauma impacted them, their work life and their home life. The expectation to compartmentalize personal issues and maintain a professional demeanour can prevent midwives from seeking the help they need (Hunter and Warren 2014). This expectation, combined with the emotional toll of their work, often results in feelings of isolation, self-criticism, and decreased job satisfaction (Beck et al. 2015).

Few studies explore midwives experience of trauma, however Toohill et al. (2019) carried out an anonymous online survey (n=249) in Australia looking at trauma and fear in midwives, relating to birth trauma. The majority of midwives reported professional and/or personal traumatic birth experiences. Reasons for personal trauma included experiencing assault, intervention and stillbirth. Professional trauma related to both witnessing and experiencing disrespectful care and subsequently feeling complicit in the provision of poor care. Feeling unsupported in the workplace and fearing litigation intensified trauma. These feelings closely align to the feelings the midwives expressed in the present study with the impact of personal traumas on practice as well as the experience of looking after women who have experienced trauma. The combination of personal and professional challenges can lead to burnout and compassion fatigue (Sheen et al. 2015), highlighting the need for trauma-informed workplace policies that address both the emotional demands of midwives and reduce the fear of legal consequences (Beck and Gable 2012).

Working with trauma survivors can expose staff to the risk of secondary traumatic stress (Henderson et al. 2024). This condition, described as the emotional strain resulting from hearing about another person's first-hand traumatic experiences (Greeson et al. 2011), can manifest in chronic fatigue, intrusive thoughts, difficulty concentrating, emotional numbness, exhaustion, avoidance behaviours,

absenteeism, and physical health issues. Staff affected by these symptoms may find it challenging to deliver high-quality care and could be prone to burnout, potentially leading to high staff turnover (Kelly et al. 2020). This turnover can create a negative cycle, intensifying similar symptoms in the remaining employees. Additionally, many individuals in the “helping professions” may have their own trauma histories, which can be aggravated by working with trauma-affected individuals (Menschner and Maul 2016). Recently, Haider (2024) highlighted the profound impact of domestic abuse on healthcare professionals, emphasizing how certain traits commonly associated with caregiving roles, such as empathy and compassion, may increase their vulnerability to experiencing abuse. Healthcare professionals, including midwives, often possess heightened levels of emotional sensitivity and a strong desire to help others, which can make them more susceptible to becoming targets of manipulative or abusive behaviours. Research into domestic abuse among healthcare workers appears to have has been largely over-looked to date (Dheensa et al. 2023), which suggests that it remains an uncomfortable, emotive, and highly stigmatised issue. When marginalised in this way, the voices of those who experience abuse are silenced (Eriksson et al. 2022). Evidence suggests that ensuring there are robust policies, education and training in the workplace to make staff familiar with domestic abuse, as well as having hospital commit to safe-guarding and supporting staff improves outcomes and experiences of those who have been abused (Dheensa et al. 2024). This response can be applicable to all trauma survivors working within the healthcare services.

### 3. Need for improved Support

There is a clear need for a holistic support system that addresses both the emotional and professional needs of midwives to effectively implement TIAC (Hunter et al. 2019). Providing structured debriefing sessions, counselling services, and mentoring programs can help midwives comprehend their experiences and develop coping strategies (Hunter and Warren 2014). Creating

supportive work environments that facilitate informal peer support, such as common rooms for breaks, is also crucial (Creedy et al. 2017). A descriptive, cross-sectional survey of Dutch midwives (Kerkman et al. 2019), explored traumatic experiences within the midwifery profession. 13% of respondents reported having experienced at least one work-related traumatic event. Among these, 17% screened positive for PTSD, revealing an estimated PTSD prevalence of 2% among Dutch midwives. Clinically relevant anxiety symptoms were reported by 14% of the respondents. Depressive symptoms were reported by 7% of the respondents. The strategies that helped midwives to cope with adverse events were, peer support from colleagues, professional support from a coach or psychologist, multidisciplinary peer support, and support from midwives who are not direct co-workers. These findings highlight the importance of both professional and peer support for traumatic experiences within maternity settings.

Peer support is identified as a critical factor in midwives' well-being and resilience (Hunter and Warren 2014). Informal networks e.g. where midwives can share their experiences and offload emotional burdens, play a significant role in their mental health (Mollart et al. 2013). However, there is often a lack of support from management and higher-level institutional structures, with midwives perceiving these structures as less compassionate and more focused on operational efficiency (Hunter and Warren 2014). Midwives have also expressed a need for practical support that addresses the realities of their work environment, such as, more supportive management structures that provide emotional support (Hunter and Warren 2014), policies that acknowledge and address the emotional demands of midwifery, not only supporting physical well-being such as staffing but also emotional resilience (Beck et al. 2015), and, family-friendly work environments that facilitate work-life balance (Fenwick et al. 2018). Managers need to practice in a way that is more midwife-centred and better mirrors a midwifery philosophy of care. To help manage the emotional challenges faced by midwives and enhance the long-term sustainability of their practice, it may be beneficial to encourage and

promote self-care practices. By integrating self-care into their routines, midwives can better cope with stress, prevent burnout, and maintain their well-being over time (Hewitt et al. 2022).

Despite the importance of self-care, it is not routinely practiced among midwives, due to the demanding nature of their work and perceived lack of time (Doherty and O'Brien 2022). The survey responses from phase one where respondents were asked about their practise of self-care which had a low mean score reflecting that the participants did not practise self-care. This was further exemplified in the focus groups where participants viewed self-care initiatives, such as meditation breaks, as impractical or insufficient. Doherty and O'Brien (2023) argue that basic self-care is necessary for midwives wellbeing, these strategies include sleep, exercise, healthy eating, reduced alcohol intake and maintaining a clutter-free environment. Mindfulness in the workplace was found to reduce stress for midwives and nurses (Foureur et al. 2013). A later study by Cummins et al. (2018) that introduced a self-care workshop for student midwives, found it useful for students to incorporate self-care strategies, and mindfulness, in aiding preparedness for stressful situations. Further research could be done to assess the feasibility of the introduction of a self-care workshop for qualified midwives.

Improving support for midwives requires a combined effort from all levels of the healthcare system. This includes fostering a supportive work culture, implementing comprehensive policies, and ensuring that management practices are both compassionate and responsive to the emotional needs of midwives (Mayra et al. 2023). Prioritizing the mental health and well-being of midwives not only benefits the caregivers but also translates into better care for women, highlighting the interconnected nature of support in healthcare settings (Hunter and Warren 2014).

Midwives face a unique set of challenges as they navigate the emotional landscape of their profession, often dealing with both personal and professional traumas. The

cumulative effect of these experiences, coupled with inadequate support, can lead to significant mental health issues and may impact the quality of care provided to women and families. To mitigate these risks, it is essential to implement sustainable support systems that address both the emotional and professional needs of midwives. By fostering a supportive work environment, promoting self-care practices, and ensuring compassionate management, the healthcare system can help midwives cope with the demands of their profession.

This study revealed that midwives across the country are doing their best to provide empathetic, compassionate and individualised care, in spite of systemic and personal challenge. Through multiple examples, midwives demonstrated the difference they made to women's lives when they were able to provide care that was trauma informed. The overarching aim of the current study was to take stock of existing trauma informed knowledge and practices, and develop recommendations to enhance workplace culture, and influence policy to ensure that frontline practice is fundamentally trauma informed. These findings add to the existing body of literature, that demonstrates that the implementation of TIAC across the maternity services has the potential to positively influence the both the 'carer' and the 'cared for'.

## Strengths

Mixed methods research offers a more comprehensive perspective on the research problem by combining numerical data from quantitative methods with the contextual understanding of qualitative approaches. It allows researchers to validate findings from one method through another, enhancing the depth of understanding. According to Creswell and Clark (2018) the combination of qualitative and quantitative data provides a better understanding of research problems than either approach alone.

Conducting the research within Ireland offers distinct strengths, particularly in the context of midwifery practice. Ireland's healthcare system provides a unique setting for midwifery, as it blends both public and private maternity care systems, allowing for the exploration of diverse models of care, including midwifery-led services and consultant-led units (Kenny et al. 2015). This study was open to all midwives across the Republic of Ireland working in midwifery led settings, consultant led settings and community/homebirth based models of care making it more representative to the Irish maternity landscape.

Another major strength to this study is that it's the first study on TIAC that looks at TIAC from multiple perspectives of midwifery/ perinatal care. It is also the first time a study of this kind was carried out within Ireland.

## Limitations

In quantitative research the size of the sample is crucial in determining the reliability, validity, and generalizability of the study findings. A small or non-representative sample can limit the external validity of a study, making it difficult to draw conclusions about broader populations (Fowler 2013). The generalizability of results is inherently linked to both the size and representativeness of the sample (Creswell and Creswell 2018). In this study the quantitative phase recruited participants through non-probability sampling. A major limitation with this method is the potential for sampling bias, as participants recruit others from within their own social networks, often resulting in homogenous samples that may not represent the broader population (Atkinson and Flint 2001). Additionally, non-probability sampling lacks precise control over sample size, as researchers cannot predict the number of participants that will be referred, leading to potential issues with calculating response rate (Sadler et al. 2010).

The over 60 age range that responded to the questionnaire is also under-represented as they make up a total of 12% of the work force. This could be to do with how the survey was disseminated online and advertised via social media etc., which does affect the transferability of the results to this category of people.

The time-line of the project was another challenge faced by the researcher. Quantitative data collection was due to commence between April-June 2023 but due to delays in obtaining a Qualtrics licence, the Data collection for phase one did not commence until July 2023.

**On Balance:**

The study presents many strengths that contribute to the research topic at hand. Key strengths include the comprehensive perspective on the research area by combining both qualitative and quantitative data, the location of the study being conducted within Ireland and it also being one of the first studies to look at TIAC within the perinatal services. Additionally, as previously discussed many efforts were made to enhance validity, reliability and rigour throughout the project. However, it is also important to acknowledge the limitations to this study. A notable limitation in phase one is the small sample size which can effect generalisability of findings. Despite the occurrence of these limitations, the study offers insightful and meaningful data, that contributes massively to the overall body of knowledge on the area of TIAC. Future research could address and improve on the limitations acknowledged.

## Implications:

This study explored midwives' knowledge, attitudes, and practices of TIAC in Ireland using mixed methods research and may have profound implications for policy, practice, education, and research. TIAC is an approach that recognizes the prevalence of trauma and integrates this understanding into healthcare practices to enhance care, especially in maternity settings where trauma can have long-lasting effects on both women and infants (Sperlich et al. 2017). The findings of this study have the potential to impact multiple areas of perinatal care as follows.

### *Policy:*

Through identifying the gaps in midwives' knowledge and practices of TIAC, maternity care models could be enhanced by integrating a TIAC to guideline development. Policies could advocate for TIAC as a core component of maternal healthcare, ensuring that all women, particularly those with a history of trauma, receive appropriate care that mitigates re-traumatization during childbirth.

### *Practice:*

Findings in this study highlight the passion midwives have to improve practice and their desire to implement TIAC in their everyday practice. Ensuring midwives understand the principles of TIC; such as safety, choice, and empowerment can enhance the quality of maternity services. Providing a trauma informed environment for midwives to work in could potentially impact staff satisfaction and retention while nurturing the midwife-woman relationship. By embedding TIAC in midwifery care, midwives can foster more supportive environments, reducing trauma-related stress and improving maternal outcomes. Practices would shift towards more individualized and continuity of care approaches, fostering trust and reducing the likelihood of re-traumatization.

***Education:***

This study has significant implications for midwifery education in Ireland, indicating the need to integrate TIAC into curriculum and continuous professional development (CPD) programmes. There was a notable desire among participants to know more and do more. The findings highlighted that current midwifery training may lack comprehensive education on the impact of trauma and the integration of TIAC into the workplace. Incorporating TIAC into undergraduate and in-service training may better equip midwives to recognize and respond to trauma, improving their confidence and ability to provide care that is truly trauma informed. The midwives in this study also described the ways in which they would like to receive education on TIC which must be considered when designing education programmes. It is also important to highlight the need for supportive management structures to encourage and foster midwives to participate in further education and training in relation to TIC.

***Research:***

This study highlights areas for further research, such as exploring what TIC means to the women, longitudinal research to assess the long-term impact of TIAC on both midwives and women, examining outcomes such as maternal mental health, birth satisfaction, infant development, staff satisfaction and retention. Research would also be necessary to examine the cost-effectiveness of implementing TIAC training programs in maternity services. The researcher of the current study would propose the introduction and evaluation of a pilot TIAC initiative within a maternity unit in Ireland to continue this MSc Project to a PHD project. This study adds to the overall body of research on TIAC.

***Dissemination:***

The findings from this study will be disseminated via conference presentations at both local, national and international levels, poster presentations, research publications and through educational workshops on TIAC.

## Conclusion

Very few trauma-informed models of midwifery and trauma-specific interventions have been developed and tested for the perinatal population (Barbury-Jones and Taylor 2017). The negative impact of trauma has been demonstrated time and time again (Perera et al. 2023; Downey and Crummy 2021; SAMHSA 2014). Knight et al (2022) emphasise that vulnerable groups who have experienced domestic abuse, self-harm, depression, anxiety and chronic trauma are increasingly represented within the maternal death enquiry reports.

Existing research has shown that healthcare professionals often feel helpless and hopeless about the care available to women who experience complex issues (McLellan et al. 2019). Evaluation of current knowledge and practices of TIAC within Irish maternity services, continues to illustrate the complexities of TIAC such as education provision, modest understanding of trauma and its impacts, unsupportive management structures, staffing pressures and lack of awareness of referral pathways, that all effect the delivery and implementation of a trauma informed maternity service.

Many of the issues raised by the participants such as lack of time and education deficits, demonstrate the discrepancies within maternity services that have resulted in the many barriers and challenges that midwives face in integrating TIAC into their practice  A novel finding from this study was the discovery of the impact that working with trauma has on maternity staff. This finding stood in stark contrast to the limited support provided to midwives in practice. This outcome clearly demonstrates that more needs to be done to optimise the working environment for midwives to allow them to consistently practice TIC.

Despite these daily challenges, midwives demonstrated overwhelming compassion and empathy for the women in their care. The participants gave honest, illuminating and often poignant depictions of events specific to both their personal and professional lives. They described how they overcame existing barriers, and looked towards their midwifery philosophy to guide them in their delivery of care, bringing to light the innate compassion and kindness of midwives, which is key for the delivery of TIC.

This study will hopefully open up conversations about trauma, drive polices to deliver TIAC education, and enhance the current model of maternity care to become trauma focused for everyone.

## Personal Reflection

Through my MSc journey I have made both academic and personal gains. Through the exploration of trauma informed care I have gained an insightful and deep understanding to midwives experiences, the impact on the women the barriers to implementation but most importantly I have been able to see gaps and possibilities of the improvements that could be made within the maternity services. Mixed methods research was a big undertaking for me but it enhanced the findings of my study. It is so important to recognise that numbers alone cannot capture the more personal nuances that the qualitative focus group interviews added. The benefit of the group interaction allowed the participants to have their voices heard and often they resonated with my own. I recognised the challenges of staying neutral as an interviewer and enjoyed the learning gained through this experience. I feel my abilities as a researcher have grown and that through the data I was able to honour the lived experiences of the participants which often go unheard. My hope is that this research will serve as a foundational starting point and open the space for

future research on trauma informed care. What I recognise overall is that trauma informed care only delivers benefits to the service user and service provider, there are no disadvantages. The transformation may be a whole system approach to the integration of trauma informed care into maternity services however, we know the potential that exists and it is time to act. Change starts with every person as an individual and I will continue to promote, educate and treat my colleagues and clients through a trauma informed lens. This project will hopefully pave the way for my continuing journey as a researcher.

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## Appendix A: Sample of Summary of Articles for Literature Review

| Author Year Source Location | Title / Aim of Study | Methods | Sample Size and Demographic | Themes Identified | Findings |
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| **Choi et al 2020**<br><br>**JOGNN**<br><br>**USA** | Promotion of Maternal-Infant Mental health and Trauma-Informed Care during the covid-19 Pandemic | Commentary | | | Nurses are uniquely positioned to provide TIC to women<br><br>Using TIC can promote positive mother infant outcomes<br><br>TIC should be sustained beyond the pandemic as the evidence highlights the value of and the critical need for TIC where individuals have a history of adverse childhood events, previous birth trauma or have had a negative life experience |
| **Hall et al 2021**<br><br>**JOGNN** | Education in Trauma- Informed Care in Maternity Settings can promote Mental health during the | Commentary | | | TIC techniques help clinicians to better support women during pregnancy and postpartum at a time of heightened anxiety |

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| **USA** | Covid- 19 Pandemic | | | | TIC skills increase care givers confidence in provision of maternity care<br><br>Education in TIC is critical |
| **Erten et al 2021**<br><br>**BMC**<br><br>**France** | Post-Traumatic Stress disorder following childbirth<br><br>Examine the link between history of traumatic events, child loss, modes of birth, distressing childbirth, social support, perceived mother-infant bonding, postnatal depression and symptoms of PTSD-FC | Quantitative<br><br>Cross-sectional online Survey | 916 mothers and 64 partners<br><br>Excluded deliveries less than one month and greater than one year | | Significant link between psychological and traumatic risk factors as well as perceived social support and PTSD |
| **Hanon et al 2022**<br><br>**Springer** | Maternal Mental health in the first year postpartum in a large Irish population cohort: The Mammi Study | Quantitative<br><br>Prospective cohort study | 3009 first time mothers recruited<br><br>2380 first year | Maternal mental health in pregnancy and first year: | Prevalence of depressive and stress symptoms was lowest in pregnancy increasing to 12 months post. Anxiety symptoms remained stable over time |

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| **Ireland** | Investigating prevalence and pathways of depression, anxiety and stress from pregnancy through the first year postpartum | | | Demographic and birth factors associated with mental health PN:<br><br>Birth Factors:<br><br>Health and Social factors: | 1 in 10 women reported severe anxiety<br>Being younger (<30) was associated with higher odds of reporting depression anxiety and stress symptoms. Being born in a non-EU country, not living with a partner, not having a post graduate education and being unemployed during pregnancy were associated with 2-3 times higher odds of reporting depressive symptoms<br><br>Pre-term birth increased odds of depressive symptoms. CS was associated with higher odds of pn depressive and stress symptoms<br><br>History of poor mental health associated with poor pn mental health. Relationship problems prior to birth effected PN mental health<br>Poor mental health in pregnancy increased PN mental health problems |

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| **Higgins et al 2016**<br><br>**Science Direct**<br><br>**Republic of Ireland** | Mothers with mental health problems: Contrasting experiences of support within maternity services in the Republic of Ireland<br><br>Explore views and experiences of women with mental health difficulties accessing and receiving care from publicly- funded maternity care services during pregnancy, childbirth and postnatally | Qualitative<br><br>Descriptive Design using In-dept face to face interviews | 20 women with a range of mental health problems | Lack of Integrated and women-centred services<br><br>Feeling Misunderstood<br><br>A veil of Secrecy<br><br>A way forward; Experiences of specialist Perinatal Mental Health Services | The fragmentation of care in maternity care units that do not have a specialist mental health service<br><br>A lack of knowledge and skills among midwives when women voluntarily disclosed their difficulties<br>The physical and medical aspect of the pregnancy was prioritised to the detriment of their mental health and emotional state<br><br>Specialist services meant that women felt understood, supported and accepted |
| **Nagle et al. 2022**<br><br>**Science Direct** | A survey of Perceived traumatic birth experiences in an Irish maternity sample- prevalence, risk | Quantitative<br><br>Cross- Sectional Design<br><br>Questionnaire | Postpartum women between 1-5 days Postnatal<br><br>1154 women | | 18% of women experienced birth as traumatic<br><br>Highlights the relevance of current and past history of depression, pph, induction of |

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| **Ireland** | factors and follow up<br><br>To establish the prevalence of and correlates of a subjectively traumatic birth experience in an Irish Maternity System | | | | labour & operative vaginal birth in defining birth trauma<br><br>Majority of women were resilient and few developed PTSD<br><br>A larger cohort had significant functional impairment associated with sub-clinical postpartum PTSD symptoms |
| **Sperlich et al 2017**<br><br>**Journal of Midwifery and Women's Health**<br><br>**USA** | Integrating Trauma-Informed Care into Maternity Practice: Conceptual and Practical Issues | Review | | Present current perspectives on trauma related sequele of maltreatment and adversity<br><br>Briefly review their impact on childbearing outcomes<br><br>Summarize technical assistance available about trauma informed care | Providing trauma Informed care as part of midwifery practise has the potential to prevent adverse outcomes, help to break intergenerational cycles of maltreatment and mental health disorders and change the mothers and childs life span trajectories into a positive direction<br><br>Problems stemming from childhood maltreatment and adversity are universal<br><br>The global community of midwives and ideally |

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| | | | | Examples of conceptualizations that lend themselves to tailoring trauma informed care for maternity care<br><br>Consider practical aspects of implementing trauma informed care | positioned to support each other in creating ways to mitigate them with the women in our care |
| **Viverioros and Darling**<br><br>**2019**<br><br>**Science Direct**<br><br>**UK**<br><br>**Australia**<br><br>**United States**<br><br>**Slovenia**<br><br>**Netherlands** | Perceptions and Barriers to accessing perinatal mental health care in midwifery: A scoping review<br><br>Exploring midwives and midwives perceptions of factors that impede access to perinatal mental health in high resource areas | Scoping Review | 26 Publications | | Midwives lack confidence on how to broach the subject of PMH<br><br>Screening practises remain inconsistent<br><br>Lack of specialist services<br><br>Women are hesitant to reach out in view of stigma<br><br>Lack of continuity of carer |

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| **Dawson et al**<br><br>**2021**<br><br>**BMJ** | Tauma-informed approaches to primary and community mental health care: protocol for a mixed methods review<br><br>Synthesize evidence on trauma informed approaches in care | Systematic Review | | | |
| **Carroll et al**<br><br>**2018**<br><br>**Republic of Ireland** | Knowledge, confidence, skills and practises among midwives in the republic of Ireland in relation to perinatal mental health care: The mind mothers study | Exploratory descriptive design<br><br>Anonymous Survey | 438 Midwives | Caseload<br><br>Knowledge of Perinatal Mental Health<br><br>Overall skill and confidence<br><br>Skills in perinatal mental health activities<br><br>Perinatal mental health care practices | Midwives' knowledge of perinatal mental health problems was limited<br><br>Midwives reported a lack of skill in opening discussion with women on sensitive issues such as sexual abuse, intimate partner violence and psychosis and providing information to women's partners and families<br><br>Midwives adopted a selective approach to screening for perinatal mental health problems and tended not to |

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| | | | | Education on perinatal mental health | inquire about sensitive topics or address them with women deemed at risk |
| **Stokes et al**<br><br>**2017**<br><br>**Sage Journal**<br><br>**Canada** | Exploring Nurses Knowledge and Experiences Related to Trauma-Informed Care | Qualitative<br><br>Semi-structured Interviews | 7 | Conceptualizing Trauma and trauma informed Care<br><br>Nursing Care and Trauma<br>Context of Trauma-informed care<br><br>Dynamics of the nurse-patient relationship in the face of trauma | Nurses were unfamiliar with the terminology of TIC.<br><br>Nurses understanding of trauma and what it means to be trauma sensitive closely resemble existing definitions of TIC<br><br>Participants did not describe TIC as a unique philosophy but emphasized how it is already a fundamental part of nursing care<br><br>They highlighted the importance of the nurse-patient relationship and their role in preventing re-traumatization<br><br>Safegaurding themselves from trauma |
| **Machtinger et al** | From treatment to healing: the | Commentary | | | Every member of the team should undergo training to |

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| **2015**<br><br>**Womens Health Issues**<br><br>**California** | promise of trauma-informed primary care | | | | learn about the impact of trauma<br><br>Develop skills to communicate more effectively with patients<br><br>Develop protocols for screening and to optimise response |
| **Baker et al**<br><br>**2016** | Development and Psychometric Evaluation of the attitudes related to trauma informed care (ARTIC) scale | | 760 staff members in education, human services and healthcare | | |
| **Long et al**<br><br>**2022**<br><br>**Science Direct**<br><br>**Australia** | Trauma informed care education for midwives: An integrative review | Review | 3 papers identified | | Most midwives reported receiving no previous trauma informed care<br>education and lacked confidence to provide quality care to women with lived trauma.<br><br>Midwives reported trauma informed care education as essential and relevant for providing quality practice. |

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| | | | | | Improvements in knowledge, skills and attitudes was demonstrated following trauma informed care education.<br><br>More in-depth content and content delivered in multiple ways were recommended. |
| **Simpson and Catling**<br><br>**2016**<br><br>**Science Direct**<br><br>**Australia** | Understanding psychological traumatic birth experiences: A literature review | Systematic Review | 21 Articles | | Women with previous mental health disorders were more prone to experiencing birth as a traumatic event<br><br>Poor quality provider interactions<br><br>Risk factors for birth trauma need to be addressed in the antenatal period |
| **Emsley et al**<br><br>**2022**<br><br>**BMC** | Trauma-informed care in the UK: where are we? A qualitative study of health policies and professional perspectives | Qualitative Study<br><br>Semi structured interviews | 11 healthcare professionals | How Trauma informed approaches are represented in the UK<br><br>How trauma informed policies are understood in the UK | Government backing is essential for implementing policies into practise<br><br>A coordinated more centralised approach is needed |

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| **UK** | | | | How trauma informed approaches are implemented | Increase education among healthcare professionals around trauma informed care |
| **Racine et al**<br><br>**2021**<br><br>**MDPI**<br><br>**Switzerland** | Maternal-child health outcomes from pre-implementation of trauma-informed care initiative in the prenatal care setting:<br>A retrospective study | Quantitative Study<br><br>Retrospective file review | Analysis of the medical records of 601 low risk women | | Infants of mothers who received trauma informed care were less likely to have a health risk at the birth |
| **Mosley and Lanning**<br><br>**2020**<br><br>**Science Direct**<br><br>**USA** | Evidence and guidelines for trauma-informed doula care | Narrative Review | | | Proposal of an evidence-based trauma informed model of care that includes the key principles of safety, trustworthiness, peer support, mutuality, resilience and empowerment<br><br>It is a tiered approach to trauma informed doula care that includes universal trauma-sensitive approaches, trauma-targeted services for clients who are survivors of |

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| | | | | | trauma and linkages to trauma specialists as needed |
| **Waddell**<br><br>**2019**<br><br>**The Practicing Midwife**<br><br>**UK** | Trauma histories and childbearing: what maternity workers need to know | Article | | | The complexities of women's lives need to be acknowledged and continuously reflected upon by all maternity care staff<br><br>Support tailored to the woman's individual needs Women may not feel comfortable to disclose but will appreciate being asked |
| **Hushke, Murphy-Tighe and Barry**<br><br>**2022**<br><br>**Science Direct**<br><br>**Republic of Ireland** | Perinatal Mental health in Ireland: A scoping Review | Scoping Review | 29 publications | | A significant number of women in Ireland are affected by perinatal mental health problems but prevalence rates differ between studies<br><br>A history of mental health problems and a lack of social support were key risk factors<br><br>Existing perinatal mental health services in Ireland are generally inadequate |

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| **Noonan et al**<br><br>**2018**<br><br>**Science Direct**<br><br>**Republic of Ireland** | Survey on midwives' perinatal mental health knowledge, confidence, attitude and learning needs | Quantitative<br><br>Cross-sectional survey design | 157 Midwives<br><br>Purposeful non-random convenience sampling | | Midwives indicated high levels of knowledge and confidence in identifying women who experience depression or anxiety<br><br>Midwives were less confident in caring for women with PMH<br><br>Few Midwives felt equipped to support women and only 15% reported access to adequate information<br><br>There was a desire from midwives to become more educated |
| **Madden et al**<br><br>**2018**<br><br>**Journal of Clincal Nursing**<br><br>**Dublin, Ireland** | Using Action Research to develop midwives' skills to support women with perinatal mental health needs | Qualitative<br><br>Action research using cooperative inquiry | 7 midwives | Perinatal mental health service provision | Insufficient referral pathways<br><br>Lack of communication skills<br><br>Lack of time due to heavy workload<br><br>Antenatal classes did not include education on mental health<br><br>Midwives value education to support women |

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| **Higgins et al**<br><br>**2018a**<br><br>**Ireland** | Exploring barriers to midwives and nurses in addressing mental health issues with women during the perinatal period | Quantitative<br><br>Anonymous online survey | 809 midwives and nurses | | Absence of care pathways<br><br>Lack of communication skills to address mental health issues<br><br>Increasing workload and lack of time to discuss issues |
| **Laubmann**<br><br>**2021**<br><br>**Midwifery Today** | Becoming a trauma-sensitive Birthkeeper | Article/ Commentary | | | Trauma informed care can build a link between the clients trauma history and current concerns<br><br>Understanding how childhood sexual abuse or a history of childhood trauma affects pregnancy, labour and birth can help the caregiver identify possible signs and triggers |
| **Tolan et al**<br><br>**2022**<br><br>**Australian Nursing and Midwifery Journal** | Connecting the head to the body- trauma- informed care in practice | Article- Pictorial | | | By relating to women in a way that emphases safety and a holistic trauma informed approach we can mitigate the risk of further harm and positively impact the people we work with |

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| **Cull et al**<br><br>**2023**<br><br>**Australia, USA, Sweden, England and Canada** | Views from women and maternity care professionals on routine discussion of previous trauma in the perinatal period: a qualitative evidence synthesis | Qualitative evidence synthesis | 25 papers | | Women accepted routine discussion of trauma<br><br>Maternity care workers should raise the issue of previous trauma<br><br>The importance of a trusting relationship<br><br>Recognising pregnancy is a vulnerable time |
| **Rollans et al**<br><br>**2013**<br><br>**Science Direct**<br><br>**Australia** | "We just ask some questions…" The process of an antenatal psychosocial assessment by midwives | Observsational study | 34 pregnant women and 18 midwives | | Approaches varied in the midwife's style in carrying out the assessment<br><br>Midwives generally explored women's issues in an empathetic manner |
| **Mule et al**<br><br>**2021** | Why do some pregnant women not fully disclose at comprehensive psychosocial | Mixed methods | 1796 women | | Normalising and negative self-perception<br><br>Fear of negative perceptions from others |

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| **Science Direct**<br><br>**Australia** | assessment with their midwife | | | | Lack of trust in the midwife<br><br>Differing expectation of the appointment<br><br>Mode of assessment and time issue |
| **Millar et al**<br><br>**2021**<br><br>**Canada** | "No, You Need to explain what you are doing" | Mixed Methods design<br><br>Questionaire followed by an interview | 29 adolescent mothers completed the questionnaire<br><br>5 were interviewed | | Authors recognised the priority for trauma informed care within this population<br><br>The participants wanted the midwife to acknowledge their trauma<br><br>Participants did not want to keep re-telling their story (continuity of care)<br><br>Building a relationship with the care giver<br><br>Consent<br><br>Coping strategies- the midwives had a strong understanding of trauma and assisted them |
| **Mollart et al** | Midwives' emotional | Qualitative | 3 Focus Groups | | Lack of Support |

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| **2009**<br><br>**Science Direct**<br><br>**Australia** | wellbeing: Impact of conducting a structured Antenatal Psychosocial assessment (SAPSA) | | 18 midwives | | Stress and frustration<br><br>Unhealthy coping strategies |
| **Muzik et al**<br><br>**2013**<br><br>**Science Direct**<br><br>**USA** | Perspectives on Trauma- informed care from mothers with a history of childhood maltreatment: A qualitative sample | Qualitative | 52 women<br><br>Semi structured interview | | Respectful communication and trust<br><br>Demonstrate diversity to enrich communication and understanding<br><br>Team approach to mental health care and support<br><br>Provide range of family focused tailored mental health services<br><br>Improved accessibility<br><br>Flexible, safe and relaxed welcoming atmosphere<br><br>Family centred service |

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| | | | | | Extend and strengthen social support networks<br><br>Holistic approach to wellness<br><br>Uplifting, discrete name for trauma centre |
| **Choi and Seng**<br><br>**2015**<br><br>**The Journal of Continuing Education in Nursing**<br><br>**USA** | Pilot for Nurse-Led, Interprofessional In-service training on trauma-informed Perinatal Care | Mixed methods<br><br>Single group, pre-test, post-test design | 47 participants<br><br>Convenience sampling | The mean pretest score of mental health providers was 2 points higher as was the mean post test score, however, those differences are not statistically significant | Relevance and usefulness of training<br><br>Additional learning needs<br><br>Dept and Scope of training |
| **Minooee et al 2020**<br><br>**Wiley Library**<br><br>**UK, USA, Aus, New Zealand Sweden, Scotland Israel, Denmark Netherlands Scotland & Ireland** | Scoping review of the impact of birth trauma on clinical decisions of midwives | | 40 studies | | |

**Appendix B: Ethics Application and Responses to Committee**

# Lane Galvin: Ethical Approval Application Response

Candidate | Masters in Science by Research, School of Health and Science, Dundalk Institute of Technology | lane.galvin@dkit.ie

Recipient Name

**Dear Chair,**

Thank you for considering the research ethics application for the proposed study entitled 'Mixed methods evaluation of Trauma-Informed Approach to Care (TIAC) Knowledge and Practices in Midwifery/Perinatal Settings in Ireland'.

Please find below the revised application form which has incorporated amendments in response to the issues raised, and clarifications required by the School of Health and Science Research Ethics Committee.

A summary table of the issues raised, and corresponding amendments is provided on the next page.

I hope that these amendments are satisfactory and acceptable.

Sincerely,

Lane Galvin

19/4/23

| COMMITTEE COMMENT/REQUEST | RESPONSE |
|---|---|
| 1. The study participants may be employees of the health services. Have you requested clarification if approval is needed from the relevant HSE ethics committees: https://hseresearch.ie/research-ethics/#Projects-that-require-approval-by-a-HSE | According to the HSE Research and Development Committee, a project requires approval by a HSE/Hospital Research Ethics Committee when the following applies. I have indicated after each aspect whether or not the aspect applies to the above study:<br>a) It is a health research project **[YES]**<br>b) It is under the scope of the HSE National Framework for the Governance, Management and Support of Health Research in that it involves:<br>▪ participants recruited via the HSE health service users and/or their personal data and/or their biological samples health or **[NO]**<br>▪ social care staff, HSE healthcare services, premises, or infrastructure **[NO]**<br>c) It is not a regulated clinical trial or investigation with medical devices which require approval by the National Office for Research Ethics Committees. **[It is not a clinical trial or investigation with medical devices]**<br>Given that this project does not involve participants recruited via HSE health service users and/or their personal data / samples, it does not involve social care staff, HSE healthcare services, premises or infrastructure and it is not a regulated clinical trial, the TIAC study does not require approval by a HSE/Hospital Research Ethics Committee. |
| 2. In the application form reference is made to access to the HSE EAP scheme, what supports would be available for non HSE employees? | **Response**: The researcher has created an email address/link (TIACStudy@dkit.ie) that can be used should any participant require additional support during the study.<br>All midwives working in the Republic of Ireland are either employed by the HSE directly or in service providers who have a MOU with the HSE to provide care in the community i.e. Self Employed Community Midwives (SECMs). As part of these arrangements, participant midwives can avail of readily available HSE Employee Assistance Programme at no cost.<br>For the qualitative strand of the study, in addition to details of the HSE Employee Assistance Programme being provided, an appropriately qualified support person [with both support provision and trauma subject expertise] will be available to provide support to any participants, should they wish it, in the event of their experiencing any distress. The person will be available via phone for the duration of the focus group, and for [one] hour after the termination of the group. |

| | |
|---|---|
| 3. It states in the form that the data will be stored in a locked cabinet in the HSE (Page 7). This data should be stored in DkIT. Please review. | **Response:** Data will be encrypted and stored in a locked cabinet, in a locked office within a restricted access area in DkIT. |

| | |
|---|---|
| 4. Review the poster to make it a little more user friendly. In addition, some of the text is leading in nature, please rephrase (e.g. Midwives who utilize trauma informed practice have the potential to improve client outcome etc.). | **Response:** The poster has been reviewed and amended. The updated poster is attached to this response document. |
| 5. Can the actual survey which shall be used be sent to the Committee for review, it is stated that it shall be a hybrid of Appendix 4 and 5? | **Response**: Together with my supervisors, Dr. Anita Byrne and Dr. Kevin McKenna, we have refined the final questionnaire for use in the quantitative strand of the TIAC Study, informed by the very recent publication of a robust systematic review of Trauma Informed Care Scales (Wathen et al, 2023). This review greatly enhanced both the currency and rigor of the final questionnaire, we have amended the original plan to utilize TIAC-35 and attach King et al's survey (2019) which has been chosen as the quantitative data collection tool most fit for purpose. This tool is included in Appendix 5. Demographic data, and three VAS questions related to opinions about integrating trauma informed care into midwifery/perinatal settings are also included in this instrument. |

**Ethical Approval Application Form**

1. ADMINISTRATION DETAILS

**Researcher(s): Lane Galvin, Dr. Anita Byrne, Dr. Kevin McKenna**
**School/Research Centre/Programme (as applicable**) Section of Midwifery, School of Health and Science
**Title of Project:** MSc.by Research: Mixed methods evaluation of **T**rauma-**I**nformed **A**pproach to **C**are Knowledge and Practices in Midwifery/ Perinatal Settings in Ireland **(TIAC Study)**
**Supervisor/Research Centre Director/Head of Department:** Principal Supervisor: Dr. Anita Byrne

Co-Supervisor: Dr. Kevin McKenna
**Date:** January 2023

| **Type of research quantitative** | | | |
|---|---|---|---|
| **Undergraduate** | **Postgraduate** | **Staff member** | **External to DKIT** |
| | **X** | | |

There is an obligation on the lead researcher to bring to the attention of the School Ethics Committee any issues with ethical implications not clearly covered by this application form.

2. APPLICATION FORM CHECKLIST

**Please complete the ethics application form below and provide additional information as attachments.**

| **My application includes the following documentation:** | **INCLUDED (mark as YES)** | **NOT APPLICABLE (mark as N/A)** |
|---|---|---|
| Recruitment advertisement | Yes | |
| Participant Information Leaflet | Yes | |
| Participant Informed Consent form | Yes | |
| Questionnaire/Survey | Yes | |
| Interview/Focus Group Questions | Yes | |
| Debriefing material | | **N/A** |
| Evidence of approval to gain access to off-site location | | **N/A** |
| Ethical Approval from external organizations.<br>If ethical approval from external organizations is pending give details | | **N/A**<br>**N/A** |
| Details | | |

3. PROJECT DETAILS

**a) Lay description**

Please outline, in terms that any non-expert would understand, what your research project is about, including what participants will be required to do. Please explain any technical terms or discipline-specific phrases.

The purpose of this study is to evaluate the current knowledge and practices related to a trauma informed approach to care (TIAC) within midwifery/perinatal settings in Ireland, with a view to developing recommendations for the adoption/integration of a universal trauma informed approach to care.

A mixed methods explanatory sequential research design is proposed for this study. Study participants will be drawn from registered midwives currently practicing within perinatal healthcare settings in Ireland.

As very few trauma-informed models of midwifery or trauma-specific midwifery interventions have been developed and tested for pregnant and post-partum women/people (Bradbury-Jones and Taylor, 2017), an evaluation of the current knowledge and practices in this area is needed within the Republic of Ireland in order to consider recommendations for an inclusive universal trauma informed approach to care within the maternity settings.

The study will be conducted in two phases of investigation. Phase One, will employ a quantitative approach. Data will be obtained using an online survey among a non-randomised snowball sample of Nursing and Midwifery Board of Ireland (NMBI) registered midwives. This sample will be recruited via midwifery specific accounts on established social media platforms (Twitter, Instagram etc.) additionally, the following professional organisations will host an invitation link to recruitment; NMBI, Irish Nurses and Midwives Organisation (INMO), The Midwives Association of Ireland (MAI) and Birth Rights Alliance (Appendix 1). Respondents will have to confirm that they are on the NMBI Live register of midwives before undertaking the survey.

The second phase will employ a qualitative approach which was chosen as an effective means of attaining descriptions and information about participants' thoughts and perceptions. The findings from phase one will inform qualitative data collection via focus groups in phase two. Participants in phase one can volunteer their contact information for inclusion in phase two. To ensure anonymity in phase one, this contact information will be disaggregated from the survey via a separate link i.e. the survey will be anonymous, if participants volunteer to participate in phase two they click a link that opens a separate file. Overall findings will take cognisance of both data sets.

Once ethical approval is granted for this study, the researcher will begin recruitment of study participants as outlined above. A detailed written explanation of the study will be included at the beginning of the survey (Appendix 2). Participants must indicate that they have read the participant information before proceeding to confirm that they consent to partaking in the survey. This will give the researcher permission to use their [responses] data in a final report and further dissemination via publications / conference presentations. If the participant has any queries in relation to the study they can contact the researcher or they can choose not to proceed. McGowan et al (2018) would support the use of online consent in self-test surveys where the study is uncomplicated and does not pose a high risk to participants such as health care professionals.

Together with my supervisors, Dr. Anita Byrne and Dr. Kevin McKenna, we have refined the final questionnaire for use in the quantitative strand of the TIAC Study, informed by the very recent publication of a robust systematic review of Trauma Informed Care Scales (Wathen et al, 2023). This review greatly enhanced both the currency and rigor of the final questionnaire, we have amended the original plan to utilize TIAC-35 and attach King et al's survey (2019) which has been chosen as the quantitative data collection tool most fit for purpose. This tool is included in Appendix 5. Demographic data, and three VAS questions related to opinions about integrating trauma informed care into midwifery/perinatal settings are also included in this instrument.

The focus group interviews will be informed by the findings of phase one and will be undertaken with participants who have volunteered their contact details. The participants, after full explanation and consent, will participate in one audio taped focus group interview between 40 and 60 minutes' duration. Please see a sample outline of the interview schedule attached (Appendix 4). Once the interviews are completed, transcripts will be systematically analysed using a thematic analysis approach as described by Braun and Clarke (2006) which is especially well suited to interviews which have been recorded in full.

As mentioned, participants in phase one will have the option to volunteer their contact details for participation in phase two of the study, the focus groups. Participants in this stage will also be informed that their participation is voluntary and that they have the right to withdraw at any stage throughout the study. Participants in phase two will be invited to complete a consent form (Appendix 3). This will give the researcher permission to use their data in a final report and further dissemination via publications / conference presentations. Clarity seeking questions from participants will be encouraged. In the case of all participants there will be a time interval of at

least seven days between completing written informed consent and the conduct of the interview. Consent will be re-affirmed at the commencement of the focus group.

The inclusion criteria for this study are:

- Midwives registered with NMBI
- Midwives currently working and practicing within the midwifery/perinatal settings in Ireland.

The Exclusion criterion are:

- Midwives not registered with NMBI.
- Midwives currently not working and practicing within the midwifery/perinatal settings in Ireland.

**Research objectives (Maximum 150 words):** Please summarise briefly the objectives of the research,

The aim of this study is to evaluate knowledge and practices related to a trauma informed approach to care within the midwifery/perinatal settings in Ireland with a view to considering recommendations for the adoption/integration of a universal trauma informed approach to care in these settings. Specifically, this study will:

- Define and delineate Trauma Informed Approach to Care and Trauma Informed Care Practises within Midwifery/Perinatal settings.
- Evaluate current **knowledge** related to trauma informed approaches to care within midwifery/perinatal settings in Ireland utilising a mixed methods approach
- Evaluate current **interventions** related to trauma informed care practises within midwifery/ perinatal settings in Ireland utilising a mixed methods approach
- Develop recommendations to adopt/integrate a universal trauma informed approach to care model within midwifery/perinatal settings in Ireland.

### b) Research location and duration

| | |
|---|---|
| **Location(s)/Population*** | All Registered Midwives on the NMBI active register who are currently employed in client facing services (n=3850 (NMBI, 2022)). The sample will be recruited via online/ social media/ professional organization. Participants will voluntarily complete the online survey and can agree to participate in online focus groups. |
| **Research start date** | Phase One- April 2023. Phase Two- January 2024 |
| **Research end date** | Phase One- September 2023. Phase Two- July 2024 |
| **Approximate duration** | 18 months |

* If location/Population other than DKIT campus/population, provide details of the approval to gain access to that location/population as an appendix.

## 4. PARTICIPANTS

| | | YES | NO | N/A |
|---|---|---|---|---|
| | **Minors (under 18 years of age)** | | No | |

| | | | | |
|---|---|---|---|---|
| **Do participants fall into any of the following special groups?** | **People with learning or communication difficulties** | | No | |
| | **Patients** | | No | |
| | **People in custody** | | No | |
| | **People engaged in illegal activities (e.g. drug-taking)** | | No | |
| **Have you given due consideration to the need for satisfactory Garda clearance?** | | | | N/A |
| | | | | |

5. SAMPLE DETAILS

| | |
|---|---|
| **Approximate number** | Sample size ~ 350 participants for phase one |
| **Where will participants be recruited from?** | Participants will be recruited via social media and online advertisement with professional organizations. |
| **Inclusion Criteria** | • Registered midwife with NMBI<br>• Currently practicing/working in midwifery within the Republic of Ireland |
| **Exclusion Criteria** | • Not registered with NMBI<br>• Not currently practicing/working within midwifery in the Republic of Ireland |
| **Will participants be remunerated, and if so in what form?** There will be no reward for participating in this study. **Participation is voluntary and participants are made aware that they may withdraw at any stage during the study.** | |
| **Justification for proposed sample size and for selecting a specific gender, age, or any other group if this is done in your research.**<br>• Non-Probabilistic/non-randomized volunteer snowball sampling will be employed in phase one to recruit respondents as outlined above. This sampling approach has been advocated by Leighton et al (2021) who deemed it both an effective and efficient way to recruit participants. Respondents from phase one will be asked to volunteer their consent for inclusion in phase two. The sample size of 350 participants for phase 1 is based on a population size of 3850 (NMBI, 2022). A sample size generator was used to estimate this number (https://www.qualtrics.com/blog/calculating-sample-size/) yielding a 95% confidence with 5% margin of error.<br>• There will be three focus groups in phase two. Each focus group will have 6-10 participants. This number is considered small enough to allow for all members to participate, yet large enough to draw upon participants diverse experiences and perspectives. | |

6. RISKS TO PARTICIPANTS

**a) Please describe any risks to participants that may arise due to the research. Such risks could include physical stress, emotional distress, perceived coercion e.g. lecturer interviewing own students. Detail the measures and considerations you have put in place to minimize these risks**

The study will adhere to the Nursing and Midwifery Board of Ireland Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives (NMBI, 2015) as follows:

- *Respect for Persons/Autonomy*
    - Participants will have the right to choose whether or not to participate in a research study
    - They will receive information outlining the nature of the study, including the likely risks and benefits, allowing them to make an informed choice / give informed consent
    - **Participants will have the right to withdraw from the study at any time with no consequences up to the point that the transcripts of the focus groups have been irrevocably pseudoynmised during verbatim transcription, as beyond that point in the time the original audio recordings will have been deleted.** However, participants are assured that beyond the point of transcription only pseudonyms are included and it is not feasible to attribute any contributions to any individual person

- *Beneficence and Non-maleficence*
    - Participants have the right not to be harmed. The potential benefits of this study will be balanced against potential risks to safeguard all contributors. In the unlikely event that study triggers emotional / psychological upset, data collection will be suspended and participants will be supported.
    - The researcher has created an email address/link (TIACStudy@dkit.ie) that can be used should any participant require additional support during the study. Additional support will be offered in the form of online resources and referral to a specialist in Trauma Care (if required) (Dr. Kevin McKenna). HSE EAP will also be available to participants who are employed / contracted by the HSE. All midwives working in the Republic of Ireland are either employed by the HSE directly or have an MOU with the HSE to provide care in the community i.e. Self Employed Community Midwives (SECMs). These midwives would also be able to avail of the HSE EAP scheme.
- *Justice*
    - Participants will be treated fairly and equitably before, during and after the research study. There will be no expectations about participation / continued participation during the study period. All decisions made by participants will be accepted without prejudice.
- *Veracity*
    - Participants have the right to be told the truth and not to be deceived about any aspect of the research study. All aspects of this research project will be explained by the researcher and all reasonable efforts will be made to ensure the participants understand the implications of their participation throughout the study.
- *Fidelity*
    - The researcher will ensure that the participants have an understanding of the risks and benefits of participating in the study. Participant information document(s) will be supplied to all contributors.

- *Confidentiality*
    - The researcher will ensure that anonymity will be maintained in phase one by disaggregating volunteered contact details from the survey data. **Confidentiality will be maintained in phase two by assigning an identification number / pseudonym to each participant. This will also ensure that data can be removed should a participant withdraw consent at any time.**
    - Careful consideration has been given to achieving the research objective without any/ or with minimal collection of any personal data and/or the processing of data in such a way that prevents any 'damage or distress' to study participants.
    - There are two points in the study in which personal data will be recorded. The first of these is the participants putting their name and signature on the consent form as a pre-requisite of participation. The second is the unintentional, but potential, for participants to use the name of another participant during the focus group discussion.
    - Signed consents will be managed by the principal investigator storing the signed consent forms in a sealed envelope in a locked cabinet in a locked office in a DkIT location which has secured access. These forms will be shredded at the earliest opportunity, but in any event no later than the completion of the study.
    - **The second contingency [use of a name during discussion] will be managed by having all names removed [replaced by pseudonyms] during verbatim transcription, after which the audio tapes will be irrevocably deleted. The resulting transcriptions will not therefore have any name or data which will identify any participant, and analysis of the interviews will be written up in such a manner that no particular comment will be attributable to any individual participant.**
    - **The single caveat in this undertaking is the qualified confidentiality which is explained to participants in the information provided, that an exception to absolute confidentiality in the event that disclosures revealed a situation which placed others at risk to such an extent as to impose a duty-bound obligation on researchers and/or others present.**

b) **What will you communicate to participants about any identified risks? Will any information be withheld from them about the research purpose or procedure? If so, please justify this decision.**

Participants will be informed about the purpose and procedure of this study before it commences via an online invitation link. Participants will be made aware that they can withdraw from the study at any stage. No information will be withheld from participants.

## 7. INFORMED CONSENT

| | YES | NO | N/A |
|---|---|---|---|
| Will you obtain active consent for participation? | Yes | | |
| Will you describe the main experimental procedures to participants in advance? | | | N/A |
| Will you inform the participants that their participation is voluntary and may be withdrawn at any point? | Yes | | |
| If the research is observational, will you ask for their consent to being observed? | | | N/A |
| With questionnaires, will you give participants the option of omitting questions they do not want to answer? | Yes | | |
| Will you tell participants that their data will be treated with full confidentiality and that, if published, it will not be identifiable as theirs? | Yes | | |
| Will the data be anonymous? **Strand 1 Survey Questionnaire** | Yes | | |
| Will the data be anonymous? **Strand 2 Focus Group Interviews** [Pseudonymised] | | No | |
| Will you debrief participants at the end of their participation? | Yes | | |
| Will your project involve deliberately misleading participants in any way or will information be withheld? If you answer yes, give details and justification for doing this below. | | No | |

**Please outline your approach to ensuring the confidentiality of data that is, that the data will only be accessible to agreed upon parties and the safeguarding mechanisms you will put in place to achieve this. You should include details on how and where the data will be stored/who will have access to it.**

Study data will be encrypted and stored in a locked cabinet, in a locked office within a restricted access area in DkIT.. Data from phase one will be collected via Qualtrics. No identifying information will be attached to this dataset. If participants wish to volunteer for phase two, they will be directed to an alternative link where contact details can be provided. This data will be disaggregated from survey data. Participants who volunteer for phase two will be interviewed in online focus groups. The interviews will be recorded and transcribed by the researcher. This data will be stored in a password protected file on a password protected and encrypted laptop, only made available to the researcher and her supervisors and stored as outlined above. Information gathered in phase two will be coded using pseudonyms to ensure confidentiality. **If a participant wishes to withdraw their data from the study, they can inform the researcher and their participant code with their information will be removed.** The information gathered will be destroyed 6 months after the research study has finished and findings have been published. This will be explained in the participant's information email / document. **The study intends to do no harm** to the participant and will adhere to the DKIT / NMBI ethical guidelines.

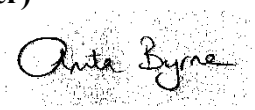
**Please outline how long the data will be retained for, if it will be destroyed and how it will be destroyed.**

**Data from both phases will be coded using pseudonyms to ensure confidentiality and stored safely for the duration of** the study in password protected files on a password protected laptop. The information gathered will be retained for the duration of the study.

| |
|---|
| The information will be destroyed once the research has been completed and reviewed approximately 6 months after the research study has finished and findings have been published. |

8. **DECLARATION**

**I have read and understand the DkIT guidelines for ethical practices in research and have read and understand the data protection guidelines.**
**Signed:** Lane Gavin **10/02/2023**
**(Researcher)**

**Signed:**  **10/02/23** **Signed:** 
**Supervisor(s)**

9. STATEMENT OF ETHICAL APPROVAL
**Supervisor/Research Centre Director/Head of Department**
This project has been considered using agreed procedures and is now approved/ referred to the Ethics Committee
**Signed:** _____ **Name:** _____
_____
**Date:** _____
**Chair of Ethics Committee**
This project has been considered by the Ethics Committee and ethical approval is granted.

**Signed:** _____ **Name:** _____
_____

**Date:** _____

## Appendix C: Ethical Approval Letter


Ms Lane Galvin,
School of Health & Science,
Dundalk Institute of Technology,
Dundalk,
Co. Louth

3rd May 2023

**Re: Mixed Methods Evaluation of Trauma-Informed Approach to Care, Knowledge & Practices in Midwifery/Perinatal Settings in Ireland**

Dear Lane,

The above study was discussed at the Ethics Committee on the 6th March 2023. I acknowledge receipt of your amendments dated the 19th April 2023. This study is now granted ethical approval. Wishing you the best of luck with your research.

Yours sincerely,

Edel Healy

_____

Dr.Edel Healy
Chair of School of Health & Science Ethics Committee

cc. Dr. Anita Byrne/Dr. Kevin McKenna

## Appendix D:

## Questionnaire King et al (2019).

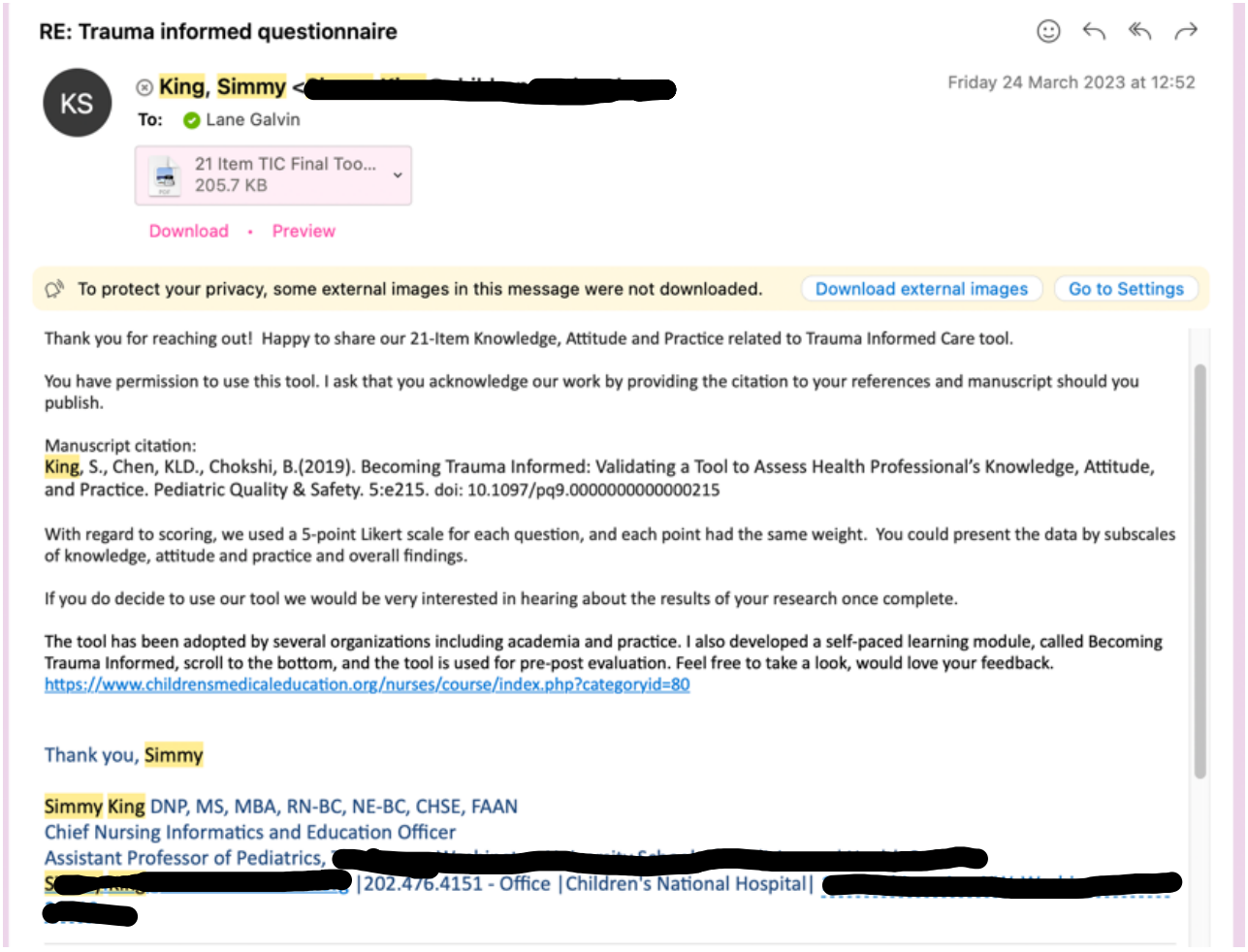
21 Item- Knowledge, Attitude and Practice Related to Trauma Informed Care

| Factor | Survey Question | Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree |
|---|---|---|---|---|---|---|
| Knowledge | 1. Exposure to trauma is common. | | | | | |
| | 2. Trauma affects physical, emotional, and mental well-being. | | | | | |
| | 3. Substance use issues can be indicative of past traumatic experiences or adverse childhood events (ACE). | | | | | |
| | 4. There is a connection between mental health issues and past traumatic experiences or adverse childhood events (ACE). | | | | | |
| | 5. Distrusting behavior can be indicative of past traumatic experiences or adverse childhood events (ACE). | | | | | |
| | 6. Retraumatization can occur unintentionally. | | | | | |
| Attitude | 7. Recovery from trauma is possible. | | | | | |
| | 8. Paths to healing/recovery from trauma are different for everyone. | | | | | |
| | 9. People are experts in their own healing/recovery from trauma. | | | | | |
| | 10. Informed choice is essential in healing/recovery from trauma. | | | | | |
| | 11. Trauma-informed practice (TIP) is essential for working effectively with our patients and their families. | | | | | |
| | 12. I have a comprehensive understanding of trauma-informed practice (TIP). | | | | | |
| | 13. I believe in and support the principles of trauma-informed practice (TIP). | | | | | |
| | 14. I share my expertise and collaborate effectively with colleagues regarding the use of trauma-informed practice (TIP). | | | | | |
| | 15. I would like to receive more training on trauma-informed practice (TIP). | | | | | |
| Practice | 16. I maintain transparency in all interactions with patients. | | | | | |
| | 17. I offer patients choices and respect their decisions. | | | | | |
| | 18. I help patients and peers to recognize their own strengths. | | | | | |
| | 19. I inform all patients of my actions before I perform them. | | | | | |
| | 20. My interaction with each patient is unique and tailored to their specific needs. | | | | | |
| | 21. I practice self-care (taking care of my own needs and well-being). | | | | | |

S. King, K.D. Chen & B. Chokshi (2018)

## Appendix E:

## Consent from Author of Questionnaire to use same in current study



RE: Trauma informed questionnaire

KS

King, Simmy <[redacted]>

Friday 24 March 2023 at 12:52

To: Lane Galvin

21 Item TIC Final Too...
205.7 KB

Download • Preview

To protect your privacy, some external images in this message were not downloaded. Download external images Go to Settings

Thank you for reaching out! Happy to share our 21-Item Knowledge, Attitude and Practice related to Trauma Informed Care tool.

You have permission to use this tool. I ask that you acknowledge our work by providing the citation to your references and manuscript should you publish.

Manuscript citation:
King, S., Chen, KLD., Chokshi, B.(2019). Becoming Trauma Informed: Validating a Tool to Assess Health Professional's Knowledge, Attitude, and Practice. Pediatric Quality & Safety. 5:e215. doi: 10.1097/pq9.0000000000000215

With regard to scoring, we used a 5-point Likert scale for each question, and each point had the same weight. You could present the data by subscales of knowledge, attitude and practice and overall findings.

If you do decide to use our tool we would be very interested in hearing about the results of your research once complete.

The tool has been adopted by several organizations including academia and practice. I also developed a self-paced learning module, called Becoming Trauma Informed, scroll to the bottom, and the tool is used for pre-post evaluation. Feel free to take a look, would love your feedback.
https://www.childrensmedicaleducation.org/nurses/course/index.php?categoryid=80

Thank you, Simmy

Simmy King DNP, MS, MBA, RN-BC, NE-BC, CHSE, FAAN
Chief Nursing Informatics and Education Officer
Assistant Professor of Pediatrics, [redacted]
[redacted] |202.476.4151 - Office |Children's National Hospital| [redacted]

## Appendix F: Recruitment Poster for Survey

## Appendix G: Participant Information Document

**Participant Information – Available Online Prior to Participation**

**Study title:** A Mixed Methods Evaluation of Trauma- Informed Approach to Care (TIAC) Knowledge and Practices in Midwifery/ Perinatal Settings in Ireland.

**Researchers Names:** Lane Galvin

Dear Participant,

You are being invited to take part in a research study to be carried out by a researcher in Dundalk Institute of Technology (DkIT). Before you decide whether or not you wish to take part, you should read the information provided below carefully and, if you wish, discuss it with your family, friends. Don't feel rushed and don't feel under pressure to make a quick decision about whether you wish to participate or not. You should clearly understand the risks and benefits of taking part in this study so that you can make a decision that is right for you. This process is known as 'Informed Consent'. You don't have to take part in this study. **You can change your mind about taking part in the study any time you like. Even if the study has started, you can still opt out.** You don't have to give us a reason. If you do opt out, be assured that the information that you have provided will be removed and will not be used to complete the study.

**Why is this study being done?**
The study is being done because the researcher wishes to evaluate the current knowledge and practices among midwives within the midwifery/perinatal setting in the Republic of Ireland in relation to a Trauma Informed Approach to Care.

**Who is organising and funding this study?**
The researcher is a Postgraduate Student in DkIT and they are conducting this study to seek information about midwives' knowledge and practises related to trauma informed care. The study is funded by the Higher Education Authority Technological Universities Transformation Fund (TUTF) and DKIT.

**Why am I being asked to take part in the study?**
You are being invited to take part in this study because you are a registered midwife currently practising and working within the Midwifery/ Perinatal Setting in the Republic of Ireland. The study will explore knowledge and practises about trauma informed care among midwives in Ireland. You will be requested to complete an anonymous online questionnaire and, if you choose, partake in an online focus group to further explore knowledge and practises. This focus group would take place approximately 3 months after the questionnaire.

**How will the study be carried out?**
The study will be carried out in two strands. You would voluntarily complete an online questionnaire. All your information in this questionnaire in anonymous. If you choose to take part in the focus groups, you will be directed to another link where you can leave your contact details for the researcher. There is no direct link to the survey data and

contact details. You will only have to take part in one focus group. The focus groups will take place approximately 3 months after the questionnaire. They will be facilitated online by the researcher and would **normally consist of 5 people** (midwives). The researcher will pose questions related to trauma informed care knowledge and practice and the group will discuss these together. The focus group interviews will take place at a time that is convenient for participants. It will be recorded with your consent, and it will be stored in a **password protected file on a password protected computer.** Your answers to the questions posed in this interview will be transcribed and reviewed by the researcher. Your information will remain confidential through the use of pseudonyms. **No one, except the researchers and her supervisors will be able to identify your answers.**

**What will happen to me if I agree to take part in the study?**
You will be asked to indicate your consent to partake in the anonymous online questionnaire data collection phase giving the researcher permission to use the information gained in this part of the study. You will then be asked to consider voluntarily supplying your contact details to the researcher so that she can plan for the online focus group data collection. The online focus groups should normally take about 40-60 minutes. You would only have to participate in one focus group. It will consist of the researcher posing semi-structured questions about your knowledge and practises of a trauma informed approach to care to the group to generate discussion. Your data will remain confidential in this phase through the use of pseudonyms. The focus group will be recorded, and the conversations will be transcribed for analysis. If you have any questions about the interview process, please do not hesitate to ask. **You can withdraw from the study at any stage.**

**What if I decide not to take part in the study?**
It is completely up to you if you wish to take part in the study. **Even if you do participate you can withdraw from the study at any point.** You will not be questioned by the researcher about your decision not to participate or not to continue with the study. Questions from participants about the study will be encouraged.

**What are the benefits of participating in the study?**
The benefits of this study are that findings will identify the current level of knowledge and practises related to trauma informed care in midwifery care/ practice in Ireland. This study will make recommendations based on findings and may represent the first step towards planning and integrating a trauma informed approach to care model within midwifery and perinatal settings in Ireland.

**What are the risks of participating in the study?**
We do not anticipate that there is any risk associated with participation in the study. We are asking you to share your knowledge and practise with regard to a trauma informed care in perinatal settings. Your participation is voluntary, and you may withdraw from the study at any point.

**Will it cost anything to take part in the study?**
The questionnaire is available online and can be completed at any time that is convenient to you. If you choose to participate in a focus group, these will also be arranged online at a time that is convenient for the participants. There will be no financial cost involved in taking part in this study, just your time.

**Is the study confidential?**
This study has received ethical approval from DKIT. Questionnaire data will be anonymous. Focus group data will remain confidential as all information will be coded through the use of pseudonyms. All names and references to any individual will be removed, once the transcription of the interviews is completed, the audio recordings will be deleted. Once the findings have been written up, the transcripts will be destroyed. No one, except the researcher and her supervisors, will be able to identify your answers. Your consent will be obtained before taking part in all aspects of the study.

**Where can I get further information?**
If you have any further questions about the study or if you want to opt out of the study, please contact:

**Lane Galvin**
**Lane.Galvin@dkit.ie**

## Appendix H: Quantitative Questionnaire (King et al, 2019)

### Section 1

**1) Job Title / Professional Role**

- Registered Midwife (BSc. (Hons) in Midwifery)
- Registered Midwife (Higher Diploma in Midwifery)
- Clinical Midwife Manager (Client-facing service provision)
- Clinical Midwife Specialist
- Advanced Midwife Practitioner
- Other (please specify): _____

**2) Area of Practice (Select all that apply)**

- Antenatal Clinic
- Gynaecology ward
- Antenatal ward
- Sonography Department
- Labour Ward
- Midwifery Led unit
- Postnatal Ward
- Community care
- Specialised area (Please specify) _____
- Other (Please Specify) _____

**3) What is your age bracket?**

| | | | | | |
|---|---|---|---|---|---|
| 20-29 | 30-39 | 40-49 | 50-59 | Over 60 | Prefer not to say |

**4) Gender: How do you identify?**

- Male
- Female
- Non-Binary
- Prefer not to say
- Other (Please Specify) _____

**5) How many years' experiences do you have as a practicing midwife?**

| | | | |
|---|---|---|---|
| Less than a year | 1-5 years | 5-10 years | Greater than 10 years |

6) **During your midwifery education (certifications, undergraduate, graduate, etc.), was Trauma Informed care (TIC) addressed?**

   Yes No

7) **Have you received any training related to Trauma Informed Practice (TIP) that was not provided through your midwifery education program?**

   Yes No

8) **If you answered yes to question 5 please specify if you sought the training yourself or if the training was provided by your employer**

---

**Section 2**

9. Exposure to trauma is common.

| | | | | |
|---|---|---|---|---|
| Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree |

10. Trauma affects physical, emotional, and mental well-being.

| | | | | |
|---|---|---|---|---|
| Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree |

11. Substance use issues can be indicative of past traumatic experiences or adverse childhood events (ACE).

| | | | | |
|---|---|---|---|---|
| Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree |

12. There is a connection between mental health issues and past traumatic experiences or adverse childhood events (ACE).

| | | | | |
|---|---|---|---|---|
| Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree |

13. Distrusting behaviour can be indicative of past traumatic experiences or adverse childhood events (ACE).

| | | | | |
|---|---|---|---|---|
| Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree |

14. Retraumatization can occur unintentionally.

| | | | | |
|---|---|---|---|---|
| Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree |

15. I believe in and support the principles of trauma-informed approach to care (TIAC).

| | | | | |
|---|---|---|---|---|
| Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree |

16. I share my expertise and collaborate effectively with colleagues regarding the use of trauma-informed approach to care (TIAC)

| | | | | |
|---|---|---|---|---|
| Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree |

17. I would like to receive more training on trauma-informed approach to care (TIAC)

| | | | | |
|---|---|---|---|---|
| Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree |

18. I maintain transparency in all interactions with women/people.

| | | | | |
|---|---|---|---|---|
| Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree |

19. I offer women/people choices and respect their decisions.

| | | | | |
|---|---|---|---|---|
| Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree |

20. I help women/people and peers to recognize their own strengths.

| | | | | |
|---|---|---|---|---|
| Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree |

21. I inform all women/people of my actions before I perform them.

| | | | | |
|---|---|---|---|---|
| Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree |

22. My interaction with each woman/person is unique and tailored to their specific needs.

| | | | | |
|---|---|---|---|---|
| Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree |

23. I practice self-care (taking care of my own needs and well-being)

| | | | | |
|---|---|---|---|---|
| Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree |

24. Recovery from trauma is possible.

| | | | | |
|---|---|---|---|---|
| Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree |

25. Paths to healing/recovery from trauma are different for everyone.

| | | | | |
|---|---|---|---|---|
| Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree |

26. People are experts in their own healing/recovery from trauma.

| | | | | |
|---|---|---|---|---|
| Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree |

27. Informed choice is essential in healing/recovery from trauma.

| | | | | |
|---|---|---|---|---|
| Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree |

28. Trauma-informed approach to care (TIAC) is essential for working effectively with the women/people and their families.

| | | | | |
|---|---|---|---|---|
| Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree |

29. I have a comprehensive understanding of trauma-informed approach to care (TIAC).

| | | | | |
|---|---|---|---|---|
| Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree |

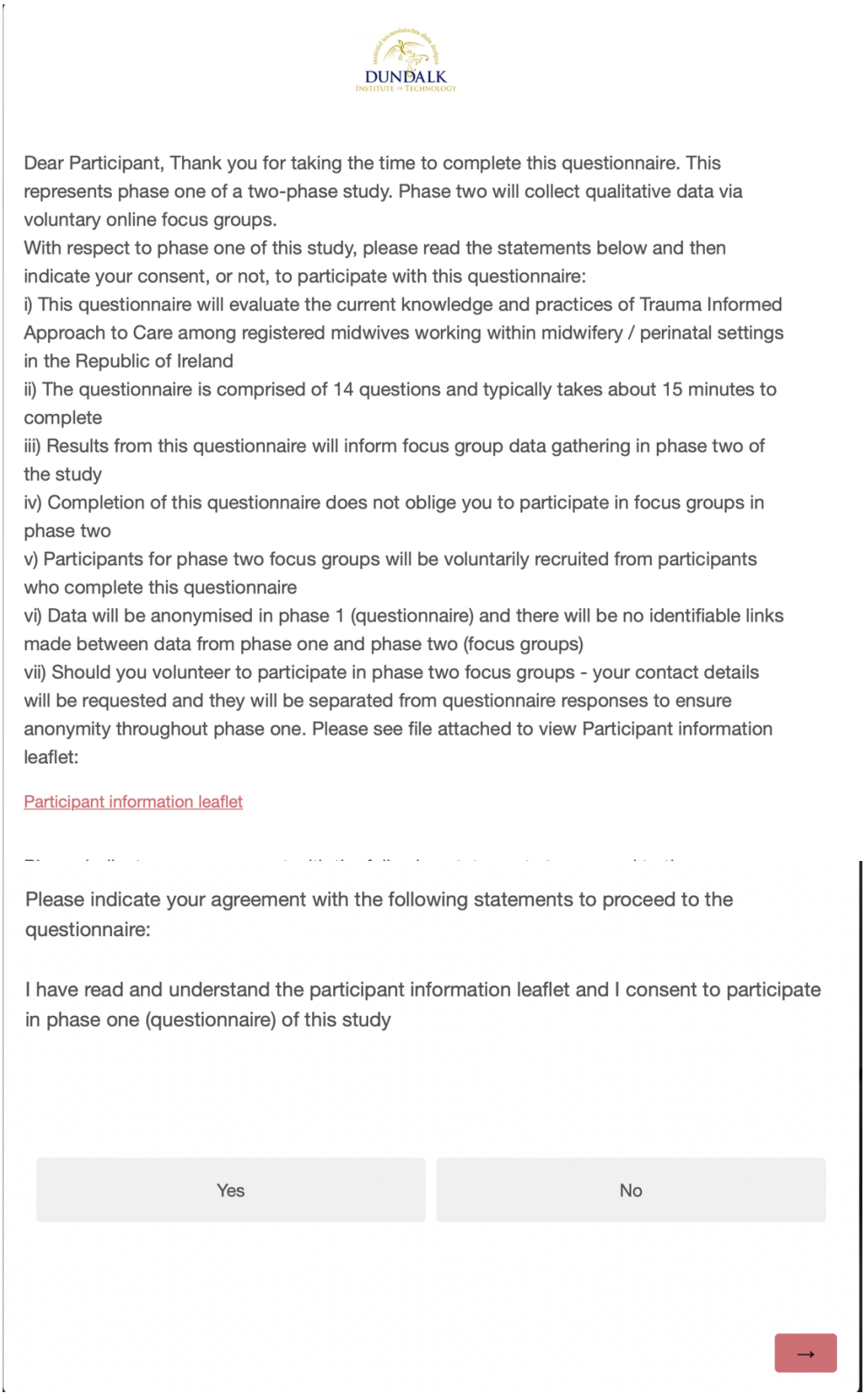
## Section 3

| On the slider scale below please indicate the degree to which you would welcome the opportunity to enhance **<u>your own</u> 'Knowledge'** of 'Trauma Informed Approach to Care' | | |
|---|---|---|
| **Not Knowledgeable** |  | **Very Knowledgeable** |

| On the scale below please indicate if you think that a service utilising a Trauma Informed Approach would enhance the care experience of people in your care | | |
|---|---|---|
| **Not Enhanced** |  | **Very Enhanced** |

| On the scale below please indicate the extent to which 'Trauma Informed Approach is evident in your area of service (i.e. in everyday use) | | |
|---|---|---|
| **Not Evident** |  | **Very Evident** |

## Appendix I
## Study Explanation at the beginning of the questionnaire:



## Appendix J

## Consent Form

### Participant Consent Form

| | | |
|---|---|---|
| I have read and understood the information about this research project. The information has been fully detailed to me. | **Yes** ☐ | **No** ☐ |
| I understand that I don't have to take part in this study and that I can opt out at any time. I understand that I don't have to give a reason for opting out and I understand that opting out won't have any affects | **Yes** ☐ | **No** ☐ |
| I have been assured that information about me will be kept private and confidential* | **Yes** ☐ | **No** ☐ |
| If I have chosen to participate in the focus group, I have been given a copy of the Information documentation and the completed consent form for my records. | **Yes** ☐ | **No** ☐ |
| **Storage and future use of information:** I give my permission for information collected from me to be stored and/or electronically processed for the purpose of research and to be used in related studies or other studies in the future (once approval has been obtained by a Research Ethics Committee). I also consent to this information being used for publication and/or conference presentation. | **Yes** ☐ | **No** ☐ |
| *While giving full respect to the necessity for confidentiality, in order that we may discuss issues frankly; it does not need to be made explicit that in the event of a disclosure which suggests a potential or actual risk to safety of others, that I understand the professional duty to disclose such potentialities will take precedence over confidentiality | | |

| | |

---

Participant Name (Block Capitals) | Participant Signature | Date

**To be completed by the Researcher:**

I, Lane Galvin, have taken the effort to fully explain to the above participant the nature and purpose of this study in a way that they could understand. I have explained the risks involved as well as the possible benefits. I have invited them to ask questions on any aspect of the study that concerned them.

---

Names (Block Capitals) | Qualifications | Signature | Date

## Appendix K- Answers to Question 32

Q32
Beyond education alone, are there factors that may enable / support midwives in their day to day implementation of Trauma Informed Approach to care?
To work it needs to be a multidisciplinary approach. All the midwifery education and utilisation of Trauma Informed Approach is pointless if the doctors, consultants, and management don't get involved or practice it to the same extent. The 'this is for your own good/well-being' approach is all too often being practiced. Even when as midwives we intervene our voices are often ignored.

**COLLABORATION OF MDT**
**MIDWIVES IGNORED**
**BIRTH ENVIRONMENT/ BIRTH OPTIONS/ CLU vs. MLU**
**SUPPORT**

Proper staffing to give patients effective care

**ADEQUATE STAFFING**

Informal sessions, ie debriefing sessions for all members of the team in every area, not just labour ward staff that may have been involved in the case. Using these cases as examples throughout education sessions.

**STAFFING DEBRIEFS WITH EVERYONE IN CARE**
**EDUCATION AND TRAINING**

Better staffing levels and better staff care to support an environment conducive with trauma informed care

**ADEQUATE STAFFING**
**WORK ENVIRONMENT/ INFRASTRUCTURE**

Past experience. Time constraints. Space to provide care in a sensitive manner. Supportive and educated managers. Midwives belief in the value of such practice

**WORK ENVIRONMENT/ INFASTRUCTURE**
**Experience**
**ADEQUATE TIME**

A great continuity of care, allowing midwives to debrief with women whom they have met, allowing women to report their trauma and it's causes, and midwives to learn from this to identify possible ways practice could be changed to prevent this in future practice

**CONTINUITY OF CARE**
**INDIVIDUALISE/ WOMAN CENTRED/ COLLABORATING WITH CLIENTS**

PPI input to care plans/approaches to care would be important given the context.

**INDIVIDUALISE/ WOMAN CENTRED/ COLLABORATING WITH CLIENTS**

More staffing, allowing midwives to spend an adequate amount of time providing trauma informed care

**ADEQUATE STAFFING**
**ADEQUATE TIME**

More debriefing for staff and service users

**STAFFING DEBRIEFS WITH EVERYONE IN CARE**

Support from specialised midwife perinatal mental health, bereavement midwife

**COLLABORATION OF MDT**

DEDICATED CARE PATHWAY/ TEAM

Further training around recognition of symptoms related to trauma and what can be done to help alleviate them. A CMS post would be ideal for referral but for floor staff better recognition of people who have endured trauma and how to
adapt our care approach

EDUCATION AND TRAINING
DEDICATED CARE PATHWAY/ TEAM

Minimization of vaginal examinations

REDUCTION OF VE'S

More staffing so that we have the proper amount of time to spend with women, to explain things properly, get to know them and build up trust. Continuity of care would go a long way to addressing this too.

ADEQUATE STAFFING
ADEQUATE TIME

CONTINUITY OF CARE

A multidisciplinary approach, not just midwives but all specialties being taught equally the importance of TIAC. Clinically for the women, consistency would remove a lot of the fear involved.

CONTINUITY OF CARE
COLLABORATION OF MDT

Model of care and removal of fragmented or fractured approach to care. Midwifery philosophy is also a factor, where the importance of a relationship or equally balanced approach to care influence how we give care to women. Organisational recognition that our current model of 'one size fits all ' may indeed be facilitating or compounding trauma for some women and families. We are not always asking the questions that we may not like the answers to. Our own colleagues around us carry evidence of previous trauma and it can influence behaviour and compassion for others

BIRTH ENVIRONMENT/ BIRTH OPTIONS/ CLU vs. MLU
DEDICATED CARE PATHWAY/ TEAM
CONTINUITY OF CARE
THE INTERPLAY OF PERSONAL AND PROFESSIONAL TRAUMA

Knowledge on referral for women who have experienced trauma.

DEDICATED CARE PATHWAY/ TEAM
EDUCATION AND TRAINING

By being offered a day course in trauma information relevant to midwifery care

EDUCATION AND TRAINING

Continuity of care would allow a midwife-woman relationship to be built and assist with the sharing of information between the  woman and her care provider.

CONTINUITY OF CARE

Being supported to work in environments that support choice, informed decision making, birth environments that support birth physiology, less bullying and exclusion of midwives, respect for midwifery practice, less technocratic birth model

SUPPORT

MIDWIVES IGNORED
BIRTH ENVIRONMENT/ BIRTH OPTIONS/ CLU vs. MLU

Having a good mental health team or at least one continuity of career as women may be more open to disclosing previous traumatic events in which intimate exams or child birth may bring back traumatic events for the woman of staff are more aware of these events they can individualise care more often. Having more availability to single/more private rooms to discuss with women their care preferences/birth plan or previous traumatic event. More staff to enable midwives time to discuss these events with women at length and not feel rushed.

CONTINUITY OF CARE
DEDICATED CARE PATHWAY/ TEAM
INDIVIDUALISE/ WOMAN CENTRED/ COLLABORATING WITH CLIENTS
ADEQUATE STAFFING
ADEQUATE TIME

Peer support group. Common rooms for breaks, provides informal peer support.

SUPPORT
WORK ENVIRONMENT/ INFRASTRUCTURE

Mentoring, peer support

SUPPORT

Simulation training , designated midwives for TIA

EDUCATION AND TRAINING
DEDICATED CARE PATHWAY/ TEAM

Immediate access to mental support team, a unit that actually encouraged and supporting the concept of trauma informed care

SUPPORT
DEDICATED CARE PATHWAY/ TEAM
COLLABORATION OF MDT

Being involved in risk management, managing complaints and being exposed to service users stories of their experience

EDUCATION AND TRAINING
RISK MANAGEMENT FOR ALL STAFF

More time to spend talking to clients

ADEQUATE TIME

Having time to listen to woman and/or their partner

ADEQUATE TIME

Resources, staffing levels

WORK ENVIRONMENT/ INFRASTRUCTURE
ADEQUATE STAFFING

Reflection, discussion, drills

EDUCATION AND TRAINING
STAFFING DEBRIEFS WITH EVERYONE IN CARE

Work load , physical availability, self conscious,

ADEQUATE STAFFING
ADEQUATE TIME
THE INTERPLAY OF PERSONAL AND PROFESSIONAL TRAUMA

better staffing levels so better care can be provided

ADEQUATE STAFFING

Continuity of Care. Support Services for Staff

CONTINUITY OF CARE
SUPPORT

Listening to women

ADEQUATE TIME

If policies/guidelines were made up to help support midwives

SUPPORT

Uniform adaption of the approach in practice

COLLABORATION OF MDT
DEDICATED CARE PATHWAY/ TEAM

Giving women the language of o articulate it. Making it a part of the booking

INDIVIDUALISE/ WOMAN CENTRED/
COLLABORATING WITH CLIENTS

Increasing staff levels

ADEQUATE STAFFING

Training instead of education, information leaflets for women and staff, short video on HSELAND

EDUCATION AND TRAINING

Ensuring midwives are supported to give time to the women they care for.

SUPPORT

ADEQUATE TIME

Self care time in work

SELF CARE AT WORK
SUPPORT

It needs to be directed towards doctors - they have no idea what impact their actions have on couples birthing experiences I have witnessed doctors saying things like baby is too big - mother to be worried and stressed so much and builds up shoulder dystopia pph third degree tear - it's scare mongering and taking the believe from women and the push towards inductions to accommodate consultants holidays is appauling
More of that precious commodity time!

ADEQUATE TIME
BIRTH ENVIRONMENT/ BIRTH OPTIONS/ CLU vs. MLU

Community similar people, online support.

SUPPORT

It may aid staff in dealing with personal trauma perhaps in turn benefiting women in our care

SUPPORT

Many factors including the overall work environment, staffing levels etc

ADEQUATE STAFFING
WORK ENVIRONMENT/ INFRASTRUCTURE

Meeting people who have experienced trauma
Life experiences

Experience

Supporting midwives in their own trauma is also imperative. To support our patients in their trauma, we too as clinicians require support

SUPPORT

THE INTERPLAY OF PERSONAL AND PROFESSIONAL TRAUMA

Support for midwives own stresses and trauma occurring in the workplace. Debriefing, counselling etc.

SUPPORT
STAFFING DEBRIEFS WITH EVERYONE IN CARE
THE INTERPLAY OF PERSONAL AND PROFESSIONAL TRAUMA

Appropriate history, support from colleagues

SUPPORT

We can only help the women if they help us. They need to be open and accepting. This day and age there's a huge element of blame which makes our job very difficult.

INDIVIDUALISE/ WOMAN CENTRED/ COLLABORATING WITH CLIENTS
BLAME

Better staffing levels

ADEQUATE STAFFING

More time to speak with the person to tease out information regarding past events. I do believe not enough time is allotted to the clinic schedule to allow for deeper investigation and a pathway forward for the person is needed

ADEQUATE TIME
INDIVIDUALISE/ WOMAN CENTRED/ COLLABORATING WITH CLIENTS
DEDICATED CARE PATHWAY/ TEAM

Easily accessible information

WORK
ENVIRONMENT/ INFRASTRUCTURE

Time, more staff, all disciplines involved with hse commitment.

ADEQUATE TIME
COLLABORATION OF MDT
ADEQUATE STAFFING

More education on TIAC

EDUCATION AND TRAINING

Time, staffing and CLU vs MLU care

ADEQUATE TIME
ADEQUATE STAFFING
BIRTH ENVIRONMENT/ BIRTH OPTIONS/ CLU vs. MLU

Standardised and / or local guidelines

DEDICATED CARE PATHWAY/ TEAM

I feel life experience or personal experience as a massive impact on the care we deliver

THE INTERPLAY OF PERSONAL AND PROFESSIONAL TRAUMA

**Experience**

Yes, being involved in postnatal clinic and reviews/debriefs

STAFFING DEBRIEFS WITH EVERYONE IN CARE

Yes

Support from senior staff and other disciplines

**SUPPORT**

Experience

**Experience**

Support from colleagues

**SUPPORT**

I feel as student midwife there is no enough teaching about trauma

**EDUCATION AND TRAINING**

More supportive management structures and better staffing and this will allow for more training

**ADEQUATE STAFFING**

**EDUCATION AND TRAINING**

**SUPPORT**

Having appropriate staffing levels to provide this care to women and their families

**ADEQUATE STAFFING**

## Appendix L: Interview Schedule based off Phase One

Introduction

This will be an outline of the focus group that will be recorded and transcribed in Microsoft TEAMS

Introduce self and welcome everyone.

Brief overview of the study- Explain Trauma informed care, what the aim of the study is, why the participants were selected and what the study hopes to achieve.

Obtain verbal consent again.

Discuss basic focus group guidelines and how the focus group will work-

- Focus group is being recorded and transcribed by Microsoft Teams software. The recordings will only be used for the duration of the study and only available to the researcher and the two researcher supervisors, confidentiality will be maintained, pseudonyms used.

- Questions will be open-ended to encourage discussion, there are no right or wrong answers only differing points of view you don't need to agree with others but listen respectfully, one person talk at a time.

- Keep laptop/ device microphone off when you are not talking to avoid noise disturbances.

- Try not to talk calls or be on the phone during the focus group, if you must take an urgent call please do so quietly and as quickly as possible to avoid disturbances to the group

- Converse with each other

- Remind everyone that this is voluntary, they can withdraw from the study at any time.

- Explain role as interviewer is to guide the discussion, at times I may seek clarity or ask to expand, this does not mean you're wrong it's just to further insight.

Opening Question:

We are all from varying clinical areas with different levels of experience and training, I'd like you all to think back over your time as a practicing midwife and recall when/where you may have learned about trauma informed care or used it in your practise.

In the survey midwives scored quite high on the knowledge section of the survey, however the open ended question at the end which asked you what you would suggest to assist in the implementation of TIAC suggests that there is a differing of understandings of TIAC so tell me what trauma informed care is to you…..

May be some confusion between trauma informed care and birth trauma what are your opinions on this?

Sample Questions:

Maintaining confidentiality, Could you share a time when you were involved in providing a trauma informed approach to care?

How and when do you use a TIAC?

What worked well about practising trauma informed care? / Tell me about a your experience with incorporating a trauma informed approach to care to your practise
What could improve upon this?

How did you feel in this scenario?

Is there anything that influences your ability to using a trauma informed approach to care in your practise? … Anything that hinders your ability or facilitates it….

Do you think your practise is effected mostly by the factors of TIAC that are dependent on you the service provider or the system you work within?

How do you feel midwives rank their knowledge on TIAC? Why? The elements of Trauma Informed Care closely align with that of woman centred care, do you feel this gives a false representation of the knowledge base…

Suppose you were looking at your workplace with the ability to change practise and introduce a trauma informed approach to care, how would you do that?

Self-care was ranked very low on the survey how might practising self-care/ promoting it be improved upon in the clinical area

The survey indicated a desire to learn more about trauma informed care, what is your vision of how this education would be delivered?

Let's imagine a 'gold standard' TIC service How does that look? How might that be accomplished?

Closing Questions:

Of all the things we've discussed today, What do you feel is the most important? ……
How would you summarise what we've discussed?
Would anyone like to add anything?
Is this an adequate summary……..

## Appendix M: Thematic Analysis

Phase one data was transcribed and numbers given
Phase two items of interest were identified and extracted from the data set as seen in column 2.
Phase 3 Codes were added across the data set as seen in column 1.

**Focus group One Themes and Quotes**

P1
P2
P3

| | |
|---|---|
| Communication<br><br>MDT | its just about being aware and being compassionate for them and, you know, speaking to them as best as you can and you know, and involving all the multi-disciplinary team. Especially if they have, like if there's any history of depression, anxiety and like that, you can link them with perinatal support in the hospital- P3 |
| Awareness | a lot of the time, women don't. -P1 |
| Continuity of Care | it's just picking up on their queues or any previous history as well and it's kind of, I suppose it's the benefits of having that continuity is that you can, as midwives, pick up on things. -P1 |
| Environment | being aware that even coming into the hospital might be even traumatising. - P3 |

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| Midwives experience trauma too | we all bring trauma, be it from a previous birth or from life, that everybody has some sort of life trauma and it's being aware and it's supposed trying to always consider there probably is some trauma in someone's life you know and to be mindful of that. -P1 |
| Continuity of Care<br><br>Treating the Trauma | And I used to try things like and it's not always possible.<br>Maybe that when they'd come in a certain day that they'd asked for me.<br>So one specific midwives, so they didn't have to could be continually having to tell this story or whatever. Yeah, that would be my thing about it would be to try and give them some continuity during their pregnancy.- P2 |
| The impact of treating trauma | two women out that did have that I cared for that did have child sexual abuse. That actually impacted on me as well because I built a relationship with her and all these years later we're still friends and it was paving this pathway for her throughout her pregnancy. - P2 |
| Midwives experience trauma too | You do bring some of your own trauma into if you've had, you know, like and sometimes you, I jokingly say why did I become midwife because of my birth do you know what I mean because of what I experienced and I felt that it could be better. - P2 |
| Systematic Challenges<br><br>Continuity of Care | if somebody was, say, there were attending community midwifery and then they disclosed domestic violence and somebody said Ohh then we'd have to bring them in and get them under the care of the hospital and looks like, why would you do that? Could you're taking away their whole continuity? They're trusts and you're going to put them into a system where they might only see a doctor every time it did come for a visit and nobody will be checking in with them or stuff like that, you know? So yeah, we have a funny way of thinking of things sometimes. - P2 |

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| Communication | During COVID we reverted to doing a lot of, you know, taking bookings on the telephone and all that kind of thing. I think it's sad that in 2023 a lot of units haven't reverted back to one to one in person. I think **trauma informed care is what you see.** I think, , you said that even when they, you know, somebody comes in, you can kind of feel it and you know from their body language and you know not everybody's going to start crying, But you can see something that's going on and I think that that's really missing now when a booking history is being done over the phone. We need to be, you know, making that connection at the at the very beginning. - P2 |
| Peer Support<br><br>Staffing | I suppose the pressures of different departments and different jobs when people are stressed and short staffed, they're not thinking of their fellow team members and what's going on in their lives are just thinking of the current situation. -P1 |
| Peer Support | we should be caring for each other. -P1 |
| Peer Support | as the management structure goes up, the lack of kind of compassion there is then and there's an awful lot of this. From my experience, there was very little compassion before I left, and even afterwards. the higher you go, the less and, yeah, the less care. . - P2 |
| Self-Care | I'm so busy taking care of everyone else. I'm probably the last one to be taken care of and I'm just so used to that. That's just the way it is. I don't even know how to self care. -P1 |
| Peer Support<br><br>Management | I could we all understood that the gesture was well meant, but one day an ice cream van came in, we all got a free ice cream cone and we used to be like just give me another midwife for just, you know, yeah, we just felt it was totally bizarre and then it was big thing about it on social media, you know, and you're like, what is it for or who is it for you to, you know, and not that we didn't welcome the ice cream, but it just seemed very kind of is if it was like a tick box saying, you know, yeah, the band aid is on, you know. . - P2 |
| Self-Care | I think there's some meditation breaks and stuff like that but again, I don't think it was that well responded to. It's just people didn't have the time to go down and I think you're just stressing constantly thinking, oh gosh, have to go back. - P1 |
| Self-Care | Relax and or meditation and what you're actually not asking me is how my work space is, what the environment is like, you know, actually valid stuff that you have to say and yeah. . - P2 |
| Self-Care | if you could improve work environments, if you could improve how you all work together and you know and how you how you again that respect and speaking to each other and recognizing someone needs a break or someone needs that just even a break it time out off the ward for 10 minutes like if they need that then recognizing that would probably be more beneficial than offering a meditative break or something. -P1 |
| Peer Support | sometimes as a midwife, you need time to depress before you can go into the next room and look after the next room. But you just don't get it. - P3 |

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| | it's hard, you have to nearly compartmentalize what's happened there and deal with it later. So you know, as was maybe if their managers were more aware of that, but I know again it's time constraints and system must keep moving. - P3 |
| | So I was really lucky in my first few years as a midwife. I had the one manager and she was amazing. She was just great. You never felt you couldn't go to her if you hadn't read something right. Or do you know it was all very, Well, what we what can we do about that? So she'd try and have a monthly meeting, like a kind of where, Maybe if we had half an hour together, you know? and she always made it really positive. it was time to kind of find out how the work is at the moment, And is there any area you know you think where we're not doing this right or whatever? I think I didn't actually appreciate her. it was only then when I became under a different style of management that I couldn't believe it because the other person you know never would even think about and you would be scared going to her if you know I I say if you were for, as I say, newly qualified midwife or something, and I don't mean scared, would you be kind of you wouldn't feel comfortable, you know, you'd be anxious, you know? maybe that something had happened. I don't know, but so she was minutely then trying to manage her midwives and that didn't work because then you're, you know, it hits on part to you. You're trauma. I don't know. - P2 |
| Peer Support | she really did encourage us. - P2. |
| Continuity of Care<br><br>Environment | They become more comfortable with you when they met here and a few times, even in space in the week that we take care of for them at home and the in their own environment as well. - P3 |
| Environment | If you're seeing them in their own house, they're way more comfortable telling you things- P3 |
| Knowledge | everybody's own vision of trauma is different. - P3 |
| Knowledge | it's individualizing that experience And humanizing the whole thing. - P2 |
| | we talk a lot about humanizing birth, You know, we just don't do enough of that. - P2 |
| Continuity | we should be using the same approach with every woman. -P1 |
| Systematic Challenges<br>Time Constraints | don't have the time to advocate. . - P2 |
| Barriers to TIAC | There's the staffing levels, there's structure wise, there's all sorts of things that now impact on how you can, you know, get somebody to trust you enough that they would tell you that. . - P2 |
| Barriers to TIAC | So I'd say environment and you know, practical things like staffing and space, you know, even the private space, they, they are all barriers to, you know, trauma, informed care and supporting a woman through something like that. . - P2 |
| Barriers to TIAC | Women may not want to disclose because They'll see that the midwife, they're seeing is really busy. Like I don't want to bother them. - P3 |
| education | better education pathways for, you know, when a woman do disclose domestic abuse and we do have a pathway to follow. - P3 |

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| | can I keep her safe? Isn't my responsibility to keep her safe? . - P2 |
| education | You talk about empowering women. You have to empower your midwives as well and like 99% of these questions are asked by midwives, you know and that's the thing we are, you know, you're holding that space, you know and to expect us to do that without education. . - P2 |
| education | You know, would anybody have sat us down and said OK, so this is trauma informed care? . - P2<br>No, no, there's no education around it. - P3 |
| | I've got to be honest, I'm not really too sure, I have to say that I don't know what it (TIC) should be like. Every woman should be treated with empathy anyway.<br>I don't think it's another checklist. -P1 |
| | It has to be more individualized- P3 |
| Barriers to TIAC | You're looking after so many women, so many babies. You're thankful that you get through a day or a night shift without anything happening and you're lucky enough if you can support a breastfeeding mum and then you know, is it really, you know, when you look at that working environment, how on Earth are you supposed to then, you know, provide trauma, informed care? . - P2 |
| | Now, at the minute the amount of refugees and different things coming in from Ukraine and what have you like they have been through so many traumas there that we would have absolutely no idea of. - P3 |
| | And then you have ohh DNA. You know, and all this kind thing. God, look, look beyond the DNA. Why? Why? Why? Why is she doing that? . - P2 |

**Focus Group 2 30/01/2024 @ 18:00 Themes:**

**Participant 4**

**Participant 5**

**Participant 6**

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| understanding | I acknowledge that probably 1/3 of women probably come out of their birth feeling traumatized, with trauma it's what woman say it is, it's not, you know, something that we tell her she is or isn't.<br>And it's probably more associated with the psychological trauma as opposed to a physical trauma that's probably measured differently, which talk about trauma, informed care.- P4 |
| understanding | women are coming into birth with their own experiences, their own trauma. some women come in to birth well and leave traumatized and some women come into birth with their own personal traumas and leave more traumatized. - P4 |
| Lack of Knowledge, training and experience | I have to admit, in my own practice I wouldn't have really thought about it that much until I came across women who disclosed trauma or it had been mentioned in their notes.<br>I certainly never received any training in the area of how to prepare, you know, for trauma informed care or it's more that when you come across someone you probably try and use your own compassion and then your own judgment and how you care for that person and try and make it as person centred as you can. Like I said, hands up in my own practice, I try to use my own judgment, but I have never received any |

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| | training and would not really feel like the optimum person to advise women on what to do as well, which can be a little bit challenging.- P5 |
| Lack of Knowledge, training and experience | I remember the term about talking about trauma, and I remember discussions about this when I was in college.<br>But otherwise, like my own personal experience and exposure, has been very little and anything that I would have in terms of knowing how to deal with trauma or even recognizing that there could be something here. .- P6 |
| Time | I met a woman in the labour ward and she was traumatized by having had a vaginal examination that morning, I spent a little while later and talking through it, I was just passing through, so I passed that on to the midwife, and the CMM who were looking after her. And they just nearly rolled their eyes and were like, alright, whatever, but it saddened me because I had given her the time,<br>I'd recognize there was something not right there, but the staff on the floor didn't want to listen to it.<br>They didn't have time to deal with it.<br>They didn't have time to be able to sit down with that woman and see exactly what was going on.<br>And then to possibly amend what their plan for her would have been because they just didn't have the time to do it. .- P6 |
| Institutionalised | I do think that obviously there's a caring aspect to anybody who becomes midwife, but I think that a lot of people are institutionalized. .- P6 |
| Lack of Knowledge, training and experience | the really is a lack of knowledge on the ground about what is what services are available and what's out there.- P6 |
| Time | I think that it's probably specific midwives on the ground trying to push the agenda and maybe not having time or not being supported enough to actually deliver the care that they want to.<br>And enough to the detriment of women, unfortunately. .- P5 |
| Continuity | if you have that continuity with a woman you should be in a better position to be able to pick up any issues, we know that very few women in Ireland are cared for within a continuity of care model and really to me it's an awful shame .- P6 |
| Time | Department of Health is about cost efficiency, they see this short term picture as opposed to the to the long term picture. You know what I mean? You can't really value sitting on the bed or giving a woman an hour and a half appointment, or bringing her back an extra time. They don't see the value of that. - P4 |
| Trauma treating trauma | we go straight to blaming ourselves in many ways. - P4 |
| Trauma treating trauma | everyone goes home to something, a sick parent, a child with autism, a sleepless child, a breastfeeding toddler. You just can't know what's going on. - P4 |
| Peer Support | But you know, having a stuff going on in my personal life and needing time off, I actually found a lot of the times I was accommodated without needing to ask and that was really, really appreciated and it tends to be the not the manager of the whatever department, but it's your friends and colleagues who are doing rosters and things like that. I felt you know, looked after and minded. .- P5 |

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| Peer Support | I really think that there are the backbone really to midwifery support. It is your colleagues and that are standing beside you. .- P6 |
| Staffing gives time, time gives staff | I suppose it all comes back to staffing levels really, which I know there's no quick fix for that.<br>But really, if we're kind to each other, if we're recognizing each other's traumas, not even each other's traumas, just each other's personal Attributes that they have, you're going to end up hopefully retaining your midwives more than we currently are.<br>And then if you manage to retain, you're managing to hopefully increase your staff in the long run. .- P6 |
| | I think your relationship based care and the named health professional that you know I and identifying asking the questions and identifying the needs of the women who and coming back to them and trust and having responsive maternity services. - P4 |
| Woman Centred Care | respond to the needs of the woman as opposed to the system- P4 |
| Education | educate women to speak up- P4 |
| Understanding trauma | It's just, I mean, I think that women can have what looks like a terrible experience and feel nurtured and cared for and come out of it fully understanding it, and someone else can just have it. You know someone like a very what looked like a very normal experience on paper and then umm and then might be totally traumatized- P4 |
| Birth Trauma vs TIAC | I think that that's probably one of the first ways that we can have address any trauma from developing further or developing in first space if it's birth related. .- P5 |
| Education | I think a big part of women's experiences, and particularly when it comes to trauma, is their understanding of what's going on and a lot of that for me, comes back to education that they've had and information they've been given all the way through their pregnancy. .- P6 |
| Broken Trust | But now, really they're coming to home birth from a place of trauma and avoiding the hospital system and free birth. you know we're having 10-15 free births in every county.<br>Probably you know what I mean.<br>So like it's just, you know the and these are women who trusted the system.<br>First they came to the hospital where a previous birth because they trusted the hospital and they were let down by the system. - P4 |
| | medicalization is a huge problem. - P4 |
| Desire to change | I think we need to do, we must do better, - P4 |
| | The don't want to waste their time by bringing it up, so there's.- P6 |
| Know better, do better | think we know better now, so we just need to try and do a little better. We can't ignore the evidence anymore. - P4 |
| **Experience and Skills** | we just need to, you value what women tell us now, it's the soft skills, it's that you know that listening at the time and that sitting on the bed and, asking the question and waiting for an answer, not answering the question yourself.<br>You know when the there's a momentary pause, that does come with experience. - P4 |

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| **Experience and Skills** | I think when you're a newly qualified midwife, it's hard enough to keep up with the actual conversation, Never mind the subtext underneath the conversation and that's absolutely when I think maybe you're at the most risk of not recognizing or maybe contributing to trauma. .- P5 |

**Focus Group 3 Analysis**

P7
P8
P9
P10
P11

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| Knowledge | I'm going to be really honest I had to go and read up on this, I perceived it being is if a woman had had a poor experience, just maybe on a previous pregnancy and maybe poor outcome or difficult delivery or whatever, and that, you know, then on the next occasion we were supporting her until I went and read up a little bit about it.<br>So I suppose I've realized now that it's more.<br>It's about, you know, trauma back from every childhood or Post Traumatic stress disorder.<br>And you know, women coming now from these migrant countries that are bringing issues with them and then maybe staff themselves having you know.<br>Personal experience is coming up through looking after women who've had different maybe childhood experiences of sexual abuse or whatever.<br>And so I suppose it's being aware of it and screening for it and support and the women and supporting ourselves. -P8 |
| Knowledge | Maybe we're good if somebody discloses a trauma or a trauma is very obvious, but I don't think we're good at asking. .- P7 |
| Lack of Support<br>Lack of service Provision | you can go into the clinic and ask them as many questions as you want and they might be very honest with you and they walk out and then you've brought everything back up for them and they have nowhere to go.- P10 |
| Inadequate debrief | I think part of the problem is well, with the debriefs is that the purpose of the debrief is to explain to them what happened and why it happened.<br>A lot of women understand what happened and why it happened, but that doesn't make it OK.- P9 |
| Time | I suppose the big thing is to listen if the women feel they're being listened to that's a big starting point and it's to have that it's to have that time and to but we're constantly pressed for time.- P11 |
| Kindness | there's no magic wand here. From my experience it's to be kind, that seems to be a lost skill, but I think it's having courtesy and having respect and being kind is a big thing. Time is a harder commodity to try and harness to give the women what they need.- P11 |
| Knowledge | with the women were good when it's disclosed.<br>We're good when it's big. We're good when it's obvious we're not so good with the day-to-day, you know?-P9 |
| Fear | I have noticed sometimes where there might be a particular incident and you can see where it's maybe, just triggering something with somebody you know that they may get more upset than you would actually expect and always have to be mindful of that, that you could be hitting on a raw nerve with something that's after happening. -P8 |

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| Internalising Trauma | You know you give something of yourself and your story, while the main focus of course, is on her and her needs. But I think we all internalize, otherwise we couldn't do our job. -P11 |
| Internalising trauma | We definitely have to box things off. Like you deliver a miscarriage and then you have to go off and put a CTG on and act like nothing has happened. -P10 |
| Sharing Caring Support | I do think we do share these experiences with each other.- P7 |
| Prepared for Trauma | I don't think our training makes us ready for it. (dealing with trauma). -P10 |
| Vicarious Trauma | we do focus on that positive piece. That's what we do.<br>That's how we keep going, I suppose.- P7 |
| | In general, our workforce at the moment, they're quite junior but how resilient I see them. And I know that trauma is probably there underneath somewhere. You're all saying there just to carry on, but you'd wonder. What's going on underneath all that? Does it catch up on you eventually or whatever, you know? -P8 |
| Awareness | we don't know what's going on in people's personal lives or what has gone on, you know that they're also trying to deal with as trauma then they're seeing it at work, it could be triggering things for them, that they're trying to deal with, I think there needs to be more awareness. -P8 |
| Kindness | I think that for me it's somebody that comes in and greets you kindly and is really empathetic. -P9 |
| Inconsistent approach to care | I think most women do feel safe, but if they come across people who one person tells them one thing, another person tells them another thing and If we're not all singing the same song, then that will immediately put their guard up and they will feel unsafe. -P10 |
| Kindness | it's just being kind actually. If you are kind to somebody that means you're listening and you're being empathetic and you're giving them time, that's really all you have to do for most people to open up to you and people do people.- P7 |
| Prejudice | I think judgment is a really big thing that we have now as we're getting more and more complicated in the women that are coming into us. I think everyone that comes in feels they're being judged; for their relationship, their decision to have baby, their situation. You have women coming in at 1516 that feel like they're being judged for their age. You have women coming in in their late 40s, early 50s, feeling like they're being judged for their age. You have women coming in who are drug users, who are just out of prison, all sorts and they all feel like they're being judged for something. What have they done with their life before they ended up here? I treat every single woman the same, whether she's 15 or 50, or she is the ideal picture of a mother, or she's what you can only imagine the worst image of the mother. They all get treated exactly the same, and I think that helps women open to me because I don't go this ones looking to go for a cigarette, I go in and say, you know, do you smoke? I know you've just had a section. Do you need a wheelchair? We'll get you down for your cigarettes and they automatically feel that this is someone who's not going to judge them and that they can say things too without that fear of somebody kind of maybe impacting their care or changing their care bears based on what? What? They're what they're saying or who they are. -P9 |

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| Kindness<br>Time | I think we need to be more open, by actually asking women, have they got anything that they'd like to disclose to us instead of expecting that by being kind and giving them the time that they'll willingly disclose. -P9 |
| Internalising trauma | It's grand saying we understand you're traumatized, but we're not actually doing anything about it. -P10 |
| What happening to you? | we're saying what happened, as in the emergency section, but we're not actually asking what happened to you. You know what actually happened to you? No more than as a midwife. You know, we're saying you were at a still birth and you did that, but how did that make you feel? So we're missing that piece and I do think we need to be using the word trauma, we are a bit afraid of saying it cause I'm putting an idea in someone's head that you're traumatized and but it's still widely recognized and mental health and trauma are involved together, but they're actually quite separate and maybe, you know, actually having a trauma midwife who's there for both staff and the women, but it's it's a huge role. I would like to see a a trauma team set up and be and be using the word far more often.- P7 |

**Data Analysis Pt.I Trauma Informed Approach to Care Focus Group 4 -07/02/2024 @ 15:30**

**P12**

**P13**

**P14**

**P15**

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| Awareness<br>And<br>understanding | making an effort to understand that the woman in front of you may be in a specific situation, you have no idea what came before or what's going to come after the situation you're in at that moment.<br>Being aware of body language that's used. -P13 |
| Lack of understanding | There is probably a certain amount of assumptions that people can make based on information they see on the page as well as their own understanding of trauma. -P12 |
| Trauma treating trauma | I think of it from what colleagues may have experienced and the previous traumas of the caregiver. -P14 |
| Understanding trauma | sometimes you read something and you perceive it differently, the woman could have a difficulty in their care due to a trauma in their history or whatever, but they could go plain sailing and then you could read someone else's history and their trauma is actually you feel is not as bad as someone else's and they could have a very different view of the care that you're given and how they would like to you to look after them, touch them, do things with them. – P15 |
| Disclosing of information | When I thin back now I probably wrote her off as a young one who wasn't really that proactive about her pregnancy, then at one particular appointment I had a lot of time to give her and she told me she couldn't engage because she was terrified of labour due to a history of a sexual assault is there. I asked was there anything that you think might help you? I don't know what gave me that feeling, but I definitely don't think you'd pick up on us at any other stage. I think it was just so specific to the exam and I think it was really interesting that she didn't. -P12 |
| Antenatal recognition | You get that feeling, and sometimes you're better off just tackling it before they walk in the door at the labour room. -P12 |

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| Time | Recalling a situation of a lady with a concealed pregnancy as a result of rape, the midwife felt she was lucky enough the ward was not busy that night and the midwives could like, sat and spoke with her and chatted with her. she's spoke for hours and cried for hours. And I just felt like if she didn't, if I had been really busy that night, I don't know what would have happened. -P15 |
| Midwife led care | I suppose we're are at an advantage for identifying those women because we do build up such a rapport with them. you can have midwife LED care everywhere. -P14 |
| Woman centred | The pregnancy part is obviously a part of it, but you've got to start with the woman and then everything else will come. -P14 |
| MDT<br><br>Knowledge<br><br>Communication | I think for us to actually provide a kind of a trauma informed service wherever we work, every single person on the team and every single person who faces a woman or a family should have that knowledge and understanding because like, a lot of the women that I see, the damage is done usually by communication and usually by midwives and by doctors and usually people are rushed and they, you know, they didn't want to talk to me about this. You can see women who are really struggling with the birth that they've just had and midwives turn around and saying you had a great birth, you did so well there.<br>I think actually needs to be just an A huge amount more training and understanding around what trauma informed care is and how we all bring it in every single day. -P12 |
| Continuity | continuity more than anything else, be it midwife, ladder, obstetric Ladd or whatever it is. -P13 |
| Communication | I think every small interaction is that moment where we should be taking maybe a little bit more care in the language we're using. -P13 |
| Continuity | It would be lovely if you know everybody was singing from the same hymn sheet with the way that we approached the care. It just it's at the moment that's not the kind of practice I'm seeing now. -P14 |
| Continuity | if there is continued to care, it definitely makes a huge difference. -P14 |
| Knowledge and understanding | Do you know that on paper you would think there was no problem, but she had huge trauma from it. -P14 |
| Kindness | They kept saying like everything is your choice they were very, very kind . -P14 |
| Kindness<br>Time | If you can give them the time and the respect and speak to them the way that they deserve it can make a huge difference in the way that they're going to reflect back on this (the experience) . -P14 |
| Time<br>Staffing<br>Guilt | if you don't have the time, you can say things without thinking of the effect you're going to have on the person. We're so understaffed and the women are coming with more complex physical needs and mental needs And you, you do tie yourself up thinking Oh, did I give that woman the best care that I could? -P14 |
| Guilt/ What else can I do? | I know myself, coming home from a hard day like you do that yourself, driving home in the car, you are constantly going. What else could I done? you do kind of beat yourself up going home in the car. -P15 |

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| Taking it home | I'd love to be able to say that 'Yeah, I'm great at leaving it all at the door, but I think as midwives, nurses, caregivers were not very good at that.' –P13 |
| Internalising Trauma | Like you know, there's women that I remember from my very first placement as a student midwife that I won't forget about it. And then you think how many more women am I going to be able to fit into my brain. -P14 |
| New understandings | I think there is that shift is starting in how we recognize on how we deal with and what we kind of accept trauma to be. -P13 |
| Understanding | I think that on the whole, we're not very trauma informed yet we might like to think that we are, but there's a lot of aspects of trauma that we don't fully understand. -P12 |
| Training | a lot of our knowledge and what we're doing needs to be updated. -P12 |
| Desire to learn and improve | I would have always considered myself very trauma informed and the more reading I did about it, I realized like that actually things I was doing or saying weren't not necessarily helpful And I think that it comes from just a lack of training. -P13 |
| Communication<br>Education | I think that in terms of education around trauma, informed care, I would like to see a really big emphasis on on the language. -P13 |
| Staffing | my thing would be more staff, that's basically I could nearly fix everything if we'd more staff. -P14 |
| Sharing is caring<br>Peer support | it's kind of nice to hear that other midwives are experiencing the same thing and that I'm not going crazy. -P13 |

**Focus Group Trauma Informed Care-Focus Group 5**

P16
P17
P18

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| Birth trauma vs TIAC ???Understanding | And I suppose for me, I would nearly put it all down to birth trauma simply because of where we work. When you think about it like you see women coming in and they're carrying other traumas, and that might be, you know, leading to them then maybe to substance abuse or other different things as well, then they're carrying on through because of trauma that they've had in their life. -P17 |
| Birth trauma vs TIAC ???Understanding | And so when I hear birth trauma, I it's probably associated really with their births, some births, their birth aspect has been traumatic for them and that it's been a negative experience. -P16 |
| Lack of knowledge | If you're talking about trauma informed care you, they've obviously had a trauma before. They've been informed of it. They've probably had a debrief thing, but probably need more debriefing and obviously going forward, being very aware of that. -P16 |
| Poor Care | I'm very disheartened with the service, to be honest. I feel really peeved off. I've had a lot of people that I know go through the service and they've had different negative outcomes, be it, you know, they're not getting care that they thought they would get simple things like asking for paracetamol. Right. But took four hours and then they're talking about, well, if I can't get paracetamol, what are they going to do for me when I'm in actual labour? And there's a fear there constantly. So they're going home and they feel like they haven't had the proper care. -P16 |

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| Recognising Trauma | But what I've noticed as well is some women. When you ask them to adopt positions for vaginal examination, they actually some cry, some tremble. Some are, yeah, they just get really emotional and they can't actually verbalise you. Why? They're feeling emotional. -P17 |
| Desire to learn and know more | Not part of my where I work, but just my everyday I've just been learning about stomatic exercise and releasing trauma from your body and one of the places that we hold trauma is in our pelvis. I'm really mindful now that if I'm, if I'm looking after a woman and asking her to go into that position of, you know, bringing the feet up, letting the legs fall out to the side that actually she might have some trauma in her body that she's not recognised, that she has never acknowledged. And it comes out at that point.<br>I that's me personally. I'm just not. That's where we. That's where we tend to store our traumas in our pelvis. -P17 |
| Kindness | sometimes time is an issue, but more so it's the person and maybe they want to keep whatever they're feeling private or whatever they've gone through in the past, private. So then it's just about Informed consent as best you can. You know, it just comes down to that. Then I'm just going to be compassionate and empathetic to her. -P17 |
| Barriers to care | like language barriers is huge for that, and like cultural differences and foreign nationals that don't speak English. -P18 |
| | in some places a lot of women are unfortunately subjected to sexual violence, abuse by their partners. And you know, you can see that in them. They're so, like, afraid they're so withdrawn. And when you go to do anything with them, they just can't.<br>You can't cope and then they start to cry, but you can't actually have that. You don't have the skills to have that conversation with them, and even sometimes if you do like I know I've asked women for like, are you OK? Do you feel safe? Like, you know, when their partners haven't been present or whatever and they just go? Yeah, but they're crying. And you know that they're not, you know, you know that they're holding something back. You know that they're lying. And then you then feel worse. -P18 |
| Recognising trauma | But you're aware of their vulnerability because of the way their body languages and their skills. -P16 |
| Training | When was training, obviously we did cover bits about birth trauma and whatever else, but I don't think it (trauma informed care) was really focused on. -P18 |
| Birth trauma vs TIAC ???Understanding | You look back on their notes and you think, oh, they had a one traction Kiwi or they had an episiotomy or they had an SVD on all fours. Like, what was traumatic about that? But you don't know, you know, you just have to kind of go by what they're saying. But I think that's just more learned experience. Like, I think that's something that is difficult to teach like, reading of body language. It's just something I think that comes with time. -P18 |
| Understanding | trauma is the person's perception. -P17 |
| Immunity to trauma | And what's major is when they come in, they feel so violated and I think we've just taken it as oh she just had a forceps. But because we're so used to it every day we get we're a bit immune to it. -P16 |
| Internalising trauma | Well, I think when we were in college, one of the things that was drummed into us was and our students was you leave it at the door, you don't bring your troubles to work with you. You're here to look after that woman. It's not about |

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| | you. It's about them. So there is that, you know, where and there is still that where it doesn't matter what's going on with you. No, it does. And if you know your colleagues well and you feel like you can open up to them or they can open up to you, you're, you know, you're mindful that somebody's going through something. So if you're working with them, maybe you're going to give them a bit more of a dig out or you're going to help them or you're going to, like, make sure maybe that they get their breaks 1st and, you know, stuff like that. But Unless somebody feels that they can tell you that, like you know, unless you have a good relationship with your colleague, you might know that. But definitely with college and probably with management it doesn't matter. It's nothing to do with work. Leave it at the door, collect it on your way out but while you're here, You're here to work. -P17 |
| Internalising trauma | I would agree with that. -P18 |
| Peer support<br><br>From management down | We're probably all traumatised in different ways, shapes and forms. But you know, if you've had like say even, you know, looking after miscarriages or looking after Iud's, like your colleagues will, ask Are you OK? your managers will try and be like, right, well, you know, if you've delivered that person, you're not going to have another person labour that day or whatever else, as much as is possible. But I know we are like, I don't know. I find from, like, higher up. There's not very much. Unless it's been something particularly horrendous.<br>Like it's just kinda like. Oh, right. OK. It's just another day and a lot of it is, you know, I know I would say that like, I'll come home and tell my husband stuff. And he's like, what? And I'm like, oh, yeah. But it's just another day But like, he's like horrified. -P18 |
| Lack of Support | I was eight weeks pregnant, working in the labour ward, and I had a normal delivery which ended up a PPH, after it, it was half three in the day. I hadn't been relieved for break. They (management) were just saying you need to do the incident report forms. She said well, sure, thats all you because you can't manage everything. So like that was wrong. And I always remember that. -P!6 |
| Learning through trauma | I think I'm very kind. So when I see students coming along, if I see them like I'll always go to support. Like, I'm not blowing my own trumpet here. But I'm very much like a mother figure. Like, I wouldn't be like do this do that. I'm not one of those old school people. I'm very much like, I'll help them and I'll say, you know, do this will make it better and make it easier on you. So I'm very much empathetic with the newer staff coming through definitely because I hated the way I was made feel, so I will definitely support the ones coming through. Definitely more empathetic. -P16 |
| Training and Education | I've encountered it with kind of newer girls (midwives) They're like, I don't know what to say to this woman. Tell me what to say. How do I talk to her? And you know, it's even just if you've done it kind of once or twice, you do kind of pick up on things to say and the right way to say it. But even if you had a little bit of that kind of included into your training or maybe just even as like a workshop or a study day or whatever it is. That somebody just sat down and said right, OK, well, this is the kind of language that we want you to use that women find beneficial, you know, rather than going into a situation where you're not entirely confident. -P18 |
| Lack of Compassion | So I was like how can you not have the compassion to see. That that was the right thing to do at the time. -P18 |
| Support | I Get a bit disheartened. You know, if you can have one person like, even coming back to a person who's had a tough time and just visiting them, I think they do appreciate it. They're actually not a number that actually people care about them. -P16 |

Phase 4- Search for themes

Codes were extracted and grouped

Antenatal recognition
Awareness
Barriers to care
Barriers to TIAC
Birth Trauma vs TIAC
Broken Trust
Communication
Continuity of Care
Desire to change
Desire to learn and improve
Disclosing of information
Education
Environment
Experience and Skills
Fear
Guilt/ What else can I do?
Immunity to trauma
Inadequate debrief
Inconsistent approach to care
Institutionalised
Internalising Trauma
Kindness
Know better, do better
Knowledge
Lack of Compassion
Lack of knowledge, training and experience
Lack of service Provision
Lack of Support
Lack of understanding
Learning through trauma
Management
MDT
Midwife led care
Midwives experience trauma too
New understandings
Peer Support
Poor Care
Prejudice
Prepared for Trauma
Recognising Trauma
Self-Care
Sharing Caring Support
Staffing
Support
Systematic Challenges
Taking it home
The impact of treating trauma
Time
Training
Trauma treating trauma
Treating the Trauma
Understanding trauma
Vicarious Trauma
What happening to you?
Woman Centred Care.

Barriers to Care
Barriers to TIAC
Communication
Environment
Fear
Management
Inconsistent Approach
Lack of Service Provision
Staffing
Time
Training
Systematic Challenges

Desire to Change
Desire to Learn
Education
Know better, do better
Knowledge

Birth Trauma vs TIAC
Experience & Skills
Institutionalised
Lack of Understanding
New Understandings
Understanding Trauma
What happened to you
Recognising Trauma

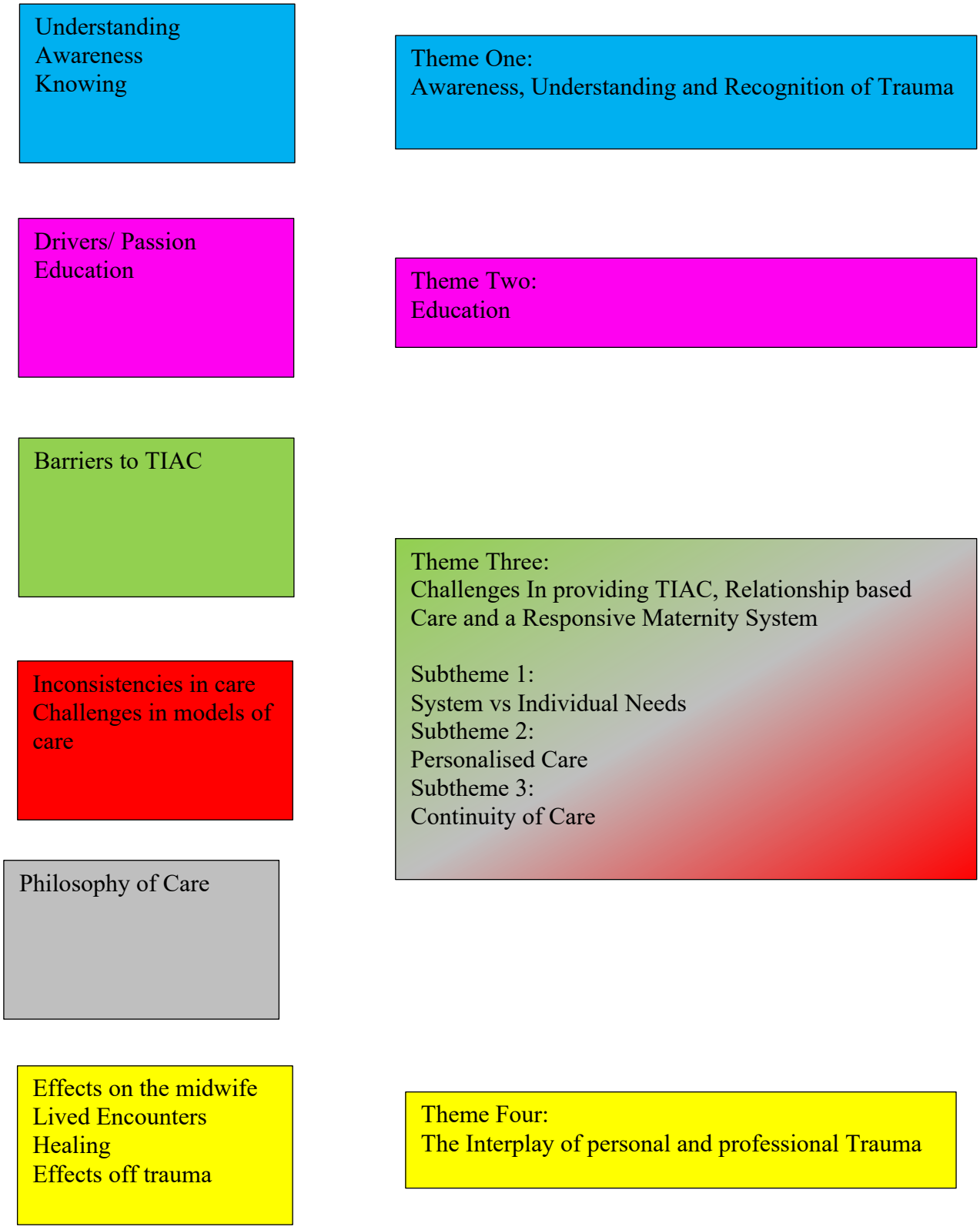
Kindness
Compassion / Lack of

Antenatal Recognition
Awareness
Broken Trust
Continuity of Care
Disclosing Information
Inadequate Debrief
Lack of Knowledge
Lack of Support
MDT
Midwife-Led Care
Poor Care
Prejudice
Woman Centred Care

Guilt/ What else can I do
Immunity to trauma
Internalising Trauma
Learning through trauma
Midwives experience trauma too
Peer Support
Trauma treating trauma
The Impact of treating Trauma
Prepared for Trauma
Self-Care
Sharing is Caring
Support
Taking it home
Vicarious Trauma
Treating trauma

**Phase 5: Review Themes**

**Phase 6: Final Analysis**



**Appendix N: Mixing of Data Table**

**Integrating Qualitative and Quantitative Data**

| Quantitative Findings | Qualitative Themes | Overlap/Integration |
|---|---|---|
| **Quantitative Finding 1:**<br><br>**A significant majority of respondent's did not receive any training on trauma informed care either before (71.6% of total sample) or after qualifying (66.5% of total sample).** | **Education:**<br><br>The participants in the focus groups underlined the critical need for comprehensive education and training for midwives in TIAC to ensure they can support and empower women effectively. | The quantitative findings the majority of participants did not receive any training on trauma informed care pre or post registration is corroborated in the qualitative findings where the need for comprehensive training was stressed by participants. |
| **Among those who did receive training post registration, most sought it independently.**<br><br>**Clear desire to further training on trauma informed care. Composite analysis of participants attitudes had the highest mean score representing the readiness and** | One participant decided to explore their understanding of the physical manifestations of trauma to optimise the care they provide. This may display a desire among midwives to learn and practise trauma informed care. | The proactive nature of the participants is highlighted in the quant findings in showing that many of those who sought training on TIC sought it themselves. This is resonates with a participant in the focus groups who gives a vignette of a time they further explored TIC.<br><br>These findings highlight the gaps in the current training and education in relation to trauma informed care. |

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| **positivity of participants towards Trauma informed care** | | The Centre for Early Child development (2021) highlighted that providing staff education and training as one of the key components to becoming a trauma-informed system. |
| **"further training around recognition of symptoms related to trauma and what can be done to help alleviate them."** | The participants identified the dearth of TIAC education<br><br>*"I certainly never received any training in the area of how to prepare for trauma-informed care." -P5* | |
| **Education and Training was one of the top factors that midwives felt would support their implementation of trauma informed care.**<br><br>**They listed suggestions to how that might be provided:**<br>- **"Informal Sessions"**<br>- **"Debriefing sessions for all team members"**<br>- **"Short Video on HSE land"**<br>- **"Reflection"**<br>- **"Discussion"**<br>- **"Drills"**<br>- **"Simulation Training"**<br>- **"Day course in trauma information relevant to maternity care"** | The need for improvements in education, knowledge and training provision within the maternity services was unanimous.<br><br>The participants highlighted that their existing knowledge and education on trauma informed care came from their exposure and clinical experience. There was a huge value placed of the individuals soft skills. | |

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| **Quantitative Finding 2:**<br><br>**Strong knowledge regarding the effects of trauma on wellbeing and the potential for re-traumatization, as indicated by high mean scores and low standard deviations.** | **Awareness and Understanding:**<br><br>The focus group discussions revealed a fragmented understanding of trauma-informed care in the maternity services. Participants in the focus groups appear to have expressed a moderately limited understanding of the full scope of trauma informed care within the maternity services. | Focus groups suggested that the knowledge and understanding they have around trauma is specific to birth trauma, this equipped them to answer questions on trauma quite confidently however in the FG when asked further details to trauma other than birth related trauma the participants had limited knowledge. This echoes the findings of the NMAHP Summary Report (2021). |
| **Theory- Practise Gap**<br><br>**The quantitative data reflects theoretical knowledge about trauma, which participants might have acquired through formal education or training sessions** | **Theory- Practise Gap**<br><br>However, the qualitative insights suggest that this knowledge does not fully translate into practical understanding or application within the specific context of maternity care. | This distinction between theoretical knowledge and practical application is well-documented in the literature, where training alone is often insufficient without practical, context-specific implementation strategies (Fixsen et al 2005). |
| **Quantitative Finding 3:**<br><br>**Exposure to Trauma being seen as common had a high variability in responses indicating potential gaps in the knowledge** | **Exposure to Trauma:**<br><br>In the focus groups there was an interesting dynamic that the participants recognised that trauma exists in everyone's lives particularly staff themselves, conversely when considering trauma among clients it's | Kirkmann et al (2019) found that after experiencing trauma or being exposed to a traumatic event midwives sough support from their colleagues (peer support) |

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| | not something they consider unless it is disclosed to them by the woman | |
| **Participant recognized and had a strong understanding of the impact that trauma can have on well being** | A commonality amongst Focus group participants highlighted the lack of support offered to staff who were exposed to a traumatic experience<br><br>Many participants detailed traumatic experiences they had in work<br><br>Despite them understanding and recognising the negative effects of this there was little support offered | Without safeguards in place to help staff process their emotions, anyone working with patients who have experienced trauma may be subject to chronic emotional stress. This stress can then negatively affect their own physical and psychological health (Menschner and Maul 2016). |
| **Quantitative finding 4:**<br><br>**Self-Care among midwives had a low mean score and high variability, indicating that it is not a consistent practise.** | **Self-care:**<br><br>Self-Care was not routinely practised by the participants<br><br>*'I'm so busy taking care of everyone else. I'm probably the last one to be taken care of and I'm just so used to that. That's just the way it is. I don't even know how to self-care.' - P1* | Menschner and Maul (2016) released a brief on strategies for encouraging staff wellness in trauma informed organisations. Two of the barriers to supporting staff wellness included funding and making time for self-care. They identified funding and time as barriers to providing wellness in the workplace but also suggest how these barriers can be overcome |
| **Only one person commented on self-care in the open ended question- They suggested more** | Self-care in the workplace was not well received and was perceived as impractical. There was a desire for practical support over token gestures. | |

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| **time be made for self-care practises in the workplace** | | |
| **Quantitative finding 5:**<br><br>**Sharing expertise and collaborate effectively with colleagues regarding the use of trauma informed approach to care had a lower mean score indicating that this is not embedded in routine practise.** | **Lack of recognition of the importance of TIC/ Challenges:**<br><br>When asked about this in the focus groups- Participants overwhelmingly agreed saying knowledge wasn't shared between colleagues. "Nope"- P5, "No"- P4 and "Absolutely Not"- P6.<br><br>Reason for same being "It's just not something on that is on the agenda"- P6 | The focus groups indicate a systemic issue where knowledge sharing is not prioritized within their work culture or institute.<br><br>This finding is consistent with the research. Huo et al (2023) reported that the perceived relevance of trauma-informed care to the health setting and target population as well as influences within the organisation e.g. leadership etc. were barriers to implementing trauma informed care. |
| **Quantitative Finding 6:**<br><br>**With a high mean score, it is clearly evident that midwives welcome trauma informed care to practise** | **Barriers to implementation:**<br><br>The qualitative findings highlight potential barriers to implementing trauma-informed care in maternity services. These barriers might include organizational constraints (staff, time etc.), lack of interdisciplinary collaboration, and insufficient support for integrating trauma-informed principles into everyday practice. | The literature supports the idea that without addressing these systemic barriers, even well-educated practitioners might struggle to apply their knowledge effectively (Kreindler et al 2012). |