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Trauma-Informed Midwifery Care: An Integrative Review

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TRAUMA-INFORMED MIDWIFERY CARE: AN INTEGRATIVE REVIEW

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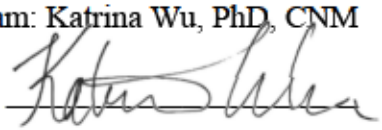
Director of Nurse-Midwifery Program Signature: 

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Abstract

Introduction: Trauma exposure is a common experience for people of all ages and demographics, especially women. During vulnerable times such as pregnancy and childbirth, midwives can address these concerns by providing trauma-informed care (TIC) and preventing retraumatization. As these issues are brought to light in health care, standardization in educating and equipping midwives on TIC in the health care setting is needed. The aim in this systematic literature review was to investigate the actions and conversations midwives need to incorporate in their routine antepartum, intrapartum, and postpartum care to integrate TIC.

Methods: A systematic literature search was conducted using CINAHL, PubMed, ScienceDirect, and PsycINFO databases and a citation and hand search. Inclusion criteria included research on mothers 18–44 years of age, singleton pregnancy, and biologically female published between 2018–2022. Exclusion criteria included studies on mothers younger than 18 years old and biologically male. Relevant study demographics and findings were extracted and organized according to Kolcaba's theory of comfort during the antepartum, intrapartum, and postpartum periods.

Results: Findings from 5,671 women with a history of past or current trauma demonstrated the need for TIC during the antepartum, intrapartum, and postpartum periods. As evidenced by the results, no matter the type of trauma the individual faces, there are benefits seen when using different interventions to ensure care is administered to prevent retraumatization. The findings also revealed various TIC forms that are relevant during each pregnancy phase.

Discussion: This review showed that participants with trauma histories overwhelmingly agreed that measures should be taken to prevent further retraumatization. Access to resources should be integrated into care and offered to clients. Findings in this review highlighted the need for

additional TIC research and literature and for leading organizations to create policies endorsing TIC as a standard.

Keywords: pregnancy, midwifery, trauma-informed care, posttraumatic stress disorder, perinatal trauma

Trauma Informed Midwifery Care: An Integrative Review

The Centers for Disease Control estimates that in the United States, 1.5 million women are raped or assaulted yearly (Agency for Health Care Research and Quality [AHRQ], 2016).Trauma exposure is a common experience for people of all ages and demographics, especially women. These experiences can adversely impact an individual and last for a lifetime (Kuzma et al., 2020). Vulnerable populations are even more at risk of being impacted by traumatic experiences, with pregnant women and newborns part of this category. These risks are often short and long term and can lead to disorders such as posttraumatic stress disorder (PTSD), postpartum depression, and poor child health and development (Long et al., 2022). During these vulnerable times, midwives can address these concerns by providing trauma-informed care (TIC) and preventing retraumatization.

TIC can help guide midwives in providing care regardless of trauma disclosure. TIC, a patient-centered approach to health care that requires health care professionals to attune to the distinct experience of trauma survivors, includes six principles: safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment and choice; and cultural, historical, and gender responsiveness (Substance Abuse and Mental Health Services Administration, 2014). By understanding trauma's negative consequences and how to alleviate them, midwives can use tools to help lessen trauma's impact on patient behavior and overall health during the perinatal period (Kuzma et al., 2020).

Background

Trauma is an emotional response to an event that a person perceives as terrible or unpleasant (American Psychological Association, 2022). The American Psychological Association (2022) defines trauma as "exposure to actual or threatened death, serious injury, or

sexual violence in one or more ways." This traumatic event can be witnessed, experienced by a family member or close friend, or result from repetitive exposure to aversive details related to a traumatic event.

Traumatic events are common. According to the World Health Organization (2021), an estimated one third of women globally have been subjected to sexual and/or physical intimate partner violence or nonpartner sexual violence in their lifetimes. At least 1 in 5 girls in the United States experience sexual abuse by age 13 years, and 1 in 3 adult women experience at least one physical assault by an intimate partner during adulthood (AHRQ, 2016).

Trauma survivors populate the health care system. The American College of Obstetricians and Gynecologists (ACOG, 2021) endorses the importance of obstetrician-gynecologists and other health care practitioners incorporating trauma-informed approaches to delivering care and understanding trauma's prevalence and effects on patients. The American College of Nurse-Midwives (ACNM, 2021) recommends that certified nurse-midwives should screen regularly for past and current violence experiences, including reproductive coercion, using best practices to create environments in which patients are safe and supported.

TIC recognizes that effective care requires an understanding of the client's lived experiences and may improve treatment, adherence, client participation, health, and provider well-being (Dowdell & Speck, 2022). TIC also recognizes the signs and symptoms of traumatic stress and acknowledges trauma's role in a patient's life (Dowdell & Speck, 2022). Health care providers can use TIC to understand the sequelae of trauma and support and accept trauma survivors through healing and positive adaptation.

Midwives are uniquely positioned in the health care setting to ensure that all women in their care receive TIC, regardless of disclosure. Midwifery care often involves situations or

procedures that can cause retraumatization, vaginal and pelvic exams, and labor or birth. Not surprisingly, retraumatization is the most common type of perinatal trauma (Simpson et al., 2018). To prevent retraumatization, midwives need to have trauma-informed backgrounds.

The aim in this study was to investigate the actions and conversations midwives need to incorporate in their routine antepartum, intrapartum, and postpartum care to integrate TIC into client care. Kolcaba's theory of comfort, a theoretical framework developed by Katharine Kolcaba in the 1990s, is a guide for assessing, measuring, and evaluating client comfort (Petiprin, 2023). The authors of this integrative review used this theory to guide their assessment of different modalities used to alleviate trauma found in the research and evaluate their effectiveness in decreasing these effects. These findings can provide midwives with an understanding of how to develop, implement, and continue to evaluate the client's comfort needs in a TIC approach.

Methods

Design

The following steps outlined by Whittemore and Knafl (2005) were used in this integrative review to ensure analysis quality and rigor: problem identification, literature search, data evaluation, data analysis, and problem identification. The integrative review method included both qualitative and quantitative evidence and involved synthesizing literature representing varied methodologies.

Search Strategy

In January 2023, the authors consulted a Bethel University reference librarian to assist in constructing an effective search strategy and generating applicable terminology. A systematic search was undertaken in February 2023 using four electronic databases: CINAHL, PubMed,

ScienceDirect, and PsycINFO. The following keywords were used with Boolean operators: domestic violence, sexual abuse, intimate partner violence, childhood trauma, birth trauma, PTSD, trauma-informed care, traumatic birth, postpartum trauma, PTSD following childbirth, maternal trauma, posttraumatic stress disorder, maternal birth-related trauma, obstetric trauma, psychological birth trauma, trauma-informed maternity care, fear of childbirth, tokophobia, postpartum PTSD, midwife-led debriefing, and trauma sensitivity.

Articles had to meet the following criteria for study inclusion: original investigations of trauma or trauma prevention strategies in the peripartum period. In addition, studies needed to be available in English and published between 2018-2022. Articles were excluded if they included mothers younger than 18 years of age or if participants were biologically male.

Covidence systematic review software (Covidence, 2014) was used to screen the articles to identify articles for analysis. The searches identified 2,477 articles (CINAHL = 1,152; PubMed = 1,031; PsycINFO = 53; ScienceDirect = 241), of which 58 duplicates were removed.

The authors of the integrated review independently analyzed the remaining 2,419 titles and abstracts. Two hundred and nine publications met the screening criteria to be examined in full text, yielding 13 studies selected for inclusion in this analysis of current literature. Any conflicts between the publications were directly resolved between the authors of this integrative review.

A hand search was also conducted across the *Journal of Health and Psychology*, *Journal of Midwifery and Women's Health*, *Midwifery,* and *Frontiers in Psychology* for any applicable research since 2018. Four articles yielded results significant to the literature review. In addition, citation searching generated three articles for a total of 20 studies in this literature review. The

preferred reporting items for systematic reviews and meta-analyses (PRISMA) flow diagram (see Figure 1) summarizes the review process.

Lastly, using the Johns Hopkins Nursing Evidence-Based Practice appraisal tool the two researchers assessed each study and assigned a level of evidence (I–V) to each based on the research design and quality of evidence. The studies were arranged in a literature matrix to include the quality of evidence, purpose, design, strengths, and limitations (Table 3). Using Kolcaba's three forms of comfort, relief, ease, and transcendence, the studies demonstrated how midwives can use TIC to develop and implement these techniques into each pregnancy. By dividing the research into antepartum, intrapartum, and postpartum periods, the results were analyzed using TIC to evaluate how different strategies used by midwives demonstrate these three forms of comfort for this client population.

Results

Design

Twenty research articles from four electronic databases were included in this integrative review. These articles were used to investigate the actions and care midwives can incorporate during the antepartum, intrapartum, and postpartum periods to provide TIC to women in alignment with Kolcaba's theory of comfort. The studies were conducted in a variety of settings: the United States (n = 4), Iceland (n = 1), Netherlands (n = 2), United Kingdom (n = 5), Iran (n = 2), Israel (n = 1), Kenya (n = 1), Australia (n = 2), Canada (n = 1), and Turkey (n = 1). The designs included mixed methods studies (n = 3), randomized controlled trial (RCT) studies (n = 4), nonexperimental studies (n = 2), a longitudinal study (n = 1), and qualitative studies (n = 10).

The overall sample size was 5,797 individuals; six were midwives, 120 were partners of the pregnant individuals, and 5,671 were pregnant at the time of enrollment or had at least one prior pregnancy. These individuals were selected for this review because of the evolving evidence of the importance of midwifery-led TIC for women with past or current trauma histories. The level of evidence for the 20 articles ranged from I to III, and were all appraised as good quality.

Besides the partners and midwives included in two of the studies, all participants had or were having a baby at the time of the study. They also had faced some form of trauma, including past trauma, current trauma, birth trauma, or trauma related to fear of birth. The individuals included in the studies represented diverse locations, first languages, and socioeconomic statuses. A summary of the themes that emerged from the studies is shown in Table 1.

Main Findings

Kolcaba's theory of comfort places comforts at the forefront of healthcare. According to Kolcaba, comfort exists in three forms: relief, ease, and transcendence (Petrin, 2023). Kolcaba also described four contexts in which patient comfort can occur: physical, psychospiritual, environmental, and sociocultural. This theory was integrated into the present review by researching how midwives decrease trauma by using TIC for women during the antepartum, intrapartum, and postpartum periods and the effectiveness of these actions. The actions and conversations midwives use during those times to implement TIC are organized following Kolcaba's three forms of comfort: relief, ease, and transcendence. Relief is felt when an individual comfort need is met (Krinsky et al., 2014). Ease is felt when patients are in situations that allow them to feel calm or content. Finally, transcendence occurs when the patient can rise above the challenge she is currently facing.

Antepartum

Seven papers were identified detailing studies that investigated TIC themes during the antepartum period, including trauma screening, adverse childhood experiences (ACEs) screening, and a trusting patient–provider relationship (Gokhale et al., 2020; Onchonga et al., 2020; Patterson et al. ,2019; Greenfield et al., 2019; Jackson et al., 2020; Olsen et al., 2020; Flanagan et al. (2018).

Relief. Relief themes that emerged during the antepartum period included fear, anxiety, feeling unsafe, and losing control. In their qualitative study, Patterson et al. (2019) revealed the parallel processes of care–provider interactions that contribute to women developing post childbirth PTSD. The themes the women identified needing from their midwives to decrease trauma included keeping them safe, support, respect, allowing them to keep their power, nonthreatening interactions, and trust (Patterson et al., 2019). Greenfield et al. (2019) also found that women with trauma histories reported their relationships with health care providers characterized by fear, mistrust, and avoiding loss of control. Comments from these women included the following: "I'd like more control . . .I put a lot of trust in the team last time . . . And a few of them let me down" (Greenfield et al., 2019, p. 5) and "I'm . . . quite anxious . . . quite worried" (Greenfield et al., 2019, p.8).

Ease. Ease themes during the antepartum period include trusting patient–provider interactions and screening for past trauma. Greenfield et al. (2019) stated that providers need to identify and support women with trauma histories early in the antenatal period to prevent further traumatic experiences. In Olsen et al. (2021), and Flanagan et al. (2018), over 65% of women agreed that performing ACEs screening can be beneficial during the antepartum period for

various reasons, including preventing retraumatization and obtaining resources for their mental health. The ACEs Questionnaire was used in both studies.

Olsen et al. (2021) screened 154 women using all 10 questions from the ACEs Questionnaire. On average, the study participants reported a history of 2.56 ACEs ($SD = 2.37$), with 31.8% reporting four or more. Flanagan et al. (2018) screened 375 women using eight of the 10 ACEs questions. Fifty-four percent of the participants reported zero ACEs, 28% reported one to two ACEs, and 18% reported three or more ACEs (Flanagan et al., 2018).

Transcendence. Transcendence themes during the antepartum period include comfort with discussing trauma, increased excitement for childbirth, and increased trust and confidence in patient–provider relationships. Jackson et al. (2020) explored how trauma and violence-informed cognitive behavioral therapy impacted mothers' experiences following trauma. Themes gathered from the mothers' reports included increased support, coping, maternal–infant bonding, and a change in self-perception as a trauma survivor (Jackson et al., 2020). Patterson et al. (2019) also found themes of transcendence, including allowing women to keep their power during pregnancy and childbirth.

Three articles identified the theme of increased trust and confidence in patient–provider relationships through screening for ACEs: Flanagan et al. (2018), Olsen et al. (2021), and Gokhale et al. (2020). Flanagan et al. supported this theme by reporting that out of 210 participants who received ACEs screening, 11% said it changed their relationship with their clinician, and 53% reported it increasing their trust in their clinicians. Flanagan et al. also found that patients with one or more ACEs were more interested in ACE resources than those with none, $p < 0.001$.

Intrapartum

Five articles (Akbaş et al., 2022; Baptie et al., 2020; Howard et al., 2017; Buchanan & Humphreys, 2020; Patterson et al., 2019) were included in the intrapartum interventions portion of the review. These articles represented two qualitative studies, one nonexperimental study, one RCT, and one mixed methods study, all focusing on the causes of trauma during birth and how trauma can be reduced through interventions.

Relief. Relief themes that emerged during the intrapartum period included fear, anxiety, pain, loss of control, and feeling alone. Akbaş et al. (2022) conducted an RCT on how different interventions positively or negatively affected women during labor. Three scales were used to test holistic birth strategies: the Coping Assessment for Laboring Moms (CALM), the Birth Satisfaction Scale (BSS), and the Wijma Birth Expectation/Experience Scale, Version B (W-DEQ-B). These scales test fear, coping ability during labor, and low versus high birth satisfaction (Akbaş et al., 2022). Without the interventions present, the CALM scale scores for the different phases of labor were Latent = 22.15, Active = 23.61, and Transition = 24.44. The BSS score for the control group was 28.57 ($SD = 5.83$), while the mean score for the W-DEQ-B was 61.96 ($SD = 9.78$); Akbaş et al., 2022).

Baptie et al. (2020) looked at pain and fear during labor using the Traumatic Event Scale, the Perception of Labor and Delivery Scale, and the Intrapartum Intervention Score to measure women's birth experiences. Buchanan and Humphreys (2020) also touched on the theme of fear, but unlike women in the other studies, the women in their study feared abuse from their significant other, not fear related to childbirth. One woman shared this experience of fear and anxiety by stating, "I was scared because I thought he was going to hurt us and everything" (Buchanan & Humphreys, 2020, p. 329) while another woman exclaimed, "I carried the baby

and blood everywhere on him (the baby) because he (the partner) hits me really badly" (Buchanan & Humphreys, 2020, p. 330).

Hollander et al. (2017) studied attributions of trauma during labor and found that 54.6% of study participants identified loss of control as a significant contributing factor. Patterson et al. (2019) had similar findings: finding and losing power and struggling for power were central themes in their qualitative study. Feeling alone was a cumulative theme seen in all five studies, with Patterson et al. portraying an example by quoting a patient who stated, "Nobody came, nobody informed us, nobody asked us what we wanted" (p. 28).

Ease. Ease themes that emerged during the intrapartum period included birth support, nurturing environment, effective communication, and continuity of care with providers. Multiple methods for providing TIC were exhibited during the intrapartum period to patients experiencing symptoms of trauma past, present, and future. Birth support was a significant theme identified throughout the articles; Akbaş et al. (2022) represented this by showing how the CALM, BSS, and W-DEQ-B scores changed after holistic birth support measures were introduced. The CALM scale scores for the experimental group were much higher during labor, with Latent at 43.52, Active at 41.97, and Transition at 41.08 (Akbaş et al., 2022). The BSS also showed higher satisfaction with the experimental group with a mean score of 128.57 ($SD = 5.83$), and the W-DEQ-B score showed a significant difference in the mean score between the two groups ($t(62) = -28.024$, $p < .001$; Akbaş et al., 2022). Baptie et al. (2020) also showed how increased trauma symptoms were increased using the subscale of the Perception of the Labor and Delivery Scale which linked lower perceived support ($r = -.49$, $p < 0.01$), with greater self-reported fear ($r = 0.50$, $P < 0.001$) and pain ($r = 0.30$, $P < 0.001$).

Hollander et al. (2017) and Paterson et al. (2019) showed how continuity of care and birth support were essential to TIC. Patterson et al. used a reflective approach to interview six women diagnosed with PTSD after childbirth and six midwives assisting women during the intrapartum period. Multiple themes and subthemes were identified in this study. One of the themes was that of "being with me," which included the subthemes of "talking and listening to me," "building a relationship with me," "supporting me," and "see me—I need you" (Patterson et al., 2019, p. 27). Hollander et al. (2017) showed how midwives, through support, could have prevented a traumatic birth experience ($p = 0.06$). Hollander et al. (2017) also found that a traumatic birth could have been prevented with better provider communication in 39.1% of responses.

Transcendence. The final portion of this review related to the intrapartum period of birth was shown in the themes that portrayed patients reaching transcendence, including increased birth satisfaction, ability to cope with labor pain, decreased anxiety and fear during childbirth, and having a support network. All five qualitative and quantitative articles portrayed how different relief aspects allowed women to labor with a decreased risk of trauma (Akbaş et al., 2022; Baptie et al., 2020; Buchanan & Humphreys, 2020; Howard et al., 2017; Patterson et al., 2019). Akbaş et al. (2022) showed this outcome of increased coping in labor with a statistically significant difference found between both groups in the RCT with mean scores of the BSS, $t(62) = 27.41$, $p = 0.0$. Hollander et al. (2017), Akbaş et al., Baptie et al. (2020), Buchanan and Humphreys (2020), and Patterson et al. (2019) verified the need for more trauma-informed interventions to increase satisfaction and decrease negative aspects of labor.

Postpartum

Seven articles (Abdollahpour et al., 2015; Asadzadeh et al., 2020; Ayers et al., 2018; Buchanan & Humphreys, 2021; Patterson et al., 2019; Sigurdardottir et al., 2019; Xu et al., 2021) on studies investigating TIC themes during the postpartum period were included in the postpartum portion of this integrative review.

Relief. Relief themes that emerged during the postpartum period included PTSD, depression, anxiety, confusion, and feeling alone and uncomfortable. Authors of all seven articles noted that patients with birth trauma or a trauma history felt increased depression and anxiety after birth (Abdollahpour et al., 2015; Asadzadeh et al., 2020; Ayers et al., 2018; Buchanan & Humphreys, 2021; Patterson et al., 2019; Sigurdardottir et al., 2019; Xu et al., 2021). Supporting this claim, Ayers et al. (2018) found that in a sample of postpartum women (N = 950), 90.6% reported experiencing one or more symptoms of PTSD following childbirth. Ayers et al. also found that 72 participants in the study (n = 72m) fulfilled all *DSM-5* diagnostic criteria for PTSD (7.8%, CI 6.08%–9.52%).

Buchanan and Humphreys (2020) and Patterson et al. (2019) both depicted how participants facing trauma in all forms felt alone after childbirth. Buchanan and Humphreys revealed the effects that having an abusive partner can have on childbirth. One participant commented on this feeling after delivery by stating, "I would say I was very isolated because I had to withdraw because of the stress, and the shame and the exhaustion" (Buchanan & Humphreys, 2020, p. 331). Patterson et al. (2019) also demonstrated how patients feeling abandoned by their midwife after delivery can have negative effects. One woman during her interview spoke to this by stating, "I felt like they were done with me um yeah the baby was born the baby was fine and I didn't really matter… right we've done her she's okay, next one" (Patterson et al., 2019, p. 31).

Ease. Ease themes that emerged during the postpartum period included discussion and debriefing on birth. Three studies—two RCTs and one qualitative—that focused on postpartum discussion of birth and debriefing showed that participants reported the need for this intervention to occur during the postpartum period to decrease trauma or retraumatization. Abdollahpour et al. (2019) investigated the effect of brief cognitive behavioral counseling (CBC) and debriefing on preventing postpartum PTSD. Both CBC and face-to-face debriefing for 40–60 min within the first 48 hr after childbirth significantly improved PTSD symptoms. Results of a one-way analysis of variance showed statistical differences in the mean score of PTSD in traumatic births between the intervention and control groups 4–6 weeks and 3 months after the intervention ($p < 0.001$; (Abdollahpour et al., 2019).

Asadzadeh et al. (2020) found that postpartum debriefing significantly decreased symptoms from 72 hr to 4–6 weeks and 3 months after giving birth in the intervention group, showing midwife-led brief counseling as a practical approach to reducing the psychological distress of women who have experienced traumatic childbirth. Sigurðardótt et al. (2019) also illustrated the need for postpartum debriefing; one participant recognized this need in stating "[It] is important to give all women an opportunity to talk about their experience" (p. 34).

Transcendence. Transcendence themes that emerged during the postpartum period included trauma-informed postpartum mental health support. Women in Sigurðardóttir et al. (2019) reported that if the provider used active listening without belittling the client's birth experience discussion, the client could regain control and strength to move on. Sigurðardóttir et al.'s findings also supported initiating conversations about the birth experience being included in routine care for all women within the first weeks after birth to determine which women need to process and reconcile their birthing experiences.

An RCT conducted by Abdollahpour et al. (2019) showed that participants (n =179) who received CBC within 48 hr of delivery by a trained midwife had significantly reduced PTSD scores. CBC also had a significant level of effectiveness ($p < 0.001$) when measured at 4–6 weeks and again at 3 months (Abdollahpour et al., 2019).

Table 2 is a taxonomic structure of Kolcaba's comfort theory produced by the three forms of comfort and four contexts of holistic human experience. The three forms of comfort are relief, ease, and transcendence (Krinsky et al., 2014). Relief is felt when an individual comfort need is met. Ease is felt when patients are in situations that allow them to feel calm or content. Finally, transcendence occurs when patients can rise above the challenges they currently face (Krinsky et al., 2014).

Discussion

Violence toward women, including women with past trauma histories, is common, and trauma's harmful effects are well documented. For example, leading organizations report that one third of women globally are impacted by sexual and physical violence in their lifetime (World Health Organization, 2021). At least 1 in 5 girls in the United States has been sexually abused by age 13 years, and at least 1 in 3 women experience physical assault by an intimate partner during adulthood (AHRQ, 2016). Understanding these numbers lets providers acknowledge that trauma survivors populate the health care system. It should ignite the need for TIC guidelines and a more powerful endorsement of standardization of TIC in midwifery care and throughout health care systems. Midwives are uniquely positioned in the health care setting to ensure that all women in their care receive TIC, regardless of disclosure (Flanagan et al., 2018).

This integrative review aimed to examine the actions and conversations midwives can implement to decrease trauma's impact during the antepartum, intrapartum, and postpartum periods that may also lessen trauma's impact on future generations. The integrative review method included qualitative and qualitative evidence and involved synthesizing the literature representing varied methodologies. Nine key themes were identified across the 20 studies: trauma screening, ACEs screening, trusting patient–provider relationships, birth support, nurturing environment, effective communication, continuity of care with providers, discussion/debriefing of the birth experience, and mental health support. For this review, these findings were integrated into Kolcaba's theory of comfort, which includes relief, ease, and transcendence. These comfort measures were then placed into the perinatal categories of antepartum, intrapartum, and postpartum.

Antepartum

Trauma screening, ACEs screening, and trusting patient–provider relationships are all interventions midwives can incorporate into antepartum TIC (Flanagan et al., 2018; Gokhale et al., 2020; Greenfield et al., 2019; Jackson et al., 2020; Olsen et al., 2021; Onchonga et al., 2020; Patterson et al., 2019). A trusting patient–provider relationship should be foundational to all antepartum care. This relationship will help women feel more comfortable when trauma and ACE screenings occur during their antepartum appointments. In addition, TIC during the antepartum period allows providers to focus on preventing trauma or retraumatization.

Intrapartum

Birth support, effective communication, continuity of care with a trusted provider, and a nurturing environment are interventions midwives could incorporate during labor and birth (Akbaş et al., 2022; Baptie et al., 2020; Buchanan & Humphreys, 2020; Howard et al., 2017;

Patterson et al., 2019). These interventions help women decrease fear, anxiety, pain, loss of control, and feeling alone. In turn, these interventions decreased the likelihood of perceiving the birth as traumatic. Several of these interventions align with ACNM's hallmarks of midwifery, including promoting continuity of care, skillful communication, and person-centered care for all, and should be a standard of routine intrapartum care for the midwifery profession (ACNM, 2020).

Postpartum

After a traumatic birth, women overwhelmingly struggle with anxiety, depression, PTSD, confusion, and feeling alone and uncomfortable during the postpartum period (Abdollahpour et al., 2015; Asadzadeh et al., 2020; Ayers et al., 2018; Buchanan & Humphreys, 2021; Patterson et al., 2019; Sigurdardottir et al., 2019; Xu et al., 2021). Trauma-informed postpartum mental health support can support TIC during this period. Discussion and debriefing are the most effective interventions for midwives to implement and can be CBC or face to face.

It is important to note that for various reasons, including fear of retraumatization, lack of trust, concerns about inadequate follow-up, cultural norms, and personal beliefs, TIC techniques implemented by midwives may not be favorable in every scenario. An example of this is seen in debriefing, a method used in the postpartum period after delivery. Greenfield et al. (2019) found that for some women, debriefing during the postpartum period may lead to worsening symptoms of depression or could be linked to causing PTSD as opposed to treating it. Similarly, most women (82.2%) in Olsen et al. (2021) thought prenatal care should include TIC conversations about ACEs. However, it is essential to remember that the remaining participants (17.8%) in Olsen et al. had concerns about how the information would be used.

Participants in the included studies shared their trauma histories. They also overwhelmingly endorsed that measures should be taken to prevent further retraumatization and access to resources should be integrated into care and offered to clients (Abdollahpour et al., 2019; Asadzadeh et al., 2020; Flanagan et al., 2018; Gokhale et al., 2020; Greenfield et al., 2019; Olsen et al., 2021; Rousseau et al., 2021; Xu et al., 2021).

Findings in this review highlight the need for additional TIC research and literature. The U.S. Department of Health and Human Services (2023) listed maternal mental health as a high-priority public health issue with evidence-based interventions to address it. Increasing the proportion of women screened for postpartum depression is a HealthyPeople 2030 objective. Maltreatment and ACEs can lead to chronic and multiple adverse mental health sequelae, including anxiety, depression, and PTSD (Sperlich et al., 2017). Providers need to consider past experiences and their possible impact on mental health surrounding birth, even if the traumatic experiences happened in the past. The American College of Obstetricians and Gynecologists (2021) and the ACNM (2021) both acknowledge trauma's prevalence and the need to incorporate TIC in order to create an environment where survivors feel safe and supported.

Implications for Advanced Practice Nursing Leadership and Practice

TIC should be implemented into routine antepartum, intrapartum, and postpartum care for all women to decrease the risk for retraumatization that can lead to further issues, including PTSD and anxiety. In addition, policies need to be developed and placed into practice to decrease the risk of undermining the TIC provided by one midwife that could potentially be challenged by another midwife, provider, or other health care personnel and possibly cause a setback in the patient's care (Greenfield et al., 2019). Having policies in place can ensure that

certified nurse-midwives can offer care that promotes the patient's sense of control throughout the entire peripartum period using the various techniques discussed in this paper.

Educational workshops must be established to integrate TIC into care nationwide. Advanced practice nursing leadership can come together to develop a unified approach for every patient visit during pregnancy, including the intrapartum and postpartum periods. Through integrating TIC into routine care, improved outcomes can be seen along with decreases in negative impacts that result from not implementing these techniques.

Identification of Research Gaps and Recommendations for Future Research

There are various types of TIC seen in practice, although there is limited research on TIC, specifically on how midwives can integrate it into their everyday routines. With the high rate of people affected by trauma, there needs to be a standardized approach to addressing it during the antepartum, intrapartum, and postpartum periods. A standardized approach can help ensure that TIC related to pregnancy can be transferable to all individuals. However, gaps in the research make this integration difficult due to the lack of knowledge on trauma's effects and how they relate to women's health.

Research is needed on techniques in midwifery care that can decrease individuals' retraumatization through evidence-based and standardized approaches. Additional studies should evaluate the effectiveness of trauma-informed interventions by midwives when there is a history of trauma, including past and present trauma. Studies on trauma assessment approaches should also be conducted to identify ways to include these approaches in routine care. Trauma does not gravitate only toward specific populations, and there is a need for research in all communities to formulate a professional recommendation that can be used in all settings.

Limitations

Searches for literature to include in this integrative review yielded few midwifery-specific TIC studies. Another limitation was that the type of trauma varied in each study, and each participant's trauma background varied as each person experiences trauma differently. However, there were similarities in participant perspectives on interventions that would help them avoid further trauma or that would have helped to lessen the trauma regardless of their backgrounds. Although some studies used in the review had small participant numbers, the results were significant and provided insights that helped to answer the research question. Many international studies in this integrative review demonstrated a multicultural influence that may impact the results regarding individuals' feelings about disclosing a trauma history or receiving TIC.

Conclusion

This review demonstrated the impact of trauma on women throughout pregnancy and birth and the need for TIC as a part of routine midwifery care. Given trauma's impact on women throughout pregnancy and afterward, midwives need to begin educating themselves on TIC. Likewise, midwives should advocate and develop additional research on TIC and advocate for TIC guidelines as a standard for the entire profession. This review directs simple actions and conversations midwives can implement for including TIC into their routine antepartum, intrapartum, and postpartum care.

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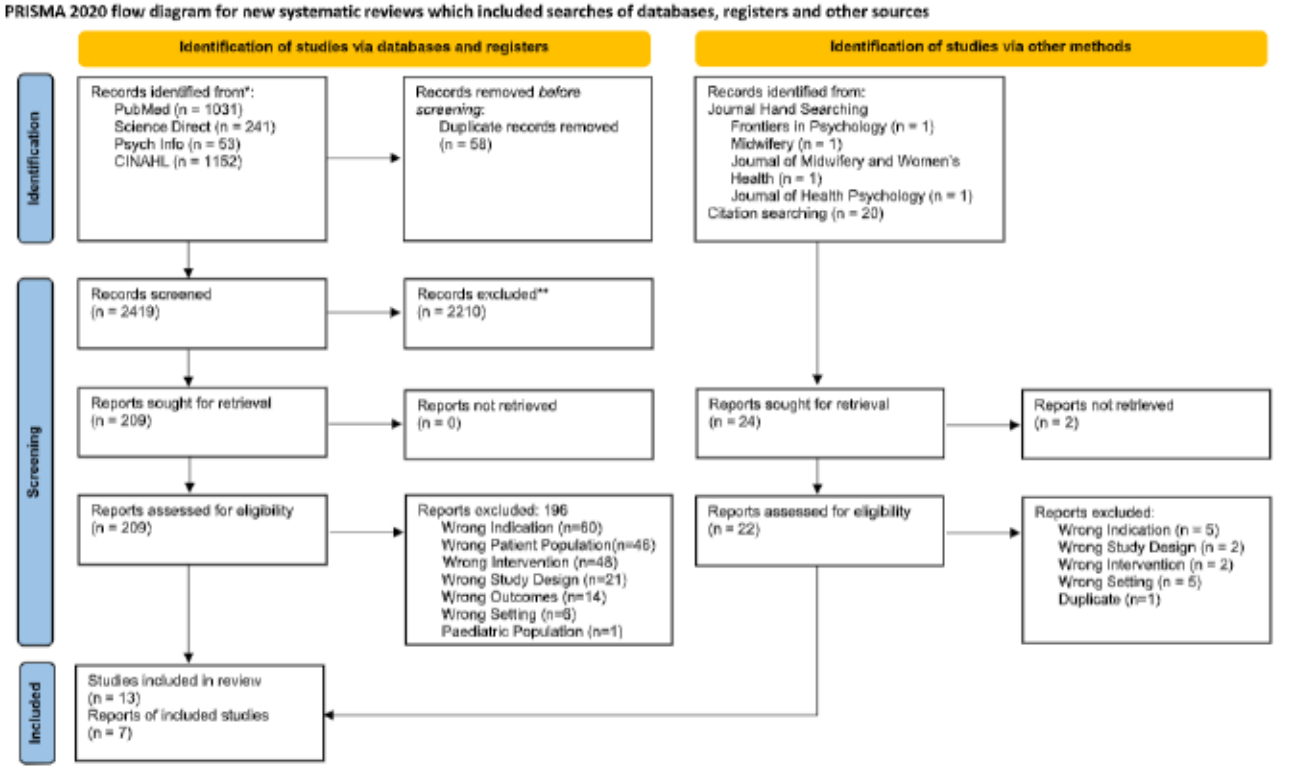
Figure 1

Prisma Flow Diagram



*Consider, if feasible to do so, reporting the number of records identified from each database or register searched (rather than the total number across all databases/registers).
**If automation tools were used, indicate how many records were excluded by a human and how many were excluded by automation tools.

From: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372:n71. doi: 10.1136/bmj.n71. For more information, visit: http://www.prisma-statement.org/

Table 1

Emerging Trauma-Informed Care Interventions

Perinatal Period	Emerging Themes	Emerging Themes	Emerging Themes
Antepartum	Patient-provider relationship	Adverse childhood experiences screening	Birth trauma screening
Intrapartum	Birth support	Nurturing environment	Effective communication/ continuity of care with provider
Postpartum	Debriefing/discussion of birth experience	Counseling	Birth trauma screening

Table 2

Taxonomic Structure of Women's Comfort Needs During Antepartum, Intrapartum, and Postpartum Periods

Period	Need	Comfort form		
		Relief	Ease	Transcendence
Antepartum	Psychospiritual	Fear, anxiety	Form trusting patient-provider relationships Midwife led group sessions	Comfortable with discussing trauma Increasing self-esteem, excitement, and anticipation for positive childbirth experiences
	Environmental	Insecurity, retraumatization	Assess for past adverse childhood experiences to avoid certain environmental triggers	Confident in environment and trusting relationship with provider
	Sociocultural	Feeling alone	Positive care provider interactions	Build feeling of trust and safety
Intrapartum	Physical	Pain, dehydration	Holistic birth support: Holding the patients hands, massage, encouraging position changes and warm showers, encourage hydration. Effective communication	Increased birth satisfaction Patients able to cope with labor pain through continuous support.
	Psychospiritual	Fear, anxiety	Holistic birth Support: Inward focusing, saying words of appreciation, providing spiritual care, helping focus on positive things.	Decreased anxiety and increased birth satisfaction. Decreasing fear of childbirth through continuous support.
	Environmental	Increased noise, unfamiliar space, unfamiliar faces (loss of control)	Holistic birth support: Providing a home environment, continuity of care, nurturing environment.	Feelings of a calm and inviting environment
	Sociocultural	Feeling alone, separation anxiety	Holistic birth support: Providing spiritual care, ensuring constant communication with	Patient has a support network in place and is able to labor with less anxiety.

Period	Need	Comfort form		
		Relief	Ease	Transcendence
			family and support persons.	
Postpartum	Psychospiritual	Posttraumatic stress disorder, depression, anxiety, confusion	Face-to-face counseling, debriefing, screening for birth trauma, mental health support and resources	Able to acknowledge birth experience was traumatic and address mental health issues related to it.
	Environmental	Uncomfortable Noisy Bright lights Visitor/staff disturbances	Visiting patients at the best times for them	Patient feels comfortable and safe in the environment.
	Sociocultural	Feeling alone Family not present	Ensuring family support	Patient has a supportive network in place.

Table 3

Literature Review Matrix

Matrix One

Source: Baptie, G., Andrade, J., Bacon, A. M., & Norman, A. (2020). Birth trauma: The mediating effects of perceived support. *British Journal of Midwifery*, *28*(10), 724–730 https://doi.org/10.12968/bjom.2020.28.10.724

Purpose/Sample	**Design (Method/Instruments)**	**Results**	**Strengths/Limitations**
Purpose: Measure the relationship between obstetric intervention, perceived support in childbirth and mothers' experiences of postnatal trauma, and to identify salient aspects of the birth experience that are considered traumatic. **Sample/Setting:** 222 women who had given birth in the last 12 months (UK) **Level of evidence:** III **Quality of evidence:** Good	Mixed Methods The data from the quantitative measures were analyzed using correlational analyses to assess the relationship between all variables, and regression analysis to measure the relationship between subjective and obstetric experiences of birth with postnatal trauma symptoms. Mediation analysis was conducted to explore the relationship between the level of intrapartum intervention and trauma symptoms, as mediated by perception of support.F The free-text response data were organized into meaningful groups and important aspects were identified.	Overall, 29% of mothers experienced a traumatic birth and 15% met full or partial criteria for post-traumatic stress disorder. Feeling supported mediated the relationship between obstetric intervention and postnatal trauma symptoms. **Conclusion:** This study reinforces the value of supportive healthcare professionals and the power of a nurturing environment, which can buffer the potentially negative effects of an obstetrically complicated birth on postnatal trauma symptoms.	**Strengths:** • This survey was completed online by a large cohort of women who were up to one year postpartum. The use of online research allows access to a larger and broader sample of mothers. **Limitations:** • As this study was retrospective, the possibility of women presenting PTSD symptoms from previous trauma unrelated to the birth experience cannot be ruled out. • Mothers recruited online are more likely to report greater PTSD symptoms compared to community samples of women recruited from hospitals or antenatal clinics • Future research would benefit from a longitudinal design to assess PTSD symptoms antenatally and childbirth specific PTSD symptoms during the postnatal period.

Author Recommendations: When obstetrical birth interventions are necessary, providers need to create a positive and supportive childbirth experience for the mother to reduce later trauma symptoms.

*Intrapartum intervention

Matrix Two

Source: Patterson, J., Hollins Martin, C. J., & Karatzias, T. (2019). Disempowered midwives and traumatized women: Exploring the parallel processes of care provider interaction that contribute to women developing post-traumatic stress disorder (PTSD) post childbirth. *Midwifery*, *76*, 21–35. https://doi.org/10.1016/j.midw.2019.05.010

Purpose/Sample	**Design (Method/Instruments)**	**Results**	**Strengths/Limitations**
Purpose: To understand how women who develop PTSD-PC and midwives, experience their interactions during care provision. In particular, how they feel during their interactions and what this means to them. **Sample/Setting:** 6 midwives and 6 childbearing women in Scotland. Interviews took place in informants' homes, cafes or university offices. **Level of evidence:** III **Quality of evidence:** Good	The qualitative method of Interpretative Phenomenological Analysis that incorporates a reflective approach, was used to gain deep understanding of the lived experience of care provider interaction. The 8 steps of the IPA analysis process used: 1. Reading and re-reading 2. Initial noting 3. Developing emergent themes 4. Searching for connection across emergent themes 5. Moving to the next case 6. Looking for patterns across cases 7. Writing up the analysis 8. Identifying convergent or divergent themes across both groups.	1) Failing to recognize and meet the human needs of both women and midwives, results in poor quality interactions from midwives and poor perception of care provider interaction by women; 2) The study groups of women and midwives both identified the quality of their relationship as central to positive interactions. **Conclusion:** Maternity services need to highlight the importance of the quality of care provider interaction alongside perinatal psychological wellbeing.	**Strengths:**' • The qualitative methodology provided a strong platform for researching the lived experience of all the informants. • In-depth IPA, and specifically the double hermeneutic and reflexive processes involved enabled a rich understanding of informants' experiences. • Also, exploring convergent perspectives of both sides of the story highlighted key areas for attention of the maternity services. **Limitations:** • The study being retrospective, and as such relying on memories that may have become re-constructed. • Although, childbirth memories remain strong and coherent and while factors other than Care Provider Interactions (CPI) may have contributed to PTSD-PC, all of 'The Women' highlighted CPI related trauma hotspots. While homogeneity is desired for IPA, this limits our understanding of the experiences of CPI, particularly from a wider range of women. • Self-selection for participation may have created bias. Within midwives' demanding roles they also experience trauma and PTSD and this may have influenced participation. Accompanying this point, awareness that a negative perception of CPI contributes to the development of PTSD-PC, may have initiated the Hawthorne Effect.

Author Recommendations:

- Raise the status of psychological wellbeing for childbearing women and make it of equal importance to physical wellbeing, with clear focus upon CPI.
- Create a midwife centered system to enable midwives to provide optimal CPI and improve relationship-based care in keeping with government strategies.
- Challenge underlying toxic cultures That currently persist in the maternity services system, which undermine the work of midwives and consequently the experience of women. *Antepartum, Intrapartum, Postpartum Intervention

Matrix Three

Abdollahpour, S., Khosravi, A., Motaghi, Z., Keramat, A., & Mousavi, S. A. (2019). Effect of brief cognitive behavioral counseling and debriefing on the prevention of post-traumatic stress disorder in traumatic birth: A randomized clinical trial. *Community Mental Health Journal*, *55*(7), 1173–1178. https://doi.org/10.1007/s10597-019-00424-6

Purpose/Sample	**Design (Method/Instruments)**	**Results**	**Strengths/Limitations**
Purpose: To determine the effectiveness of two counseling methods on prevention of post-traumatic stress after childbirth. **Sample/Setting:** 179 **Level of evidence:** I **Quality of evidence:** Good	Randomized clinical trial (parallel design with three arms).	Debriefing and brief cognitive behavioral counseling (CBC) significantly improved the symptoms of postpartum traumatic stress disorder. After 3 months, CBC had a significant effect on the symptoms. **Conclusion:** Screening of traumatic childbirth, implementation of supportive care, and early counseling prior to the initiation of post-traumatic stress are recommended.	**Strengths:** • Study design • Subjects in our study were counseled by Master counselors who had attended special training courses on counseling and psychotherapy. • To avoid the information bias, the follow up measurements were carried out by another researcher that was blind to the interventions. **Limitations:** • Mothers from each group dropped out before the study was completed. • Small sample size. • Completed in a single setting.

Author Recommendations: Due to the effectiveness of brief cognitive behavioral counseling, which is easy, feasible, and less costly, it is recommended to provide this service in the postpartum period.

*Antepartum / Postpartum Intervention: CB counseling if known history or if retraumatization resurfaces during PP. Screening of traumatic childbirth, implementation of supportive care, and early counseling prior to the initiation of post-traumatic stress are recommended.

Source: Greenfield, M., Jomeen, J., & Glover, L. (2019). "It can't be like last time" - Choices made in early pregnancy by women who have previously experienced a traumatic birth. *Frontiers in Psychology, 10*(56), 1-12. https://doi.org/10.3389/fpsyg.2019.00056			
Purpose/Sample	**Design (Method/Instruments)**	**Results**	**Strengths/Limitations**
Purpose: Understand the women's choices in subsequent pregnancies and the reason behind them after experiencing a traumatic birth. **Sample/Setting:** 9 Mothers in the UK who had previously experienced a traumatic birth **Level of evidence:** III **Quality of evidence:** Good	Qualitative A constructivist grounded theory approach was used, underpinned by feminist research principles. Data were generated from a series of three semi-structured interviews conducted during pregnancy and the early postnatal period.	-Women focused on searching out and analyzing information trying to avoid repeating their previous birth experiences and trying to avoid loss of control to other people during their birth. -Many early relationships with healthcare professionals were characterized by fear and mistrust . **Conclusion:** Correctly identifying and supporting women who have previously experienced a traumatic birth in the early antenatal period is a necessary preventative measure to decrease the likelihood of a further traumatic experience.	**Strengths:** • The study met its aims. • Conceptual categories were established, which allows providers insight into commonalities in how women deal with a past traumatic birth. **Limitations:** • Number of participants was small. • The participants were white, all identified as heterosexual, and all lived with a partner at the time of recruitment. Unfortunately, this means the sample was not diverse as intended.
Author Recommendations: A trusting relationship between woman and midwife is essential after a woman has experienced a traumatic birth. All care providers involved in a woman's care must employ strategies that promote her sense of control. Continuity of care has been found to encourage a trusting relationship between a woman and those providing maternity care. *Antepartum Intervention: This study clearly shows that women who have had a previous traumatic birth begin to ensure they have a different experience and more control early on in consecutive pregnancies. If providers helped traumatized women navigate their consecutive pregnancies early on, it could increase trust and control over the next birth experience.			

Source: Gokhale, P., Young, M. R., Williams, M. N., Reid, S. N., Tom, L. S., O'Brian, C. A., & Simon, M. A. (2020). Refining trauma-informed perinatal care for urban prenatal care patients with multiple lifetime traumatic exposures: A qualitative study. *Journal of Midwifery & Women's Health*, *65*(2), 224–230. https://doi.org/10.1111/jmwh.13063

Purpose/Sample	**Design (Method/Instruments)**	**Results**	**Strengths/Limitations**
Purpose: To refine ongoing development of a trauma-informed care framework for perinatal care **Sample/Setting:** 30 women receiving care at an urban clinic **Level of evidence:** III **Quality of evidence:** Good	Qualitative Semi Structured interviews Participants also completed a trauma history questionnaire. Inductive coding was used to generate themes and subthemes.	Participants described multiple lifetime traumatic exposures as well as background exposure to community violence. Not all participants desired routine trauma screening; factors limiting disclosure included fear of retraumatization and belief that prior trauma is unrelated to the current pregnancy. **Conclusion:**This study supports a trauma-informed care approach to caring for pregnant women with prior traumatic exposures, including trauma screening without retraumatization and trusting patient-provider relationships.	**Strengths:** • Identification of themes and subthemes. **Limitations:** • Discussion topics in these interviews may be viewed as sensitive, which may have affected participants' willingness to discuss experiences. • The convenience sample may limit the generalizability of responses. • The majority of participants in this study reported multiple traumatic exposures and primarily reside in areas with a high concentration of background violence, and thus these results may not be generalizable to all patients.

Author Recommendations: Strong therapeutic relationships were critical to any trauma history discussion and should focus on all providers. In addition, because trauma has been so well documented to have adverse effects during pregnancy and childbearing, psychoeducation about trauma and signs of PTSD might be recommended as the standard training for perinatal care providers. Also, providers' should provide info to patients to normalize retraumatization or stress during pregnancy from past adverse events.*Antepartum Intervention - This study encourages all perinatal care providers to adopt trauma-informed care practices as they are needed for women with wide-ranging trauma exposure experiences.

Source: Sigurðardóttir, Gamble, J., Guðmundsdóttir, B., Sveinsdóttir, H., & Gottfreðsdóttir, H. (2019). Processing birth experiences: A content analysis of women's preferences. *Midwifery*, *69*, 29–38. https://doi.org/10.1016/j.midw.2018.10.016

Purpose/Sample	**Design (Method/Instruments)**	**Results**	**Strengths/Limitations**
Purpose: To explore women's experience and preferences of reviewing their birth experience at a special midwifery clinic. **Sample/Setting:** 131 women who attending special counseling clinic form 2005 to 2011 in Iceland **Level of evidence:** III **Quality of evidence:** Good	A qualitative content analysis of women's written text responses to semi-structured questions, included in a retrospective study.	Two themes and three sub themes were identified. The first was *'on my terms'* with the subthemes of *'being recognized'*, *'listening is paramount'* and *'mapping the unknown'*. The final theme was *'moving on'*. **Conclusion:** This study provides insights into women's views about processes designed to assist women to reconcile emotions associated with birth experience. It describes the process in a multifocal dimension, with women's views about different components of the midwifery interview intervention.	**Strengths:** • All women attending special counseling clinics for a five-year period (2006–2011) had the opportunity to participate and provided a range of responses. • Providing women with an opportunity to express themselves in their own words provided richer data about their experience of the interview and how the clinic could be improved, rather than a fixed response survey. **Limitations:** • The sample is a self-selected group and does not necessarily reflect all women who have negative birth experiences or all women who used the clinic. • The higher educational level of participants limits the generalisability of the findings to the wider population. • The data is dated as it was collected between 2006 and 2011.

Author Recommendations: Findings support the importance of recognising women's need to review their birth experiences and offer an intervention to reflect on their perceptions. A discussion of the birth experience should be a routine part of maternity services.

Matrix Seven

Source:Source: Olsen, J. M., Galloway, E. G., & Guthman, P. L. (2021). Exploring women's perspectives on prenatal screening for adverse childhood experiences. *Public Health Nursing (Boston, Mass.)*, *38*(6), 997–1008. https://doi.org/10.1111/phn.12956			
Purpose/Sample	**Design (Method/Instruments)**	**Results**	**Strengths/Limitations**
Purpose: To learn more about women's views on screening for adverse childhood experiences (ACEs) during healthcare visits in pregnancy. **Sample/Setting:** 154 women rural region of a Midwest state. **Level of evidence: II** **Quality of evidence:** Good	Mixed methods with an online survey	Strong preference was indicated for screening by one's physician or midwife, in an exam room, using an independently completed questionnaire. **Conclusion:** Findings inform strategies for efficiently and sensitively screening for ACEs during pregnancy, highlight the importance of using a trauma-informed approach, and provide direction for educational and interventional resource development.	**Strengths:** • The results from this study can be used to guide implementation of sensitive and acceptable strategies leading up to, during, and following ACEs screening in prenatal care settings **Limitations:** • Women who participated in this study were well-educated and reported above average household incomes for the region
Author Recommendations: Pre screen - Train all HCP's in principles of TIC, establish a trusting relationship prior to screening / define ACE Screening - in a calm and private room with a female provider. Post screening - educate how ACE's are relevant to pregnancy, parenting, and general health, coping strategies and resources.			

Matrix Eight

Source: Van der Meulen, Veringa-Skiba, I. K., Van Steensel, F. J. A., Bögels, S. M., & De Bruin, E. I. (2023). Mindfulness-based childbirth and parenting for pregnant women with high fear of childbirth and their partners: Outcomes of a randomized controlled trial assessing short- and longer-term effects on psychological well-being, birth and pregnancy experience. *Midwifery*, *116*, 103545–103545. https://doi.org/10.1016/j.midw.2022.103545

Purpose/Sample	**Design (Method/Instruments)**	**Results**	**Strengths/Limitations**
Purpose: To examine the short- and longer-term outcomes of MBCP on psychological well-being, pregnancy and birth ECAU, in pregnant women with high fear of childbirth and their partners. **Sample/Setting:** 141 pregnant women and 120 partners in Netherlands in midwifery care settings **Level of evidence:** I **Quality of evidence:** Good	Randomized Control Trial Participants were randomly assigned to Mindfulness-Based Childbirth and Parenting (MBCP) or experience, as compared to enhanced care-as-usual (ECAU) and completed questionnaires pre intervention (T1), immediately after intervention (T2), two to four weeks after childbirth (T3) and 16-20 weeks after childbirth (T4). Both intention-to-treat and per-protocol analyses were conducted.	No differences between MBCP and ECAU in the total group of birthing women were found. However, women with labor that participated in MBCP reported a better birth experience compared to ECAU at T3. **Conclusion:** MBCP and ECAU demonstrate similar effects on psychological well-being, birth and pregnancy experience. However, MBCP appears superior to ECAU for laboring women in having a better childbirth experience.	**Strengths:** • The inclusion of partners, having an active control group, using both short- and longer term assessments. • The use of a study protocol, blinded outcome assessors and conducting both ITT and PP analyses. • Mean scores before intervention of both women and partners did not differ between MBCP and ECAU, which indicates successful randomization. **Limitations:** • The missing data of the birthing women is not completely random; women with more complaints at start were less likely to fill in questionnaires 16-20 weeks after birth, making the data at this time point less trustable. • The large amount of missing data in the evaluation questionnaires, especially of the partners.

Author Recommendations: MBCP only positively affects the childbirth experience of those who experience (onset of) natural birth. It might be advisable to include partners at risk for psychological complaints in the MBCP.

Matrix Nine

Source: Asadzadeh, L., Jafari, E., Kharaghani, R., & Taremian, F. (2020). Effectiveness of midwife-led brief counseling intervention on post-traumatic stress disorder, depression, and anxiety symptoms of women experiencing a traumatic childbirth: A randomized controlled trial. *BMC Pregnancy and Childbirth*, *20*(1), 142. https://doi.org/10.1186/s12884-020-2826-1

Purpose/Sample	**Design (Method/Instruments)**	**Results**	**Strengths/Limitations**
Purpose: Investigate the effectiveness of a brief midwife-led counseling approach in decreasing post-traumatic stress disorder, depression, and anxiety symptoms among a group of women who had experienced a traumatic childbirth. **Sample/Setting:** 233 **Level of evidence:** I **Quality of evidence:** Good	Randomized Control Trial	**Results**: The intervention group showed significantly higher improvement on post-traumatic stress disorder, depression, and anxiety symptoms compared to the control group. **Conclusion:** Midwife-led brief counseling could be an effective approach to reduce psychological distress of women who have experienced a traumatic childbirth.	**Strengths:** • Relatively large sample size, having a follow-up period, and measuring a variety of psychological outcomes. **Limitations:** • Only used self-report questionnaires to assess the outcome variables.

Author Recommendations: Negative impacts of the mothers' depression and anxiety can influence her bond with the child. So, it is important to reduce postpartum distress as soon as possible with effective psychological interventions. Women receiving two counseling sessions had greater reduction in depression and anxiety symptoms than women who only received routine care. These findings are consistent with previous studies that stated brief psychotherapeutic intervention is superior to routine care in terms of improvement of depression and anxiety symptoms

Matrix Ten

Source: Xu, L., Boama-Nyarko, E., Masters, G. A., Moore Simas, T. A., Ulbricht, C. M., & Byatt, N. (2021). Perspectives on barriers and facilitators to mental health support after a traumatic birth among a sample of primarily White and privately insured patients. *General Hospital Psychiatry*, *73*, 46–53. https://doi.org/10.1016/j.genhosppsych.2021.08.010

Purpose/Sample	**Design (Method/Instruments)**	**Results**	**Strengths/Limitations**
Purpose: To hear the perspectives of individuals who have had a traumatic birth experience, and look at barriers to receiving mental health support in the postpartum period. **Sample/Setting:** 32 Women, 1 in Canada and 31 in US **Level of evidence:** III **Quality of evidence:** Quantitative- Good Qualitative-Good	Mixed methods study -The quantitative portion looked at the individual's Post-traumatic Stress Disorder Checklist (PCL-5), Patient Health Questionnaire (PHQ-8) and Generalized Anxiety Disorder scale (GAD-7). Analysis of categorical variables were conducted using chi-square. A *p*-value of <0.5 was considered significant. - The qualitative data was organized theoretically, using a modified grounded theory approach, "Coding consensus, Co-occurrence, and Comparison." The coding schema was created using themes that emerged from the interviews.	Among participants, 34.4% screened positive for PTSD, 18.8% for depression, and 34.4% for anxiety. Participants described multi-level barriers that prevented clinicians from recognizing and supporting patients' postpartum mental health needs; those involved lack of communication, education, and resources. **Conclusion:** Obstetric professionals must recognize that any individual can perceive their delivery experience as traumatic. All patients deserve to have traumatic delivery experiences be acknowledged, validated and addressed	**Strengths:** • A large and geographically diverse sample for the qualitative study with an in-depth focus on patient experiences with postpartum mental health care after traumatic births and recommendations that can inform health care system interventions. **Limitations:** • The sample was primarily White individuals with private health insurance, due to recruitment strategies. The BIPOC (Black, Indigenous, and People of Color) is likely greater due to known racial/ethnic disparities in pregnancy-related morbidity and mortality • People of color are underrepresented in mental health research • The individuals who met inclusion criteria, only a third enrolled in the study and completed the interview, given a disproportionate number of participants who were educated on their trauma and were willing to speak about their experience.

Author Recommendations: Utilizing a trauma-informed approach throughout the postpartum period can increase opportunity to recognize childbirth trauma and understand who may need additional mental health assessment and support. Postpartum mental health support should be an ongoing process and systems-wide goal of care for all patients.

Matrix Eleven

Source: Yapp, E., Howard, L. M., Kadicheeni, M., Telesia, L. A., Milgrom, J., & Trevillion, K. (2019). A qualitative study of women's views on the acceptability of being asked about mental health problems at antenatal booking appointments. *Midwifery*, *74*, 126–133. https://doi.org/10.1016/j.midw.2019.03.021

Purpose/Sample	**Design (Method/Instruments)**	**Results**	**Strengths/Limitations**
Purpose: To explore women's views on the acceptability of being asked about mental health problems at antenatal booking. **Sample/Setting:** Women in a private setting at a hospital or at women's homes. 52 women in UK **Level of evidence:** III **Quality of evidence:** Good	Qualitative Study Interviews were audio-recorded, transcribed verbatim, and analyzed using thematic and framework approaches.	Women wanted to be asked clear questions about mental health problems, to have sufficient time to discuss issues, and to receive responses from midwives which were normalizing and well-informed about mental health. **Conclusion:** Women want midwives to ask clearly-framed questions about mental health problems [addressing past and current mental health concerns.	**Strengths:** • Ethnically diverse sample **Limitations:** • Small sample size • A substantial proportion of eligible women opted not to participate in this research, which may have introduced participation bias. • It is also notable that a number of women did not recall being asked the Whooley questions and were therefore unable to participate in the current research; this may be suggestive of selective enquiry, and should be explored further.

Author Recommendations: For enquiry to be viewed favorably by women, midwives first and foremost need to be prepared to listen to and validate any disclosures that are made. Midwives should acknowledge disclosures of current mental health problems by reassuring and normalizing the problem, and concerns about past or prevailing mental health problems should be properly explored to establish the appropriate or desired means of support.
Women should be given the opportunity to disclose mental health problems without a partner or other family member present, for although some people wanted their partner present, for others, the presence of their partner was a barrier to case identification.

Source: Jackson, K. T., Mantler, T., Jackson, B., Walsh, E. J., Baer, J., & Parkinson, S. (2020). Exploring mothers' experiences of trauma and violence-informed cognitive behavioral therapy following intimate partner violence: A qualitative case analysis. *Journal of Psychosomatic Obstetrics and Gynecology*, *41*(4), 308–316. https://doi.org/10.1080/0167482X.2019.1707799

Purpose/Sample	**Design (Method/Instruments)**	**Results**	**Strengths/Limitations**
Purpose: Explore the positive impact of Trauma and Violence-Informed Cognitive Behavioral Therapy (TVICBT) for women who have experienced IPV and are living with mental health challenges **Sample/Setting:** Three Caucasian, postpartum women who had experienced IPV. **Level of evidence:** III **Quality of evidence:** Good	Qualitative study (This case analysis is part of a larger mixed-methods study) In-depth, semi-structured interviews completed to determine the perceived value and acceptability of this intervention. Each interview was one-to-one and lasted approximately one hour in length.	TVICBT provided during pregnancy may hold promise for the treatment of IPV-related mood and anxiety disorders. **Conclusion:** Given that improved perinatal mental health has been linked to enhanced maternal resiliency and quality of life, greater maternal-infant attachment, and positive child health outcomes, this research has the potential to bridge the critical knowledge gap at the intersection of motherhood, trauma, and mental health.	**Strengths:** • Recruitment of participants was restricted to those who had completed the intervention within the past year **Limitations:** • Small sample size (n ¼ 3) resulted in a relative lack of diversity within the sample. • Interviews were used as a form of retrospective data collection, rather than occurring concurrently with Trauma and violence-infromed cognitive behavioral therapy (TVICBT) participation. As a result, the reflective nature of participant interviews increased the likelihood of recollection bias by women.

Author Recommendations: The benefits of CBT for childbearing women, suggest that CBT combined with a TVIC approach, may hold promise as a novel but potentially effective mental health care intervention for pregnant women with histories of IPV. Integrating principles of TVIC, which include: 1) understanding trauma and violence and its impacts on people's lives/behaviors; 2) create emotionally and physically safe environments for clients; 3) foster opportunities for choice, collaboration, and connection; and 4) provide strengths-based and capacity building approaches to support client coping and resilience into CBT approaches for pregnant women who have experienced violence and/ or trauma may offer a safer, more inclusive treatment alternative for childbearing women with

Source: Akbaş, P., Özkan Şat, S., & Yaman Sözbir, Ş. (2022). The effect of holistic birth support strategies on coping with labor pain, birth satisfaction, and fear of childbirth: A randomized, triple-blind, controlled trial. *Clinical Nursing Research*, *31*(7), 1352–1361. https://doi.org/10.1177/10547738221103329

Purpose/Sample	**Design (Method/Instruments)**	**Results**	**Strengths/Limitations**
Purpose: Evaluate the effects of interventions conducted in line with holistic birth support strategies on women's coping with labor pain, birth satisfaction, and fear of childbirth. **Sample/Setting:** Research Hospital - 64 women **Level of evidence:** I **Quality of evidence:** Good	Single-center, parallel-group randomized, three-blind, controlled trial.	It was found that the women in the experimental group were able to better cope with labor pain, had higher birth satisfaction, and had less fear of childbirth. **Conclusion:** Raise awareness of midwives/nurses so that Holistic Birth Support Strategies can be routinely applied during the birth process.	**Strengths:** • During the research process, no adverse effects were observed in the experimental group **Limitations:** • Minor biases that may arise from the nature of care when evaluating the research results • Conducted in a single center

Author Recommendations: Apply Holistic Birth Support Strategies such as protecting the privacy of the woman, respecting her existence and preferences as a human being, ensuring constant communication with her family and her relatives, using effective communication, informing her about the birth process, and ensuring the continuity of care, uninterrupted birth support, respectful care, and good behaviors during the birth process to the woman during childbirth can help her control her behaviors, feel good, increase self-confidence, and satisfaction rates from their birth experience and positively affect birth processes and outcomes.

Matrix Fourteen

Source: Onchonga, Vámagy, Á., Keraka, M., & Wainaina, P. (2020). Midwife-led integrated pre-birth training and its impact on the fear of childbirth. A qualitative interview study. *Sexual & Reproductive Healthcare*, *25*, 100512–100512. https://doi.org/10.1016/j.srhc.2020.100512

Purpose/Sample	**Design (Method/Instruments)**	**Results**	**Strengths/Limitations**
Purpose: The study aimed at exploring women's experience from midwife-led integrated pre-birth training and its impact on the fear of childbirth. **Sample/Setting:** 33 women interviewed in a maternal and child health clinic in Samburu, Kenya from December 2019 to January 2020 **Level of evidence:** III **Quality of evidence:** Good	A qualitative interview was conducted using a thematic analysis.	Their contributions covered three themes: 'the significance of midwife-led pre-birth training', 'the role of efficient communication during pregnancy,' and 'adaptation to procedures for improved childbirth experience'. In this study 85% (n = 29) of the participants revealed that midwife-led integrated pre-birth training enhanced their expectations for birth processes. **Conclusion:**In this study, women revealed that midwife-led integrated pre-birth training directly improved their certainty on the childbirth process.	**Strengths:** • Several interviews were conducted until new insights were exhausted considering the demographic diversity of the study participants. • The investigators upheld neutrality and objectivity to ensure the confirmability of the study findings. **Limitations:** • It has been critiqued that qualitative research methodology does not intend to explore causal relationships. • The selection of participants was limited to those who visited the hospital and were screened for fear of childbirth.

Author Recommendations: Cultivating women's confidence in their capability to cope with normal physiological and emotional challenges during labor is crucial for midwife-led integrated pre-birth training.

Matrix Fifteen

Source: Buchanan, F., & Humphreys, C. (2021). Coercive control during pregnancy, birthing and postpartum: Women's experiences and perspectives on health practitioners' responses. *Journal of Family Violence, 36*(3), 325-335. 10.1007/s10896-020-00161-5			
Purpose/Sample	**Design (Method/Instruments)**	**Results**	**Strengths/Limitations**
Purpose: Investigates the importance of health practitioners' responses to women's experiences. **Sample/Setting:** 16 women who had birthed and mothered babies while enduring domestic violence. **Level of evidence:** III **Quality of evidence:** Good	Qualitative A feminist epistemology, which centers the voices of women with lived experiences as 'knowers'	The research suggests that health practitioners' acknowledgement of coercive control, and the involvement of social workers conversant with feminist informed dynamics of domestic violence, can impact positively on women's agency. **Conclusion:** The study illustrates how coercive control may be evident in different ways during ante-natal, birthing and postpartum periods. It is also suggested that reproductive coercion may be a facet of coercive control that precedes pregnancy	**Strengths:** • An inductive approach allowed the researchers to gain depth and insight of concerns emerging from the data set. **Limitations:** • Small cohort • Further research is also needed to explore the links between coercive control and reproductive coercion and to consider intersections between culture, age and class. • Given the data in this study was collected using semi structured interviews and focus groups with minimal input from the researcher, it is possible that some women choose not to discuss the actions of health professionals.
Author Recommendations: Women's experiences give credence to a call for additional training for health practitioners and for health practitioners and social workers to work closely together to identify and respond to instances where coercive control is evident. This study underlines the importance of offering empathy, support and information at a time when women may feel particularly vulnerable and distressed because their transition to a mothering role may be impeded by a partner's coercive controlling behaviors.			

Source: Flanagan, T., Alabaster, A., McCaw, B., Stoller, N., Watson, C., & Young-Wolff, K. C. (2018). Feasibility and acceptability of screening for adverse childhood experiences in prenatal care. *Journal of Women's Health (2002)*, *27*(7), 903–911. https://doi.org/10.1089/jwh.2017.6649

Purpose/Sample	**Design (Method/Instruments)**	**Results**	**Strengths/Limitations**
Purpose: To evaluate the feasibility and acceptability of screening for adverse childhood experiences (ACEs) in standard prenatal care. **Sample/Setting:** 405 women over age 18 between 16 and 23w gestation at 2 medical centers in Kaiser Permanente Northern California **Level of evidence:** III **Quality of evidence:** Good	Qualitative Evaluation of a 4-month pilot to screen pregnant women for ACEs and resilience. Examined the acceptability of the screening to patients through telephone surveys and to clinicians through surveys and focus groups.	Most patients were somewhat or very comfortable completing the questionnaires (91%) and discussing ACEs with their clinician (93%), and strongly or somewhat strongly agreed that clinicians should ask their prenatal patients about ACEs (85%). **Conclusion:** ACEs screening as part of standard prenatal care is feasible and generally acceptable to patients.	**Strengths:** • All providers had to complete the same trainings in preparation for the screening implementation including four components: (1) education about ACEs and resilience and their associations with health outcomes; (2) education on providing patients with trauma-informed care; (3) review of the patient resource handout; and (4) information on workflow changes and protocols for reviewing the questionnaires and connecting patients with resources. Medical assistants received a 1-hour training that included education about ACEs and resilience and an overview of workflow changes. **Limitations:** • English-speaking female prenatal adults and results may not be generalizable to other healthcare systems or the U.S. population; lack of diversity. • ACEs measure included the term "sexual abuse" and future studies should instead use descriptive questions that avoid emotion-laden words, such as abuse. Additional studies with validated expanded questionnaires that include neglect as well as additional adversities (*e.g.*, living in foster care, bullying) are needed.

Author Recommendations: During pregnancy, ACEs predict a variety of difficulties, including mental health problems, discomfort and health complaints, excessive weight gain, obstetric problems, and more frequent contacts with the healthcare system. Further, during the early postpartum period, ACEs are associated with difficulties breastfeeding and adverse infant outcomes, including insecure attachment and poor socioemotional functioning. Screening pregnant women for ACEs as part of standard prenatal care may offer an important opportunity to prevent associated prenatal and postpartum risks, and promote long-term health for women and their children. As frequent visits are part of routine prenatal care, obstetricians are ideally positioned to break the transgenerational cycle of ACEs by letting patients know that ACEs can significantly affect their health, conveying that they are not alone, and connecting them with helpful resources

Source: Rousseau, S., Katz, D., Shlomi-Polachek, I., & Frenkel, T. I. (2021). Prospective risk from prenatal anxiety to post traumatic stress following childbirth: The mediating effects of acute stress assessed during the postnatal hospital stay and preliminary evidence for moderating effects of doula care. *Midwifery*, *103*, 103143–103143. https://doi.org/10.1016/j.midw.2021.103143

Purpose/Sample	**Design (Method/Instruments)**	**Results**	**Strengths/Limitations**
Purpose: To explore if doula care during childbirth moderated risk of prenatal trait-anxiety to acute stress following childbirth. **Sample/Setting** 149 pregnant women in last trimester of pregnancy at community hospital in Israel **Level of evidence:** III **Quality of evidence:** Good	Longitudinal study Current sample part of a larger longitudinal cohort study. One group was women with elected doula care plus standard medical care and the second group received standard medical care only. Mothers then completed self-report questionnaires at three points; 1. Last trimester of pregnancy 2. 48 hours after childbirth 3. One month postpartum	Indicated a trend-significant moderation by doula care of the association between prenatal trait anxiety and AS-FC ($\beta = -0.41$; $SE = 0.23$; 95% CI [-0.85, 0.04]), thereby significantly breaking the indirect pathway from prenatal trait anxiety to PTS-FC (index of moderated mediation: $\beta = -0.24$ $SE = 0.13$; 95% CI [-0.53, -0.03]). **Conclusion:** Findings inform preventive screening implicating the prenatal period as well as the postnatal hospital stay as important time windows for preventive screening. Finally, preliminary support for moderating effects of doula care suggest that preventive interventions administered during the perinatal period may effectively reduce anxiety-related risk for Post-Traumatic-Stress-Following-Childbirth.	**Strengths:** • Major strength lies in its' prospective, longitudinal design **Limitations:** • The study did not characterize or assess the precise content of doula care – and were thus unable to include these data in estimating doula-effects. • This study did not adopt a random control design, and therefore factors that are associated with mothers' choice for a doula-assisted birth might have influenced the results.

Author Recommendations: These findings underscore the potential of utilizing both pregnancy checkups and the postnatal hospital-stay as important opportunities for preventive screening. Such screening efforts would allow for the identification of at-risk populations who can then be specifically targeted to receive preventive interventions. Initial evidence for moderating effects of doula care underscore the perinatal period as a potential effective time window for the implementation of such preventive interventions.Social support is thought to contribute to emotion regulation in times of stress, and therefore protect against trauma. A traumatic event challenges beliefs that the world is safe, predictable, and controllable.

Source: Hollander, M. H., van Hastenberg, E., van Dillen, J., van Pampus, M. G., de Miranda, E., & Stramrood, C. A. I. (2017). Preventing traumatic childbirth experiences: 2192 women's perceptions and views. *Archives of Women's Mental Health*, *20*(4), 515–523. https://doi.org/10.1007/s00737-017-0729-6

Purpose/Sample	**Design (Method/Instruments)**	**Results**	**Strengths/Limitations**
Purpose: To explore and quantify perceptions and experiences of women with a traumatic childbirth experience in order to identify areas for prevention and to help midwives and obstetricians improve woman-centered care **Sample/Setting:** 2192 women in Netherlands who self-reported a traumatic birth experience **Level of evidence:** III **Quality of evidence:** Good	Non-experimental study A retrospective survey was conducted online among 2192 women with a self-reported traumatic childbirth experience.	Perceived causes of or contributions to the traumatic experience, were Lack and/or loss of control (54.6% of participants), Fear for baby's health/life (49.9%), High intensity of pain/physical discomfort (47.4%), and Communication/explanation (43.7%). **Conclusion:** Lack and/or loss of control and interaction with caregivers (concerning communication/explanation, listening, emotional and practical support) were main findings r/t a traumatic birth experience.	**Strengths:** • The design of this study created the opportunity to quantify the opinions of a much larger sample than has ever been reported in previous qualitative studies. • Disseminating the questionnaire online through social media proved an efficient way to reach many women with a traumatic birth experience. **Limitations:** • the inability to generalize findings to all women with a traumatic birth experience due to self-selection of the participants • more than half of the participants report on a delivery that occurred more than 2 years ago, making recall bias a distinct possibility

Author Recommendations: Caregivers should discuss realistic expectations of delivery during pregnancy and pay sufficient attention to preparation and birth plans. It is recommended that every woman should be offered a postpartum visit with the caregiver who assisted her during their delivery.

Matrix Nineteen

Source: Brunton, R., Wood, T., & Dryer, R. (2022). Childhood abuse, pregnancy-related anxiety and the mediating role of resilience and social support. *Journal of Health Psychology*, *27*(4), 868–878. https://doi.org/10.1177/1359105320968140

Purpose/Sample	**Design (Method/Instruments)**	**Results**	**Strengths/Limitations**
Purpose: This study aimed to fill current gaps in knowledge about the association between child abuse and pregnancy-related anxiety. **Sample/Setting:** 638 pregnant women in Australia **Level of evidence:** III **Quality of evidence:** Good	Non-experimental study Pregnant women recruited online using social media advertising. The online survey consisted of the Pregnancy-related Anxiety Scale (PrAS), Brief Resilience Scale, and Multidimensional Scale of Perceived Social Support.	Women with a history of abuse had higher scores of pregnancy-related anxiety that showed improvement with resilience and social support. **Conclusion:** The results of this study highlight the need for specific antenatal screening of child abuse. The use of screening tools such as the PrAS which includes items that may indicate previous abuse history will further assist midwives and other caregivers in this identification serving as starting points for conversations	**Strengths:** • Examining abuse individually provides insights into each abuse type's potential effect on pregnant women. • Ability to examine occurred and frequency of each abuse type separately. **Limitations:** • Limited socio-economic and socio-cultural data. • Not examining any accumulation effect of the different types of abuse and how that may contribute to increased pregnancy-related anxiety.

Author Recommendations: A large proportion of pregnant women reported the experience of childhood abuse is concerning with implications for antenatal care. These implications include for example additional considerations for sensitive care given the risk that some women may be re-traumatised by intimate antenatal procedures or childbirth. Resilience-informed therapies, such as cognitive-behavioral therapy, aimed at improving resilience resources through teaching skills in building social support networks and harnessing positive social attitudes, could also be helpful

Source: Ayers, S., Wright, D. B., & Thornton, A. (2018). Development of a measure of postpartum PTSD: The city birth trauma scale. *Frontiers in Psychiatry*, *9*, 409. https://doi.org/10.3389/fpsyt.2018.00409

Purpose/Sample	**Design (Method/Instruments)**	**Results**	**Strengths/Limitations**
Purpose: Develop a questionnaire measure of PTSD specifically for postpartum women that measures PTSD according to DSM-5 criteria. **Sample/Setting:** 950 postpartum women recruited online **Level of evidence:** III **Quality of evidence:** Good	Qualitative Questionnaire that comprised 31 questions: 29 questions which map onto DSM-5 diagnostic criteria; and 2 questions from DSM-IV criteria.	Results showed the City Birth Trauma Scale had excellent reliability (Cronbach's α = 0.92) and was easy to understand (Flesch reading score 64.17). **Conclusion:** This study is the first to develop a specific measure of postpartum PTSD according to DSM-5 criteria. Consistent with previous research into postpartum PTSD it was best conceptualized as two symptom clusters of birth-related symptoms and general symptoms.	**Strengths:** • Large sample size. • Development of a new measurement of postpartum depression. **Limitations:** • Sample was recruited online so it is self-selected and potentially not representative of postpartum women. • Lack of ethnic minority population representation. • This research was primarily focused on the development of a measure of postpartum PTSD and, as such, does not offer a validation because no tests of external validity or test-retest reliability were conducted. Future research is therefore needed to look at reliability over time and examine the predictive validity of the scale for identifying PTSD cases using clinical interviews to establish the validity of the scale as a diagnostic tool.

Author Recommendations: The City Birth Trauma Scale provides a promising measure of birth-related PTSD for use in research and clinical practice.

*Not a comfort measure - postpartum tool.