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| Title | Asking in pregnancy about previous trauma: a review of evidence |
|---|---|
| Type | Article |
| URL | https://clok.uclan.ac.uk/51499/ |
| DOI | ##doi## |
| Date | 2024 |
| Citation | Cull, Joanne orcid iconORCID: 0000-0001-8990-154X, Thomson, Gill orcid iconORCID: 0000-0003-3392-8182, Downe, Soo orcid iconORCID: 0000-0003-2848-2550, Fine, Michelle and Topalidou, Anastasia orcid iconORCID: 0000-0003-0280-6801 (2024) Asking in pregnancy about previous trauma: a review of evidence. The Practising Midwife, 27 (3). pp. 24-28. ISSN 1461-3123 |
| Creators | Cull, Joanne, Thomson, Gill, Downe, Soo, Fine, Michelle and Topalidou, Anastasia |

It is advisable to refer to the publisher's version if you intend to cite from the work. ##doi##

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**Title**

# Asking in pregnancy about previous trauma: a review of evidence

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**Financial Disclosure**

Joanne Cull is funded by a National Institute for Health Research (NIHR) Wellbeing of Women Doctoral Fellowship (grant number NIHR301525). This paper presents independent research funded by the National Institute for Health Research (NIHR) and the charity Wellbeing of Women. The views expressed are those of the authors and not necessarily those of Wellbeing of Women, the NHS, the NIHR or the Department of Health and Social Care. The funders had no role in study design, data collection and analysis, decision to publish, or preparation of the manuscript.

https://www.nihr.ac.uk/

https://www.wellbeingofwomen.org.uk

## Summary

This review brings together the views of women and maternity care professionals on routine discussion of previous trauma in the perinatal period. We included 25 papers, from five countries, published between 2001 and 2022.

Women and clinicians generally felt trauma discussions were valuable provided there was adequate time and resources. Women were more likely to disclose trauma when they had a trusting relationship with the clinician, but some women chose not to share their histories regardless. Hearing trauma disclosures could be emotionally difficult for clinicians.

National guidelines are needed to help midwives navigate discussions with pregnant women about past traumas.

## Background

One in three pregnant women have experienced difficult or traumatic experiences such as sexual abuse or violence in childhood or adulthood.[1] This equates to a quarter of a million pregnant women in the UK each year. Traumatic experiences can have long term effects on women's mental and physical health, their relationships with others, and how they feel about themselves.

Pregnancy can be a difficult time for women with trauma in their past. They can find themselves reflecting on their own childhoods for the first time, and some women who do not remember their abuse begin to get flashbacks.[2] Aspects of maternity care can also be challenging, such as vaginal examinations, or more broadly feeling out of control. Some women face complex situations like the continued presence of the abuser in their life.

While the perinatal period can be a difficult time, it is also a uniquely powerful time to offer support. For many women, pregnancy is their first prolonged interaction with healthcare services. Perhaps particularly in continuity of care models, midwives are trusted professionals.[3] This can be a time of healing and an opportunity for support and improved care. However, strong social taboos can prevent women discussing these issues.

As awareness of the impact of trauma has grown, there has been a move toward pregnant women routinely being asked about previous trauma, usually at the booking appointment. Routine enquiry for lifetime history of abuse or trauma is beginning to be introduced in America, Australia and some trusts in the UK. For example, midwives in some trusts ask women at the booking appointment whether they have ever been sexually abused, and in healthcare services more widely there have been pilots of asking patients to complete adverse childhood experience questionnaires to discuss with their clinician.[4]

Routine trauma discussion has been introduced at a trust, rather than national level, so implementation is inconsistent and there is no national guidance on how to have these conversations or how to respond to a disclosure. There is little evidence that these conversations have any benefit for women, and they could be upsetting or increase unnecessary and unwanted referrals to safeguarding and mental health. Careful consideration and sensitivity are needed to ensure discussions of previous trauma create value rather than causing harm.

To understand whether routine discussion of previous trauma should be carried out, and if so, how, we reviewed qualitative evidence to find out the views of women and maternity care professionals on routine discussion of previous trauma in the perinatal period.[5] We use the term ‘routine’ to mean raising the issue with all pregnant women, rather than selectively for women who the

maternity care provider believes may have suffered trauma. We chose to talk about ‘discussion’ instead of ‘enquiry’ because trauma could be raised by maternity care professionals without direct questioning.

## Methods

The review is part of a doctoral study called the EMPATHY study: EMpowering Pregnant women Affected by Trauma HistorY. It is a critical participatory action research study and is supported by a Research Collective of experts by experience, voluntary sector experts, and specialist midwives. We involved the Collective in designing the review and analysing the findings. Before we began the review, the review team talked through our own beliefs about routine trauma discussion and how these beliefs could affect how we carried the review out.

The study was registered in PROSPERO with the reference number CRD42021247160. We used the terms ‘trauma-informed’ and ‘trauma informed’ to search the databases MEDLINE, CINAHL Plus, EMBASE, APA Psycinfo, and Global Index Medicus. Forward and backward citation tracking and key author searches were used to identify additional relevant studies. The searches took place in July 2021 and were updated in April 2022. We focused on qualitative studies, and the qualitative aspects of mixed methods studies, because the review is about understanding the needs and experiences of pregnant women, and of clinicians who care for them.

Included papers were uploaded to the software program MAXQDA Plus 2020 for thematic synthesis. We used a standardised data extraction form developed in Excel to record contextual and methodological information about each study. We assessed the quality of each paper using the CASP checklist for qualitative studies and excluded studies which scored ‘weak’ so that the credibility of the

review findings was not compromised by including studies with limitations in their methodology.[6] Data were synthesised using the method developed by Thomas and Harden, and we used the GRADE CERQual approach to assess confidence in the findings. [7] [8]

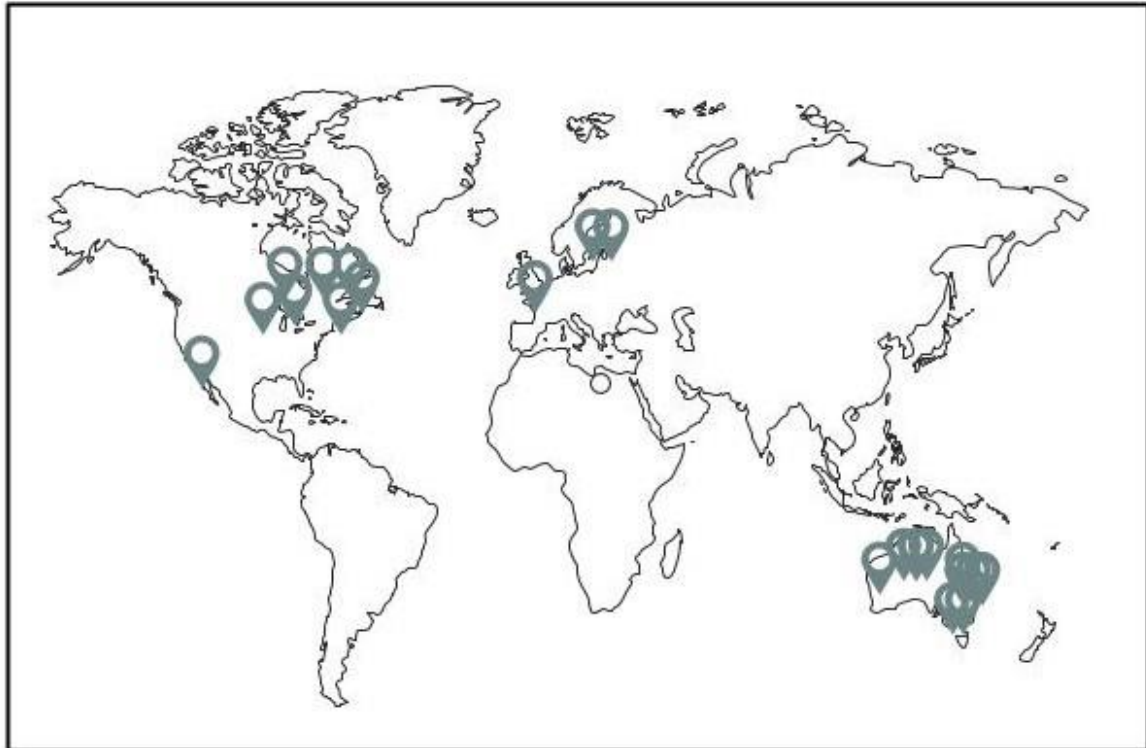
## Results of the search

After removing duplicates, we identified 3,888 papers, of which 25 met the inclusion criteria for the review. Three papers were excluded based on quality; including these papers would not have changed the final themes.

The geographical spread of the 25 included papers can be found at Figure 1. The studies were carried out in Australia (12), the United States (9), Sweden (2), England (1) and Canada (1). Trauma discussions were explored from the perspective of childbearing women in 13 papers, clinicians in 8 papers, and the remaining four papers looked at both viewpoints. The papers were published between 2001 and 2022 and included the views of 1,602 women and 286 maternity care professionals and experts from the voluntary sector.

*Figure 1.*

*Geographical spread of included papers*



Of the included studies, nine were assessed as methodologically adequate and sixteen strong. Confidence in the majority of review findings was high or moderate. However, all included studies were from high-income countries so the findings cannot be applied to low- or middle-income countries.

## Findings

We created six analytical themes, which are shown in Figure 2.

*Figure 2.*

*Thematic map*

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

Most women and maternity care professionals felt routine trauma discussion was valuable, even when women did not intend to disclose. Some participants said they would not disclose unless the clinician raised the issue:

*"At the time, I could not and did not tell the healthcare professionals of my survivor status. I did not know how to say it, and no one asked me".* [9]

However, many women found questions about previous trauma unexpected and intrusive, or felt that their previous experiences were not relevant to this pregnancy. Both women and care providers only supported routine discussion of previous trauma if there were adequate resources and time:

*"I only think that they should ask about them [adverse childhood experiences] if there is a known way to make a difference - in other words, if they are going to ask and nothing is done differently, then I don't think it is beneficial."*[10]

**'A real whitefella way to start': Standardisation and tick-boxes in trauma discussion**

Most of the studies had used questionnaires to ask about previous trauma, but some participants felt this was impersonal and could prevent disclosure, including this Aboriginal woman:

"*You talk about things because they are important to talk about not cause they happened one week ago*! *It is a real whitefella way to start*. *It's like you're in or you're out*. *You see that hey*? *Like what happens if it was a bit longer*, *then the lady might think oh no*, *it's not important*, *I won't talk about that."* [11]

Participants felt broad, gentle questions were more likely to encourage women to share their histories, but some care providers worried this would take too long or position them as a counsellor.

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

Women were very aware of the widespread belief that the abused become abusers, and concerns that they would be judged as a bad or even dangerous parent were a key barrier to disclosure:

*"You guys are bound by law [to report certain things]… You say it is confidential… but you are going to report me"* [12]

Women frequently said they wanted to establish a relationship with their care provider before discussing their prior trauma, and it took a few visits to establish that sense of trust and safety. If handled badly, participants felt this could create further distress and cause people to disengage from care or avoid health care in future. Participants in several studies said they would not disclose previous trauma to a healthcare provider, irrespective of whether they had a trusting relationship and were asked in a sensitive manner.

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

Participants often found the perinatal period challenging; they felt a loss of control and many suffered flashbacks during birth, vaginal examinations, or seemingly innocuous procedures like blood pressure measurement. Even women who appeared to be far along in recovery and living happy lives were often unprepared for the intensity of the perinatal period:

*"It's hard to put into words because I'm not quite sure what is going on*, *but I feel really super vulnerable"*. [13]

At the time of pregnancy some women were not fully aware of the trauma they had suffered, so even if they were asked, they would not be able to disclose. There was the potential for post-traumatic growth in the perinatal period, but that was not always easy:

*"I kind of knew in some way it was affecting me, but I just couldn't connect the dots ever… but when I got pregnant it all just came out, came clear, and it was hard, and I'm grateful… and I think it's going to help me grow past it and deal with it… but pregnancy is enough to deal with."* [13]

## Embedding trauma discussion in routine practice

Generally, clinicians felt routine trauma discussion was valuable and feasible within their workload. Partner presence at appointments was challenging, as some women may feel more comfortable with the support of their partner, but others may not have told their partners about their histories. Women with limited English faced an additional challenge, because they often did not want to share their experiences with the interpreter or the family member or friend interpreting for them.

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

Trauma disclosures were emotionally challenging for care providers and affected their stress levels: they worried about women and sometimes used unhealthy coping strategies like alcohol:

*"... I can debrief 10, 20, 30 times and the information is still with me, and I don't know where to channel that sometimes. Sometimes you channel that into other things that are probably not appropriate."* [14]

There was little consideration or recognition that many clinicians have themselves experienced trauma which can make these conversations particularly challenging. Clinical supervision was felt to be vital, but not all clinicians who were offered it chose to access it.

## Discussion and implications for practice

The review found that most women and care providers believe routine trauma discussions to be valuable. However, this is contingent on having adequate time

for these complex conversations, which is a serious caveat in understaffed maternity systems. [15] Many participants were caught unawares by the intensity of the perinatal period, exemplifying the difficulties in supporting women at different stages of recovery. Women with limited English may face additional barriers to disclosing trauma which include reluctance to disclose in the presence of an interpreter or lack of literacy in their own language.

There are clear recommendations for practice based on the findings of the review. Women should be forewarned that the issue of previous trauma will be raised to enable them to decide whether they would like to share this information. Staff should work with women to ensure that, within the limits of safeguarding requirements, documentation and information sharing is sensitive and acceptable to women. Where possible, previous trauma should be raised by a care provider who the woman knows, and after disclosure follow up maternity care should be provided by a known midwife. All women should be provided with information and support which they can access without having to disclose they have suffered previous trauma.

Discussing previous trauma can be challenging, and midwives need appropriate training and support. This could include training on the impact of trauma, basic counselling skills, safeguarding considerations and sensitive documentation. It is important that all staff working in maternity care are trained to support women who may have suffered trauma. The review found that hearing women's stories of abuse and violence can be upsetting for care providers, perhaps even more so if they have also suffered trauma. It is important that staff are well supported to understand and deal with the emotional impact of routine trauma discussions.

Using the findings from the review and subsequent interviews, we are working to develop national guidelines to help maternity care professionals navigate conversations with women about past traumas.

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