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DISCURSIVE PAPER

Trauma and the perinatal period: A review of the theory and practice of trauma-sensitive interactions for nurses and midwives

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Abstract

Aim: With high rates of trauma in the population, known links between trauma and perinatal distress, and the intimate and close nature of the nursing and midwifery roles, ensuring awareness and understandings of trauma is crucial for guiding practice. This paper aims to explore the relationship of trauma to the perinatal period, based on theory and practice, to consider on how nurses and midwives can deliver trauma-sensitive interactions.

Design and Methods: This discursive discussion draws on relevant research from the fields of trauma therapy, attachment theory and nursing and midwifery practice to consider elements of trauma-sensitive practice in the perinatal period.

Results: Nurses and midwives can foster safety for people who have experienced trauma through noticing and responding to triggers, supporting awareness of attachment and its relationships to trauma, undertaking psychosocial screening with care, supporting linearity and cohesion in narratives and developing collaborative care plans that maximise safety and agency. For nurses and midwives, understandings of the relationship between trauma, pregnancy, birth, early parenting and distress is crucial for effective care delivery. Delivering perinatal nursing or midwifery care of any kind, without universal trauma precautions risks reinforcing, misinterpreting or re-enacting dynamics of trauma. To be trauma-sensitive in this period requires nurses and midwives to have awareness of the dynamics of trauma in relation to pregnancy, birth and attachment.

Implications for the Profession and/or Patient Care: This paper fills a gap in the translation of theory to practice for trauma-sensitive care in the perinatal period, with a focus on the therapeutic relationship formed by nurses and midwives. The findings highlight that nurses and midwives can foster safety for people who have experienced trauma within their practice, when they hold a robust understanding of the relationship between trauma, pregnancy, birth, early parenting and distress.

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KEYWORDS
mental health, midwives, nursing, parenting, perinatal, pregnancy, psychological trauma

1 | INTRODUCTION

Internationally, lifetime trauma is recognised to be prevalent amongst the general population with 70% of adults reporting experiencing some form of trauma (Benjet et al., 2016; Kessler et al., 2017). Trauma refers to the lasting effects of exposure to life experiences, which are experienced as harmful, and encompasses the events or acts, and their effects (Isobel, Goodyear, & Foster, 2019). Traumatic events commonly include exposure to violence, abuse, neglect, accidents, coercion, control and manipulation (D'Andrea et al., 2012). Trauma can be related to single incident events that involve fear, or overwhelm coping mechanisms, sometimes referred to as 'simple trauma'; trauma can also be 'complex' when associated with cumulative or sustained exposure to similar or differing events (Wauthier-Freymann, 2014). Complex trauma is often relational and develops within important human relationships, comprising elements of betrayal or safety violation (Herman & van der Kolk, 2020).

Exposure to trauma can alter assumptions about self, others and the world and, as demonstrated by the seminal Adverse Childhood Experiences study, has well-known physical and mental health impacts across the lifespan (Anda et al., 2006; Felitti et al., 1998). People respond differently to trauma; some may show minimal distress across life domains and stages; others may have subclinical symptoms only be present in certain contexts; and a small percentage of people with a history of trauma meet criteria for trauma-related disorders (Bryant, 2019; Kessler et al., 2017). Indeed, resilience is the most common response to a traumatic event (Galatzer-Levy et al., 2018) and may be best understood as interwoven with trauma rather than distinct. Many of the 'symptoms' of trauma are coping mechanisms that have enabled survival (Herman & van der Kolk, 2020).

With trauma prevalent in society, it is inevitable that a significant number of people accessing perinatal services who are pregnant or have become parents will have experienced trauma in their lives that may impact upon their experiences of pregnancy, birth and early parenthood, as well as their interactions with perinatal care providers.

2 | TRAUMA AND INTERACTIONS

Trauma, particularly complex trauma, can impact upon experiences of trust, social safety, threat detection, sensitivity to power and closeness to others (Biruski et al., 2014; Hepp et al., 2021). Subsequently, people may not feel safe in interactions (Isobel & Delgado, 2018), although they may have developed effective or less effective coping mechanisms to manage this. Trust and a basic level of safety is essential for social engagement (Porges, 2022); however, when trust in the world or others has been violated, people may consider mistrust as a mechanism of maintaining safety (Bell et al., 2019). Feeling safe is a dynamic 'felt sense' and not an objective measure (Porges, 2022), and interpersonally can be chronically challenged by basic assumptions, and acutely disrupted by internal or external triggers.

Triggering refers to the re-experiencing of trauma-related effects including flashbacks or physiological responses in response to cues directly or indirectly reminiscent of trauma (American Psychiatric Association, 2013). Such cues do not need to be replications of traumatic events but can instead be sensory cues, sensations or experiences, and dynamics or settings. When traumatic effects are triggered, they are experienced in the present as relevant to the 'here and now' rather than linked to memories of the past (Sündermann et al., 2013). People often experience distress and physiological reactions when trauma memories are triggered (Raja et al., 2014).

Memories and their associated emotions are usually stored in the limbic system and integrated alongside other memories to form a cohesive autobiographical 'story' (Flemke, 2009). Nontraumatic memories are usually organised and processed logically. Traumatic memories, however, are stored differently, in part due to changes in the brain that occur during trauma to aid survival, such as decreased functioning of the hippocampus, Broca's area, prefrontal cortex and activation of the amygdala (Hull, 2002; Sherin & Nemeroff, 2022). Subsequently, memories from traumatic moments are frequently fragmented, lack cohesion or context, can be overwhelming and difficult to articulate or describe (van der kolk, 1998). Rather than being integrated into an overall narrative, traumatic memories can be experienced in the present with the emotions from the past—that is, overwhelming distress, fear, physiological responses or feelings of helplessness (Flemke, 2009).

3 | TRAUMA-SENSITIVE INTERACTIONS AND TRAUMA-INFORMED CARE

Many people who have experienced trauma experience multiple barriers to accessing and engaging in health care due to services not taking the possibility of trauma into consideration, not creating safety within interactions and inadvertently retraumatising or disempowering patients (Lovell et al., 2022). People may avoid services or disconnect due to mistrust, shame, distressing interactions or ineffective care (Reeves & Humphreys, 2018).

Awareness of, and sensitivity to, trauma is being increasingly recognised as crucial for all areas of healthcare delivery, including perinatal care. Calls for 'trauma-informed care' have occurred in obstetric and gynaecology (Nagle-Yang et al., 2022; Sobel et al. 2018), obstetric anaesthetics (Vogel & Coffin, 2021) perinatal psychiatry (Sachdeva et al., 2022) and midwifery (LoGiudice et al., 2023; Sperlich et al., 2017). Trauma-informed care (or trauma-sensitive care as it is referred to herein) describes a way of considering and delivering care, which is sensitive to needs of patients, clinicians and staff who may have experienced trauma. Trauma-sensitive care relies on principles of safety, choice, collaboration, empowerment and trustworthiness (Harris & Fallot, 2001); the principles then guide the delivery of care that is sensitive to the possibility of trauma in the lives of people accessing care and reduces the likelihood of trauma occurring in the course of care. Rather than being specific to certain populations, trauma-sensitive care is relevant to all people accessing

perinatal care (Hillard, 2019). For nurses and midwives, awareness of trauma and its effects is crucial to empathic engagement with people who may have experienced trauma. Yet, trauma awareness can appear theoretical without consideration of how it influences practice.

Rather than being specific to certain populations, trauma-sensitive care is relevant to all people accessing perinatal care (Hillard, 2019). Trauma-sensitive interactions refer to interacting with people in ways that assume the possible presence of trauma. Despite an increase in awareness about 'trauma-informed care', there is limited guidance for nurses and midwives around what trauma-sensitive interactions in the perinatal period may look like (Gokhale, 2020).

4 | STRUCTURE OF PERINATAL CARE

The perinatal period refers to the period around birth, commonly inclusive of pregnancy and the first year postpartum. It is a time of significant change. It can also be a time of reflection or introspection, loss of control over body, emotions and self, and a period of increased engagement with health services and bodily intrusive observations and interventions. Many of the healthy and less healthy coping mechanisms people use to minimise the effects of trauma upon their lives (such as exercise, drinking, or maintaining tight control over self and events) can be disrupted, alongside altered bodily autonomy and perceptions of self.

In addition to personal challenges, trauma is also linked to adverse physical and mental health experiences during pregnancy and early parenthood including preterm birth, instrumental births, low birthweight and postpartum distress and depression (Gokhale, 2020; Kuzma et al., 2020; McDonald et al., 2020).

In Australia, much perinatal care is undertaken by midwives and nurses. In the public health system, all people can access pregnancy birth and postnatal care through the universal Medicare system. This care is primarily provided by midwives and obstetricians. In some settings, midwifery-led care and community-based outreach midwifery is available. A total of 99% of parents in Australia birth in a hospital setting with 95% attending at least five antenatal appointments (Australian Institute of Health and Welfare, 2022). All parents who birth in public hospitals are linked to child and family health nursing services who then provide universal support to families from birth to 5 years (Schmied et al., 2014). Throughout this time, families may be referred to specialist perinatal nurses including for lactation or mental health support. These public services are free for all citizens, with similar models also available through private services.

5 | SCREENING FOR TRAUMA

Pregnancy can be a unique time of accessing services and an opportunity for assessment and intervention (Makregiorgos et al., 2013). People accessing maternity services have reported wanting to be asked about trauma (Millar et al., 2021). While screening for trauma does not necessarily occur in perinatal settings across the world, (Flanagan et al., 2018), processes for screening for trauma are well-established within perinatal services in Australia. Significant government funding has been contributed to establish universal screening within existing health services, with 79% of birthing parents reportedly being screened for emotional distress and psychosocial risk factors during the antenatal and/or postnatal period (Moss et al., 2020), usually by nurses or midwives. Screening occurs through a series of structured questions that midwives or child and family nurses ask at antenatal and postnatal time points, accompanied by the Edinburgh Depression Scale. Initial screening is incorporated into the comprehensive antenatal booking-in appointment for the purposes of identifying psychosocial risks and enable additional support to minimise adverse mental health outcomes (Dong et al., 2023).

While for many expectant parents, asking about trauma can be acceptable during pregnancy, others may be ambivalent or reluctant (Gokhale, 2020). This is linked to a lack of clarity about why screening occurs, a lack of sensitivity in approach and a fear of implications. Parents may position past trauma as disconnected from their current pregnancy (Gokhale, 2020), or may wish to not focus on the past during a future-focussed time. Nurses and midwives having sensitivity and confidence in talking about trauma is crucial. The literature suggests it is important to frame trauma inquiry as confidential and routine, explaining the relevance and potential benefit of screening and making resources available (Gokhale, 2020). It is also important to recognise the reasons why people may respond unexpectedly or disjointedly to questions about their lives and capability to link screening to care-planning to reduce exposure to feelings of shame or stigma.

Safety and trust are reciprocal and active processes that require constant attention when engaging in trauma-sensitive ways. This means that nurses and midwives need to read non-verbal cues that people may be experiencing distress or discomfort throughout screening, keep people focussed on the present through guidance, managing their own emotional states and ensuring enough time to undertake screening with care. Non-verbal cues of discomfort may include tense muscles, fidgeting, a lack of eye contact or increased breathing (Kuzma et al., 2020). Through listening and being curious, nurses and midwives can support linearity and cohesion of narratives even in brief interactions. It can be helpful to start interactions at the present by addressing what is currently happening for people, then carefully venturing back to the past through prompts and questions, with the aim of working the conversation back to the present by linking how the past may be impacting the present, and moving towards the future (such as plans for birth, hopes for parenting and support needs going forward). Such a structure to therapeutic engagement can make the overwhelming manageable for both the parent and the nurse or midwife.

During perinatal care, triggering of trauma can result in hypersensitivity, disproportionate distress or experiences of sadness, fear, pain, anger and shame. Like any healthcare encounter, triggering in perinatal care can occur within services through power differentials, a lack of transparency of process, screening and assessment,

layout of clinical settings and busy or distracted clinicians (Hall & Hall, 2013), and directly reminiscent bodily experiences. Hospital visits involving standard clinical procedures can iatrogenically trigger trauma responses; however, triggers can also occur in the course of any care from communication or interactions that unintentionally replicate dynamics of betrayal, boundary violation, objectification, powerlessness, vulnerability or lack of agency (Butler et al., 2011). In perinatal care settings, patients commonly experience intrusive procedures or questioning, a loss of bodily autonomy and sensations that unintentionally replicate traumatic experiences (Owens et al., 2021). While intrusive memories and flashbacks are commonly recognised as part of trauma responses, many people may also experience emotions and trauma-related responses without a memory of trauma; that is, they lack the awareness of what is occurring and instead may just experience disproportionate or inexplicable distress.

The lack of cohesion in some trauma memories, particularly complex relational experiences as opposed to single incident events, may result in people being confused about the order or nature of events upon screening, having gaps in memory or failing to recall details that seem significant (Ehlers et al., 2002), and emphasis on the details of moments or sensations rather than linear stories.

It is not possible or necessary to avoid all triggers during screening or other interactions. However, nurses and midwives can recognise the possibility of triggering occurring and respond to observed activation of people's autonomic trauma response systems. Approaches include noticing changes in people's arousal levels, using grounding strategies such as focussing on breathing or soothing tone of voice to help people return to a regulated state and supporting reflection on ways to collaboratively support safety. Scaffolding all interventions, including screening, with descriptions of the process, negotiation of consent and predetermined signals if a break is required can also assist. In this way, relatively small changes in practice can be beneficial for establishing the trust required for effective therapeutic relationships (Raja et al., 2014).

6 | TRAUMA AND ATTACHMENT

Rather than being linked to specific interventions or conversations, sometimes the triggering of trauma is sustained or interwoven into the experience of pregnancy itself. Trauma that has occurred within attachment relationships can be triggered during pregnancy and early parenting due to activation of the attachment system. For some people, pregnancy may be the first time they experience the effects of trauma; as the embedded nature of relational traumas is such that their effects may not be realised until a similar relationship is engaged in (Amos et al., 2011). That is, trauma from peoples own experiences of being parented can be triggered during the experience of becoming a parent themselves due to the attachment process.

Attachment processes begin prenatally through physical, kinaesthetic and intellectual awareness of the infant (Leifer, 1977). Many pregnant people experience complex attachment responses during pregnancy including preoccupation, closeness or distance, tenderness or irritation, and positive or negative feelings towards the infant. This can also present as fear, avoidance, anger, ambivalence or sadness. Parents may not link these emotions to attachment and may instead feel shame or confusion about their emotions. Attachment responses can commonly be explored by nurses or midwives through questions about preparation for the infant, visions of self as a parent and direct emotional responses to the foetus. While questions about how people feel about the pregnancy are common place in perinatal care, when undertaken with trauma sensitivity, the nurse or midwife should be attuned to not only the response, but the expressions of emotions, the content and the coherence of responses.

For parents with knowledge and awareness of their own attachment backgrounds, particularly those involving relational trauma, they may worry overtly about replicating the experiences of the past- leading to anxiety or 'over-protection' of their developing infant, expressed as perpetual worry, preparation and expectation. Alongside such experiences of preoccupying anxiety, are those who find themselves feeling strangely numb, awaking in terror or imaging themselves running away, despite being pregnant with a long-awaited or loved infant. While these experiences are not uncommon, they raise opportunities for nurses and midwives to support increased consciousness of the attachment process and how past experiences can influence the present.

While new parents may feel engulfed or overwhelmed by the reliance of their infant upon them, they may also concurrently experience positive emotions of joy, relief or happiness. Attachment experiences during pregnancy differ from early parenting attachment experiences as there are less opportunities for reciprocation. Without reciprocity during pregnancy, anxiety may embed as a mechanism of responding to experiences of fear and loss of control. Supporting understanding of how these unexpected experiences may relate to the process of attachment itself, rather than feelings about the infant directly can be a critical task for nurses and midwives.

7 | TRAUMA AND BIRTH

The process of birth may be a trigger for the activation of trauma memories and responses (Sachdeva et al., 2022). Parents have reported experiences of dissociation and flashbacks, as well as altered physical experiences (Leinweber et al., 2022). Care in the perinatal period is intrinsically intimate and frequently requires boundaries of self to be intruded upon, potentially re-enacting trauma. While the link to sexual traumas is apparent, vulnerability and the loss of safety, control and power during birth can be retraumatising for nonsexual traumas also (Long et al., 2022). The shock of birth not meeting expectations can also be traumatic (Sachdeva et al., 2022), although people can experience trauma, regardless of expectations (Leinweber et al., 2022).

Nurses and midwives providing care associated with birth can increase safety through vigilance to the possibility of triggering

trauma or retraumatisation, as well as enhancing agency and control. One strategy is through the collaborative development of birth plans with people with a history of trauma. These differ from traditional birth plans about hopes and wishes for pain relief or mode of delivery, and are instead focused on what may be helpful for healthcare providers to know and do in relation to supporting regulation during birth. Such plans can aid in identifying aspects of labour and delivery that may be particularly difficult, support retaining control and communicate coping mechanisms (Sobel et al., 2018). Developing trauma informed birth plans involves empathetic listening and inquiry regarding the type and degree of support the person desires (Owens et al., 2021). The intent is to create a sense of control and safety within whatever events occur. Plans may include avoiding intrusive examinations where possible, narrating choices, observing for cues of distress, seeking ongoing consent and identifying effective soothing techniques for when signs of stress beyond that expected by events are observed. Care with words is also essential, for example, avoiding phrases and platitudes that endorse compliance (Owens et al., 2021).

At times it is the process of birth itself that is traumatic with approximately half of new parents describing their birth experience as traumatic (Long et al., 2022). Like any other trauma, it is frequently the experience and effect not the events itself that comprise trauma particularly, feelings of powerless, fear, intrusion and betrayal by their body or those around them or responses or actions of professionals (Sobel et al., 2018). While many parents will openly identify that their birth was traumatic, it can be helpful for nurses and midwives to also be able to recognise possible trauma responses and respond sensitively. Recognising trauma responses requires awareness of the ways trauma can present and confidence in responding in ways that allow for distress while also supporting integration of traumatic memories. Recognising birth trauma also requires an openness to acknowledging that even experiences of 'good care' can be nuanced in their dynamics and effects. Many experiences of birth trauma are psychological and relational, embedded in interactions with care providers and dynamics of violation, betrayal or coercion (Reed et al., 2017).

Like any traumatic event, it can take a few days or weeks for initial emotional responses to traumatic events during birth to settle. Sleep is known to assist with processing traumatic memories (Zeng et al., 2021), with sleep, of course, difficult in the days and weeks after birth, prolonging the intensity of flashbacks and other intrusive ruminations. Nurses and midwives can reassure parents that intrusive memories, distress or rumination are usual processes and will settle, while supporting parents to safely engage with their memories. Reliving the event through storytelling may be helpful, with parents often going over events in attempts to make sense of what happened, however the focus should also remain on validating emotions and reactions rather than trying to justify or endorse actions or events. Many hospitals offer post-birth debriefs which can aid in building coherence and integration of memories of the extraordinary event into everyday life experiences (Selkirk et al., 2006). Postnatal debriefing differs from psychological debriefing after other traumatic events, as it is often undertaken by nurses and midwives, with a focus on listening, providing information, gaining a greater understanding of the birth experience and the facilitation of telling the story of the birth (Baxter, 2019).

Indicators of possible trauma responses beyond the first month after birth include how close to the surface distress is when talking about it. Often people may cry unexpectedly when talking about birth, suggesting a lack of integration of the memory (Scotland, 2020). Gentle questions about whether they experience intrusive memories of the birth or find it impacting upon their sleep and dreams may also help identify whether there is a need for more trauma-focused intervention. Helping people to understand how the body responds to trauma may also be beneficial. When something scary and threatening happens, the survival reflex is commonly to 'fight or flight'. When it is not possible to do so, other defence mechanisms are activated. Instinctually people may turn to those around them to protect them (in this case midwives, doctors or their birth partner) but if they feel stuck or helpless, then the instinct is to freeze. Freeze is a dissociative response which enables survival (Roelofs, 2017). When activated during birth it can leave people feeling like they should have done something but they did not and they do not know why they did not. It can be helpful for nurses and midwives to remind people that in a survival response, their automatic systems activate to protect them without conscious choice. Supporting parents to understand why they did not do anything differently is crucial as the brain will commonly ruminate on traumatic memories in an attempt to regain control and make sense of the experience.

Nurses and midwives may at times may feel unsure how to best respond to trauma, leading to avoidance. Listening and noticing can keep nurses and midwives focused while also facilitating connection. This may include noticing how people talk about the birth, what words they use, what metaphors or similes they use, noticing when they cry in the story or what moments seem 'stuck' leading to rumination. Moments that seem stuck are apparent in the retelling of trauma narratives (Scotland, 2020), where people may encounter bits of the story that appear difficult to make sense of or they keep returning to. Identifying these moments and spending time recognising the emotions and thoughts that occurred in that moment, can supporting integration into a cohesive narrative as fragmented memories are known to impair an individual's ability to coherently organise traumatic memories (Harvey & Bryant, 1999).

Responding to birth stories is already a standard component of much nursing and midwifery perinatal care and to do so in a trauma-sensitive way may not appear much different to usual practice but is underpinned by understandings of trauma, awareness of traumatic effects and a focus on fostering safety (Isobel & Delgado, 2018).

8 | TRAUMA AND PARENTING

Trauma can intersect with early parenting in many ways. Parents have described unique challenges such as those associated with breastfeeding and how they feel about their bodies (Sobel

et al., 2018). Many parents identify the period of early parenting as one of tumult and overwhelm. Parents who have experienced trauma may experience additional challenges in this period. This can include unexpected detachment from the infant as a defensive coping mechanism, feelings of being rejected by the infant, engulfed by the burden of care or overwhelming fear or worry about keeping the infant safe. Parents may also experience sadness associated with the intensity of their love and drive to protect their infant, as they reflect on why they were unable to be kept safe in their own life. Rather than being discrete experiences, how parents are cared for during the antenatal, birth and postnatal period impacts on how they manage early parenthood (Priddis et al., 2018).

Experiences of trauma are inextricably intertwined with parenting and can increase the risk of postnatal distress, disrupted bonding, impaired development and attachment pathology (Long et al., 2022), but they can also be experiences which are processed or resolved within the parenting role, rather than concurrent to it. Resolving trauma does not erase it but moves experiences and effects to conscious awareness (Isobel, Goodyear, & Foster, 2019), and facilitates posttraumatic growth and meaning making. Resolving trauma and weaving it into the conceptualisation of self as parent is crucial for parent wellbeing, parent-infant attachment and preventing intergenerational impacts of trauma. Work in this area requires specialised skills, yet, nurses and midwives are well placed to start to help parents identify the need for trauma-specific parenting support, referring to appropriate services and guiding processes of mentalisation.

Mentalisation allows for thinking about both self and others as psychological beings, and considering underlying mental states and motivations when interpreting behaviours (Berthelot et al., 2015). This encompasses parents being able to separate their infant's distress and their own distress-triggered by the infant's (Isobel, Goodyear, Furness, et al., 2019). Parents' capacity to coherently structure their understanding of their own attachment experiences and its impacts is inherently linked to their narrative coherence of their infants' attachment, suggesting the critical opportunity that interactions with services and engagement in preventative interventions in this period can have. Infants develop a sense of themselves reflected in the eyes of their parent's delight in them (Winnicott, 2018). However, for parents who have experienced trauma, the reverse can also be true, with their sense of self bolstered by seeing their infant's delight in them. In this way, the bi-directional nature of attachment experiences can be both challenging and healing. Supporting mentalisation is key for many early parenting nursing and midwifery interactions, focused on fostering attunement to the infant, self-regulation and responsiveness to cues. Parents may also require referral to public and private child and family or perinatal mental health services that provide preventative or therapeutic attachment focused interventions embedded within the parent and child relationship, which concurrently support parental reflective functioning, self-representation, wellbeing and sensitivity (Broberg, 2000; Erickson et al., 2019). Nurses and midwives also play key roles in developing and advocating for access to short-term, cost-effective, trauma and attachment sensitive parenting interventions (Gregory et al., 2020).

During pregnancy, a shift occurs from seeing oneself as care-recipient to caregiver (Solomon & George, 1996). Parents' capacity to coherently structure their understanding of their own attachment experiences and their impacts is inherently linked to their subsequent infants' attachment. However, for many adults, they may not be aware of their attachment system until its activation during pregnancy. Attachment issues are often intergenerational; attachment disruptions can preoccupy parents' minds and distort responsiveness to the infant, leading to ambivalence (Siegel, 2006). To support parents to be able to respond to the needs of their infants, nurses and midwives need to hold in mind that people who have experienced trauma likely have compromised innate senses of security, leading them to require trauma-sensitive interactions that promote care, positive regard and support. Reflecting on parents' strengths and survival capacity despite adversity is also crucial, alongside acknowledging the dynamic nature of attachment and the capacity for recovery and learnt security. Midwives and nurses can play a key role in providing trauma-sensitive actions (See Table 1).

Experiences of pregnancy, birth and parenthood are not stand alone events but are entwined with the wider context of people's lives, including past experiences of trauma. They often require reconstructions of identity, attempts to regain embodiment in changing bodies and the disempowerment of healthcare, and mixed emotional experiences (Byrne et al., 2017). At times experiences may be both disempowering and empowering at the same time (Byrne et al., 2017) as the process of becoming a parent can involve immense joy, healing and strength, alongside suffering and despair. For many people who have experienced trauma, despite challenges and the need for sensitivity in interactions, the perinatal period is a time of incredible growth, resilience and life-affirming empowerment (Ward, 2020).

9 | THE POLITICS OF TRAUMA-SENSITIVE PRACTICE

Responding to trauma during the perinatal period requires disruption of mainstream discourses of pregnancy, birth and parenting. Discursive ideals around this period commonly maintain a dichotomy of 'magical and monstrous' (Gatrell, 2014), with parents expected to fit a binary of 'coping or not coping'. Feminist scholars have long critiqued depictions of mothering that obscure (largely) women's suffering, or place personal responsibility on people who are pregnant to manage their own emotions, while simultaneously exercising scrutiny and control through a risk framework (Law et al., 2021). Unrealistic and idealised narratives about pregnancy and parenthood, shape experiences and engagement with services (Law et al., 2021) and are likely amplified for people who have experienced trauma. While understandings of trauma should lead to trauma-sensitive care of individuals, recognising trauma in individuals does not remove the need to recognise the social and structural context in which trauma occurs (Muldoon et al., 2021), and which continue to silence the voices of survivors. While experiences of trauma are

TABLE 1 Key nursing and midwifery trauma-sensitive identified actions.

Identified nursing and midwifery trauma-sensitive practices	
In all interactions	• Have sufficient knowledge and understanding of trauma to ensure the provision of trauma-sensitive care to all patients, regardless of known trauma history. • Be guided by the principles of trauma informed care, underpinned by awareness of the prevalence and effects of trauma. • Pay attention to interpersonal cues of social safety such as posture, tone of voice, language, facial expressions and demeanour. • Be attentive to symbols and use of power, ensure transparency of processes, review environments and monitor milieu. • Hold in mind the possibility that people may have altered innate senses of security, leading them to require trauma-sensitive interactions that promote care, positive regard and support • Avoid generic trauma-sensitive practices and instead adapt interactions and actions to meet the needs of individuals and their family • Maintain awareness of the risks of vicarious or primary trauma occurring in the course of work, with a focus on systemic advocacy, collegial connection and self-care.
During psychosocial screening	• Foster sensitivity and confidence when talking about trauma, including during routine screening • Provide narration of the intent, purpose and usage of screening and interventions • Reduce experiences of shame or stigma through self-awareness, reading interpersonal cues and purposeful and respectful communication. • Support linearity and cohesion of trauma narratives through staging, listening and curiosity.
During antenatal care	• Use caution with clinical procedures, be guided by trauma informed principles to minimise dynamics of betrayal, violation, objectification, powerlessness, vulnerability, or lack of agency • Recognise the possibility of triggering occurring in interventions or interactions, and respond to observed activation of people's autonomic trauma response systems • Notice changes in people's arousal levels and where possible use simple grounding strategies to help people return to a regulated state. • Scaffold all interventions with descriptions of processes, negotiation of consent and pre-determined stop signals • Explore attachment responses antenatally through questions about preparation for infant, visions of self as a parent and emotional responses to the foetus, with attunement to associated emotions and cohesion. • Support parents to reflect on their own attachment processes to separate past attachment cognitions and emotions from developing connections with the infant.
Surrounding birth	• Increase interpersonal safety through vigilance to the possibility of triggering trauma or retraumatisation occurring during birth, and work to enhance agency and control • Collaboratively develop birth plans focused on supporting regulation during birth, including strategies for retaining control and accessing coping mechanisms • Use empathetic listening and inquiry to explore the type and degree of interpersonal support desired during birth to create safety and control • During birth, avoid intrusive examinations where possible, narrate choices, observe for cues of distress, seek ongoing consent and identify effective soothing techniques. Avoid phrases and platitudes that endorse compliance. • Recognise the possibility of birth being traumatic due to feelings of powerless, fear, intrusion and betrayal, regardless of objective events. • Reassure parents that intrusive memories, distress or rumination are usual processes after potentially traumatic events and support parents to safely engage with memories through debriefing or empathic listening. • Where possible provide postnatal debriefing with a focus on listening, providing information, gaining a greater understanding of the birth experience and the facilitation of telling the story of the birth
In the postpartum period	• Recognise possible trauma responses in the postpartum period and respond sensitively to support the integration of traumatic memories and attachment experiences. • Recognise indicators of possible trauma responses beyond the first month after birth and support identification of need for trauma-specific interventions or referrals for birth trauma. • Facilitate connection through listening and noticing how people talk about their birth and early parenting experiences, what words they use, what metaphors or similes they use and how they are feeling about their parenting identity and infant. • Emphasise positive coping strategies, resilience and parenting capacity. • Have an understanding of intergenerational trauma and attachment to support the development of parenting and family identity alongside challenges. • Support mentalisation and separation of the infant and parents' distress. • Foster attunement to the infant, self-regulation and responsiveness to cues, with awareness of the bidirectionality. • Confidently reflect on, observe, validate and explore attachment related experiences, emotions and cognitions to support awareness and integration. • Help parents identify the need for trauma-focused parenting support when necessary and refer to appropriate services • Reflect on the interwoven nature of resilience with all experiences of trauma.

universal, complex trauma is a gendered phenomenon with women more likely to have experienced relational forms of trauma (Herman, 1992). Power cannot be divorced from experiences of trauma and also influences which voices are heard and validated. Birth trauma, for example, remains under researched compared to other forms of trauma (Fameli et al., 2023). While trauma awareness is important, medicalising trauma (like birth) can also lead to limiting understandings of the context of trauma, and long-held individual and community embedded ways of coping and thriving.

Modern trauma theory is underpinned by feminist values, emerging from the women's liberation movement and emphasising the socio-political context of people's lives, in particular the high levels of trauma experienced by women, and the impact of these experiences on their mental health (Herman, 1992; Tseris, 2013). Women's experiences of domestic and interpersonal trauma have historically been hidden behind awareness of the legacy of more male-dominated experiences such as combat trauma (Herman, 1992). Synchronously, feminist movements have also played key roles in critiques of medicalised responses to distress (Morrow, 2007). Feminist approaches are not exclusive to the needs of women, instead holding nuance to analyses of gendered power relations, allowing for recognition of diversity and recognising acts of resistance (Tseris, 2019). This can aid nurses and midwives in engaging beyond gender binaries to recognise the impacts of intersectional structural inequalities, including those linked to trauma. Nurses and midwives encounter lesbian, gay, bisexual, transgender, and other sexually and gender diverse populations daily, many of whom may have experienced trauma. Delivering evidence-based care for trans and non-binary people who birth, and across the perinatal period, is not a specialised clinical challenge but a fundamental part of regular care (Roosevelt et al., 2021). However, trauma-sensitive practice should not be generic, instead adapted to meet the needs of individuals and their family (Roosevelt et al., 2021).

While nurses and midwives enacting trauma-sensitive practice can appear like basic good practice, it is also a political act of reclaiming the humanistic ideals of nursing and midwifery, while acknowledging the often unacknowledged experiences of trauma survivors. Trauma is inherently political, and to bring it to shared awareness requires a context that holds space for the voices of those who have been disempowered (Herman, 1992). While trauma survivors have been disempowered, nurses and midwives have also been historically disempowered by medical hegemony. Fragmented hospital-based funding structures, such as those seen in Australia and many other high-income countries, concurrent to rigid policies and chronic under-resourcing, has led to devaluing of the professions. Despite gender diversity in the professions, nursing and midwifery have long been seen as 'women's duty' (Kane & Thomas, 2000) and the nurturing and caring aspects overlooked in paternalistic hospital and healthcare structures (Kane & Thomas, 2000). Yet, resistance is also apparent. For example, midwifery offers an alternative to 'patriarchal, technocratic medical models of care' through partnership and collaboration, reciprocity, equality, agency, emancipation and sharing of power to enable a holistic alternative to clinical biomedical birthing (Ashley et al., 2022). Similarly, mental health nursing centralises a relational approach to recovery in response to the medicalization of distress (Raingruber, 2003) and the biomedical and pharmacological dominance of psychiatry. Finding power as professions in providing trauma-sensitive to care to the people who access services, is in itself a revolutionary act.

10 | SIDE EFFECTS OF TRAUMA-SENSITIVE PRACTICE

With increased awareness of trauma, comes increased awareness of the risks that nurses and midwives face in their roles. Nurses and midwives may experience trauma through direct witnessing of traumatic events, or engaging with people who are experiencing events including pregnancy loss, traumatic deliveries, stillbirth, self-harm or child protection threats. Such events can lead to feelings of guilt, self-blame, and self-doubt, amplified by organisational cultures of blame (Shorey & Wong, 2022). Nurses and midwives often have their own experiences of trauma or experience guilt, horror or distress associated with their work (Choi et al., 2022; Leinweber et al., 2017).

Engaging closely and empathically with people who have experienced trauma, while also disrupting the status quo of services, can put nurses and midwives at risk of secondary and vicarious traumatisation. Secondary trauma occurs from stress associated with trying to care for people who have experienced trauma (Ratrout & Hamdan-Mansour, 2020), while empathic engagement and compassion with people who have experienced trauma can also be a precursor to the vicarious re-experiencing of the emotions of the person receiving care (Isobel & Thomas, 2022). Occupational trauma can also arise from medical authority overshadowing attempts to advocate for people who have experienced trauma or are distressed, leading to feelings of powerlessness and disillusionment amongst nurses and midwives. In the relationships between midwives and obstetricians, and those between mental health nurses and psychiatrists, an overemphasis on hierarchy has been shown to lead to conflict, misuses of power and defensive attitudes (Shorey & Wong, 2022). Thus experiences of wanting to practice in trauma-sensitive ways but feeling the organisation or hierarchy impedes this can also lead to experiences of moral distress, leading to anger, guilt and frustration (Tiedje, 2000).

While effective multidisciplinary team communication and collaboration is essential, a collective voice and commitment to the professional ideologies of nursing and midwifery (Kedy, 1993) can also minimise division within the professions and facilitate trauma-sensitive collegial interactions. People who provide care (such as nurses and midwives) often have the same needs as those who receive it: the need to not be isolated, to have their experiences heard and validated, to have opportunities to collaborate and share power and to reduce the likelihood of harm occurring in the course of care.

11 | CONCLUSION

During pregnancy, birth and early parenting many people have access to services that they do not have at other stages of their lives. They may engage in psychosocial screening and have conversations about their bodies, emotions and circumstances in intimate ways with health professionals for the first time in their lives. Many of these interactions are with nurses and midwives. This suggests a window of opportunity, and a necessity, for nurses and midwives to enact preventative and responsive trauma-sensitive interactions with all parents.

Trauma informed perinatal care requires nurses and midwives (and others) to prioritise supporting attachment, supporting regulation and co-regulation between the dyad and creating a safe space for parents such that they can then enact this for their infant. To be trauma-sensitive across this period requires awareness of the dynamics of trauma in relation to pregnancy, birth and attachment. Parents and parents-to-be who have experienced trauma are more likely to present to numerous perinatal care settings but also have difficulty engaging in care due to internal conflicts between ambivalence and hope (Muzik et al., 2013). Nurses and midwives are uniquely positioned to implement of trauma-informed care, however to do so requires more in depth knowledge of trauma and how it can inform care (Stokes et al., 2017). There are obvious barriers to nurses and midwives delivering trauma-sensitive care, such as lack of training, lack of time and inadequate resources. However even in brief interactions, trauma sensitivity can contribute to relational safety and enhance experiences of care.

With high rates of trauma in the population, known links between trauma and perinatal distress, and the intimate and close nature of the nursing and midwifery roles, ensuring awareness and understandings of trauma is crucial. Nurse and midwives can foster safety for people who have experienced trauma through noticing and responding to triggers, supporting awareness of attachment and its relationships to trauma, undertaking psychosocial screening with care, supporting linearity and cohesion in narratives and developing collaborative care plans that maximise safety and agency. To do so is also a form of activism against the silencing of people's experiences of trauma across the lifespan, during the perinatal period and in the course of work. Nurses and midwives may find engaging with the politics of trauma helpful in understanding resistance and power in the workforce. Interactions are reciprocal experiences and subsequently there is a need for ongoing nursing and midwifery led research into the challenges and possibilities of delivering trauma-sensitive interactions, alongside lived experience perspectives of birthing parents on the relationship of trauma to pregnancy, birth, early parenting and perinatal care.

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