

**Midwives' insights into birth trauma and awareness of
compassionate listening services after birth**

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**Investigating midwives' insights on birth trauma and awareness of
"Compassionate Listening Services after Birth" in South Yorkshire-UK**

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Abstract:

Background: This project was designed to explore community midwives' (CMW) awareness of birth trauma (BT), wider support and barriers to supporting those in need.

Aims: CMW's knowledge of specialist BT services and training requirements; along with psychological, physical, and motivational factors supporting those with BT were explored.

Methods: CMW's were interviewed utilising a COM-B framework and semi-structured questions regarding knowledge of signs/symptoms of BT, including experiences and barriers to identifying and support.

Results: The knowledge of the signs/symptoms and the identification and support of individuals with BT was broadly good, however some limitations in knowledge and resources identified.

Conclusions: The motivation of CMW's to support those with BT was strong. Nevertheless, specific barriers included time constraints, reduced continuity of care affecting the midwife-mother relationship. Cultural, social, and language barriers further limited abilities to identify/support individuals with BT or enable some women to disclose.

Keywords: Birth trauma; PTSD; COM-B model; Birth in Mind Services; compassionate listening services; community midwives

Key points: This article highlights areas for further consideration to improve care for women with birth trauma:

1. Community midwives' psychological and physical capability in identifying and supporting women with birth trauma.
2. Community midwives' knowledge of specialist services and compassionate listening services available for women with birth trauma.
3. Learning and resource needs of community midwives to support their understanding, confidence, identification and access to women with birth trauma
4. Psychological, physical and motivational barriers faced by community midwives supporting women with birth trauma

Reflective Questions:

1. How do the insights from this article reflect NMC Code principles like putting people first, ensuring safety, and upholding professionalism?
2. What insights did you gain from the article, and how have they enhanced your skills or practice?
3. Considering the article, what would you do differently to improve patient care?
4. How can you apply these insights to enhance your daily practice when caring for those with birth trauma?
5. What additional development needs have you identified, and how will you address them for ongoing professional development?

Background and aim of study:

Not everyone who perceives their birth as traumatic will develop Post Traumatic Stress Disorder (PTSD), and not all individuals with PTSD have experienced Birth Trauma (BT) (Egan 2025). There is no consensus on the definition of 'BT' or systematic methods for diagnosis (Elmir et al. 2010). Approaches range from asking women; to using trauma-based questionnaires. When there is ongoing emotional distress following a birth, this is often referred to as BT (Elmir et al. 2010). A NICE guideline (2018) defines BT as birth-related events that may be linked to the onset of PTSD, including trauma-related to serious health issues or childbirth experiences (for instance, intensive care admission or neonatal death).

The symptoms (Table 2) of BT can be significant and long lasting, impacting relationships and ability to live a normal life; with potential effects on cognitive development for some children (Parfitt et al. 2013). Community midwives (CMW) awareness of BT, the signs and symptoms, how to refer to specialist services is crucial for the delivery of appropriate care and support for individuals.

The project aims to build on prior related research (O'Donoghue et al. 2024; Long et al. 2024; de Vries et al. 2020; Huang et al. 2019; Stokes et al. 2017; Reed et al. 2014) by exploring CMW's perspectives of BT, to provide information to policy makers and service providers on how to better support CMW's. Questions were designed to explore CMW's perceived role in supporting women distressed following childbirth; evaluate potential barriers and facilitators to identifying and providing support to those recovering from traumatic birth; with particular emphasis on supporting women from vulnerable black, brown, and minority ethnic groups.

This project utilised the COM-B framework (Michie et al. 2011) to structure questions around the three main components crucial to behaviour change (Capability, Opportunity and Motivation). These components interact, containing sub-themes (see Image 1), which were used as an evidence-based

model to help to categorise questions (Appendix 1) and collate information from interviews (Appendix 2) to explore the main barriers and facilitators to CMW's supporting those with BT.

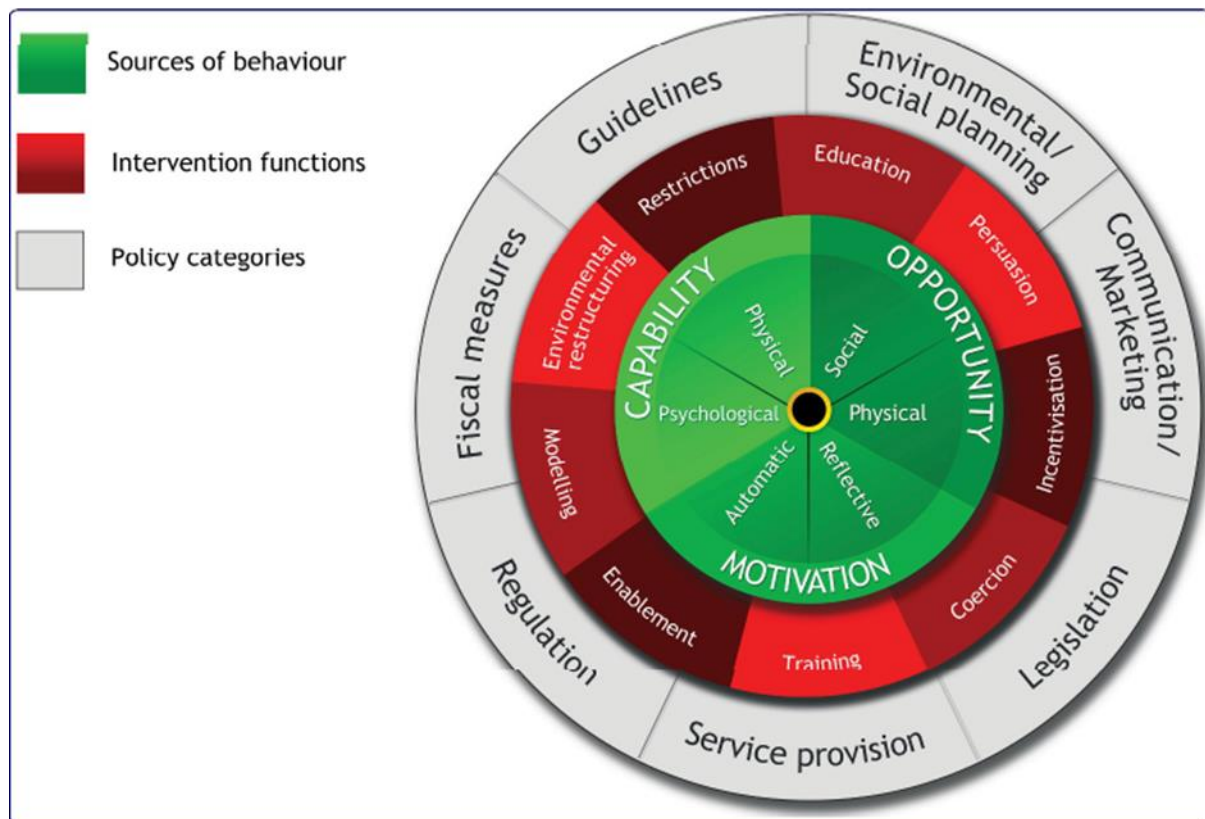


Image 1: Reproduced with kind permission: From: Mitchie et al. 2011 – The Behaviour Change Wheel: A new method for characterising and designing behaviour change interventions

Methods

Study Design: After obtaining consent, data was collected through virtual semi-structured interviews (30 minutes) recorded on Microsoft Teams; and included questions (Appendix 1) based on the COM-B model (Mitchie et al. 2011). Audio was transcribed separately, pseudonyms were used, and personal data securely stored.

Participants: A purposive sampling strategy was used to recruit participants, defined as ‘qualified midwives working in the community setting’. Three South Yorkshire maternity hospitals were identified offering birth trauma and Compassionate Listening Services for women post-childbirth. An invitation to participate was sent via the work email from the Community Matron or Head of Midwifery.

Data Collection: Psychological Capability was assessed (Table 2) through a knowledge evaluation of the 26-item signs/symptoms of BT defined by Ayers et al. (2018) and three questions exploring understanding of BT, postnatal depression (PND) and postnatal anxiety (Table 3). Twenty-one predefined interview questions were developed by the Psychologist in the research team, to explore 'Capability', 'Opportunity', and 'Motivation' in caring for women with BT (Appendix 1).

Data Analysis: Qualitative analysis of interview data used an inductive thematic analysis method per Braun & Clarke's (2006) six-stage process, including familiarisation with the data, initial coding of the transcripts, comparing and merging results, combining codes into the broad themes focused on the COM-B structure. Themes identified were reviewed and refined by the whole team, ensuring they accurately reflected the 'Thematic Map'. An iterative approach confirmed the themes and subthemes captured the essence of the data and addressed the research questions.

Reflexivity: We acknowledge as researchers, our backgrounds may contribute bias in viewpoints when analysing data, to mitigate this, the team ranged from different professions, ethnicities and backgrounds, we met regularly to review and explore our interpretations of the data.

Ethical Considerations: - Ethical approval was granted by the South Birmingham Research Ethics Committee (REC reference: 21/WM/0207). Local Research and Development (R&D) approval was obtained from each site, along with a Principal Investigator (PI) identified to facilitate the study.

Results

Seventeen midwives attended for interviews out of the twenty recruited, between May to July 2022, all were employed and working as a CMW. Themes identified (within COM-B framework), along with supporting quotes, are in Appendix 2 and summarised in Table 1.

Table 1: Main themes and sub-themes from interview analysis (using COM-B structure for analysis) exploring barriers and facilitators to CMW's providing appropriate support to those with BT		
COM-B themes	Sub-themes	Examples of sub-themes
Capability	Psychological	<ul style="list-style-type: none"> • Loss of control • Not as expected • Interactions with healthcare staff • Women's perception of trauma • Injury for Mum or Baby
	Physical	<ul style="list-style-type: none"> • Time • lack of continuity • language or cultural barriers • Stress & pressure • overworked, too much to do • burnout • knowledge around trauma care and MMH
Opportunity	Physical	<ul style="list-style-type: none"> • Time restrictions • Specific training needs identified around birth trauma • Continuity of carer helpful • Cultural and language barriers • Screening tools to help identify trauma • Additional support services were identified and referred to
	Social	<ul style="list-style-type: none"> • Team leader support • Specialist midwife support • Relevant mandatory training • Matron/supervision • Some felt they had no support • More time/ good staffing • Rapport with service user, more likely with continuity of care • Help when Language/communication barriers • Education about trauma and services available to support • Lack of private space to discuss due to busy clinics
Motivation	Reflective	<ul style="list-style-type: none"> • view their role in signposting/referring to and liaising with additional support services • Listening role and/or debriefing • Advocacy role and coordinating care • Feel confident in identifying and supporting birth trauma • Aware of impact on mental health if trauma not supported or addressed at the time e.g. bonding, delay having children, request ELCS in future pregnancy. • Potential impacts of not helping motivates some to support/signpost/refer

	Automatic	<ul style="list-style-type: none"> • Feels it's their responsibility as part of their job • Wants to make a positive difference to reduce harm, especially as some witnessed impact of trauma when not supported • Feel they are caring people • Satisfaction in helping people • Receiving positive feedback from clients • Identify there are challenges to helping, barriers in access, communication, language which can effect motivation
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Midwives reported varying contact with women based on hours worked and care model, averaging 39 weekly interactions (5-100). When asked about proportion they met with traumatic birth experiences, responses varied between 2-50% (mean=26%). Many felt that factors such as education, ethnicity, and socioeconomic status influenced women's birth experiences, their understanding, and ability to communicate BT to midwives, in turn affecting CMW's ability to identify cases. The midwife/mother relationship was highlighted as important for identifying BT sufferers, with limitations including lack of continuity of care and meeting someone postnatally for the first time.

Psychological Capability

Psychological capability and knowledge of BT signs/symptoms was good, all participants being aware of seven signs of BT (see Table 2) and over 70% familiar with 19/26 signs. Reduced awareness found for two signs/symptoms.

Table 2: 26-item signs and symptoms of BT (re-living aspects of the birth)	Aware of sign/symptom of BT N (%)
Feeling that the trauma is happening again (reliving)	17 (100%)
Thinking or experiencing images about an aspect of their birth when they didn't want to	17 (100%)
Nightmares	15 (88%)
Becoming distressed at actual or symbolic reminders of their birth	17 (100%)
Physical sensations such as pain, sweating, nausea, or trembling	14 (82%)
Alertness or Feeling on Edge	
Feeling on edge or very alert (hypervigilance)	14 (82%)
Becoming easily startled or upset	15 (88%)
Increased feeling of irritability	15 (88%)
Difficulty concentrating even on simple tasks	12 (71%)
Trouble sleeping	17 (100%)
Increased feelings of anxiety	17 (100%)

Feelings/behaviours of Avoidance	
Feeling like they always need to be on the move	7 (41%)
Avoiding people, places or situations that remind them of birth	16 (94%)
Feeling detached or numb	16 (94%)
Unable to remember details about their birth	14 (82%)
Difficult feelings/beliefs	
Struggles to trust others, particularly healthcare staff	16 (94%)
Feels like their baby needs to be close to them at all times	12 (71%)
Avoids bonding with their baby	16 (94%)
Self-blame for what has happened	17 (100%)
Feels alone and that nobody understands	17 (100%)
There is nowhere that feels safe	6 (35%)
Overwhelming feelings of sadness, shame, guilt, anger	17 (100%)

Opinion was varied on the differences between BT, postnatal depression, and anxiety, with all participants agreeing one could experience all three simultaneously (Table 3) but most agreed ‘signs’ were not the same.

	Answer	N	100% (N =17)
Are the signs of postnatal depression and birth trauma: different conditions, are similar or are the same?	Different	4	24% (4/17)
	Different but similar	4	24% (4/17)
	Similar	8	47% (8/17)
	Similar but different	1	6% (1/17)
	The same	0	0% (0/17)
Are the signs of postnatal anxiety and birth trauma: different conditions are similar or are the same?	Different	4	24% (4/17)
	Different but similar	3	18% (3/17)
	Similar	8	47% (8/17)
	Similar but different	2	12% (2/17)
	The same	0	0% (0/17)
Can someone experience birth trauma, PND and postnatal anxiety together?	Yes	17	100% (17/17)

Dominant themes of causes of BT included women feeling a ‘loss of control,’ the gap between expectations and reality, harm from healthcare interactions, and physical injuries to mother/infant. Many described the difference between their experience/perception of a traumatic birth could often be different to their expectation; the importance of appropriate questions, rather than assumptions was highlighted.

'... you think, God, you've had a really good birth and actually they're very traumatized by it. So, I don't think it relates necessarily to the type of birth that you have or, kind of, the events within the birth. I think it's women's perception of those events.' (Part.12)

Many described how this posed a challenge for identifying vulnerable people.

Physical Capability

When asked about limitations in identifying and supporting those affected by their birth, the primary response was time constraints. Large workloads led to fatigue and stress, impacting the ability to provide quality person-centred care. Some felt time pressures restricted their capacity to support those with BT, making them less likely to ask open questions or create opportunities for conversation, thus reducing the chances for women to disclose trauma.

'...that does impact the fact that you've not that time to then sort of delve into things with them because you know that's gonna have a knock-on impact on the rest of your day.' (Part.7)

Some described time pressures causing stress, resulting in feelings of dread or avoidance and feeling the need to work 'efficiently', therefore not providing 'safety' to discuss emotional issues,

'I've just thought, oh God, I hope there's no problems today, that no one cries, I hope, because then you've got to deal with it. And it takes longer. And you're aware then people are waiting. It's awful. It's awful to say that, but it's true.' (Part.2)

Some described multitasking to deliver all the care required and acknowledged this may not create an environment conducive to identifying trauma. Most described the need for extra time to support women with trauma

'...the 30 minute slot often cannot be quite enough for ladies that really do want to talk and go through previous birth experiences and their anxiety.' (Part.4)

A consistent theme was the desire to support mothers, however, some felt physically unable without approaching 'burnout'. One midwife mentioned 'always making the time' by working longer (unpaid) hours, including evenings and weekends, but noted that this led to sacrificing personal time with her family to care for clients.

Physical Opportunity

Midwives identified the resources needed to assist birthing individuals affected by BT. Time pressures were noted as a limiting resource, over half felt insufficient time hindered their ability to identify affected individuals. A third acknowledged despite lack of time they would 'make the time' by working over. Managing short-staffing, sickness, and leave created challenges, leading some to burnout. Training needs were identified as crucial in the identification of BT

'to have the information about the signs and symptoms of trauma as well, to know what you're watching out for and what you might need to refer on to'. (Part.16)

Most were unaware of specific tools/psychological measures for BT screening. Some mentioned using general mental health tools, acknowledging they weren't specific for BT. Cultural and language resources, e.g leaflets, posters, and interpreters, were felt to be valuable for connecting/communicating with women from different cultures. Some described the 'Continuity of Carer' model was a resource that would aid in the identification of trauma and help develop midwife/mother relationships.

'..so a lack of continuity and them not already knowing me as a person so not feeling comfortable enough to tell me about it, I think does does hinder it' (Part.15)

High-quality discharge summaries were considered essential; many suggested adding emotional and psychological health sections could be added. Most were aware and utilised support services for BT, particularly the 'Birth in Mind' (also known as 'Birth Afterthoughts') and Perinatal Mental Health (PMH) Services.

Social Opportunity

Midwives noted that Team Leaders and specialist midwives, such as those from Psychological Wellbeing Services, were their primary sources of social support for addressing BT. A third of the interviewees felt insufficient support was available. Additional support mentioned included mandatory training (n=4), Supervision (n=2), psychologist (n=1), Matron (n=1), and GP (n=1).

Consistently, time was a dominant theme creating barriers to supporting those with BT, alongside lack of continuity, connection, and trust. A third of those interviewed noted their lack of knowledge of BT hindered their supporting mothers.

It was described how some women may feel ashamed to ask for help or disclose mental health issues, whilst some might not recognise their trauma, and it was felt cultural stigmas may also cause women to withhold information from midwives.

One midwife highlighted how environment may pose a potential barrier to identifying and supporting women experiencing BT, for instance, non-confidential or overly public settings, thin walls, and limitations in the physical spaces making individuals less likely to disclose any issues.

Reflective Motivation

Interviewees emphasised that all maternity care providers should support individuals affected by BT, particularly midwives, obstetricians, perinatal mental health specialists, and psychological well-being midwives. Additionally, one added community managers have a role also.

When asked about their role in supporting those affected by BT, many mentioned guiding, referring, or communicating with other services while being supportive listeners. Fewer than 50% identified as coordinators who manage/coordinate additional referrals.

When asked how capable they considered themselves in identifying and supporting BT, half felt 'quite confident', with five 'very confident'. A few who felt confident expressed some reservations, for example:

'If I was seeing a lady..... who I've not met all through a pregnancy, I'm not gonna pick up on any sort of difference in mannerism, that she's behaving differently'. (Part.7)

Those who felt less confident were asked what would help to increase their confidence; they described education of signs/symptoms of BT and 'harm reduction'.

Overall, awareness of the consequences of not addressing BT was strong and most felt women might endure ongoing distress and risk further mental illness. Dominant themes included anxiety about future pregnancies, relationship breakdowns, and issues bonding with their child. Some may delay or decide against more children, despite initially wanting more. A few discussed significant harms from untreated trauma, such as neglect or suicide. Some believed untreated trauma could increase caesarean rates, distrust of health professionals (HP) or negative attitudes towards pregnancy due to untreated trauma. Most expressed motivation to address identified harms by inquiring about women's mental health and signposting/referring to additional support. The opportunity to positively impact women's lives drove their efforts.

Automatic motivation

When asked what motivates them to support distressed mothers after birth, most said it was their job, with some adding they loved making a positive difference in mothers' lives. *'I do my job because I care about the impact that you can have on somebody's life'.(Part.12)*

Most expressed wanting to care for women was a motivating force; and this quality maintained their motivation, to help women get the support they need. *'It's my job as a midwife and I do the job because*

I care' (Part.18). Many were motivated by making a positive difference to women's lives and positive feedback helped.

One midwife described total commitment to her caseload and midwifery...

'I don't just switch off when I go home.....on my days off I still check'. (Part.3)

Midwives were asked about the specific challenges that vulnerable and diverse groups of birthing women might face with BT. Most focus was on cultural, ethnic and language difficulties as the most significant challenges, making it more difficult for women to disclose information to HP or articulate what might be wrong.

'..even when we use interpreters, sometimes women don't feel comfortable explaining it to an interpreter, especially if kind of in their culture, mental health and things is frowned upon.'(Part.20)

The availability, quality and preference for female interpreters were raised as potential challenges when caring for non-English speakers, *'you can't get an interpreter on the phone sometimes because it's just not possible'* (Part.3) and some midwives discussed the barriers faced between using the telephone versus face-to-face interpreters.

'Sometimes you get great ones, but sometimes you don't get great ones..... So, there's a massive barrier there'.(Part.12)

Some felt a barrier to engaging/building rapport with HP was when women had busy lives or insufficient support, women might fear disclosing personal information, feel shame or be worried about judgement from HP. Some felt vulnerable groups may fear Social Services involvement, which may present a barrier to disclosing information.

'a lot of vulnerable women do expect that they're going to be judged.....and I think that can really compromise the ability for them to feel that they can safely open up and say exactly how they're feeling'.(Part.19)

Quality trauma resources/training for HP were felt essential for managing challenges, with emphasis placed on culturally sensitive screening and clearer referral pathways. Reducing stigma around mental illness through open discussions was felt important. Whilst specialist services are utilised; it was felt improved integration of services, peer support groups, and community support workers were needed, alongside increasing use of face-to-face interpreters for appointments beneficial.

Many midwives noted their personal experiences enhanced empathy for those affected by BT. Some shared their traumatic births, feeling these experiences increased their sensitivity towards others. A few either had no personal experience or chose not to discuss. No one felt prior experiences hindered their ability to support others dealing with trauma.

Some felt their professional experience and exposure to helping those with trauma had improved their communication, support, and advocacy skills in this area. One person discussed the importance of not saying 'platitudes' and personal experience, having taught them not to prejudge how they think someone might feel.

Discussion

This study provides insights into CMW's understanding of BT, their roles in supporting affected women, and the barriers they face in caregiving. Using the COM-B model (Michie et al. 2011), it identifies key factors influencing how midwives engage in support while identifying BT in daily practice.

Psychological Capability

Participating midwives had a strong knowledge of BT signs and symptoms, with over 70% awareness of 19/26 symptoms. This supports prior research indicating that healthcare providers understand trauma's common psychological effects (Huang et al. 2019; Williamson et al. 2021). Fewer than half recognised less common symptoms, such as feeling unsafe and needing to be in constant motion; this suggests that

while basic understanding is solid, it reflects findings from Vries et al. (2020) that more specialised training is needed to help midwives recognise the full presentations of BT symptoms.

Physical Capability and Time Constraints

Time pressures emerged as a critical barrier affecting midwives' ability to support women with BT. Many participants reported high caseloads, physical exhaustion, and stress due to the demands of their roles. The average number of women reported seen per week by participants was 39, with some midwives seeing up to 100 women in a single week. The workload demands limited their ability to ask open-ended questions and engage in meaningful conversations with women who might be experiencing trauma, aligning with previous studies that highlight the negative impact of time constraints on patient-centred care (Elmir et al. 2010). If there were fewer time restraints and higher knowledge of birth-related symptoms, midwives could identify and signpost to appropriate services sooner.

Many interviews revealed tension between a desire to provide compassionate care and the reality of overstretched resources. While some midwives committed to "*always making time*" by working overtime or outside their contracted hours, this solution is unfunded and unsustainable and can lead to burnout, as several participants noted. These findings underscore the need for systemic changes in workload management to ensure that midwives have the physical and mental capacity to support women experiencing trauma effectively.

Opportunity: Physical and Social

Regarding physical opportunity, the study identified several environmental and resource-related factors that impact midwives' ability to provide care. A significant theme was the lack of specific focused education and screening tools for BT, with many midwives relying on more general training and mental health tools, this highlights and reflects the finding by Reed et al. (2014); Long et al. (2024) and O'Donoghue et al. (2025) of the need and benefit of focused educational packages/resources when implementing a trauma informed framework across maternity services. The absence of culturally

sensitive resources, such as language support and interpreters, was also raised as a barrier, particularly for women from diverse backgrounds. This finding reflects the need for improved access to culturally appropriate care, echoing previous research that identified communication barriers as a significant challenge in providing equitable maternal care (Elmir et al. 2010).

Social opportunity was also discussed, with most participants noting the importance of team leaders, specialist midwives, and psychological well-being services as critical sources of support, this correlates with findings by Dr Vies et al. (2020) where most knew how and who to refer to. However, approximately a third of midwives felt insufficient support for addressing BT, suggesting a need for more robust social support structures within maternity care teams.

Motivation: Reflective and Automatic

Reflective motivation, or the conscious decision-making processes that guides behaviour, was strong among participants. Many midwives expressed a clear responsibility for supporting women with BT, often describing their role as "signposting" or "referring" to specialist services and providing emotional support, for which they are uniquely placed to provide, enhanced when continuity of care is provided. Importantly, all participants were aware of the potential harms associated with untreated BT, such as further mental health issues or affecting mother/baby bonding. This awareness motivated midwives to engage with BT, when possible, despite the barriers they faced.

Automatic motivation was also a significant factor, which refers to the emotional and intuitive drives behind behaviour. Many midwives cited their inherent caring nature and the desire to make a positive difference in women's lives as critical motivators for addressing BT. Some participants noted that personal experiences, either as professionals or through their own traumatic birth experiences, enhanced their empathy and motivation to support affected women. This finding is consistent with other research that suggests personal and emotional connections to patient care can improve healthcare providers' engagement with their roles (Williamson et al. 2021).

Implications for Practice

The findings of this study have several practical implications. First, there is a clear need for additional and focused training and resources to support midwives in identifying and addressing BT. Enhancing midwives' knowledge of less common symptoms and providing access to specific trauma screening tools could improve early identification and intervention. Additionally, addressing time pressures through more manageable caseloads and increased staffing would enable midwives to engage more fully with women experiencing BT.

Culturally sensitive resources, including interpreters and multilingual materials, are essential for ensuring that all women, particularly those from minority ethnic backgrounds, receive equitable care. Finally, strengthening the social support structures within maternity teams, including better access to specialist services and peer support, would provide midwives with the resources they need to support women more effectively.

Conclusion

This study highlights the complex interplay between capability, opportunity, and motivation in midwives' ability to support women experiencing BT and identifies areas where improvements in caring for women with BT can be made. While midwives generally have a strong understanding of the core symptoms of trauma and are motivated to provide support, significant barriers—particularly time constraints, training and resource limitations—hinder their ability to do so effectively. Addressing these barriers through training, improved resource allocation, and enhanced social support structures will be essential in improving care for women affected by BT in the future. Further research evaluating which tools/resources and training packages are most useful within the community setting is advised.

<u>Appendix 1 : Interview Schedule</u>
The following questions were asked as part of the interview.
Causes of birth trauma <ul style="list-style-type: none"> - What can cause a birth to be experienced as traumatic? - How many birthing women and people do you see approximately each week? - How many of these do you think experienced some aspect of their birth as traumatic?
Physical Capability <ul style="list-style-type: none"> - Which factors influence your ability to identify, engage and support those impacted by their birth? (for example, physical strength, stamina, burnout, stress levels).
<u>Opportunity</u>
Physical Opportunity <ul style="list-style-type: none"> - What resources do you need to be able to identify birthing women and people most affected by their birth? - Currently, do you have the time to identify those most affected by their birth? - Do you have access to psychological measures to screen for birth trauma? - Do you know which specialist services are available for birthing women and people affected by their birth?
Social Opportunity <ul style="list-style-type: none"> - What support do you receive which enables you to address birth trauma in those affected? - What are the barriers that prevent you from identifying or supporting birthing women and people experiencing birth trauma?
<u>Motivation</u>
Reflective Motivation <ul style="list-style-type: none"> - Which staff group(s) do you feel are responsible for supporting those who have experienced a traumatic birth? - What do you understand your role to be in supporting those affected? - How capable would you consider yourself in being able to identify and support birth trauma? - If participant doesn't consider they are capable, enquiry what would strengthen this? - What do you think would be the consequences if birth trauma wasn't addressed in your role? - In what way does this impact on your decision to address it or not?
Automatic Motivation <ul style="list-style-type: none"> - What motivates you to support those who are distressed following their birth? - What is it that maintains this motivation for you? - What specific challenges do vulnerable and diverse groups of birthing women and people face in relation to their birth trauma? - How could these challenges for vulnerable and diverse groups of birthing women be managed better? - Have you had any personal experiences which you feel helps or hinders you supporting those affected by birth trauma?

Appendix 2: Summary of Com-B themes and quotes			
COM-B components (Michie et al, 2011) COM-B components applied to:	COM-B components applied to MW knowledge of birth trauma and support available	Themes from this study	Illustrative quotes
Capability: <i>the individual's 'capacity to engage in the activity concerned'</i>			
Psychological capability: <i>'the capacity to engage in the necessary thought processes i.e. comprehension, reasoning etc.'</i>	Healthcare professionals' knowledge about birth trauma, signs, symptoms, and how to support	<ul style="list-style-type: none"> • Loss of control • Not as expected • Interactions with healthcare staff • Women's perception of trauma • Injury for Mum or Baby 	<ul style="list-style-type: none"> ➤ 'Definite physical trauma' (17) ➤ 'So, I think sometimes it's misconception of what to expect'(13) ➤ 'Feels like she's been messed about with or it can be things like if things haven't been communicated well'(8) ➤ 'Anything out of what they've perceived might happen'(17) ➤ 'it can be sort of physical trauma. It could be just not going according to plan....., sort of the physical trauma.....when it's all been rushed and everything's taken out of their hands..... problems with baby. The baby needs resuscitating. I mean, it's endless, isn't it? It's an endless list'(18) ➤ 'I think one of the biggest things is sort of lack of communication and lack of...erm...like, informed consent'(15) ➤ 'Just their expectations of birth and what they expected from it'(4) ➤ 'I think a lot of that will depend on the compassion and the care you get from the caregivers as well'(14) ➤ 'it might be that somebody's not being counselled appropriately afterwards'(14) ➤ 'ladies I have looked after there's been a massive spectrum of what they've considered to be traumatic in the birth'(5) ➤ 'And if women feel like they've had things done to them without their consent or without things being explained properly'(20) ➤ 'it's completely subjective and I don't think you can box people in and say this is a traumatic birth and this isn't. Because it's how it affects the individual'(5)
Physical capability: <i>'physical skills to enact the behaviour'</i>	Healthcare professionals' skills to communicate and support around birth trauma	<ul style="list-style-type: none"> • Time • lack of continuity • language or cultural barriers • Stress & pressure • overworked, too much to do • burnout • knowledge around trauma care and MMH 	<ul style="list-style-type: none"> ➤ 'Well, time. Time is obviously a key player in all of this'(19) ➤ 'How can you focus on a woman when you've got all this other stuff to deal with? It's impossible. We can't'(2) ➤ 'And that does impact the fact that you've not that time to then sort of delve into things with them because you know that's gonna have a knock on impact on the rest of your day'(7) ➤ 'Erm.. you try to obviously, you want to spend quality time with patients so that you can discuss things with them. Erm.. and we don't always get that'(17)

			<ul style="list-style-type: none"> ➤ 'We're all a bit tired aren't we' (14) ➤ 'Time and time. Always.....It's always something that I, I've always given. Tried to give women time to, you know, give me feedback when I see them post natally initially, you know, to talk through' (18) ➤ 'but I think for most of us, we generally just tend to fit it in and give the women the time we need, I mean. Most of the time we end up catching up with the other bits when we get home, on the night time'(14) ➤ 'I'd like more refreshers on mental health trauma, psychological well being, that kind of thing'(12) ➤ 'some midwives might be sort of feeling stressed, burned out and might not ask the right questions or might not, sort of, fully discuss the women's birth'(8) ➤ 'Sort of cultural barriers. I mean, sometimes not just women, women from other cultures, but sometimes mental health is still seen as quite a stigma'(8) ➤ 'There are cultural aspects that come into it I think, language barriers...erm... you know those kind of issues'(19) ➤ '..it's harder in a clinic setting because the appointments are more rigid. So you're aware that there might be someone waiting outside'(16) ➤ 'So a lack of continuity and them not already knowing me as a person so not feeling comfortable enough to tell me about it, I think does does hinder it'(11) ➤ 'You can usually pick up whether or not they're suddenly presenting differently, whereas if it's someone that you've never met before erm... you don't know anything about them, then that can make it more difficult'(20)
Opportunity: <i>'the factors that lie outside of the individual that make behaviour possible or prompt it'</i>			
Physical opportunity: <i>'afforded by the environment'</i>	How healthcare professionals are enabled or prevented from supporting women with birth trauma	<ul style="list-style-type: none"> • Time restrictions • Specific training needs identified around birth trauma • Continuity of carer helpful • Cultural and language barriers • Screening tools to help identify trauma • Additional support services were identified and referred to e.g. PMH and Talking therapies/IAPT 	<ul style="list-style-type: none"> ➤ 'I still don't think we have the adequate amount of time to... to be thorough'(19) ➤ 'Nobody's got time to listen to everybody's birth story'(2) ➤ 'You cannot really kind of unpack it. Those feelings too much in that small time period that you've got'(7) ➤ 'Again, possibly time to do things and maybe a clearer pathway and an easier pathway for sort of birth afterthoughts'(4) ➤ 'So, I do think there's always time for five minutes just to ask how everything's gone'(13) ➤ 'a lot of the time we are sort of, rushed off our feet, covering with, sort of, sickness and people that are off and people that have left that haven't been replaced'(8) ➤ 'so I think kind of having a bit of a history of that woman'(20) ➤ 'sort of publications would be would be useful and leaflets and things'(15)

			<ul style="list-style-type: none"> ➤ <i>'Maybe like some kind of Leaflet that we can give them or. Erm..we don't have very many resources for traumatic birth'(13)</i> ➤ <i>'an awareness of the signs and symptoms and maybe that being included in your routine postnatal check'(11)</i> ➤ <i>'resources and access to training for us about birth trauma, to be able to know the signs and and symptoms'(11)</i> ➤ <i>'Reduced continuity of care plays a good part because of obvious reasons'(19)</i> ➤ <i>'more refreshers about things like signs and symptoms and, like, kind of case studies, that kind of thing'(12)</i> ➤ <i>'more directed training, specifically for birth trauma'(17)</i> ➤ <i>'it's six weeks after delivery, so it's not an initial service because they might not of fully processed the birth and things before they speak to them and they kind of debrief them and go over, you know, what happened? Why it happened, things like that'(7)</i> ➤ <i>'we've obviously got our specialist midwives who we've got the birth afterthoughts as well'(3)</i> ➤ <i>'We have the perinatal mental health specialist midwife..... who we can refer to if we feel that she needs support from her'(5)</i>
<p>Social opportunity: <i>'afforded by the cultural milieu' which 'dictates the way we think about things'</i></p>	<p>Social influences/enablers to healthcare professionals supporting women with birth trauma</p>	<ul style="list-style-type: none"> • Team leader support • Specialist midwife support • Relevant mandatory training • Matron/supervision • Some felt they had no support • More time/ good staffing • Rapport with service user, more likely with continuity of care • Help when Language/communication barriers • Education about trauma and services available to support • Lack of private space to discuss due to busy clinics 	<ul style="list-style-type: none"> ➤ <i>'But actually my team leader was amazing'(3)</i> ➤ <i>'we get support from the GP's, from perinatal psychiatry...erm...you know these channels are open for us to tap into for help and advice and support'(19)</i> ➤ <i>'...as midwives, we do a lot of debriefing amongst ourselves'(17)</i> ➤ <i>'the specialist, she will talk to everybody on the mandatory study days every year'(5)</i> ➤ <i>'I would just directly refer straight to birth in mind for every woman even if I'm, not sure ... how severe it might be' (10)</i> ➤ <i>'Yeah, staffing. Time. How many clinics there are.....I don't think we're probably really following all these women up after they've delivered' (13)</i> ➤ <i>'I think sometimes the women just don't tell you, that's the biggest barrier'(20)</i> ➤ <i>'they might not tell you at booking, but they might tell you further down the line.....then is that a trust thing because they've, you've built up that confidence in them maybe' (10)</i> ➤ <i>'So one of the biggest barriers I feel is ... non-English speaking and it's difficult to gauge from them how they're feeling and then also because you've got that third party (interpreter)'(7)</i> ➤ <i>'Well, big one is language.... That's a massive one..... I suppose women don't open up, they keep everything inside' (18)</i>

			<ul style="list-style-type: none"> ➤ 'if someone doesn't wanna tell you, it's not the right time or the right space for them to do that, you're just guessing, really'(16) ➤ 'from perinatal mental health we get our yearly training. And they try to cover the birth afterthoughts and birth in mind..... yeah, it's only brief'(4)
<p>Motivation: 'all those brain processes that energise and direct behaviour'.</p>			
<p>Reflective motivation: <i>'analytical decision making', 'reflective processes (involving evaluation and plans)'.</i></p>	<p>How healthcare professionals analyse their motivation to discuss and support women with birth trauma</p>	<ul style="list-style-type: none"> • view their role in signposting/referring to and liaising with additional support services • Listening role and/or debriefing • Advocacy role and coordinating care • Feel confident in identifying and supporting birth trauma • Aware of impact on mental health if trauma not supported or addressed at the time e.g. bonding, delay having children, request ELCS in future pregnancy. • Potential impacts of not helping motivates some to support/signpost/refer 	<ul style="list-style-type: none"> ➤ '..and being able to, you know, either refer them or signpost them to what might be useful for them'(16) ➤ '..so probably a nice combination between just generally supporting, talking through things, referring on to different, you know, different people'(15) ➤ 'I feel like I can refer to the appropriate service and then coordinate care with that service to try and meet the needs of the woman'(12) ➤ 'Well, for me it's providing a listening service'(14) ➤ 'direct them to the right support and to give them space to talk about it'(11) ➤ 'So you could be like a sounding board for women'(12) ➤ 'And it's then my role really to follow that up and manage that to make sure she's managed to get that care that she needs and if there's anything else she needs from us'(14) ➤ 'It could snowball into a much bigger mental health issue. It could affect maternal bonding with baby And.....She could end up like chronically depressed and yeah, it could snowball into a much bigger thing if it's not identified and supports not given'(7) ➤ '..well it can lead to permanent, to...you know, it can lead to things like PTSD and erm...You know, fear of childbirth'(7) ➤ 'a woman who had birth trauma, who hadn't been, hadn't been picked up or and hadn't been referred on for intervention or support. Then that can have an impact on their relationship with the baby, of their experience of being a mom, their relationship with their partner'(16) ➤ 'So that's probably increasing the C-section rate definitely'(13) ➤ 'these ladies having these massive gaps between babies'(5) ➤ 'the woman could then sort of spiral into postnatal depression'(8) ➤ 'I would always address it and have a conversation with them. And if they didn't have a birth trauma, if they were, you know, just happy enough then, then. Fine. You've asked the question. You've been down that path with them, but you're always address it because like I said, the consequences on peoples lives could be massive'(5)

			<ul style="list-style-type: none"> ➤ 'Oh...it has a massive impact and when I do come across it, I always address it. I think it's like... it's it's vital'(2) ➤ 'but if they've then gone on to have a pregnancy where they've felt supported and they've felt like they made the right decisions for them.....and you see them postnatally.... and they're not more traumatised or they're happy with their care, then I feel like that's probably the biggest driver'(10)
<p>Automatic motivation: <i>'involving emotions and impulses that arise from associative learning and/or innate dispositions.</i></p>	<p>How professionals are motivated to support health behaviours in relation to their own (perhaps unconscious) emotions or understandings about those behaviours</p>	<ul style="list-style-type: none"> • Feels it's their responsibility as part of their job • Wants to make a positive difference to reduce harm, especially as some witnessed impact of trauma when not supported • Feel they are caring people • Satisfaction in helping people • Receiving positive feedback from clients • Identify there are challenges to helping, barriers in access, communication, language which can effect motivation. 	<ul style="list-style-type: none"> ➤ 'It's my job as a midwife and I do the job because I care'(18) ➤ 'It's my job! (laughs) It's the right thing to do'(16) ➤ 'I couldn't give you a reason. It's just what you do' (5) ➤ 'I couldn't be a midwife who was going to just, you know, push that to the side and let those women suffer'(10) ➤ 'so it's kind of wanting to see them at the end of it in a good place where they're enjoying being a Mom and having their baby and things'(20) ➤ 'Compassion and wanting to make the next experience better'(2) ➤ 'I want to have a good impact on patients'(15) ➤ 'I do my job because I care about the impact that you can have on somebody's life. And if you can make, even if it turns out it's only a small difference, you know, you feel like at least you you've given it your best shot for women'(12) ➤ 'I want them to have a pleasant experience and if they haven't had that then they need to understand why because I don't want anybody to suffer'(3) ➤ 'It motivates me every day seeing the ladies, seeing the babies, seeing them come back over and over again'(4) ➤ 'And the satisfaction you get from doing something like that is immense.... somebody coming out and saying thank you. Thank you for listening to me'(5) ➤ 'you probably do need to put some posters up in their own languages'(14) ➤ 'leaflets or referring them to some sort of way of accessing the information themselves, and again that being in different languages so that that women can understand it' (11) ➤ 'In terms of, like, the language barriers, I think using the interpreters more, I don't think we do, we're quite, you know, when you have got time pressures and they say ohh my husband will translate and it's very easy to do and just to be like, OK, yeah, we'll do that'(11) ➤ 'sometimes women don't feel comfortable like explaining it to an interpreter, especially if kind of in their culture, mental health and things is frowned upon'(20) ➤ 'I think a lot of women from these vulnerable groups, find it difficult to speak to healthcare professionals. Who I think, often they think are on a different wavelength to them in terms of their socioeconomic standing'(19)

			<ul style="list-style-type: none">➤ <i>'There may be a cultural thing as well where people don't want to discuss mental health'(7)</i>➤ <i>'you should be using an interpreter, but that can be a bit of a barrier, getting the nuances in difficult conversations like that, so might not be as easy to detect'(16)</i>➤ <i>'even if you're doing everything by the book, I still think it's gonna have some effect on the quality of the conversation that you're having about things such as birth trauma' (15)</i>
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