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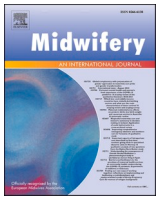

Review Article

A rapid evidence review of postnatal listening services for women following a traumatic or negative childbirth experience

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ABSTRACT

Problem: Currently there is a lack of clear guidance to underpin postnatal listening services for women who have had a traumatic or difficult birth.
Background: Postnatal listening (or birth reflections) services are important to help women review their birth and ask questions about their care, but currently there is no clear guidance on how these services should be provided.
Aim: To synthesise existing evidence on postnatal listening services for women following a traumatic or negative childbirth experience.
Methods: A rapid evidence review using four databases (PsycINFO, CINAHL, Medline, Web of Science), backward and forward chaining, and hand searches of previous systematic reviews. The Mixed Methods Appraisal tool was used to appraise the studies. Quantitative and qualitative data were synthesised into descriptive themes.
Findings: Database searches (n = 9,459 hits), backward and forward chaining and hand searching identified 27 articles for inclusion. Nineteen different services are described, evaluated as part of controlled trials (n = 16) or using quantitative and/or qualitative data (n = 8); three studies are audits of UK services. Findings are reported in 5 themes, *'Who provides the service?', 'Types and quality of care', 'Targeting the support', 'Timing and location',* and *'Training and experiences of maternity staff'*.
Discussion: The findings identify who, how, when, where and what should be provided within postnatal listening services. Services should be flexibly provided by trained maternity staff via active listening, empathy, and a non-judgmental approach.
Conclusion: Further work is needed to develop an optimum training programme, to identify key components of effectiveness, and to ensure these services are culturally relevant.

Introduction

Evidence highlights that up to 45 % of women perceive their child's birth as traumatic (Alcorn et al., 2010), and ~4 % of women in community samples develop childbirth-related post-traumatic stress disorder after childbirth (Yildiz, Ayers, and Phillips, 2017). Women who have experienced a negative or traumatic birth often report trauma-related symptoms including nightmares, flashbacks, avoidance (of people, places and events that serve as reminders) and low mood (Fenech and Thomson, 2014). Following a difficult or distressing birth women want opportunities to fill in the missing pieces, to have their birth experience validated, to help relieve feelings of blame, and to know what support is available (Affonso, 1977; Thomson and Downe, 2016).

A key intervention to help women process their birth memories is postnatal listening services. These services were introduced in the UK in the 1990s for women to review and discuss their birth with a maternity care professional (Charles and Curtis, 1994). While these services were originally developed based on structured psychological interventions, i.e., Critical Incident Debriefing (Parkinson, 1997), there has been a lack of clarity as to what constitutes postnatal 'debriefing'. Psychological debriefing is generally a one-off structured intervention designed to process facts, thoughts, and feelings to ameliorate psychological adversity (Parkinson, 1997). Postnatal debriefing is generally less structured, with the session being woman-centred and generally ill-defined (Steele and Beadle, 2003). An audit to explore postnatal debriefing services within two UK health regions offered a distinction as to what constitutes postnatal 'debriefing' versus 'good postnatal care' (Steele and Beadle, 2003). The authors postulate that opportunities for women to discuss and review what happened during the birth, how they are feeling and to be referred to additional support signifies 'good

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postnatal care'. Postnatal 'debriefing' represents a more therapeutic-based support that moves beyond these discussions by deliberating how women may feel in the future, normalising women's responses, providing therapeutic input, and consideration of sensory perceptions (e.g., what triggers women's negative memories) (Steele and Beadle, 2003).

Postnatal 'debriefing' is not recommended within maternity guidelines (NICE, 2014). This decision is based on a lack of effectiveness reported in Cochrane reviews despite the included evidence being heterogeneous in terms of trial designs, outcome measures, provider, and eligibility criteria (Bastos et al., 2015; Rose et al., 1996). A more nuanced interrogation of postnatal 'debriefing' interventions found that interventions targeted to women who experience trauma symptoms are efficacious (Sheen and Slade, 2015), and positive views of these services are reflected in qualitative findings (Baxter, McCourt, and Jarrett, 2014; Thomson and Downe, 2010). Furthermore, as postnatal 'debriefing' is provided by maternity carers, who either have or have not received any specific training (Ayers et al., 2006; Thomson and Garrett, 2019), and does not constitute psychological debriefing per se, it is considered more useful to refer to this support as a 'listening' (or 'birth reflections') service or 'childbirth review' (Sheen and Slade, 2015). In this paper, we use the term 'listening' rather than debriefing to clarify the distinction.

The current situation is that there is no best practice standards or guidelines on how postnatal listening services should be provided for women following a traumatic or difficult birth. Nevertheless, maternity trusts continue to provide these services in response to what women want (Kirkup, 2022; Thomson et al., 2021), but without clear evidence of effectiveness. To date only one review has integrated different forms of evidence about postnatal listening services undertaken a decade ago (Baxter et al., 2014): as this review described current evidence as well as hypothetical accounts, it is difficult to identify what components were important. We aimed to update this review and to only include actual accounts of interventions and services to identify what matters most. A rapid evidence review was undertaken as part of a larger project that aims to set up and evaluate a new postnatal listening (birth reflections) service for women.

Methods

Review aim and questions

The aim was to synthesise existing evidence on postnatal listening services for women following a traumatic or difficult childbirth experience to answer the following questions:

- What are the features of postnatal listening services?
- What is the evidence (outcome or experience) of the impact of these services?
- What are the facilitators and barriers to the delivery of postnatal listening services?

Review method

A rapid evidence review was undertaken enabling a systematic approach but with some adaptations to streamline and expedite the review process. The adaptions involved plans to adjust the search process had more than 5000 titles/abstracts been identified (although in this case no adjustments were needed), single-person quality appraisal (with 20 % accuracy check by another reviewer), and to produce narrative summaries of the findings rather than more detailed analyses (i.e., meta-analysis, meta-synthesis). We used the Preferred Reporting Items for Systematic Review and Meta-Analysis Protocols checklist (PRISMA) as a framework and followed rapid review guidelines (King et al., 2022). The review protocol was registered with PROSPERO (RecordID=406,290). A rapid evidence approach was used due to the restricted timescales of the project, and for the review findings to inform the next phase of the project - consultations with service users and providers.

Search strategy

Four bibliographic databases were searched on 13th March 2023, with a final search conducted before submission for publication on 11th March 2024: PsycINFO, CINAHL, Medline and Web of Science. Search terms are displayed in Table 1 and the search strategy was adapted to meet the truncation and Boolean operations of each database as appropriate. Backward (checking the reference lists) and forward (checking citations) chaining of included studies and hand searches of previous systematic reviews were undertaken.

Inclusion and exclusion criteria

Inclusion and exclusion criteria are detailed in Table 2. Eligible articles needed to provide insights into the features, and/or experiences of impacts of postnatal listening services from a provider or service user perspective. We included all types of primary peer-reviewed studies published in English.

Study selection

Records from database searches were exported to EndNote and duplicates removed, then transferred to Rayyan (an online web tool to support screening and study selection) with any further duplicates identified and removed at this stage. One reviewer completed all the screening, with 20 % of titles/abstracts and 20 % of full-text papers reviewed by a second reviewer. Any disagreements in screening decisions were made by consensus.

Quality appraisal

The Mixed Methods Appraisal tool (MMAT) (Hong et al., 2018) was used for quality appraisal purposes . In line with rapid review methodology guidelines (Garrity et al., 2024), 20 % of the papers were independently appraised by two reviewers, and single screening then commenced due to interrater agreement being higher than the recommended 80 %+ (i.e., 94 % agreement).

Data extraction and synthesis

A data extraction form was developed flexibly so data columns could be added as extraction continued. This form collected information including study country, design, methods, details of the implemented service, eligibility criteria, outcomes or experiences. The first author extracted data from all the studies, with the accuracy of 20 % of the extracted data checked by the second author.

All the papers were uploaded to MaxQDA (qualitative software programme) for data analysis purposes. Rather than discussing findings under each review question separately which could have been repetitive e.g., features of the service (review question 1) could also operate as a facilitator or barrier (review question 3), the data was narratively synthesised. Additionally, in line with the purpose of a narrative synthesis, rather than simply describing or summarising the data, we also investigated the similarities and differences between the postnatal listening services (Lisy and Porritt, 2016). This involved comparing key components of the included interventions (e.g., whether the intervention was targeted to those who reported a traumatic birth; delivered by trained staff; and whether the service reflected 'good postnatal care' or included 'listening-type service' elements (originally referred to as 'debriefing' by Steele and Beadle, 2003), against the study's effectiveness. A qualitative content analysis approach was used (Elo and Kyngäs, 2008), whereby narrative summaries of the quantitative findings were combined with the qualitative findings and subjected to line-by-line coding, merging the data into sub-themes and then descriptive themes that represented

Table 1
Search Terms.

Search Terms
postpartum OR postnatal OR labour OR labor OR delivery OR childbirth OR antenatal OR pregnan* OR birth OR perinatal OR intrapartum AND debrief* OR counsel* OR listen* OR "critical incident" AND trauma* OR difficult OR negative OR "Post-traumatic stress disorder" OR "post traumatic stress disorder" OR "posttraumatic stress disorder" OR PTSD OR distress OR anxiety

Table 2
Inclusion and exclusion criteria.

	Inclusion	Exclusion
Population	Parents or maternity care providers.	
Exposure	Postnatal (debriefing) listening services for service users to review and discuss their traumatic or negative birth experience with maternity care professionals.	Relating to listening services that do not concern a traumatic or difficult birth or not provided by maternity care providers
Outcome	Studies that describe the needs, activities, outcomes and/or experiences of postnatal listening services.	
Study types	All research study designs and peer reviewed published articles	Editorials, erratum, opinion pieces, conference abstracts, books and book chapters
Language	English only	Non-English

the whole data set. Analysis was undertaken by the first author and reviewed by the second author.

Findings

As reported in Fig. 1, the searches across the databases retrieved a total of 9,459 hits. After removal of duplicates, 5,106 studies underwent title and abstract review, of which 25 articles were deemed potentially relevant. Backward and forward chaining also revealed a further 18 articles that appeared suitable. These 43 articles underwent a full-text review and assessment of eligibility of which 16 were excluded (see PRISMA for reasons). The remaining 26 studies were included. The additional search conducted before submission for publication (March 2024) revealed an additional one article increasing the number of total articles included to 27.

Overview of included studies

Details of the included studies are displayed in Table 3. Studies were conducted in the UK ($n = 9$), Australia ($n = 7$), Iran ($n = 5$), Sweden ($n = 2$), Iceland ($n = 2$), China ($n = 1$) and Scotland ($n = 1$). Twenty-four papers discuss experiences or outcomes of postnatal listening services, and the remaining three were UK audits (Ayers, et al., 2006; Steele and Beadle, 2003; Thomson and Garrett, 2019). The papers describe 19 different postnatal listening interventions or services (see Table 3), 13 of which were evaluated as part of 14 controlled (or pragmatic (Meades et al., 2011)) trials, and these findings being reported in 16 different studies. Two studies report findings from the same RCT, but each reports a different outcome, e.g., depression (Abdollahpour et al., 2018) or post-traumatic stress (Abdollahpour et al., 2019). One trial (Small et al., 2000) also reports on the longer-term impacts of the intervention some four to six years later (Small et al., 2006). Two studies explored the efficacy of the 'Promoting Resilience on Mothers Emotions' (PRIME) midwife-led counselling intervention, first evaluated in Australia (Gamble et al., 2005) and then adapted for use in Iran (Asadzadeh et al.,

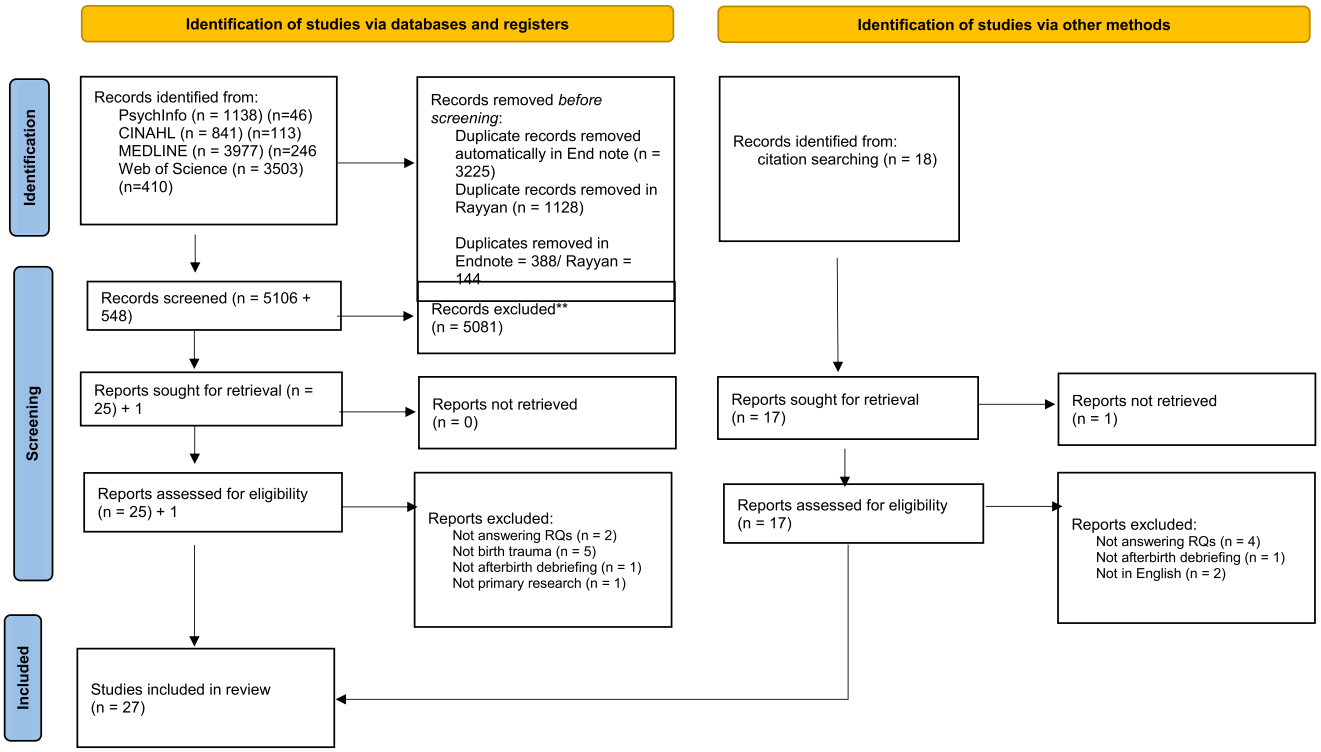

Fig. 1. PRISMA Flow chart of selection and screening process.

Table 3
Details of included studies.

First author	Year	Country	Aim	Participant type (and number)	Design	Measures and timings	Type/model of support	MMAT
Abdollahpour	2018	Iran	Investigate the effect of debriefing and brief cognitive-behavioural therapy on postpartum depression following traumatic childbirth	Parents (n=179)	RCT	Edinburgh Postnatal Depression Scale: 4-6 weeks and 3 months after delivery	Debriefing and CBT	**
Abdollahpour	2019	Iran	Determine the effectiveness of two counselling methods on prevention of post-traumatic stress after childbirth.	Parents (n=179)	RCT	Impact of Event Scale-Revised: 4-6 weeks and 3 months after birth	Debriefing and CBT	***
Asadzadeh	2020	Iran	Examine effectiveness of brief midwife-led counselling in decreasing post-traumatic stress disorder, depression, and anxiety symptoms among women who had experienced a traumatic childbirth	Parents (n=90)	RCT	Edinburgh postnatal depression scale, Hamilton's anxiety rating scale, 4-6 weeks, and 3 months after birth.	Counselling model (Gamble et al)	***
Ayers	2006	UK	Establish the type and availability of postnatal services in the UK for women who have a difficult or traumatic birth	Service providers (n=71)	Audit	N/A	Various	****
Bahari	2022	Iran	Determine the effect of supportive counselling on mother psychological reactions and mother-infant bonding following traumatic childbirth	Parents (n=166)	RCT	Edinburgh Postnatal Depression Scale, Post-Traumatic Stress Disorder checklist, and the postpartum bonding questionnaire, day after delivery and after 2 months	Counselling model of support	***
Bailey	2008	UK	Explore and evaluate women's experiences of the Birth Afterthoughts Service	Parents (n=7)	Grounded theory	N/A	Listening and information service	*****
Charles	1994	UK	Describe the service and findings of the service evaluation	Parents (n=48)	Service evaluation	N/A	Information and listening service	**
Fenwick	2013	Australia	Describe perceptions of participating in a study testing the effectiveness of a perinatal emotional support intervention (Promoting Resilience in Mothers Emotions; PRIME) by women identified as experiencing emotional distress after birth.	Parents (n=33)	Qualitative descriptive	N/A	Midwife-led counselling	*****
Gamble	2005	Australia	To assess a midwife-led brief counselling intervention for postpartum women at risk of developing psychological trauma symptoms	Parents (n=103)	RCT	Edinburgh Postnatal Depression Scale (EPDS), Depression Anxiety and Stress Scale-21. EPDS was repeated at 4 to 6 weeks, and all measures at 3 months. At 4 to 6 weeks and 3 months completed the Mini-International Neuropsychiatric Interview–Post-Traumatic Stress Disorder	Midwife-led counselling	****
Inglis	2003	UK	Establish elements of the service women found most useful as a means to informing its future development	Parents (n=46)	Mixed-methods	N/A	Debriefing	*
Kershaw	2005	UK	Determine if two debriefing sessions following an operative delivery could reduce a woman's fear of future childbirth.	Parents (n=319)	RCT	Wijma Delivery Expectancy Scale; Impact of Event Scale; 10 days, 10 weeks and 20 weeks postpartum. Midwives complete questionnaire.	Midwife-led debriefing	***
Lavender	1998	UK	Examine if postnatal "debriefing'' by midwives can reduce psychological morbidity after childbirth	Parents (n=114)	RCT	Hospital Anxiety and Depression 3 weeks after delivery.	Midwife-led debriefing	***
Meades	2011	UK	Evaluate postnatal debriefing as it occurs in healthcare practice	Parents (n=80)	Pragmatic trial	Edinburgh Postnatal Depression Scale; PTSD Symptom Scale before debriefing and one month later.	Debriefing	*****
Memon	2021	Scotland	Examines steps of midwifery afterthoughts service and maternal experience of a midwifery led afterthoughts service	Parents (n=66)	Survey	N/A	Debriefing	***
Mousavi	2022	Iran	Determine the effect of debriefing intervention on post-traumatic stress disorder (PTSD) following traumatic childbirth.	Parents (n=70)	RCT	Post-traumatic Stress Checklist; Edinburgh Postnatal Depression Scale (EPDS) before intervention and 4-6 weeks after childbirth	Debriefing	*****

(*continued on next page*)

Table 3 (*continued*)

First author	Year	Country	Aim	Participant type (and number)	Design	Measures and timings	Type/model of support	MMAT
Priest	2004	Australia	Test whether critical incident stress debriefing after childbirth reduces the incidence of postnatal psychological disorders	Parents (n=1745)	RCT	Postal questionnaire - Impact of Event Scale R; Edinburgh Postnatal Depression Scale at 2, 6 and 12 months postpartum.	Midwife-led debriefing	*****
Reed	2014	Australia	Describe midwives' experiences of learning new counselling skills and delivering a counselling intervention entitled 'Promoting Resilience on Mothers Emotions' (PRIME).	Service providers (n=42)	Qualitative descriptive	N/A	Midwife-led counselling	*****
Ryding	1998	Sweden	Try a model of early postpartum counselling for women after emergency caesarean section (emcs)	Parents (n=99)	RCT	Wijma Delivery Expectancy/ Experience Questionnaire; Impact of Events Scales; Symptoms Check List, few days, one month and six months postpartum.	Counselling model of support	**
Ryding	2004	Sweden	Test a model of group counselling for mothers after emergency caesarean section, and examine its possible effects	Parents (n=147)	RCT	Wijma Delivery Expectancy/ Experience Questionnaire; Impact of Event Scale (IES), and the Edinburgh Postnatal Depression Scale at at 6 months postpartum.	Group counselling	***
Selkirk	2006	Australia	Assess the effect of midwife-led postpartum debriefing on psychological variables	Parents (n=149)	RCT	Dyadic Adjustment Scale; State-Trait Anxiety Inventory; Edinburgh Postnatal Depression Scale; Perception of Birth Scale; Impact of Events Scale; Parenting Stress Index Short Form; T1; varied times frames 28th week of gestation and their delivery; a day or two after giving birth); 1 month after giving birth and 3 months postpartum.	Midwife-led debriefing	***
Sigurðardóttir	2019	Iceland	Explore women's experience and preferences of reviewing their birth experience at a special midwifery clinic	Parents (n=125)	Qualitative content analysis	N/A	Counselling model of support	*****
Sigurðardóttir	2023	Iceland	To describe the construction and evaluate the feasibility and acceptability of a postpartum midwifery counselling intervention for women following high-risk pregnancies.	Parents (n=30), Midwives (n=8)	Descriptive content analysis	N/A	Midwife counselling	*****
Small	2000	Australia	Assess the effectiveness of a midwife led debriefing session during the postpartum hospital stay in reducing the prevalence of maternal depression at six months postpartum among women giving birth by caesarean section, forceps, or vacuum extraction.	Parents (n=1041)	RCT	Edinburgh Postnatal Depression Scale (EPDS) and the SF-36 maternal health status measure	Midwife-led debriefing	****
Small	2006	Australia	Assess longer-term maternal health outcomes in a trial of midwife-led debriefing following an operative birth	Parents (n=534)	Follow-up of RCT	Edinburgh Postnatal Depression Scale (EPDS) and the SF-36 maternal health status baseline and 6 months.	Debriefing	*****
Steele	2003	UK	Explore current practice and describe the provision of postnatal debriefing in two health regions of England	Service providers (n=43)	Audit	N/A	Various	*****
Tam	2003	China	Examine whether proactive educational counselling, in addition to routine clinical care, reduces psychological morbidity and improves quality of life	Parents (n=516)	RCT	Hospital Anxiety and Depression Scale; World Health Organisation Quality of Life scale - at six weeks and six months post-delivery.	Educational counselling	****
Thomson	2019	UK	To explore afterbirth provision for women who have had a traumatic/distressing birth in NHS hospital trusts in England.	Service providers (n=59)	Audit	N/A	Various	****

2020). The remaining six postnatal listening services were evaluated using quantitative and/or qualitative data (Bailey and Price, 2008; Charles and Curtis, 1994; Inglis, 2002; Memon et al., 2021; Sigurðardóttir et al., 2019, 2023).

Outcome measures differed across the trials, with most measuring depression ($n = 13$) and/or PTSD ($n = 9$) as well as secondary outcomes such as anxiety/stress, fear of childbirth, or bonding. Most studies examined outcomes 4–6 weeks after delivery and at 3 months after delivery (see Table 3). Only five of the 13 different trial interventions (Abdollahpour et al., 2018, 2019; Asadzadeh et al., 2020; Bahari et al., 2022; Gamble et al., 2005; Meades et al., 2011; Mousavi et al., 2022) targeted women who had trauma symptoms, five were offered based on

clinical reasons (e.g., operative delivery) (Kershaw et al., 2005; Ryding, Wijma, and Wijma, 1998; Ryding et al., 2004; Small et al., 2000; Tam et al., 2003) and three were provided to all women following childbirth (Lavender et al., 1998; Priest et al., 2003; Selkirk et al., 2006). In Table 4 we detail the content of the postnatal session using Steele and Beadle's (A.M. 2003) classification ('good postnatal care' verses 'listening-type' (debriefing) service). Further features of the postnatal listening services and whether the intervention was effective are detailed in Table 5. Positive changes in outcome measures were shown in seven (64.2 %) out of the 13 different trial interventions, with two of these studies only finding changes at a later follow-up (3 months) (Abdollahpour et al., 2018; Gamble et al., 2005). Details of any comparisons in features and effectiveness are included in the thematic findings below.

Quality of included studies

The intention was to present a rapid summary of the evidence, rather than a detailed risk of bias for the RCT/intervention studies. However, we did note several biases across the data set. For example, in Kershaw's (2005) trial, women who were younger, single or non-White were less likely to complete the questionnaires and 44 % of those who completed the questionnaire had not accessed the intervention. Similarly, in Small's (2000) trial women who completed outcome measures were more likely to be older, married, better educated, have higher family incomes, speak English well, and have private health insurance. In Tam (2003) study, usual care was provided by midwives trained to provide counselling for emotionally disturbed mothers. In Ryding's (2004) group-based intervention, some 23 out of the 82 women allocated to the intervention arm did not attend. Whereas in Meades (2011) pragmatic trial, women in the intervention group had a greater proportion of caesarean deliveries, were more likely to consider birth worse than expected, had higher depression, and more negative appraisals compared to controls. Overall, only four of the studies scored a 2* or less on quality appraisal due to a lack of methodological detail (Abdollahpour et al., 2018; Inglis, Sharman, and Reed, 2016; Ryding, Wijma, and Wijma, 1998) and inaccuracy in reporting (Abdollahpour et al., 2018).

In the following sections, the data is presented in five themes that highlight key components of postnatal listening services that appear important.

Who provides the service?

Most of the intervention/service models were delivered by midwives (see Table 4) and while a multidisciplinary approach was valued (Ryding et al., 2004), it was not always possible in practice (Thomson and Garrett, 2019). Women considered midwives most suitable due to them having an embodied understanding of childbirth (Bailey and Price, 2008; Sigurðardóttir et al., 2019, 2023), and thus able to demonstrate empathy to the woman's situation - *'unless you're actually with women in labour and can see things from their perspective, I don't think you would really know how to take that on*' (n.p, Bailey and Price, 2008). Some women also highlighted the qualities they valued in providers such as being non-judgemental, understanding, (Bailey and Price, 2008), and caring and knowledgeable of childbirth to '*explain* [..] *medical things'* (p.220, Fenwick et al., 2013). Although important to note that not all women's relationships with the midwife who provided this support were positive (Fenwick et al., 2013).

The importance of the woman knowing the maternity professional who provided the listening support was discussed. Some women felt this was not important (Sigurðardóttir et al., 2019), particularly if the contact was via telephone (Fenwick et al., 2013), whereas others would have preferred their care provider, as trust was already established (Sigurðardóttir et al., 2019, 2023). Although in one of these studies, ~40 % of the women did not consider their birth to have been traumatic, which may have influenced their opinion (Sigurðardóttir et al., 2023).

Types and quality of care

From the 19 different postnatal interventions/services, 13 (68.4 %)

Table 4
Content of postnatal listening session.

Studies	Content of postnatal listening session						
	Review labour/ birth (i.e., maternity notes)	Women share personal accounts	Discuss emotion responses	Normalise emotional responses	Therapeutic elements (e.g., strategies to manage anxiety, coping)	Referral to wider support	Classified as listening-type service or good postnatal care
Abdollahpour et al., 2018; Abdollahpour et al, 2019		Yes	Yes		Yes		Listening-type service
Bahari et al., 2022		Yes	Yes		Yes		Listening-type service
Bailey & Price, 2008							No information reported
Charles & Curtis, 1994							No information reported
Gamble et al., 2005; Asadzadeh et al., 2020 (qualitative papers - Fenwick et al., 2013; Reed et al., 2014)	Yes	Yes	Yes	Yes	Yes	Yes	Listening-type service
Inglis, 2003	Yes						Good postnatal care
Kershaw et al., 2005	Yes	Yes	Yes		Yes	Yes	Listening-type service
Lavender et al., 1998	Yes	Yes	Yes				Good postnatal care
Meades et al., 2011	Yes	Yes				Yes	Good postnatal care
Memon et al., 2021	Yes	Yes	Yes	Yes	Yes	Yes	Listening-type service
Mousavi et al., 2022		Yes	Yes		Yes		Listening-type service
Priest et al., 2004	Yes	Yes	Yes	Yes		Yes	Listening-type service
Ryding et al., 1998	Yes	Yes	Yes	Yes	Yes		Listening-type service
Ryding et al., 2004	Yes	Yes	Yes	Yes	Yes	Yes	Listening-type service
Selkirk et al., 2006	Yes	Yes	Yes	Yes		Yes	Listening-type service
Sigurðardóttir et al., 2019	Yes	Yes	Yes	Yes	Yes	Yes	Listening-type service
Sigurðardóttir et al., 2023	Yes	Yes	Yes		Yes	Yes	Listening-type service
Small et al. 2000; Small et al., 2006		Yes					Good postnatal care
Tam et al., 2003	Yes		Yes		Yes		Listening-type service

Table 5
Features and effectiveness of different models of postnatal listening services.

Studies	Timing/dosage	Eligibility	Who delivered	Training/ support to providers	Positive change/ evidence of effectiveness
Abdollahpour et al., 2018; Abdollahpour et al, 2019	One 40-60 min session within 48 postpartum hrs in the postnatal ward	Asked whether they had felt any threat of death or serious injury to themselves or their babies intrapartum	Research midwife	MSc Obstetric Counselling	(2018) At 3 months only for depression ($p<0.001$) (2019) Yes – PTSD lower in intervention groups 4-6 weeks ($p< 0.001$), lower in CBT group at 3 months only ($p< 0.001$)
Bahari et al., 2022	Session 1 - 24–48 hours after delivery (before discharge) for 45–60 mins, Session 2-10–15 days postnatal for 45–90 mins; Session 3 - via telephone 4–6 weeks postnatal for 15–20 mins.	Screened for traumatic childbirth	Counsellor/ psychologist supervised sessions	Trained and certified counsellor in supportive counselling	Yes – depression and PTSD ($p<0.001$)
Bailey & Price, 2008	Self-referral/referred by professionals - Six self-referred when babies aged 6-14 weeks old. One sought help when baby was 9 months.	Self-referral	Midwives	Not specified	
Charles & Curtis, 1994	Varies (shortest time 6 weeks, and longest 6 years postnatal)	Self-referral	Midwives	Not detailed -bimonthly meetings with counsellor and psychotherapist.	
Gamble et al., 2005; Asadzadeh et al., 2020 (qualitative papers - Fenwick et al., 2013; Reed et al., 2014)	72 hrs and 4-6 weeks postnatal by telephone (both sessions 40-60 minutes)	Screened for stressful or traumatic birth	Midwives	PRIME training comprising workshop, print and web-based resources, as well as face-to-face and telephone clinical supervision. (Gamble) (Asadzadeh) One of authors is Clinical Psychologist who provided PRIME training and supervision	(Gamble) Reduction in PTSD symptoms at 3 months ($p= 0.035$) (Asadzadeh) Yes – reduction in depression ($p=0.0001$) and anxiety ($p=0.0001$)
Inglis, 2003	Self-referral/referral – time varies depending on need (usually over an hour).	All women given a discharge summary sheet including telephone number for service.	Delivery suite leader	Not specified	
Kershaw et al., 2005	10 days and 10 weeks postnatal	Mothers who delivered a first child by operative delivery.	Community midwives	Training by a consultant clinical psychologist in critical incident stress debriefing - 3 hrs	No
Lavender et al., 1998	Prior to discharge (2 days postnatal)	Women who had had a vaginal delivery of a healthy baby	Midwife	No formal training	Yes – reduction in HADs scores ($p<0.01$)
Meades et al., 2011	Varies between 1.3 to 72.2 months after birth (median 16 weeks), lasted 1 to 1.5 hours.	Women who met criteria for a traumatic birth	Midwives	One midwife trained in counselling techniques; one trained in CBT and solution-focused therapy.	Yes – reduction in PTSD ($p<0.05$) and negative appraisals ($p<0.01$) not for depression
Memon et al., 2021	Varies between less than 6 months to more than 5 years. 66.7 % (n=44) had discussions with midwife for 1-2 hours followed by 21.2 % (n=14) attended further meeting (2-3 hours). Less than 10 % needed time duration of < 3 hours	Not mentioned	Midwives	Not specified	
Mousavi et al., 2022	3-5 days postnatal (90-180 mins)	Invited to take part if have experienced birth trauma	Not mentioned	Not specified	Yes – reduction in PTSD ($p=0.01$), not depression
Priest et al., 2004	Single session lasting 15 minutes to one hour, 1-4 days postnatal.	All women delivering near or at term	Research midwives	Training in critical incident stress debriefing.	No
Ryding et al., 1998	~1-5 days postnatal, before discharge, 2 and 3 weeks postpartum	Emergency caesarean	Obstetrician with psycho-therapy qualification	Not specified	For fear of birth ($p<0.01$) not PTSD scores
Ryding et al., 2004	Groups met twice, at ~1-2 months postpartum; Consultations lasted for 2 hours. Four to five women invited to each group.	Emergency caesarean	Maternity and child welfare psychologist and an experienced delivery ward midwife	Not specified	No
Selkirk et al., 2006	On second or third day postnatal (30-60 mins)	All women eligible	Hospital midwife	Not specified	No
Sigurðardóttir et al., 2019	Most women had one face-to-face appointment, lasting approximately one hour. As self-referral timings differ from less than 4 weeks to greater than 1year from birth.	Self-referral to discuss previous birth experience or fear of birth.	Experienced midwives	Trained in communication and counselling skills, regular peer-guidance meetings for professional development and to promote fidelity.	

(*continued on next page*)

Table 5 (*continued*)

Studies	Timing/dosage	Eligibility	Who delivered	Training/ support to providers	Positive change/ evidence of effectiveness
Sigurðardóttir et al., 2023	4-6 weeks after birth contacted to discuss birth/recruit for study; 6-8 weeks woman writes about her birth/has counselling intervention with midwife; follow-up contact 12-14 weeks postnatal	High-risk pregnancy (i.e., history of stillbirth, premature infant, fear of birth)	Midwives	Counselling framework by Gamble et al adapted; 12 hours training including active listening and CBT approaches. Educational material provided.	
Small et al. 2000; Small et al., 2006	Prior to discharge (up to one hour).	Operative delivery	Research midwives	None	No
Tam et al., 2003	Number and timing of sessions decided by the research nurse (and doctors could be contacted to discuss obstetric management plan). Number of sessions ranged from 1-4, and timing ranged from 25-50 mins (median 35 mins).	Suboptimal outcomes including admission due to antenatal complicationselective C/S, emergency C/S,	Senior research nurses	Trained in midwifery course and psychological counselling for one year	No

had elements that reflected a 'listening-type service', four (21.1 %) met the criteria for 'good postnatal care' and two (10.5 %) had no clear information detailed (Bailey and Price, 2008; Charles and Curtis, 1994) (see Table 4). Overall, women valued a safe space (Fenwick et al., 2013) to tell their birth story to a maternity professional who listened, acknowledged and *'understood without judgement'* (Bailey and Price, 2008; Fenwick et al., 2013; Sigurðardóttir et al., 2019, 2023). In one study, this process was aided by midwives being able to read the women's birth narrative in advance as it helped them *'to realise the woman's emotions in the interview and help her to connect them with events'* (p.103508, Sigurðardóttir et al., 2023), although not all women were willing to do this. Opportunities to discuss care decisions and interventions, answer unresolved questions and clarify the sequences of events (Charles and Curtis, 1994; Fenwick et al., 2013; Sigurðardóttir et al., 2019, 2023) helped women to *'get the whole picture of what really happened'* (p.35, Sigurðardóttir et al., 2019) and to provide cognitive and emotional benefits. From a cognitive perspective, women reported how this information helped them raise self-awareness by understanding what happened (Bailey and Price, 2008; Charles and Curtis, 1994; Fenwick et al., 2013; Inglis, 2002; Sigurðardóttir et al., 2019) and how they were feeling (Fenwick et al., 2013). From an emotional perspective, women referred to feeling an enhanced sense of control and confidence (Bailey and Price, 2008; Fenwick et al., 2013; Inglis, 2002; Sigurðardóttir et al., 2019) and how the support provided a sense of relief (Bailey and Price, 2008) through releasing feelings of blame – '*the session was tremendously helpful especially to challenge my feelings of failure*' (p.220, Fenwick et al., 2013). In one of the Icelandic studies, the support was felt to have provided a resolution that facilitated healing, and new knowledge that the next birth would not be the same (Sigurðardóttir et al., 2019).

Criticisms were raised when the session lacked depth (Fenwick et al., 2013; Sigurðardóttir et al., 2019) such as *'telling the mother everything was normal rather than listening to her experience and provide support, understanding, and warmth*' (p.35, Sigurðardóttir et al., 2019). There were also complaints of how reviewing what happened had heightened their distress - a situation made worse when no further support was offered:

> I felt that actually made things worse because there was no follow-up from her. There was no counselling provided afterwards (p.222, Fenwick et al., 2013)

Other complaints concerned the midwife/healthcare professional not acknowledging specific areas of complaint, *'you are not acknowledging any incompetency or mistake made by the staff'* (p.34, Sigurðardóttir et al., 2019). In the PRIME intervention, midwives were required to refrain from offering excuses or apologising for poor care (Fenwick et al., 2013). However, in Inglis's (2002) study the women who accessed the service to manage a specific complaint felt no better afterwards.

Targeting the support

There was some evidence that women who were older (Meades et al., 2011), better educated (Sigurðardóttir et al., 2019) and had less emotional and practical support available (Meades et al., 2011) were more likely to access a postnatal listening service. A further bias in age was reflected in Kershaw's (2005) trial when midwives did not want to debrief teenagers for fear of encouraging future pregnancies. All trials appeared to be eligible for native speakers only and as many did not report on ethnicity data and there were wide variations in the demographic and obstetric information collected, it was impossible to make any inferences. For example, Inglis's (2002) study only included information on when women access the service, and Charles & Curtis's (1994) study only reported on the women's type of birth – with this evidence, as reflected by others (Bailey and Price, 2008; Charles and Curtis, 1994; Memon et al., 2021) - demonstrating that women with different types of birth access these services.

All the trials ($n = 6$) that were targeted to women who had a traumatic/difficult birth rather than, e.g., offered on a universal basis or perceived clinical need, were more likely to have a positive impact on outcomes such as trauma and/or depression symptoms (Abdollahpour et al., 2018, 2019; Asadzadeh et al., 2020; Bahari et al., 2022; Gamble et al., 2005; Meades et al., 2011; Mousavi et al., 2022), even if at a later postnatal timepoint (Abdollahpour et al., 2018; Gamble et al., 2005). While some women suggested that a birth conversation should be offered to all women to enable them *'to talk about their experience*' (p.34, Sigurðardóttir et al., 2019)), this view was not supported by all midwives (Sigurðardóttir et al., 2023): some participants in Inglis's study felt they would not have benefited from the conversation had it been routinely provided (Inglis, 2002).

Timing and location

The timing of postnatal discussions varied across the trial designs with the first contact, for example, varying from 48 h (Abdollahpour et al., 2018, 2019), 10 days (Kershaw et al., 2005) and up to 1–2 months (Ryding et al., 2004). In the evaluations of existing services, the timing of access fluctuated from 6 weeks – 14 weeks (Bailey and Price, 2008), or from under 6 months to over 5 years (Memon et al., 2021), although women attending years after the event could relate to a lack of awareness of service provision (Charles and Curtis, 1994; Sigurðardóttir et al., 2019). In some studies, a 4–6-week timeframe was preferred (Sigurðardóttir et al., 2019, 2023), as too early could be '*too emotional*' (p.371, Inglis, 2002).

Regarding the number of sessions provided (see Table 5), seven out of the 19 different interventions/services offered more than one session (36.8 %) (with this information not reported in three studies (Bailey and

Price, 2008; Charles and Curtis, 1994; Inglis, 2002)), reflecting insights from the recent UK audit that most services offer multiple contacts as needed (Thomson and Garrett, 2019). Overall, there was no clear pattern in effectiveness based on the number of sessions provided. Only 11 % ($n = 4$) of women in Charles & Curtis's (1994) evaluation stated that they would have liked more than one meeting with this number increasing to 30 % (Memon et al., 2021) and 33 % (Sigurðardóttir et al., 2019) in other included studies. Some women in the PRIME trial valued the follow-up contact as it provided a sense of being cared for (Fenwick et al., 2013). While only nine of the included interventions/services reported that they would signpost women to additional support (see Table 4), it was more commonplace in practice (Thomson and Garrett, 2019). While the length of the sessions varied (see Table 5), women valued time to talk *'without feeling rushed'* (Charles and Curtis, 1994), and a lack of time to provide the support was reported as a key barrier by healthcare professionals (Kershaw et al., 2005; Steele and Beadle, 2003; Thomson and Garrett, 2019).

Regarding the preferred location, some expressed a preferencefor home, due to childcare, and feeling more relaxed (Charles and Curtis, 1994; Sigurðardóttir et al., 2019) and others reported challenges of the discussion taking place where they gave birth – '*Difficult to come back to the location where the difficult event took place'* (p.34, Sigurðardóttir et al., 2019). While over 30 % of women in Charles & Curtis's (1994) study either 'possibly' or 'definitely' would not have attended if the discussion took place in the hospital, some women in an Icelandic study felt a visit to the birth environment was an essential part of the healing process - *Still, I think it is essential that the woman goes back to the birthplace again…'* (p. 34, Sigurðardóttir et al., 2019).

Training and experiences of maternity staff

The training for providers varied (see Table 5). Eight (42.1 %) of the 19 different interventions/services did not provide any specific details about training and on a further two occasions, no training was provided (Lavender et al., 1998; Small et al., 2000). In nine of the 13 different trial interventions, staff had received either psychotherapy, counselling, or critical skills training (previously or as part of intervention/service delivery), five of which reported some evidence of impact on women's trauma and/or depression symptoms (Abdollahpour et al., 2018, 2019; Asadzadeh et al., 2020; Bahari et al., 2022; Gamble et al., 2005; Meades et al., 2011). As the remaining four interventions were not targeting women who had trauma symptoms (Kershaw et al., 2005; Priest et al., 2003; Ryding et al., 1998; Tam et al., 2003), the lack of effectiveness emphasises the importance of needs-led care.

In some studies, the training was reported to have helped prepare the midwives (Sigurðardóttir et al., 2023), and provided *'new'* and *'foreign'* skills to work with the women to identify their solutions (Fenwick et al., 2013). Some midwives reported professional and personal benefits of providing the listening sessions, such as having a greater understanding of trauma, and feeling more empathetic and understanding of women's needs - *'I feel more like a midwife now'* (p.273, Reed et al., 2014). Some midwives described their experience as *'rewarding'* and *'empowering'* (Reed et al., 2014) or *'instructive'* signalling the value of these learning opportunities in understanding women's experiences (Sigurðardóttir et al., 2023). Midwives also spoke of how their newfound skills benefitted themselves, family members and colleagues, with some perceiving the training could offer a remedy for the *'emotional fallout'* of midwifery practice (p.273, Reed et al., 2014). However, from a negative perspective, in one intervention some of the midwives withdrew from the study due to feeling ill-equipped (Fenwick et al., 2013), and the need for additional training was reported in several studies (Fenwick et al., 2013; Kershaw et al., 2005; Reed et al., 2014; Sigurðardóttir et al., 2019).

Discussion

This review provides a comprehensive overview of existing evidence for postnatal listening services. Despite the heterogeneity, evidence highlights that these services should be provided by trained midwives and offered to women who demonstrate evidence of need, and that support should be flexibly provided via active listening, empathy and a non-judgmental approach that allows for women to narrate their stories and for their questions to be answered. This work aligns with the findings from a very recent UK All-Party Parliamentary Review of birth trauma which calls for standardised birth reflections services to provide mothers with a safe space to talk about their birth experience (The All-Party Parliamentary Group on Birth Trauma, 2024).

Consideration of when and where the postnatal listening service is provided appears important. Most RCT studies involved the intervention being delivered in the early postnatal period, e.g., within three days postpartum, which may have disturbed the natural coping mechanisms for psychological trauma (Hobbs et al., 1996), and exacerbated rather than reduced their trauma responses. Data generated from the naturalistic evaluation studies indicated that 4–6 weeks postpartum onwards was the most preferred time point to receive support. However, it may be that this benchmark needs to be flexibly applied depending on the needs of the presenting woman, and if necessary, referrals made to more specialist support as required (Rodriguez et al., 2021). Providing an intervention on women's terms rather than at set time points may be crucial for its effectiveness. Flexibility was also required as to where the postnatal conversation took place. While hospital-based appointments could invoke painful memories, revisiting the scene of the trauma with sufficient support could be a healing process (Sigurðardóttir et al., 2019), as reflected in wider literature (Thomson and Downe, 2010). Most included interventions focused on creating a safe space for women to recount their experiences, and to understand what happened and why, with cognitive and emotional benefits reported (Bailey and Price, 2008; Charles and Curtis, 1994; Fenwick et al., 2013; Inglis, 2002; Sigurðardóttir et al., 2019). One new approach in the Icelandic study was women being asked to share their birth narratives in advance (Sigurðardóttir et al., 2023). Writing about the experience of a distressing birth has been found to help reduce trauma symptoms and depression (Di Blasio, Ionio, and Confalonieri, 2009; Di Blasio et al., 2015). However, the finding that less than half the women were willing to share their narratives (Sigurðardóttir et al., 2023) indicates that women may need further encouragement or instruction.

The intervention trials comprised a wide range of measures, with most assessing the impacts on trauma-related and/or postnatal depression scores, and notably the interventions generally had less impact on depression when compared to trauma symptoms. This is reflected in wider literature exploring perinatal mental health that emphasises that the same type of psychosocial intervention may be ineffective in the simultaneous reduction of both depression and anxiety (Shaohua and Shorey, 2021). It is also arguable as to whether an intervention fundamentally designed to raise awareness and understanding of birth-related processes and clinical decision-making would impact postnatal depression when other biopsychosocial variables influence its onset (Boyce and Condon, 2001). Overall, this work adds to the debate as to what listening sessions should comprise in maternity care. Most included interventions veered towards a 'listening type' service, rather than 'good postnatal care' (Steele and Beadle, 2003) due to normalising women's responses and/or using therapeutic approaches to help resolve negative emotions. Further research to compare outcomes of interventions more clearly demarcated as a 'listening-type service' or 'good postnatal care' may help understand what approaches can impact on maternal well-being. This work should also involve process evaluations, as qualitative insights into women and providers views of formal interventions were found to be generally lacking.

The training and delivery of the postnatal listening services had professional as well as personal benefits for maternity professionals

(Fenwick et al., 2013; Reed et al., 2014; Sigurðardóttir et al., 2023). Training in counselling skills and opportunities to connect with women and their birthing experiences may help offset the increasing risks of emotional stress and burnout in maternity staff (Banovcinova and Baskova, 2014). However, as some midwives felt ill-equipped to deliver the intervention (Fenwick et al., 2013), and expressed further training needs (Fenwick et al., 2013; Kershaw et al., 2005; Reed et al., 2014; Sigurðardóttir et al., 2019), more work is needed to develop the core competencies for this role. A key area of criticism concerned staff defensiveness or avoidance of complaints, which could exacerbate women's feelings of blame and marginalisation (Fenwick et al., 2013). While historically these services were set up as a risk management tool (Smith and Mitchell, 1996), UK national maternity reviews emphasise that they need to be provided by trained health professionals to support women's recovery, rather than managing risk and avoiding litigation (Kirkup, 2022). The dissatisfaction of how complaints were managed in some studies (Inglis, 2002), also underlies a potential training need to ensure a sensitive and trauma-informed approach to these conversations.

The strength of this work is that a robust and comprehensive review was undertaken. While a decision was made to undertake a rapid review, the only quality-related process that lacked rigour was only 20 % of quality appraisals and data extraction being undertaken by two authors (albeit with 90+ % interrater agreement). While the findings are reported descriptively, this was intentional to identify the key components that matter, and to inform the design of a new listening service, particularly when there is such variation in provision. A key gap within the existing literature concerns the lack of consideration for those who do not speak the native language, and little evidence of adaptions being made for minoritised ethnic populations. As cultural barriers prevent access to mental health support among minoritised ethnic parents (Webb et al., 2024), the need to ensure culturally safe care is highlighted (Chen, Zhang, and Kuper, 2023).

Conclusion

This rapid review provides a comprehensive overview of existing evidence for postnatal listening services for women following a traumatic or difficult childbirth experience. While evidence of heterogeneity was identified, the synthesised findings provide insights into the key features that should underpin who, how, when, where and what should be provided. Listening services are an important first step for women to access help. These services should be flexibly provided, generally after a sufficient period to allow for natural coping, via active listening, empathy and a non-judgmental approach that allows for women to piece together their birth narrative, for their questions to be answered, and for referral to more specialist services as appropriate. Further work is needed to ensure these services are culturally safe, to identify the optimum training for service providers, and to identify the key components that matter.

CRediT authorship contribution statement

Gill Thomson: Writing – original draft, Validation, Project administration, Methodology, Funding acquisition, Formal analysis, Conceptualization. **Rebecca Nowland:** Writing – review & editing, Methodology, Data curation.

Declaration of competing interest

The authors declare that they have no competing interests.

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Ethical statement

This is a secondary review, so no ethics approval was required.

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