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Ollscoil na hÉireann, Corcaigh

National University of Ireland, Cork



**Exploration of the Implementation of Trauma Risk Management
(TRiM) in an Irish Maternity Care Setting**

Thesis presented by

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Declaration

This is to certify that the work I am submitting is my own and has not been submitted for another degree, either at University College Cork or elsewhere. All external references and sources are clearly acknowledged and identified within the contents. I have read and understood the regulations of University College Cork concerning plagiarism.

Signed:

Aoife Lyons

Aoife Lyons

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Abstract

Maternity staff are frequently exposed to potentially traumatic clinical events, yet there remains limited understanding of how workplace support is experienced or what shapes staff engagement with it. Existing literature has tended to focus on prevalence and broad outcomes, with less attention to the psychological and organisational processes through which support is encountered, and very limited attention to the experiences of those delivering peer-led support. This thesis addresses this gap by examining Trauma Risk Management (TRiM), a structured peer-led model of post-incident support, within a regional Irish maternity directorate, drawing on participant and practitioner perspectives.

Chapter 1 presents a critical review of trauma in maternity care, arguing that staff responses to traumatic events are shaped not only by exposure itself but by relational and organisational conditions. It introduces Self-Determination Theory (SDT) as a framework for understanding how support is experienced in relation to the basic psychological needs for relatedness, autonomy, and competence, and argues that clinical psychology is well placed to operate across individual and organisational levels in this developing area of staff support.

Study 1 (Chapter 2) provides the first empirical account of maternity staff experiences of TRiM. Thirty staff in a regional Irish maternity service completed a cross-sectional mixed-methods survey, with open-text responses interpreted through SDT. Quantitative findings showed TRiM was generally evaluated as useful, with the strongest perceived impact on understanding of trauma responses. Perceived change in personal psychological outcomes was more limited, with approximately a third reporting no change in stress or wellbeing. Qualitative findings, interpreted through SDT, suggested that engagement depended on whether basic psychological

needs were supported or undermined in how TRiM was introduced and delivered. Staff were more likely to engage with TRiM when it was introduced clearly and experienced as supportive and psychologically safe. Mismatched expectations and dismissive senior responses limited its perceived value.

Study 2 (Chapter 3) addressed a further gap by examining the experiences of peer-facilitators delivering TRiM. Semi-structured interviews with nine trained practitioners were analysed using reflexive thematic analysis. Practitioners described delivering TRiM within an organisational context shaped by hierarchy, fear of blame, and limited protected time, where psychological safety and managerial endorsement were central to engagement. Their confidence and way of delivering TRiM developed through experience rather than being established through initial training, and the role carried emotional demands that required active support to sustain. Practitioners also described TRiM as legitimising emotional conversations among colleagues and contributing to a workplace culture more open to acknowledging staff distress. Access to clinical psychology supervision was identified as essential to making the role sustainable and safe.

Chapter 4 develops a multi-level account of how TRiM operates in maternity care. Drawing on implementation science, psychological safety, and SDT, it integrates findings across the two studies and examines where participant and practitioner accounts converge and diverge. It argues that TRiM's perceived value is conditional and contextually shaped, depending less on its content than on how it is implemented and sustained within the organisation over time. Across both accounts, TRiM was experienced as more useful where leadership endorsement legitimised engagement and where psychological safety supported open participation.

This thesis contributes to an underdeveloped evidence base by providing the first combined examination of participant and practitioner experiences of TRiM in a maternity setting. It extends existing work by showing that peer-delivered trauma support is shaped by how it is implemented within its organisational setting. The findings suggest that introducing and sustaining TRiM in maternity services requires attention to practical conditions such as pre-briefing, role clarity, protected time, and supervision, while also highlighting the emerging contribution of clinical psychology to staff support in maternity care.

Chapter 1: Extended Critical Literature Review

Word count: 10,825

1.1 Introduction

Maternity services occupy a unique and paradoxical position in healthcare. They are places associated with new life and of family expansion. Yet beneath this cultural expectation of joy, maternity care is also a setting defined by clinical complexity, unpredictability, and the ever-present possibility of loss. Within the same shift, sometimes within the same hour, a midwife may support the birth of a healthy baby and witness the death of another. An obstetrician may move from a straightforward delivery into a shoulder dystocia or a maternal haemorrhage. This juxtaposition is central to understanding the psychological demands of maternity work.

Research consistently demonstrates that maternity staff are frequently exposed to potentially traumatic events at work (Andre et al., 2016; Dahlen & Caplice, 2014; Healy et al., 2025; Uddin et al., 2022). However, frequency and severity alone do not capture the impact of these events. That impact is closely tied to the relational and organisational conditions in which events occur and how they are handled afterwards. In maternity settings, where professional responsibility is closely tied to maternal and neonatal outcomes, distress is often entangled with perceptions of accountability, competence, and fear of blame (Bingham et al., 2023; Scamell & Alaszewski, 2012; Schröder et al., 2016).

Despite the increasing recognition of the psychological impact of traumatic exposure, evidence suggests that the available support for maternity staff remains inconsistent, underutilised, or poorly aligned with the needs of staff (Sweet & Kruger, 2025). Existing interventions are frequently evaluated based on whether they are available or acceptable (Sweet & Kruger, 2025), with much less attention given

to the psychological processes that shape how support is experienced by staff. This chapter will examine how trauma is conceptualised within the maternity literature, how it impacts staff, how organisations respond, and how support is understood and delivered. In doing so, it will adopt a critical and theory-informed approach, focusing not only on what is known, but on the assumptions and gaps within the existing evidence. These gaps are directly relevant to clinical psychology, particularly in relation to how distress is understood beyond diagnostic thresholds and how interventions are designed within complex organisational systems. They are also increasingly relevant in practice, as clinical psychologists take on a growing role in staff support and the development of psychologically informed support pathways within healthcare settings. Yet there is still limited literature examining how clinical psychology is applied with this population in maternity services, or how psychological models are adapted to the realities of workplace trauma in this context.

This thesis focuses on maternity staff, including midwives, nurses, doctors, ancillary staff, health and social care professionals, and other staff involved in the delivery of maternity care. The terms “traumatic”, “adverse” and “critical” events are used to refer to incidents that are experienced as distressing or psychologically impactful within the workplace, including but not limited to shoulder dystocia, cord prolapse, maternal death, intrauterine or neonatal death, patient resuscitation, therapeutic hypothermia, and other complex or unexpected obstetric emergencies. Consistent with the literature, this definition includes both direct and indirect exposure to trauma, recognising that staff may be affected through direct involvement in traumatic events, through witnessing or hearing about them, and through repeated exposure to distressing experiences over time (Pezaro et al., 2016; Sheen et al., 2014; Uddin et al., 2022).

This chapter also examines how support is provided to staff following these events, including both formal approaches (e.g., counselling, structured interventions, and debriefing processes) and informal supports. The emphasis is on the psychological processes that shape how support is experienced in practice in workplace settings, particularly in maternity care. It is informed by a clinical psychology perspective, by providing a framework for examining how responses to traumatic events are shaped across individual and organisational levels, and what may be addressed through different forms of support. It is particularly relevant to areas such as formulation, supervision, and reflective practice, and to how staff support is designed and delivered within complex maternity healthcare systems.

This chapter will start by examining how trauma exposure is conceptualised within maternity care. Next, it will look at the psychological and professional consequences of such exposure. Following this, it will critically analyse the relational and organisational influences on staff trauma. Subsequent sections review workplace support, including peer-based approaches, and structured interventions such as Trauma Risk Management (TRiM), before introducing a clinical psychology perspective and Self-Determination Theory as a framework for understanding how support is experienced in practice.

1.2 Trauma exposure in the maternity setting

Maternity care is considered to be a high-risk clinical environment where staff are exposed to potentially traumatic events. Even where adverse outcomes are relatively infrequent, they remain an anticipated part of the work (Andre et al., 2016; Schröder et al., 2016), meaning exposure to potentially traumatic events forms part of the routine environment in which care is delivered. Estimates from a recent systematic review on the perceived impact of birth trauma witnessed by maternity

staff suggest that between 45% and 96.9% of maternity healthcare professionals report experiencing work-related traumatic events (Uddin et al., 2022). However, this range warrants scrutiny, with Uddin et al. (2022) noting that variation in prevalence estimates reflects differences in how traumatic events are defined and measured across studies.

The nature of that traumatic exposure is varied. Midwives may be exposed to traumatic events through direct involvement in care, as well as through indirect exposure, including witnessing distressing events or hearing women recount traumatic experiences in postnatal or antenatal care (Sheen et al., 2014). Indirect exposure of this kind has been identified as a potential source of traumatic stress, particularly in roles involving sustained engagement with women and families (Sheen et al., 2014). In clinical settings like maternity, these forms of exposure are often shared across teams rather than experienced by individuals in isolation (Buhlmann et al., 2021). Adverse events in maternity care frequently involve multiple staff members, who may be present during the event, involved in its management, or affected by its aftermath. Exposure to trauma may also be cumulative and distress may build over time through repeated encounters with emotionally demanding or traumatic work (Pezaro et al., 2016). Vicarious traumatisation has been described as a response that develops through ongoing exposure to others' distress, rather than from a single event (Sheen et al., 2014). This pattern of exposure is less easily captured by models that focus on discrete incidents. This is relevant to clinical psychologists working with maternity staff, as it suggests that exposure alone may be insufficient to explain psychological impact and instead points to the role of interpretation and context in shaping how events are experienced.

Existing diagnostic frameworks do not fully capture the ways in which trauma is experienced by maternity staff. This is important for clinical psychology because it suggests that staff distress in maternity care cannot be understood solely through diagnostic definitions of trauma but requires formulation-based attention to context and the meaning attached to adverse events. The Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) defines trauma in relation to exposure to actual or threatened death, serious injury, or sexual violence (American Psychiatric Association, 2013). While several events in maternity settings clearly meet some of these criteria, such as maternal or neonatal death and severe obstetric emergencies, other experiences commonly described as distressing by staff are more varied, including witnessing complications, involvement in care perceived as suboptimal, and events influenced by communication or the workplace environment (Fontein-Kuipers et al., 2018). Evidence suggests that these differences are not due to the event itself, but rather how individuals interpret and respond to the event (Sheen et al., 2016b), meaning that the same event may be experienced differently depending on how it is interpreted by the individual. As a result, trauma becomes a term used to describe experiences that can differ in intensity and clinical relevance. Fixed definitions, like those in the DSM-5 (American Psychiatric Association, 2013), risk overlooking forms of distress that may still be impactful for staff, while broader definitions can group together experiences that widely vary in severity and clinical significance.

This inconsistency in trauma definition has direct consequences for how the prevalence literature can be interpreted. Some studies rely on self-defined experiences of trauma while others apply diagnostic criteria, making direct comparison difficult. Nieuwenhuijze et al. (2024) attributed variation in prevalence

estimates directly to methodological inconsistency, suggesting these differences were due to how traumatic events were defined and measured across studies, rather than actual variation in occupational exposure across maternity settings. This has practical implications for how the evidence base is used, as prevalence estimates often inform decisions about the need for support and the design of interventions. This creates a risk that supports may not always align with staff needs, particularly where the forms of exposure most relevant to staff experience are not clearly captured in the evidence base.

1.3 Psychological and professional responses to trauma exposure

Exposure to traumatic events in maternity care has been associated with a range of psychological symptoms and responses experienced by staff members. These include, but are not limited to, symptoms consistent with post-traumatic stress disorder (PTSD), such as intrusive memories, avoidance, and heightened arousal, with some cases meeting thresholds for diagnosis (Aydın & Aktaş, 2021; Bingham et al., 2023). However, prevalence estimates vary considerably across studies (Nieuwenhuijze et al., 2024), with rates appearing substantially higher among those directly exposed to traumatic events, alongside elevated levels of anxiety and depression (Kerkman et al., 2019), suggesting that using diagnostic thresholds does not capture all of those affected.

Evidence indicates that psychological responses extend beyond PTSD to include secondary traumatic stress, burnout, and compassion fatigue, which frequently co-occur and fluctuate over time, reflecting the cumulative and ongoing nature of trauma exposure in maternity settings (Healy et al., 2025; O’Riordan et al., 2020). Distress is experienced across cognitive, emotional, and behavioural responses, including rumination, fear, guilt, helplessness, and difficulties with

concentration or sleep (Aydın & Aktaş, 2021; De Boer et al., 2011; Nieuwenhuijze et al., 2024; Simms-Ellis et al., 2025). These findings suggest that trauma responses in maternity care are not well captured by discrete diagnostic categories. Many staff experience persistent forms of distress that do not necessarily meet diagnostic thresholds but remain clinically and professionally significant (Healy et al., 2025; Simms-Ellis et al., 2025). This raises a methodological and clinical issue for how distress is identified and responded to within maternity services. Approaches that rely primarily on symptom thresholds risk overlooking forms of distress that are subthreshold yet persistent and functionally significant. For a clinical psychologist working in staff support roles, this points to the relevance of formulation-based approaches, which prioritise the relationships between cognitive, emotional, and environmental factors over categorical diagnosis (Johnstone & Dallos, 2006).

Furthermore, emotional responses such as guilt, shame, and helplessness are central to staff experiences following traumatic events in maternity care (Aydın & Aktaş, 2021; Buhlmann et al., 2022). These emotions are widely reported across qualitative studies, systematic reviews, and meta-analyses. Staff describe a range of intense feelings, such as shame, failure, self-blame, and responsibility for adverse outcomes, even where events were clinically unavoidable (Andre et al., 2016; Aydın & Aktaş, 2021; Bingham et al., 2023; Schröder et al., 2016). These responses may reflect the relational and professional context that is unique to the role of maternity care, a context in which clinicians often become emotionally invested in their relationships with women while also working within a setting that emphasises responsibility and safe outcomes (Andre et al., 2016; Schröder et al., 2016). When outcomes deviate from these expectations, distress is frequently experienced in relation to perceived responsibility and having failed to meet professional and moral

expectations of care (Aydın & Aktaş, 2021; Sheen et al., 2016b). These emotional responses also have implications for professional functioning, with staff reporting reduced confidence, altered perceptions of risk, and, in some cases, shifts toward more defensive or interventionist practice (Aydın & Aktaş, 2021; Bingham et al., 2023).

At an organisational level, such experiences have been associated with burnout, sickness absence, and intention to leave the profession, suggesting that the effects of trauma impact not only the individual but the service as a whole (Healy et al., 2025). These findings point to the importance of how events are interpreted in relation to responsibility and identity, with implications for both individual wellbeing and clinical practice. From a clinical psychology perspective, this highlights the relevance of approaches that consider how experiences are understood within the circumstances in which they occur, rather than relying solely on symptom-based descriptions of distress.

1.4 Staff trauma as relational and organisational

The literature reviewed in Section 1.3 highlights a range of psychological and professional consequences following traumatic events in maternity care and argues that they can be experienced within a larger system. However, these consequences are often understood through frameworks that frame distress as an individual problem experienced by the clinician. In much of the literature, particularly in that informed by PTSD, trauma is understood as a response to specific events, with a focus on identifying symptoms and treatment. While this has some value, it is just one view of how distress develops and is sustained. In particular, these approaches do not adequately capture the role of meaning making and responsibility in shaping responses to traumatic events. For clinical psychologists working in staff support

roles, their task is not only to recognise distress, but to understand how it has developed and why it persists in that context. As highlighted in cognitive models of trauma, distress is not determined solely by exposure but by how events are appraised, including perceived responsibility and threat (Ehlers & Clark, 2000). In maternity care, where clinicians are closely involved in outcomes and often hold a strong sense of professional accountability, these appraisals are central to understanding the intensity and persistence of distress.

The “second victim” framework has been influential in recognising that healthcare professionals can be significantly affected by adverse workplace events. Originally introduced by Wu (2000), the concept has been widely adopted to describe the emotional and professional impacts experienced by staff following incidents, including feelings of guilt, fear, and anxiety (Scott et al., 2009; Seys et al., 2013, 2023). This framework has also contributed to increased awareness and the development of support initiatives (e.g., Edrees et al., 2016; Schröder et al., 2022). However, it has been subject to critique by some. The language of “victimhood” has been argued to be at risk of minimising professional accountability and focusing on the experiences of staff at the expense of patients (Clarkson et al., 2019). More broadly, the framework tends to individualise distress, focusing on the affected clinician rather than the organisational conditions in which incidents occur and are subsequently managed (Buhlmann et al., 2022; Clarkson et al., 2019). As a result, it may overlook the extent to which distress is shaped by workplace and management responses, including legal investigations, risk management responses, team dynamics, and the availability and quality of support (Aydın & Aktaş, 2021; Buhlmann et al., 2022; Seys et al., 2013).

Furthermore, concepts such as moral distress and moral injury highlight the role of perceived violations of professional values, conflicts between competing responsibilities, and the experience of witnessing or being unable to prevent harm (Foster et al., 2022; Litz et al., 2009; Rost et al., 2025). In maternity settings, where clinicians must navigate the needs of both mother and baby within complex and often unpredictable situations, these tensions are particularly relevant. Distress in this context can therefore be closely tied to how events are interpreted, including perceived responsibility and their implications for professional identity and integrity (Aydın & Aktaş, 2021; Ehlers & Clark, 2000; Uddin et al., 2022).

Importantly, further research also highlights the role of the social environment, including whether individuals feel supported following an incident (Busch et al., 2021; D'Alessandro et al., 2022). Evidence from maternity and wider healthcare settings suggests that unsupportive workplace cultures can make distress harder to manage and more likely to persist, whereas more supportive and responsive environments may help staff process and move forward from these experiences (Bingham et al., 2023; Buhlmann et al., 2022). This implies that organisational culture, leadership, and team dynamics play a critical role in shaping how distress and trauma develop over time, making them important factors for clinical psychologists to consider when supporting staff exposed to trauma.

1.5 Organisational culture, blame, and psychological safety

Across the literature, there is an indication that workplace cultures often prioritise scrutiny and accountability, with a strong focus on identifying what went wrong (Cauldwell et al., 2017; Parker & Davies, 2020). While these processes are intended to support learning and safety, they can also create conditions in which staff feel exposed, judged, and unsupported following adverse events (Bingham et al.,

2023; Sheen et al., 2014). Fear of litigation and professional consequence appears to be a key feature of this environment. Maternity staff describe heightened vigilance, ongoing anxiety, and shifts in clinical decision-making following traumatic events, often characterised by more cautious or defensive approaches to care (Aydın & Aktaş, 2021; Bingham et al., 2023). These changes may reflect expectations embedded within the wider culture within the working environment.

In midwifery and obstetrics, Symon (2000) describes defensive practice as changes in clinical decision-making in the face of complaints or litigation which is made to reduce or avoid risk, rather than to benefit patient safety. Defensive practice has been linked to more interventionist care in favour of self-protection (Bingham et al., 2023). It prioritises avoiding future scrutiny, even where this may conflict with usual models of care or professional judgement (Scamell & Alaszewski, 2012).

It is important for clinical psychologists working in this area to look at how staff are supported within the maternity environment, especially when the literature indicates that formal support is not always available or accessible. Although colleagues are often identified as an important source of reassurance, staff frequently describe uncertainty about whether it is safe to speak openly about their experiences (Busch et al., 2021; Sheen et al., 2016a). The concept of psychological safety helps to understand why this happens. Psychological safety refers to whether individuals feel able to raise concerns, admit difficulty, or seek help without anticipating negative repercussions (Edmondson, 1999). In maternity settings, where accountability is a key feature of the culture, these conditions are not always reliably present. As a result, regardless of supports being made available, they are not always used.

The way psychological safety is applied in maternity literature warrants some scrutiny. A common interpretation in the research, is that non-disclosure functions as a way of self-protection, in that staff do not speak up because they anticipate blame or negative professional consequences (Andre et al., 2016; Brás et al., 2024; Elliott-Mainwaring, 2021). However, O'Donovan et al. (2021) found that the reason senior healthcare workers may remain silent is because they do not believe that speaking up will produce any change. This suggests that non-disclosure may be shaped not only by whether it feels safe to speak but by whether speaking is perceived to carry any weight. This highlights the role of power and organisational trust in shaping staff behaviour (Elliott-Mainwaring, 2021; Morrison, 2014). This distinction has practical implications for clinical psychologists when determining what conditions are required for staff to engage with available support (Edmondson, 1999). Where non-disclosure reflects anticipatory fear, creating safer relational conditions through better peer support, visible leadership, or shifts in team culture may be sufficient to increase engagement. Where it reflects a more entrenched belief that the organisation will not act, relational safety becomes necessary but not sufficient. Staff may feel safe enough to speak and still choose not to, because prior experience has taught them that doing so changes very little.

Broader structural pressures within maternity services, such as high workload, long hours, staffing shortages, and limited time for reflection reduce opportunities for staff to process difficult experiences (Bingham et al., 2023; Sweet & Kruger, 2025). As a result, emotional responses are often managed privately, with few opportunities to process or discuss these experiences within the workplace (Bingham et al., 2023; Sheen et al., 2016a). Organisational hierarchies and resource constraints may also limit the extent to which clinicians feel able to act in line with

their professional values, contributing to experiences of frustration, powerlessness, and moral distress (Bingham et al., 2023; Rost et al., 2025). In this situation, trauma is not only linked to acute events, but also to the everyday environment in which staff work.

Processes such as debriefings that focus on medical risk and clinical skills are typically activated following critical events in maternity. These are usually orientated towards understanding adverse events and preventing them from recurring. However, when the focus remains on performance or error, these processes may be experienced as unsupportive, with evidence suggesting that workplace responses, including debriefing, are often perceived as inadequate and may undermine professional confidence (Buhlmann et al., 2021). This can lead to experiences of rumination and fears about future consequences for staff (Scott et al., 2009; Seys et al., 2013). In contrast, environments where staff feel listened to, acknowledged, and supported appear to enable more constructive engagement with these experiences and may reduce longer-term impact, although evidence linking these environments to longer-term psychological outcomes remains limited (Bingham et al., 2023; D'Alessandro et al., 2022).

For a clinical psychologist working in staff support, creating conditions in which staff can feel psychologically safe and supported involves attention to team dynamics, power, and the relational context in which support is offered (Keleher et al., 2022). Approaches such as reflective spaces, consultation, and psychologically informed supervision are intended to address these processes (The British Psychological Society, 2007), although their effectiveness remains contingent on the wider organisational context rather than the intervention itself. However, a recent study suggests that a psychologist-led training and support helped improve

psychological safety and morale within a maternity settings (Marks et al., 2026), suggesting that the skillset of clinical psychologists may play a role in supporting culture change within this setting.

These findings suggest that the impact of traumatic events is shaped as much by what happens afterward as by the event itself. Organisational responses and workplace conditions influence whether distress is contained or prolonged, as well as whether staff feel able to engage with and benefit from available supports. In maternity care, this shifts attention towards the environments in which staff are expected to process these experiences and continue providing care.

1.6 Workplace supports following traumatic events

Staff support following traumatic events sits within broader literature on healthcare worker health and wellbeing. Poor wellbeing and burnout among healthcare staff have been associated with absenteeism, presenteeism, turnover, and poorer patient safety outcomes, although causal relationships remain difficult to establish (Hall et al., 2016; Lawrence et al., 2022). The intervention literature suggests that well-designed mental health interventions can improve outcomes for healthcare workers, but also shows that existing approaches remain weighted towards individually directed intervention, such as coping skills (Anger et al., 2024). This is a limitation, as staff wellbeing is also shaped by organisational conditions. Evidence from burnout intervention research supports this view, with organisation-directed approaches showing larger effects than physician-directed approaches (De Simone et al., 2021). Similarly, staff consultation work suggests that wellbeing initiatives are more likely to be meaningful when they are grounded in the realities of healthcare work, including whether staff have the time, staffing, and trust needed to engage with them (Lawrence et al., 2022). Trauma-focused support should therefore be part of a wider organisational approach to healthcare worker wellbeing.

There has been a wide range of interventions developed to support healthcare staff following exposure to traumatic or adverse events, including formal approaches such as employee assistance programmes (EAPs), counselling, psychological therapies, structured post-incident interventions, and psychoeducational resources, alongside more informal sources of support including colleagues, managers, and

team-based responses (Andre et al., 2016; Busch et al., 2021; Uddin et al., 2022).

Despite this diverse range of support, there is little clarity in the literature about what constitutes effective support for this population, and a mismatch between the types of support staff report wanting and what organisations typically provided. This lack of clarity is particularly relevant as clinical psychologists become more involved in staff support and service development within maternity settings, often in the absence of a strong evidence base for what support is most useful to staff.

Across studies of healthcare professionals, including maternity staff, individuals frequently express a preference for timely, relational, and clinically informed support, particularly from colleagues who understand the clinical context of the event (Busch et al., 2021; Sheen et al., 2016a; Simms-Ellis et al., 2025). However, in a recent systematic review of support for healthcare staff following patient safety incidents, Simms-Ellis et al. (2025) found that while peer support needs appeared to be broadly met, the desire for a supportive learning-oriented culture and practical guidance was often unaddressed. Furthermore, no examples of proactive and preventive interventions were reported across the sample (Simms-Ellis et al., 2025), with other studies reporting that no meaningful support was offered to staff following critical incidents at all (Buhlmann et al., 2021, 2022).

The reasons for this are not hard to identify. Much of the literature frames staff distress as an individual response to a specific event, for example the second victim model (see Section 1.4), and as a result, the interventions that tend to get developed and funded are shaped by this lens. Simms-Ellis et al. (2025) note that targeting or changing individuals is generally treated as more feasible, less disruptive, and more cost-effective than addressing organisational conditions. Anger et al. (2024) found that 83% of 118 evaluated interventions for healthcare workers'

mental health were individually directed, with only 7% addressing the organisation. This striking imbalance reflects the assumption that the correct point of intervention is at the individual level, which is not well supported by the evidence. De Simone et al. (2021) found that organisation-focused interventions produced larger reductions in physician burnout than individual-focused ones (standardized mean difference = -0.45 compared to -0.18). Furthermore, they found that individual-level interventions often appeared to depend on organisational conditions being in place to have any effect at all (De Simone et al., 2021). In the maternity setting specifically, Knezevic et al. (2025), found that lack of leadership trust, protected time, and organisational commitment were barriers for engagement in a thoughtfully designed staff-led wellbeing programme.

Reviews of post-incident psychological interventions indicate that although a wide range of approaches are implemented, there is little high-quality evidence demonstrating their effectiveness (Billings et al., 2023; Brooks et al., 2021). Interventions are often evaluated in terms of acceptability rather than psychological outcomes, and findings often vary widely in both design and quality. Whether staff found an intervention reasonable to attend tells us relatively little about whether it reduced distress or supported recovery. This is particularly evident in relation to approaches such as single-session psychological debriefing, which has historically been widely used but is now not recommended due to a lack of benefit and potential for harm (National Institute for Health and Care Excellence [NICE], 2018; Rose et al., 2002). Similarly, psychoeducational interventions have been found to improve knowledge and attitudes in the short term, but there is limited and inconsistent evidence that they reduce longer-term psychological distress when delivered in isolation (Brooks et al., 2021).

Furthermore, many of the existing approaches make the assumption that distress follows a discrete event and can be addressed through a time-limited response. As the literature reviewed in earlier sections suggests, distress in maternity care is often cumulative, relational, and shaped as much by what happens after an event as by the event itself. Interventions that are designed around single incidents, or delivered once and not followed up on, may simply be responding to the wrong model of how distress develops in this population. Simms-Ellis et al. (2025) found that when staff were asked what would most improve their wellbeing at work, their responses emphasised better communication, staffing, and interpersonal connection rather than the wellbeing programmes organisations tend to provide.

These limitations have clear implications for clinical psychology. Although still limited in number, there are emerging examples of clinical psychologists contributing to staff support within maternity services, including the development of psychologically informed approaches to staff care (Archibald et al., 2025). This reflects a recognition that the existing evidence base is limited and leaves considerable room for more theoretically grounded and outcomes-focused approaches. Furthermore, it raises questions about what those approaches should look like in practice, and whether the structural conditions needed to make them effective can be created within the settings where they are most needed.

Overall, this literature suggests that workplace support following traumatic events is characterised by several limitations, including a lack of alignment between formal support and staff needs, a limited evidence base regarding effectiveness, and overemphasis on individual-level interventions rather than organisation-level supports for staff wellbeing (Simms-Ellis et al., 2025). While many interventions are valued by staff and may provide short-term reassurance and validation, it remains

unclear how they actually work in maternity settings, who they benefit, and when they are most effective.

1.7 Peer support in maternity care

Peer support has received increasing attention in maternity and wider healthcare settings, in part as a response to evidence that formal support provisions often fail to meet staff needs (Buhlmann et al., 2021; Simms-Ellis et al., 2025). It is often positioned in the literature as a more accessible and acceptable alternative form of support, particularly where staff are reluctant to engage with external services (Brooks et al., 2019; Edrees et al., 2016; Fontein-Kuipers et al., 2018; Kerkman et al., 2019). Yet a recent scoping review found that there were no studies designed to evaluate peer support as a primary focus with midwives in clinical practice (Sweet & Kruger, 2025), and while staff consistently report preferring it to formal alternatives (Edrees et al., 2016; Kerkman et al., 2019), the evidence base says comparatively little about how it works or under what conditions it does so.

The rationale most often cited is that a colleague with shared clinical experience requires less explanation and can offer a form of recognition that external support cannot easily replicate (Buhlmann et al., 2022; Sheen et al., 2016a). Shared professional experience may reduce the need for explanation, but it does not in itself determine whether the support offered is experienced as helpful or whether it is accessed at all. Watson's (2019) review of peer support processes in healthcare settings identifies several distinct processes that may underpin its effects, including the explicit use of lived experience, the emotional work involved in sustaining a supportive relationship, the provision of practical and social support, and the potential psychological benefit for those in the supporter role. These processes are related but not interchangeable, and they are not automatically present simply

because two people share a professional background. The maternity peer support literature rarely makes these distinctions explicit. As a result, peer support is often discussed as if shared experience alone is sufficient, without considering the specific conditions needed for different aspects of support to take place.

The question of when peer support provides validation and reassurance is therefore more complicated than the literature often suggests. Buhlmann et al. (2022) found that peer support provided validation and reassurance for nurses and midwives following critical incidents, though it is worth noting that the sample was drawn from participants who had already identified themselves as having moved on from the event, which may overrepresent those for whom support had been relatively adequate. Sheen et al. (2016a), using a purposively stratified sample grouped by levels of distress, found a more differentiated picture. Midwives with high levels of post-traumatic distress were more likely to report difficulty accessing peer support from colleagues, and more likely to describe the support received as absent, inaccessible or inappropriate. Both groups valued talking to peers, but those with greater need encountered more barriers doing so. This suggests that peer support may function reasonably well where distress is moderate and the social conditions for it already exist but may be least available where it is most needed.

Several features of the maternity setting compound this problem. Peer support typically takes place within the same organisational setting in which traumatic events occur, meaning the same dynamics that shape reluctance to disclose distress also influence whether peer support feels accessible or safe (Busch et al., 2021; Sheen et al., 2016a). In maternity, this includes teams that are characterised by hierarchy, accountability, liability, and at times, fear of judgement. An integrative literature review found that relationships between junior and senior midwives in

hospital settings were frequently a source of tension rather than support, with intra-professional divisions along seniority lines producing real consequences for communication and wellbeing (Hunter, 2001). Bridson et al. (2021) note that peer support is more likely to function effectively when offered between staff at similar career stages, as this reduces some of the hierarchical and role-based constraints that otherwise shape what can be disclosed and how it is received. In practice, peer support in maternity settings is rarely structured in this way, and treating shared professional identity as enough to foster openness overlooks how strongly team hierarchies shape those conditions.

Concerns about confidentiality, professional reputation, and potential consequences may further limit what staff are willing to share, even within peer relationships (Busch et al., 2021). In a setting where adverse events generate formal investigations and where professional identity is closely linked to perceptions of clinical competence, speaking openly about distress can be perceived as risky (Bingham et al., 2023; Busch et al., 2021; Simms-Ellis et al., 2025). The relational conditions that may support effective peer support, including trust, some degree of distance from the immediate team, and a reasonable expectation of confidentiality, are not consistently present in informal peer support as it typically occurs within maternity services (Busch et al., 2021).

One response to these limitations has been the development of structured peer support programmes that seek to formalise some of these conditions through training, defined roles, and organisational integration (Bridson et al., 2021; Connors et al., 2021; Edrees et al., 2016; Schröder et al., 2022). The evidence from these programmes is generally positive with respect to acceptability, though whether staff found a programme reasonable to attend tells us relatively little about whether it

reduces distress or addressed the conditions limiting access. Furthermore, in a study of a structured peer support programme following adverse obstetric outcomes, a statistically significant proportion of those enrolled continued to seek support from peers outside their allocated group (Rivera-Chiauzzi et al., 2022). Similarly, Schröder et al. (2022) found that self-selection of peer relationships was central to whether structured support created a genuinely safe space for disclosure. This suggests that formalisation alone does not produce the relational conditions that make peer support effective and may in some cases work against them if it removes the element of choice or assigns relationships that do not carry sufficient trust.

A further gap in the literature is the lack of attention to the role of the peer supporter. While peer support is frequently evaluated in terms of the perceived benefit for those receiving support, considerably less attention has been paid to the experiences of those delivering it (Busch et al., 2021). A small number of studies suggest that peer support roles may be experienced as meaningful and rewarding, with staff reporting increased confidence, professional growth, and a sense of contributing to colleagues' wellbeing (Connors et al., 2021; Schröder & Assing Hvidt, 2023). At the same time, data from the RISE programme at Johns Hopkins found that 28% of peer responders report burnout associated with the role (Connors et al., 2021). Emotional strain, time pressure, concerns about competence, and a need for support and supervision have also been reported by peer supporters in healthcare settings (Schröder & Assing Hvidt, 2023). In maternity, these demands are likely to be compounded by the fact that peer supporters are themselves embedded in the same clinical environment, exposed to the same events, and operating under the same organisational pressures as those they support. Where supervision and protected time are not available, the sustainability of the role is uncertain (Busch et

al., 2021; Connors et al., 2021). This has implications for clinical psychologists responsible for staff support within healthcare, particularly in ensuring access to psychologically informed supervision and clear pathways for consultation as part of sustainable implementation (Conniff, 2022; The British Psychological Society, 2007).

This raises further questions about how peer support is understood and implemented. Simms-Ellis et al. (2025) note that organisations which offer formal peer support programmes without first addressing the cultural and organisational conditions that generate distress are at risk of staff experiencing them as tokenistic. Peer support is likely to function best not as a stand-alone response, but as part of an environment in which staff distress is already taken seriously. Overall, the literature suggests that while peer support in maternity care aligns with staff preferences and may offer valuable support, its availability and impact are shaped by relational, structural, and organisational conditions that shared professional experience alone does not address (Sweet & Kruger, 2025). One response to some of these limitations has been the development of more structured approaches to peer-delivered support. This thesis therefore examines Trauma Risk Management (TRiM) as one structured peer-delivered model of staff support, with the aim of exploring how TRiM is experienced by maternity staff who receive it, how it is experienced by practitioners who deliver it, and what these accounts suggest about the conditions shaping peer-led trauma support in maternity care. This addresses the over-arching research question from multiple perspectives.

1.8 Trauma Risk Management (TRiM) in maternity

Trauma Risk Management (TRiM) is a peer-delivered, organisational mental health process originally developed within the UK Armed Forces to support

personnel following exposure to potentially traumatic events (Greenberg et al., 2008; Jones et al., 2003). It was designed as a proactive system for identifying individuals who may be at risk of developing longer-term psychological difficulties and facilitating timely access to appropriate support. Unlike traditional clinical interventions, TRiM is embedded within the workplace and delivered by trained peers rather than mental health professionals. TRiM practitioners are typically senior staff within the organisation who receive specific training to provide structured support following critical incidents. The model is therefore positioned not as a therapeutic intervention in itself, identification-and-signposting support within occupational settings (Greenberg et al., 2008; Whybrow et al., 2015). The model is informed by clinical evidence that most individuals exposed to traumatic events will recover without formal intervention (NICE, 2018), so the primary task of TRiM is to identify those whose recovery does not follow an expected trajectory (Flaherty & O'Neil, 2022). In this sense, TRiM operates across prevention, early intervention, and organisational support, rather than fitting neatly within any single category.

This literature provides a specific context for considering TRiM as a response. In contrast to the predominantly individualised, informal or expert-led, and externally located interventions described earlier, TRiM is peer-delivered, embedded within the workplace rather than outside it, and oriented towards normalising distress and monitoring recovery rather than treating a diagnosed condition. Whether these features are sufficient to avoid the assumptions that have limited other approaches, or whether TRiM reproduces them in a different form, remains an open question.

TRiM differs from other trauma support models in both structure and emphasis. The model combines peer support, psychoeducation, and structured psychological risk assessment delivered in a staged and time-sensitive manner

(Greenberg et al., 2005). Following a potentially traumatic event, all staff who were involved are typically invited to attend a TRiM Incident Briefing (TIB), delivered typically within 72 hours of the critical incident. These briefings aim to provide factual information about the incident, normalise common psychological responses, and offer guidance on coping strategies and available supports. A key feature of TRiM is that these briefings are structured to provide information, normalise responses, and orientate staff to available supports, rather than explore emotional responses in depth. TIBs function as a structured opportunity to acknowledge that a significant event has occurred, provide psychoeducation, and encourage staff to look after themselves and one another in the immediate aftermath of a critical incident. There is a limited scope within this structured space for detailed discussion of the event or exploration of emotional responses.

This is followed, where appropriate, by individual or group-based Structured Conversations in which TRiM practitioners conduct an assessment of psychological risk using standardised indicators of distress (Flaherty & O'Neil, 2022). Structured Conversations are focused on assessing current functioning, support systems, and potential risk. While discussion of the event may occur, the primary focus is on identifying whether the individual requires further support beyond TRiM. This reinforces TRiM as a triage and referral mechanism. A defining feature of TRiM is its emphasis on follow-up. Individuals who engage in Structured Conversations are typically reassessed approximately one month after the incident, in line with best practice guidance on post-trauma monitoring (Jones et al., 2003; NICE, 2018). This allows for the identification of delayed or persistent difficulties that may not be evident in the immediate aftermath of the event and provides an opportunity to refer individuals on to more formal psychological supports where required.

Beyond individual assessment, TRiM also seeks to influence the broader social environment in which recovery takes place. By normalising stress responses and framing distress as an expected occupational experience rather than a sign of individual weakness, the model aims to reduce stigma and facilitate earlier help-seeking (Greenberg et al., 2008). In doing so, it implicitly targets known risk factors for poorer outcomes, including limited social support and high occupational stress. However, while these mechanisms are frequently described in the literature, the literature rarely specifies how different components of TRiM (e.g., peer-delivery, psychoeducation and monitoring) contribute to outcomes, or under what conditions they are most effective.

The evidence base for TRiM is largely derived from military and emergency service populations, with more limited application in healthcare settings (Flaherty & O’Neil, 2022; Greenberg et al., 2010; Romano, 2023; Watson & Andrews, 2018; Whybrow et al., 2015). Overall, findings suggest that TRiM is acceptable to staff and does not appear to cause harm, in contrast to earlier models such as single-session psychological debriefing, which have been associated with adverse outcomes (Greenberg et al., 2010; Rose et al., 2002). Some studies indicate that TRiM has been associated with improved occupational functioning, including reductions in sickness absence and improved organisational outcomes (Hunt et al., 2013; Whybrow et al., 2015). There is also tentative evidence that it may facilitate help-seeking and reduce stigma associated with psychological distress, although findings in this area are mixed (Gould et al., 2007; Greenberg et al., 2010; L. Watson & Andrews, 2018).

However, the evidence base is subject to several limitations. Much of the research has been conducted within military populations, often by research teams

affiliated with the organisation in which TRiM is implemented, raising questions about independence and generalisability (Whybrow et al., 2015). Samples are frequently drawn from male-dominated professions, and methodological approaches vary considerably in rigour. Furthermore, some studies have been limited by low exposure rates during evaluation periods, restricting the ability to detect meaningful effects (Greenberg et al., 2010). A further limitation, again, is the tendency for studies to focus on acceptability and broad outcomes, with comparatively little attention to the processes through which TRiM brings about its effects. As a result, it remains unclear whether observed benefits can be attributed to the intervention itself, the peer-based model of delivery, or the wider organisation in which it is implemented.

The application of TRiM to maternity care requires careful consideration. While the model has been implemented in some healthcare contexts (Bedor, 2018; Flaherty & O'Neil, 2022), it was originally developed for use in environments characterised by discrete, high-impact incidents (Jones et al., 2003). Maternity care, however, is marked by ongoing relational work, cumulative exposure to distress, and a strong connection between clinical outcomes and clinicians' sense of professional competence and identity (Andre et al., 2016; Bingham et al., 2023; Schröder et al., 2016; Uddin et al., 2022). These features may shape both the nature of traumatic exposure and the ways in which support is experienced. As such, assumptions underpinning TRiM, particularly those relating to recovery trajectories and the role of peer support, may not transfer neatly to this setting. Preliminary service-level evaluations suggest that TRiM may be perceived as beneficial by maternity staff, with reports of improved coping and retention following traumatic events (Delport-Riches, 2023). However, these findings are typically drawn from non-peer-reviewed

sources and should be interpreted with caution. At present, there is limited high-quality empirical research examining the implementation or effectiveness of TRiM specifically within maternity services.

TRiM is typically embedded within a broader system of staff support rather than functioning as a standalone programme. In healthcare settings, clinical psychology input appears to play a key role within this system, providing supervision for TRiM practitioners, and referral pathways for staff identified as requiring further support (Flaherty & O'Neil, 2022). This integration reflects an implicit division of labour within the system where peer supporters provide immediate, on-site support and early identification, while more in-depth psychological processing is located outside the TRiM pathway. This distinction is particularly important given that TRiM practitioners may be exposed to distress through their role (Cohen & Collens, 2013).

While shared experience may enhance credibility and facilitate engagement, it also raises questions about boundaries, emotional labour, and the support available to those delivering the programme. Access to supervision, opportunities to step back from the role, and clear referral pathways are therefore critical to maintaining both the effectiveness and sustainability of the intervention (Flaherty & O'Neil, 2022). In this sense, TRiM cannot be understood independently of the wider psychological and organisational infrastructure in which it is embedded. Furthermore, the model may be experienced differently depending on levels of psychological safety and trust within teams. These observations raise important questions about how staff experience and engage with TRiM in real-world settings and suggest that its effectiveness may depend not only on its structure but on the psychological

conditions it creates. This provides a rationale for examining TRiM through a theoretically informed lens (see Section 1.10).

1.9 Clinical psychology and staff support in maternity care

Clinical psychologists bring expertise in assessment, formulation, and evidence-based intervention, as well as in supervision and reflective practice (Psychologists Registration Board, 2026; Stige et al., 2026). Across international competency frameworks, these skills are understood as extending beyond individual clinical encounters to include prevention, service evaluation, and the capacity to work within complex systems, including occupational health settings (EACLIPT Task Force, 2019). This is directly relevant to TRiM in maternity care, because TRiM is not designed to provide in-depth psychological intervention, but instead follows a structured, psychoeducational, and identification-and-signposting model. Clinical psychology, therefore, becomes important not as an alternative to TRiM but for clarifying what TRiM can reasonably provide and when additional input may be needed.

At the level of the individual, clinical psychology contributes a formulation-based approach to understanding distress. This is relevant as the profile of post-incident distress in maternity settings is not well captured by symptom thresholds alone. As reviewed in earlier sections, staff frequently experience responses that include intrusive memories, self-blame, and challenges to professional identity following adverse events, responses that often persist below the diagnostic threshold but remain clinically significant (Healy et al., 2025; Simms-Ellis et al., 2025). NICE (2018) guidance acknowledges that most individuals will recover following traumatic events without formal intervention, which makes accurate identification of those who will not a clinically important task. Formulation-based assessment moves

beyond symptom counting to offer a theoretically grounded account of a person's difficulties: how they relate to one another, why they may have developed in this particular context, and what they suggest about the kind of support that might be most useful. Critically, formulations are understood as provisional and open to revision as new information emerges (Johnstone & Dallos, 2006, p. 11). It is this capacity for person-specific, contextually grounded assessment that distinguishes the clinical psychology contribution from broader peer monitoring and risk identification.

Clinical psychology is also relevant to understanding why TRiM may be experienced differently across staff. These appraisal processes do not occur in isolation but are shaped by the organisational conditions previously discussed in this chapter (see Section 1.5). This has direct implications for how TRiM functions in practice, since a clinician whose appraisal of an adverse event is already shaped by fear of scrutiny or professional consequence is unlikely to engage openly with peer-delivered support in the same environment (Bingham et al., 2023; Busch et al., 2021). Clinical psychology, as a discipline, is well placed to hold both of these levels simultaneously: to engage with how individual staff make sense of events and to attend to the organisational conditions that shape it. The British Psychological Society (2007) described this dual orientation as fundamental to applied psychology, noting that contexts, including the organisations in which people work, impact powerfully on individual psychological wellbeing and that interventions must be directed at both. For TRiM, this means that its effectiveness is unlikely to depend only on the peer interaction itself, but also on whether the wider setting makes that interaction feel safe and credible.

Supervision is particularly relevant in peer-led models such as TRiM, where those providing support may themselves be affected by what they are hearing (Cohen & Collens, 2013). As noted earlier in this chapter (see Section 1.7), peer supporters in healthcare settings are themselves vulnerable to burnout and emotional strain associated with the role (Connors et al., 2021; Schröder & Assing Hvidt, 2023). In the context of this thesis, this is reflected in the role of the staff support clinical psychologist within the Ireland South Women and Infants directorate, who forms part of the wider support structure around TRiM by providing supervision and access to more specialist support where needed. This highlights how psychological supervision may be an important feature of how TRiM is sustained in a maternity setting. Without it, the sustainability of peer-delivered support may rest too heavily on individual resilience rather than organisational infrastructure, which the broader literature suggests is inadequate for support of this kind (Simms-Ellis et al., 2025; Turner & Lancaster, 2025).

Beyond this supervisory role, clinical psychologists may also contribute at a wider systems level. A growing number of staff support roles are being created for clinical psychologists in maternity settings that combine direct clinical work with oversight of peer support programmes, facilitation of reflective practice, supervision of specialist midwifery roles, and input into service development (Archibald et al., 2025; Marks et al., 2026). In Ireland, dedicated staff support psychology roles in maternity are still emerging and, at the time of writing, only two such posts were in place nationally. Emerging findings suggest that psychologist-led training and support can improve psychological safety among maternity staff, with positive implications for staff retention (Marks et al., 2026). Archibald et al. (2025) found that a clinical supervision service led by senior psychologists was associated with

improved wellbeing, reduced burnout, and lower traumatic stress symptoms. Taken together, these developments suggest that support for maternity staff may be most effective when organised as a layered system in which different forms of psychological input are available depending on need. On this basis, TRiM may function best as one component within that wider support structure, rather than as a standalone programme. This is also consistent with its current implementation within the Ireland South Women & Infants Directorate, the setting in which this thesis is based, and aligns broadly with what Simms-Ellis et al. (2025) describe as a multilevel model of support following adverse events.

This thesis examines how staff experience TRiM within a maternity setting. Clinical psychology provides that framework to help understand variability in engagement, what staff find helpful, what constrains their participation, and under what conditions support is experienced as meaningful. It does this by attending to both individual psychological processes and the organisational environment in which those processes unfold. Within that framework, the contribution of clinical psychology is not to replace peer-delivered support, but to clarify its function, support its implementation, and identify where additional intervention may be needed.

1.10 Self-Determination Theory and the psychology of staff support

Self-Determination Theory (SDT) offers a useful framework for understanding how staff experience support following a traumatic event. Rather than focusing only on whether or not support is available, SDT directs attention to the psychological conditions that influence whether it is taken up or experienced as helpful. Central to the theory is the proposition that motivation and wellbeing depend on the satisfaction of three basic psychological needs: autonomy, competence, and

relatedness (Ryan & Deci, 2000). These needs are not simply preferences but are understood within SDT as necessary conditions for psychological functioning and overall wellbeing (Baard et al., 2004; Vansteenkiste & Ryan, 2013). When supported, they are associated with increased motivation and effective psychological functioning. In contrast, when these needs are frustrated, they are linked to disengagement and psychological distress (Baard et al., 2004; Vansteenkiste & Ryan, 2013). Importantly, SDT distinguishes between low levels of need satisfaction and the active frustration of needs. While unmet needs may limit wellbeing over time, need frustration refers to conditions in which autonomy, competence, or relatedness are actively undermined (Vansteenkiste & Ryan, 2013). This distinction is particularly relevant in maternity settings, where organisational culture and professional expectations may not only fail to support staff but may also shape how distress is experienced and expressed. From an SDT perspective, such conditions can be understood as undermining basic psychological needs (Vansteenkiste & Ryan, 2013).

Within this framework, relatedness refers to the need to feel connected to others and to experience a sense of belonging, as well as feeling cared for and significant to others (Ryan & Deci, 2000). In relation to staff support, this is reflected in whether individuals feel recognised in their experiences and able to share them with others who understand the clinical context, particularly in environments where it feels safe to speak openly without fear of judgement or negative consequences. Peer-based approaches, such as TRiM, may support relatedness through shared experience and credibility. Evidence from health-related peer support interventions suggests that peer interaction can support a sense of connection and shared understanding between individuals (Stenberg et al., 2022). However, this is

not guaranteed. Evidence from maternity settings suggests that while staff often value support grounded in shared experience and understanding (Buhlmann et al., 2021; Sheen et al., 2016a), support is not always experienced as credible, particularly in workplace environments that are often characterised by strained staff relationships and limited trust in leadership (Knezevic et al., 2025).

Autonomy refers to the experience of choice and a sense of volition. Within a staff support lens, this relates to whether engagement is experienced as voluntary and safe, rather than expected or imposed. SDT highlights that engagement is more likely to be meaningful when it is self-endorsed rather than driven by pressure or obligation (Ryan & Deci, 2000). In healthcare settings, however, engagement may be shaped by concerns about judgement, blame or perceptions of weakness (Bingham et al., 2023; Busch et al., 2021). Under these conditions, staff may attend support while remaining guarded or disengaged. This highlights that availability alone is not sufficient. How support is offered, and whether staff feel psychologically safe to openly engage on their own terms, is central (Edmondson, 1999).

Competence refers to the need to feel capable and effective (Ryan & Deci, 2000). Following adverse clinical events, this need may be particularly vulnerable. Experiences of trauma in maternity care have been associated with self-doubt and ongoing rumination, alongside questioning of professional judgement (Sheen et al., 2016a; Uddin et al., 2022). Support that helps staff make sense of what has happened and regain confidence in their clinical practice may support this need. Within TRiM, elements such as psychoeducation and structured follow-ups may contribute to this process. However, where staff remain uncertain about their responses or continue to question their clinical judgement following an event, competence may remain undermined (Sheen et al., 2016a; Uddin et al., 2022). This suggests that support

which does not help staff make sense of what has happened may be less effective in restoring a sense of professional confidence.

Taken together, these needs provide a way of linking organisational context to psychological process. Conditions characterised by low psychological safety, fear of blame, and limited trust may not only fail to support basic psychological needs but actively frustrate them. For example, environments in which staff feel unable to speak openly may constrain autonomy (Busch et al., 2021), while blame-oriented responses may undermine competence through self-doubt and heightened scrutiny (Bingham et al., 2023; Sheen et al., 2016a). Similarly, a lack of relational support or experiences of judgement may limit opportunities for relatedness, contributing to feelings of isolation (Busch et al., 2021). From this perspective, organisational conditions shape how trauma is experienced in part through their impact on basic psychological needs.

SDT also highlights the importance of internalisation, referring to the extent to which individuals engage in and make use of the support offered to them (Ryan & Deci, 2000). Therefore, engagement is not simply a matter of attending an intervention, but of whether support is experienced as meaningful and relevant. Internalisation is more likely in settings that support relatedness, autonomy and competence, allowing individuals to integrate support in ways that are in line with their values and professional identity (Ryan & Deci, 2000). When these conditions are not met, engagement may remain superficial or be avoided altogether. Evidence from healthcare settings supports the relevance of these processes. Satisfaction of basic psychological needs has been associated with improved wellbeing, work engagement, and a reduction in burnout among healthcare professionals (Babenko, 2018; Nunes et al., 2024). Within maternity, work environments characterised by

higher control and social support have been linked to better mental health outcomes through their influence on these needs (Ferrand et al., 2017). On the other hand, environments perceived as unsupportive or judgemental may make it more difficult for staff to engage with available supports (Bingham et al., 2023; Busch et al., 2021).

While much of the literature focuses on those receiving support, emerging research from Connors et al. (2021) suggests that similar dynamics may apply to those delivering it. Studies of peer support programmes in healthcare indicate that facilitators often experience their role as meaningful and personally rewarding, with high levels of perceived impact and confidence reported. At the same time, this role can involve significant demands, including time pressures, emotional labour, and, for some, experiences of burnout (Busch et al., 2021; Connors et al., 2021). Concerns about preparedness, particularly in more complex group settings, and limitations in opportunities for follow-up have also been identified (Busch et al., 2021; Edrees et al., 2016). However, research in this area remains limited, with relatively few studies examining the experiences of peer supporters themselves. This highlights that understanding how support roles are experienced and how they are sustained within healthcare settings remains an important but underexplored area.

SDT offers a way of understanding staff support that extends beyond the interventions themselves to the conditions in which they are delivered. It suggests that interventions may be experienced differently depending on whether they support or constrain autonomy, competence, and relatedness. This provides a framework for examining variations in how staff engage with support, and for understanding why interventions that are available and acceptable in principle may not always be experienced as helpful.

1.11 Rationale for thesis

Across the literature reviewed in this chapter, several patterns emerge. Firstly, exposure to potentially traumatic events is not an occasional feature of maternity work but a routine aspect of clinical practice. These experiences are associated with a range of psychological and professional consequences, including distress, changes in clinical decision-making, and, in some cases, intent to leave the profession (Andre et al., 2016; Aydın & Aktaş, 2021; Bingham et al., 2023; Nieuwenhuijze et al., 2024; Sheen et al., 2014; Uddin et al., 2022). However, the impact of these events is not determined solely by their severity or frequency. Rather, it is shaped by how they are interpreted and by the organisational conditions in which they occur and are subsequently managed.

Secondly, workplace environments play a central role in shaping how trauma is experienced and responded to. Across studies, workplace cultures characterised by scrutiny, fear of blame, and limited psychological safety are associated with increased distress, reduced disclosure, and greater reliance on defensive practice (Bingham et al., 2023; Buhlmann et al., 2021, 2022; Sheen et al., 2016b). In contrast, environments in which staff feel supported, acknowledged, and able to speak openly appear to facilitate more adaptive engagement with these experiences (Bingham et al., 2023; Edmondson & Lei, 2014; Sheen et al., 2016b). This suggests that trauma in maternity care cannot be understood purely at the level of the individual clinician but must be situated within the relational and organisational systems in which care is delivered.

Finally, while there has been increased attention to staff support, provision remains inconsistent and often poorly aligned with what staff describe as helpful (Sweet & Kruger, 2025). What organisations provide often centres on medical

debriefings focused on risk management and clinical skills, whereas staff more commonly describe needing practical guidance, relational understanding, and access to professional support (Buhlmann et al., 2021; Simms-Ellis et al., 2025). As a result, the presence of support does not necessarily translate into engagement or perceived benefit. This gap between provision and need raises questions about how support is conceptualised and evaluated within the literature.

Peer support appears as a promising response to some of these limitations, particularly given its emphasis on shared experience and contextual understanding (Sweet & Kruger, 2025). Staff consistently report a preference for support from colleagues who understand the clinical and emotional experience of their work (Fontein-Kuipers et al., 2018; Kerkman et al., 2019). However, the literature also indicates that peer support is not inherently effective. Its accessibility and impact are shaped by the same organisational conditions that influence trauma more broadly, including hierarchy, staffing, workload, and psychological safety (Busch et al., 2021; Sheen et al., 2016a). In addition, relatively little attention has been paid to the experiences of those delivering peer support, despite emerging evidence that these roles involve emotional labour, and potential psychological cost (Busch et al., 2021; Connors et al., 2021).

Overall, these findings highlight several unanswered questions. Although peer support is widely advocated, current findings do not clearly establish under what conditions it is experienced as helpful to staff (Busch et al., 2021; Sweet & Kruger, 2025). The literature has largely focused on acceptability and broad outcomes, with comparatively limited attention to the psychological processes that shape engagement, such as how individuals interpret support, whether they feel safe to use it, and how it supports staff mental wellbeing (Sweet & Kruger, 2025).

Similarly, while organisational factors are repeatedly identified as important, there has been limited adaptation of specific interventions for the maternity setting (Bingham et al., 2023; Sweet & Kruger, 2025).

These gaps are directly relevant to clinical psychologists practising in staff support roles, particularly in services where peer-led models such as TRiM sit within a wider staff support pathway. In these settings, clinical psychologists may contribute through supervision and access to more specialist support where needed, while also helping to think about how distress is understood across individual and organisational levels. This is particularly relevant in maternity settings, where staff responses are shaped by both individual interpretations of traumatic events and the organisational environments in which they occur.

This also points to the need for a more explicitly psychological account of how support functions within maternity settings. In particular, there is a need for a framework that can account for both individual experience and organisational context, and that can explain variability in how support is perceived and used. Self-Determination Theory (Ryan & Deci, 2000) offers one potential framework. By focusing on how social environments support or frustrate basic psychological needs for relatedness, autonomy, and competence, SDT provides a way of examining not only whether support is available, but how it is experienced and why it may or may not be effective in this setting.

The present thesis addresses these gaps by examining Trauma Risk Management (TRiM), a structured, peer-delivered approach to post-incident support, within a maternity setting. Across two complementary studies, the research explores both staff experiences of engaging with TRiM, and practitioner experiences of delivering it. Study 1 uses a mixed methods design to examine the perceived impact

of TRiM and the psychological factors shaping engagement. Study 2 adopts a qualitative approach to explore how TRiM practitioners experience the implementation and delivery of peer-led trauma support. Together, these studies are positioned as offering complementary perspectives on the same intervention. In doing so, the thesis aims to move beyond questions of whether TRiM is acceptable or effective, towards a more nuanced understanding of how peer-led trauma support operates in maternity settings, the conditions under which it is experienced as supportive by clinical staff, and to inform the knowledge base and practice of clinical psychologists working in staff support roles.

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Chapter 2: Empirical Study 1

Maternity staff experiences of Trauma Risk Management (TRiM): A mixed-methods exploration of psychological factors shaping perceived impact and engagement

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Abstract

Aim(s)

To examine maternity staff experiences of Trauma Risk Management and identify psychological factors shaping engagement and perceived impact.

Design

Cross-sectional mixed-methods survey.

Methods

An anonymous online survey was completed by 30 maternity staff within a regional maternity service who had previously participated in Trauma Risk Management.

Quantitative Likert-scale data were analysed descriptively. Open-text responses were analysed using inductive content analysis and subsequently interpreted using Self-Determination Theory.

Results

Participants reported generally positive experiences, particularly in relation to increased understanding of trauma responses and perceived peer support. However, engagement and perceived impact were varied. Supportive facilitation and visible organisational endorsement were associated with more positive experiences, while limited opportunity for emotional expression, insufficient preparation for group participation, and dismissive senior clinician attitudes were associated with need frustration and reduced engagement.

Conclusion

Trauma Risk Management was generally experienced positively by maternity staff in this service, particularly as a source of peer support and psychoeducation. Its perceived usefulness depended on the relational and organisational conditions surrounding its delivery.

Implications for the profession and/or patient care

Peer-delivered interventions may be strengthened by integration within wider systems of staff support. Access to additional psychologically informed support may also be important where staff needs extend beyond the scope of peer-delivered intervention.

Impact

This study provides the first examination of maternity staff experiences of Trauma Risk Management. Findings are relevant for healthcare services implementing peer support interventions in high-risk clinical environments.

Reporting Method

This study was reported with reference to the Good Reporting of a Mixed Methods Study (GRAMMS) recommendations.

Patient or Public Contribution

This study did not include patient or public involvement in its design, conduct, or reporting.

What does this paper contribute to the wider global clinical community?

- Provides the first empirical evidence on how maternity staff experience Trauma Risk Management (TRiM) as participants within a healthcare setting.
- Demonstrates that engagement with peer support interventions is shaped by organisational and relational conditions, not the intervention alone.

1. Introduction

Maternity care providers are among the healthcare professionals most frequently exposed to potentially traumatic events in the workplace. A recent scoping review found that traumatic birth events have a lasting psychological impact on staff who witness or are involved in them (Nieuwenhuijze et al., 2024), regardless of their professional role (Healy et al., 2025). The cumulative effect of such traumatic exposure is well documented, with maternity staff reporting high rates of burnout, traumatic stress symptoms, and a growing intention to leave the profession (Aydın & Aktaş, 2021; Bingham et al., 2023; Cankaya et al., 2021; Uddin et al., 2022). Despite the well-documented impact of trauma exposure, evidence suggests that health services frequently fail to provide support that is either sufficient or appropriately tailored to the needs of maternity staff (Healy et al., 2025; Nieuwenhuijze et al., 2024; Simms-Ellis et al., 2025). This has led to increased interest in accessible workplace interventions that can be delivered within maternity services.

When support is absent or inadequate, the consequences for both maternity staff and the service in which they work can be significant. Without opportunities to process traumatic experiences, staff may internalise distress, becoming hypervigilant in their practice and withdraw from their work and colleagues (Bingham et al., 2023; Sheen et al., 2016). Over time, this can manifest as reluctance to disclose distress or seek help (Busch et al., 2021), with staff describing feelings of abandonment and reporting that their emotional needs were not considered by management (Nieuwenhuijze et al., 2024). Critically, these consequences are not just individual, as unsupported staff are more likely to adopt defensive clinical practices, with implications for patient safety and care (Bingham et al., 2023; Cankaya et al., 2021). At an organisational level, leadership attitudes play a central role in shaping whether

staff feel psychologically safe enough to acknowledge distress and seek support (Edmondson, 1999; Edmondson & Lei, 2014). Research indicates that organisational conditions such as protected time and visible commitment are foundational, and in their absence, even well-designed interventions may fail to gain traction (Knezevic et al., 2025). Understanding what enables staff to engage with support and what gets in the way, is therefore as important as the support itself. Clinical psychologists are well placed to examine these questions, given their training in understanding how psychological, relational, and organisational factors interact to shape individuals' experiences and behaviour. It is partly for this reason that clinical psychologists are increasingly taking on staff support roles within healthcare settings, with emerging evidence that psychologist-informed programmes can improve psychological safety and reduce burnout among maternity staff specifically (Archibald et al., 2025; Marks et al., 2026).

2. Background

Among the approaches to staff support that have gained traction in maternity settings, peer support has emerged as a promising approach. Maternity care providers consistently report a preference for support from colleagues who share their professional context and can validate their experiences without explanation (Fontein-Kuipers et al., 2018; Kerkman et al., 2019; Nieuwenhuijze et al., 2024; Sweet & Kruger, 2025). Talking to a peer with the same clinical background is experienced as providing a more meaningful and contextually informed response than generic support services (Schröder & Assing Hvidt, 2023). However, shared experience alone does not guarantee meaningful support. Its quality often depends on the relational and organisational conditions in which it is offered (Watson, 2019). Help-seeking stigma and fear of being perceived as unable to cope represent

significant psychological barriers, particularly in high-performance clinical cultures (Busch et al., 2021). Uptake of formal peer support programmes is often lower than anticipated, typically explained with reference to barriers including fear of blame, reluctance to show vulnerability, and limited awareness of available programmes identified (Busch et al., 2021). Bridson et al. (2021) suggest hierarchical dynamics can act as a further constraint for peer support programmes in healthcare. Support offered across differences in seniority may not function as intended, particularly where disclosure carries perceived professional risk. This highlights that peer support must be embedded within a wider organisational commitment to staff wellbeing to be effective, and that understanding the psychological factors shaping engagement is as important as the support itself.

Trauma Risk Management (TRiM) has emerged as a structured approach to delivering peer-facilitated support following potentially traumatic workplace events. Originally developed for the Royal Navy (Greenberg et al., 2008), TRiM has subsequently been adopted across a variety of occupational settings exposed to critical incidents or cumulative stress, including police officers (Hunt et al., 2013), emergency services (Romano, 2023), healthcare settings (Flaherty & O'Neil, 2022). The programme is delivered by trained peer-facilitators known as TRiM practitioners and typically begins with a TRiM Incident Briefing (TIB) delivered within 72 hours of an event. The briefing provides factual information, psychoeducation, and normalisation of trauma responses. This is followed by individual or group Structured Conversations to assess psychological risk, with a further follow-up Structured Conversation approximately one month later for those who require additional support. This approach is consistent with evidence-based guidance on post-incident support, which cautions against immediate psychological processing

interventions and instead recommends monitoring and signposting to further help where needed (National Institute for Health and Care Excellence [NICE], 2018). Unlike generic wellbeing programmes, TRiM is incident-specific, time-sensitive, and delivered by peers with shared occupational experience, making it potentially well-suited to the demands of maternity care. However, the extent to which this model translates to maternity settings, where distress may not follow a single-incident trajectory, remains unclear. Evidence from non-maternity settings is cautiously encouraging, with reported benefits including lower sickness absence, reduced stigma and PTSD symptoms and barriers to help-seeking (Hunt et al., 2013; Watson & Andrews, 2018; Whybrow et al., 2015). This evidence base remains limited, with most studies focused on implementation description rather than rigorous outcome evaluation, and questions remain regarding how TRiM is experienced in practice, and the conditions under which staff engage with it.

TRiM was introduced to Ireland South Women and Infants Directorate in December 2023 by a senior clinical psychologist responsible for staff support and wellbeing within the service. Ireland South Women and Infants Directorate is a clinically led network of four maternity units in the south of Ireland comprising Cork University Maternity Hospital, University Hospital Kerry, Tipperary University Hospital, and University Hospital Waterford. Maternity care occupies a distinctive position among high-risk clinical environments, characterised by the proximity of birth and loss within the same clinical space, the relational investment staff develop with women and families, and a professional culture in which accountability and emotional demands are closely intertwined (Andre et al., 2016; Beck et al., 2015; Cankaya et al., 2021; Sheen et al., 2016). These features distinguish maternity from the military and emergency service contexts in which TRiM was originally

developed and most extensively studied. This represents the first known implementation of TRiM in an Irish maternity setting, and to date no research has examined how maternity staff experience the intervention as participants, or the psychological mechanisms shaping their engagement with it.

Existing TRiM research has tended to focus on descriptions of implementation and whether the intervention produces beneficial outcomes (Flaherty & O'Neil, 2022; Greenberg et al., 2008; Watson & Andrews, 2018; Whybrow et al., 2015), with comparatively little attention to the psychological mechanisms shaping how staff engage with the intervention or the conditions under which these effects occur. Without attention to these processes, there is a risk that the outcomes are attributed to the intervention itself rather than the interpersonal and organisational conditions surrounding its delivery. Self-Determination Theory (SDT; Ryan & Deci, 2000) offers a framework well-suited to examining these psychological mechanisms directly. SDT proposes that psychological wellbeing and motivated engagement depend on the satisfaction of three core psychological needs: relatedness, autonomy, and competence (Ryan & Deci, 2000). These are not understood as preferences but as necessary conditions for psychological functioning. Importantly, SDT distinguishes between need satisfaction and need frustration, where the latter refers to the active undermining of these needs rather than their mere absence. Where these needs are frustrated, the consequences include disengagement and poorer wellbeing (Vansteenkiste & Ryan, 2013). This distinction is particularly relevant in maternity settings, where organisational culture, hierarchies, and blame-oriented responses may not only fail to support these needs but actively undermine them (Bingham et al., 2023; Knezevic et al., 2025). SDT therefore functions as the analytic lens through which staff engagement with TRiM is examined. Relatedness is directly

relevant to the collegial and interpersonal dimensions of peer-facilitated support.

Autonomy speaks to whether engagement is experienced as voluntary and psychologically safe. Competence is relevant to the role of psychoeducation and normalisation in supporting staff confidence following potentially traumatic events.

3. The Study

Aims(s)

To examine maternity staff experiences of participating in TRiM within Ireland South Women and Infants Directorate and to identify the psychological, relational, and organisational factors shaping engagement and perceived impact.

Objectives

The objectives were to:

1. To describe staff perceptions of the perceived impact of TRiM following potentially traumatic workplace events.
2. To explore how maternity staff experienced the peer-facilitated nature of TRiM, including barriers and facilitators to engagement.
3. To identify the psychological conditions that appeared to support or undermine staff engagement of TRiM

Research question

How do maternity staff experience participation in Trauma Risk Management, and what factors shape engagement with and perceived impact of the intervention?

4. Methods

Design

The study was designed as a cross-sectional mixed-methods survey to examine maternity staff experiences of TRiM and factors influencing engagement and perceived impact. The study integrated quantitative Likert-scale items with open-text responses to capture both breadth of attitudes and contextualised staff perspectives. A convergent mixed-methods design was used, in which quantitative and qualitative data were collected concurrently through a single survey, analysed separately, and integrated at the interpretation stage. The quantitative and qualitative components were given complementary priority, with quantitative data used to describe patterns in staff experience and qualitative data used to elaborate the relational and organisational conditions shaping those patterns. This study was reported with reference to the Good Reporting of a Mixed Methods Study (GRAMMS) recommendations (O’Cathain et al., 2008).

Study setting and recruitment

Recruitment was conducted through email invitations circulated via internal communication channels, with recruitment posters displaying study information and QR codes displayed in staff common areas throughout the directorate. Both directed staff to a Qualtrics link containing a participant information sheet and consent form (see Appendix B), survey (see Appendix C), and debrief form (see Appendix D). Regular follow-up contact was maintained throughout the recruitment period, including reminder emails, manager-facilitated dissemination through internal staff communication channels, and mention during staff meetings. These multimodal strategies were selected in accordance with evidence identifying regular reminders, peer-level engagement, and manager facilitation as among the most effective

approaches to maximising response rates in nurse and midwife surveys (Cooper & Brown, 2017). Participation was entirely voluntary and no incentives were offered.

Of approximately 185 staff who had engaged with TRiM across the directorate during the recruitment period, 30 completed the survey, representing a response rate of approximately 16%. Item-level response rates varied slightly across questions, and analyses are reported on available data per item throughout. Given the exploratory aims of the study and its focus on understanding the psychological mechanisms shaping staff engagement with TRiM, a sample of N=30 was considered appropriate for identifying exploratory patterns in staff experience within this bounded population. The authors acknowledge that the sample size limits the depth of conclusions and their generalisability to other maternity settings, and findings should be interpreted accordingly.

Of the 30 survey respondents, 16 provided responses to one or more of the three qualitative open-text questions. The discrepancy between the quantitative sample (N = 30) and the qualitative sub-sample (n = 16) reflects the optional nature of the open-text questions.

Inclusion and exclusion criteria

All staff employed within Ireland South Women and Infants Directorate who had attended a TRiM Incident Briefing or Structured Conversation were eligible for inclusion, provided they had done so at least six weeks prior to participation and were able to provide informed consent. Staff who had not engaged with the TRiM service, or whose most recent participation fell within the six-week threshold, were excluded. The six-week threshold was applied in accordance with evidence that symptoms of post-traumatic stress disorder (PTSD) typically do not consolidate until at least four to six weeks following a potentially traumatic event (American

Psychiatric Association, 2013), allowing participants sufficient time to experience and reflect on any impact of TRiM on their wellbeing and functioning prior to data collection.

Data collection

Data were collected using an anonymous online survey. Items were designed in collaboration with the clinical TRiM coordinator and reviewed by other co-authors to ensure face validity and relevance to the maternity context. The instrument gathered information on role and demographics, extent of TRiM exposure, and Likert-scale ratings relating to perceived impact, usefulness, and satisfaction. A bespoke instrument was preferred over supplementing with validated psychometric scales, as evidence suggests that survey length is inversely associated with response rates among maternity staff (Cooper & Brown, 2017).

Qualitative data were obtained through three open-text questions on the survey, that invited participants to express preference in TRiM or other staff wellbeing supports available, provided feedback on aspects of the TRiM service, and suggested improvements. Open-text responses ranged from brief comments to more detailed reflections. Including both closed- and open-ended items was intended to enable examination of broad response patterns alongside contextualised accounts of staff experience.

Data analysis

Quantitative data were analysed using descriptive statistics. Frequency counts and percentages were calculated for all categorical items and Likert-scales. Given the exploratory nature of the study and the use of a bespoke instrument without established psychometric properties, descriptive analysis was considered the most appropriate analytical approach. Analyses were conducted using IBM SPSS

Statistics version 29.0.2.0. Item-level missing data was handled by analysing available responses only. The sample size for each item is reported in the corresponding table.

Qualitative responses were analysed using inductive content analysis (Elo & Kyngäs, 2008), with subsequent theoretical interpretation drawing on SDT (Ryan & Deci, 2000; Vansteenkiste & Ryan, 2013). Inductive qualitative content analysis was chosen in preference to a purely deductive or directed approach because the survey instrument was not designed to probe SDT constructs directly, and the research aims required categories to be grounded in participants' own accounts before theoretical interpretation was applied. The analysis proceeded in two sequential phases, reflecting this logic of inductive category generation followed by theoretical interpretation (Bradley et al., 2007).

In the first phase, open coding generated descriptive codes close to participants' language. Codes were grouped into sub-categories and abstracted into broader categories reflecting patterns across the dataset, with categories revised iteratively to ensure fit with the data (Elo & Kyngäs, 2008). In the second phase, the identified categories were interpreted using the SDT (Ryan & Deci, 2000). This sequence allowed the data to speak first, while enabling structured psychological interpretation in relation to the study's aims. Mapping qualitative categories onto SDT's three core needs, relatedness, autonomy and competence, facilitated structured psychological interpretation of staff experiences, while distinguishing between conditions that support or undermine psychological need (Vansteenkiste & Ryan, 2013) and support integration with the quantitative findings.

Quantitative and qualitative findings were integrated at the interpretation stage using a convergent mixed-methods approach (Creswell & Plano Clark, 2017).

Integration was conducted through narrative weaving, whereby quantitative patterns and qualitative categories were compared across key areas of staff experience to triangulate areas of convergence, complementarity, and divergence (Fetters et al., 2013).

Ethical considerations

Ethical approval was obtained from the Clinical Psychology Research Ethics Committee (CPREC) at University College Cork in October 2024 and the Local Information Governance Group (LIGG) at Cork University Maternity Hospital (CUMH) in January 2025. All participants were asked to review a detailed information page and provide informed consent via Qualtrics before gaining access to the anonymous survey. Debriefing information was issued following completion of the survey. Participants could withdraw from the study up to one week after they completed the study. Research data was pseudonymised, with identifying information removed, and stored on a secure UCC OneDrive folder accessible only to the research team. Anonymised data will be stored on the academic supervisor's UCC OneDrive and will be retained for a minimum of ten years, in line with the UCC Code of Research Conduct.

Rigour and reflexivity

Reflexive awareness was maintained throughout qualitative analysis in recognition of the first author's position as a trainee clinical psychologist and of the potential influence of this perspective on data interpretation. The first author developed the coding and category structure, and interpretations were discussed with co-authors, who reviewed the underlying qualitative responses and illustrative quotations in order to consider alternative readings and support a balanced, data-

grounded analysis. This process was used to support rigour in the development and interpretation of the qualitative findings.

5. Findings

Quantitative findings

Characteristics of participants

Thirty maternity staff within the Directorate completed the survey. The sample comprised midwives (50.0%), doctors (40.0%), and nurses (10.0%) (see Table 1). Most respondents reported a substantial professional experience, with more than half the respondents reporting more than 10 years in their role (56.7%), and smaller numbers reporting 5 – 10 years (16.7%), 3 – 5 years (10.0%), 1 – 2 years (10.0%), and less than 1 year (6.7%).

Table 1
Sample Characteristics

Role	n (%)	Years of experience	n (%)
Midwife	15 (50.0)	Less than 1 year	1 (6.7)
Nurse	3 (10.0)	1-2 years	3 (10.0)
Doctor	12 (40.0)	3-5 years	3 (10.0)
		5-10 years	5 (16.7)
		10+ years	17 (56.7)

Note. Sample size varies by item (n = 29–30) due to item-level missing data.

The participants reported varying levels of exposure to the TRiM process (see Table 2). The TRiM Incident Briefing was the most attended component (64.5%), with fewer participants attending TRiM Structured Conversations (35.5% individual; 25.8% group), and follow-up Structured Conversations (32.3%). Most had been invited to and attended TRiM on one occasion (53.3%). Prior familiarity

with the service was limited, with over half of participants reported that they were not familiar with the service prior to attending (51.7%).

Table 2
TRiM exposure and prior familiarity

TRiM components attended	n (%)
TRiM Incident Briefing (TIB)	20 (64.5)
TRiM Structured Conversation	11 (35.5)
Group TRiM Structured Conversation	8 (25.8)
Follow-up TRiM Structured Conversation	10 (32.3)
Times invited to TRiM	n (%)
Once	16 (53.3)
2 – 3 time	13 (43.3)
4 or more times	1 (3.3)
Times attended TRiM	n (%)
Once	21 (70.0)
2 – 3 time	8 (26.7)
4 or more times	1 (3.3)
Prior familiarity with TRiM service	n (%)
Not familiar at all	15 (51.7)
Somewhat familiar	10 (34.5)
Very familiar	4 (13.8)

Note. Sample size varies by item (n = 29–30) due to item-level missing data.

Perceived impact of TRiM

Participants generally reported positive perceived influences of TRiM following potentially traumatic events in the workplace (see Table 3). Most agreed or strongly agreed that participation in TRiM contributed to a sense of support in the

workplace (71.5%) and facilitated reflection on the personal impact of the incident (78.6%), though a relative minority disagreed or strongly disagreed on both items (17.8% and 17.9% respectively). High levels of agreement were also reported for increased understanding that people may respond differently to traumatic events (92.6%), insight gained into potentially helpful coping strategies (75.0%), and awareness of where to seek further help or support if required (78.6%).

Table 3

Staff perceptions of the influence of TRiM following a potentially traumatic event

Item	Strongly disagree n (%)	Disagree n (%)	Neither agree nor disagree n (%)	Agree n (%)	Strongly agree n (%)
Feeling a sense of support in the workplace	2 (7.1)	3 (10.7)	3 (10.7)	8 (28.6)	12 (42.9)
Reflecting on the personal impact of the incident	4 (14.3)	1 (3.6)	1 (3.6)	10 (35.7)	12 (42.9)
Understanding that people respond differently to such events	0 (0.0)	2 (7.4)	0 (0.0)	10 (37.0)	15 (55.6)
Gaining insight into coping strategies that might be helpful	3 (10.7)	1 (3.6)	3 (10.7)	13 (46.4)	8 (28.6)
Awareness of where to seek further help or support if needed	2 (7.1)	0 (0.0)	4 (14.3)	10 (35.7)	12 (42.9)

Note. n varies from 27 to 28 due to missing data.

Evaluation of TRiM

Evaluation of the TRiM process was similarly positive overall (see Table 4).

A majority of respondents indicated that they were aware of how TRiM functions within their workplace (78.6%), considered it useful (78.6%), and considered participating as a worthwhile use of time (71.4%), with approximately 14-18% expressing disagreement across these items. Notably, 82.1% of respondents indicated that they would consider recommending TRiM to a colleague facing similar challenges, with 17.9% strongly disagreeing.

Table 4
Staff evaluation of TRiM in the workplace

Item	Strongly disagree n (%)	Disagree n (%)	Neither agree nor disagree n (%)	Agree n (%)	Strongly agree n (%)
I am aware of how the TRiM process functions in my workplace	2 (7.1)	2 (7.1)	2 (7.1)	11 (39.3)	11 (39.3)
I feel the TRiM process is useful in my workplace	4 (14.3)	1 (3.6)	1 (3.6)	8 (28.6)	14 (50.0)
The TRiM process is a good use of my time	4 (14.3)	1 (3.6)	3 (10.7)	7 (25.0)	13 (46.4)
The information provided during the TRiM process is helpful following a potentially traumatic event	5 (17.9)	0 (0.0)	3 (10.7)	9 (32.1)	11 (39.3)
I would consider recommending TRiM to colleagues facing similar challenges	5 (17.9)	0 (0.0)	0 (0.0)	7 (25.0)	16 (57.1)

Note. n=28

Perceived changes following TRiM participation

Participants were asked to indicate whether they had noticed changes in several areas following engagement with TRiM (see Table 5). Responses showed a mixed pattern. Perceived improvements were most frequently reported in relation to interpersonal and reflective processes; 64.3% reported that their perspective on discussing mental health at work had somewhat or significantly improved, while 60.7% reported more positive views about discussing mental health issues more broadly, though small minorities reported worsening on both items (3.6% each). Similarly, 53.6% reported feeling less judged when expressing their feelings in the workplace, although 39.3% noted no change and 7.2% reported feeling more judged.

Perceived improvements were reported in peer relationships and communication. A majority of participants (71.4%) indicated that they perceived the level of peer support among colleagues had somewhat or significantly improved, and 64.3% reported greater comfort in discussing traumatic events with peers, with 3.6%

reporting worsening on each item. Perceptions of organisational support were more varied. While 60.7% reported perceiving organisational support to have improved, 25% reported no change and 14.2% reported that organisational support had worsened.

Responses were also mixed in relation to coping, stress, and wellbeing.

Participants reported perceived improvements in their ability to handle emotional challenges at work (67.9%), with no participants reporting worsening and 32.1% indicating no change. Perceived improvements were also reported in the ability to manage work-related stress (57.1%), though 39.3% indicated no change and 3.6% reported worsening. Similarly, 60.7% reported perceived improvements in overall wellbeing, while 39.3% indicated no change and no participants reported worsening.

Table 5
Perceived changes following TRiM participation

Item	Significantly Worsened n (%)	Somewhat Worsened n (%)	No Change n (%)	Somewhat Improved n (%)	Significantly Improved n (%)
My perspective on discussing mental health at work	0 (0.0)	1 (3.6)	9 (32.1)	12 (42.9)	6 (21.4)
My views on discussing mental health issues.	0 (0.0)	1 (3.6)	10 (35.7)	9 (32.1)	8 (28.6)
How judged I feel when expressing my feelings.	1 (3.6)	1 (3.6)	11 (39.3)	11 (39.3)	4 (14.3)
The level of peer support among colleagues.	1 (3.6)	0 (0.0)	7 (25.0)	11 (39.3)	9 (32.1)
My comfort level in discussing traumatic events with peers	0 (0.0)	1 (3.6)	9 (32.1)	11 (39.3)	7 (25.0)
The level of organisational support in my workplace	2 (7.1)	2 (7.1)	7 (25.0)	10 (35.7)	7 (25.0)
My ability to handle emotional challenges at work	0 (0.0)	0 (0.0)	9 (32.1)	14 (50.0)	5 (17.9)
My ability to manage work-related stress	0 (0.0)	1 (3.6)	11 (39.3)	10 (35.7)	6 (21.4)
My overall wellbeing	0 (0.0)	0 (0.0)	11 (39.3)	10 (35.7)	7 (25.0)

Note. n=28

Experiences of peer-facilitated support

Participants were also asked about their experiences of the peer-facilitated format of TRiM (see Table 6). Response rates were somewhat lower for these items ($n=25$), though the reason for the additional missing data could not be determined from the anonymous dataset. Among those who responded, 60.0% reported that they liked or strongly liked the peer-facilitated aspect of TRiM, and 68.0% indicated that they found it helpful or very helpful. However, 24.0% reported disliking or strongly disliking the peer-facilitated aspect of TRiM, and 20.0% found it unhelpful or very unhelpful, indicating that peer-facilitation was not universally well-received.

Table 6
Experience of the peer-facilitated aspect of TRiM

Item	n (%)	n (%)	n (%)	n (%)	n (%)
	Strongly disliked	Disliked	Neither liked nor disliked	Liked	Strongly liked
Overall experience	3 (12.0)	3 (12.0)	4 (16.0)	7 (28.0)	8 (32.0)
	Very unhelpful	Unhelpful	Neither helpful nor unhelpful	Helpful	Very helpful
Perceived helpfulness	3 (12.0)	2 (8.0)	3 (12.0)	8 (32.0)	9 (36.0)

Note. $n=25$

Support preferences

Participants reported varied preferences regarding the type of support they would prefer following workplace incidents. Notably, when combining those who preferred peer-facilitated support exclusively (23.1%) with those who found both peer-facilitated and non-peer-facilitated useful (30.8%), a majority (53.9%) valued peer-facilitated support in some form. However, over one third (34.6%) expressed a preference for non-peer-facilitated supports exclusively, such as the Employee Assistance Programme (EAP), occupational health, or other external services. A

further 11.5% indicated other preferences, with open-text responses suggesting these participants favoured external professional support.

Overall satisfaction with TRiM

Overall satisfaction with TRiM was generally positive. However, responses were variable. A majority of respondents reported being satisfied (30.8%) or very satisfied (42.3%) with the service, yielding a combined satisfaction rate of 73.1%. A smaller proportion reported neutral views (11.5%), while 15.3% reported dissatisfaction or strong dissatisfaction.

Qualitative findings

A total of 16 respondents contributed 31 qualitative responses across the three open-text questions in the survey. Qualitative findings are presented below and are integrated with the quantitative data in the Discussion.

Phase 1: Content Analysis

Category 1: Positive facilitation and environment

A number of responses highlighted positive experiences of TRiM, particularly in relation to the quality of facilitation and the environment in which sessions took place. Facilitators were described as kind, respectful, and genuinely invested in staff wellbeing. Where sessions were well-structured and flexibility was offered, responses indicated that participants found the process useful and supportive.

“Well run Structured Conversation, plenty of time and space given, no pressure to participate – all positive aspects of the process”

“The TRiM facilitators and psychologists supporting them were very kind, respectful and deeply invested in my wellbeing.”

Category 2: Scheduling and accessibility

Responses regarding timing and scheduling were mixed. Several participants valued the flexibility and responsiveness of TRiM, particularly the opportunity to meet shortly after an incident occurred and the option of individual follow-up conversations. The demands of clinical rotas and shift work represented practical barriers for some staff, with inflexible scheduling leaving certain individuals feeling excluded. One participant described feeling actively deprioritised when alternative times were not offered, suggesting that scheduling difficulties carried a deeper psychological cost.

"The timing of the second meeting was nice and flexible and was very useful to talk through things individually."

"I was clearly an afterthought to the whole process. When I said it wasn't convenient I wasn't offered other times to attend. Very unsatisfactory. My welfare clearly didn't count for much"

"Having multiple opportunities to partake is helpful as shiftwork often doesn't allow staff to partake, either due to shift staffing or time off"

Category 3: Organisational culture and leadership

The role of organisational culture featured across a number of responses, with accounts reflecting both supportive and dismissive experiences of leadership. Where senior colleagues engaged positively with TRiM, this was experienced as reinforcing its value and encouraging staff participation. Where senior clinicians were dismissive, this was described as undermining both the process and staff willingness to engage openly.

"The avenue of speaking to a senior colleague regarding adverse events helped with the process."

“The larger institution and certainly consultant level support and opinion on [TRiM] was very low [...] I found their eye rolling (literal and metaphorical) undermined the process and made junior staff not feel willing to engage.”

Category 4: Unmet need for emotional expression

Several responses identified a gap between the informational focus of TRiM sessions and staff need for emotional processing in the immediate aftermath of a traumatic event. While the psychoeducational content was generally valued, the absence of space for emotional expression was a recurring concern. It is worth noting that in-depth emotional processing is not part of the TRiM model as designed, with the TIBs structured to provide psychoeducation and normalise responses rather than facilitate exploratory emotional work (Greenberg et al., 2008). This is also consistent with NICE guidance, which advises against psychologically focused debriefing for the prevention or treatment of PTSD (NICE, 2018). Where participants described expecting or wanting this, it may reflect a gap between staff expectations and the intervention's intended scope, or in some instances, variation in how the protocol was applied locally. This may be a wider issue with implications for practitioner training and fidelity monitoring.

“I think for the initial group TRiM meeting it would have been nice if we were just asked how we were feeling and coping so that then we may not feel like we need to further arrange single meetings. It was a great information session but there was no opportunity for us to speak or to ask how we were feeling”

Category 5: Preparedness and structural clarity

A number of responses described feeling unprepared for the structure and expectations of TRiM sessions. This was associated with discomfort and, for some, a

sense of being put on the spot. Participants suggested that clearer information in advance about what TRiM involves and how it is intended to support staff could facilitate more comfortable and autonomous engagement.

“I was unsure of what to expect when invited to a TRiM session, I was not prepared for the "on the spot" request to share my thoughts [...] and was somewhat uncomfortable with having to give an account of my feelings [...] in a group setting.”

“I was not prepared for the structure of the debrief which I found was quite intimidating”

Category 6: Communication and continuity

Several responses identified poor communication and inconsistent follow-up as concerns. Some participants described expecting further contact or group meetings that never materialised, and some reported not being informed when TRiM sessions were taking place. This pattern suggested that TRiM was experienced as a one-off event rather than an ongoing support process. Participants suggested that embedding TRiM more visibly within workplace routines and communication channels could strengthen continuity and engagement.

“It was never discussed again despite being told we would meet as a group again”

"More incorporated into culture, i.e., an expected component of an adverse event. Mention [TRiM] at every grand rounds and as part of day to day handover."

Phase 2: SDT Mapping

Deductive interpretation of the six qualitative categories using the SDT framework (Ryan & Deci, 2000) suggested that staff engagement with TRiM was

shaped by factors relating to all three core psychological needs (relatedness, autonomy, and competence) with patterns of both need satisfaction and need frustration presented across the data set (Vansteenkiste & Ryan, 2013), as summarised in Table 7.

Relatedness was the most prominently represented domain. Need satisfaction was evidenced in accounts of warm, respectful facilitation and supportive senior colleague involvement (Category 1 and 3). Need frustration was evidenced where sessions lacked space for emotional expression (Category 4), where anticipated follow-up did not occur (Category 6), and undermining senior attitudes discouraged open engagement (Category 3).

Autonomy need satisfaction was evidenced in accounts of flexible and accommodating engagement in which staff retained control over their level of participation (Categories 1 and 2). Need frustration was evidenced where staff were invited to share personal feelings in a group setting without prior understanding of TRiM's structure (Category 5) and where scheduling inflexibility prevented attendance (Category 2).

Competence need frustrations were identified across two categories. The absence of sustained follow-up limited the opportunity to consolidate knowledge and coping strategies gained through initial TRiM contact (Category 6). In addition, accounts of feeling unprepared for what TRiM involved, and unclear about the purpose, structure, and benefits of TRiM, suggested frustration of competence needs by reducing participants' sense of understanding and confidence in how to engage with the intervention (Category 5). Evidence for competence need satisfaction was more apparent in the quantitative findings, as addressed in the discussion.

Table 7
Mapping qualitative findings to SDT domains

SDT	Categories	Interpretation of findings
Domain		
Relatedness	1,3,4,6	Where facilitation was warm and respectful, and participants felt understood and cared for, their relatedness needs were satisfied. The absence of emotional processing space, poor follow-up, and active undermining of engagement by others led to relatedness need frustration.
Autonomy	1,2,5	Where attendance was flexible and accommodating, and participation felt voluntary, autonomy needs were satisfied. Inflexible scheduling and participants felt pressure to participate or share, autonomy needs were frustrated.
Competence	5,6	Competence needs were frustrated where participants felt unprepared for what sessions involved, or the purpose, structure or benefits of TRiM were unclear.

6. Discussion

This study examined maternity staff experiences of participating in TRiM within Ireland South Women and Infants Directorate, with a focus on psychological mechanisms shaping its perceived impact and engagement. The findings indicated a mixed pattern of participant experience. Most participants reported that TRiM contributed to a sense of workplace support (71.5%), facilitated reflection on the personal impact of potentially traumatic events (78.6%), and supported perceived ability to manage work-related stress (57.1%). However, less positive responses were also observed. Almost one quarter (24%) of participants who answered the peer-facilitation items disliked or strongly disliked this aspect of TRiM, and a further 16% neither liked nor disliked it. Similarly, 20% found peer-facilitation unhelpful or very unhelpful, with a further 12% giving it a neutral response. Overall satisfaction

with the TRiM service followed the same pattern; although most respondents were satisfied or very satisfied (73.1%), 15.3% reported dissatisfaction or strong dissatisfaction. These findings suggest that TRiM was experienced as useful by most participants, but that its acceptability and perceived helpfulness should not be assumed to generalise across all staff exposed to the intervention.

The mixed-methods design enabled these findings to be interpreted at two levels. Quantitative data identified general patterns of majority endorsement alongside a sizeable minority of neutral or negative responses, while qualitative data clarified some of the conditions under which TRiM was supported or undermined. Interpreted through SDT, this pattern of findings suggests that TRiM's effectiveness as a peer support intervention is not determined by its content alone, but by whether the conditions surrounding its delivery support or frustrate staff psychological needs.

The psychoeducational elements of TRiM appeared to support competence, particularly in relation to understanding trauma responses and identifying coping strategies. By normalising distress and providing cognitive frameworks for interpreting reactions, TRiM may have helped to address a vulnerability that often follows traumatic events in maternity care, namely self-doubt and uncertainty about professional judgement (Sheen et al., 2016; Uddin et al., 2022). High levels of agreement that people respond differently to traumatic events (92.6%), alongside reported insight into coping strategies (75.0%), and awareness of where to seek further help (78.6%), suggest that the intervention was experienced as informative and practically useful. Within SDT, competence refers to feeling capable and effective in the face of challenge (Ryan & Deci, 2000). Where TRiM successfully normalised staff responses and reduced uncertainty about what they were

experiencing, it may have functioned to restore a sense of professional efficacy that traumatic events can temporarily undermine.

The findings offer partial support for TRiM's peer-facilitated format. Reported improvements in peer support (71.4%) and comfort discussing traumatic events (64.3%) suggest that, for many participants, TRiM may have supported relatedness by creating a structured context in which distress could be acknowledged by colleagues who understood the clinical setting. This is consistent with evidence that healthcare professionals often value support from colleagues who share their occupational context (Fontein-Kuipers et al., 2018; Schröder & Assing Hvidt, 2023). However, the present findings also show that peer-facilitation was not universally acceptable. The proportion of respondents who disliked or found the peer-facilitated unhelpful suggests that shared professional background alone is insufficient to produce psychological safety or relational trust. These findings are consistent with peer-support literature. Watson (2019) argues that peer support depends on specific relational mechanisms, including congruence, empathy, and unconditional positive regard, and that these mechanisms can contribute to both the benefits and difficulties of peer-support relationships. In healthcare settings, Bridson et al. (2021) further suggest that effective peer support depends on participants relating to one another as equals, with hierarchical and interdisciplinary dynamics potentially limiting this process. This is also consistent with wider second-victim support literature, where uptake and implementation are shaped by blame culture, concerns about confidentiality, reluctance to show vulnerability, and stigma around help-seeking (Busch et al., 2021). In the current study, peer-facilitated TRiM may therefore have supported relatedness for some participants, while feeling less acceptable or helpful

for others where the conditions for psychological safety and relational trust were not fully present.

There was also evidence that TRiM may have supported autonomy, particularly through perceived reductions in stigma. Within SDT, autonomy refers to voluntary, self-endorsed engagement, and conditions that constrain this can be understood as autonomy-frustrating (Ryan & Deci, 2000). Stigma may therefore operate as an autonomy-frustrating condition by limiting willingness to engage with support. Participants reported more positive attitudes towards discussing mental health (60.7%) and, for some, reduced feelings of being judged when expressing distress (53.6%). TRiM may therefore function not only as a direct source of support, but also as something that influences whether staff feel able to seek support.

Overall satisfaction was high, and most participants indicated that they would recommend TRiM to a colleague (82.1%). These findings suggest that TRiM can be experienced as a credible and acceptable form of support in a maternity setting, but this should be interpreted within a limited evidence base. Although TRiM has been adopted across police, emergency service, and healthcare settings, existing evidence remains cautiously encouraging rather than definitive, with much of the literature focused on implementation or broad outcomes rather than staff experience or mechanisms of engagement (Flaherty & O'Neil, 2022; Greenberg et al., 2008; Hunt et al., 2013; Watson & Andrews, 2018; Whybrow et al., 2015). The present findings therefore add to this growing evidence base, and suggest that TRiM was useful for many participants, while also indicating that peer-facilitation was not experienced as helpful or acceptable by all staff.

The qualitative findings indicate that TRiM's capacity to satisfy psychological needs was not consistent across all staff, and need frustration was a

meaningful part of some participants' experiences. These findings emerged from optional open-text responses, with 16 of 30 participants contributing 31 responses, so they should not be treated as prevalence estimates for the wider sample. The qualitative findings should therefore help explain why a minority of participants did not experience TRiM as helpful, and why some staff may require other forms of support alongside or instead of peer-facilitated interventions.

Qualitative responses highlighted a number of recurring issues, including limited opportunity for emotional expression, lack of preparation for group disclosure, absence of follow-up, and inflexible scheduling. Although the informational content of TRiM was often valued, some staff experienced sessions as procedural rather than relational. From an SDT perspective, relatedness involves feeling understood and supported by others, suggesting that informational support alone may be insufficient where this sense of connection is absent (Ryan & Deci, 2000). The TIB is designed to provide psychoeducation rather than in-depth emotional processing (Greenberg et al., 2008), which is consistent with post-incident guidance (NICE, 2018) but may mean that TRiM does not fully address emotional validation needs identified in maternity staff (Sweet & Kruger, 2025). The organisational context also appeared to be influential. Where senior clinicians were perceived as dismissive of TRiM, participants described reduced willingness to engage openly. Leadership plays a key role in shaping psychological safety (Edmondson & Lei, 2014), and dismissive attitudes may limit the perceived legitimacy of support-seeking. This aligns with evidence that organisational culture can act as a barrier to engagement with staff support interventions in maternity settings (Knezevic et al., 2025).

The qualitative findings raise the possibility that the three SDT needs may not be equally important in maternity settings. Relatedness appeared to be the most consistently satisfied need, which may reflect the relational nature of maternity care, where shared experience and peer connection are particularly valued following traumatic events (Schröder & Assing Hvidt, 2023; Sheen et al., 2016a). In contrast, TRiM's structured, psychoeducational design may more directly support competence, while autonomy appeared more contingent on how the intervention was delivered.

Integrating the quantitative and qualitative findings using a convergent mixed-methods approach (Creswell & Plano Clark, 2017) revealed patterns of convergence, complementarity, and divergence in the data. Convergence was most evident in relation to relatedness and competence, where positive quantitative ratings aligned with qualitative accounts of supportive facilitation and useful psychoeducation. These findings suggest that TRiM was most consistently experienced as helpful when it provided supportive peer interaction and clear, practical information about trauma responses and coping. TRiM's psychoeducational components were consistently experienced as helpful, even where other aspects of delivery were more variable.

Complementary findings were most apparent where the quantitative data indicated variability or limited change. A substantial proportion of participants reported no change in their ability to handle emotional challenges (32.1%), stress at work (39.3%), and overall wellbeing (39.3%). Qualitative responses pointed to limited opportunity for emotional expression, and inconsistent continuity and scheduling and follow-up, which may help to account for these patterns. In relation to SDT, autonomy, competence, and relatedness are not met in a single interaction,

but depend on ongoing support (Ryan & Deci, 2000). Where TRiM was not sustained over time, initial improvements in support and understanding may not have been maintained.

Points of divergence were also identified. Although most participants reported that TRiM facilitated reflection on the personal impact of incidents (78.6%), qualitative accounts suggested that this reflection was at times experienced as predominantly cognitive, with limited space for emotional processing. A further divergence was evident in relation to support preferences. Despite high levels of satisfaction and willingness to recommend TRiM, a proportion of participants expressed a preference for non-peer support (34.6%). While TRiM was acceptable to many, it did not meet all staff preferences, and that alignment between support type and individual need may be important for autonomy. This suggests that TRiM may be experienced as most useful when embedded within a broader system of support rather than as a standalone intervention (Simms-Ellis et al., 2025). A related divergence was observed in the competence domain. Although participants reported increased understanding of trauma and coping strategies, this was not clearly reflected in qualitative accounts, which did not provide direct evidence of changes in professional confidence. This indicates that increased knowledge may not directly translate into a stronger sense of competence (Vansteenkiste & Ryan, 2013).

In summary, TRiM was often experienced as a meaningful source of support for participants, particularly through its psychoeducational and relational components. However, its perceived usefulness depended on the organisational and interpersonal conditions in which it is delivered. Where delivery conditions supported autonomy, competence, and relatedness, TRiM was more likely to be experienced as useful and engaging. Its value in maternity settings therefore lay not

only in the intervention itself, but in how it is embedded, communicated, and sustained within a wider system of staff support.

Strengths and limitations of the work

This study contributes to the limited evidence base on TRiM in healthcare settings. It represents the first known examination of TRiM in an Irish maternity context, addressing a gap in the literature regarding the model's transferability to this setting. The convergent mixed-methods design strengthened the analysis by allowing quantitative patterns to be contextualised and explained through qualitative accounts. The use of SDT provided a psychologically grounded framework for examining the psychological processes shaping staff engagement, moving beyond satisfaction ratings to consider the interpersonal and organisational conditions that influence staff experience.

Several limitations should be noted. The sample was drawn from a single directorate, and the relatively small sample limits the depth of conclusions and their generalisability to other maternity settings or healthcare settings. Participation was voluntary, and the lower response rate raises the possibility of selection bias, including overrepresentation of staff who were more engaged with TRiM or more motivated to provide feedback. While qualitative responses may overrepresent more critical experiences, survey-based research also indicates that respondents with more positive views may be more likely to participate, meaning both positive and negative response biases are possible (Poncheri et al., 2008).

The bespoke survey instrument, while appropriate given the absence of validated TRiM-specific measures, has not been psychometrically tested, so the reliability and validity of individual items cannot be confirmed. The cross-sectional design means that causal relationships cannot be established, and it is not possible to

determine whether perceived changes are attributable to TRiM specifically or other concurrent factors.

There were also limitations in the mixed-methods design. The qualitative data came from optional open-text responses provided by a smaller group of participants, and these responses varied considerably in depth and detail. In addition, the open-text questions were designed to elicit feedback on service delivery rather than explore all SDT domains systematically. This may have limited the extent to which experiences of competence were captured in the qualitative data and should be considered when interpreting the relative absence of competence-related accounts. As a result, the qualitative and quantitative components did not contribute equally across all areas of analysis, which limited the extent to which the findings could be integrated.

Recommendations for further research

Future research would benefit from larger, multi-site samples, longitudinal designs, and qualitative methods specifically designed to capture the psychological mechanisms influencing staff engagement with TRiM over time.

Implications for policy and practice

The findings have several practical implications for the implementation of TRiM in maternity settings. Most significantly, the findings point to a gap between TRiM's informational focus and staff need for emotional expression, suggesting that some psychological needs may fall outside the scope of a structured peer-delivered intervention. A majority of participants expressed a preference for non-peer or external forms of support, either exclusively or alongside TRiM. Clinical psychologists working in maternity settings are well placed to complement TRiM by

providing more emotionally responsive support that sits alongside its psychoeducational and identification-and-signposting functions.

At an implementation level, these findings point to several specific refinements to TRiM delivery that may improve staff experience without altering the overall model. These include clearer pre-briefing about the purpose, structure, and boundaries of TRiM sessions, particularly in relation to expectations around disclosure, which may support more autonomous and informed engagement. This is consistent with evidence that lack of clarity and uncertainty about support interventions can act as barriers to uptake (Busch et al., 2021). Increasing the visibility and promotion of TRiM within the organisation may also be beneficial, not only to improve awareness but to normalise engagement and reduce concerns around confidentiality and stigma, which have been identified as key barriers to help-seeking in healthcare settings (Busch et al., 2021). In addition, greater attention to continuity, including more consistent follow-up and flexibility in scheduling may help address the perception of TRiM as a one-off rather than an ongoing support process.

A number of the constraints identified reflect system-level conditions rather than features of TRiM itself. In particular, these relate to leadership behaviour, including reported dismissive responses from senior clinicians, and more broadly to the extent to which organisational support was experienced as consistent and credible. This suggests that not all barriers to engagement can be addressed at the level of intervention delivery. Instead, these conditions appeared to shape whether staff felt able to engage openly with TRiM, reflecting wider issues of psychological safety. This aligns with the present findings and a wider evidence base suggesting that organisation-directed approaches may be more effective than individual-level

interventions in addressing staff distress (De Simone et al., 2021) and supporting sustained engagement with workplace support initiatives (Bingham et al., 2023; Uddin et al., 2022). Within this context, TRiM may function as one component of a broader support system, but its effectiveness is likely to remain contingent on the extent to which it is embedded within a wider organisational commitment to staff wellbeing.

This is particularly relevant for clinical psychologists working in staff support roles within such systems. Clinical psychologists are trained to work across both individual and organisational levels, using formulation, consultation, reflective practice, and multidisciplinary team working to understand how distress is shaped within specific workplace contexts and to intervene accordingly. This positions clinical psychology as well suited to supporting the delivery of interventions such as TRiM through supervision, training, and referral pathways (Flaherty & O’Neil, 2022), along with the wider organisational processes that determine whether such interventions can function as intended (The British Psychological Society, 2007). In this sense, TRiM may be most effective when embedded within a psychologically informed system of staff support, where clinical psychology contributes to both intervention-level refinement and culture-level change.

7. Conclusion

This study provides preliminary evidence that TRiM was experienced as useful by many maternity staff following potentially traumatic workplace events, particularly in relation to psychoeducation, perceived peer support, and attitudes towards discussing mental health at work. However, the findings also indicate that TRiM was not experienced as helpful or acceptable by all participants. A sizeable minority reported neutral or negative views of peer-facilitation and perceived

helpfulness, and qualitative responses identified conditions under which TRiM could feel insufficient or difficult to engage with. Interpreted through SDT, the findings suggest that TRiM's perceived usefulness is shaped not only by its structure or content, but by whether the relational and organisational conditions surrounding its delivery support or frustrate staff psychological needs.

These findings suggest that TRiM is best positioned as one component of a broader staff support pathway rather than treated as a standalone response. This includes clear pre-briefing, flexible access, consistent follow-up, visible senior endorsement, and routes into psychologically informed support where staff needs extend beyond the scope of peer-facilitated intervention. Further research using larger longitudinal design is needed before stronger claims can be made about TRiM's effectiveness in maternity or wider healthcare settings.

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Chapter 3: Empirical Study 2

Peer-led trauma support in maternity settings: Practitioners' experience of implementing Trauma Risk Management

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Abstract

Aim(s)

To explore how peer-facilitators experience the implementation and delivery of Trauma Risk Management, a peer-led trauma support intervention, within maternity services.

Design

Qualitative study using reflexive thematic analysis

Methods

Semi-structured interviews were conducted with nine trained peer-facilitators delivering Trauma Risk Management within maternity services. Data were analysed using reflexive thematic analysis following Braun and Clarke's approach.

Results

Three themes were developed: implementing Trauma Risk Management within a complex maternity environment; becoming and being a peer-facilitator; and perceived impact on colleagues and the wider workforce. Facilitators described delivering the intervention within a context shaped by fear of blame, clinical acuity and limited protected time. While the structured peer model legitimised emotional conversations and supported staff connection, facilitators also reported emotional labour, role complexity and reliance on organisational support. Psychological safety and managerial endorsement were central to engagement.

Conclusion

Peer-led trauma support in maternity care operates as a relational and organisational process rather than a discrete intervention. Successful implementation depends on psychological safety, organisational infrastructure and support for peer-facilitators.

Implications for the profession and/or patient care

Maternity services implementing peer-led trauma support should prioritise protected time and psychological support for facilitators. Without organisational investment, responsibility for managing trauma exposure risks shifting onto individual staff.

Impact

- What problem did the study address? Limited understanding of how peer-facilitators experience delivering trauma support in maternity settings.
- What were the main findings? Trauma Risk Management created a structured space for emotional support in maternity care, but its sustainability depended on organisational culture, psychological safety and support for facilitators.
- Where and on whom will the research have an impact? Findings inform nursing and midwifery workforce wellbeing strategies in high-acuity maternity services.

Reporting Method

This study adhered to the Consolidated Criteria for Reporting Qualitative Research (COREQ).

No Patient or Public Contribution

1. Introduction

Maternity staff, including midwives, nurses, doctors, ancillary staff and health and social care professionals, are frequently exposed directly and indirectly to traumatic experiences as part of their clinical role. A recent systematic review found that between 71.0% and 96.9% of maternity staff report witnessing at least one traumatic birth event during their professional career (Uddin et al., 2022). Such events may include shoulder dystocia, cord prolapse, intrauterine or neonatal death, patient resuscitation, therapeutic hypothermia, and other complex or unexpected obstetric emergencies. Exposure to these events, particularly when shaped by the demands of maternity care, organisational pressure, and limited opportunities for support, has been associated with significant psychological distress, including burnout, guilt, self-blame, symptoms consistent with traumatic stress responses (Andre et al., 2016; Aydın & Aktaş, 2021; Uddin et al., 2022). Importantly, such events typically unfold within multidisciplinary clinical teams, meaning that trauma exposure is often shared rather than experienced in isolation.

Repeated exposure to traumatic clinical events can have a lasting effect on how these teams practice and relate to their work. Maternity staff may become hypervigilant in their practice in an effort to protect themselves and their patients (Toohill et al., 2019). Over time, this may contribute to defensive practice, emotional withdrawal, burnout and increased intentions to leave the profession (Aydın & Aktaş, 2021; Beck et al., 2015; Cankaya et al., 2021; Fontein-Kuipers et al., 2018). These responses have implications not only for staff wellbeing but also for patient-staff relationships and the quality of care delivered (Beck et al., 2015; Dahlen et al., 2013; Rice & Warland, 2013).

The psychological impact of trauma exposure is further shaped by organisational and cultural factors within maternity services. Research typically describes blame-oriented and unsupportive workplace cultures, where the focus following adverse events is often placed on identifying error rather than supporting staff (Andre et al., 2016; Beck et al., 2015; Busch et al., 2021). Staff frequently report feeling judged or having their clinical competence questioned following adverse incidents, contributing to fear, self-doubt, rumination, and reluctance to disclose emotional distress (Beck et al., 2015; Sheen et al., 2016). In such environments, opportunities for informal peer-to-peer support may also be constrained, as staff feel unsafe seeking support from colleagues due to concerns about judgment or professional repercussions. Bingham et al. (2023) conceptualised this as a “vicious cycle” in maternity care, whereby blame and a lack of organisational support contribute to psychological distress, hypervigilance, and defensive practice, which in turn, may increase intervention rates and negatively affect patient experience. This cycle is reinforced by systemic pressures, including staff shortages, high workload and the ongoing impact of the COVID-19 pandemic (Cankaya et al., 2021; Toohill et al., 2019). Evidence, however, suggests that this cycle is not inevitable, and can be disrupted or prevented through supporting staff.

Peer support, psychoeducation, and opportunities for reflection have been identified as key components of effective staff wellbeing interventions in maternity care (Andre et al., 2016; Bingham et al., 2023; Kerkman et al., 2019) and may influence the impact of traumatic clinical events on staff. Peer support has been identified as a strong predictor of recovery following adverse work events among healthcare professionals (Bride et al., 2004). Maternity staff are more likely to seek support from peers than from friends and family, reflecting the importance of shared

professional understanding and validation (Edrees et al., 2016; Fontein-Kuipers et al., 2018; Halperin et al., 2011; Kerkman et al., 2019). While peer support is often the preferred source of support among healthcare professionals (Buhlmann et al., 2021; Simms-Ellis et al., 2025), concerns about judgement, professional consequences, or being perceived as incompetent may inhibit engagement with peer-based support, particularly in environments that are characterised by limited psychological safety (Bingham et al., 2023; Busch et al., 2021; Sheen et al., 2016). Furthermore, peer support in maternity settings often involves colleagues who have themselves been exposed to the same traumatic events, meaning that the support is both given and received within a context of shared vulnerability. This has implications not only for those receiving support, but also for those providing it, particularly in terms of emotional labour.

2. Background

Despite growing recognition of the importance of staff wellbeing, research consistently highlights a gap between the support maternity staff require and the support available in practice (Bingham et al., 2023; Busch et al., 2021; Simms-Ellis et al., 2025). Recent reviews have identified a lack of high-quality, evidence-based interventions in maternity settings alongside organisational barriers to the provision and uptake of support, including limited resources, time pressures, confidentiality concerns, entrenched blame cultures, and staff distrust of organisational intentions around wellbeing (Bingham et al., 2023; Busch et al., 2021; Knezevic et al., 2025; Sweet & Kruger, 2025). Together, these factors restrict engagement with available supports and limit their sustainability.

While peer support interventions are increasingly recommended within maternity services, the ways in which staff give and receive peer support in practice

remain poorly understood (Sweet & Kruger, 2025), with existing research tending to focus on outcomes and uptake rather than the lived experience of those responsible for delivering them. This is a notable gap because international consensus guidance on peer support in high-risk organisations identifies clear role boundaries, training and accreditation, ongoing supervision, access to mental health professional advice, referral pathways, and structured attention to peer supporter wellbeing as essential programme components (Creamer et al., 2012). Yet these conditions are rarely examined in maternity settings.

Peer supporters across healthcare settings were found to experience the role as meaningful, confidence-building, and professionally rewarding, while also reporting emotional strain, time pressure, concerns about competence, and, in some studies, burnout associated with the role (Busch et al., 2021; Connors et al., 2021; Schröder & Assing Hvidt, 2023). In maternity care, these pressures are compounded by the fact that peer supporters are embedded within the same clinical environments in which adverse events occur, exposed to the same traumatic events as those they are supporting, and navigating role boundaries within teams where professional relationships already carry significant weight. Research in other contexts has found that peer supporters can experience emotional labour, role ambiguity and difficulties maintaining boundaries where the role is insufficiently structured or supported (Kane et al., 2023). Understanding implementation as a lived experience for peer-facilitators is therefore critical to evaluating not only the impact but also the sustainability of peer-led support interventions in maternity settings.

One approach that has been increasingly adopted within high-risk occupational settings is Trauma Risk Management (TRiM). TRiM is an identification-and-signposting programme that was initially developed for the Royal

Navy to support personnel following potentially traumatic workplace events (Greenberg et al., 2008). The model aims to identify individuals at risk of developing long-term psychological difficulties and to facilitate them with timely access to appropriate supports. Central to the TRiM model is its peer-led approach; trained staff members deliver structured sessions to their peers, that incorporate emotional support, psychoeducation, and signposting to further services where needed. TRiM has since been successfully implemented across a range of settings including military (Greenberg et al., 2008), police (Watson & Andrews, 2018), and healthcare services (Flaherty & O’Neil, 2022) in the United Kingdom.

TRiM was introduced in December 2023 within the Ireland South Women and Infants Directorate, which comprises Cork University Maternity Hospital, University Hospital Kerry, Tipperary University Hospital, and University Hospital Waterford. Oversight is provided by the senior clinical psychologist responsible for staff support and wellbeing. This marked the first implementation of TRiM within a maternity healthcare setting in Ireland. Maternity settings present a unique clinical and emotional context, characterised by high acuity, unpredictability, and the intersection of potential trauma with birth-related expectations of safety and joy (Catling et al., 2017; Nieuwenhuijze et al., 2024). While TRiM may offer a promising framework for peer support in healthcare contexts (Flaherty & O’Neil, 2022), limited research has explored how the programme is experienced by those delivering it, particularly within complex maternity environments. Little is known about how peer-facilitators navigate the practical, emotional, and organisational challenges associated with implementing TRiM or how delivering the intervention impacts their own wellbeing.

3. The study

3.1 Aim and objective

The aim of this study was to explore how peer-facilitators experienced delivering TRiM within maternity services. The objective was to understand how practitioners navigated and made sense of implementing a peer-led trauma support intervention within the organisational and cultural context of maternity care.

4. Methods

4.1 Design

This qualitative study used semi-structured interviews and reflexive thematic analysis to explore practitioners' experiences of delivering TRiM within maternity services. This study was reported with reference to the consolidated criteria for reporting qualitative research (COREQ; Tong et al., 2007).

4.2 Sampling and recruitment

Participants were staff who had completed the full TRiM practitioner training and had experience delivering TRiM within the Ireland South Women and Infants Directorate. Recruitment occurred in two phases. First, email invitations with information sheets and consent forms (see Appendix F) were distributed by the gatekeeper to eligible staff. Then information sheets were shared and a brief recruitment video presented at a TRiM practitioner meeting in September 2025. Written informed consent was obtained before interviews were scheduled. At the time of this study, twenty staff across the Ireland South Women and Infants Directorate had completed TRiM practitioner training, of whom nine participants from a range of clinical and managerial backgrounds took part. Reasons for non-participation were not systematically collected. Recruitment ceased when the

research team judged that the dataset provided sufficient experiential and contextual depth to address the study aim.

4.3 Data collection

Individual interviews were conducted online via Microsoft Teams by the first author at a time convenient to participants. A semi-structured interview guide was developed by the research team in line with the study aims, was used to explore experiences of TRiM practitioners (see Appendix G). No relationship was established with participants prior to study commencement, and participants did not know the interviewer in advance. Interviews were video recorded with participants' consent, no non-participants were present, and repeat interviews were not conducted. Interviews lasted an average of 61 minutes. Brief field notes were made following interviews to record contextual and analytic reflections.

4.4 Data analysis

Data were analysed using reflexive thematic analysis the following Braun & Clarke (2006; 2021). Interviews were transcribed verbatim and pseudonymised. Transcripts were repeatedly read to support familiarisation with the data. Initial coding was conducted by the first author using NVivo 15, with theme development supported through ongoing discussion within the research team. An inductive, iterative process was used to generate and refine codes, which were then organised into broader patterns of meaning. Themes were developed as patterns of shared meaning across the dataset rather than summaries of individual accounts. A reflexive stance was maintained throughout the analysis, with ongoing consideration of the researcher's position and potential influence on interpretation.

4.5 Ethical considerations and data management

Ethical approval was obtained from the Clinical Psychology Research Ethics Committee (CPREC) at University College Cork in October 2024 and the Local Information Governance Group (LIGG) at Cork University Maternity Hospital (CUMH) in January 2025. Written informed consent was provided by all participants, and debriefing sheets were issued following interviews. Participants could withdraw from the study up to one week after their interview. Anonymised data will be retained on the academic supervisor's UCC OneDrive for a minimum of ten years in line with UCC's Code of Research Conduct.

4.6 Rigor

Rigor was supported through repeated engagement with the data, iterative movement between transcripts, codes and themes, and ongoing reflexive discussion within the research team. The first author maintained reflexive awareness of their position as a trainee clinical psychologist during data collection and analysis. Interpretations were reviewed with co-authors to support reflexive consideration of assumptions and potential bias. Consistent with reflexive thematic analysis, attention was given to the interpretive role of the researcher throughout the analytic process, rather than treating researcher consensus as an indicator of quality (Braun & Clarke, 2021). Verbatim quotations are presented to illustrate the analytic claims developed from the data.

5. Findings

5.1 Participants

Nine practitioners took part in the study. All had completed TRiM practitioner training and had experience delivering the intervention within maternity

services. Participants came from a range of clinical and managerial backgrounds across the service.

Three overarching themes and 10 subthemes were developed from the data, capturing how practitioners experienced delivering TRiM within the organisational and cultural context of maternity care.

Table 8

Overview of themes and sub-themes

Theme	Subthemes
Implementing TRiM within a complex maternity environment and culture	The cultural context: responsibility and disclosure in a high-scrutiny setting Transition from informal coping to structured support Legitimacy, trust and psychological safety Practical and organisational constraints on delivery
Becoming and being a TRiM practitioner	From training to practice: building confidence and developing a way to deliver TRiM Role conflict, multiplicity and emotional labour The emotional impact of facilitation and the need for practitioner support
Perceived impact of TRiM on colleagues and the wider workforce	Emotional safety, peer connection and collective care Psychoeducation and normalisation of distress Perceived suitability and the future of TRiM

5.2 Theme 1: Implementing TRiM within a complex maternity environment and culture

This first theme captures participants' experiences of the organisational conditions in which TRiM was introduced to maternity services. Participants report a context shaped by heightened scrutiny of practice, perceived blame, and high workload pressures, alongside unmet needs for psychological support. They describe how TRiM was implemented in a setting where support had traditionally focused on

clinical review rather than on the impact on staff, and how legitimacy, trust, and practical constraints have shaped engagement and delivery.

5.2.1 *The cultural context: responsibility and disclosure in a high-scrutiny setting*

Participants described maternity work as psychologically demanding, with the emotional impact of incidents closely tied to clinical outcomes for mothers and babies and to staff perception of responsibility. Several emphasised that when outcomes were poor or uncertain, distress intensified and often became intertwined with self-questioning and fears of blame. As one participant explained following a serious incident, *"that midwife is traumatised ...and what she is left with is an element of responsibility. What did I do wrong? Could there have been something that I've missed? Am I going to be blamed for this?"* (P8). Because traumatic exposure in maternity work was closely linked to professional accountability, this shaped how staff interpreted events and how willing they were to speak about their reactions.

Within this context, participants described an environment in which many staff anticipated judgement or negative consequences following adverse events, limiting openness and help-seeking. Fear of scrutiny was often linked to litigation and public visibility, with one participant describing how staff may avoid disclosing the personal impact of events because *"if you say it's affecting you, well, why is it affecting you? Did you do something wrong? So, it's all a blame game"* (P4). Others noted that being called to a meeting could be immediately interpreted as *"you've done something wrong... and you think you're in trouble"* (P5), reinforcing defensive responses and reluctance to be seen as vulnerable or overwhelmed.

Several participants also highlighted stigma around emotional vulnerability, particularly for more senior or experienced staff. As one explained, *"for senior*

people...is it harder to reach out?...Because of that presumption that you know you're experienced, you've done this before...you know how to deal with this now"

(P7). At the same time, participants' accounts reflected variation across roles and units, including examples of supportive management, with one participant describing a leadership team that *"are very much visible. They're on the floor, they're helping, they're listening"* (P1). However, many described cumulative pressures associated with chronic staff shortages and workplace demands, which they felt had eroded existing coping strategies, *"draining that defence mechanism that we had built up around us, the armour"* (P9). Together, these accounts illustrate that TRiM was introduced into a setting where the psychological impact of clinical events was widely recognised, but where disclosure and support-seeking were stigmatised, and shaped by responsibility, scrutiny, resource constraints and workplace culture.

5.2.2 Transition from informal coping to structured support

Participants described a lack of structured emotional support present prior to the introduction of TRiM. Only formal medical debriefings took place, which were experienced as clinically oriented and evaluative, and focused on potential risk to patients and learning from mistakes. This was seen to reinforce the sense of blame and defensive practice, *"...there was never a focus on you as a person. It was always on did you do enough? Could you have done more? Did you involve the team sooner? You know, it was...pointing fingers more than anything else"* (P5). TRiM was therefore widely perceived as *"filling a gap"* (P3) within the service, by offering structured, peer support with an explicit focus on wellbeing.

However, participants found that staff's first encounters with TRiM were characterised by uncertainty and shaped by expectations of factual debriefings. Participants described staff arriving prepared to *"discuss what went wrong"* (P1) and

being surprised and sceptical when TRiM was framed as a support rather than an incident analysis, *“it's about us and how we're feeling, what you mean?”* (P1). This mismatch often required practitioners to explain *“what it is and what it isn't”* (P1). Concerns about disclosure and group participation were also prominent, as illustrated by one participant: *“Is this going to be like in an AA meeting? Am I going to have to stand up and say... I'm struggling”* (P2). Initial non-attendance was often described as a self-protective response rather than resistance. As familiarity and active uptake increased and the function of TRiM became clearer, some participants observed a shift towards active uptake within their service: *“I think a lot of people have really embraced it...if something happens...people come up to me and say, ‘Did you hear about this incident?...I think they could do with a TRiM session’...I think especially anyone that's been involved in one is very much... promoting it”* (P2).

5.2.3 Legitimacy, trust and psychological safety

Engagement with TRiM across all settings was dependent on both organisational endorsement and staff perceptions of psychological safety. Participants emphasised that managerial buy-in was often a practical prerequisite, particularly in facilitating staff release and signalling that TRiM was a legitimate use of time. As one participant noted, *“if we don't get the manager buy-in, they're not going to release their staff, they're just going to just dismiss it.”* (P5). Visible endorsement from senior staff was described as something that *“carries weight”* (P7), helping to normalise engagement and reduce stigma.

Participants also shared that engagement with TRiM was contingent on staff perceiving it was non-punitive and confidential. Participants described initial fears that conversations might be recorded, fed back to management, or later used against them. One practitioner reflected that *“people are fearful initially. They're worried*

that their opinions or conversations will be used against them" (P6). As a result, practitioners described the need to repeatedly and explicitly communicate boundaries around confidentiality and the distinction between TRiM and investigative processes. Reassurance that conversations were peer-led and focused on wellbeing was described as essential in reducing fear and apprehension.

Trust was described as fragile and context-dependent, and was shaped by small-unit dynamics, facilitator identity, and staff perceptions of the potential consequences of disclosure. Participants emphasised that confidence in confidentiality could not be assumed and often needed to be actively established and maintained. As one practitioner reflected, staff initially sought reassurance that conversations would not be later used against them: *"So you're telling me that you can have a conversation with me about XY and Z today and not hold it against me?"* (P1). Others described how fears about information travelling informally within close-knit teams could limit openness, particularly in settings where *"we know each other...that coffee room is talk, talk, talk"* (P9).

Practitioners, therefore, describe being acutely aware of how their own role, reputations, and perceived proximity to management could influence engagement. Some noted that staff might be reluctant to speak freely with facilitators they viewed as senior or as authority figures, *"because of what I do... I'm potentially seen as an authority figure"* (P7). In response, participants describe offering choice and flexibility, emphasising that staff could speak to another practitioner if they preferred. Across accounts, legitimacy and psychological safety were described as developing gradually rather than being inherent features of TRiM, with trust strengthening through consistent practice, clear communication of boundaries, and repeated exposure to the intervention.

5.2.4 Practical and organisational constraints on delivery

This subtheme captures the practical and systemic constraints associated with implementing TRiM in a maternity care setting. From the perspective of practitioners, implementation involved substantial organisational labour, including identifying affected staff across multiple departments, coordinating sessions, facilitating groups, and managing practitioner availability. This work was described as time-consuming and demanding, particularly when staff involvement spanned different points in a patient journey: *“you could have three different departments, so that’s a lot of names. You know, if you’re going from, let’s say, if you’re talking about a patient journey, you know, someone comes into ED, there’s all the ED staff, you come on up then to... the Labour ward, there’s all the Labour ward staff, you go to theatre, there’s a theatre staff. So you know, you could have a lot of people, and in between that, then you have porters. You might have catering staff, you might have domestics...”* (P1).

Participants described a formal expectation that potentially traumatic incidents would be referred to the TRiM service by managers or those in charge at the time. In practice, however, this referral process was described as inconsistently enacted across units, particularly during early implementation. Some practitioners reported receiving prompt notification by email, while others described learning about incidents through informal channels days later. This created anxiety about timeliness and coverage, with one participant reflecting, *“there’s an element of me worrying about missing people”* (P6). Given the nature of staffing and shift patterns, delayed awareness was seen as particularly problematic: *“if you don’t catch that group pretty quickly they’re gone. They’re scattered. They’re all over the place. And you don’t get them back”* (P7).

Systemic pressures within maternity services further constrained access to TRiM. Staffing shortages, shift work, and lack of cover limited both practitioner capacity and staff availability to attend sessions. As one participant notes: *“we’re patient facing, so you can’t leave your patients and walk off and do it. So, you’re trying to get a group of people in a healthcare setting to attend it”* (P5). As a result, sometimes staff choose to attend TRiM on days off, raising concerns about encroachment on personal time and additional costs.

A further practical challenge related to identifying suitable spaces to hold TRiM sessions. Participants described difficulty securing private, appropriate locations within busy clinical environments, while also needing to remain close to clinical areas in the case of service needs arising. As one participant noted, *“you don’t want to take the person or the group back into the room where the incident happened”* (P7), highlighting the need to balance psychological safety with service demands.

5.3 Theme 2: Becoming and being a TRiM practitioner

This overarching theme captures the lived experience of peer-facilitators, including identity, emotional labour, training, and the impact on their own wellbeing.

5.3.1 From training to practice: building confidence and developing a way to deliver TRiM

Practitioners described the TRiM training as reassuring and clarifying, particularly in defining the scope and boundaries of the role. Many entered training with trepidations about being expected to act as a counsellor and reported relief on learning that TRiM offered a clear structure to offer peer support rather than be a therapeutic intervention. As one participant reflected, the training helped them realise that TRiM was *“just a check in...a chat, and if there’s any issues, we’re*

going to signpost them on somewhere else” (P7). This clarity was experienced as essential in making the role feel manageable and appropriate within their existing clinical responsibilities.

While training provided a strong conceptual foundation, participants consistently reported that confidence developed primarily through delivering TRiM in practice. The first TRiM session was often described as daunting, with practitioners expressing fears about saying the wrong thing or causing harm. As one participant put it, *“I was very nervous... that I might have said the wrong thing or like, I said, my biggest fear at the start was that I'd retraumatize people” (P2).*

Working in pairs was repeatedly identified as a key support during this transition, allowing practitioners to share responsibility, rehearse delivery, and learn through observation. Over time, participants noted that TRiM conversations felt more comfortable, as they recognised the familiarity of supportive peer conversation, now held within a clear framework; *“it's really... those conversations we've been having all along, but it just gives a bit of structure to them and formalises it a little bit without being too formal” (P3).*

The structured nature of TRiM was described as both protective and confidence-building. Having a clear sequence, prompts, and boundaries helped practitioners stay focused and maintain the purpose of the intervention, particularly when emotions were heightened. At the same time, some participants described a tension between following the structure and delivering support in a way that felt authentic, particularly when working with colleagues they knew well or when repeating similar content across sessions. As one participant described, *“I worry that if you have the same people attending and you're saying the same spiel that sometimes, like I'd hate for it to come across as insincere... You know, so you're*

giving the same jargon...you don't want it to come across as contrived or anything like that" (P1).

Although the online delivery of the training was generally viewed as acceptable, most participants felt that in-person training and refresher sessions would better support skills consolidation and confidence over time, *"definitely now, on reflection, the online gave me the bones of it, but I think it's too practical a thing. I think you need to be in a room and talk to people" (P5).*

5.3.2 Role conflict, multiplicity and emotional labour

This sub-theme captured how TRiM practitioners navigate the tension between their clinical, managerial, and peer support roles. Participants describe “wearing multiple hats”, often supporting colleagues who were also peers or staff they supervised, which created uncertainty about boundaries, responsibility and authority. While TRiM’s peer-led model was valued, practitioners were acutely aware that their existing roles could influence what colleagues felt safe disclosing, particularly where power differentials existed. As one participant noted, *“you will not get honesty to the same level than you would get if it is somebody who is not in senior management” (P9).* Alongside these boundary challenges, facilitating TRiM required significant emotional labour, including managing group dynamics, holding colleagues’ distress, and ensuring psychological safety. As one participant emphasised, *“you have to be careful of people, and you have to be very, very sure that you’re reassuring at all times” (P6).*

5.3.3 The emotional impact of facilitation and the need for practitioner support

TRiM practitioners described the role as personally meaningful, particularly in being able to support colleagues following difficult events. At the same time, they described an emotional impact associated with facilitation, shaped by a sense of

responsibility for colleagues' wellbeing and concern about missing signs of ongoing distress. This responsibility often extended beyond the session itself, with practitioners reflecting on whether they had adequately supported staff or identified risk: *"you just don't want someone to... tell you they're grand... and the next day... she's rang in sick for the week. And why didn't I do X, Y and Z?"* (P4).

Facilitating TRiM could also intersect with practitioners' own experience of loss or trauma, at times heightening their own emotional vulnerability. One participant described having to deliver a TRiM despite going through their own difficulties that week: *"I just had to buck up and go in"* (P6). Within this context, access to psychological support and clear boundaries around the facilitator's role were described as essential in mitigating this impact and enabling practitioners to sustain the role safely and with confidence. Support from a staff psychologist was particularly valued in providing reassurance around scope, containment, and decision-making, with one practitioner reflecting, *"I don't think I would have taken it on without that backup... the last thing I wanted to do was make it worse"* (P2).

5.4 Theme 3: Perceived impact of TRiM on colleagues and the wider workforce

The final theme explores how TRiM is perceived to influence staff wellbeing, peer relationships, and the broader maternity team and culture.

5.4.1 Emotional safety, peer connection and collective care

Participants described TRiM as creating emotional safety by legitimising vulnerability and fostering peer connection, which felt novel within the maternity setting. Sessions enabled staff to see colleagues as emotionally affected peers rather than solely as role-holders, fostering empathy and a sense of shared humanity. Participants described how being present with colleagues created solidarity and mutual understanding, particularly when staff could see that others were similarly

affected by events, “...two different people were crying from two different areas. And it was like, oh, OK, so someone else is just as affected by this as I am. And it was that kind of sense of same or togetherness...like camaraderie in a kind of a weird way” (P1).

The peer-led nature of TRiM was central to this, with participants emphasising the value of shared professional experience in creating trust and mutual understanding. Through these collective experiences, TRiM was described as supporting a shift towards recognising one another as people first, which strengthened relational bonds across teams. “Once you saw your peer being as affected as you were... they all saw each other as human beings and not as the person who didn’t make the decision” (P6).

5.4.2 Psychoeducation and normalisation of distress

Participants described TRiM as providing a structured way to help staff understand trauma responses and recognise emotional and physical reactions as normal rather than pathological. Through Structured Conversations, practitioners were able to actively name common responses to potentially traumatic events including, “Recurrent dreams, sleeplessness... palpitations” (P7), and help staff to recognise them as a normal and time-limited process rather than a personal failing. As one participant described, “if you’re sitting at home crying, or you’re crying in your car after a particularly bad shift. Well, then you know that that’s actually quite normal. You know, because of X, Y and Z you might have experienced, and you know you’re not alone in that” (P1). Others described how being able to outline the expected trajectory of recovery was particularly reassuring for staff, with TRiM helping practitioners explain that symptoms “might go on for four weeks, six weeks until the brain has really processed this event” (P3). In this way, TRiM supported

practitioners to actively normalise distress in their colleagues and facilitate more open conversations about emotional impact in the aftermath of adverse events at work.

5.4.3 Perceived suitability and the future of TRiM

Participants described TRiM as highly suitable for maternity settings, while highlighting conditions needed for its sustainability. A key concern was the need for protected time for both participants and practitioners. Some noted that the emotional nature of engaging in TRiM could make it difficult when staff are expected to return directly to clinical duties immediately after sessions. Other interviewees highlighted the difficulty in managing the duties of TRiM on top of their day-to-day role, which could be resolved with more training: *“I think you probably need to have new people joining all the time, to get the team bigger, so it’s not the responsibility of one or two people”* (P5).

Beyond individual support, participants perceived TRiM as contributing to a more supportive organisational culture, where staff felt valued, and wellbeing was recognised as an integral part of the workplace. As one participant described, *“if you have staff who feel valued, you’ll have staff who will work harder, they’ll be more positive in their work... you have less sick leave. And you’ll have patients who are actually better looked after. So in the grand scheme of things, like, if you mind your people, they’ll do the rest”* (P1).

Many felt that TRiM had become an embedded support within the service and would be noticeably missed if withdrawn: *“I think because it’s bedded in so well and the buy-in is there, I think if it was stopped now, I think people would miss it”* (P7). Participants also expressed strong support for wider implementation, describing TRiM as a transferable, structured support that should be available across maternity

services and the wider healthcare setting as opposed to only being available to staff in limited geographical locations or departments, *“I would make it available in all, in all 19 maternity units... it would just be, you know, would be part of the service”* (P3).

6. Discussion

This study examined how practitioners experienced delivering TRiM within a maternity setting, with attention to implementation, practitioner experience, and perceived impact on colleagues. Overall, the findings suggest that peer-led trauma support in maternity care is experienced not only as an intervention for those receiving support, but as a relational and organisational process that places emotional and practical demands on those delivering it. The study highlights the importance of attending to context, culture, and practitioner wellbeing when implementing peer support interventions in high-risk healthcare settings.

Implementing TRiM within a complex maternity environment and culture

Participants describe TRiM being introduced into a setting shaped by responsibility for maternal and neonatal outcomes, high public scrutiny, and fears of blame and litigation. Consistent with existing literature, emotional responses to adverse events were closely tied to perceptions of personal accountability and professional competence (Andre et al., 2016; Beck et al., 2015). Within this context, distress was often internalised, with disclosure perceived as risky when emotional difficulty could be interpreted as evidence of error or inadequacy.

These findings align closely with Bingham et al.'s (2023), description of a “vicious cycle” in maternity care, whereby blame-oriented culture contributes to hypervigilance, emotional withdrawal, and reluctance to seek support. Participants’ accounts suggest that this cycle was well established prior to the introduction of

TRiM, reinforced by litigation fears and cumulative exposure to traumatic events. TRiM therefore entered a context in which emotional safety could not be assumed and where support-seeking was historically constrained.

Within this context, TRiM represented a shift from existing post-incident responses that were largely clinically focused and evaluative. Traditional debriefings prioritise learning, accountability, and patient safety, often at the expense of staff emotional processing. Practitioners perceived TRiM as “filling a gap” by offering a structured, peer-led space centred on staff wellbeing rather than clinical performance or accountability. However, the findings make clear that the presence of supportive intervention alone was insufficient to guarantee engagement. Instead, legitimacy had to be actively built through organisational endorsement, repeated clarification of purpose, and consistent reassurance around confidentiality. This mirrors findings from maternity settings, where staff perceived a wellbeing programme as inauthentic and disengaged from it when organisational conditions did not support genuine participation (Knezevic et al., 2025). Psychological safety emerged as central but fragile, highlighting that the effectiveness of peer-led trauma support depends not only on intervention design, but on the cultural conditions into which it was introduced.

Becoming and being a TRiM practitioner

This theme highlights the emotional labour and role complexity involved in delivering TRiM while remaining embedded within the same clinical and organisational context as those being supported. Becoming a TRiM practitioner involved more than acquiring new skills; it entailed taking on ongoing responsibility for the emotional wellbeing of colleagues alongside existing clinical or managerial roles.

These findings are consistent with the limited literature on peer supporters in healthcare, which suggests that the role can be both personally meaningful and psychologically demanding. For example, Connors et al. (2021) found that most peer responders experienced the role as meaningful and impactful, but over a quarter reported burnout associated with their peer support duties. Similarly, Busch et al. (2021) argued that peer supporters' motivations, workload, distress and resilience require closer examination. The present findings extend this literature by showing how these demands may be intensified in maternity settings, where practitioners remain embedded within the same teams, hierarchies and trauma-exposed environments as the colleagues they support.

Consistent with research emphasising the relational nature of peer support in maternity care (Andre et al., 2016; Bingham et al., 2023), practitioners described providing emotional containment, validation, and reassurance to colleagues following potentially traumatic events. This work often occurred within environments characterised by high acuity, staff shortages, and continued exposure to distress, meaning practitioners were supporting others while subject to similar pressures themselves.

The present findings suggest that the emotional demands of TRiM were not only caused by exposure to colleagues' distress, but also by the ambiguity of the practitioner role. This aligns with Kane et al. (2023), who found that peer supporters' wellbeing was affected by unclear role boundaries, insufficient support, and emotional labour. In the present study, practitioners were required to hold a supportive, peer-based position while also managing boundaries, risk, confidentiality and referral decisions. Participants also described navigating blurred boundaries between being a peer supporter and being a colleague, clinician, or manager. While

the peer-led nature of TRiM was central to trust and engagement, it also created tensions around confidentiality and responsibility within shared team hierarchies. Importantly, participants did not frame these challenges as a failure of TRiM, but as an inherent feature of peer-led support delivered within a shared clinical environment.

A key mitigating factor was the presence of clinical oversight, provided in this setting by a senior clinical psychologist, which is not a requirement of the TRiM model but was experienced as highly supportive. Access to psychological expertise provided reassurance around scope, boundaries, and decision-making, allowing practitioners to feel safer in their role and more confident that responsibility for risk did not rest solely with them. These findings align with international consensus guidance for peer support in high-risk organisations, which identifies supervision, access to clinical advice, limits on availability, and regular programme evaluation as core components of safe implementation (Creamer et al., 2012). In this study, psychological oversight appeared to function as a form of organisational containment that supported practitioners' wellbeing and role sustainability.

Perceived impact of TRiM on colleagues and the wider workforce

From practitioners' perspectives, TRiM appeared to create a form of emotional safety that had previously been limited within their workplace settings. Participants perceived that TRiM legitimised vulnerability and enabled staff to acknowledge emotional responses to adverse events without fear of judgement or professional repercussion, aligning with identified gaps in maternity support cultures (Andre et al., 2016; Beck et al., 2015; Busch et al., 2021). Practitioners perceived that TRiM offered a protected relational space in which staff could be seen and recognised as emotionally affected individuals rather than solely as clinicians who

played a role in incidents. This shift appeared to foster empathy, peer connection, and a sense of collective care, particularly when staff recognised that colleagues across disciplines were similarly impacted by events.

The peer-led nature of TRiM was central to these perceived effects. TRiM practitioners emphasised that shared professional experience allowed facilitators to offer a form of validation that felt credible and meaningful within the maternity context. This aligns with existing research indicating that maternity staff are more likely to engage with support delivered by peers who understand the emotional and clinical nature of the work (Fontein-Kuipers et al., 2018; Halperin et al., 2011; Kerkman et al., 2019). From participants' accounts, TRiM appeared to support not only individual processing but also relational repair, enabling teams to reconnect following events that might otherwise fragment trust or reinforce self-blame.

Practitioners also highlighted psychoeducation as a key mechanism through which TRiM was perceived to support staff wellbeing. By naming common trauma responses and outlining expected recovery trajectories, facilitators described helping staff to reframe distress as a normal, time-limited response rather than a sign of personal weakness or professional inadequacy. This function is consistent with evidence that psychoeducation and normalisation are protective factors following occupational trauma exposure (Andre et al., 2016; Bingham et al., 2023). Within a maternity context, where emotional responses may be internalised due to expectations of resilience and competence, practitioners perceive this normalisation as particularly valuable in reducing isolation and self-criticism.

Beyond effects at an individual level, participants describe TRiM as contributing to a broader cultural shift in how staff wellbeing was understood and prioritised. While practitioners were cautious not to overstate its impact, several

perceived that the visible presence of TRiM signalled organisational recognition of emotional labour as a legitimate aspect of maternity work. This perception aligns with calls in the literature for wellbeing interventions that move beyond individual coping and contribute to cultural change by embedding care within organisational practice (Bingham et al., 2023). From this perspective, TRiM was not seen solely as a post-incident intervention but as part of a wider shift towards collective responsibility for staff wellbeing.

However, participants also emphasised that perceived benefits were dependent on practical and organisational conditions, including protected time, sufficient staffing, managerial buy-in and an adequately resourced team of TRiM practitioners. Without these supports, there was concern that engagement could diminish or that TRiM could become perceived as tokenistic. This mirrors broader critiques of wellbeing initiatives that risk becoming symbolic rather than substantive when introduced into overstretched systems (Sweet & Kruger, 2025).

Implications

The findings highlight a tension within peer-led support in maternity care. The same features that make TRiM feel credible and accessible, particularly its grounding in existing peer relationships, also places emotional and role demands on those delivering it. Without structures to support practitioners, peer-led trauma interventions risk emotional labour shifts onto individual staff rather than being held at the organisational level. This has direct implications for how TRiM is implemented and sustained.

Clinical psychology is well placed to address this through supervision, formulation-informed consultation, and governance around risk escalation. The present findings align with international consensus guidance for peer support in

high-risk organisations, which identified ongoing supervision, access to specialist clinical advice, clear role boundaries, and structured attention to practitioner wellbeing as essential programme components rather than optional extras (Creamer et al. 2012). In this study, access to a staff clinical psychologist appeared to function as a form of organisational containment, providing reassurance around scope and decision-making and allowing practitioners to feel that responsibility for risk did not solely with them. This is consistent with healthcare settings where clinical psychology involvement in TRiM implementation has included regular supervision, practitioner training, and ongoing oversight (Flaherty & O’Neil, 2022).

The perceived impacts described by practitioners, including greater openness, validation, and peer connection, suggest that TRiM can contribute to cultural shifts in how staff wellbeing is understood within maternity services. However, participants were clear that these effects depend on conditions that the intervention itself cannot create, such as organisational endorsement, protected time, adequate practitioner numbers, and managerial buy-in. Responsibility for staff wellbeing, therefore, cannot depend on peer supporters alone. Where these conditions are absent, there is a risk that wellbeing initiatives become symbolic rather than substantive (Sweet & Kruger, 2025).

TRiM is best understood not as a standalone intervention but as one component of a broader, organisationally supported approach to staff wellbeing, one in which clinical psychology plays a structurally important role in sustaining those who deliver it.

6.1 Strengths and limitations of the work

This is the first study exploring TRiM in a maternity setting. A key strength of this study is its qualitative design. Using a reflexive thematic analysis allowed for a nuanced examination of how the organisational culture and peer support process intersect in practice. By focusing on the perspectives of TRiM practitioners, this study addresses gaps in the literature as the experience of those delivering peer-led interventions are often overlooked despite their central role in implementation and sustainability. This paper further strengthens insight on the considerations when introducing such interventions to maternity settings, as they represent a distinctive clinical environment characterised by high complexity, unpredictability, and shared exposure to potentially traumatic events.

Several limitations should be acknowledged. This study was conducted within a single maternity directorate comprising of four maternity hospitals in the south of Ireland, which may limit the transferability of findings to other healthcare contexts or organisational settings. Because participants were self-selected into the study, those who took part may have been particularly engaged with or reflective about TRiM, potentially influencing the accounts they provided. Additionally, this study explored practitioners' perceptions of how TRiM affected colleagues and the wider workforce, rather than examining outcome data or the experiences of those receiving the support. As a result, the findings reflect perceived impacts rather than objective measures of effectiveness.

6.2 Recommendations for further research

Future research should continue to explore how practitioners' experiences interact with longer-term outcomes and the organisational contexts in which peer support is delivered. Such work may help inform the development of staff wellbeing

interventions that are both psychologically informed and responsive to the unique context of maternity care.

7. Conclusion

This study explored the experience and perceptions of TRiM practitioners delivering peer-led trauma support within a maternity setting. The findings suggest that implementing TRiM within this complex organisational and cultural context involves its own practical challenges and ways of working. It also found that delivering support to peers involves emotional labour and role complexity for the practitioners themselves. While practitioners perceived TRiM as contributing to greater openness, validation, and peer connection among colleagues, the study highlights that such interventions place demands on those delivering them and depend on wider organisational support to be sustainable. Peer-led trauma support in maternity care is therefore best understood as a relational and organisational process rather than a standalone intervention.

By focusing on the perspectives of those delivering TRiM, this study contributes to a more nuanced understanding of trauma-informed staff support and highlights the importance of supporting those who provide support within healthcare environments. Building on these findings, ongoing research is examining the experiences of maternity staff receiving TRiM support within the same setting, allowing for a more comprehensive understanding of how peer-led trauma support is experienced from both facilitator and recipient perspectives.

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Chapter 4: Integrative Discussion and Conclusion

Word count: 7,148

4.1 Overview

The aim of this thesis was to investigate how Trauma Risk Management (TRiM) was experienced within a regional Irish maternity directorate, and what this reveals about how peer-delivered trauma support functions when situated within a staff support pathway led by clinical psychology. This addresses gaps identified in Chapter 1, where peer support was widely advocated in the maternity literature, but the conditions under which it is experienced as helpful and the experiences of those delivering it remained poorly specified (see Sections 1.7 and 1.11). The thesis also speaks to a wider development within the discipline. Dedicated staff support roles for clinical psychologists in maternity care remain a recent and still-emerging area of practice, with only two such posts currently in place across Ireland, and the empirical literature describing what these roles contribute is limited. The thesis is positioned as contributing to both the knowledge base and the practice of clinical psychology in this developing area, in addition to exploring TRiM.

Study 1 used a cross-sectional mixed-methods survey ($N = 30$) to examine how maternity staff experienced participating in TRiM, with open-text responses interpreted through Self-Determination Theory (SDT; Ryan & Deci, 2000). Participants generally found TRiM useful, and its perceived impact appeared contingent on relational experiences and organisational conditions. Study 2 used reflexive thematic analysis of semi-structured interviews with nine TRiM practitioners to explore their experiences of delivering the intervention. It identified themes relating to implementing TRiM within a complex maternity environment,

becoming and being a practitioner, and the perceived impact on colleagues and the wider workforce.

Together, the studies suggest that TRiM is often experienced as acceptable and valuable, and align with evidence that peer-led interventions can offer contextually meaningful support for healthcare staff exposed to potentially traumatic events (Carbone et al., 2022; Sweet & Kruger, 2025). In Study 1, participants reported greater awareness of trauma responses, more openness in discussing distress, and perceived improvements in peer support and coping. In Study 2, practitioners describe TRiM as legitimising vulnerability and enabling colleagues to be recognised as emotionally affected rather than solely as clinicians involved in adverse events.

Beyond overall satisfaction, a more complex picture emerges. In Study 1, variation in participants' experiences appeared to cluster around specific conditions. Some participants felt unprepared for the structure and expectations of sessions, and others described a gap between the psychoeducational content and their need for space to process emotion. In Study 2, practitioners described a different set of challenges. Delivering TRiM involved navigating blurred boundaries between being a peer, colleague, clinician, and manager, while also managing emotional labour, including holding colleagues' distress while often carrying their own responses to the same events. The sustainability of the role was described as dependent on organisational conditions, including protected time and access to clinical oversight. Practical constraints linked to shift patterns and staffing were described in both samples, though they operated differently at each end of the intervention.

This chapter argues that TRiM's effectiveness in maternity settings is contingent, relational, and contextually mediated. Its outcomes are not adequately

explained by the content or structure of the intervention alone. They are shaped by the interaction of several mechanisms: the broader organisational content in which TRiM is implemented, the degree of psychological safety within teams, how staff interpret and engage with the intervention, and the relational work undertaken by practitioners facilitating support. Some processes, including the psychoeducational content and the legitimising effect of leadership endorsement, operated similarly across participant and practitioner accounts. Others, particularly how the structure of the model was experienced and the emotional labour involved in delivering it, diverged in ways that appear to reflect the asymmetry of the roles people held in relation to TRiM rather than inconsistencies between the datasets.

The chapter is organised in four sections. Section 4.2 examines the convergences and divergences between the two studies and develops a multi-level theoretical account drawing on implementation science, psychological safety, and SDT. Section 4.3 considers the implications at practitioner, service, and organisational levels, with particular attention to the position of clinical psychology in shaping the wider support pathway in which TRiM sits. Section 4.4 reflects on methodological strengths and limitations, and section 4.5 discusses the conclusions and contributions of the thesis.

4.2 Integrating and contextualising findings

The following sections compare the findings from the two studies and interprets them through psychological and organisational theory.

4.2.1 Converging Findings

Four processes were identified across both datasets, each highlighting how contextual conditions shaped what the intervention could achieve. The most consistent process concerned how organisational leadership influenced the perceived

legitimacy of engagement. In Study 2, practitioners described TRiM being introduced to a setting characterised by blame-orientated responses to adverse events, litigation fears, workload pressures, and a culture in which emotional distress was managed through suppression rather than disclosure. Within this context, disclosure carried risk because emotional responses could be read as evidence of professional failing. Managerial endorsement mattered not only because managers were required to release staff to engage in the programme, but because it signalled to staff that TRiM was a legitimate use of their professional time rather than a withdrawal from clinical responsibility. Study 1 showed the same process from another perspective. In one account, senior clinicians were described as dismissive, which appeared to reduce junior staff's willingness to engage. The process can be summarised as: leadership behaviour shapes perceived legitimacy, which shapes willingness to engage, which in turn shapes whether the intervention has the conditions it needs to function. This is consistent with Edmondson's work on psychological safety in organisations, in which leadership behaviour and team context set the conditions under which individuals are willing to take interpersonal risks (Edmondson, 1999; Edmondson & Lei, 2014). For TRiM, this implies that the intervention does not create these conditions but depends on them.

A second process was in relation to the psychoeducational and normalisation components of the TRiM model. In Study 1, increased understanding of trauma responses was one of the most consistently endorsed quantitative outcomes (92.6%), with qualitative accounts describing the informational content as useful even where other aspects of delivery were more variable. In Study 2, practitioners described naming trauma responses, outlining expected patterns of recovery, and framing distress as a normal response to abnormal events. In SDT terms, the

psychoeducational component supported competence by reframing distress as an expected response rather than a sign of individual failure (Ryan & Deci, 2000). This suggests that the psychoeducational component of TRiM functioned more consistently across contexts because it was less dependent on the organisational conditions that shaped other aspects of engagement.

A third process concerned peer connection and shared occupational experience. In Study 1, relatedness was the most strongly represented SDT domain, with 60.0% of participants reporting that they liked the peer-facilitated aspect of TRiM and 68.0% reporting that they found it helpful. In Study 2, practitioners described how shared professional experience allowed them to validate colleagues' responses in a way that felt credible. This is consistent with Watson (2019), who identified shared experience as a key mechanism through which peer support generates validation. The process here is that shared occupational experience supports the credibility of validation, which in turn supports relatedness. However, 24.0% of Study 1 participants reported that they disliked the peer-facilitated aspect of TRiM, and 20.0% of participants reported finding it unhelpful. This indicates that peer support does not function the same way for all staff. Study 2 helps to provide context for this variability. Practitioners described how factors such as hierarchy and concerns about confidentiality within small clinical teams may have influenced what participants felt able to share. The same mechanism that creates credibility for some staff may therefore limit disclosure for others. This suggests that peer support operates as a conditional rather than a consistent source of relatedness. Its effect depends on whether the peer relationship is experienced as safe.

A fourth process concerned practical constraints linked to shift patterns and workforce organisation, which affected both access to the intervention for

participants and the delivery of follow-up support by practitioners. In Study 1, inflexible scheduling was described as leaving some staff feeling excluded, with one participant describing being treated as "an afterthought" when alternative times were not offered. In Study 2, practitioners described how staff became harder to reach once shifts changed, with anxiety about "missing people" and concern that groups became "scattered" if not caught promptly. TRiM is designed to include follow-up as a core component, but this appeared to be difficult to consistently implement within the maternity setting. This suggests that at least some of what Study 1 participants experienced as absent follow-up may reflect constraints in implementation rather than a limitation of the model itself, with differing shift patterns acting as a systemic barrier to the delivery of a component that requires continuity.

The thread running through these four processes is that the effect of TRiM is not the same in every setting or for every person. The mechanisms by which it works are contingent, and the conditions they depend on mostly sit outside the TRiM model itself.

4.2.2 Divergent findings

The divergences between the two studies appear to reflect differences between practitioner and participant perspectives on TRiM, rather than inconsistencies in the data. In particular, they help address the gap identified around the experiences of those delivering peer support, which the maternity literature has largely underexplored (see Section 1.7).

The first divergence concerns how the structure of TRiM was experienced. TRiM is designed as a structured, psychoeducational, identification-and-signposting model rather than as a psychological debriefing model, with a clear focus on identifying risk, ongoing monitoring, and onward referral rather than on emotional

processing (Greenberg et al., 2008; Whybrow et al., 2015). TRiM practitioners in Study 2 described this structure as supportive of their role, providing a defined scope and reducing concerns about being expected to deliver therapy or to manage complex emotional needs beyond their training. Participants in Study 1 reported experiencing the same structure as limiting. While the informational content was recognised as useful, in the qualitative accounts, some participants described TIBs as procedural, with insufficient opportunity to speak or to express how they were feeling. As one participant reflected: *"It was a great information session, but there was no opportunity for us to speak or to ask how we were feeling."* The aspects of the model that practitioners experienced as supportive of their role were the same aspects that some participants experienced as constraining.

The mismatch between what staff described wanting and what TRiM provided reflects the structure of the model rather than a problem with delivery. What participants in Study 1 described needing more of, the opportunity for emotional processing and expression in a group setting, is closer to psychological debriefing than to TRiM. NICE (2018) advises against the routine use of psychological debriefing for the prevention of post-traumatic stress disorder, on the grounds that it does not reliably prevent post-traumatic symptoms and may be harmful in some circumstances. TRiM was developed in part as a response to this evidence, as an identification-and-signposting model rather than a processing model (Greenberg et al., 2008). The mismatch between staff reported preferences and TRiM as delivered is therefore structural to the intervention's design. Addressing that mismatch by turning TRiM into a form of debriefing would not improve it but shift it away from the evidence base it was built on. As discussed later in Section 4.3, this places greater importance on the need for pre-briefing and expectation-setting.

A second related divergence concerns how staff approach TRiM prior to engagement. These expectations are captured differently across the two studies. It is important to note, participant accounts in Study 1 carry direct evidential weight through lived experience, whilst practitioner accounts in Study 2 offer an indirect perspective on how TRiM is approached by participants. In Study 1, some individuals described arriving expecting a space for emotional processing and expressing disappointment when sessions were experienced as more structured. Study 2 practitioners described some participants approaching TRiM with expectations closer to a formal clinical debrief, focused on events and decisions rather than on personal impact, with practitioners then needing to clarify that TRiM was focused on emotional wellbeing rather than incident analysis. These accounts differ, but they point to the same underlying issue. When staff approached TRiM expecting something it was not designed to offer, it was experienced as falling short even when it was working as intended. This supports the argument above that the mismatch was one of expectation rather than delivery.

The third divergence concerns the emotional labour involved in delivering TRiM and has the most significant implications for how the model functions overall. Practitioners in Study 2 described concerns of being held responsible for managing the emotional impact of sessions, supporting colleagues with distress and managing risk. They also described navigating role multiplicity within the same interaction. TRiM practitioners in the directorate were often senior staff, including line managers and clinicians who sat higher in the team hierarchy than many of the participants they supported. This meant that practitioners frequently held the peer supporter role alongside roles as manager or senior clinician and moved between these roles both within individual sessions and across the wider course of support. Several

practitioners described the additional difficulty of doing this while also managing their own responses to the same events. This emotional labour is largely absent from participant accounts in Study 1. Some of this asymmetry reflects the focus of the two studies, but it also reflects something about the intervention itself. What these findings suggest is that TRiM may not reduce emotional labour so much as redistribute some of it to practitioners who, in this site, were often already in senior clinical or managerial roles. That argument needs to be made cautiously, since it is based on two studies from a single regional directorate and sits alongside practitioners' accounts of the role as rewarding as well as demanding. Still, it has implications for sustainability. Practitioners in this study identified access to a staff psychologist as essential to sustaining the role safely, with one reflecting, *"I don't think I would have taken it on without that backup"*. Clinical psychology oversight is not a routine feature of how TRiM is implemented elsewhere, but it was a feature of how TRiM was implemented in this site, and practitioners identified it as part of what made the role manageable. This finding is consistent with wider evidence that emotional labour in healthcare is often shaped by organisational expectations yet remains insufficiently supported (Riley & Weiss, 2016), and that peer support roles can carry emotional burden in the absence of clear role structures (Kane et al., 2023). It also addresses directly the gap identified in Chapter 1 (see Section 1.7) relating to the experiences of those delivering peer support, which the maternity peer support literature has largely treated as secondary to participant experience.

4.2.3 Theoretical integration

This section draws on psychological and organisational theory to help make sense of the findings and examine the mechanisms through which TRiM operates in maternity settings. Engagement with TRiM appears to be influenced by processes

across multiple levels, including the organisational context in which it is implemented, the relational conditions within which it is delivered, and the individual psychological needs of staff. The three levels of this account are addressed in sequence below.

Organisational context (system level)

Both studies indicate that the organisational context in which TRiM was introduced shaped how staff engaged with it. The Consolidated Framework for Implementation Research (CFIR; Damschroder et al., 2022) is useful here because it treats organisational context as a determinant of implementation outcomes rather than as background. Within CFIR, the inner setting, which includes organisational culture, relative priority of the innovation, and available resources, is what shapes whether an intervention is implemented in name or in practice.

Across the two studies, the inner setting in this directorate was not consistently aligned with what TRiM required to function. In Study 1, reported dismissive attitudes from senior clinicians were described as undermining willingness to engage openly. In Study 2, practitioners described TRiM being introduced into a setting where the post-incident responses were evaluative and blame-oriented, and where distress was often managed through suppression rather than disclosure. Whether staff were released to attend sessions and how TRiM was supported by senior staff appeared to signal how legitimate it was, before staff had any direct experience of the intervention itself. Engagement with TRiM therefore started before the TIB. This pattern is consistent with the wider literature. Knezevic et al. (2025) found that staff were less likely to engage with a maternity wellbeing programme when organisational support was perceived as inauthentic, particularly

where leaders did not visibly reinforce it. Nazir et al. (2026) reported a parallel finding, with staff more likely to engage with wellbeing support when it felt genuine.

These findings suggest that staff judge the credibility of a wellbeing intervention through leadership behaviours. When there is a gap between what is said and what is seen in practice, it can create a level of scepticism that the intervention itself struggles to overcome. Within maternity settings specifically, where high levels of scrutiny and accountability shape how staff respond to events (Bingham et al., 2023; Sheen et al., 2016a), Turner & Lancaster (2025) describe a “coping culture” in which distress is often managed privately and support is not routinely sought. Engagement with TRiM in this directorate appears to have been shaped by the wider organisational culture, rather than determined by the intervention on its own terms. The findings are also consistent with the framing of engagement as help-seeking. Acknowledging distress within maternity settings carries interpersonal and professional risk, and staff often underutilise support even where need is high (Kuosmanen et al., 2025).

Psychological safety (relational level)

The findings from both studies suggest that organisational conditions did not shape staff engagement directly. Their effects were shaped by psychological safety within teams. Nembhard & Edmondson (2006) argue that professional status differences in healthcare exert their effects through psychological safety, with lower-status staff feeling less safe to speak up. Hierarchy mattered here through its effects on the perceived safety of speaking, disclosure, and help-seeking. Whether staff engaged depended on how risky these actions felt within a particular team.

Across both studies, staff accounts suggested that wider organisational conditions mattered through how safe or risky engagement felt within the immediate

team context. In Study 1, reported dismissive attitudes from senior clinicians were described as undermining willingness to engage openly, suggesting that hierarchical relationships in the wider directorate shaped what staff felt able to disclose within sessions. In Study 2, practitioners described how staff arrived in sessions already cautious about who would hear what they said, whether conversations might travel through tight-knit teams, and whether being seen to struggle would alter how they were perceived professionally afterwards. These concerns are consistent with Edmondson et al.'s (2016) account of healthcare as a setting in which the high stakes of clinical work, professional hierarchy, and strong norms around competence make psychological safety especially difficult to establish. They further note that perceived interpersonal risk may limit action even when motivation is present, which matches practitioners' descriptions of staff arriving willing to engage but cautious about what could safely be said.

What Study 2 adds is an account of how psychological safety in TRiM was actively produced rather than already present. Practitioners described needing to establish safety within each session through explanation, reassurance, explicit confidentiality talk, and boundary-setting. They did this knowing that staff would approach each session through the lens of prior organisational experience, and that even with active reassurance, some staff remained cautious. This maps closely onto Nemhard & Edmondson's (2006) account of leader inclusiveness, where leaders invite and value others' contributions in contexts where status differences might otherwise inhibit speaking up. Practitioners in this study appeared to be doing more than facilitating sessions competently. Their accounts suggest that they were also engaged in the interactional work needed to establish a sense of interpersonal safety within a hierarchical setting.

This suggests that psychological safety in TRiM could not be assumed. Its variability is therefore better understood not simply as an implementation problem, but as a feature of the relational context in which TRiM is delivered. In this sense, psychological safety appeared to vary from session to session and from team to team, rather than existing uniformly across the directorate. This helps explain why staff disclosure in TRiM was not predictable from organisational conditions alone, and why staff responses to the intervention varied across sessions even within the same workforce.

Self-Determination Theory (personal level)

Once organisational and relational conditions have shaped how safe a team feels, the next step is to consider how staff make sense of those conditions and act on them. SDT is useful here because it helps explain how workplace conditions support or frustration of psychological needs. As outlined in Chapter 1 (see Section 1.10), SDT proposes that wellbeing and motivated engagement depend on the satisfaction of three core needs: relatedness, autonomy, and competence (Ryan & Deci, 2000). Study 1 applied this framework directly in the analysis, allowing for a more detailed interpretation of how these needs were supported or constrained in practice. Overall, the findings from this thesis suggest that TRiM did not support all three needs equally. Patterns of need frustration are especially informative about where the intervention worked less well than expected.

The clearest pattern across both studies concerned relatedness. In Study 1, 60.7% of participants reported a sense of improved support in the workplace following TRiM, and 71.4% reported improvements in peer support among colleagues. Similarly, in Study 2, practitioners described how recognising that others were similarly affected by an event contributed to a sense of connection and

normalisation. The peer-led nature of the intervention appeared to play an important role in this, with shared professional experience allowing for forms of understanding that felt relevant to the maternity context. These findings are consistent with evidence that maternity staff are more likely to seek support from colleagues who share their occupational context and can validate their experiences without needing explanation (Fontein-Kuipers et al., 2018; Kerkman et al., 2019; Sweet & Kruger, 2025), and it is this shared context that gives peer support its credibility (Watson, 2019).

However, relatedness was also the most easily frustrated need in some cases. In Study 1 qualitative accounts, some participants described sessions as overly informational, with limited opportunity to express how they were feeling. Difficulties with follow-up appeared to compound this. Although TRiM is structured around brief contacts at planned intervals rather than ongoing support, some participants in the directorate described expecting follow-up that did not occur with one noting that *“It was never discussed again despite being told we would meet as a group again.”* In these cases, the sense of connection established in the first session was not sustained. Within SDT, relatedness involves more than social contact; it involves a sense of connection and belonging, and feeling cared for by others (Ryan & Deci, 2000). These findings suggest that while TRiM can create the conditions for relatedness, it does not always result in that experience.

Findings relating to autonomy were more mixed. In Study 1, some participants described feeling unprepared for the structure or expectations of TRiM, particularly in group settings where emotional disclosure was invited without prior explanation. This appeared to create discomfort and a sense of being caught off guard. Within SDT, autonomy refers to engagement that feels voluntary and self-

directed, and where individuals feel able to make informed choices about their involvement (Ryan & Deci, 2000). These accounts reflect a form of autonomy frustration, not because participation was explicitly forced, but because the conditions for meaningful choice were not fully established. Where autonomy satisfaction was supported, this tended to be associated with flexible and non-pressured sessions in which staff retained control over their level of participation. This suggests that relatively small aspects of delivery, such as pre-briefing and expectation-setting, may have a significant impact on how autonomy is experienced.

Evidence relating to competence is less clear. The quantitative data in Study 1 showed consistent endorsement of increased understanding of trauma responses (92.6%), knowledge of coping strategies (75.0%), and awareness of where to seek further help (78.6%). These are clearly positive outcomes and align with the psychoeducational aims of TRiM. The qualitative data, however, did not consistently reflect a corresponding increase in confidence or sense of capability in managing distress. Competence need satisfaction involves not just acquiring information but experiencing a sense of effectiveness in dealing with challenges (Vansteenkiste & Ryan, 2013). The findings suggest that while TRiM supports knowledge acquisition, this does not necessarily translate into a stronger sense of competence. This may reflect the limits of the intervention structure, but it may also relate to how competence was captured in the study.

Taken together, these findings indicate that the three psychological needs outlined in SDT were not equally supported within the context of TRiM. Relatedness was both the most consistently supported and the most easily frustrated, making it central to understanding what the intervention did and did not achieve. Autonomy was more variable, and appeared sensitive to how sessions were introduced and

facilitated. Competence was supported at the level of knowledge, but less clearly at the level of perceived capability. These patterns relate back to the organisational and relational conditions described in the preceding sections. Where organisational factors limited engagement, or where psychological safety was not established within sessions, staff were less able to engage in ways that supported relatedness and autonomy. In this sense, need satisfaction was not inherent to the design of TRiM, but depended on the conditions under which it was encountered.

What this section suggests is that TRiM in the Ireland South Women and Infants Directorate operated through three connected layers. Organisational conditions influenced what was possible at the team level. Psychological safety within teams influenced what felt safe to say and do. Need satisfaction at the individual level influenced whether staff engaged with what TRiM offered. This points to a multi-level account of how TRiM functions in maternity care, in which the intervention's effects depend not only on its content but on the conditions through which staff encounter it. It also aligns with the clinical psychology approach to staff support outlined in Section 1.9 of this thesis, in which distress is understood in relation to the wider context in which it arises rather than as an individual problem alone.

4.3 Implications

Practitioner-level

Study 2 is the first study to examine TRiM from the practitioner's perspective within a maternity setting. The findings indicate that delivering TRiM places specific demands on those facilitating it, which has implications for how they are prepared for and supported in the role. Practitioners described the transition from training into delivery as something that took time, as they worked to apply the model within the

realities of a complex clinical environment. This suggests that competence in delivering TRiM is not fully established through initial training alone, but develops through experience of delivering sessions.

One implication is the need for ongoing practitioner development beyond initial training. While training appeared to provide a clear understanding of the model and its boundaries, some practitioners described a gap between this and the relational confidence required to facilitate sessions. This points to the value of refresher training and opportunities for peer learning rather than relying on one-off training as sufficient preparation. The finding that working in pairs was experienced as supportive during early implementation suggests that paired facilitation may be particularly beneficial, allowing practitioners to share responsibility, observe different facilitation styles, and build confidence over time.

A second implication concerns role clarity. Practitioners described navigating multiple roles simultaneously, sometimes supporting staff whom they also supervised or worked closely with. Although the structured nature of TRiM was experienced as helpful in maintaining boundaries, this did not remove the complexity of delivering the intervention within existing hierarchical team relationships that characterise maternity services. Clearer definition of the practitioner role, including when it may be more appropriate to step back from facilitation, may help reduce uncertainty and support safer delivery.

The findings also highlight the extent of emotional labour involved in delivering TRiM. Practitioners described holding colleagues' distress, managing group dynamics, and, at times, facilitating sessions while themselves affected by the same or similar events. Formal opportunities for supervision, reflective spaces, and shared responsibility across a pool of trained practitioners may help sustain

practitioner capacity over time. This is consistent with wider findings that healthcare roles involving emotional support can carry substantial emotional demands, which are often under-recognised and insufficiently supported (Riley & Weiss, 2016).

In this directorate, clinical psychology support was already part of how TRiM operated. Practitioners identified access to a staff psychologist as essential to sustaining the role and described drawing on that support not only for supervision but for consultation on boundaries and clarity about what TRiM is and is not. This kind of input involves helping practitioners hold the line between peer support and therapy, particularly after complex incidents where the boundary is unclear. It draws on clinical skills in containment, formulation, and systemic thinking that are central to the clinical psychology role and applies them in a context where the psychologist is supporting the supporter rather than working directly with the person in distress. As a growing area of practice within clinical psychology in maternity settings, the evidence base for this contribution remains limited, which makes practitioner accounts of its value in this thesis particularly relevant.

Service-level

At the service level, the clearest implication concerns how TRiM is introduced and explained to staff before they attend. Across both studies, there was a consistent mismatch between what some staff expected from TRiM and what they encountered. Study 1 participants described arriving unprepared for group disclosure, finding the structured format intimidating, and experiencing sessions as informational where they had anticipated something more emotionally responsive. Study 2 practitioners described staff at times arriving with expectations more consistent with a clinical debrief. Where expectations diverge from what TRiM offers, engagement may be compromised before the intervention has had a chance to

function. This makes pre-briefing a core component of implementation rather than an optional extra. Staff need clear information about what TRiM is, what it is not, what will be asked of them, and how it relates to other post-incident processes.

Increasing the visibility of support interventions and improving staff awareness has been identified as a key factor in facilitating engagement and reducing uncertainty about confidentiality and purpose in healthcare settings (Busch et al., 2021). Similarly, barriers to help-seeking among healthcare professionals have been linked to limited awareness of available supports and concerns about how they operate in practice (Nazir et al., 2026). Within an SDT framework, autonomy requires that engagement feels informed and self-directed. Where staff do not know what they are attending, the conditions for voluntary engagement have not been established, regardless of how well the session itself is facilitated. In this context, clearer communication about TRiM can be understood not as an optional extra, but as a condition of informed and voluntary engagement.

This point also has implications for continuity and follow-up. Findings suggest that further support following initial TRiM contact was not always experienced as clear by staff, particularly where the distinction between brief initial intervention and later opt-in or structured follow-on support was not well understood. Services should therefore communicate more explicitly what happens after different forms of TRiM contact (e.g., TIB, Structured Conversation, and Follow-up Structured Conversation), including whether further support is automatically offered or needs to be actively taken up. Making follow-up more explicit and procedural within local TRiM delivery may help reduce inconsistency in staff experience and strengthen continuity of support.

A further implication concerns access. Across both studies, workload pressures and shift patterns made it difficult for staff to attend and for practitioners to deliver sessions consistently. Even where TRiM was viewed as valuable, engaging with it was not always feasible in practice. These challenges are not specific to TRiM, but reflect broader difficulties in delivering staff support within acute healthcare settings. In a study with the same clinical population at Cork University Maternity Hospital, O’Riordan et al. (2020) found that staffing pressures and long shifts can limit access to support interventions. This suggests that implementation depends not only on making TRiM available, but on whether organisation make attendance feasible.

Finally, the findings suggest that TRiM is better understood as one component within a broader support pathway rather than as a complete response to staff psychological need in maternity services. In Study 1, 65.4% of participants indicated a preference for non-peer support, either alongside or instead of TRiM. The qualitative findings also suggest that some staff were looking for something more emotionally responsive than TRiM is designed to provide. This does not indicate a failure of the model so much as the importance of its boundaries and intended scope. In Chapter 1, a framework by Simms-Ellis et al. (2025) was used to describe TRiM as a secondary-level intervention that functions most appropriately as part of a layered support system, and the findings of this thesis are consistent with that framing. The implication at service level is that TRiM should sit within a stepped or layered model of support, with clear onward pathways to individual or more intensive support where required.

Clinical psychologists have a specific role at the service level that goes beyond individual clinical work. In this directorate, the staff support psychologist

was involved not only in supporting individual staff but in overseeing TRiM's place within a broader pathway, including managing the boundary between what TRiM provides and what requires more intensive or individualised input. This is particularly important given the expectations mismatch described earlier in this chapter (see Section 4.2.2). Where staff preferences pull toward emotional processing closer to debriefing, psychological oversight is what keeps the model aligned with the evidence base on which it was built. Without that oversight, the organisation may be drawn toward reshaping TRiM in ways that move it away from its design rationale. The clinical psychologist's contribution at this level is not delivering TRiM but guiding and shaping the stepped-care pathway through which it sits, a function that is specific to the professional role and difficult to replicate through managerial oversight alone.

Organisational-level

At an organisational level, the findings point to conditions that neither practitioners nor services can create on their own. Most importantly, TRiM cannot establish psychological safety on its own where the wider organisational culture makes it difficult for staff to disclose distress or seek support openly. In both studies, where senior staff did not clearly support TRiM, engagement was compromised before sessions had begun. Staff appear to read organisational signals about whether distress is legitimate and whether support-seeking is safe before engagement with any intervention.

This suggests that organisational endorsement needs to be demonstrated in practice rather than simply stated. It is reflected in leadership behaviour and in the consistency of messages about staff wellbeing. This extends to who is selected and supported as TRiM practitioners. Where the organisation trains staff who are visibly

committed to staff wellbeing, it reinforces the credibility of the model. Where selection is less considered, TRiM risks being perceived as a procedural exercise rather than a genuine support. The organisation therefore shapes not only whether TRiM is available, but whether it is experienced as credible.

A further implication relates to protected time and scheduling. Across both studies, staffing pressures and a lack of cover made it difficult for staff to attend and for practitioners to deliver sessions consistently. TRiM is unlikely to function well where participation depends on staff giving up their own time or stepping away from already stretched clinical work without support. Making time available for both staff and practitioners communicates how seriously staff support is taken in practice. Where engagement with TRiM is facilitated, rather than left to individual discretion, it is more likely to be experienced as a legitimate part of work.

The broader implication is that TRiM is most likely to function when embedded within a wider organisational approach to staff wellbeing rather than relied on in its place. In the Ireland South Women and Infants Directorate, it formed part of a broader staff support offering within the setting, and the staff support clinical psychologist played an important role both in introducing the model and in supporting pathways beyond it. This suggests that maternity settings planning to implement TRiM should consider not only the intervention itself, but the wider support structures around it and the availability of psychological input to guide its implementation.

Clinical psychologists in staff support roles within maternity settings contribute at the organisational level, not by delivering additional intervention but by shaping how the organisation understands and responds to staff distress. This includes influencing leadership's understanding of why staff struggle to engage with

support, drawing attention to the cultural and systemic conditions that make engagement possible or impossible, and supporting the development of psychologically informed systems in which TRiM can function as intended. Without that broader alignment, TRiM risks being experienced as symbolic rather than supportive.

4.4 Methodological reflections and limitations

This thesis has a number of methodological strengths, including the use of a mixed-methods design and the inclusion of both participant and practitioner perspectives. However, there are also limitations that are important to consider when interpreting the findings. A key limitation relates to recruitment within Study 1. The original design intended to complement the survey with qualitative interviews to allow for a more in-depth exploration of staff experiences. However, despite an extended recruitment period of approximately one year, no participants consented to take part in interviews. A subsequent attempt to recruit focus groups following additional ethical approval was also unsuccessful. Recruitment was conducted using multiple strategies, including email invitations, posters with QR codes, repeated reminders, and manager-supported dissemination. These approaches were informed by evidence suggesting that multimodal strategies, follow-up contact, peer-level engagement, clarity about the purpose and process of the study, and the extent to which the research is perceived as relevant to clinical practice can support response rates among healthcare professionals (Cooper & Brown, 2017; VanGeest et al., 2007). Despite this, recruitment to the qualitative components remained unsuccessful.

While this limits the depth of qualitative insight available for Study 1, it is also consistent with wider evidence that surveys and research involving healthcare

professionals are often characterised by low response rates, raising concerns about nonresponse bias and the representativeness of findings (VanGeest et al., 2007). In this context, the Study 1 sample may overrepresent staff who were already willing to engage with TRiM or with research more generally. At the same time, the difficulty in recruiting participants to qualitative components may reflect the same barriers to engagement identified within the findings themselves, including hesitancy around disclosure and the perceived risks associated with discussing workplace experiences.

A further consideration relates to the nature of the survey data collected. Although the inclusion of open-ended responses allowed for qualitative insight, research on open-ended survey responses suggests that employees who are less satisfied are more likely to provide comments, and that these responses tend to be more negative in tone and more elaborated than those provided by more satisfied respondents (Poncheri et al., 2008). The qualitative findings are therefore best interpreted alongside the quantitative data rather than as a standalone account of staff experience. In addition, Study 1 was not designed specifically to assess SDT constructs, meaning that this framework was applied interpretively at the analysis stage. Future research could strengthen this aspect by designing data collection more directly around SDT-informed questions or measures.

Further limitations relate to the characteristics and size of the samples included in both studies. The Study 1 sample was relatively small, although it represented approximately 16% of all eligible TRiM participants within the directorate, supporting the relevance of the findings within this specific context. In contrast, Study 2 focused on TRiM practitioners, a group who may be more motivated to engage with the model and with research exploring it. The interview sample represented 45% of all trained TRiM practitioners within the service.

Despite these limitations, the thesis provides a detailed and methodically transparent account of how TRiM is experienced and implemented within a maternity setting. Drawing on both participant and practitioner perspectives allowed findings to be examined from complementary positions, and convergence across the datasets supports the credibility of the interpretations offered.

4.5 Conclusion

In conclusion, this research contributes to a relatively underdeveloped evidence base by examining how TRiM is experienced within a maternity setting through two complementary lenses: Study 1 provides the first empirical account of maternity staff experiences of participating in TRiM, while Study 2 addresses a gap in the literature by examining the experience of those delivering the intervention as peer-facilitators. Taken together, the findings suggest that TRiM can provide a structured and acceptable form of support following adverse events. Both studies found that TRiM was generally valued, particularly in its psychoeducational content and its capacity to foster peer connection. However, its impact is shaped by the conditions around it. Where conditions supported openness and engagement, TRiM was more likely to be experienced as helpful. Where they did not, its potential was more limited.

The findings also highlight the importance of considering the experience of those delivering TRiM. Practitioners were not simply delivering the model but were actively navigating the demands of the role within a complex working environment. Their ability to deliver TRiM as intended depended not only on training but on ongoing support, role clarity, and the availability of psychological input to sustain them in the role.

This thesis proposes a multi-level account of how TRiM functions in maternity care, in which the intervention's effects depend on the interaction between organisational conditions, psychological safety within teams, and individual need satisfaction. This shifts the focus from whether TRiM works, to the conditions under which it is experienced as useful by staff. The findings also point to a role for clinical psychology in supporting TRiM implementation. In the Ireland South Women and Infants Directorate, clinical psychology oversight was not a standard feature of the TRiM model but was identified by practitioners as essential to sustaining their role. This suggests that the clinical psychologist can contribute by shaping the wider support pathway in which TRiM sits and supporting those who deliver it. In that sense, the findings are relevant not only to TRiM implementation, but to the developing role of clinical psychology in maternity staff support, where the evidence base remains limited. Improving staff wellbeing in maternity services requires more than offering support. It requires attending to the system in which staff work. TRiM can contribute to that, but it cannot do it alone.

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Appendices

Appendix A: Publication Guidelines for Journal of Advanced Nursing

Author Guidelines

Sections

1. [Submission and Peer Review Process](#)
2. [Article Types](#)
3. [After Acceptance](#)

1. SUBMISSION AND PEER REVIEW PROCESS

We are delighted you are choosing to submit to *Journal of Advanced Nursing*. While we cannot provide any assurance of acceptance, we can say that following all of the following guidelines very carefully and asking any questions you might have along the way to this email address: jan@wiley.com might go a long way towards facilitating a favourable outcome for your submission.

- Once all of your submission materials have been prepared in accordance with these Author Guidelines, manuscripts should be submitted online at <https://authors.wiley.com/journal/JAN>
- You will be asked to complete a submission form as part of the process and these author guidelines may be helpful to refer to as you do so.
- For help with submissions, contact: jan@wiley.com
- This journal does not charge submission fees. If you choose to publish your paper Open Access, you will be asked to pay an Article Publication Charge.

This journal does not charge submission fees.

Article Preparation Support

Wiley Editing Services offers expert help with English Language Editing, as well as translation, manuscript formatting, figure illustration, figure formatting, and graphical abstract design – so you can submit your manuscript with confidence.

Also, check out our resources for [Preparing Your Article](#) for general guidance about writing and preparing your manuscript.

Free Format submission

The Journal of Advanced Nursing offers [Free Format submission](#) for a simplified and streamlined submission process.

Before you submit, you will need:

- Your manuscript: this should be an editable file including text, figures, and tables, or separate files—whichever you prefer. All required sections should be contained in your manuscript, including abstract, introduction, methods, results, and conclusions. Figures and tables should have legends. Figures should be uploaded in the highest resolution possible. If the figures are not of sufficiently high quality, your manuscript may be delayed. References may be submitted in any style or format, as long as it is consistent throughout the manuscript. Supporting information should be submitted in separate files. If the manuscript, figures or tables are difficult for you to read, they will also be difficult for the editors and reviewers, and the editorial office will send it back to you for revision. Your manuscript may also be sent back to you for revision if the quality of English language is poor.
- An ORCID ID, freely available at <https://orcid.org>. (*Why is this important? Your article, if accepted and published, will be attached to your ORCID profile. Institutions and funders are increasingly requiring authors to have ORCID IDs.*)
- The title page of the manuscript, including:

- Your co-author details, including affiliation and email address. (*Why is this important? We need to keep all co-authors informed of the outcome of the peer review process.*)
- Statements relating to our ethics and integrity policies, which may include any of the following (*Why are these important? We need to uphold rigorous ethical standards for the research we consider for publication*):
 - data availability statement
 - funding statement
 - conflict of interest disclosure
 - ethics approval statement
 - patient consent statement
 - permission to reproduce material from other sources
 - clinical trial registration

Important: this journal operates a double-anonymized peer review policy.

Please anonymize your manuscript and supply a separate title page file.

Guidelines on Publishing and Research Ethics in Journal Articles

This journal requires that you include in the manuscript details IRB approvals, ethical treatment of human and animal research participants, and gathering of informed consent, as appropriate. You will be expected to declare all conflicts of interest, or none, on submission. Please review Wiley's policies surrounding [human studies, animal studies, clinical trial registration, biosecurity, and research reporting guidelines](#).

This journal follows the core practices of the [Committee on Publication Ethics \(COPE\)](#) and handles cases of research and publication misconduct accordingly (<https://publicationethics.org/core-practices>).

This journal uses iThenticate's CrossCheck software to detect instances of overlapping and similar text in submitted manuscripts. Read [Wiley's Top 10 Publishing Ethics Tips for Authors](#) and [Wiley's Publication Ethics Guidelines](#).

2. ARTICLE TYPES

Carefully review the types of articles the Journal considers for publication in the chart below and all the guidelines included throughout. You will be asked to select an article type when you enter your submission into Research Exchange (our manuscript management system). Contact the editorial office (jan@wiley.com) if you have any questions. We provide guidance on maximum number of references but if more are required, please address this in the covering letter.

RESEARCH ARTICLES

REPORTS ORIGINAL RESEARCH

ALL RESEARCH ARTICLES MUST ADHERE TO THE RELEVANT EQUATOR RESEARCH REPORTING CHECKLIST. Research Articles include the following: Clinical Trials, Empirical Research Mixed Methods, Empirical Research Qualitative, Empirical Research Quantitative, Feasibility Study, Pilot Study

EMPIRICAL RESEARCH MIXED METHODS, EMPIRICAL RESEARCH QUALITATIVE, EMPIRICAL RESEARCH QUANTITATIVE

WORD LIMIT: 8,000

FIGURES AND TABLES: Up to 10

REFERENCES: 35 or fewer, or reasons for requiring more addressed in cover letter to Editor.

Main Text File

Manuscripts can be uploaded either as a single document (containing the main text, tables and figures), or with figures and tables provided as separate files. The main manuscript file can be submitted in Microsoft Word (.doc or .docx) or LaTeX (.tex) format.

ABSTRACT:

The abstract format for all article types is structured, except these article types do not include abstracts: Brief Report, Commentary, Letter to the Editor, and Editorial.

Structured Abstract Format

- a. 300 words maximum.
- b. No abbreviations.
- c. Do not report p values, confidence intervals and other statistical parameters.

Include the Following Headers in Abstracts:

Aim(s) (of the paper, simply state 'To...')

Design

Methods

***Data Sources** (Include search dates) **for reviews only*

Results

Conclusion

Implications for the profession and/or patient care

Impact (Addressing:)

- What problem did the study address?
- What were the main findings?
- Where and on whom will the research have an impact?

Reporting Method: State here that you have adhered to relevant EQUATOR guidelines and name the reporting method.

Patient or Public Contribution ([read more here](#)): Include a statement that details how patients, service users, caregivers or members of the public were involved in your study. This does **not** include being a research participant. This may be the design or conduct of the study, analysis or interpretation of the data, or in the preparation of the manuscript. Your paper will be unsubmitted and returned to you if this section is not included.

In your statement, please use one of the following templates to describe patient/public involvement with the project:

1. No Patient or Public Involvement:

This study did not include patient or public involvement in its design, conduct, or reporting.

2. Patient and Public Involvement Template:

Patients and members of the public were involved in [specific stage(s): e.g., study design, data collection, interpretation of findings]. Their contributions included [specific actions: e.g., reviewing protocols, co-designing surveys, participating in advisory groups], ensuring the research addressed [specific needs or outcomes: e.g., patient-relevant priorities].

3. For Minimal PPIE (acknowledgment of limited involvement):

Limited patient and public involvement was incorporated, focusing on [specific stage: e.g., feedback on study materials].

Keywords (You will be able to choose keywords when you begin the submission process, and you can select up to ten).

What does this paper contribute to the wider global clinical community? Include one to three bullet points.

Trial and Protocol Registration: Include the following for papers that require **trial and protocol registration**:

- Include the name of the trial register, the clinical trial registration number, and a link to the trial at the registration website.
- If there is a protocol that does not require registration, it must still be made accessible at: Open Science Framework (<https://osf.io/>) ” or “Figshare (<https://figshare.com/>). Include the name of the website, the protocol number, and a link to the registration site.

MAIN TEXT HEADINGS

Find your **ARTICLE TYPE** below and use the relevant headings below in your main text file:

EMPIRICAL RESEARCH – QUALITATIVE article type:

1. Introduction
2. Background
3. The Study
 - Aim(s)Objective(s), Research Question
4. Methods/Methodology
 - Design
 - Theoretical Framework
 - Study Setting and Recruitment
 - Inclusion and/or Exclusion Criteria
 - Data collection

- Data Analysis
- Ethical Considerations
- Rigor and reflexivity

5. Findings

- Characteristics of participants

6. Discussion

- Strengths and Limitations of the Work
- Recommendations for Further Research
- Implications for policy and practice

7. Conclusion

EMPIRICAL RESEARCH MIXED METHODS article type: Use Quantitative and/or Qualitative Main Text headers.

TABLES (each table complete with title and footnotes).

Appendix B: Study 1 Qualtrics Information Page and Consent Form

What are the impacts of TRiM on staff in a maternity setting and what psychological phenomena influence this?

Thank you for considering participating in this survey. The information below outlines the purpose of the research and what your participating will involve to help you decide whether you would like to take part.

Primary Investigator Details

Aoife Lyons, Trainee Clinical Psychologist, University College Cork

Investigator Details

Samantha Dockray, PhD, School of Applied Psychology, University College Cork

Dr Kim Keating, Senior Clinical Psychologist & Practice Educator, University College Cork

Dr Coleen Cormack, Senior Clinical Psychologist Staff Support & Wellbeing, TRiM Coordinator, Ireland South Women & Infants Directorate

Purpose of the Study

The researchers are interested in exploring your experience of engaging in Trauma Risk Management (TRiM), which was introduced to your workplace in December 2023. Particularly we are interested in exploring if there are impacts of TRiM in your workplace and what psychological phenomena might influence this.

What will the study involve?

If you are a staff member who has attended a TRiM Incident Briefing and/or TRiM Structured Conversation at least 6 weeks ago you are invited to complete this online survey on Qualtrics which will last approximately 15 minutes. You will be asked to give consent before taking part in the survey. The survey will ask you for some information about your current role, and to rate your experience regarding certain aspects of TRiM. It will also offer an opportunity for you to provide any individual feedback about your experiences. All perspectives and experiences are welcomed, whether it is positive, neutral or negative. Surveys may be completed during working hours.

Why have you been asked to take part?

You have been asked because you are a staff member in Ireland South Women and Infants Directorate who attended a TRiM Incident Briefing and/or TRiM Structured Conversation at least 6 weeks ago.

Do you have to take part?

No, you don't have to take part, it is completely voluntary. Choosing to not take part in the study will have no negative implications on your position at Ireland South Women and Infants Directorate or your ability to access TRiM in the future. You will have some time to think about doing the study and ask questions about what it involves in detail. You can also omit questions you do not wish to respond to. You can withdraw at any time up to one week after completing the survey, with no consequences. The reason there is a one-week time limit is because after that point we will anonymise and combine the data. After that time we won't be able to find which data belongs to you.

Will your participation in the study be kept confidential?

Yes, the researchers will ensure that no clues to your identity appear in the research data or results reported. We will not ask you for your name or share any identifying information in the research data or results. We will not talk about your participation to anybody outside of the research team.

What will happen to the information which you give?

We will keep your consent forms until the data is collected and anonymised. After that is done, your consent form will be destroyed. The data will be kept confidential for the duration of the study, available only to me and my research team. We keep the data for ten years and then it is destroyed. It will be anonymised and securely stored in a shared folder on a secured drive that only the research team have access to. Anonymised data may be shared with other researchers.

If you have any complaints in connection with our processing of your personal data, you can contact UCC's Data Protection Officer (DPO): DPO, Information Compliance Section, Office of Corporate & Legal Affairs, University College Cork, Western Road, Cork E: gdpr@ucc.ie

You also have the right to lodge a complaint with the Data Protection Commission if you are unhappy with our processing of your personal data. Details of how to lodge a complaint can be found on the Data Protection Commission's website (www.dataprotection.ie), or by telephoning 1890 252 231.

What will happen to the results?

The results of this study will be based on anonymised data that will be shared with relevant partners, like the HSE, and reported in academic papers and at academic conferences.

What will happen to the results?

The results of this study will be based on anonymised data that will be shared with relevant partners, like the HSE, and reported in academic papers and at academic conferences.

What are the possible advantages of taking part?

By participating in this research, you will help us to understand more about TRiM in a maternity setting and assess if TRiM is meeting the needs of you and others in the service.

What are the possible disadvantages of taking part?

We don't anticipate any negative consequences for you in taking part. We will be asking questions only about your experience of attending TRiM and not about the event that resulted in your invitation to attend TRiM. We believe this is a low-risk study but if you have a concern about any aspect of this study or if you have been affected by any issues raised by this study and require additional support, please do not hesitate to contact the following services for support:

Dr. Coleen Cormack (Senior Clinical Psychologist, Staff Support & Wellbeing): Coleen.Cormack@hse.ie
HSE Employee Assistance Programme: 0818 327 327

Who has reviewed this study?

Approval must be given by the Clinical Psychology Research Ethics Committee of UCC before studies like this can take place. This study was approved by the Clinical Psychology Research Ethics Committee in October 2024 and by the Local Implementation Governance Group (LIGG) in December 2024.

Any further queries?

If you need any further information, you can contact:
Aoife Lyons, 122104917@umail.ucc.ie.

If you agree to participating in this study, please select the arrow at the bottom of the page to bring you to the consent page.



I confirm I have read the information sheet and understand the purpose of the study and what my participation will involve.

I can confirm that it has been at least 6 weeks since I participated in a TRIM incident briefing (TIB).

I am aware that my participation is voluntary, that I can omit questions I do not wish to respond to and I can withdraw up to one-week after completing the survey without giving any reason and my occupation or legal rights being affected.

I understand that the survey will be recorded on Qualtrics.

I understand that the information collected may be used to support other research in the future and anonymised, group level data may be shared with other researchers.

I understand that anonymised demographic information will be collected.

I understand that my anonymised data will be stored in on a shared folder only accessible by the research team. I am aware of who I can contact to receive support if participating in the study results in any distress.

I am aware that the findings from this research may be shared with relevant research partners, like the HSE, and published in academic journals.

I understand that my information will be stored securely in line with University College Cork research policy.

I have had time to consider my participation and voluntarily agree to partake in this research. Please select your response

Please select your response:

☐ I AGREE and give informed consent

☐ I DO NOT AGREE or give informed consent

Appendix C: Study 1 Survey

Thank you for taking the time to participate in this survey. Your insights and experiences are invaluable in helping us better understand the impact of Trauma Risk Management (TRiM) and how staff can be supported effectively. This survey will ask about your experiences with TRiM and gather your thoughts on various psychological factors, such as peer support, stigma reduction, and emotional well-being.

Your responses are completely confidential, and the survey should take about 15 minutes to complete. You can omit questions you do not wish to respond to. All perspectives and experiences are welcomed. There are no right or wrong answers—please answer honestly based on your experiences.

1. Which of the below best describes your role?

- Midwife
- Nurse
- Doctor
- Healthcare Assistant
- Ancillary Staff (e.g. housekeeping, porter, orderly)
- Health and Social Care Professional
- Administrator
- Other

2. How many years have you worked in this role?

- > 1
- 1 - 2
- 3 - 5

- 5 - 10
- 10 + years

3. TRiM has several parts; you may have participated in some or all of them.

Please tick all that apply to you from the following list.

- **A TRiM Incident Briefing (TIB)** – this occurs very soon after the incident. It is a short meeting with other colleagues who may have been impacted by the same potentially traumatic incident to hear an update about the incident and some information on normal reactions to abnormal events, how to look after yourself after the incident and what happens next in the TRiM process. If you did not have an opportunity to attend a full Incident Briefing, one of the TRiM team members may have met you for a brief individual check-in.
- **An individual TRiM Structured Conversation** - this takes place within two weeks after the event and is separate from the TRiM Incident Briefing. It gives you the opportunity to talk about what happened before, during and after the event and how you are feeling now. The conversation is between you and a trained TRiM Practitioner.
- **A group TRiM Structured Conversation** - this takes place within two weeks after the event and is separate from the TRiM Incident Briefing. It is a group meeting that gives you and other colleagues an opportunity to discuss what happened before, during, and after the event and how you each feel now. The conversation is between a number of staff and two trained TRiM Practitioners.
- **A follow-up TRiM Structured Conversation** - this takes place about a month after the TRiM Structured Conversation and gives you the chance

to talk through how you are feeling now that some time has passed since the incident.

- **None of these** - I didn't take part (action: end survey)
4. How many times have you been invited to TRiM?
 - Only once
 - 2-3 times
 - 4 or more times
 5. How many times have you attended TRiM?
 - Only once
 - 2-3 times
 - 4 or more times
 6. When did you last attend TRiM?
 - Less than 6 months ago (action: end survey)
 - More than 6 months ago
 7. Before participating, how familiar were you with the TRiM service?
 - Not familiar at all
 - Somewhat familiar
 - Very familiar
 8. Based on your experience, to what extent do you agree or disagree that TRiM influenced the following aspects after the potentially traumatic event? (Uses a 5-point Likert scale ranging from “Strongly Disagree” to “Strongly Agree”):
 - Feeling a sense of support in the workplace
 - Reflecting on the personal impact of the incident
 - Understanding that people respond differently to such events
 - Gaining insight into coping strategies that might be helpful

- Awareness of where to seek further help or support if needed

9. Please tell us how much you agree or disagree with the following statements

(Uses a 5-point Likert Scale ranging from “Strongly Disagree” to “Strongly Agree”)

- I am aware of how the TRiM process functions in my workplace
- I feel the TRiM process is useful in my workplace
- The TRiM process is a good use of my time
- The information provided during the TRiM process is helpful following a potentially traumatic event
- I would consider recommending TRiM to colleagues facing similar challenges.

10. To what extent have you noticed any changes after participating in TRiM in

relation to the following statements? (Uses a 5-point Likert Scale:

"Significantly Worsened," "Somewhat Worsened," "No Change," "Somewhat Improved," "Significantly Improved")

- My perspective on discussing mental health at work.
- My views on discussing mental health issues.
- How judged I feel when expressing my feelings.
- The level of peer support among colleagues.
- The level of organisational support in my workplace.
- My comfort level in discussing traumatic events with peers.
- My ability to manage work-related stress.
- My ability to handle emotional challenges at work.
- My overall wellbeing.

11. We are interested in exploring the peer-facilitated aspect of TRiM. Please respond to the statement below. My experience of the peer-facilitated aspect of TRiM, is something that I... (Uses a 5-point Likert Scale ranging from “Strongly disliked” to “Strongly Like”)
12. We are interested in exploring the peer-facilitated aspect of TRiM. Please respond to the statement below. My experience of the peer-facilitated aspect of TRiM, is something that I found... (Uses a 5-point Likert Scale ranging from “Very unhelpful” to “Very helpful”)
13. Do you have preference for peer-facilitated support (i.e., TRiM) or external-facilitated support (e.g., EAP, occupational health, external service)
- a. peer-facilitated support (e.g., TRiM)
 - b. non-peer-facilitated support (e.g., EAP, occupational health, external service)
 - c. Both
 - d. Other [open text box]
14. Aside from the information shared by TRiM facilitators, can you provide feedback on other aspects of the TRiM service? (e.g., the structure, timing, environment, or group dynamics)
- [open text box]
15. Overall, how would you rate your satisfaction with TRiM?
- Very Dissatisfied
 - Dissatisfied
 - Neutral
 - Satisfied
 - Very Satisfied

16. Do you have any suggestions for the improvement of TRiM in your workplace?

[open text box]

Appendix D: Study 1 Debrief Sheet



Dear participant,

I would like to thank you very much for taking part in this survey. Your contribution is valuable to the research team, and we hope will make a difference for people who engage with TRIM in the future.

As part of this study we are also conducting individual interviews to further explore staff experience of TRIM. If you would be interested in participating in an interview please email Aoife Lyons, Primary Researcher at 122104917@umail.ucc.ie.

If you have been affected by any issues raised by this study and require additional support, please do not hesitate to contact the following services for support:

Dr. Coleen Cormack (Senior Clinical Psychologist, Staff Support & Wellbeing): Coleen.Cormack@hse.ie Employee Assistance Programme: 0818 327 327

Feedback and complaints procedure

If you have any feedback or concerns about this research study, please feel free to contact me, the Primary Researcher (122104917@umail.ucc.ie), or one of my Academic Supervisors, Dr. Samantha Dockray (S.Dockray@ucc.ie) or Dr. Kim Keating (KKeating@ucc.ie).

If you have any complaints in connection with our processing of your personal data, you can contact UCC's Data Protection Officer (DPO): DPO, Information Compliance Section, Office of Corporate & Legal Affairs, University College Cork, Western Road, Cork E: gdpr@ucc.ie. You also have the right to lodge a complaint with the Data Protection Commission if you are unhappy with our processing of your personal data. Details of how to lodge a complaint can be found on the Data Protection Commission's website (www.dataprotection.ie), or by telephoning 1890 252 231.

Warm regards,

Aoife Lyons
Trainee Clinical Psychologist
University College Cork

Appendix E: Publication Guidelines for Nursing Open

Author Guidelines

1. SUBMISSION AND PEER REVIEW PROCESS

We are delighted you are choosing to submit to *Nursing Open*. While we cannot provide any assurance of acceptance, we can say that following all of the following guidelines very carefully and asking any questions you might have along the way to this email address: Nursingopen@wiley.com might go a long way towards facilitating a favourable outcome for your submission.

Please do not submit your paper to the Journal if it is not relevant to nurses, nursing, and the topics that nurses are involved with and care about.

New submissions should be made via the [Research Exchange submission portal](#).

You may check the status of your submission at any time by logging on to submission.wiley.com and clicking the “My Submissions” button. For technical help with the submission system, please review our FAQs or contact submissionhelp@wiley.com.

Statistical Guidelines

[Click here to read Statistical Guidelines](#).

Article Preparation Support

[Wiley Editing Services](#) offers expert help with English Language Editing, as well as translation, manuscript formatting, figure illustration, figure formatting, and graphical abstract design – so you can submit your manuscript with confidence.

Also, check out our resources for [Preparing Your Article](#) for general guidance about writing and preparing your manuscript.

Free Format Submission

Nursing Open now offers Free Format submission for a simplified and streamlined submission process.

Before you submit, you will need:

- Your manuscript: this should be an editable file including text, figures, and tables, or separate files—whichever you prefer. All required sections should be contained in your manuscript, including abstract, introduction, methods, results, and conclusions. Figures and tables should have legends. Figures should be uploaded in the highest resolution possible. If the figures are not of sufficiently high quality your manuscript may be delayed. References may be submitted in any style or format, as long as they are consistent throughout the manuscript. Supporting information should be submitted in separate files. If the manuscript, figures or tables are difficult for you to read, they will also be difficult for the editors and reviewers, and the editorial office will send it back to you for revision. Your manuscript may also be sent back to you for revision if the quality of English language is poor.
- An ORCID ID, freely available at <https://orcid.org>.
- Statements relating to our ethics and integrity policies, which may include any of the following (Why are these important? We need to uphold rigorous ethical standards for the research we consider for publication):
 - data availability statement
 - funding statement
 - conflict of interest disclosure
 - ethics approval statement
 - patient consent statement

- permission to reproduce material from other sources
- clinical trial registration

Please see the details below on what to include in your title page and main document. Your manuscript may be returned to you if you do not submit all the required information.

Important: the journal operates a double-blind peer review policy. Please anonymize your manuscript and supply a separate title page file.

To submit, login at <https://wiley.atyponrex.com/journal/NOP2> and create a new submission. Follow the submission steps as required and submit the manuscript.

Preprint Policy:

Find the Wiley preprint policy [here](#). This journal accepts articles previously published on preprint servers.

This Journal operates a double-blind peer review process. Authors are responsible for anonymizing their manuscript in order to remain anonymous to the reviewers throughout the peer review process (see *Main Text File*). Since the journal also encourages posting of preprints, however, note that if authors share their manuscript in preprint form this may compromise their anonymity during peer review.

Wiley's Preprints Policy statement for open access journals:

Nursing Open will consider for review articles previously available as preprints. You are requested to update any pre-publication versions with a link to the final published article. You may also post the final published version of the article immediately after publication.

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Data Citation

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You will be asked to select an article type when you enter your submission into ReX (our manuscript management system) and it is important that you have prepared your paper as we have detailed here. Contact the editorial office (Nursingopen@wiley.com) if you have any questions as you do this work.

ARTICLE TYPE: EMPIRICAL RESEARCH QUALITATIVE

BRIEF DESCRIPTION: Empirical research where the data is not in the form of numbers. Must use sound qualitative research approaches.

(See *Main Text Headers* for specific and detailed information about what to include)

WORD LIMIT: 8,000 maximum

FIGURES AND TABLES: Up to 10

REFERENCES: 25 or less. If you need to include more than 25 you may do so, and then you must address why in the *title page* where indicated.

- Do not exceed limits.

Must be no older than 5 years from date of submission.

- Use primary, not secondary, sources where possible.

- All references must be in English.

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For all article types except Brief Reports, Letter to the Editor, and Editorial the main text file to include the following information and/or headers:

1. Repeat the *brief informative title* (maximum 20 words) you included on the title page here.

2. The full names of the **authors** (last name in CAPITALS) including institutional affiliations where the work was conducted (maximum of three per author) and a footnote for the author's present address if different from where the work was conducted.

3. **Abstract:**

The abstract format for all article types is structured, except these article types do not include abstracts: Brief Report, Letter to the Editor, and Editorial.

Structured Abstract Format

- a. 300 words maximum.
- b. No abbreviations.
- c. Do not report p values, confidence intervals and other statistical parameters.

INCLUDE THE FOLLOWING HEADERS IN ABSTRACTS:

Aim(s) (of the paper, simply state 'To...')

Design

Keywords (You will be able to choose keywords when you begin the submission process, and you can select up to ten).

Review Methods

Data Sources (Include search dates)

Results (If statistical component is not minor e.g. more than basic descriptive statistics)

Conclusion

Implications for the profession and/or patient care

Impact (Addressing:)

- What problem did the study address?
- What were the main findings?

- Where and on whom will the research have an impact?

Reporting Method: State here that you have adhered to relevant EQUATOR guidelines and name the reporting method.

Patient or Public Contribution: Include a paragraph that details how patients, service users, caregivers or members of the public were involved in your study. This may be the design or conduct of the study, analysis or interpretation of the data, or in the preparation of the manuscript.

OR

Include a statement at the end of the abstract titled “No Patient or Public Contribution” if such details are not necessary or don’t apply to your work and state why. Your paper will be unsubmitted and returned to you if this section is not included.

Trial and Protocol Registration: Include the following here for papers that require **trial and protocol registration**:

- Include the name of the trial register, the clinical trial registration number, and a link to the trial at the registration website.
- If there is a protocol that does not require registration, it must still be made accessible at: Open Science Framework (<https://osf.io/>) ” or “Figshare (<https://figshare.com/>). Include the name of the website, the protocol number, and a link to the registration site.
- If the trial is not registered, or was registered retrospectively, explain the reasons why.

Implications for the Profession and/or Patient Care

MAIN TEXT HEADINGS

1. Introduction; 2. Background; 3. The Study; 3.1 Aim(s) and Objective; 3.2 technical terminology used to describe the aim (if any); 3.3 primary, secondary, or other objectives (if applicable); 4. Methods/Methodology; 4.1 Design; 4.2 Theoretical Framework; 4.3 Sampling and Recruitment; 4.4 sample size and power; 4.5 population and sample; 4.6 data abstraction; 4.7 Inclusion and/or Exclusion Criteria; 4.8 Data Sources/Collection; 4.9 Data Analysis; 4.10 Ethical Considerations; 4.11 Rigor; 5. Findings; 5.1 Participants; 6 Discussion; 6.1 Strength and Limitations of the Work; 6.2 Recommendations for Further Research; 7. Conclusion

Find your ARTICLE TYPE in the chart below and use all the Main Text File

Headers indicated in your submission:

ARTICLE TYPES: QUALITATIVE ARTICLE TYPE: EMPIRICAL

RESEARCH – QUALITATIVE

5. FILES TO SUBMIT SEPARATELY

A. IF APPLICABLE, AS SEPARATE DOCUMENTS:

- Trial report
- Protocol
- Trial registration documentation
- Any relevant checklist, including completed *CONSORT* checklist, *EQUATOR network* or *JBIR* checklists and registry.

It is not possible to anonymize the trial registration entry. Reviewers will be able to view who conducted the trial when making essential checks of the registration entry.

B. TABLES (each table complete with title and footnotes).

C. FIGURE LEGENDS: Supply as a complete list in the text. Upload figures as separate files (see below).

D. FIGURES AND SUPPORTING INFORMATION

Supply figures, *supporting information*, and appendices as separate files. Review the [basic figure requirements](#) for manuscripts for peer review, as well as the more detailed post-acceptance figure requirements.

Appendix F: Study 2 Information Sheet and Consent Form



Information Sheet

Study Title: Maternity staff experiences of Trauma Risk Management (TRiM): A mixed-methods exploration of psychological factors shaping perceived impact and engagement

Chief Investigator Details

Aoife Lyons, Trainee Clinical Psychologist, University College Cork

Investigator Details

Dr Samantha Dockray, School of Applied Psychology, University College Cork

Dr Kim Keating, Senior Clinical Psychologist & Practice Educator, University College Cork

Dr Coleen Cormack, Senior Clinical Psychologist Staff Support & Wellbeing, TRiM Coordinator, Ireland South Women & Infants Directorate.

Purpose of the Study

The researchers are interested in exploring the experiences and perceptions of TRiM Practitioners involved in delivering Trauma Risk Management (TRiM) within maternity settings.

What will the study involve?

If you are a trained TRiM Practitioners within the Ireland South Women and Infants Directorate you are invited to take part in an interview online via Microsoft Teams at a time that is convenient to you. It may be possible to complete this study during work hours with approval from your manager. You will be asked to give consent before taking part in the interview. The interviewer, Aoife Lyons, Trainee Clinical Psychologist, will ask you questions relating to your experience of facilitating TRiM within your workplace. The interviews will last approximately 45 minutes.

Why have you been asked to take part?

You have been asked because you are a TRiM Practitioner within the Ireland South Women and Infants Directorate who has experience delivering a TRiM Incident Briefing and/or TRiM Structured Conversation.

Do you have to take part?

No, you don't have to take part, it is completely voluntary. Choosing to not take part in the study will have no negative implications on your position at Ireland South Women and Infants Directorate or your ability to be part of the TRiM team in the future. You will have some time to think about doing the study, and ask questions about what it involves in detail. You can also omit questions you do not wish to respond to. You can withdraw at any time up to one week after completing the interview, with no consequences. The reason there is a one-week time limit is because after that point analysis may be in progress.

Will your participation in the study be kept confidential?

Yes, the researchers will ensure that no clues to your identity appear in the research data or results reported and your data will be pseudo-anonymised. This means we will never use people's names or any identifying information in the research data or results.

What will happen to the information which you give?

We will keep your consent forms for until the data is collected and pseudo-anonymised. After that is done, your consent form will be destroyed. The data will be kept confidential for the duration of the study, available only to me and my research team. We keep the data for ten years and then it is destroyed. It will be anonymised and securely stored in a shared folder on a secured drive that only the research team have access to. Pseudo-anonymised data may be shared with other researchers.

If you have any complaints in connection with our processing of your personal data, you can contact UCC's Data Protection Officer (DPO): DPO, Information Compliance Section, Office of Corporate & Legal Affairs, University College Cork, Western Road, Cork (Email: gdpr@ucc.ie).

You also have the right to lodge a complaint with the Data Protection Commission if you are unhappy with our processing of your personal data. Details of how to lodge a complaint can be found on the Data Protection Commission's website (www.dataprotection.ie), or by telephoning 1890 252 231.

What will happen to the results?

The results of this study that will be based on anonymised data will be shared with relevant partners, like the HSE, and reported in academic papers and at academic conferences.

What are the possible advantages of taking part?

By participating in this research, you will help us to understand more about TRiM in a maternity setting and your experience of facilitating TRiM with your peers.

What are the possible disadvantages of taking part?

In this study, we will ask you to briefly tell us about how potentially traumatic events are managed in your workplace and the challenges you experience as a TRiM Practitioner. Talking about a potentially traumatic event may cause distress for some people who experienced them and TRiM Practitioners who are exposed to this. We will check-in with you and provide debriefing information at the end of the study. If you have a concern about any aspect of this study or if you have been affected by any issues raised by this study and require additional support you can contact the following services for support:

Dr. Coleen Cormack (Senior Clinical Psychologist, Staff Support & Wellbeing):

Coleen.Cormack@hse.ie

HSE Employee Assistance Programme: 0818 327 327

Who has reviewed this study?

Approval must be given by the Clinical Psychology Research Ethics Committee of UCC before studies like this can take place. This study was approved by the Clinical

Psychology Research Ethics Committee in October 2024 and by the Local Implementation Governance Group (LIGG) in December 2024.

Any further queries? If you need any further information, you can contact:

Aoife Lyons, 122104917@umail.ucc.ie



Consent Form

Study Title: Maternity staff experiences of Trauma Risk Management (TRiM): A mixed-methods exploration of psychological factors shaping perceived impact and engagement

Chief Investigator / Interviewer Details

Aoife Lyons, Trainee Clinical Psychologist, University College Cork

Investigator Details

Dr Samantha Dockray, PhD, School of Applied Psychology, University College Cork

Dr. Kim Keating, Senior Clinical Psychologist & Practice Educator, University College Cork

Dr. Coleen Cormack, Senior Clinical Psychologist Staff Support & Wellbeing, TRiM Coordinator, Ireland South Women & Infants Directorate

Answer yes or no to each statement by ticking the relevant box. Yes No

I confirm I have read the information sheet and understand the purpose of the study and what my participation will involve.	☐	☐
I can confirm that I am a trained TRiM facilitator within the Ireland South Women and Infants Directorate who has experience delivering a TRiM Incident Briefing and/or TRiM Structured Conversation	☐	☐
I am aware that my participation is voluntary, that I can omit questions I do not wish to respond to and I can withdraw up to one-week after completing the survey without giving any reason and my occupation or legal rights being affected.	☐	☐

I understand that the interview will be recorded on Microsoft Teams.		
I give person for my quotations to be used within the write up or any publications.		
I understand that the information collected may be used to support other research in the future and may be shared anonymously with other researchers.		
I understand that my pseudo-anonymised data will be stored in on a shared folder only accessible by the research team.		
I am aware of who I can contact to receive support if participating in the study results in any distress.		
I am aware that the findings from this research will be shared with research partners, such as the HSE, and may be published in academic journals.		
I understand that my information will be stored securely in line with University College Cork research policy.		
I have had time to consider my participation and voluntarily agree to participate in this research.		

Should you wish to participate please complete the following section indicating your contact details, consent, sign, and date.

Participant Signature

Date

Participant email address: _____

Your email address will be used to invite you to a video call for interview.

Please return to Aoife Lyons 122104917@umail.ucc.ie

Thank you very much for your interest in this research study and we are very grateful for your time and consideration of our invitation

Appendix G: Study 2 Interview Guide

Introduction

1. Interviewer introduce self and role
2. Introduce study / purpose of interview
3. Reiterate pseudo-anonymization of data
4. Inform interview will take max. 1 hour – can pause or end at any time
5. Remind participant that they can omit questions you do not wish to respond to
6. Re-affirm participants consent to record and transcribe

Questions

- Can you tell me a bit about your role within the maternity unit and how long you have worked in this role?
- How did you first hear about TRiM, and what led to you getting involved?
- When did you train to become a TRiM facilitator?
- Can you describe your journey from training to becoming an active TRiM facilitator?
- How would you describe the training process for becoming a TRiM facilitator?
- How prepared did you feel to deliver TRiM sessions after the training? Were there any gaps in your preparation?
- Looking back, what aspects of the training were most useful, and what areas could be improved?
- What is it like facilitating a service to your peers?

- Have you noticed any differences in how staff engage with TRiM depending on their role or experience level?
- Can you share any rewarding moments or positive experiences you've had as a TRiM facilitator?
- What personal or professional challenges have you faced in your role? How have you managed them?
- Before TRiM was introduced, how were potentially traumatic incidents handled in your workplace?
- Since TRiM's implementation, what changes (if any) have you observed in how traumatic incidents are addressed?
- Have you noticed any shifts in workplace culture regarding mental health and peer support since TRiM was introduced?
- In your opinion, what factors encourage staff to engage with TRiM sessions?
- In your opinion, what factors discourage staff from engaging with TRiM sessions?
- Can you describe any barriers that have made it difficult to implement TRiM effectively?
- What strategies have you or your team used to overcome these barriers?
- Has being a TRiM practitioner had any impact on your own mental health and job satisfaction? Can you tell me more about this?
- Have you received adequate support in your role? What additional support would be beneficial?

- What recommendations would you make to improve TRiM within your unit?
- If you could change one thing about TRiM, what would it be?
- How do you see TRiM evolving in the future within maternity settings?
- Is there anything else you would like to share about your experience with TRiM that we haven't covered?
- Do you have any final thoughts on how TRiM could be developed in the future?

Appendix H: Study 2 Debrief Sheet



Dear participant,

I would like to thank you very much for taking part in this interview. Your contribution is valuable to the research team, and we hope will make a difference for people who engage with TRiM in the future.

If you have been affected by any issues raised by this study and require additional support, please do not hesitate to contact the following services for support:

- Dr. Coleen Cormack (Senior Clinical Psychologist, Staff Support & Wellbeing): Coleen.Cormack@hse.ie
- HSE Employee Assistance Programme: 0818 327 327

Feedback and complaints procedure

If you have any feedback or concerns about this research study, please feel free to contact me, the Primary Researcher (122104917@umail.ucc.ie), or one of my Academic Supervisors: Dr. Samantha Dockray (S.Dockray@ucc.ie) or Dr. Kim Keating (KKeating@ucc.ie)

If you have any complaints in connection with our processing of your personal data, you can contact UCC's Data Protection Officer (DPO): DPO, Information Compliance Section, Office of Corporate & Legal Affairs, University College Cork, Western Road, Cork E: gdpr@ucc.ie

You also have the right to lodge a complaint with the Data Protection Commission if you are unhappy with our processing of your personal data. Details of how to lodge a complaint can be found on the Data Protection Commission's website (www.dataprotection.ie), or by telephoning 1890 252 231.

Kind regards,
Aoife Lyons