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RESEARCH ARTICLE

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Exploratory pedagogical research of a bespoke eye movement desensitisation and reprocessing therapy training for midwives

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Abstract

Eye movement desensitisation and reprocessing (EMDR) therapy is a transdiagnostic, comprehensive, integrative, evidence-based treatment intervention for post-traumatic stress disorder (PTSD), complex PTSD, and perinatal PTSD. PTSD can arise from an experience of pregnancy or birth related trauma. Despite this, there is limited availability and access to EMDR therapy within the United Kingdom National Health Service. EMDR is a psychotherapeutic intervention which is usually delivered by highly specialist mental health professionals. However, with such a robust protocol, it is appropriate to consider if other health professionals should be trained to deliver EMDR. Humanitarian trauma capacity-building projects in a global context have shown that task shifting can assist with addressing unmet mental health therapy needs. Midwives are highly skilled graduates working in the perinatal period who understand that women's emotional health is as important as their physical health. Therefore, it was proposed that EMDR knowledge and skills could be efficiently task shifted to midwives. The aim and objectives were to train midwives to deliver modified EMDR scripted protocols and techniques and explore qualitative and quantitative outcomes of a bespoke EMDR for midwives (EMDR-m) educational programme. The online training was delivered to the midwives over 4 days with clinical practicums incorporated throughout. Pre and post-tests demonstrated an increase in their EMDR knowledge, skills and confidence. EMDR Group Supervision provided by three experienced EMDR Accredited Practitioners was mandatory for 6 weeks post-training and ongoing one-to-one supervision was made available. Midwives scored the course 9.6/10 (range 8–10) and described it as 'amazing' and 'invaluable'. Challenges for the future include ring-fenced time and an appropriate space to deliver the therapy. Those midwives who completed the training have progressed to deliver early

Significance: This paper has significance as it evaluates innovative bespoke training for midwives in psychological therapy techniques (EMDR-m) which were used to treat peripartum post-traumatic stress disorder, for women.

EMDR-m interventions in a perinatal mental health research study in their own Health and Social Care Trust (reported elsewhere).

KEYWORDS
EMDR, midwives, perinatal mental health, professional education

1 | BACKGROUND

Pregnancy and birth can be seen as a major life event for most women, the enormity of which has the potential to impact on women's mental health. The risk of experiencing mental ill health is increased if previous trauma has been experienced (O'Hara & Wisner, 2014). Following a review and meta-analysis of 59 studies by Dikmen-Yildiz et al. (2017) the prevalence of Post-Traumatic Stress Disorder (PTSD) in pregnancy was found to be 3.3% whilst birth-related trauma was 4%. This increased to a mean of 18.5% for women in high-risk group. A recent UK population-based cross-sectional study found PTSD specifically associated with childbirth had a mean prevalence of 2.5% (Harrison et al., 2021). Early psychological interventions have been found to ameliorate symptoms when delivered within 72 h following a traumatic birth, highlighting the benefit of immediate treatment, and have been found to be more effective in reducing symptoms at four to 6 weeks postpartum than treatment as usual (Taylor Miller et al., 2021).

The World Health Organisation (World Health Organization, 2013) and National Institute for Health and Care Excellence (National Institute for Health and Care Excellence, 2018) recommend Eye Movement Desensitisation and Reprocessing (EMDR) therapy for PTSD in the perinatal period (International Society of Traumatic Stress Studies ISTSS Online, 2018a; 2018b; 2018c). Preliminary findings from a recent randomised controlled trial (RCT) investigating the effectiveness of EMDR as an early intervention for reducing birth trauma symptomatology reported an improvement after only one session (Chiorino et al., 2020). EMDR was also found to be more effective at 6 weeks postpartum than treatment as usual with women experiencing less flashbacks and reduced distress (Chiorino et al., 2020).

EMDR Therapy was first developed by Francine Shapiro as a treatment for PTSD (Shapiro, 1989). The theoretical framework supporting EMDR is the Adaptive Information Processing (AIP) model (Laliotis & Shapiro, 2022; Solomon & Shapiro, 2008). AIP suggests that when an individual experiences an event that is overwhelming, the memory can become frozen within their neural network and stored with the associated feelings and sensations remaining intact. These dysfunctional memories are therefore stuck and unable to connect with other neural networks that hold adaptive information. These dysfunctional linked memory networks can result in mal-adaptive responses such as those phenomena associated with PTSD. Moreover, the AIP model postulates that negative behaviours and symptoms are a result of dysfunctional linked memory networks rather than the cause of current dysfunction: this is a trauma-focused approach to understanding mental ill health. EMDR is a transdiagnostic trauma-focused psychotherapy and can be utilised for a myriad of mental health conditions such as grief, anxiety, obsessive compulsive disorders and depression (Javinsky et al., 2022; Udo et al., 2022).

EMDR follows a three-pronged, eight phase protocol, with specific procedural steps that address past disturbance, present dysfunction and anticipated future outcomes. Those receiving EMDR therapy are led through eight phases: history taking, preparation, assessment, desensitisation, installation, body scan, closure and re-evaluation. It uses dual attention stimuli/alternating bilateral stimulation (DAS/ABS) such as saccadic eye movements, auditory tones or tapping to facilitate memory processing and integration (Balkin et al., 2022; Hase, 2021; Portigliatti Pomeri et al., 2021; Udo et al., 2022). Whilst the mechanism of action for EMDR is still under investigation, there is broad support that the dual attention required for EMDR during alternating bilateral stimulation taxes working memory which has limited capacity (de Jongh et al., 2013). This results in the facilitation of integration into memory networks and a reduction in intensity of affect (van den Hout et al., 2011). A further neuro-biological mechanism of action proposed by Miller et al. (2018) suggests that there is an innate biological mechanism found within the human nervous system, known as stochastic resonance. They elucidate that the DAS/ABS generates a stochastic signal to create 'noise' similar to the normally present neural activity that is present in the form of cortico-thalamic activity which is supressed during trauma. This noise subsequently facilitates a return to normal neurobiological functioning resulting in memory integration and a reduction in levels of disturbance.

As EMDR is a psychotherapeutic intervention it has traditionally been delivered by psychologists, psychiatrists, psychotherapists, and registered counsellors. However, with such a robust protocol it is pertinent to consider if other allied health practitioners should be trained to deliver EMDR (Carriere, 2014; Pupat et al., 2022). A systematic review and meta-analysis exploring the efficacy of psychosocial interventions in the perinatal period, delivered by providers who were not mental health specialists, pooled outcomes from 10 trials (n = 18,738) and found that psychological interventions were effective at reducing symptoms (Clarke et al., 2013). Particularly salient is the consideration of enabling midwives to provide early psychological interventions to women in the perinatal period.

Research exploring midwives' experiences of women's emotional and mental well-being in pregnancy found that midwives understood that women's emotional health was as important as their physical health (Fletcher et al., 2021). Significantly, participants described how the 2021 Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the United Kingdom (MBRRACE-UK)

report highlighted the risk of suicide and the importance of emotional wellbeing (Fletcher et al., 2021). An equally significant aspect to consider is the impact of midwifery continuity of care (MCOC). A MCOC model enables women to build relationships with their midwives during their pregnancy and birthing journey. It provides women with a primary midwife throughout their antenatal, intrapartum and postnatal care. MCOC is supported by research that found women have a higher satisfaction with their experience of maternity care, are more likely to have a normal birth and already know the midwife caring for them during labour (Sandall et al., 2016). Given these advantages, and the likelihood that a therapeutic alliance may already exist, it seemed reasonable to explore training midwives who are experts in the perinatal period, to deliver EMDR for women who have experienced the negative effects of perinatal trauma.

2 | RATIONALE FOR TRAINING MIDWIVES IN EMDR-BASED INTERVENTIONS

Midwives are graduates, highly skilled working in the perinatal period, and may be described as 'non-mental health professionals'. Some of the research team (DPF and PWM) have experience of humanitarian trauma capacity building projects in a global context (Blenkinsop et al., 2018; Farrell, Keenan, Knibbs, Hicks, 2013; Farrell et al., 2020). These projects, dealt with the challenge of a lack of specialist clinicians to respond to unmet needs and provide evidence this can be done through task-shifting. The WHO defines task-shifting as a rational redistribution of required tasks within the available healthcare workforce. It involves efficient shifting of specific tasks from highly specialist professionals to professionals who usually have shorter training and fewer qualifications (WHO, 2013). In the global mental health context, task shifting, and task sharing are viewed as approaches with the potential to address unmet mental health needs in areas that traditionally lack such resources and specialist professionals (Hoeft et al., 2018; van Schalkwyk et al., 2020). Dr Margaret Chan, Director-General of the WHO states:

> "*The task shifting approach represents a return to the core principles of health services that are accessible, equitable and of good quality. These recommendations and guidelines on task shifting provide a framework that is informed by all we now know about the ways in which access to health services can be extended to all people in a way that is effective and sustainable*." (World Health Organization, 2013, p 3).

EMDR early intervention scripted protocols and EMDR derived techniques constitute a clearly defined curriculum of knowledge and skills (Shapiro & Maxfield, 2019). This presents a specific task that could be efficiently shifted from highly specialist mental health professionals to midwives who are experts in the perinatal period. However, it is essential to conduct research to assess the feasibility of task-shifting in this specific context, hence the need for this study.

3 | RESEARCH AIM

To train midwives to deliver modified EMDR scripted protocols and techniques that have been adapted specifically for delivery by midwives, known as EMDR therapy for midwives (EMDR-m).

4 | OBJECTIVES

1. To assess midwives' prior knowledge and understanding of EMDR as an intervention for perinatal trauma before receiving the specialised and bespoke EMDR-m training.
2. To provide midwives with the necessary EMDR-m training (knowledge and skills) in EMDR early intervention (EEI) for women experiencing perinatal trauma.
3. To test midwives' knowledge and understanding of EMDR-m and their ability to apply it in the care of pregnant and postnatal women who have experienced perinatal trauma following training.

5 | METHODOLOGY

This study explored qualitative and quantitative outcomes of a bespoke EMDR-m educational programme. The programme was designed to train midwives, with no formal trauma focused mental health expertise, in EMDR knowledge and skills enabling them to provide EMDR-m therapy to women in their care. The EMDR-m training course was supported by their employing health and social care (HSC) Trusts and involved the successful completion of a number of mandatory elements.

The course was taught online over 4 days and included EMDR theory and instructor supported practicums. This was followed by self-directed practice; completion of case studies; attendance at group supervision and online learning assessment.

Due to COVID-19 pandemic restrictions, training took place online using Zoom over 4 days in January/February 2021. Four trainers who were fully qualified EMDR therapists and EMDR Europe Accredited Consultant trainers, and three facilitators trained to level two in EMDR therapy, led the EMDR-m training. Bespoke online EMDR-m training was offered to 12 midwives from two HSC Trusts in Northern Ireland who had a keen interest in perinatal mental health. Their knowledge and skills before and after the EMDR-m training were assessed using the EMDR Personal Development Plan II (PDP II) (Farrell et al., 2020). The PDP II is based on the Dreyfus model (2004) which also forms the framework for EMDR Europe Competency Frameworks for both Practitioners and Consultants whereby the student goes through the following stages of learning: novice, competence, proficiency, expertise, and mastery as they acquire new skills and knowledge. The EMDR PDP II asks trainees '*to critically reflect upon your current knowledge, understanding and application of EMDR so as to then determine the areas you consider you may wish to develop further as an EMDR Clinician*.' (Farrell, Keenan, Knibbs, Jones, 2013, p16). The PDP II enables EMDR Therapy learners to assess their

own knowledge and competency on a numerical scale 0 = None; 1 = Limited; 2 = Basic; 3 = Proficient; 4 = Advanced; 5 = Expert.

6 | TAUGHT SESSION ON EMDR THEORY

The EMDR-m training was based on the trauma model and the delivery of the therapy was based on the Group Traumatic Episode Protocol (G-TEP) intervention, developed in 2014, by Elan Shapiro and Brurit Laub who first created it as a one-to-one version called the Recent Traumatic Episode Protocol (R-TEP) (Shapiro & Laub, 2008). G-TEP has been deployed internationally within humanitarian projects and found to be effective in reducing post-traumatic stress (Yurtsever et al., 2018).

R-TEP and G-TEP are consistent with the AIP model developed by Roger Solomon and Francine Shapiro (2008). The core curriculum focused on psychotraumatology in the perinatal period. Research using this protocol is also being carried out by academics and EMDR clinicians in collaboration with Worcester University, which is based on G-TEP (Shapiro & Laub, 2008).

The taught sessions also included explanation of the G-TEP EMDR therapy protocol as a blind-to-therapist methodology. The blind-to-therapist protocol incorporates all eight phases of Francine Shapiro's original EMDR protocol but enables clients to complete a session without disclosing the traumatic material they are working on. This protocol can be particularly useful for clients who have shame attached to their experience, such as those who have experienced child abuse or rape. It is also helpful for those with cultural and language barriers or for individuals who may fear reprisal, such as professions who make life and death decisions (Blore & Holmshaw, 2009; Farrell et al., 2023) and may be used as videoconference psychotherapy (Farrell et al., 2023). Similarly, G-TEP provides clients an opportunity to work through their traumatic material without disclosing it to the group.

Although the therapy protocol was provided in a training manual, midwives felt it was difficult to follow and an annotated flow diagram was developed and provided as an alternative guide (Figure 1).

During and following the training, the EMDR-m Trainers were available to provide additional one-to-one support for the midwife trainees.

7 | INSTRUCTOR SUPPORTED PRACTICUM

Using Zoom breakout rooms, dyads of midwives took turns to practice the EMDR-m skills with each other while a third midwife observed and acted as the support person. One facilitator joined these practicums as an observer but did not participate and turned off their audio and video unless called upon to assist. The trainers visited each breakout room during the practicums to assist and answer any questions as required. In the event of any issues with which the facilitator required further assistance, the lead trainer was available to join the breakout room.

8 | SELF-DIRECTED PRACTICE AND EMDR-M CASE STUDIES

Following the 4-day training midwives practiced the EMDR-m skills with each other and friends and family, face-to-face or via Zoom to gain confidence and develop their skills. Each midwife completed and submitted three case studies. These were based on reflections on their practice and learning and also feedback from their client/s if they felt able to provide it.

9 | GROUP SUPERVISION

Supervision is an important aspect of EMDR practice development and for those aiming for EMDR Europe Accreditation as a Practitioner (Farrell, Keenan, Knibbs, Jones, 2013). Following training, midwives were supervised by experienced EMDR-m trainers for a period of 6 weeks via Zoom. Their newly acquired EMDR-m knowledge and skills were discussed and assessed during the supervision. They practiced their new skills with each other and explored potential clinical applications. In addition, the midwives were observed by their supervisor undertaking an EMDR-m one-to-one practicum with a colleague.

10 | ONLINE LEARNING ASSESSMENT

Midwives' knowledge of EMDR and perinatal mental health was tested in an online assessment. Participating midwives logged on to a Zoom call and completed an open book exam lasting 1 h 15 min. The exam included 47 multiple choice and four short answer questions on EMDR theory and practice, and knowledge of perinatal mental health in Northern Ireland and the UK.

11 | FEEDBACK ON THE EMDR-M COURSE

Participating midwives provided quantitative and qualitative feedback using an online anonymous questionnaire following the 4-day training course and this was analysed using Braun and Clarke's (2021) Reflexive Thematic Analysis method. This approach was considered to be the most suitable as it provided an opportunity to explore the midwives' experiences of the training, therefore, enabling the evaluation of the EMDR-m course and providing actionable outcomes for enhancement. Following the supervision period supervisors also provided feedback relating to the midwives' progress using EMDR-m.

12 | RESEARCHER REFLEXIVITY

During the analysis process the researchers (JM and PG) approached the data acknowledging their positions, values, and previous experiences. The disciplinary assumptions that come with previously working as a midwife,

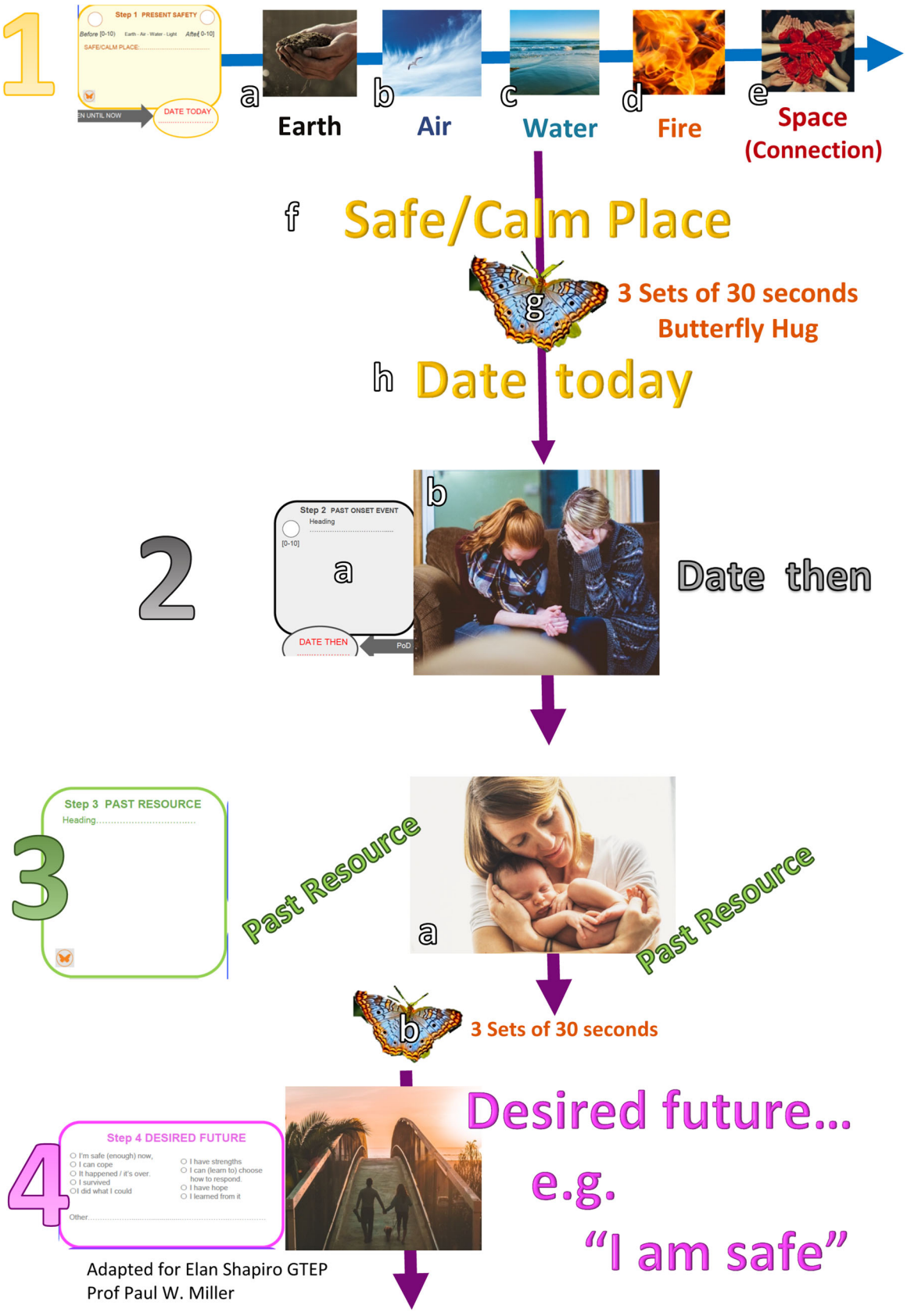

FIGURE 1 GTEP process flow diagram (EMDR-m).

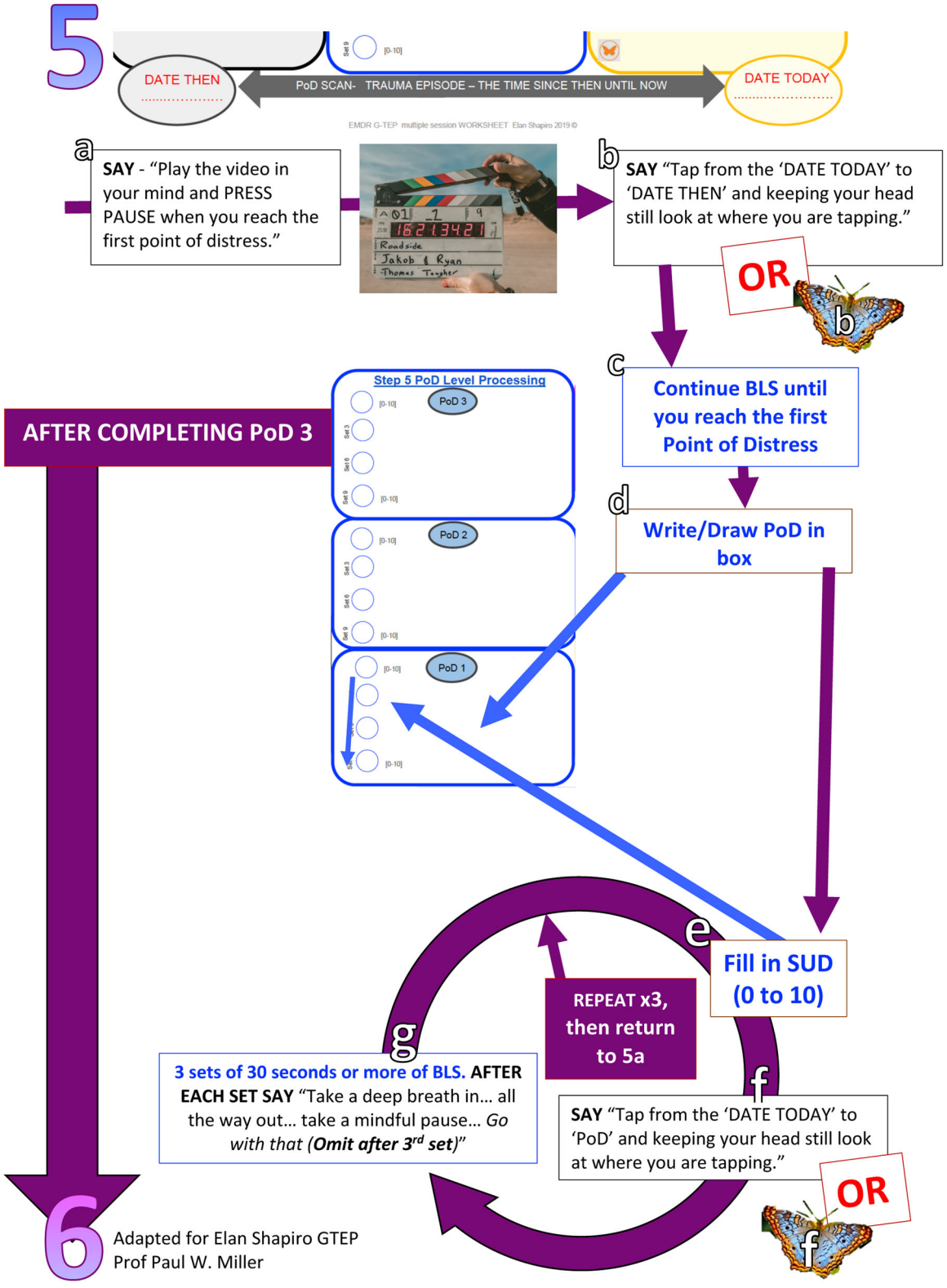

FIGURE 1 (Continued)

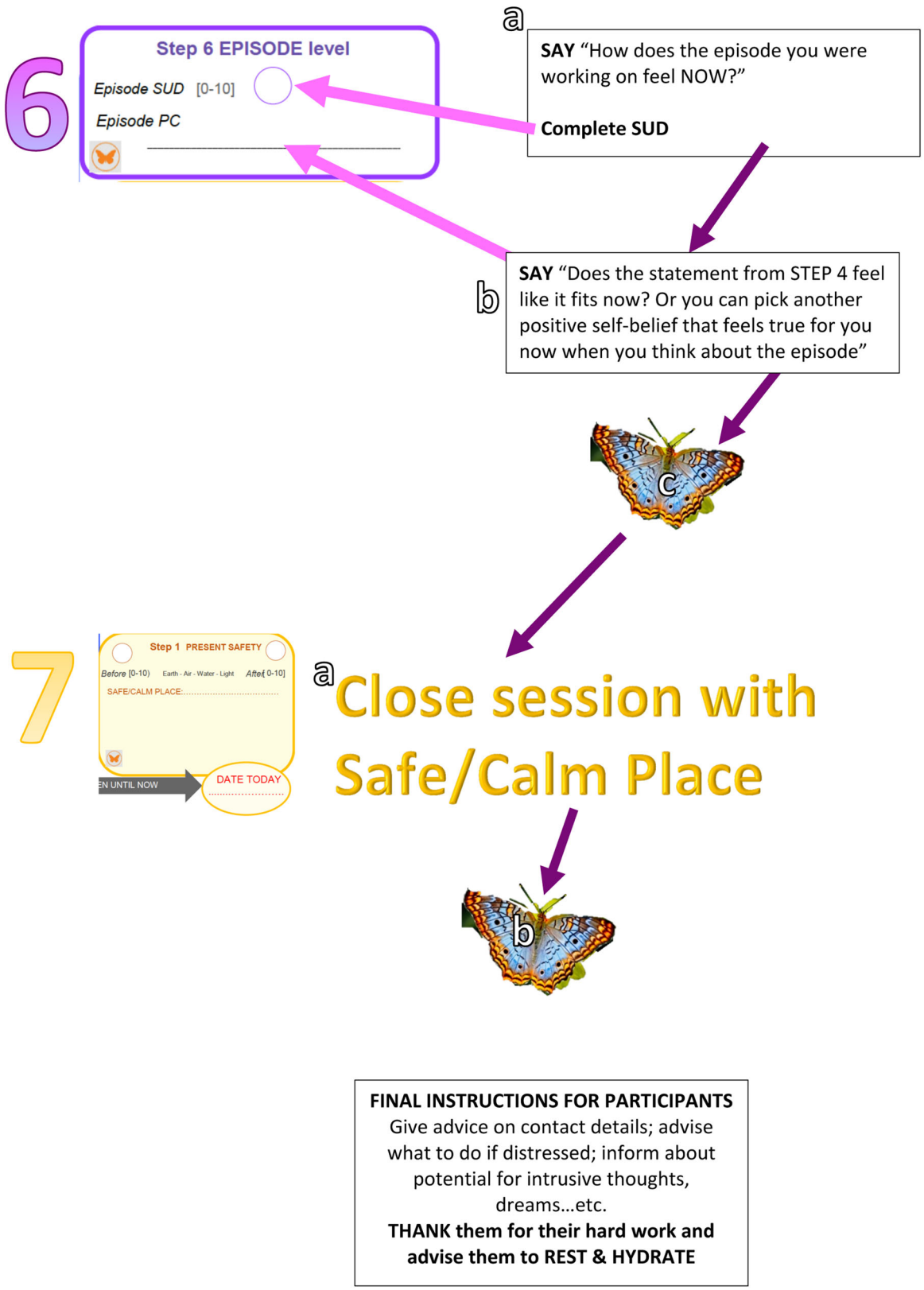

FIGURE 1 (Continued)

previous training in EMDR and their conceptual lens as researchers meant that theme development and interpretation will have been situated within these and informed by them.

13 | ETHICS

Ethical approval was granted by Ulster University Nursing and Health Research Ethics Filter Committee on 28/01/2021 (FCNUR-20-018-A) and Confirmation and Capability at Southern Trust was granted on 16/12/2020 (HSC Trust Reference: ST2021/32).

14 | RESULTS

Twelve midwives were enrolled on the EMDR-m training course with six midwives completing all parts of the training. Analysis of the midwives' feedback of the course using Braun and Clarke's (2021) Reflexive Thematic Analysis identified 10 key themes (Table 1).

15 | COURSE INFORMATION

15.1 | Preparation for training

All midwives received precourse information. Overall, the feedback indicated that the content and pre-course information was *"informative"* (ID 101) and *"accessible"* (ID 112) with "*The manual…very comprehensive and will be very useful moving forward*" (ID 106). However, one midwife indicated that the pre-course information was *"a little overwhelming"* (ID 107).

15.2 | Anticipation of acquisition of new skills

The midwives indicated that they were looking forward to developing a new skill that would help them provide an additional service for women:

> "*optimistic to obtain and develop a skill which can enhance care for woman within perinatal period*" (ID 105).

16 | EMDR-M ONLINE TEACHING AND PRACTICUMS

16.1 | Organisation of the training

Midwives rated the training as 9.6/10 on a 1–10 numerical rating scale of overall satisfaction. One midwife highlighted *"The online training was very well organised with ample guidance and provision of resources"* (ID 106).

Participating midwives were available to attend each of the online training days except for one who did not attend day three. However, as all sessions were recorded, they were instructed to watch the recording for day three before attending day four. Three midwives (25%) had minor difficulties with online connection that were quickly rectified.

16.2 | Experience of online EMDR-m training and assessment

Midwives described their experience in mostly positive language which included *"inspiring"* (ID 101 and 113) and *"amazing"* (ID 102 and 111). There was recognition that it was:

> *"Invaluable training, delivered to an excellent standard by a dedicated and knowledgeable team*" (ID 106).

The challenge of undertaking EMDR-m and the novel aspect of the training was recognised, with one midwife indicating it was *"ground-breaking and initially a bit scary*" (ID 109). Following the training midwives reported they had learned new skills and increased in confidence. This included their understanding of EMDR techniques and their belief that they worked and could be applied in practice. The small group practicums were particularly welcomed.

> *"The technique…works, good experience from the practicums, great to link with other midwives who have an interest in perinatal mental health and caring for the mothers"* (ID 104).

TABLE 1 Thematic analysis of feedback from midwives.

Training area	Themes
Course Information	• Preparation for training • Anticipation of acquisition of new skills
EMDR-m online teaching and practicums	• Organisation of the training • Experience of online EMDR-m training and assessment • Relevance to midwifery practice • Feeling respected as skilled midwives
Using EMDR-m in midwifery practice	• Confidence in delivering EMDR • Potential clients • Working with other midwives to provide care • Challenges to providing EMDR

Midwives reported the benefit of the Zoom breakout rooms to learn together and complete the practicums in small supportive groups and the importance of feeding back after every breakout session. Learning from others during the practicums and their questions was important, although stressful:

> *"The practicums were nerve-wrecking but very useful"* (ID 106).

16.3 | Relevance to midwifery practice

The importance of the EMDR-m training to midwifery practice and service provision for women was acknowledged:

> *"Enjoyable and relevant to clinical practice"* (ID 112).

> "*EMDR-m has been transforming, inspiring and has been delivered in an effective and efficient manner which will allow easy implementation with further practice, supervision and support"* (ID 113).

One midwife commented:

> *"What started as a scary experience with zero knowledge has been a positive enjoyable learning experience which will hopefully result in new skills for the benefit of the women in my care"* (ID 109).

16.4 | Feeling respected as skilled midwives

Midwives deeply appreciated that:

> *"…the knowledge and skills we already have as a midwife were respected, that we can use EMDR-m as an additional skill set"* (ID 113).

While the practice of task-shifting was not discussed with participating midwives they believed that their skill set served them well in providing perinatal mental health therapy, stating that *"…the transferrable skills of midwives can be useful to this process."* (ID 109).

17 | USING EMDR-M IN MIDWIFERY PRACTICE

Following completion of the 4-day course the midwives were asked to rate two questions on a 10-point Likert *scale 'how confident do you feel about delivering EMDR-m to women in your care in the future?'* which scored an average of 7.1/10 (range 5–10) and *'how likely are you to utilise EMDR-m techniques with the women in your care?'* which scored an average of 9.5/10 (range 8–10).

17.1 | Confidence in delivering EMDR

The midwives were aware of the growth in their EMDR-m skills and knowledge and understanding of trauma and memory on an individual's mental health and wellbeing with confidence gained in using the taught EMDR techniques.

> *"I had no knowledge of EMDR-m before the course. On completion I feel that after the supervision period that I would be able to confidently use the techniques that I have been taught in my area of clinical practice"* (ID 106).

17.2 | Potential clients

Midwives expressed how they thought they might use their EMDR-m training with women and their partners antenatally, intranatally, postnatally, in the community or in hospital and following birth trauma, a previous traumatic birth and/or bereavement.

> *"I currently work in community and almost daily meet women who have anxiety issues and trauma around their birth. reality v expectations and this could be a useful tool to help them work through the trauma in a timely manner as referrals to services at present are long"* (ID 109).

Midwives also recognised that not only would it be useful for women but also for fathers, and staff in the preconception, antenatal and postnatal period in the hospital, clinic or community (ID 101, 102, 106, 107, 110,112 and 113). The EMDR-m midwives recognised the value of their midwifery skills and combined skill set to enhance the lives of women and babies:

> *"We all have the ability to improve clients experience at critical points in their lives. Thus, impacting on individuals, families and communities for generations of the future"* (ID 112).

17.3 | Working with other midwives to provide care

Midwives looked forward to working with others to provide timely and appropriate support to women:

> *"I have a caseload of women and hopefully will be able to embed this in daily practice. Also, hopefully with colleagues we can operate on a referral and clinic-based system too"* (ID 105).

> And "*connecting with like-minded professionals who want to make a difference"* (ID 102).

17.4 | Challenges to providing EMDR

Midwives were asked what they considered to be challenges to the implementation of EMDR-m in the future. The challenges included time, space in which to provide EMDR-m, and support from midwifery managers, other midwives, and perinatal colleagues. In addition, consideration was needed as to how EMDR-m could be incorporated into current workloads including protected time.

18 | ADDITIONAL FINDINGS

18.1 | EMDR-m online assessment

Eight midwives (75.8%) attended the online open book assessment. The reasons given for non-attendance focused mainly on difficulties securing time off work. The average score achieved was 81% (range = 59.8%–93.5%).

18.2 | EMDR-m case studies

Midwives completed case studies based on their practicums during their 6 weeks supervision and these were reviewed by two members of the research team. They demonstrated confidence in undertaking EMDR-m techniques, and feedback from clients provided a clear description of perceived benefit from the therapy.

18.3 | EMDR-m supervision feedback

Three experienced EMDR practitioners provided group supervision for midwives involved in the training course. The supervisors were asked to provide their feedback on the EMDR-m group supervision sessions and reported that midwives were *"committed"* and *"motivated"* (Supervisor ID 111). The sessions were interactive and enjoyable with open and honest discussions demonstrating the midwives' high level of understanding about EMDR-m. The midwives *"sought to provide the highest standards of care and attention and therapeutic practice for women in their care"* (Supervisor ID 112) and were keen to continue developing their skills and knowledge.

Supervisor's comments demonstrate evidence of observed impact:

> *"…great skill and competency in conducting the G-TEP exercise with peers during an observed practice on completion of the six sessions of supervision."* (Supervisor ID 112).

> *"The applicability of EMDR-m, and the fact that each midwife was able to understand the protocol and to conceptualise its utility for their patients, was commendable, and indicative of their potential to use this innovative approach in a clinical setting."* (Supervisor ID 113).

Midwives demonstrated a good level of understanding of the EMDR-m techniques and interventions and the AIP trauma-focused model and used it appropriately to understand the impact of a traumatic event in the perinatal period. A high level of attunement was observed during therapy work in practicums and the general opinion of the research team was that trained midwives are evidentially capable of effective deployment of EMDR-m techniques as non-mental health professionals.

18.4 | EMDR personal development plan II

Six midwives completed both PDP II (Farrell et al., 2020) time points: namely before commencing training and again within 7 months following training (Table 2). The maximum score for any section of the PDP II is five which denotes an 'expert' level of competency.

19 | DISCUSSION

Women trust and seek support from their midwife, and midwives recognise the need for some women to have urgent and rapid access to perinatal mental health services (Madden et al., 2018). They understand the transgenerational impact of trauma and poor mental

TABLE 2 Midwives EMDR-m training personal development plan II scores.

Personal development plan II section	Mean pretraining score ($n = 6$)	Mean post-training score ($n = 6$)
Section 1: The adaptive information processing theoretical framework, neurobiology of trauma and psycho-traumatology	0.6	2.6
Section 2: EMDR therapy eight-phase protocol	0.3	2.7
Section 3: Further skills in EMDR therapy and wider applications	0.2	1.8
Section 4: EMDR therapy clinical supervision and consultation skills	2.3	3.0

health on women, their infants, families and communities (Hernández-Martínez et al., 2019; Knight et al., 2014) and advocate for the development of perinatal mental health services (Royal College of Midwives, 2020). Traditionally, as non-mental health professionals, midwives have not received training to provide trauma focused care (Fletcher et al., 2021; Higgins et al., 2018; Madden et al., 2018). A recent systematic review (Long et al., 2022) highlighted that most midwives have little or no trauma informed education and feel training in practical and theoretical knowledge must be prioritised. This exploratory and descriptive mixed methods study aimed to train midwives in EMDR scripted protocols and techniques specifically adapted for delivery by midwives, and to evaluate the training. We have called this novel bespoke training EMDR therapy for midwives (EMDR-m).

Midwives demonstrated their ability to undertake EMDR training and were enthusiastic, active participants. The pedagogy around EMDR-m training and learning demonstrated meaningful acquisition of skills using the PDP II (Farrell, Keenan, Knibbs, Jones, 2013). Section 1 demonstrated the midwives EMDR therapy skills rose from none to basic. In Section 4 of the PDP II, midwives' self-assessment of their 'EMDR Therapy Clinical Supervision & Consultation Skills', developed from basic to proficient. This is to be expected as midwives are experts in supportive, empathetic, non-judgemental enquiry with women and work closely with student midwives providing mentorship and feedback as part of their role. These skills are solid foundations for providing psychological therapy in a responsive and intuitive way.

The bespoke online training was accessible, and daily Zoom recordings facilitated memory retention and a deeper understanding of the theory. The open book exam challenged midwives to respond to closed and open-ended questions which focused on their understanding of perinatal health and key aspects of the EMDR techniques. Supervised practice provided interactive support from experienced EMDR trainers within a psychologically safe space with options for more in-depth, one-to-one support. Using technology to train midwives in EMDR techniques was feasible, acceptable, and enjoyable. Using Zoom allowed them to gain the necessary skills in a safe way during lockdown and also saved the time and expense of travelling, additionally reducing the carbon footprint. Online delivery of EMDR is particularly well suited to the blind-to-therapist methodology. Ensuring women did not have to verbally disclose the traumatic experience they were working on, neither to an online group therapy session, nor risk being overheard by others nearby enhanced their safety and privacy.

The midwives also gained valuable skills in the use of Zoom videoconferencing technology including using the private chat function and breakout rooms. Technical skills are essential when delivering EMDR virtually and have been cited as a barrier to providing online EMDR (Papanikolopoulos et al., 2022). Through the case studies and supervision, the midwives developed their skills and became confident and competent in delivering EMDR online and face-to-face. Online EMDR provision meets the aims of the Northern Ireland Mental Health Strategy (Department of Health, 2021) of *'Increased access to digital mental health solutions'* and *'Support the traditional delivery of mental health services with new digital methods'*. The provision of online EMDR in the perinatal period is a powerful enabler for women who may face challenges in accessing services outside the home due to their physical and mental health, childcare needs, and time constraints. Women who experience digital exclusion or digital poverty must not be at a disadvantage. Therefore, enabling midwives to practice EMDR therapy face-to-face as part of their case studies was an essential part of the EMDR-m training.

It is incumbent on maternity care providers to design and make available evidence based accessible training and services that meet the perinatal mental health needs of women. The NI Mental Health Strategy (DoH, 2021) proposes the need to '*continue the rollout of specialist perinatal mental health services*' and '*promote mental health through early intervention and prevention*'. In addition, the Strategy notes that the future of the HSC workforce must include training for therapists. As explained by the EMDR-m trainees, midwives possess transferable perinatal mental health knowledge and expertise making them ideal EMDR therapy practitioners. The Nursing and Midwifery Council (NMC) Code states that all midwives should ensure that they are competent to practice safely and effectively (Nursing and Midwifery Council, 2018). Having high level interpersonal skills, they quickly build trusting, empathetic relationships with women in the perinatal period. While birth can be a highly empowering experience for many women, it can also lead them to feel profoundly emotionally, physically and psychologically vulnerable with midwives well placed to provide responsive EMDR therapy to women in their care. Perinatal professional knowledge gives midwives a unique insight into the experiences of women as they have likely been present before, during and after the traumatic perinatal or birth experiences.

Given the exceptional circumstances during which the EMDR-m course took place, namely the COVID-19 pandemic, and the extensive and intensive training elements which were often challenging for the midwives, the feedback from them was highly positive. They deeply valued the profound benefits that EMDR had for women during their case studies and how their new skills would significantly enhance their practice. Furthermore, the feedback from the supervisors demonstrated midwives rapid understanding and exceptional skill which is particularly important given they had no previous trauma informed training. The midwives quickly adapted to using Zoom to provide expert digital health care to vulnerable women and they continue to develop their skills and grow in confidence.

20 | LIMITATIONS

Even in the midst of the COVID-19 lockdown, the additional maternity service pressures, and daily concerns for their personal health and wellbeing, midwives were keen to complete this training

and understood the necessity for it. The training was completed by six of the 12 midwives who commenced the training. However, this was not due to attrition but instead pressures within the health service that were not compatible with the training schedule.

21 | CONCLUSIONS

The midwives who completed the EMDR-m training have progressed to deliver EMDR early interventions and EMDR derived techniques in a perinatal mental health PhD study in their own HSC Trust (reported elsewhere).

EMDR-m has proved to be a definable skill and knowledge based mental health training, suitable for task-shifting from highly skilled mental health professionals to highly skilled perinatal professionals. The assessment of knowledge and skills acquisition demonstrates that the midwife learners experienced EMDR-m as a training that acknowledged and respected their perinatal expertise and skills as non-mental health professionals, and efficiently increased their potential to address unmet mental health needs in the perinatal period. A supervision framework and the continuing support of mental health experts equips the perinatal workforce with ways to increase access to mental health services and provide digital health care solutions in a manner that is both effective and sustainable.

AUTHOR CONTRIBUTIONS

Contribution: Initial of author. *Conceptualization*: Marlene Sinclair, Patricia Gillen, Julie Elizabeth May McCullough, Paul William Miller, Paula Taylor Miller Ideas; formulation or evolution of overarching research goals and aims. *Methodology*: Marlene Sinclair, Julie Elizabeth May McCullough, Patricia Gillen, Paul William Miller development or design of methodology; creation of models. *Software*: Julie Elizabeth May McCullough programming, software development; designing computer programs; implementation of the computer code and supporting algorithms; testing of existing code components. *Validation*: Julie Elizabeth May McCullough, Marlene Sinclair, Patricia Gillen, Rachel Jane Black, Paula Taylor Miller verification, whether as a part of the activity or separate, of the overall replication/reproducibility of results/experiments and other research outputs. *Formal analysis*: Julie Elizabeth May McCullough, Patricia Gillen, Marlene Sinclair application of statistical, mathematical, computational, or other formal techniques to analyze or synthesize study data. *Investigation*: Paul William Miller, Marlene Sinclair, Julie Elizabeth May McCullough, Patricia Gillen Conducting a research and investigation process, specifically performing the experiments, or data/evidence collection. *Resources*: Paul William Miller, Patricia Gillen, Julie Elizabeth May McCullough provision of study materials, reagents, materials, patients, laboratory samples, animals, instrumentation, computing resources, or other analysis tools. *Data curation*: Julie Elizabeth May McCullough, Patricia Gillen management activities to annotate (produce metadata), scrub data and maintain research data (including software code, where it is necessary for interpreting the data itself) for initial use and later reuse. *Writing–original draft*: Julie Elizabeth May McCullough, Patricia Gillen, Marlene Sinclair, Paul William Miller, Rachel Jane Black Preparation, creation and/or presentation of the published work, specifically writing the initial draft (including substantive translation). *Writing–review and editing*: Julie Elizabeth May McCullough, Patricia Gillen, Marlene Sinclair, Paul William Miller, Rachel Jane Black, Paula Taylor Miller, Derek Patrick Farrell preparation, creation and/or presentation of the published work by those from the original research group, specifically critical review, commentary or revision–including pre or postpublication stages. *Visualization*: Julie Elizabeth May McCullough, Patricia Gillen Preparation, creation and/or presentation of the published work, specifically visualization/data presentation. *Supervision*: Marlene Sinclair, Paul William Miller, Julie Elizabeth May McCullough, Patricia Gillen, Derek Patrick Farrell oversight and leadership responsibility for the research activity planning and execution, including mentorship external to the core team. *Project administration*, *Management and coordination responsibility for the research activity planning and execution*: Julie Elizabeth May McCullough, Patricia Gillen, and Marlene Sinclair. *Funding acquisition*, *Acquisition of the financial support for the project leading to this publication*: Patricia Gillen and Julie Elizabeth May McCullough.

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CONFLICT OF INTEREST STATEMENT

Professor Paul W. Miller: EMDR Trainer accredited by EMDR Europe and operates a specialist trauma clinic. All other authors do not have any Conflicts or Competing Interests to declare.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

ETHICS STATEMENT

Ethical approval was granted by Ulster University Nursing and Health Research Ethics Filter Committee on 28/01/2021 (FCNUR-20-018-A) and Confirmation and Capability at Southern Trust was granted on 16/12/2020 (HSC Trust Reference: ST2021/32).

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