

***“Recognise psychological trauma as much as physical”*: Understanding birth-related trauma knowledge, experience, and educational needs in maternity staff**

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Abstract

Background: Birth-related trauma is a common occurrence in maternity settings, negatively impacting women and healthcare providers. However, little clinician education exists to prevent or mitigate negative outcomes.

Objectives: To investigate healthcare providers' knowledge and experience of BRT and education needs, to inform the development of a BRT education module.

Design: A cross-sectional, mixed-methods design was adopted.

Methods: Descriptive statistics and thematic analysis were used to analyse closed and open-ended questions in the online survey completed by 138 healthcare staff working in a maternity unit.

Results: Most staff (88.4%) had witnessed BRT at least once in their professional role, though less than a third (26.8%) reported having engaged in any form of professional training. In-person and online modules were the preferred method of training, and participants requested a range of training topics, including the provision of trauma-informed care, working with women declining care, general BRT knowledge, shared-decision making, screening, consent, and clinician well-being.

Conclusion: Findings underscore the need for accessible BRT education to be embedded within professional development frameworks, and to position trauma-informed as a core competency. The findings also highlight the importance of providing support for staff experiencing vicarious trauma, recognising its prevalence and impact on clinician wellbeing and quality of care.

Introduction

The transition to parenthood is a profoundly personal and emotionally complex time. For some, however, this period is overshadowed by experiences of birth-associated trauma, which can have significant and lifelong impacts.¹ Leinweber et al.² provide a widely accepted definition of birth trauma, describing it as a woman's experiences of childbirth-related interactions and events that cause significant emotional distress, negatively impacting short and long-term health and well-being. Past research suggests that birth trauma may be experienced by close to half of all birthing individuals. A large longitudinal study found that 45.5% of women reported some form of traumatic birth event, and 3.1% of these developed Post-Traumatic Stress Disorder (PTSD) at 24 weeks postpartum.³

Psychological birth trauma refers to the distressing emotional or mental health impacts that may arise during pregnancy, labour, or the postnatal period. It is often shaped not by clinical outcomes, but by how care was experienced; whether the woman felt safe, respected, informed, or supported.⁴ Trauma may result from feelings of powerlessness, inadequate communication, coercion, lack of informed consent, or a perceived loss of dignity and autonomy during care.⁵ Notably, the quality or satisfaction associated with health provider interactions has been identified as a major risk factor for birth trauma.^{6,7} The

effects of such trauma can be profound and may include impaired mother-infant bonding and fear of future pregnancies.⁸ These impacts are not limited to the birthing person; partners and non-birthing parents may also experience vicarious or direct trauma in the perinatal period.⁹

As awareness of birth trauma grows, so too does the responsibility to ensure that maternity care providers are adequately equipped to respond. Midwives occupy a central role in perinatal care and are often the first, and sometimes only, point of support for women during pregnancy, birth, and the postnatal period.¹⁰ However, there is compelling evidence that midwives do not receive sufficient preparation to address trauma or perinatal mental health challenges.¹¹⁻¹⁴ In their survey of Australian midwives, Noonan et al.¹⁴ found that although over 70% of participant midwives felt confident identifying women experiencing depression or anxiety, fewer than half felt confident in providing care, and only 17.8% felt equipped to support women effectively. Similarly, Delicate et al.¹⁵ found that only half of health providers reported routinely assessing women for psychological trauma, and many were unaware of its prevalence or key indicators. Given the prevalence of birth trauma and the resulting impacts on perinatal mental health, this indicates an urgent need to improve the education and training of maternal health care providers.

Trauma-informed care is a holistic framework that seeks to recognise and respond to the impacts of trauma within health systems. It is based on principles of safety, trust, collaboration, empowerment, and cultural responsiveness.¹⁶ In maternity care, TIC means acknowledging the possibility of past or present trauma and actively working to reduce the risk of re-traumatisation through respectful, choice-driven care.¹⁷ Several studies have demonstrated that education significantly improves practitioners' confidence and capacity to respond appropriately to trauma. Reed et al.¹¹ reported that trauma education and upskilling not only enhanced midwives' clinical confidence but also improved communication with women and support for colleagues. Importantly, many midwives have expressed a *desire* for further education.¹² Long et al.¹⁸ found that midwives described trauma-informed care (TIC) training as essential to midwifery practice, yet noted that most had not received it as part of their professional preparation.

Despite its relevance, however, TIC is not consistently taught or implemented across maternity systems, and many midwives report lacking the necessary knowledge or confidence to apply it in practice.¹⁹ A recent systematic review by Benton, Wittkowski²⁰ synthesised findings from eleven studies and recommended eight key strategies for trauma-informed maternity care. These included screening for trauma, clear communication, culturally safe and individualised care, collaborative approaches with families, and, importantly, ongoing education and supervision for care providers.

Healthcare providers, particularly midwives, can experience secondary or vicarious trauma after witnessing traumatic childbirth-related events.²¹ A sense of responsibility to their patient can also lead to feelings of guilt, self-blame, and diminished self-confidence after observing patient distress and harm.²² This form of trauma arises from repeated exposure to distress and may manifest as emotional

exhaustion, heightened anxiety, or avoidance.^{22, 23} In maternity settings, where clinicians are present at more frequent traumatic birth events, the cumulative impact of these exposures can be substantial. This exposure can also contribute to burnout and compassion fatigue.²⁴ Pre-registration education, reflection, and debriefing are some of the strategies that have been proposed to help prevent vicarious trauma, build resilience, and improve coping.²² TIC has the potential to address these challenges through reflective practice, supportive team environments, and by promoting greater awareness of both patient and provider experience and well-being through open communication.²⁰ TIC, therefore, can not only improve the quality of care delivered to patients, but may also help to mitigate the vicarious trauma and associated burnout experienced by many healthcare staff.²⁵

The international call for improved trauma education in maternity services is growing.^{12,18, 26} Yet access to consistent, high-quality training remains variable.²⁷ Challenges such as time constraints, staffing shortages, limited funding, and geographic isolation continue to restrict access to continued professional development for health care providers, particularly in rural or remote areas.²⁸ To overcome these barriers, several innovative training initiatives have emerged, many integrating use of online and blended learning platforms.^{13,29, 30, 31}

One example of an existing training program, The Australian e-PMHEP (Perinatal Mental Health Education Program), was shown to improve midwives' knowledge, confidence, and skills in supporting women with mental health needs, particularly in rural settings.²⁹ However, this program consists of six 1-hour modules, which may be prohibitive for midwives who lack the time, flexibility, or institutional support to engage in such a time-intensive training resource.

By exploring healthcare providers' self-identified strengths, knowledge gaps, and perceived barriers to trauma-informed care, this study aimed to inform the development of an education resource that is both relevant and accessible. Supporting midwives in this way not only benefits individual clinicians but has the potential to transform the experiences and outcomes of women and families across the perinatal journey.

Methods

Study design

This study employed a mixed-methods design using a cross-sectional survey conducted in November of 2024. The study adhered to the STROBE guidelines for reporting of observational studies.³²

Participants and setting

Participants were multidisciplinary staff members currently working at a large, Australian, metropolitan maternity hospital with both public and private hospital beds, recruited via purposive sampling and word-of-mouth. It was not a requirement for staff to have personal experiences with birth trauma.

Ethics

The project was approved by the Mater Research HREC (Project ID: QACR/MML/121316).

Data collection and study tool

A bespoke survey, including multiple-choice and open-ended questions, was developed in consultation with the Birth Trauma Working Party (BTWP): a multidisciplinary team established in 2023, comprising 27 stakeholders across maternity, mental health and allied health services. It contained 12 items that were divided into three blocks of three, five, and four questions, respectively. Block one comprised of questions relating to participants’ professional roles and experience. Block two investigated personal and professional experiences of birth-related trauma and previous professional training, and block three assessed birth-trauma training needs and preferences, as well as concerns around screening for birth-related trauma.

Data analysis

Quantitative data were analysed descriptively in frequencies and percentages using Excel. Where missing data was identified, data were reported as a fraction of the total responses submitted for that item. Qualitative analysis was conducted on the free-text survey responses to identify themes and patterns that provided context to the quantitative data, using an analytic approach informed by Braun and Clarke.³³ A second rater reviewed and confirmed codes and themes. Discussion between the two reviewers was used to resolve any conflicts in thematic coding. The study was an evaluation of participant experiences and opinions rather than a hypothesis-driven analysis. Therefore, the sample size was determined pragmatically based on the number of eligible participants available during the study period. A total of 138 participants were included in the analysis, which was considered adequate to provide a broad range of perspectives and enable meaningful descriptive and exploratory analyses.

Results

Overall, 146 participants submitted responses to the survey, however, only 138 were included in the final analysis due to excessive missing data. Demographic information is summarised in Table 1. Most of the participants were either midwives or nurses, with almost half reporting over 10 years’ experience in their chosen profession.

INSERT TABLE 1 HERE

Most or all midwifery and medical professionals had witnessed birth trauma at least once in their professional careers (see Table 2). Close to half (44%) of midwifery staff reported having witnessed birth-related trauma more than 10 times in their careers. In comparison, 35% of medical staff reported the same. Around one third of midwifery and nursing staff also reported personal experiences of birth

trauma. Notably, only midwifery staff disagreed or strongly disagreed that birth-related trauma was an important issue to address.

INSERT TABLE 2 HERE

Most participants (73.2%) reported not having engaged in any formal professional development on birth-related trauma. Many of the participants were open to any training method for professional development, with the remainder reporting a varied mix of in-person and/or online modules. The most common education topics that interested participants were providing trauma-informed clinical care and working with women who decline recommended care (see Table 1). Five participants provided one or more of their own topic preferences, including debriefing patients and their families (n = 3), evidence-based techniques for supporting patients with prior trauma (n = 1), coping strategies for staff burnout (n = 1), and informed consent (n = 1).

Qualitative Findings

This clinical training needs analysis was based on internal survey data collected from maternity workers across a range of professional backgrounds and settings. The purpose of the analysis was to identify current gaps in knowledge, perceived barriers in practice, and staff priorities in relation to birth-related trauma. Four major themes were identified: (1) Trauma-informed clinical practice; (2) Professional knowledge and support; (3) Systems and structures; and (4) Person-centred care. Subthemes are outlined in Table 4, and further explored below, with illustrative quotations selected to reflect frequently shared perspectives and training needs.

INSERT TABLE 3 HERE

Theme 1: Trauma-informed Clinical Practice

This theme reflects the importance of embedding trauma-informed principles into all aspects of maternity care, including communication, consent, and staff wellbeing.

Subtheme 1.1: Communication and Consent

Participants frequently raised concerns about the need for respectful, clear communication and consent, particularly during time-critical situations. Respondents consistently called for clinical training that reinforces respectful communication and consent as foundational to safe maternity care.

"How to ensure informed consent in an emergency situation." [Midwife 001, Birthing Services]

Comments by several participants suggested they had witnessed or heard about interactions where consent was bypassed:

"Staff who are performing procedures on non-consenting women (e.g. vaginal exams)... saying 'I'm just going to examine now', or when a woman says to stop and the response is 'I'm almost done'." [Midwife 018,

Subtheme 1.2: Recognition of Psychological Trauma

Participants urged better recognition of psychological trauma, particularly following preterm births or neonatal admissions.

"Just to recognise psychological trauma as much as physical. The neonatology department regularly attends traumatic births... We could be a significant help to prepare families for trauma." [Medical 050, Inpatient Wards]

Clinicians also requested guidance on intervening in situations involving potentially traumatising practices:

"How to respectfully stop other clinicians from causing trauma to your patients, i.e., performing procedures without consent..." [Midwife 097, Midwifery Group Practice]

The emotional toll of witnessing or participating in traumatic births was a shared concern. Several respondents identified the need for training in self-regulation and mental health maintenance:

"Would love to learn de-stress and decompressing strategies so I don't take stress/trauma home." [Midwife 062, Birthing Services]

Theme 2: Professional Knowledge and Support

This theme encompasses the knowledge gaps and professional development needs identified by clinicians when managing birth trauma in practice.

Subtheme 2.1: Education for All Disciplines

Many respondents expressed a desire for targeted birth trauma education across the entire perinatal workforce, including nurses, neonatologists, and obstetricians.

"As an RN [Registered Nurse] with no midwifery experience, I feel it would be great for RNs who work in the nursery to gain knowledge about general birth-related issues..." [Nurse 033, Nursery]

There was a strong preference for content grounded in high-quality evidence:

"I would love evidence-based training please. I do not want to see things that have no credible scientific research backing it." [Midwife 041, Antenatal Clinic]

Clinicians also noted that current training often excludes partners and families from trauma education. Participants commonly reported a desire for education relating to support persons' experiences of trauma, *"support for the support people"*, and debriefing and providing post-trauma care for patients and their families:

"How to talk to families about the trauma of being a NCCU parent which is currently under-acknowledged."
[Nurse 026, Nursery]

Subtheme 2.2: Supporting Clinician Wellbeing

The emotional impact of birth trauma was not limited to patients. Staff described experiences of vicarious trauma, compassion fatigue, and the absence of formal institutional support:

"We are often left to figure out how to get past the trauma on our own with no acknowledgment of the fact..." [Midwife 132, Birthing Services]

There was interest in incorporating reflective practice and structured debriefing into training modules:

"Hot and cold debrief – an overview of when to request these... it was extremely helpful for the whole team."
[Midwife 138, Maternal Foetal Medicine]

Theme 3: Systems and Structures

This theme captures barriers at the organisational and structural level that impede timely trauma identification and referral.

Subtheme 3.1: Referral and Screening Barriers

Several participants described confusion around referral pathways for birth trauma, citing time constraints and unclear responsibilities:

"Time restraints. Not knowing where or how to refer." [Midwife 001, Birthing Services]

Others highlighted challenges unique to private care settings:

"If the woman had birth trauma via a private OB [obstetrician] and wants to be referred to social work... What if the woman doesn't want her OB to know? We need a process for this." [Midwife 042, Private Postnatal Ward]

Concerns were also raised about overreliance on screening tools that may exclude affected individuals:

"Our psychologist won't accept women who have trauma but don't score high enough on the EPDS [Edinburgh Post-Natal Depression Scale]... we identify a problem and then have no means to treat." [Midwife 046, Midwifery Group Practice]

Subtheme 3.2: Service Gaps and Fragmentation

Participants described gaps in trauma services and disrupted continuity of care due to staffing models or resource limitations:

"No continuity in debriefing for women, families and staff due to shift rotations." [Midwife 018, Birthing Services]

Several clinicians stressed that trauma often presents well after the immediate postpartum period, at which point care options are limited:

"Birth trauma does not emerge within 72 hours of birth... By then, these women have nowhere to go." [Midwife 041, Antenatal Clinic]

Theme 4: Person-centred Care

This theme reflects calls to centre maternity care around the experiences, preferences, and emotional needs of birthing people and their families.

One participant stressed the importance of validating patient narratives and incorporating lived experience into care planning:

"Listening to women who have experienced it." [Midwife 137, Maternal Foetal Medicine]

Comments suggested that existing antenatal education may be inadequate or poorly tailored to diverse populations:

"How can we provide better antenatal education about the potential complications/risks with birth without terrifying our patients?" [Nurse 055, Nursery]

"Antenatal education – not accessible for low socioeconomic, triggering environment... Need option that will be trauma-informed and comprehensive." [Midwife 074, Birthing Services]

Recommendations were made to create accessible, trauma-informed resources for both patients and staff:

"Places to direct people so we can easily provide numbers and websites etc." [Midwife 070, Antenatal Clinic]

Additionally, the unique experiences of neonatal parents were identified as an area requiring tailored support:

"Trauma-informed care for the NCCU parent." [Nurse 028, Nursery]

Discussion

This study provides important insights into the incidence of birth-related trauma (BRT) within a large tertiary maternity setting and the perspectives of clinicians regarding training needs. The findings affirm the well-documented prevalence estimates of psychological trauma in maternity care^{7, 34} but extend current evidence by demonstrating that the majority of surveyed midwives, nurses, and medical

practitioners had witnessed traumatic births in their professional roles. Notably, over 65% of midwives reported exposure to BRT on more than ten occasions, a figure substantially higher than that reported by nurses within our study. Furthermore, 94.5% of midwives reported exposure to at least one instance of birth trauma, a similar figure to that reported by Toohill, Fenwick.³⁵ This gradient likely reflects the centrality of midwives to intrapartum care and aligns with prior research demonstrating midwives' heightened exposure to both clinical emergencies and interpersonal conflict in maternity services.³⁶⁻⁴⁰

The survey findings highlight several practice gaps. First, while the majority of staff recognised the importance of addressing BRT, fewer than one-third had engaged in any structured professional development on the topic. This is consistent with prior studies reporting insufficient preparation of maternity professionals to manage trauma and perinatal mental health concerns.^{13, 41} The reported lack of confidence is concerning given strong evidence that provider communication and interpersonal behaviours, rather than clinical complications, are the most common drivers of traumatic birth experiences.^{4, 5}

Our qualitative analysis further underscored clinicians' concerns around informed consent, communication, and psychological safety. Numerous participants reported a desire for information and education for dealing with consent violations or dismissive practices, echoing international literature identifying coercion, lack of agency, and disrespect as key contributors to trauma.^{4, 42} Importantly, clinicians also highlighted their own exposure to secondary or vicarious trauma and how this impacts their clinical practice. Participant responses highlight a lack of clinical support, alongside a desire for education and additional services related to this issue. This reflects prior evidence that maternity professionals experience compassion fatigue and burnout in response to repeated exposure to distressing events^{22, 24, 39, 43}, reinforcing the need for staff support and reflective practice.

Barriers at the systems level were a recurring theme, with respondents citing unclear referral pathways, inadequate service integration, and an over-reliance on depression screening tools such as the Edinburgh Postnatal Depression Scale (EPDS). These findings align with critiques that existing perinatal screening tools insufficiently capture trauma-related symptomatology, leading to under-identification of affected women.⁴⁴

Staff training needs identified in this study, particularly trauma-informed communication, shared decision-making, respectful care, and debriefing skills, are consistent with recommendations from recent systematic reviews.^{19, 20} Trauma-informed care (TIC), with its emphasis on safety, trust, collaboration, empowerment, and cultural responsiveness^{16, 17}, was seen as a critical gap. Importantly, respondents requested evidence-based, multidisciplinary training delivered in flexible formats, reflecting well-documented barriers to professional development including workload and time constraints.^{28, 30} Taken together, these findings suggest that addressing BRT within maternity services requires a multipronged approach: embedding trauma-informed principles into all clinical encounters, providing accessible and evidence-based education across disciplines, and strengthening systemic structures to ensure timely

referral and continuity of care. Supporting clinician wellbeing is equally critical; evidence suggests that greater clinician wellbeing is linked with reduced rates of burnout and improved quality of care and patient outcomes.^{45, 46}

Strengths and Limitations

This study represents one of the first systematic examinations of clinicians' training needs regarding BRT within an Australian tertiary hospital, capturing multidisciplinary perspectives. The mixed-methods design enabled a nuanced understanding of both prevalence and perceived gaps. However, limitations include potential self-selection bias, with participants who had stronger interests in BRT more likely to respond, and the single-site nature of the study, which may limit generalisability. This study did not distinguish between psychological and physiological forms of birth trauma, which may have contributed to an overestimation of prevalence. The study was also conducted at a single location, which may limit generalisability of findings. Furthermore, due to administrative complexities, birthing women's perspectives were unable to be captured, limiting understanding of how provider and consumer perspectives compare.

Conclusion

Our findings highlight an urgent need for structured, accessible BRT education embedded within professional development frameworks for all perinatal staff. Given the reported prevalence of witnessing birth trauma, trauma-informed maternity care should be recognised as a core competency, not an optional addition. Policymakers and hospital leaders must also ensure adequate referral pathways, continuity of care, and institutional supports for staff exposed to trauma. Future research should explore the effectiveness of different training modalities, particularly brief or modular approaches that address time and resource constraints.

Declarations

Ethical considerations: The project was approved by the Mater Research HREC (Project ID: QACR/MML/121316).

Consent to participate: Participation in the project was voluntary, and completion of the survey was considered implied consent.

Consent for publication: Not applicable

Declaration of competing interests: The authors have no competing interests to declare.

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Author contributions

Maddie Power: Conceptualisation, Methodology, Data Curation, Writing – Review &

Editing; Tess Willis: Conceptualisation, Methodology, Data Curation, Writing – Review & Editing; Charlotte Scott: Formal Analysis, Writing – Original Draft; Kerri Gillespie: Formal

Analysis, Writing – Review & Editing; Grace Branjerdporn: Conceptualisation,

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Tables

Table 1 to 3 are available in the Supplementary Files section.

Supplementary Files

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