RESEARCH ARTICLES

Australian community nurses' encounters with early relational trauma: a qualitative study of lived experiences and the impact of specialist training

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ABSTRACT

Objective: We report on a qualitative study of community nurse encounters with early relational trauma in parent-infant dyads.

Background: Early relational trauma involves interactional or emotional disturbance in the parent-infant dyad. Earliest possible detection is needed to mitigate negative impacts on socio-emotional development, but early relational trauma is often challenging for practitioners to detect and respond to.

Study design and methods: Maternal and Child Health nurses in Victoria, Australia received workforce training to address this. We interviewed 20 nurses both before and after they received specialist training, to understand their lived experiences in encountering client trauma and perceived changes to their professional confidence and competence post-training. The study comprised two areas of enquiry: i) a phenomenological analysis of nurses' lived experiences in encountering possible trauma; and ii) a grounded theoretical analysis of the context of trauma encounters at baseline, and perceived change in competence at follow-up.

Results: Nurses who coped well when working with trauma maintained a level of emotional distance and were able to draw on a repertoire of well-established practice skills. The specialist workforce training resulted in clear gains in nurses' confidence and capacity to identify and respond to early relational trauma.

Implications: Findings highlight a need for frontline services to provide specialist training and supervision in relational trauma and to cultivate cultures of communication and support. Such programs would optimally be deployed widely, to equip professionals with enhanced knowledge and confidence to create timely change in the face of early relational trauma.

RESEARCH ARTICLES

What is already known about this topic?

- Effective recognition of early relational trauma is critical to enable relational repair.
- Frontline health services are well placed to achieve timely identification of early relational trauma, but it can be challenging for practitioners to detect and respond to the signs of early trauma.
- Working with relational trauma and feeling uncertain about trauma-related decision-making are distressing, but little is known about the *lived experiences* of professionals required to detect and respond to parent-infant trauma when lacking specialist knowledge.

What this paper adds

- We interviewed nurses i) before and ii) after they received specialist training in early relational trauma, to understand their lived experiences in encountering possible trauma and their perceived changes to professional confidence and competence post-training.
- We found that nurses who coped well when working with trauma maintained a level of emotional distance and drew on a repertoire of well-established practice skills.
- The specialist workforce training described here resulted in clear gains in nurses' confidence and skills for identifying and responding to early relational trauma, and we interpret findings with reference to recommendations for broader workforce training and supervision.

Keywords: maternal and child health; nursing; trauma-informed practice; relational trauma; workforce training, phenomenology

BACKGROUND

The Maternal and Child Health (MCH) nursing workforce in Australia provides universal healthcare to families and children from birth to preschool age. The primary service focus has been to ensure optimal child physical health and development, but increasingly MCH nurses are required to detect and respond to risk in the family environment. Key risks are those emerging from early relational trauma within parent-child attachment relationships. Being part of a universal platform, MCH nurses are uniquely positioned for frontline detection of such seminal risks to children's development.

Early relational trauma refers to interactional or emotional disturbance in the parent-child dyad and is associated with stressed or distressed parental caregiving. These early distortions of emotional care can cause infant anxiety, uncertainty or fear in primary attachment relationships,[1] which may disrupt or distort developmental processes in the neonatal and early childhood periods. In turn, this can affect social and emotional development across the life-course.[2-4] Relational trauma is in contrast to single-incident trauma which may occur through isolated, unpredictable experiences such as severe accidents.[5] Aetiological factors are diverse and include parental mental illness and substance misuse; unresolved intergenerational grief, abuse or loss; and stressors such as family violence, interpersonal conflict or homelessness.[6,7] Effective recognition of relational trauma symptoms in parents and/or infants is critical to enable early support for repair.

MCH nurses in Australia are highly qualified, having completed nursing, midwifery, and child, family and community health degrees. Nevertheless, workforce reviews identified a demand for trauma-informed training yet identified none that were adequate for the perinatal and preschool population. As such, authors JM, LN, EC and AB, together with a broad team delivered a specialist workforce training program in response to a state government request in 2018. The 20-hour program, titled 'MERTIL' (My Early Relational Trauma Informed Learning) was designed by early trauma specialists (authors JM and LN) and delivered with input from the broader team via multimedia online learning and clinical workshops. The program provided the Victorian state MCH workforce (1,650 nurses) with practical and theoretical skills to extend knowledge and enhance confidence in identifying and responding to signs of relational trauma. All nurses and managers were eligible to participate in an in-person clinical workshop and to engage in an accompanying suite of self-paced online resources including learning modules, fact sheets, video vignettes, podcasts, and links. MERTIL translates attachment and caregiving theory and evidence for application in frontline early childhood settings. The course content emphasises recognition of traumatised states in the parent-infant dyad and the delivery of early support through frontline engagement, strengths-based conversations and well targeted practical resources.

A separate MERTIL program evaluation of process and learning data from baseline ($N = 1450$), exit ($n = 734$) and follow-up surveys ($n = 651$) completed by MCH practitioners indicated excellent uptake, satisfaction and impact.[8] Further detail on the MERTIL program and its quantitative evaluation can be found in that paper.[8] To build on the findings of the quantitative evaluation, we designed the current study to further explore the *lived experiences* of MCH nurses in their work with early relational trauma. We noted a lack of evidence on what it is *like* for nurses required to detect and respond to relational trauma, where professional knowledge is often limited and uncertainty about how to proceed is common.

Early relational trauma has not always been well understood by frontline professionals and can be particularly challenging to detect and respond to effectively.[9] Many frontline practitioners lack specialist developmental knowledge and observational skills essential to trauma recognition in infants. Resulting 'healthcare uncertainty' may be destabilising and discomforting.[11] Judgment and decision-making are key healthcare processes that are inherently attended by uncertainty,[10,11] especially when knowledge about a topic is limited. Critically, healthcare uncertainty can undermine outcomes for both practitioners and clients.[12] Research shows that nurses and other professionals working with trauma use various conscious and unconscious strategies to manage healthcare uncertainty.[11,13] These range from desensitisation and avoidance,[11] to defensive processes that focus on alternate explanations for developmental problems, such as neurobiological deficits, when confronted with trauma.[13]

Nursing research has typically focused on nurses' experiences of responding to acute or physical trauma rather than relational trauma, and on emergency inpatient settings rather than community settings.[14,15] For example, a phenomenological account of nurses' emotional distress experiences in caring for survivors of intimate partner violence was situated within the emergency inpatient setting.[16] Qualitative research on traumatic experiences of British midwives illuminates the nature of practitioner vulnerabilities in responding to distressing events,[17] highlighting a tension between manualised care and intuitive approaches. Recent mixed-methods research involving home visitors in a US Maternal, Infant and Early Childhood Home Visiting program has illuminated the experiences of and contexts for secondary traumatic stress when working with trauma.[18] Recent qualitative research on Norwegian practitioners' experiences of addressing early life trauma and abuse has shed light on practitioner secondary suffering, challenges associated with dysfunctional work structures, and feelings of doubt about ability and skills among psychologists and child protection workers.[13]

While these studies have addressed nurses' and other healthcare professionals' key challenges and experiences of work with vulnerable families, published research on this remains limited overall, and there is a critical gap where the phenomenon of *uncertainty* in detection of and response to signs of relational trauma is concerned. While studies have explored uncertainty in healthcare decision-making,[10,11,19] to date we know very little about healthcare professionals' experiences of uncertainty when required to detect and respond to early relational trauma on the front line. Because of the tendency for defensive process and the high risk for secondary traumatic stress in this area of work, we need to better understand practitioner experiences, challenges and coping mechanisms. This knowledge will benefit both practitioners and clients.

The Australian MCH workforce is responsible for attending to both the physical and emotional health needs of infants and young children in the context of often great uncertainty, in the absence of specialist training, about what early relational trauma looks like and how to effectively respond when it is detected. MCH nurses have broad remits that include statutory reporting requirements. It is therefore in the interests of this service and other, similar services to better understand frontline professionals' lived experiences of detecting and responding to possible signs of early relational trauma. Understanding what it is *like* for professionals working in this arena is critical to designing appropriate and useful professional education and support initiatives that will see good uptake and engagement.

RESEARCH AIMS

Aims were:

Enquiry (i): Phenomenological Analysis

(1) At baseline, articulate a General Phenomenological Structure of nurses' lived experiences of feeling uncertain in detection of and response to possible early relational trauma in the parent-infant dyad.

Enquiry (ii): Grounded Theoretical Analysis

(2) At baseline:

- Describe core features of scenarios where nurses identified or suspected signs of early relational trauma, including features of these scenarios that made trauma detection or response difficult.
- Identify knowledge or resourcing that may have helped nurses in these scenarios.

(3) At follow-up:

- Describe how the MERTIL specialist training impacted nurses' confidence and knowledge in recognising and responding to signs of early relational trauma.

METHODS

RESEARCH DESIGN

We used qualitative methodologies to analyse findings from the two areas of enquiry outlined above: i) a study of nurses' lived experiences of feeling uncertain in detection of and response to early relational trauma; and ii) a study of the core features of scenarios where relational trauma was identified or suspected, and of the impact of the specialist training provided. The theoretical framework comprised two complementary approaches: descriptive phenomenology to address enquiry (i) and grounded theory with descriptive synthesis to address enquiry (ii).

CONTEXT OF THE CURRENT STUDY AND TRAINING PROGRAM

This study occurred alongside a separate, quantitative evaluation of the state-wide MERTIL workforce training for MCH nurses in Victoria, Australia.[8] MERTIL trained MCH nurses working across three publicly funded service programs: the 'Universal' and 'Enhanced' services, and the telephone service. The state-wide Universal service provides primary surveillance and support for infants and young children. In this service, regular 30-60-minute appointments from birth to 3.5 years of age monitor the physical and mental health of both infants and parents. The Enhanced service supports families experiencing problems such as family violence, drug and alcohol misuse, mental illness, disability, homelessness, social isolation, youth pregnancy, and with these, parent-baby bonding and attachment problems. Regular clinical supervision and debriefing are provided for staff delivering this service. The telephone service provides 24-hour, 7-day information about maternal and child health, nutrition, breastfeeding and parenting.

ETHICAL CONSIDERATIONS

Ethical approval was granted by the Victorian Department of Education and Training (2018_003741) and Deakin University's Human Research Ethics Committee (HEAG92-2019). Participation was voluntary and nurses provided written, informed consent prior to participation. Nurses were under no obligation to participate; their managers circulated study information which prompted interested nurses to make direct contact with the researchers about their potential involvement. No reimbursement was offered.

PARTICIPANTS, RECRUITMENT AND DATA COLLECTION

Twenty-two MCH nurses were recruited via their managers, who were asked by the researchers to circulate study information to nursing staff. Two participants were lost to follow-up after participating in the baseline interviews, with no reasons for attrition available. The sampling framework was designed to recruit representative samples across the three different MCH service levels and various geographical areas, with participants selected on a first-in basis. Participants represented a range of experience levels spanning one to 32 years' practice in the sector, with a median MCH employment history of 14 years. Four nurses had been employed between 1-5 years; three between 6-10 years; eight between 11-20 years; and five more than 21 years. Seventeen nurses practiced in the Universal service (twelve exclusively and five across an additional service level); five in the Enhanced service; and three in the telephone service. Eleven were based in metropolitan services and nine in regional/rural services. Participants were informed of the research purpose and no prior relationships were established with participants.

The female researchers (AB & EH) were at the time of data collection and analysis both postgraduate Psychology research students employed by the university. Neither researcher had studied or practiced in nursing but EH was training in clinical psychology at the time.

The researchers conducted one-on-one, in-depth, semi-structured telephone interviews with nurses first at baseline and secondly after they had engaged in MERTIL training. Interviews of about 30 minutes were conducted in a private setting at Deakin University in English and were audio-recorded for transcription. Data were collected between July-November 2018. Findings are reported in line with the Consolidated Criteria for Reporting Qualitative Research Checklist.[20] Table 1 presents the interview schedule and analytic details for each core area of enquiry.

CHOICE OF METHODOLOGIES

We draw on the complementary approaches of descriptive phenomenology and grounded theory, which are interested in meanings of experience.[21] Descriptive phenomenology aims to understand how a core phenomenon is experienced in its lived context: in other words, its psychological *essence*.[22,23] Grounded theory uses flexible, iterative analytic strategies to develop inductive theory by way of connecting categories and making implicit meanings explicit.[24] In this process, emerging theoretical ideas are checked and refined while remaining grounded in the data.[24] Grounded theory is well placed to complement other qualitative methodologies, including phenomenology,[21] in this case to explore the details of the *contexts* in which possible relational trauma was recognised.

Sample size for qualitative analysis is determined by theoretical 'saturation', a point at which additional data do not produce new themes.[25] Sample sizes for grounded theoretical analysis tend to range from around 10-60,[26] or 20-30,[27] and for phenomenological analysis, from 1-10,[26] or 5-25.[27] Focused study objectives, semi-structured interviews and relatively homogenous samples, all relevant to the current study, contribute to early saturation.[28]

TABLE 1. SEMI-STRUCTURED INTERVIEW SCHEDULE ACROSS EACH TIME POINT WITH ACCOMPANYING ANALYTIC METHODOLOGIES USED TO ANALYSE INTERVIEW DATA

Time	Interview schedule	Analysis
Baseline [Enquiry (i)]	I'd like you to think about a time in which you were conducting a scheduled visit with a parent and infant/child and suspected you may be seeing signs of early relational trauma. I'd like you to focus on a time in which you felt unsure about these signs, and/or about how to respond. (Cue general response) Could you describe that moment in which you recognised feeling uncertain in that way? What was it like?	Descriptive phenomenology
Baseline [Enquiry (ii)]	What did you specifically think might be going on; what range of possibilities did you consider? What responses did you consider, and what did you end up doing?	Grounded theory
Follow-up [Enquiry (ii)]	Is there any additional knowledge, skill or resources that, looking back, might have helped you to feel more confident in managing that scenario? Is there anything in particular that you would like to gain from the training program?	Grounded theory/ Descriptive synthesis
Follow-up [Enquiry (ii)]	Could you tell me about your learning experiences with the training program? From a professional point of view, which points have made their way into your thinking and practice? We would like to take you back to the scenario that you told us about in the earlier part of the study. I'll summarise this for you and then I'll ask you to rate how confident you would feel now, in first recognising and then responding to a similar case. What, if anything, has changed in your practice since the training? Were there any unexpected outcomes for you from the training experience? What training and other practice gaps are there yet to be filled with respect to your work with early relational trauma?	Grounded theory/ Descriptive synthesis

DATA ANALYSIS

Interviews were transcribed verbatim by AB and EH, with any identifying details removed from the transcript. Baseline interviews were conducted with 22 participants. Two interviews were omitted from baseline reporting: one due to poor audio quality, and one which did not meet baseline criteria, with that participant having already commenced the MERTIL online training. All 22 participants were eligible for the follow-up and of these, 20 participated. Two could not be contacted.

For the descriptive phenomenological analysis, data were analysed across five phases by a single researcher (AB): first, the transcript was read as a whole; second, it was organised into meaning units; third, meaning units were transformed into summary meaning units from the nurse's perspective; fourth, transformed meaning units were reviewed to derive an individual summary for each nurse. Finally, individual summaries were synthesised into a Summary General Structure of the lived experience of feeling uncertain in first encounters of early relational trauma. A second researcher (JM) reviewed 25% of cases to ensure accuracy and depth in thematic extraction. In two cases, minor variations were noted and accepted. Table 2 presents an overview of these analytic phases.

For the grounded theoretical analysis, meaning units describing each core area of enquiry were clustered into thematic and sub-thematic categories, with categories either accepted or rejected according to new data throughout the process. A second researcher's view was sought at category change points. For both approaches, syntheses were audited via inter-coder agreement, with differences resolved via conferencing between key researchers (AB or EH) and a senior researcher with extensive methodological experience (JM). Table 2 presents the analytic phases for each stage of this enquiry.

TABLE 2. DATA ANALYTIC PHASES FOR EACH KEY METHODOLOGICAL ENQUIRY

Area of enquiry	Data analytic method	Analytic iterations				
(i)	Descriptive phenomenological analysis	1. Entire transcript read by researcher	2. Transcript organised into meaning units	3. Meaning units transformed into summary meaning units from participant's perspective	4. Transformed meaning units reviewed to derive individual summary for each participant	5. Individual summaries synthesised into Summary General Structure of the lived experience of feeling uncertain in first encounters of early relational trauma
(ii)	Grounded theoretical analysis	1. Entire transcript read by researcher	2. Transcript organised into meaning units	3. Meaning units describing each core area of enquiry clustered into thematic and sub-thematic categories	4. Categories accepted or rejected according to new data	

FINDINGS

PHENOMENOLOGICAL ANALYSIS OF LIVED EXPERIENCES

To contextualise nurses' lived experiences, all encounters with possible relational trauma occurred in either the MCH nursing clinic or in the client's home. In all encounters, the focal parent was the mother, and in each encounter, both the mother and child were present together. Focal children's ages ranged from neonate to three-and-a-half years. In all but one scenario, the nurse approached the consultation naïve to the circumstances. In other words, they were unaware of any prior details about the possibility of relational trauma occurring.

A Summary General Structure, outlined below, comprises five core themes that were common across all participants. Both central meanings and individual variations of these lived experiences are interpreted and illustrated with narrative excerpts from individual summaries. Themes describe various features of nurses' lived experiences of feeling uncertain, and at times destabilised, when first encountering signs of trauma. All nurses became present to an early awareness of possible relational trauma as they observed interactions between mother and child, nurse and mother, or nurse and child.

SUMMARY GENERAL STRUCTURE FOR THE EXPERIENCE OF FEELING UNCERTAIN IN DETECTION OF AND RESPONSE TO RELATIONAL TRAUMA: CORE THEMES

1. Worry

Affective experiences of worry for *safety* and for *wellbeing* were present for all participants. The affective experience ranged in intensity from mild concern to a visceral pre-occupation with safety in the moment. Experiential variations were such that worry was directed toward different recipients: the infant, mother, and/or the self as practitioner. Where worry was directed toward the infant, dominant experiences included sadness and concern for the infant's wellbeing, reflections on the possibility of developmental problems, and empathy for the needs of vulnerable children in general, accompanied by a felt obligation to ensure that children have their own 'voice' in the family and the healthcare system:

> *Upon acutely feeling the infant's extreme vulnerability… participant expressed a strong feeling of sadness on the infant's behalf. (6)*

Nurses' worry for mothers presented as intense concern for the mother's wellbeing. Affective experiences were characterised by a high-level reflective capacity marked by authentic compassion toward the mother despite her struggles with effective caregiving. This enabled orientation toward a non-judgmental stance.

For some, the dominant direction of worry was toward the self as practitioner. Here, nurses were explicitly concerned about their own physical safety or emotional wellbeing. This particular lived experience was characterised by an acute consciousness of risk to personal safety. Experiences were situated in home-visit consults where nurses felt personally at-risk, typically due to the presence of a client's violent or abusive male partner. In these circumstances, nurses' concern for their own personal safety eclipsed concern for the client in the moment.

2. Anxiety about the adequacy of response

All nurses experienced a level of anxiety about the adequacy of their response to identified or suspected trauma. The locus of this anxiety varied across characteristics of the self to characteristics of others. For some, anxiety stemmed from high expectations of self or an intense duty of care felt in relation to their client. Several *(1, 2, 4, 7)* felt deep discomfort about the possibility of being unable to effect change for the client. One *(2)* felt distressed when trying to reconcile their professional duty of care with the limitations of the job. One *(14)* felt deeply obligated to protect the vulnerable family beyond what might actually be feasible. This burden of responsibility emerges in several accounts, for example:

> *Participant felt inadequate in the realisation that they would never be able to guarantee client safety. A dissonance emerged between the acknowledgment of their practice limitations, and the anxiety stemming from their expectations of self in trying to ensure client safety. (4)*

For some nurses, anxiety about response adequacy was situated against a 'collapse' in the strategies that they would normally use for engaging the infant or client to effect change. For example, they knew that they lacked knowledge of strategies that would be helpful, or the strategies they used were ineffective:

> *Participant felt that the case exceeded their expertise… they felt lesser and inadequate in the face of uncertainty, and in the face of knowing there was "better care" available elsewhere. (1)*

For others, anxiety stemmed from perceived external pressures (frustrations with clients or with the broader service system). Some *(2, 17)* described anxiety arising from perceived system inadequacies.

Only a select few were shielded from undue worry about the adequacy of their response. Common here was an overall cultivation of affective distance from, rather than preoccupation with, the trauma scenario. In addition, these nurses demonstrated an assured sense of experience and competence. For example, one *(9)* referred to a repertoire of practice strategies that they had consolidated over time and that they knew they could rely on. Common also was a reflective capacity that enabled observation of difficult experiences at a distance. For example, while one nurse *(15)* was aware of compounding levels of futility in regard

to helping a client within an 'impossible' service system, she remained reflective about what makes an effective practitioner and remained open to the complex needs of vulnerable families.

3. Awareness of the inadequacy of resources

Most nurses described an inevitable struggle with inadequacy of *resources* with which to manage the focal scenario. A common experience was the perceived lack of *time* available to form an adequate understanding and shape an adequate response to client needs. Felt inadequacies at the *personal* level were based on role inexperience and perceived lack of trauma knowledge. At the *relational* level, inadequacies were felt in contexts of insufficient clinical supervision, limited collegial support, and encounters with client trauma in the absence of a prior client relationship. At the *contextual* level, inadequacies were identified locally and in the broader service system to make effective referrals and affect timely responses.

A majority of nurses were frustrated with perceived service constraints or the capacity to make referrals to higher-level services. For example, one *(2)* felt that other frontline professions had clearer roles and templates to inform trauma responses within their remit. Several *(3, 4, 15)* felt frustrated by the inabilities of other services to meet client needs immediately in contexts of urgency. Several were especially aware of the possibility of lasting damage in the face of trauma and were earnest about the need to effect change within a timeframe that was developmentally useful for the child.

In exceptions to this theme, *(5, 8, 9, 12, 14)* nurses were preoccupied with experiences that did not, in the moment, warrant a reflection on the availability of resources for responding to the identified trauma. For example, the dominant experiential tone of the client encounter was fear for personal safety, and this eclipsed other reflections on how to approach the case. Some nurses *(9, 12, 14)* were simply resigned to the occurrence of trauma, with a sense that no additional resources would do much to help.

4. Management of personal discomfort

Attempts to manage personal discomfort in the face of possible trauma varied. Two main, underlying approaches characterised the locus of discomfort: (i) a cultivation of affective distance from the client or case (dominant affects of sadness and sympathy; i.e., 'distanced' affects), and (ii) a preoccupation with the client or case (dominant affects of anxiety, exasperation, betrayal, frustration, despair and helplessness; i.e., 'intense' affects). In the former approach, nurses tended to manage their feelings of discomfort by maintaining observational and affective distance from the scenario. For example:

> *Participant needed to self-protect by distancing their mind and sense of personal responsibility from the scenario. (15)*

In the latter approach, nurses were preoccupied with the client or presenting case and tended to have lasting emotional reactions to it.

Coping styles and capacities varied in the face of discomfort, and these informed nurses' ability to manage role demands and respond effectively. Several nurses *(1, 7, 14)* felt hopeless in the face of identifying signs of trauma. For these, normal strategies for engaging the client were felt to be ineffective. Others *(2, 6, 11, 12, 15, 18)* were able to remain engaged, either by cultivating a productive level of distance from the scenario or by relying on strategies that remained effective.

Two of three case variations were nurses practicing within the Enhanced MCH service level, who might have been reinforced by their high level of experience and the additional supervision provisions made available to them.

5. Poor connection with client which limited the capacity to effect change

The tone of the connection or partnership between nurses and clients at times made it difficult for nurses to feel they could bring about positive change. Several nurses felt alone and helpless, with no prospect of partnership with their client. They felt unable to connect or collaborate with their clients, who lacked insight and motivation to change. Implicit here was a tension between the nurses' undoubted capacity to assist in affecting change, and the client's willingness to collaborate. Some felt anxious to preserve rapport in the face of the possibility of alienating the client.

In two of three variations to this theme, the central feeling of uncertainty was again situated in a context in which the nurse felt their own personal safety was at risk. For these, the felt capacity to effect change was instead precluded by an overwhelming preoccupation with personal safety. For the other variation to this theme, the central feeling of uncertainty was because the healthcare visit was a first-time meeting with the client.

GROUNDED THEORETICAL ANALYSIS OF THE IMPACT OF SPECIALIST TRAINING

We then used a grounded theoretical approach to (i) describe, pre-training, the core features of scenarios in which nurses encountered possible early trauma. Baseline interviews explored six core areas: (a) contexts that created concern; (b) what made *detection* of early relational trauma difficult; (c) what made *response* to trauma difficult; (d) how nurses responded in challenging scenarios; (e) skills and knowledge that would have been beneficial; and (f) hopes and learning goals for the workforce training. Details on the core themes and findings from baseline data are summarised in Table 3.

TABLE 3. THEMES AND INTERPRETATIONS ARISING FROM BASELINE DATA, ENQUIRY (II)

Theme	Sub-themes/Scenarios
(1) Contexts that created concern	Six main scenarios raised concerns about possible relational trauma (most participants reported multiple concerns): i) aberrant infant/child engagement or behaviour (including marked disengagement of the child from parent or nurse, and generally disturbed or atypical behaviour) ii) child safety concerns iii) separation/family violence iv) marginalisation or isolation v) aberrant parent engagement/attitude/behaviour vi) parent mental health/substance use
(2) What made detection of relational trauma difficult	Core problems impeding confident detection of trauma centred on two themes: i) complexity regarding trauma diagnoses (including difficulty in distinguishing signs of relational trauma from developmental problems; disparities between parent reports and actual observation of the infant; difficulty in detecting whether parent had experienced trauma; and cases where the source of the trauma was unclear) ii) subjective confidence (where trauma detection was affected by limited confidence, either in a context of personal MCH role inexperience or lack of familiarity with the family and feeling ill-equipped to assess situational nuances)
(3) What made response to trauma difficult	Core problems blocking effective response were situated in four themes: i) the family-nurse relationship (where the parent was disengaged from the nurse, where the nurse had to balance situational urgency with preserving client relationships, and where the nurse needed to meet multiple family members' needs) ii) limited subjective confidence (characterised by feelings of inexperience, uncertainty and helplessness) iii) confidence with wider systems (e.g. capacity to support a referral) iv) service-level constraints (limited time)
(4) How nurses responded in challenging scenarios	Nurses' responses to possible trauma encounters were clustered within one of 10 courses of action: the nurse i) discussed the parent's needs (related to family violence, mental health, and self-care) ii) sought consultation and/or supervision iii) arranged a referral for additional relational support iv) organised a rapid follow-up v) discussed support for child's behaviour (behavioural management, care strategies, external support) vi) offered developmental and attachment psychoeducation vii) referred to safety and/or statutory service viii) arranged housing and/or financial services ix) referred to child support services x) focussed on establishing a strong relationship with the family
(5) Skills and knowledge that would have been beneficial in responding	Additional knowledge or skills that would have been beneficial in managing the scenario: i) professional training (in infant mental health, developmentally specific trauma detection, family violence and attachment principles) ii) internal and external resources iii) supervision and support iv) effective engagement with external support services v) connecting and communicating productively with parents
(6) Hopes and learning goals for impending workforce training	Nurses wished to gain the following skills and knowledge from workforce training: i) skills for engagement and response to families ii) skills for recognising trauma iii) practice principles (including self-care guidelines and shared sector-wide practice principles) iv) continued professional development v) knowledge for translating skills or theory into practice vi) tangible/instrumental resources.

We also used a grounded theoretical approach, with descriptive synthesis, to (ii) describe, post-training, how training had impacted nurses' confidence and knowledge in recognising and responding to early relational trauma. Nurses were asked to reflect on the scenario they had reported at baseline and to describe whether they would feel differently about managing the same scenario post-training. Nurses endorsed various changes in the following themes and areas: a) Theory and Learning; b) Attitude to Practice; c) Observation and Detection; d) Communication with Clients; e) Communication with Others; and f) Response. Gains in knowledge and skill were consistent with nurses' baseline learning hopes and also with the quantitative evaluation findings reported in the earlier study.[8] Details on themes and outcomes can be found in Table 4.

TABLE 4. THEMES AND OUTCOMES OF SPECIALIST TRAINING ARISING FROM FOLLOW-UP DATA, ENQUIRY (II)

Theme	Outcomes of Specialist Training
(1) Improvements in Theory and Learning	Deeper understanding of the principles of infant communication; mechanisms of early relational trauma; and breadth in sources and types of early relational trauma.
	Reinforcements to existing knowledge and therefore enhanced subjective confidence in approach to practice.
(2) Changes in Attitude to Practice	Relational trauma brought to the forefront as a primary lens for approach to practice. (For some, a felt tension between a heightened understanding of relational trauma while remaining unable to translate new knowledge into practice within service-level limits.)
	Realisations about the importance of carefully orienting to the infant's or child's perspective, and reflective practice.
	Intuitions more reassuringly grounded upon evidence-based principles.
	Feelings of validation and esteem arising from realisations about the uniqueness of the frontline position in identifying trauma.
(3) Improved Skills for Observation and Detection	Heightened overall alertness to signs of trauma, improved skill in detecting subtle signs, more attention to intuitive feelings, proficiency in case formulation, and improved client listening skills.
(4) New Skills for Communication with Clients	New skills for client discussions: confidence in approaching conversations about family violence and mental health; the capacity to engage in psychoeducational discussions about trauma mechanisms; the importance of orienting to the child's perspective.
	Better skills for engaging vulnerable families and were present to using trauma-informed language in conversations with clients.
	The importance of adopting non-judgmental and collaborative approaches with clients since engaging in the training.
(5) New Skills for Communication with Others	More effective approaches to communication with others (both colleagues and external services).
	Benefits of a common 'language' for use within the MCH workforce and in communication with external services.
(6) Response Options	A larger repertoire of follow-up options.
	A propensity to arrange follow-up care more promptly, in contrast to a 'wait and see' approach that was common prior to training.
	Greater inclination to enquire about and apply their knowledge of family histories where relevant.
	Use of creative solutions in spite of limited referral pathways, tailoring responses more carefully to client needs.
	Making additional consult time available as needed.

DISCUSSION

We aimed to understand community nurses' lived experiences of first encounters with possible relational trauma in mother-infant dyads, and change in nurses' capacity to recognise and respond to signs of early relational trauma after engaging in specialist training. Phenomenological findings, which extend upon the findings from the grounded theoretical and descriptive syntheses, provide unique insights into the challenges and lived experiences that frontline nurses face in these encounters.

THE LIVED EXPERIENCE: NURSE ENCOUNTERS WITH RELATIONAL TRAUMA

Nurses recognised signs of early trauma through the infant's withdrawn or disturbed behaviours in interactions with their parent or the nurse, or unusual parent attitudes. These signs were evident across contexts including family violence, marginalisation or isolation and parent mental ill-health or substance use.

A key source of distress for nurses in these encounters included a shutdown in thinking and response when nurses were uncertain about how to respond, or when their regular practice strategies were felt to be ineffective. Nurses felt destabilised when there were resource inadequacies at both individual and organisational levels. For example, when time and resources were limited, nurses felt their capacity to provide quality care was affected. For many, this brought about acute feelings of frustration where nurses felt that the limitations of their job impinged upon their duty of care to protect vulnerable children. In these experiences, nurses tended to ruminate on the case and at times feel ineffective as a practitioner. Similar findings are noted elsewhere in the literature: among a sample of practitioners responding to child abuse, the greatest source of disillusionment was not the confronting content of the work itself but instead all that practitioners could *not* do in light of service constraints and dysfunctional work structures;[13] among a sample of maternal, infant and early childhood home visitors, feelings of acute demoralisation emerged in cases where clients were unresponsive to practitioner efforts.[18] Nurses derive role satisfaction from the felt capacity to effect client change and there is evidence that perceived failure to do this can lead to feelings of inadequacy.[11,29,30]

In the current study, nurses who were shielded from overwhelming distress when working with relational trauma reported an ability to hold themselves at a safe, reflective distance from difficult feelings. This may reflect a distancing or avoidant protective mechanism and aligns with the findings of a review on secondary traumatic stress and nurses' emotional responses to trauma,[31] which positions disengagement as an emotional reaction to trauma and a focus on technical, task-oriented practice as a defense against distress. In this study, a reliable repertoire of practice strategies for coping and response helped nurses to remain engaged and effective in their work. Approaches that were core to nurses' felt efficacy in contexts of trauma included deploying a framework for understanding what they were seeing, using a productive level of affective distance from the scenario, and flexibility in case formulation and response. A level of reflective capacity, involving awareness of one's own personal response to trauma, is also key. For some, the experience of confronting signs of possible trauma is disorienting, and may in a shutdown of reflection.[32]

OUTCOMES OF MERTIL TRAINING

Qualitative findings reported here align with and expand upon those from the earlier program evaluation.[8] In that study, nurses reported significant increases in all areas of self-rated learning, post-training. Gains in confidence and capability were sustained at three months post-training. Similarly, in the current study, nurses' engagement in the MERTIL training resulted in gains in subjective confidence and skills-based competency for identifying and responding to signs of early relational trauma. One central remaining barrier to confidence in practice remained at follow up, which was that inadequate or inefficient referral pathways for clients experiencing relational trauma sometimes meant that when nurses were deeply invested in affecting positive change for families, they still felt restricted in their ability to do so. This aligns with findings of the program evaluation which also noted nurses' continuing concerns about pragmatic issues with referral networks and intervention pathways.[8]

Nevertheless, lived experience data reported here suggest an overall desire to cultivate flexible ways of addressing client needs as nurses felt armed with a fresh repertoire of knowledge and skills, post-MERTIL training.

STRENGTHS AND LIMITATIONS

All participants were female, reflecting the broader gender profile of the MCH workforce in Victoria. However, we recruited a diversity of MCH nurses with respect to service level, location, and sector experience. The sample comprised nurses from each of the Universal, Enhanced and telephone-based services and from a range of service locations (metropolitan, regional and rural) representing different sociodemographic settings. While current investigations were restricted to a sample of MCH nurses, findings may be relevant to other frontline professions in which practitioners are required to manage uncertainty and stress in trauma practice.

IMPLICATIONS FOR WORKFORCE SUPPORT

Some nurses reported feeling overwhelmed by their scope of practice, and this was compounded by the perception that receiving more training equals having more responsibility. Community healthcare professionals often operate within constraints across a multiplicity of intersecting and burdened services.[29] Perceptions of work overload and unclear domains of practice can present feelings of uncertainty and overwhelm.[11,33] Critically, the MERTIL training emphasised how even brief, in-the-moment encounters can make a difference to clients and families. This approach was effective in addressing nurses' feelings of overwhelm.

Uncertainty is often inherent in healthcare decision making. Many nurses in the current study remarked that feelings or actions in their practice that were previously based 'only' on intuition had been deepened and validated in the process of being equipped with new evidence-based theory and knowledge. This amounted to greater feelings of confidence in detection of possible trauma and a proclivity to organise prompt responses in cases of suspected trauma.

Those who remained resilient in challenging circumstances reflected a diversity of service levels, locations, and role experience. This aligns with findings that protective factors in trauma work include not only organisational factors but also personal characteristics including hardiness, self-esteem, and an internal locus of control.[34] Given that nurse resilience can be shaped through education, support, and meaningful recognition,[35] and promoted by management through humanistic leadership, advocacy, and development of reflective capacity,[36] there is potential for specialist training to stimulate resilience at both the person- and sector-level. Management can achieve this through relational leadership,[37] cultures of quality supervisory support and through individual-group interventions, worker-environment interventions, and organisational interventions.[17,18,38]

Rapport is central to nurse-client interactions and essential for therapeutic change through awareness and shared understanding.[39] In the current study, nurses felt ill-equipped or powerless to promote positive change when they were unable to cultivate rapport and connection with their clients, often where clients were felt to be difficult to work with. Reflective trauma-focussed supervision examining personal responses is recommended for professionals working with trauma. While translation of such supervisory models to frontline healthcare remains unclear, we identified a critical need for clinical supervision to enable non-reactive responses in difficult scenarios and allow space for guided reflection.

Beyond the need for external supports, MERTIL training emphasised the additional importance of self-care for professionals working with early relational trauma. Self-care is essential for practitioners in trauma work but surrounding discourse often centres on activities naturally sitting outside practice contexts.[34,38,40] Frontline practitioners may be better served by tools that integrate self-care into real-time practice, securing benefit at the time of response.

CONCLUSION

The experiences of community nurses articulated here may better position supervisors, educators and policymakers to optimise frontline healthcare workforce capacity to skillfully recognise and respond to signs of relational trauma, and to confidently manage feelings of uncertainty and overwhelm. Findings illuminate the need for solutions at both organisational and individual levels. At the individual level, nurses would optimally be equipped with various strategies to enhance resilience and reflection in the face of uncertainty. Organisational level targets include adequate supervision, and cultivation of cultures of communication and support. The MERTIL specialist training described here provides an example of how evidence-based, trauma-informed training can equip frontline professionals with enhanced skills and knowledge to sustain their resilience and efficacy when required to detect and respond to signs of early trauma in challenging healthcare encounters.

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