

ORIGINAL ARTICLE

Experiences of midwives and midwifery students with workplace violence: an Italian survey

Workplace violence in midwifery: an Italian survey

Antonella **Cromi**^{1,2,*}, Sonia **Paolucci**², Arianna **Roncoroni**¹, Alessia **Bonaccorso**¹,
Daniela **Mastromauro**², Jvan **Casarin**^{1,2}, Fabio **Ghezzi**^{1,2}

¹ Midwifery Education Program, University of Insubria, “Filippo Del Ponte” Hospital, Varese, Italy.

² Department of Obstetrics and Gynecology, “Filippo Del Ponte” Hospital, University of Insubria, Varese, Italy.

***Corresponding author:** Antonella **Cromi**, M.D., PhD. Midwifery Education Program, University of Insubria, “Filippo Del Ponte” Hospital, Piazza Biroldi 1, Varese, Italy.
Email: antonella.cromi@uninsubria.it.
ORCID: 0000-0003-1697-5139.

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ABSTRACT

Objective. Workplace violence (WPV) is a serious global issue affecting healthcare professionals. Since research about its effects on midwives and midwifery students is limited, this study aimed to assess the extent, characteristics and consequences of WPV experienced by both group during their clinical placements and professional practice.

Patients and Methods. An anonymous online survey was distributed via email to all members of Local Midwifery Boards and all midwifery students in Italy. A total of 1059 eligible respondents participated: 687 registered midwives and 372 midwifery students. The questionnaire investigated personal experiences of WPV, including type, context, perpetrators and consequences.

Results. Overall, 45% of midwives and 27% of students reported being victims of WPV, primarily in the form of verbal abuse. Violence was primarily verbal (99% among midwives and 100% among students). Midwives identified as the main perpetrators the women's partners or other family members (65.4%), patients (21.9%), and physicians/residents (29.1%). Midwifery students experienced violence mostly from supervising midwives (40.2%) or other midwives (56.8%). Reporting rates were low (36.6% of midwives and 36.3% of students). Many reported negative impacts on motivation and caregiving gratification. The main consequences of WPV included decreased job satisfaction (42.5% of midwives and 44.1% of students) and thoughts of resignation or leaving the course (27.1% of midwives and 22.5 % of students).

Conclusions. Our findings highlight the high exposure of midwives and midwifery students to workplace violence in Italy. Future research is needed to better understand this phenomenon and to support the implementation of uniform policies and prevention strategies.

Key words

Workplace violence; midwives; midwifery students; bullying; occupational violence; healthcare workforce

Introduction

Workplace Violence (WPV) in healthcare has been recognized by the World Health Organization and the International Council of Nurses as a significant global issue [1]. The healthcare sector is considered one of the most at-risk environments for WPV, to the extent that some healthcare professionals perceive violence as “just part of the job” [2]. Sources of violence may include patients, their relatives, visitors, and even colleagues. Horizontal violence (peer-to-peer) and vertical violence (between individuals at different levels of hierarchy) are well-documented phenomena that negatively impact healthcare professionals and students, particularly during clinical training [3-5].

Despite growing concern over the nature and extent of WPV, there is still no universally accepted definition across countries and settings [6-8]. A widely cited definition describes workplace violence as “any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the work site” [9]. The Workplace Bullying and Trauma Institute (WBI) further defines workplace bullying as “repeated, health-harming mistreatment, verbal abuse, or conduct which is threatening, humiliating, intimidating, or sabotaging that interferes with work, or some combination of these behaviors” [10].

Studying WPV is crucial because it is associated with professional disengagement, reduced efficiency and burnout. These outcomes negatively affect staff retention and may ultimately compromise the quality of patient care [11-15].

Midwives are considered particularly vulnerable to WPV due to their close contact with women in extreme pain and their work in high-pressure, often emotionally intense environments. Midwifery students share similar challenges but face them with fewer skills and less authority, making them especially susceptible to mistreatment [16-18]. Clinical placement, a key component of midwifery education, strongly influence students' career

trajectories [17-18]. However, research exploring WPV in midwifery remains limited, and few studies have examined its effects on midwifery students [17,18,20]. Most existing studies are qualitative or provide only descriptive statistics, limiting the ability to assess the true scope and prevalence of the issue [16-20]. There is a critical need to produce quantitative evidence showing that both intraprofessional violence and conflicts involving patients or their families pose serious risks in the maternity settings. Such evidence is essential for developing targeted interventions and transforming hostile environments into supportive, respectful workplaces. This need aligns with recent contributions in the Italian literature that emphasize the importance of recognizing and addressing different forms of violence in healthcare settings. A national observational study explored healthcare professionals' attitudes towards female genital mutilation, underlining the ethical and educational responsibilities of care providers when confronted with culturally rooted forms of violence [21]. Another recent article analyzed the phenomenon of gender-based violence in healthcare, taking into consideration Italian legislation and calling for greater institutional awareness and coordinated professional responses [22].

In Italy, in 2020, after lobbying by nurses, the country's parliament approved a new law to address violence against health workers, which extended prison sentences from 4 to 16 years for individuals who cause serious personal injuries to health personnel and increased the administrative penalty for an action that, short of a crime, involves violence, abuse, offense, or harassment toward health-care workers [23]. Further, a National Day of Education and Prevention of Violence against Health Personnel was created to raise awareness of the subject. Despite increased awareness of the issue, no studies have examined WPV against midwives or midwifery students in our country, and there is no epidemiological data on the phenomenon in the setting of maternity wards. The primary purpose of this study was to investigate the frequency and patterns of WPV experienced

by registered midwives and midwifery students across Italy. Key areas of focus include the type of WPV experienced, the primary perpetrators, the most affected work settings, reporting practices, and the personal and professional outcomes associated with such experiences.

Materials and Methods

An email invitation was sent to the presidents of all Local Midwifery Boards and the directors of all Midwifery Programs in Italy to inform them about the study's purpose and to request their collaboration. All 31 educational programs and 60 local boards agreed to participate. Each institution was asked to distribute an email to all registered midwives and students under their jurisdiction. The email described the aim of the study and included a link to the anonymous online questionnaire. The survey was administered using the Google Forms platform and remained open for responses for nine months, starting in January 2021. The first page of the questionnaire provided participants with a summary of the study and clear instructions for completing the form. Participation was voluntary and anonymous. Because no validated tool was available at the time to assess WPV specifically in midwifery, the questionnaire was developed based on widely used items from the literature and underwent expert content validation. The questionnaire included 20 items derived from the literature [16-20] to answer the following research questions: 1) what is the extent of vulnerability to WPV during midwifery practice and midwifery education?; 2) What types and patterns of violence do midwives and students experiences and who are the perpetrators?; 3) what mechanisms, if any, are used to report incidents?; 4) What are the personal and professional impacts of WPV?. The questionnaire was divided into three parts: Part 1 (4 items) demographic and professional characteristics; Part 2 (12 items) experiences of WPV including type (verbal or physical), frequency, context (location and time) and identity of the perpetrators; Part 3 (4 items): consequences

of WPV including Likert-scale questions on perceived impact. Response formats included multiple choice, Likert scales, and free-text comment boxes. Participants who reported not having disclosed WPV were invited to explain their reasons in an open comment section. The estimated time to complete the questionnaire was 10 minutes. The questionnaire was tested for content validity by a panel of experts in the field. All responses were coded descriptively and subsequently for emerging themes. To allow different perspectives, this process was performed by the author and then reviewed by the entire team.

Study Population

The study relied on a voluntary, self-selected national sample consisting of 687 registered midwives and 372 midwifery students. At the time of data collection, the total number of registered midwives in Italy was 20.558, resulting in a response rate of 3,3%. Among the 2190 midwifery students enrolled in Italian programs during the same period, 372 completed the questionnaire, corresponding to a response rate of 19 %.

Of the student respondents, 99.2 % were female and 91.4 % were aged 20-29. Over half were in their third year of the bachelor course in midwifery (n=200, 53.8%), while 44 (11,8%) students were in their first year. A total of 51.1% students completed their clinical placements in Northern Italy, with the remainder distributed between Central (n=89, 23.9%) and Southern Italy (n=93, 25%). Among certified midwives, fewer than 1 % were male (n=5) and the largest age group was 30 - 39 years (n=239, 34.8%).

Study registration, ethical and methodological standards

According to institutional policy, studies involving anonymous surveys without identifying information are exempt from formal Institutional Review Board (IRB) approval.

Statistical analysis

Data analysis was conducted using SPSS (Statistical Package for the Social Sciences Version 20.0, SPSS Inc, Chicago, Illinois, USA). Descriptive statistics were computed, and inferential statistics were used to compare groups using a t-test. All results are two-tailed unless otherwise stated. The results will be considered significant if the p value is <0.05 . For analytic purposes, respondents were classified into three geographic categories (Northern, Central, and Southern Italy) based on the location of the program or the institution where they practice.

Results

The level of perceived risk regarding work-related threats and violence was absent/negligibly low for 71.6% (492/687) of registered midwives compared to 80.4% (299/372) of midwifery students ($P=0.002$).

Of the students surveyed, nearly one-third ($n=102$, 27.4%) had experienced at least one form of violence associated with clinical placement. No significant difference was found in the rate of students experiencing violent events by geographical area of clinical placements (24.7% of the Northern Italy students vs. 29.2% of Central Italy and 32.6% of Southern Italy samples. ($P=0.39$).

Almost 45% ($n=306$) of certificated midwives reported having been exposed to WPV in their professional lives. Among those reporting WPV, almost half ($n=129$, 42.2%) had been practicing for less than 5 years when the violent event occurred. Most midwives who became victims of WPV worked in Northern Italy ($n=218$, 71.2%), followed by Central Italy ($n=53$, 17.3%).

Table 1 displays the type of violence experienced by participants in the present study.

The most common form of violence experienced by students whilst on clinical placement

was verbal abuse (n=102, 100%), followed by verbal abuse that escalated to include physical aggression (n=14, 13.7%). Among certificated midwives, verbal violence accounted for 99% (n=303) of reported incidents, both verbal and physical violence accounted for 24.5% (n=75), and physical abuse alone accounted for 0.9% (n=3). The major types of verbal abuse faced by participants overall were rudeness, humiliation, and foul language (reported by 89.2% of students and 72.9% of midwives). In one case verbal abuse has repeatedly occurred over the phone. Although physical abuse was less frequent than verbal abuse, it was reported by more than one in four midwives (25.5%) and 13.7% of students. Specific forms of physical aggression included shoving (9.8% of midwives), hitting (5.9% in both groups), and rarer but alarming incidents such as biting, spitting and even attempted strangulation. One in four registered midwives who experienced violence, reported being hit by people or with objects and one of them reported visual sexual harassment while at work (exposure of the genitals). In one case a patient's caregiver followed the midwife from the workplace to home, suggesting that in some cases violence extended beyond the workplace.

Individuals responsible for the workplace violence incidents reported in this study are shown in **Table 2**. The most common aggressors against midwives were patients' partners or relatives (65.4%), followed by patients themselves (21.9%) and medical colleagues such as physicians or residents (29.1%). In contrast, students were most frequently targeted by midwives (56.8%) and supervising midwives (40.2%), followed by caregivers (30.4%) and patients (25.5%).

When participants were asked to choose from a pre-defined list of the factors thought to contribute to their experience of WPV (**Table 3**), the majority did not identify any specific contributing factor (50% of midwives, 74.5% of students). Among those who did,

commonly cited triggers included anger at staff (43.1%), alcohol intoxication (5.6%), substance abuse (5.2%) and cognitive impairment (1.2%).

WPV occurred most frequently in the labor and delivery ward (n=195, 47.8%), followed by the maternity ward (n=163, 39.9%) and by the obstetric emergency department (n=90, 22%). Findings from the registered midwives indicated that the likelihood of violent behavior to occur is higher during the night shift (n=112, 36.6%) than during the other shifts. Over half (n=194, 63.4%) of registered midwives who experienced an episode of violence did not report and seek assistance through formal channels. Similarly, only 36.3% of midwifery students reported incidents to supervisors or the university staff.

Participants provided additional details about their decision not to report in comments. When the participants described why they did not take any action against WPV, the top six reasons included fear of retaliation, no faith in the reporting system if there was one, fear the one's career would suffer, concern that they would not be believed, not wanting to rock the boat, or feared they would lose their job. In particular, the midwives reported a prevalent normalization of violence in the workplace, the fear of consequences on their job and the deep-rooted idea that reporting is useless. Conversely, comments by the students mainly show the fear of compromising their university career and the results of their upcoming exams.

The experience of WPV undermined, at the highest level ("major effect" on the Likert scale), job motivation of students (n= 39, 38.2%) and midwives (n=106, 34.6%). Likewise, almost half of respondents (44.1% of students and 42.5% of midwives) reported that caregiving gratification was affected "very much" by involvement in an episode of violence. Following being victims of WPV, 27.1% (n=83) of midwives had the desire to resign and 5.9% (n=18) did resign. Of the midwifery students, 22.5% (n=23) reported thoughts of leaving the course because of WPV.

Discussion

This study sought to explore the exposure to WPV of midwives and midwifery students in the Italian healthcare system. The findings confirm that midwifery care, although not traditionally considered high-risk, is significantly affected by workplace violence, with emotional intensity, relational proximity, and organizational factors contributing to this phenomenon. While previous research in Italy has documented high rates of WPV among healthcare professionals [24,25], this is to our knowledge, the first national study to focus specifically on midwives and students in maternity settings.

The limited visibility of midwifery in international WPV research – often merged with nursing or omitted due to small sample sizes [16,19,26] – may have contributed to an underestimation of the issue in this field. Although midwifery is not typically associated with high-risk environments like emergency or psychiatric units [27-29], recent data suggest that midwives may face a comparable or even higher risk of aggression [19,30]. In a cross-sectional study conducted in a large Italian University Hospital, Viottini et al. found that midwives had the highest risk of experiencing aggression among healthcare workers, with a relative risk of 12.9 compared to physicians [25]. These findings highlight the unique relational dynamics of maternity care: midwives assist during emotionally charged events, often in enclosed settings such as birthing suites, in close and prolonged contact with women and their families. The predominance of violence from patients' partners and relatives – particularly in labor and delivery – reflects this relational intensity. It also underscores the importance of understanding not only the clinical environment, but also the emotional and social context in which care is provided. Prior research has linked family-related violence to emotional distress, substance use and behavioral disorders [31-32]. Organizational factors, such as regional differences in staffing and healthcare

delivery, as well as regional disparities in how workplace violence is perceived, managed and reported might partly explain the higher frequency of WPV observed in Northern Italy. Further research is needed to investigate factors influencing regional differences. Verbal abuse emerged as the most common form of violence, consistent with literature identifying misunderstanding, stress, and a poor communication as key trigger [33-36]. While physical and sexual violence were reported less frequently in our study, international evidence suggests that sexual harassment in healthcare is often under-reported, especially in professions perceived as female-dominated and low-risk [37,40]. Whether this reflects a genuinely lower prevalence or a tendency to overlook or normalize such behaviors within maternity settings remains an open question.

The timing and circumstances of violent episodes offer further insight. Incidents occurred most frequently during the night shift and among midwives with less than 5 years of experience. These patterns are echoed in the literature [38-40] and may point to staff vulnerability in low-resourced or poorly supervised contexts. The relationship between experience and exposure to WPV is complex, and while some studies suggest a protective effect of seniority, findings remain inconsistent, often due to methodological differences.

The inclusion of midwifery students in our study sheds light on a particularly vulnerable population. A substantial number experienced horizontal violence, primarily from preceptors and other midwives. These findings align with Capper et al's review [40], which describes bullying by clinical mentors as a widespread, systemic problem. The hierarchical and enclosed nature of midwifery work, coupled with emotional and organizational pressures, may create an environment where students are especially susceptible to mistreatment. Alarming, only a minority of students in our study reported these experiences to academic or managerial staff.

Under-reporting was a recurrent issue among both midwives and midwifery students, often driven by fear of being dismissed, labeled as problematic, or jeopardizing one's academic

or professional future. Participants' comments reflected a broader organizational culture where violence is normalized, retaliation is feared, and institutional responses are distrusted. These dynamics are well-documented in the literature [26, 41 - 43], particularly in hierarchical healthcare settings where speaking out may be perceived as risky. Addressing under-reporting requires more than raising awareness, it calls for structural interventions such as anonymous reporting systems, visible leadership support, targeted education on workers' rights, and institutional campaigns that actively challenge the culture of silence.

Finally, the psychological and professional consequences of WPV are considerable. For some participants, the experience eroded their sense of vocation, prompting thoughts of resignation or withdrawal from the profession. These findings are particularly concerning in a field already affected by workforce shortages and high levels of stress. Although the impact of WPV on patient safety in maternity care has been less studied, evidence from other settings suggests that violence may contribute to poorer outcomes, including delays, errors, and decreased quality of care. In conclusion, WPV in midwifery is a significant yet under-recognized issue. Our study suggests that systemic, cultural and relational factors all contribute to a climate in which violence is not only possible but, at times, expected. This calls for a coordinated, multi-level response involving institutions, policymakers and professional bodies to foster safer, more respectful environments for both healthcare workers and the women they serve.

Further research should explore the effectiveness of institutional strategies such as conflict resolution training, support services and workplace policy reforms. Cross-national comparison and longitudinal studies may also help elucidate systemic solutions to reduce WPV.

Strengths and Limitations

We should acknowledge that an important limitation of this study is the poor response rate, particularly for the certificated midwives group. The very low response rate among registered midwives (3.3%) severely limits the generalizability of our findings. This may reflect a selection bias, as individuals with stronger feelings or experiences regarding WPV may have been more likely to participate. Consequently, the prevalence estimates may be inflated and not representative of the entire midwifery population in Italy. Moreover, we acknowledge the potential for non-response bias and self-selection bias due to the type of data collection. It is likely that engagement in the issue is critical to participation. Indeed, it is not known whether there are significant differences between those who responded to the online survey and those who did not. However, when respondents have a genuine interest in the survey, careless responses are less probable [46]. The low response rate may be an indicator that potential respondents were not interested in this topic, however, we cannot exclude, given the mediation role of the local Midwifery Boards, that not every midwife was presented with the survey. Furthermore, this is a retrospective study in which the participants were asked to self-report their experiences and this approach may lead to a risk of recall bias. The questionnaire was based on widely used items from the literature, nonetheless the lack of a formal process to establish validity and reliability remains a significant limitation. These limitations are mitigated by the large sample size, representative of all Italian regions. Moreover, the midwifery students' cohort is highly representative of second- and third-year students of midwifery programs in Italy, who have had more experience with clinical placements.

Conclusions

The results of this study show that midwives and midwifery students experience workplace violence at seriously high levels. What was once tolerated as part of the job should now be seen as unacceptable. Further work is necessary to provide a more accurate estimate of

the prevalence and severity of WPV in the midwifery context. Studies like these can serve as a basis for future prospective research on a larger scale, which will help to raise awareness of the problem and lead policy and organizational responses aimed at protecting workers from any violent behaviors and ensuring a safe learning environment for students. Dealing with episodes of WPV requires taking preventative measures, such as de-escalation training, strengthening more effective reporting protocols, and boosting security systems. However, the findings also highlight the problem of horizontal violence and the necessity of specific interventions inside the institutions themselves. Limiting this phenomenon is fundamental in reducing workplace stress, limiting the turnover of medical staff, and ultimately improving the quality of care for mothers and children. Future research should explore the effectiveness of institutional strategies such as conflict resolution training, support services and workplace policy reforms. Cross-national comparisons and longitudinal studies may also help elucidate solution to reduce WPV.

COMPLIANCE WITH ETHICAL STANDARDS

Authors' contribution

A.C.: interpreted the results and wrote the final manuscript. S.P.: contributed to the writing of the manuscript and data analysis. A.R.: collected the data, contributed to data analysis. A.B.: conceived and planned the study and contributed to the manuscript writing. D.M.: contributed to data analysis. J.C.: contributed to the critical revision of the manuscript. F.G.: supervised the work and revised the manuscript.

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Study registration

N/A.

Disclosure of Interests

The authors have no relevant financial or non-financial interests to disclose.

Ethical Approval

N/A.

Informed consent

Midwives and students were offered to participate in the survey voluntarily and anonymously.

Data sharing

N/A.

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Type of violence	Midwifery students (n=102)*	Registered midwives (n=306)*
Verbal abuse	102 (100%)	303 (99%)
Discourtesy/Rudeness	91 (89.2%)	223 (72.9%)
Foul language	28 (27.4%)	96 (31.4%)
Humiliation	76 (74.5%)	155 (50.6%)
Threatened with physical violence	14 (13.7%)	93 (30.4%)
Threatened with weapons	2 (1.9%)	6 (1.9%)
Threatened with legal actions	0	10 (3.3%)
Threatened with death	0	2 (0.6%)
Threatened with negative career consequences	2 (1.9%)	0
Physical abuse	14 (13.7%)	78 (25.5%)
Biting	1 (0.9%)	11 (3.6%)
Spitting	0	7 (2.3%)
Scratching	2 (1.9%)	8 (2.6%)
Punching	2 (1.9%)	10 (3.3%)
Pulling hair	0	6 (1.9%)
Being hit by an object	0	8 (2.6%)
Being hit by a person (punches, slaps, kicks)	6 (5.9%)	18 (5.9%)
Attempt to strangle	0	1 (0.3%)
Shoving	6 (5.9%)	30 (9.8%)
Being sexually harassed	0	1 (0.3%)
Being robbed	0	1 (0.3%)
Verbal abuse (alone)	88 (86.3%)	228 (74.5%)
Physical abuse (alone)	0	3 (0.9%)
Both verbal and physical abuse	14 (13.7%)	75 (24.5%)

Data are expressed as number (%)

*multiple responses per variable allowed

Table 1. Type of workplace violence experienced by the study participants

Perpetrator of violence	Midwifery students (n=102)*	Registered midwives (n=306)*
Patient	26 (25.5%)	67 (21.9%)
Caregiver	31 (30.4%)	200 (65.4%)
Doctor / resident physician	24 (23.5%)	89 (29.1%)
Supervising midwife	41 (40.2%)	0
Midwife	58 (56.8%)	65 (21.2%)
Another user at the hospital	11 (10.8%)	11 (3.6%)
Head nurse	1 (0.9%)	10 (3.3%)

Data are expressed as number (%)

*multiple responses per variable allowed

Table 2. Perpetrators of workplace violence reported by the study participants

	Victims of workplace violence (n=408)*
Dementia or Alzheimer's Disease	5 (1.2%)
Mental health issues	17 (4.2%)
Upset person or state of anger	176 (43.1%)
Alcohol abuser	23 (5.6%)
Drugs or abuse substances, drugs withdrawal syndrome	21 (5.2%)
No specific features	229 (56.1%)

Data are expressed as number (%)

*multiple responses per variable allowed

Table 3. Antecedents of workplace violence reported by the study participants