

Islamic-Informed Spiritual-Empathic Listening Support for Postpartum Trauma: A Rapid Evidence Review

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ABSTRACT

Background: A worldwide health concern is postnatal psychological discomfort, which includes symptoms of anxiety, and despair. Although listening-based therapies have become popular as flexible, low-cost ways to treat maternal mental health, there is currently little data on their efficacy and cultural fit. With an emphasis on Islamic-informed approaches, this study sought to compile the most recent data on the efficacy, viability, and cultural significance of listening services in enhancing maternal psychological outcomes.

Methods: A Rapid Evidence Review (RER) was conducted following PRISMA 2020 guidelines. Twelve empirical studies published between 2018 and May 2025 were included (4 randomized controlled trials, 3 quasi-experimental studies, 3 observational studies, 1 qualitative, and 1 mixed-method design).

Results: Ten of the twelve studies (83%) reported statistically significant reductions in maternal psychological distress. Randomized controlled trials demonstrated measurable decreases in EPDS, PCL-5, and DASS-21 scores following structured midwife-led debriefing or counseling sessions. Several interventions showed significant reductions in postpartum anxiety and PTSD symptoms after brief (1–4 session) models. Faith-integrated listening approaches in Muslim-majority settings enhanced spiritual resilience, emotional validation, and cultural acceptability. Digital and telehealth modalities improved accessibility, particularly during the COVID-19 pandemic, although higher attrition rates and short follow-up durations were frequently noted.

Conclusion: Postnatal listening services are an efficient and affordable way to improve the psychological well-being of mothers when paired with treatment that is sensitive to cultural and spiritual differences. Future studies and clinical applications should place a high priority on formalizing Islamic informed listening frameworks in midwifery practice in Muslim communities.



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INTRODUCTION

For many women, giving birth can result in psychological anguish even though it's an important life event (Sun et al., 2023). Studies show that up to 30% of women have a traumatic delivering experience, which can result in problems including PTSD, anxiety, and postpartum depression as well as a disruption in the mother-child bond (Schobinger et al., 2020). Prevalence

estimates in developed countries range from 1.0 % to 5.6 % for a severe form of depression and from 6.5 % to 12.9 % for less severe forms of depression during pregnancy and 12 months after childbirth. Studies focusing on the time period of 3 months after childbirth showed the highest prevalence of PPD, for severe form of depression 7.1 % and 19.2 % for mild form of depression (LEARMAN, 2018).

In response to this gap, several countries have adopted postnatal listening programs, also known as birth debriefing or reflective discussions, as an early intervention strategy (Bannister et al., 2025). These programs are designed to help mothers process their birth experience, communicate their emotions, and reclaim control of their life. They are typically led by certified nurses or midwives (Gauci & Parascandalo, 2025). Research indicates that these interventions can improve maternal satisfaction with postnatal care and considerably lower symptoms of anxiety, sadness, and PTSD (Tavares et al., 2025). However, there are still differences in implementation between countries, particularly in low- and middle-income countries where clinical outcomes are frequently given precedence over psychosocial recovery in health systems (Bolton et al., 2023).

Women's perceptions of their delivery experiences are greatly influenced by their spiritual and cultural beliefs in nations with a predominance of Muslims (Á et al., 2023). Beyond psychological coping, healing is frequently understood through spiritual meaning-making processes, including *sabr* (patience), *tawakkul* (trust in divine wisdom), and the perception of childbirth as part of a divinely ordained life test (*ibtila'*) (Nasrin, 2025). This emphasizes how crucial it is to provide postpartum therapies that are sensitive to cultural and religious differences and that reinforce the woman's beliefs and values in addition to listening to her with empathy (Hanach et al., 2024). Postnatal listening services could have a greater emotional and spiritual impact if Islamic concepts are incorporated, especially in Middle Eastern and Southeast Asian cultures (Institutional, 2023).

Midwives, who often serve as primary maternal care providers in Muslim contexts, are strategically positioned to deliver culturally and spiritually sensitive support (Hassan, 2022). They can provide spiritual-psychological care that is in line with Islamic ethics of compassion (*rahmah*) and care (*ihsan*), and they are trustworthy community members who also act as caretakers (Ali et al., 2025). Nevertheless, empirical synthesis examining the effectiveness and feasibility of Islamic-informed listening services remains limited (Vega-esca, 2022). Existing studies are fragmented across settings and methodologies, and no recent review has specifically consolidated evidence on faith-integrated postnatal listening interventions within midwifery practice (Bentley et al., 2022).

Therefore, this study aims to conduct a Rapid Evidence Review to synthesize current empirical evidence on postnatal listening services for women experiencing traumatic or distressing childbirth, with particular attention to their cultural and spiritual relevance in Muslim communities (Thomson & Nowland, 2024). This study combines global research and identifies culturally relevant practices to offer recommendations for faith-sensitive midwifery therapies that honor the psychological and spiritual dimensions of postpartum recovery.

METHODS

Study Design

A Rapid Evidence Review (RER) was conducted to evaluate both the effectiveness and the cultural-spiritual relevance of postnatal listening services for women experiencing traumatic or distressing childbirth (Damani, 2020). The RER methodology was selected due to its ability to balance methodological rigor with timeliness, enabling rapid synthesis of emerging evidence to inform clinical practice and policy. The review adhered to the PRISMA 2020 guidelines (Page et al., 2021).

Review Framework (PICO)

The evaluation was guided by the PICO framework to ensure a structured synthesis of evidence:

- a. Population (P): Postpartum women who had a traumatic or unpleasant delivery, including those reporting anxiety, depression, spiritual distress, or post-traumatic stress disorder.

Studies involving women in late pregnancy were included if outcomes were assessed postnatally.

- b. Intervention (I): Listening-based or empathic support, such as midwife-led debriefing, story therapy, structured reflections, narrative counseling, supportive conversations, or faith-integrated trauma healing (e.g., Islamic approaches).
- c. Comparison (C): Standard postpartum care without additional emotional or listening-based support. Some studies also included waitlist controls or routine education without structured emotional support.
- d. Outcomes (O): Reduction of psychological distress (e.g., depression, anxiety, PTSD), improvement of maternal well-being and functioning, spiritual resilience, and satisfaction with care (Page et al., 2021).

Eligibility Criteria

Peer-reviewed empirical research published in English or Bahasa Indonesia between January 2018 and May 2025 (including RCTs, quasi-experimental, cross-sectional, qualitative, and mixed-methods designs) were included in the review. Women in late pregnancy, if outcomes were measured postnatally, or postpartum women were eligible groups. These included listening-based or empathic support (e.g., narrative counseling, spiritual contemplation, Islamic trauma healing, community or online sessions, or debriefing conducted by a midwife). Psychological and psychosocial variables, such as PTSD, anxiety, postpartum depression, maternal functioning, spirituality, and well-being, were among the outcomes of interest. research involving non-postpartum populations, therapies lacking a listening or empathetic component, results restricted to biological measures, reviews, protocols, commentaries, or grey literature, and research not published in English or Indonesian were among the exclusion criteria.

Search Strategy

Along with manual reference checking and citation tracking, a thorough electronic search was carried out in PubMed, Scopus, ScienceDirect, CINAHL, and PsycINFO. Three domains were combined by Boolean operators: (1) listening-based interventions (e.g., “postnatal listening,” “birth debriefing,” “reflective conversation,” “emotional support”); (2) psychological outcomes (e.g., “traumatic birth,” “birth trauma,” “postpartum PTSD,” “maternal psychological distress”); and (3) contexts based on spirituality or faith (e.g., “Muslim women,” “Islamic context,” “spiritual care”). Table 1 contains a list of all search phrases.

Table 1. Search Terms

Search Terms
postnatal listening OR birth debriefing OR childbirth debriefing OR reflective conversation OR emotional support OR midwifery support
AND
traumatic birth OR negative childbirth experience OR birth trauma OR postpartum PTSD OR maternal psychological distress
AND
Muslim women OR Islamic context OR spiritual care OR faith-based intervention

Screening and Selection

A search of the database produced 662 records. 571 records were left for title and abstract screening after duplicates were eliminated. 550 of these were disqualified because they did not fit the requirements for inclusion. Nine full-text articles were eliminated for methodological or content-related reasons out of the twenty-one that were evaluated. In the end, the review contained twelve papers (Figure 1).

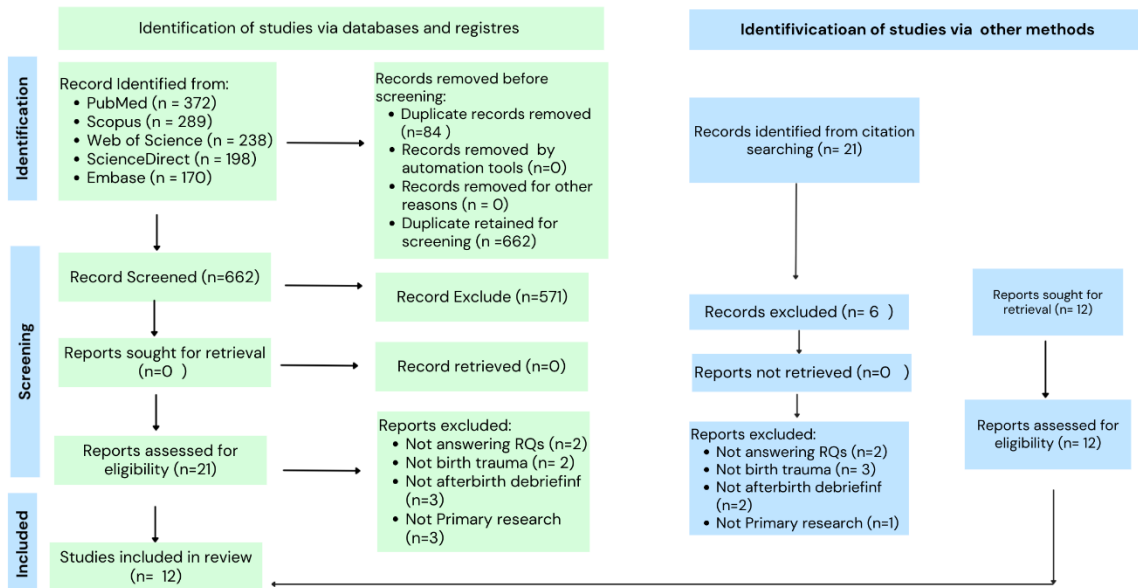


Figure 1. Screening and Selection using PRISMA

Data Extraction and Quality Appraisal

Data on study design, population, intervention components, comparison groups, outcomes, and cultural-spiritual elements were extracted independently by two reviewers. Methodological quality was assessed using the Joanna Briggs Institute (JBI) Critical Appraisal Tools appropriate to each study design (RCT, quasi-experimental, observational, qualitative, or mixed-method). Disagreements were resolved through discussion until consensus was reached.

While methodological rigor remained the primary appraisal criterion, cultural responsiveness was evaluated as a complementary dimension using the predefined cultural assessment domains described above.

No formal quantitative weighting system was applied across study designs due to the exploratory nature of the Rapid Evidence Review. However, randomized controlled trials were prioritized when interpreting evidence of intervention effectiveness. Qualitative and observational studies were primarily used to contextualize feasibility, acceptability, and cultural relevance.

Cultural and Spiritual Relevance Assessment

In addition to methodological quality appraisal, cultural and spiritual relevance was systematically assessed using predefined criteria developed for this review. Four domains were evaluated:

- Explicit integration of spiritual or faith-based components within the intervention (e.g., Qur'anic reflection, religious coping constructs);
- Cultural adaptation of intervention delivery to local maternal beliefs, values, or practices;
- Involvement of culturally trusted facilitators (e.g., community-based midwives, religious leaders, or culturally embedded health workers); and
- Inclusion or reporting of culturally relevant outcomes, such as spiritual well-being, religious coping, or cultural acceptability.

Based on these domains, each study was categorized as demonstrating high, moderate, or low cultural integration. This structured approach enhanced transparency and consistency in evaluating contextual validity across heterogeneous study designs.

Data Synthesis

A narrative thematic synthesis was conducted to organize findings into three analytical domains: (1) psychological outcomes, (2) service delivery models, and (3) cultural-spiritual relevance. Cultural-spiritual findings were interpreted using relevant Islamic conceptual constructs (e.g., *sabr*, *tawakkul*, *maqashid syariah*) when explicitly described in the primary studies. These constructs were used as interpretive lenses to contextualize faith-integrated interventions, without replacing empirical outcome analysis.

Table 2. Inclusion and exclusion

Criteria	Inclusion	Exclusion
Population	Postpartum women (including late pregnancy if outcomes were assessed postpartum).	Non-postpartum populations.
Intervention	Listening-based or empathic support (e.g., debriefing, narrative counseling, spiritual reflection, midwife-led sessions, Islamic trauma healing).	Interventions without a listening or empathic component (e.g., pharmacological, purely medical).
Outcomes	Psychological/psychosocial outcomes: depression, anxiety, PTSD, maternal functioning, spirituality, well-being.	Non-psychological outcomes only (e.g., biomedical without psychological measures).
Study Design	Peer-reviewed empirical studies (RCTs, quasi-experimental, qualitative, cross-sectional, mixed-methods).	Reviews, protocols, commentaries, grey literature.
Other limits	English or Bahasa Indonesia; published 2018–2025.	Non-English/Indonesian, or published before 2018 (unless highly relevant).

Using Table 2 as a basis Studies with postpartum or late-pregnancy women whose results were assessed during the postpartum period were taken into account. Listening-based or empathetic support strategies included community-based discussions, Islamic trauma healing, online or phone listening sessions, spiritual meditation, narrative counseling, and midwife-led debriefing. The psychological or psychosocial outcomes of interest were postpartum depression, anxiety, PTSD, mother functioning, spirituality, well-being, and other related indicators. Only English-language, peer-reviewed empirical studies (RCTs, quasi-experimental, cross-sectional, qualitative, or mixed-methods) published between 2018 and 2025 were included. The exclusion criteria included non-postpartum populations, non-peer-reviewed literature, therapies that did not entail listening, studies that exclusively addressed biological results, and papers published in other languages without translation.

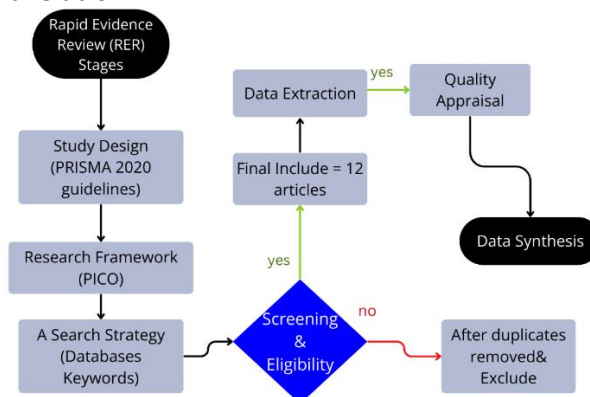


Figure 2. Methodological Framework of the Rapid Evidence Review (RER)

RESULTS

Table 3. Summary of included studies on postnatal listening interventions (2018–2025).

1 **Table 3. Summary of included studies on postnatal listening interventions**

First Author (Year)	Country	Design	Participants (n)	Listening Intervention	Outcome Measures	Main Psychological Effect	Cultural Integration Level	Strength of Evidence
Small et al. (2020)	Australia	RCT	Mothers (1,041)	2 midwife-led debriefing sessions (45 min)	EPDS (>13)	Significant reduction in depressive symptoms	Moderate	Strong
Miriam et al. (2018)	England	RCT	Postpartum women (89)	One telephone listening session (iWaWa)	GAD-7, DASS-21	Partial improvement; high attrition	Low	Moderate
Bentley (2022)	Somalia	Quasi-experimental	Mothers (102)	Islamic Trauma Healing model	Descriptive community outcomes	Community-perceived emotional improvement	High	Moderate
Nurbaeti et al. (2023)	Indonesia	Observational	Adolescent postpartum mothers (20)	Islamic spiritual reflection	Spirituality scale	Increased spiritual acceptance	High	Limited
Sakineh et al. (2021)	Iran	Quasi-experimental	Postpartum women (200)	Online sessions Zoom	Anxiety scores	Significant anxiety reduction	Moderate	Moderate
Aston et al. (2024)	North America	Qualitative	Postpartum parents (37)	Virtual narrative sharing	Semi-structured interviews	Emotional validation and coping improvement	Low-Moderate	Limited
Baker et al. (2024)	Australia	RCT	Postpartum women (68)	4-session counseling STA	BIMF	Improved maternal functioning	Low	Strong
Rahman et al. (2021)	Nigeria	Observational	Postpartum mothers (182)	Community religious support group	Structured questionnaire	Improved coping and social support	High	Limited
Mousavi et al. (2024)	Iran	RCT	Women with traumatic birth	CISD-based counseling	PCL-5, EPDS	Significant PTSD and depression reduction	Moderate	Strong
Abhar et al. (2020)	Iran	RCT	Primiparous women (60)	Gamble-based midwife counseling	DASS-21	Significant reduction in anxiety	Moderate	Strong
Oliveira et al. (2022)	UK	Observational	Postpartum mothers (447)	Narrative counseling	Self-control, acceptance	Improved emotional processing	Low	Limited
Trinko et al. (2025)	USA	Mixed-method	New mothers (18)	6-week matrescence education	Mindfulness, stress, well-being scales	Improved mindfulness and well-being	Low-Moderate	Moderate

3 Table 3 summarizes the characteristics, psychological outcomes, cultural integration levels,
4 and strength of evidence of the included studies. Overall, randomized controlled trials
5 demonstrated the most consistent reductions in postpartum depression, anxiety, and PTSD
6 symptoms, particularly in structured midwife-led or trauma-focused listening interventions using
7 standardized instruments such as EPDS, DASS-21, and PCL-5. These findings indicate strong
8 empirical support for clinically structured listening models.

9 Quasi-experimental and observational studies reported improvements in coping, emotional
10 processing, and spiritual well-being, although causal inference was limited due to weaker designs
11 and shorter follow-up periods. Digital or telephone-based models improved accessibility but
12 showed higher attrition rates.

13 Faith-integrated interventions conducted in Muslim-majority contexts demonstrated high
14 cultural relevance and enhanced spiritual resilience; however, most relied on descriptive or non-
15 standardized measures. Overall, structured clinical models provided the strongest measurable
16 psychological effects, while culturally integrated approaches enhanced contextual acceptability.
17 Combining both approaches may offer the most comprehensive benefit for postnatal listening
18 services.

19 **Comparative Effectiveness Across Intervention Models**

20 A comparative analysis across study designs indicates that structured clinical listening
21 interventions, particularly randomized controlled trials involving midwife-led debriefing or
22 counseling models, demonstrated the most consistent reductions in postpartum depression and
23 PTSD symptoms. These interventions were typically associated with statistically significant
24 decreases in EPDS, PCL-5, or DASS-21 scores following one to four structured sessions.

25 Quasi-experimental and observational studies also reported improvements in anxiety,
26 maternal functioning, and emotional processing; however, these designs provided limited causal
27 inference. Faith-integrated interventions implemented in Muslim-majority settings demonstrated
28 strong cultural acceptability and improvements in spiritual resilience, though most lacked long-
29 term follow-up data and standardized outcome measures.

30 Digital and telehealth-based interventions improved accessibility, particularly during the
31 COVID-19 pandemic, but were frequently associated with higher attrition rates and shorter
32 follow-up periods compared to face-to-face models.

33 **Variability and Contradictory Findings**

34 Although most studies reported positive outcomes, variability in effect magnitude and
35 methodological rigor was evident. For example, pilot or feasibility studies demonstrated high
36 acceptability but reported substantial dropout rates, limiting interpretation of sustained
37 effectiveness. Some observational studies indicated improvements in self-reported coping or
38 spirituality without statistically significant changes in standardized depression scores.

39 Additionally, heterogeneity in intervention duration, delivery format, outcome
40 measurement tools, and follow-up periods limited direct comparison of effect sizes. These
41 inconsistencies underscore the need for standardized intervention protocols and longer-term
42 evaluation.

Table 4. Thematic Review of Listening Interventions for Postpartum Trauma

First Author (Year)	Review Labour/ Birth Notes	Personal Accounts Shared	Emotional Responses Discussed	Emotional Responses Normalised	Therapeutic Elements (Coping/Anxiety)	Referral to Wider Support	Classified As
Small et al. (2020)	Yes	Yes (mothers shared their own accounts)	Yes (anxiety, sadness, trauma discussed)	Yes (validation of emotional experience)	Midwife-led debriefing helped reduce EPDS scores	Referral possible if needed	Structured clinical debriefing
Miriam et al. (2018)	Not explicitly	Yes (via telephone session)	Yes (stress and anxiety)	Partially	Feasible but high dropout rate	Limited	Pilot feasibility intervention
Bentley (2022)	No	Yes (based on Islamic trauma healing narratives)	Yes (distress within faith context)	Yes (normalized via Qur'an-based reflection)	Effective within Muslim community	Integrated in community practice	Faith-based trauma healing model
Nurbaiti et al. (2023)	No	Yes – spiritual reflection from adolescents	Yes (spiritual distress and growth)	Yes (through Islamic values)	Increased spirituality and acceptance	Not specified	Cultural-spiritual reflection
Sakineh et al. (2021)	No	Yes – via online session (Zoom)	Yes (postpartum anxiety)	Yes (normalized in group)	Anxiety reduced significantly	Not specified	Virtual group support
Aston et al. (2024)	No	Yes (parents' narratives in interviews)	Yes (emotional burdens and coping)	Yes (acknowledged by peers)	Emotional support highlighted	Not specified	Qualitative exploration
Baker et al. (2023)	No	Yes (through counseling sessions)	Yes (maternal stress discussed)	Yes (within counseling context)	Improved maternal functioning (BIMF)	Referral possible	Skills-based listening counseling
Rahman et al. (2021)	No	Yes (community discussions)	Yes (emotions shared)	Yes (normalized in religious group)	Affordable and socially relevant support	Yes (community links)	Community religious support
Mousavi et al. (2024)	Yes	Yes (traumatic birth accounts)	Yes (PTSD and depression openly discussed)	Yes (normalization key element)	CISD reduced PTSD scores	Yes (for severe cases)	Critical Incident Stress Debriefing
Abhar et al. (2020)	Yes	Yes (maternal narratives)	Yes (PTSD symptoms shared)	Yes (normalized by midwife)	Improved DASS-21 scores significantly	Yes (referral available)	Structured midwife counseling
Oliveira et al. (2022)	No	Yes (narrative counselling)	Yes (emotional processing)	Yes (acceptance promoted)	Enhanced self-control and acceptance	Not specified	Narrative therapy
Trinko et al. (2025)	No	Yes (via group sharing)	Yes (stress and mindfulness needs)	Yes (supported through group exercises)	Improved mindfulness and self-compassion	Yes (broader health education)	Matrescence-based education

Across the 12 included studies, most interventions emphasized narrative sharing of maternal experiences during labour and postpartum, which consistently facilitated the discussion of emotional responses such as anxiety, sadness, stress, and trauma. A common feature was the normalisation of emotions, achieved through midwife led validation (Abhari et al., 2020; Small et al., 2000), peer acknowledgement in groups, and integration of cultural-spiritual frameworks.

Therapeutic components varied: structured debriefing and counselling models demonstrated significant reductions in EPDS and PTSD scores, while narrative and mindfulness-based approaches enhanced self-acceptance and coping. Faith- and community-based interventions provided accessible and socially congruent support, strengthening maternal resilience in culturally diverse contexts. Importantly, several studies highlighted the need for referral pathways to specialised care for severe cases (e.g., PTSD, major depression).

Overall, the evidence indicates that listening-based interventions whether clinical, community, or spiritual are effective in reducing maternal psychological distress, normalising emotional responses, and promoting adaptive coping during the postpartum period (Bentley et al., 2022; Nurbaeti, 2023). The structured midwife-led debriefing and counseling models demonstrated the strongest empirical support for reducing postpartum psychological distress. Faith-integrated models showed high contextual relevance and enhanced emotional normalization in Muslim-majority settings, though standardized effect measurement was less consistent. Digital delivery formats improved access but presented challenges related to retention and engagement.

Interventions combining structured counseling with cultural-spiritual adaptation appeared to offer the most comprehensive benefits, addressing both psychological symptoms and meaning-making processes.

DISCUSSION

This rapid evidence review synthesized 12 empirical studies published between 2018 and 2025 examining postnatal listening services for women with traumatic or distressing birth experiences. The review assessed the efficacy, feasibility, and cultural sensitivity of these interventions across diverse healthcare contexts.

Positive Impact on Maternal Mental Health

Quantitative studies, including randomized controlled trials (Baker et al., 2024), consistently demonstrated significant reductions in postpartum psychological distress. Structured listening interventions (particularly those led by midwives) were associated with measurable decreases in EPDS, PTSD, DASS-21, BIMF scores. In total, 10 of the 12 included studies reported improvements in maternal outcomes such as anxiety, depression, and trauma symptoms. Nevertheless, effect magnitude varied across studies, and follow-up periods were generally short. Most outcomes were assessed within weeks or a few months postpartum, limiting conclusions regarding long-term sustainability. In addition, heterogeneity in intervention duration, delivery format, and outcome measurement tools restricts direct comparison of effect sizes.

These findings remain consistent with previous evidence suggesting that unresolved birth trauma may contribute to persistent maternal mental health disorders if not addressed promptly (Garapati et al., 2023). Early emotional support through listening sessions therefore plays a protective role, facilitating psychological recovery, reducing isolation, and fostering resilience (Horsch et al., 2024).

Emotional Validation and Narrative Reconstruction

Observational, Qualitative and mixed-method studies (Aston et al., 2024) emphasized the therapeutic importance of empathetic validation and reframing birth experiences. Women frequently described listening sessions as an opportunity to be “heard without judgment,” enabling reconstruction of traumatic narratives and restoration of control. However, these studies often relied on self-reported outcomes and small sample sizes, which may introduce response bias and limit generalizability. While qualitative findings provide important contextual depth, further

rigorous quantitative evaluation is required to establish replicability and broader applicability. (Trinko et al., 2025; Aston et al., 2024; Rezeck Nunes et al., 2019).

Spiritual and Cultural Dimensions in Islamic Contexts

A distinctive contribution of this review lies in the inclusion of studies conducted in Muslim-majority settings. Faith-integrated approaches incorporating Qur'anic affirmations, du'a, and acceptance of divine will (takdir) were reported to enhance emotional acceptance and spiritual resilience (Nasrin, 2025). These culturally embedded interventions demonstrated strong contextual relevance and community acceptability. Nevertheless, most faith-integrated studies were quasi-experimental or observational in design, with limited standardized outcome measures and smaller sample sizes. Consequently, while culturally tailored interventions appear promising, stronger experimental designs are needed to confirm their effectiveness beyond community-perceived benefit. Furthermore, the transferability of explicitly Islamic frameworks to non-Islamic or secular healthcare systems requires careful adaptation. In pluralistic settings, spiritual elements may need to be reframed within broader culturally sensitive or trauma-informed care models to ensure inclusivity and acceptability (Bentley et al., 2022; Nurbaeti, 2023; Hassan, 2022).

Feasibility and Innovation in Delivery Models

Listening interventions were delivered through in-person debriefing, telephone counseling, and virtual platforms. Digital delivery demonstrated feasibility, particularly during the COVID-19 pandemic and in geographically remote areas. Even brief or single-session formats yielded measurable psychological benefits in some studies. However, digital models were occasionally associated with higher attrition rates and variable engagement levels. Implementation in resource-limited contexts may also face structural barriers, including limited trained personnel, competing clinical priorities, and insufficient mental health infrastructure. Structured listening services require time allocation, supervision, and training, which may not be readily available in overstretched healthcare systems. (Mousavi et al., 2024; Aston et al., 2024; Sakineh et al., 2022).

Integration into Midwifery Practice

Embedding listening services into routine midwifery care aligns with continuity-of-care models and woman-centered practice philosophies. Midwives are strategically positioned to provide structured emotional debriefing with targeted training. Integrating such services into postpartum care may enhance maternal well-being and normalize emotional support as an essential component of maternal healthcare. Nonetheless, implementation feasibility depends on workforce capacity, institutional support, and integration within broader mental health referral systems. Without systemic reinforcement, listening interventions risk being perceived as optional rather than foundational components of postpartum care. (Omar et al., 2024; Trinko et al., 2025).

CONCLUSION

This rapid evidence review indicates that structured postnatal listening interventions are associated with improvements in maternal psychological well-being, particularly when delivered through midwife-led or trauma-informed models. Faith-integrated approaches implemented in Muslim-majority settings demonstrate strong cultural resonance and community acceptability, suggesting the value of culturally adapted emotional support services.

However, the current evidence base remains heterogeneous and limited by short follow-up periods and variability in methodological rigor. To advance the field, several priorities are recommended. First, the development of a standardized Islamic-informed listening framework is warranted. Such a framework should integrate trauma-informed care principles with culturally grounded concepts (e.g., *sabr*, *tawakkul*, and *maqashid shariah*) while incorporating validated psychological outcome measures to ensure both cultural and clinical robustness. Second, future research should prioritize multicenter randomized controlled trials with longer follow-up durations to evaluate the sustainability of psychological improvements beyond the immediate postpartum period. Third, implementation research is needed to assess feasibility, scalability, and

workforce training requirements across diverse healthcare systems, including secular, pluralistic, and resource-limited settings. Adaptation strategies should be explored to ensure inclusivity when applying culturally embedded models outside Muslim-majority contexts. Ultimately, integrating structured listening services into routine postpartum care may strengthen holistic maternal health services globally.

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