



Traumatised Midwives; Traumatised Women

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My recent PhD research explored the development of Post Traumatic Stress Disorder in women following childbirth. Almost half of all childbearing women find childbirth traumatic [\(1\)](#), and 1 in 25 subsequently develop full Post Traumatic Stress Disorder (PTSD) [\(2\)](#) ([Box A](#)).

Box A: Features of Post Traumatic Stress disorder

The traumatic event involved:

experiencing or witnessing,
actual or threatened,
death or harm.

Experiencing symptoms in the following groups for more than 1 month

1. Flashbacks/nightmares related to the trauma
2. Avoidance of reminders of the trauma
3. Negative beliefs/thoughts, shame, blame
4. Hypervigilance, irritability, anger.

Women may experience trauma due to physical birth complications, medical interventions, or poor outcomes for themselves or their babies. However, the strongest predictors for the development of PTSD following childbirth are interpersonal factors, with a woman's negative perception of interacting with her care providers being significant [\(3\)](#). Thus, the woman/midwife interaction was the key focus of

my research.

While many factors can influence midwives' interactions with women, here I discuss how witnessing women experiencing potentially traumatic birth events may compromise midwives' abilities to maintain positive interactions with women.

Secondary traumatic stress

Up to 60 times each year midwives may care for women who have been or are enduring a birth event where either the woman or her baby are at risk of, or suffer harm, which midwives may perceive as traumatic (4). Around 70% of midwives witness poor, disrespectful, or indifferent interpersonal care of women or high levels of obstetric interventions (Box B:1). Witnessing women's trauma leaves midwives feeling horror (intense feeling of fear, shock and disgust) and guilt, both emotions more likely when witnessing interpersonal care-related trauma. A normal response to witnessing trauma, particularly to multiple exposure and through helping or wanting to help women, is for midwives to experience Secondary Traumatic Stress (STS). This increases their risk of full PTSD, as experienced by 17% to 33% of midwives (5, 6), which wreaks havoc on their lives (7).

Midwives are particularly vulnerable to STS

Midwives provide uniquely intimate support to women, often carrying heightened senses of empathy and responsibility. Midwives can develop close mutual relationships with women that are transformative and comforting for both, but may challenge normal professional/client boundaries. Yet, maintaining such boundaries might damage the sensitivity, effectiveness, and satisfaction of their role (8). This strong emotional involvement often means midwives open themselves and put aside their own needs. So, when a traumatic event occurs they can feel unprepared, unsupported, and overwhelmed, with a sense of failure and personal bereavement (Box B: 2, 3).

Box B: Quotes from the midwife informants in my PhD study

1. *"Things were very badly managed, she was very badly treated (...) It's so frustrating. I was so angry!" Brenda*
2. *"You do feel your care's then substandard (...) feelings of 'oh' almost feelings of guilt actually" Susan*
3. *"cos I've not been able to do my job (...) really upset (...) really emotional" Brenda*
4. *"Sometimes I just switch off a little bit (...) that's a really bad thing to say but I think it's just self-protecting (...) you're battling all the time against the system (laughs)" Alice*
5. *"conflicts between everybody" (Rosie)*
6. *"go between the two kind of parallel universes (laughs) and sort of try and make a bridge" (Brenda).*
7. *"A lot of the time the outcomes are devastating for people and we don't have any support" Rosie*
8. *"Not engaging with them very well but it's, it's like a personal...protection...of me because I can't, I know I can't" Brenda.*

Torn between two models of care

As highlighted in my research, midwives experience distress through trying to offer intimate, connected support through a midwifery model of 'Care as Gift' that encompasses trust, commitment, generosity, openness, respect and love. This is difficult within a medicalised model of 'Vigil of Care' that is surveillance-orientated and where the professional holds power (8, 9) (Box B: 4, 5, 6). This conflict is worsened by a dysfunctional and toxic culture in many NHS maternity services. Lack of support, disrespect, undermining, and bullying are rife, with midwives feeling vulnerable, betrayed and abandoned by their peers, and even more so by management (Box B: 5, 7). This is particularly so for student and junior midwives (7).

The impact on midwives

During traumatic birth events, midwives describe feeling the agony of being powerless to protect women while feeling responsible. They experience guilt and horror, with a sense of failing and wondering what they could have done differently (8, 10). When organisational demands leave midwives unable to provide compassionate care and feeling complicit in poor care, this creates shame, blame and further guilt that hurts midwives (11). These issues are often deepened by midwives' personal stresses and prior traumas. Yet, the pressured environment means midwives are unable to disengage and process these emotions, leaving them very vulnerable to STS and PTSD (12-14).

"It adds another scar to my soul" (13) p 4194

For some midwives, STS can diminish over time. For others it can weaken their ability to adapt in future and lead to burnout, and a cycle of increased errors, more stress, more burnout. Midwives suffer extreme tiredness (6), become fearful, and their belief in the birth process is diminished (10). Midwives' confidence is damaged through this diminished belief alongside associated fears of causing harm or death, receiving criticism or facing litigation. Midwives cease to view childbirth as normal and natural and so increase vigilance, risk management, and the use of interventions (6, 8, 10). In order to cope and feel less guilt midwives may gradually change their aim to offer 'Care as Gift' and align themselves to the reality of the system (15). This can reduce job satisfaction and leave midwives struggling to maintain a professional role with women, sometimes to the point of leaving the profession.

The impact on midwives' interactions with women

Midwives' experiences of STS and conflicting care models within systemic pressures that leave no time to comfort women affected by traumatic events or allow midwives to take care of their own wellbeing, can result in midwives withdrawing or switching off from women. Midwives may suppress their emotions and present a hardened demeanour, thus becoming less empathic or compassionate towards women, no longer be willing or able to enter intimate mutual relationships with women (4) (Box B: 4, 8).

While this may protect midwives from further STS, the loss of empathy and compassion, alongside being

fearful, may lead to compromised care that ignores women and instils fear in women (6, 13). This is crucial, as for women who develop PTSD post childbirth, being ignored is the most frequent negative experience in women's interaction with midwives (3). My PhD research showed that positive interactions are most likely when the human needs of both women and midwives are acknowledged and met within the maternity care system, alongside the promotion and protection of compassionate woman/midwife relationships.

Positive growth for midwives

Following traumatic events and the development of STS, some midwives experience positive growth in areas of personal strength, appreciation of life, relating to others, spiritual change, and new possibilities. While personal characteristics influence this, being able to access safe, non-judgemental peer or managerial support to process their stories is beneficial (16). Often STS strengthens a midwife's resolve to better support women. They want their experience to inform and improve their practice and future collaboration with their colleagues. Positive growth following trauma can reduce fear and improve confidence. Midwives feel they can become better midwives, are able to maintain positive interactions and relationships with women and reduce their future risk of STS (6, 13).

The resilience of midwives versus organisational responsibility

Witnessing and being involved in traumatic childbirth events are inherent aspects of the midwife role. The ability to grow from these events or be brought down by them can depend on resilience. The responsibility for midwives to practice self-care and develop resilience is widely called for and an important skill in midwifery (17). However, when midwives experience trauma through witnessing poor interpersonal care; being prevented from providing best care due to systemic pressures; or being disrespected, undermined or bullied; the responsibility for improvement lies with the organisation. This requires NHS services to acknowledge and address damaging cultures. Throughout the hierarchy of staff, there must be an attitude of zero tolerance towards all actions and inactions that serve to undermine and harm midwives; damage care quality and interactions with women; and compromise midwives' abilities to cope during traumatic events.

When midwives experience trauma from witnessing adverse obstetric events or poor interpersonal care towards women, they require a non-judgemental culture in which their normal human responses and subsequent needs are acknowledged and appropriately responded to. This requires management to prioritise listening, providing time, offering nurturing care and psychological treatment as appropriate. Often, simply spending time with a sympathetic listener can help restore midwives to a place of equilibrium rather than trauma (12). Talking through traumatic experiences in a safe, supportive, non-judgemental environment can heal without scarring. Also, the traumatic event can be safely absorbed into the midwife's body of knowledge, while feelings of self-blame, responsibility, and incompetence can be alleviated. Midwives can explore how to do better rather than becoming defensive, which can help them offer and maintain positive compassionate interactions with women (13).

Take home points

1. Midwives can experience STS and PTSD from witnessing traumatic birth events or poor interpersonal care of women, or from conflict between models of midwifery care and working within a toxic culture.
2. STS and PTSD negatively impact on midwives' lives and wellbeing and their abilities to provide positive compassionate interactions with women.
3. Women's negative perceptions of their interactions with midwives is a significant factor in the development of PTSD in women following childbirth.

Steps for improvement

1. A non-judgmental culture is required to acknowledge and respond to midwives needs.
2. Damaging workplace cultures must be recognised and addressed.
3. An attitude of zero tolerance needs to be developed towards actions/inactions that undermine midwives' interactions with women.

While individual midwives can strive to support peers and challenge damaging behaviour, the ultimate responsibility lies at the highest levels. Such steps need to be sanctioned and upheld across UK maternity services by CCG's, Trusts, Health Boards, and management.

Improving the workplace culture and addressing midwives' needs will improve not only the working lives of midwives, but their interactions with women, and thus, women's mental health outcomes.

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