

RUNNING HEAD: The experience and impact of traumatic perinatal event experiences in 1
midwives

1 ABSTRACT

2 **Background:** Through their work midwives may experience distressing events that fulfil
3 criteria for trauma. However there is a paucity of research examining the impact of these
4 events, or what is perceived to be helpful/unhelpful by midwives afterwards. **Objective:** To
5 investigate midwives' experiences of traumatic perinatal events, and to provide insights into
6 experiences and responses reported by midwives with and without subsequent posttraumatic
7 stress symptoms. **Design:** Semi-structured telephone interviews were conducted with a
8 purposive sample of midwives following participation in a previous postal survey.

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10 **Methods:** 35 midwives who had all experienced a traumatic perinatal event defined using
11 the Diagnostic and Statistical Manual of Mental Disorders (version IV) Criterion A for
12 posttraumatic stress disorder were interviewed. Two groups of midwives with high or low
13 distress (as reported during the postal survey) were purposefully recruited. High distress was
14 defined as presence of clinical levels of PTSD symptomatology and high perceived
15 impairment in terms of impacts on daily life. Low distress was defined as any symptoms of
16 PTSD present were below clinical threshold and low perceived life impairment. Interviews
17 were analysed using template analysis, an iterative process of organising and coding
18 qualitative data chosen for this study for its flexibility. An initial template of four *a priori* codes
19 was used to structure the analysis: event characteristics, perceived responses and impacts,
20 supportive and helpful strategies and reflection of change over time Codes were amended,
21 integrated and collapsed as appropriate through the process of analysis. A final template of
22 themes from each group is presented together with differences outlined where applicable.

23
24 **Results:** Event characteristics were similar between groups, and involved severe,
25 unexpected episodes contributing to feeling 'out of a comfort zone.' Emotional upset, self-
26 blame and feelings of vulnerability to investigative procedures were reported. High distress
27 midwives were more likely to report being personally upset by events and to perceive all
28 aspects of personal and professional lives to be affected. Both groups valued talking about
29 the event with peers, but perceived support from senior colleagues and supervisors to be
30 either absent or inappropriate following their experience; however, those with high distress
31 were more likely to endorse this view and report a perceived need to seek external input.

32 **Conclusion:** Findings indicate a need to consider effective ways of promoting and facilitating
33 access to support, at both a personal and organisational level, for midwives following the
34 experience of a traumatic perinatal event.

35
36 **KEYWORDS.** Indirect exposure to trauma, midwives, posttraumatic stress, template analysis

37

1 CONTRIBUTION OF THE PAPER

2 What is already known about the topic?

- 3 • Maternity professionals may encounter events that fulfil criteria for trauma whilst
4 providing care to women, with potential implications for their own psychological
5 wellbeing
6 • There is a paucity of research considering the experience, impact and management
7 of responses as reported by midwives following exposure to traumatic perinatal
8 events

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10 What this paper adds:

- 11 • Findings from this interview study indicate that the characteristics of traumatic
12 perinatal events were similar between midwives with high and low levels of resulting
13 distress, but that differences arose in the appraisal of responses, impacts and receipt
14 of support
15 • Midwives valued the opportunity to talk about their experience with peers, but felt that
16 access to support from clinical midwifery managers or supervisors of midwives was
17 not always available or accessible; midwives with high distress sought external input
18 • Midwives with high distress following a traumatic perinatal event were more likely to
19 feel personally upset and perceive all aspects of their life (personal and professional)
20 to be adversely affected

21

1 MAIN TEXT

2

3 INTRODUCTION

4 Adverse perinatal events are rare in the developed world. However, situations can arise
5 where there is a potential threat to the mother or her child, which can fulfil criteria for trauma
6 (APA, 2013). The potential for mothers to experience birth as traumatic has been identified in
7 previous research (Czarnocka & Slade, 2000). There is a paucity of research considering the
8 experiences of midwives who, through providing care during the perinatal period, may also
9 encounter difficult events that they perceive to be traumatic (Sheen, Spiby & Slade, 2014).

10

11 Indirect exposure to trauma can elicit posttraumatic stress disorder (PTSD). PTSD is
12 characterised by involuntary and distressing recollections of the traumatic event in the form
13 of flashbacks, nightmares and intrusive imagery. These responses occur with avoidance of
14 reminders (people, places, thoughts) of the event and heightened arousal, where
15 concentration and sleep can be disrupted. PTSD also encompasses alterations to worldview
16 beliefs and affective states, including feelings of guilt, fear or shame (APA, 2013).

17

18 Emerging international research highlights the potential for maternity professionals to
19 experience some maternity events as traumatic, and for a proportion to develop PTSD
20 symptoms (Beck & Gable, 2012; Goldbort et al., 2011). Beck and Gable (2012) reported that
21 a third of surveyed US labour and delivery nurses (total n= 464) experienced symptoms
22 synonymous with PTSD after a difficult obstetric experience encountered through
23 professional practice. A qualitative study of US intrapartum nurses reported evidence of
24 flashbacks following traumatic birthing events (Goldbort et al., 2011). Variations in role
25 autonomy between maternity professionals in different contexts (Malott et al., 2008) and
26 limited research with UK midwives indicate a need for specific exploration, especially where
27 compassionate care is a contemporary policy driver (Department of Health, 2012).

28

29 Sheen, Spiby and Slade (2015) conducted the first large-scale UK survey of midwives' (n=
30 421) experiences of traumatic perinatal events. One third of respondents to the survey
31 reported clinically significant levels of PTS symptoms. However the overall response rate
32 was low at 16% (n=464), with 90% (n= 421) reporting an experience of trauma. It is likely
33 respondents were those for whom the survey was most relevant and therefore biased to
34 those with distress. To be conservative in any extrapolation of findings in reporting we have
35 assumed that the survey respondents included all midwives experiencing distress following a
36 traumatic perinatal event, and that all non-respondents were entirely non-symptomatic. Using
37 these conservative assumptions the findings still indicate that at a minimum of 1 in 6 UK

1 midwives have experienced trauma, and that 1 in 20 are suffering with clinically significant
2 posttraumatic stress symptoms. This will certainly underestimate the number of midwives
3 with difficulty as some will not have returned their questionnaire due to, for example, potential
4 for distress from recounting their experience,

5
6 Experiencing trauma had implications for midwives' personal and professional wellbeing.
7 Midwives reported taking time away from practice, changing their clinical allocation and
8 considering leaving midwifery following their traumatic perinatal experience. The majority of
9 people who experience a traumatic event will not develop PTSD (Ehlers & Clark, 2000). It is
10 useful to compare perceptions of individuals with and without elevated levels of distress
11 following trauma exposure, to identify any differences in experiences, impacts or receipt of
12 support. Through this, preventive and supportive strategies can be developed.

13 14 **Aim**

15 To provide an in-depth investigation into the experience, perceived impact and management
16 of responses in midwives.

17 18 **Design**

19 Semi-structured telephone interviews were conducted with a purposive sample of midwives
20 following participation in a postal survey (Sheen et al., 2015).

21 22 **Ethical Approval**

23 Ethical approval was obtained in May 2011 from the Department of Psychology at the
24 University of Sheffield. Representatives from the Royal College of Midwives' (RCM)
25 Education and Research Committee reviewed the aims and methods of the research and
26 considered it acceptable for members.

27 28 **Procedure**

29 The initial sample was a random sample of qualified midwives, contacted via the Royal
30 College of Midwives (please see Sheen et al., 2015 for a detailed procedure). All midwives in
31 this sample had experienced at least one traumatic perinatal event corresponding to Criterion
32 A of the DSM-IV for PTSD (APA, 2000). Midwives were sent a questionnaire, and as part of
33 this they could indicate willingness to take part in a telephone interview about a traumatic
34 perinatal experience. The questionnaire included scales measuring PTSD (Impact of Event
35 Scale-Revised; IES-R; Weiss & Marmar, 1987) and perceived impairment to home, social
36 and work life (Sheehan Disability Scale; SDS; Sheehan, 1983). Scores >33 on the IES-R

1 were considered to indicate clinical levels of PTSD symptoms (Rash et al., 2008) and scores
2 >4 on the SDS were inferred to indicate high impairment.

3
4 The sample for the present study was recruited from midwives who consented to be
5 contacted and either 1) scored >33 on the IES-R and >4 on all SDS subscales or 2) scored
6 <34 on the IES-R and <5 on all subscales of the SDS. Thus two groups were formed; high
7 distress (n= 16; HH; high PTS symptoms and high impairment) and low distress (n= 19; LL;
8 low PTS symptoms and low impairment). An additional 'mixed distress' group was formed
9 (high PTS, low impairment; n=5). However the small sample limited cohesion in midwives'
10 descriptions and so these are not presented in this analysis. As would be expected no
11 midwives reported low distress and high impairment. Midwives who consented to interview
12 were informed that the purpose of the study was to explore their experience of a traumatic
13 perinatal event.

14 **Interview Guide**

15 The interview guide included four sections; event characteristics, perceived response and
16 impact, supportive and helpful strategies and reflection of change over time. The guide was
17 piloted with three midwives (one HH, two LL) and an amendment was made to recheck the
18 criteria for a traumatic perinatal event immediately prior to commencing the interview. Pilot
19 interviews were not included in the final analysis.

20

21 **Data collection**

22 Semi-structured, one-to-one telephone interviews of up to one hour were conducted between
23 August and December 2012 by the first author. All interviews were digitally recorded and
24 transcribed verbatim.

25 **Analysis**

26 Transcripts were analysed using template analysis (King, 2012). This method was selected
27 for its flexibility and utility in structuring analysis according to initial areas as identified in an
28 outline template, whilst allowing for the main focus to be population of the template by
29 emergent subthemes. However if indicated by the data, there can also be emergence of new
30 main themes or restructuring/collapsing of initial themes. The initial 'template' consisted of
31 four *a priori* codes; event characteristics, responses and impacts, supportive and helpful
32 strategies and reflections over time. Analysis began with close reading of the text and
33 preliminary open coding. The template was developed through an iterative process of
34 discussion between the researcher (KS) and supervisors (PS and HS). Emergent patterns
35 across interviews were identified and codes merged or amended. Four iterations of the

1 template were conducted. The final template was developed through discussion with the
2 supervisory team and checks for contradictory evidence were routinely employed.

3
4 Interviews from each group (HH and LL) were analysed separately. The penultimate
5 template for the HH group provided a framework to compare with the LL group. The final
6 template included themes identified in both groups and themes distinct to one group only.
7 Table 2 displays the final template; distinct themes are denoted in **bold**.

8
9 **Analytic approach**

10 Midwives' reports were considered to provide an insight into the experience of a traumatic
11 perinatal event but it was assumed that these perspectives were constructed from personal,
12 social and contextual circumstances.

13
14 **Reflexivity**

15 Reflexivity in qualitative research acknowledges the potential for the interviewer's personal
16 disposition to influence the interpretation of data (Finlay, 2002). The researcher was a
17 Psychology postgraduate student with no personal experience of childbearing but awareness
18 of the potential impact of indirect trauma exposure. Potential for bias was managed by
19 adopting clear focus throughout the interview process; to explore midwives' experiences from
20 their perspective.

21
22 RESULTS

23
24 Demographic details of midwives are provided in Table 1. Midwives in both groups reported
25 a similar number of traumatic perinatal experiences throughout their career (Table 1). Thirty
26 percent (31% HH, 32% LL) of midwives had experienced a traumatic perinatal event during
27 the year prior to the interview. Themes are displayed in Table 2.

28
29 **1. Event characteristics (4 themes)**

30 Themes in this section related to aspects that were perceived to increase difficulty during the
31 traumatic perinatal event. The first three were present in both groups. The fourth theme was
32 salient for midwives with high distress only.

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34 **1.1. Sudden, unpredictable and uncontrollable events (HH and LL)**

35 Events were severe and sudden;
36

1 *“You know, you can get help in but when it is unexpected and everything’s been so*
2 *low risk and low key and then it goes from joy to utter trauma and devastation in the*
3 *flick of a coin [ID 40, LL]*

4

5 Some events included situations where access to personnel or resources was limited or
6 delayed; for example, when waiting a long time for theatre staff to arrive;

7

8 *“We were all there scrubbed in theatre and basically it was- we were there for twenty-*
9 *nine minutes. And it was just horrendous, you know. And we knew this baby had*
10 *died, and we just were helpless you know, we couldn’t do anything about it all.” [ID*
11 *203, HH]*

12

13 Midwives reported encountering events that were unlike any of their previous experiences,
14 attributed either to a limited professional experience or the unusual severity of the situation.

15

16 *“I was a Band 5 midwife at the time I was newly qualified and when you’re a student*
17 *midwife you always have a midwife working with you and to suddenly be on your own*
18 *in a situation that you really don’t feel comfortable in” [ID 433, HH]*

19

20 *“I mean don’t get me wrong I’d seen babies die before. But nothing – not – you know*
21 *an unexpected stillbirth at delivery at term and it is so phenomenally rare [...]” [ID 387,*
22 *LL]*

23

24 This contributed to a general perception that ‘everything was going wrong,’ especially where
25 multiple obstetric complications occurred in succession, or where attempts to improve the
26 situation were ineffective.

27

28 *“I just wanted to shout ‘for God’s sake just get the baby out.’” [ID 129, HH”]*

29

30 **1.2. Responding to the parents (HH and LL)**

31 Midwives perceived events to be more difficult when they held an existing relationship with
32 the mother;

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34 *“Although it’s a horrible, you know - it’s a horrible experience- it’s not...overall it’s*
35 *worse if you’ve got a relationship with them.” [ID 458, LL]*

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37 Some midwives reported difficulties when relaying sad news to parents;

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“...the absolute worst bit was walking back into that room with that dead baby in my arms and telling the parents [...] and that was just the worse thing I’ve truly ever done. And that woman’s scream will live with me forever.” [ID 40, LL]

Midwives were aware that mothers and their partners were upset by the event, and tried to ‘buffer’ the impact of the event for them through providing additional support, reassurance and ensuring that communication was as effective as it could be.

“I had anxieties because obviously the woman was anxious. I’m trying to calm her down and reassure her at the same time.” [ID 129, HH]

There was a distinction identified in this theme; midwives with high distress appraised implications of the event in a personal way, and reported feeling personally upset following the event.

“Well they, you know that person has lost a child, lost their baby, and they’re in shock, you equally as the midwife are in shock, you haven’t lost the baby but because of the relationship that you build up with the women that you care for you know there is this extended feelings of going through a journey with them. [...] So you feel shocked as well at what’s happened [...] you go down that grief trajectory definitely.” [ID 242, HH]

In contrast, midwives with low distress acknowledged the sadness of the event for the parents, but did not report feeling personally affected.

“Just that, ‘oh god what a waste of a’ – you know cause he was such a perfect little baby – what a waste of a little life.” [ID 172, LL]

1.3. Managing feelings to maintain a professional appearance (HH and LL)

Both groups reported ‘going into auto-pilot’, ignoring their feelings and focusing on completing the relevant procedures, in order to maintain a professional appearance.

“...you have to maintain an air of professionalism when you’re at work [...] I’m not saying you should never well up in front of a parent but actually your responsibility is to look after them not make them feel any worse than they feel already. So I think you hold it in all the time you’re at work.” [ID 129, HH]

1 However, after the event had occurred, those with high distress struggled to carry on in their
2 duties;

3

4 *“[...] it's a spiral that happens emotionally, you're a spinning top, you can't really have*
5 *a conversation, I don't think I was capable of having a conversation you know, until*
6 *maybe after a week.” [ID 242, HH]*

7

8 Midwives with low distress were able to maintain the 'auto pilot' and continue with less
9 difficulty.

10

11 *“So in that first hour or so of just continuing with the clinic that automatic pilot cut in -*
12 *and obviously I'm middle aged I've been in this field for 30 years, so perhaps that*
13 *enabled me to just carry on like that.” [ID 320, LL]*

14

15 **1.4. Feelings of isolation (HH only)**

16 A sense of physical and psychological isolation during the event was identified only in the
17 high distress group. Midwives did not feel supported or listened to by colleagues during the
18 situation or where they disagreed with the clinical decisions made by other members of staff.

19

20 *“I felt as if I was... quite low... my knowledge and experience weren't being taken into*
21 *consideration. I felt kind of lowly on the part of the decision making process. So I*
22 *was like the bottom of the pile really. I felt like I was the least important person*
23 *whose opinion counted.” [ID 129, HH]*

24

25 **2. Initial response and impacts (6 themes)**

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27 This section included midwives' perceptions of their initial responses to the event, and the
28 way in which their lives were impacted over time.

29

30 **2.1. Emotionally distraught; feelings of shock and despair (HH and LL)**

31 A powerful sense of initial emotional upset and shock was reported by midwives from both
32 groups.

33

34 *“It's a sense of disbelief. It's so horrific that it's too big for your head. Almost too big*
35 *for your brain to grasp and of course there's the human side of you that's witnessing*
36 *this awful tragedy and then there's the professional side where you have a role. You*
37 *know you can't crumble.” [ID 362, LL]*

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However, midwives with low distress also acknowledged that they were not alone in feeling like this.

“My colleague came back and was just the same – I mean she was more shocked than me because she entered the labour room and I said oh my god [name omitted] baby’s dead. And she just went – she was in more shock than I was and that shocked me- her, you know, she just – she went to pieces nearly. Went and started crying and ‘oh my god’ you know. [...] I mean we were all upset.” [ID 172, LL]

2.2. Self-blame and guilt (HH and LL)

Uncertainty about the cause of many events led midwives from both groups to automatically question their practice after the event;

“I put added stress on myself by beating myself up about the fact that could I have done something about it? That was the overwhelming feeling of what could I have done differently.” [ID 129, HH]

This led to feelings of guilt and self-blame, and midwives reported feeling that they had ‘let the mother down’ when a birthing episode ended with an unfortunate outcome.

“I felt that I’d let them down, you know even though it was beyond my control and there was nothing that I could have done about it [...] I knew that, but it was my job to present them with a healthy baby, that’s what midwives do, they look after mothers don’t they and at the end that is the end result and everybody’s happy.” [ID 362, LL]

2.3. Attempting to make sense of what happened (HH and LL)

Due to the ambiguous nature of many of the events reported, midwives attempted to process details of their experience and reported a period of rumination. This was sometimes voluntary (i.e., purposefully replaying the event) but for some this was involuntary;

“Oh it – I was very upset actually. Just couldn’t get her out of my mind. It was constantly on my mind and then you know the day that I was told that she’d died was very, very sad.” [ID 108 LL]

Midwives also attempted to ‘pull together’ facts of the event, by calling the ward after the event to ascertain the outcome or seeking diagnostic information.

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“...you know when you’ve pieced the jigsaw together, the reason was the baby was born with haemolytic strep which is an infection. Now that was the cause you know- if you start to unpick.” [ID 242, HH]

2.4. Feelings of vulnerability and judgement (HH and LL)

Midwives in both groups felt vulnerable to investigative procedures that were taking place, however the nature of this vulnerability differed in focus between groups.

“Because of the high level of people that were in the room. People who – you know the head consultants were there. Representative chief executive of the hospital was there. You know, these people you only just hear their names you don’t actually sit around a table with them and to suddenly have to give a resume of what happened [...]” [ID 108, LL]

Midwives with low distress felt intimidated by the seriousness of the investigative procedures; however, they also recognised that such procedures were not necessarily to apportion blame.

“I had to write a statement out [...] so that was rather sort of disconcerting but you know that’s what they have to do” [ID 362, LL]

In contrast, midwives with high distress were more likely to feel that they personally (and their practice in general) were under scrutiny.

“So what they then do is like ask other people, so what else has she done this midwife that is bad? So like, punitive against you.” [ID 203, HH]

Some in the HH group but none in the LL group perceived investigative procedures to be ‘heavy handed,’ and to feel personally ‘punished’ as a result.

“I was absolutely devastated. Absolutely, I broke down, I was sobbing and I just thought I’d done nothing to hurt this person, this mum, nothing at all. I went to the funeral because she wanted me to go to the funeral and all they’ve done is... I feel like I’m being punished.” [ID 328, HH]

2.5. A permeating impact on professional life (HH and LL)

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1 For both groups, the impact of the event permeated aspects of professional life. Midwives
2 reported practising in an increasingly defensive manner to prevent similar occurrences
3 happening again or felt less confident in their practice.

4
5 *“Just if anybody had a tweak or a pain or a twinge I was nearly on overkill then. You*
6 *know just - when maybe there was no reason to worry, I was worrying because I*
7 *didn't want things to go wrong again, you know- just being over anxious.” [ID 358,*
8 *HH]*

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10 Some midwives also reported considering leaving midwifery, or changing their clinical
11 allocation as a result;

12
13 *“It actually led me to look for other work outside of the acute side of midwifery and I*
14 *actually got a job to go and work out in the Community because I couldn't, I really*
15 *couldn't face having to work in the same environment where that potential situation*
16 *could have happened again.” [ID 15, HH]*

17
18 Midwives with high distress reported impacts to their personal lives; for example, becoming
19 fearful about potential adverse events occurring to other people in their life or vigilant for the
20 safety of those around them.

21
22 *“No it sort of just set off this anxiety in me. I think it was almost like vulnerability of life*
23 *or something. [...] Like one of my daughters – just her driving. She'd been driving for*
24 *several years. She drives around all the time. And suddenly I was worried – she's*
25 *out driving, she might have an accident. Nothing at all relating to the actual thing.” [ID*
26 *251]*

27
28 Midwives with high distress also noticed changes in the way they felt or their general
29 demeanour following the event. This ranged in severity, with some midwives reporting feeling
30 low in their mood and withdrawn, to others reporting serious implications for their
31 psychological health. Family and home lives were also impacted.

32
33 *“Personally it has really affected me because, well it ruined my relationship with my*
34 *ex-husband, my divorce, my children- they have all suffered because of it.” [ID 203,*
35 *HH]*

36

37 **2.6. An enduring psychological impact (HH and LL)**

1 Both groups reported the memory of the traumatic perinatal event as vivid and enduring.

2

3 *"I can't forget it. I can't forget it. I can still see the lady's face. I can't forget that. I'm*
4 *not going to forget it."* [ID 316, HH]

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6 However, unlike midwives with high distress, midwives with low distress reported being able
7 to recall their traumatic experience without negative affect.

8

9 *"It's not something that haunts me or anything"* [ID 391, LL]

10

11 **3. Helpful aspects and use of support (4 themes)**

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13 This section included ways that midwives attempted to manage any responses to traumatic
14 perinatal events, and their perceptions of accessing and receiving support.

15

16 **3.1. Taking steps to prevent a similar occurrence from happening again (HH and** 17 **LL)**

18 Midwives valued the opportunity to learn from their experience and improve their future
19 practice, to prevent a similar occurrence (or feeling a similar way). This included practical
20 changes to procedure or protocol in organisational settings and personal changes to
21 practice, such as becoming more assertive.

22

23 *"I've used it as a learning tool, I've kind of tried to turn it the other way round and think*
24 *what can I use from this, and I've used it to develop my confidence back again, I've*
25 *used it to cope with similar scenarios, how I deal with those kind of stressful*
26 *scenarios [...]"* [ID 15, HH]

27

28 **3.2. Helpful strategies to manage responses in personal lives (HH and LL)**

29 Midwives reported implementing coping strategies in their personal lives.

30

31 *"Yeah I just, I just need that hour and you know just once a week just knowing that I*
32 *could just clear my mind, clear my thoughts, switch my phone off. My kids were in*
33 *school safe and that was just an hour for me."* [ID 172 LL]

34

35 There were also reports in both groups, albeit predominantly reported by those with low
36 distress, of speaking about events with partners.

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1 *"My husband's almost a midwife by proxy I think really [laugh]" [ID 391, LL]*

2
3 **3.3. Wanting to talk about it: accessing and receiving helpful support from peers**
4 **(HH and LL)**

5 Speaking to colleagues about the event was a valuable source of support for midwives in
6 both groups however it was more prominently reported by midwives with low levels of
7 distress.

8
9 *"Once you've talked to somebody about it properly it's as if a weight is just lifted off*
10 *your shoulders and you can actually speak about it and you feel like you, you know*
11 *you've just got it off your chest and you can sort of move on in a way." [ID 433, HH]*

12
13 Midwives particularly valued speaking to colleagues with similar (traumatic) experiences.

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15 *"So I think there is definitely you know a source of support from the sort professional*
16 *subculture in a way that you know only somebody who's been through what you've*
17 *been through can understand you know how you cope with it." [ID 283, LL]*

18
19 Talking about the event was reported as a helpful way to reduce personal feelings of
20 culpability. However there was a distinction in the mechanism behind the helpfulness of this
21 between groups. Midwives with high distress valued emotional support and reassurance.

22
23 *"I just needed somebody telling me that it wasn't all my fault." [ID 358, HH]*

24
25 However midwives with low distress valued talking through the event with colleagues as a
26 method of gaining an objective perspective of the event.

27
28 *"I think it's incredibly helpful to talk things through and I think even explaining this to*
29 *you so thoroughly actually confirms with me that yes you know its ok now" [ID 320,*
30 *LL]*

31
32 **3.4. Perceived absence or inappropriateness of support from senior colleagues or**
33 **senior management (HH and LL)**

34 There were mixed perceptions about the nature of support received from senior managers or
35 colleagues. Whilst there was evidence for some midwives accessing helpful support from
36 their supervisor of midwives, a predominant perception reported by both groups was that
37 support from senior colleagues or management was lacking;

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“It’s often you know on a tick list that the parents have been debriefed. It’s never on the tick list that the staff have debriefed.” [ID 207, LL]

Furthermore, midwives in both groups felt that the focus of any contact with senior colleagues was to determine the extent of wrongdoing, rather than to ascertain the nature of impact upon them.

“When I actually saw her that she wasn’t in the least bit interested in making feel better about it or anything else. She just wanted to analyse her notes to see where we could get sued or not if necessary. I didn’t feel at all that she was doing it any way to support me.” [ID 251, HH]

A small proportion of midwives with high distress felt that support was inaccessible, or that senior colleagues and managers did not acknowledge or understand the nature of impact that the event held for them.

“Yeah, I don’t get any support really. There’s nobody really I can go to. They say you can go to your supervisor. But my supervisor isn’t always available. And she can be busy.” [ID 10, HH]

Some midwives with high distress reported a need to seek professional input. Where the source of this input was indicated, this included counselling. Midwives with low levels of distress acknowledged that external support was available for them, but did not perceive this as necessary.

“It’s been easier just to have counselling - to kind of talk it through with somebody that way.” [ID 57, HH]

4. Reflective statements (4 themes)

The final section relates to general perceptions held by midwives about the nature of impacts over time, and contextual issues about practice that are influenced by or associated with the experience of traumatic perinatal events.

4.1. ‘Overcoming the impact’: Gaining acceptance and the value of time (HH and LL)

1 Midwives in both groups reported obtaining a sense of acceptance about the inevitability of
2 experiencing an adverse event that would be personally distressing for them at a point during
3 their career.

4
5 *"You can't prevent it from happening no matter how scientifically advanced we get."*
6 *[ID 129, HH]*

7
8 Midwives with low distress, however, also reported an acknowledgement of their own (and
9 other people's in general) limitations in preventing or improving adverse situations.

10
11 *"I suppose for me it made me rationalise that you can do your very best for somebody*
12 *but still have a poor outcome and that doesn't mean it's anybody's fault it's just that,*
13 *you know, we're not Gods and we can't solve everything."* [ID 283, LL]

14
15 Midwives with high distress reported that, over time, the severity of response was
16 diminishing. This was particularly facilitated where midwives attended subsequent, positive
17 birthing episodes.

18
19 *"I had a lovely home birth last night. You know that was lovely. Restored my faith in*
20 *midwifery completely. You know when you have a bad week and you have a lovely*
21 *delivery experience you just think 'oh I know why I'm doing the job now.'" [ID 316, HH]*

22 23 **4.2. Working in the context of a stressful job (HH and LL)**

24 Midwives perceived that they worked within a 'blame culture,' and felt that adverse
25 occurrences were naturally followed by attempts to assess culpability in their working
26 environment.

27
28 *"Unfortunately in this country there is a blame culture in maternity services that*
29 *parents do want to blame the midwife when anything goes wrong you know and*
30 *everybody expects a wonderful outcome and unfortunately babies do die in this*
31 *country of unknown causes."* [ID 172, LL]

32
33 Midwives also reported feelings of stress from their role; however, the nature of this stress
34 differed between groups. Midwives with high levels of distress reported feelings of stress
35 specifically in relation to a perceived lack of staff, low morale in the workplace, and limited
36 resources in their job role.

1 *“But it’s so- what I feel is they force you into these emergency situations and the way*
2 *that everything is organised is just dangerous in some ways. You know? And this*
3 *becoming more and more with all the staff shortages and whatever.” [ID 203, HH]*

4
5 However midwives with low distress reported feelings of stress that were more generalised,
6 and related to the high level of responsibility that is intrinsic to the midwifery role. This was a
7 generalised recognition that their role as a midwife held significant responsibility that,
8 although stressful, could not be realistically avoided.

9
10 *“Basically every day we go to work you just put your life on the line really, your career*
11 *on the line that’s how it feels. This is just one really easy example of that.” [ID 223,*
12 *LL]*

14 **4.3. Events contradicting the public perception of childbirth (HH and LL)**

15 There was reference also to the difference between the way in which childbirth, and
16 midwifery as a profession, differed in reality to public perceptions or expectations.

17
18 *“You can do all you can and it still doesn’t always work, which is not what people*
19 *come in for when they expect to come out with a nice, happy baby don’t they - that’s*
20 *there laughing and crying with them, that they can take home, and you know you feel*
21 *a bit of a failure yourself if you can’t achieve that for them.” [ID 25, LL]*

23 **4.4. Recognition of a need for change (HH and LL)**

24 Midwives felt that aspects of their working environment could be altered to increase the
25 amount of personalised support available.

26
27 *“There needs to be some, a better support network particularly for the younger*
28 *midwives and you know, or less experienced midwives coming forward [...] it can be*
29 *isolating for some people and if they haven’t got anybody to go to, to talk to, then that*
30 *obviously, you know can lead to you know people having unnecessary time off work,*
31 *depression.” [ID 293, LL]*

32
33 Midwives with high distress felt unprepared to experience trauma through their professional
34 practice.

35
36 *“You don’t get any formal training. I don’t remember at any point in my training*
37 *someone saying you’re going to have something that will happen to you in your*

1 *career that will make you never want to go back to work and will make you doubt your*
2 *ability to do your job properly [...] Because you prepare soldiers on the battlefield for*
3 *how they might feel when they get home. I'm not likening it to a battlefield but it's still*
4 *a traumatic event." [ID 129, LL]*

5

6 DISCUSSION

7 This study provided the first in-depth investigation into the experience, perceived impacts
8 and helpful or supportive strategies used by UK midwives who experienced a work-related
9 traumatic perinatal event. Comparison of midwives with high or low resulting distress
10 highlights differences in the perceived impact and receipt of support between groups. Whilst
11 there may be some differences in professional roles and scope of practice between different
12 countries (Malott et al., 2008), midwives and nurse-midwives in other settings are likely to
13 experience similar obstetric events or involvement in investigations of adverse events. These
14 factors render the findings of this research of international importance.

15

16 *Event characteristics*

17 There was a high degree of similarity in events described by midwives with both high and low
18 levels of resulting distress, suggesting that the groups differed not in the nature of the events
19 experienced, but in the appraisal of impacts and the receipt of support.

20

21 Existing relationships with families for whom they were providing care was perceived to
22 increase difficulty. Findings are consistent with a qualitative study with Australian midwives,
23 where 'feeling for the woman' was perceived to increase the likelihood of experiencing an
24 event as traumatic (Rice & Warland, 2013), and a recent mixed-methods survey with
25 American nurse-midwives where presence of a bond with the mother was an element
26 identified in their reported experiences (Beck, LoGiudice & Gable, 2015). Findings from our
27 study emphasises relationships with women receiving care as a potential vulnerability factor
28 for midwives.

29

30 Quantitative analysis of findings from our previous postal survey, which included respondents
31 from this interview study, did not identify a statistical association between the number of
32 years experience in the profession and PTS symptomatology (Sheen et al., 2015). However
33 findings from this in-depth analysis highlights a vulnerability for midwives with fewer years
34 working as a midwife perceiving events as traumatic and indicates the requirement for
35 preventative strategies or increased support for more junior members of staff.

36

1 Midwives identified a need to manage personal feelings during events to maintain a
2 professional appearance. Managing feelings to conform to perceived 'feeling rules' within an
3 organisational climate (Hochschild, 1983, p. 7) is referred to as 'emotion work,' which is
4 associated with increased feelings of stress and can contribute to burnout (Mackin & Sinclair,
5 1998).

6

7 *Initial response and impacts*

8 Midwives reported practising in an increasingly defensive manner (e.g., intervening sooner
9 than they may have done previously). Whilst defensive practice of this kind is not necessarily
10 harmful for mothers, it is associated with the potential for increasing interventions (Symon,
11 2000). Midwives also reported changing their clinical allocation or considering leaving the
12 profession altogether. This is consistent with recent research with American nurse midwives
13 where changing allocation or leaving midwifery were identified implications of witnessing
14 traumatic birth (Beck et al., 2015). With existing strain on maternity services in the UK (in
15 part) due to a rising birth rate and general shortfall of midwifery staff (RCM, 2013); supporting
16 midwives and preventing further attrition from the workforce is essential.

17

18 The guilt and self-blame reported by midwives parallel findings from a smaller qualitative
19 study of Australian midwives who reported feeling as though they had "failed" the mother,
20 even when not directly responsible after an adverse event (Rice & Warland, 2013, p. 1060).
21 Feelings of guilt are also implicated in the development of PTS responses (Ehlers & Clark,
22 2000), and therefore may require further attention when developing preventative
23 interventions.

24

25 Furthermore, ruminative thoughts about a traumatic event predict, and are associated with,
26 the maintenance of PTSD (DiGangi et al., 2013; Ehling, Frank & Ehlers, 2008; Michael et al.,
27 2007). It is hypothesised that persistent focus on 'what if' and 'why' serves as a form of
28 cognitive avoidance from the acute, intrusive details of the event (Michael et al., 2007).
29 Furthermore, focus on specific aspects of an event may inhibit cognitive processing required
30 to integrate the event into autobiographical memory (Foa & Kizak, 1986; Michael et al.,
31 2007). In many settings midwives are encouraged to be reflective practitioners. There may
32 be a requirement to address the potential for midwives to ruminate following traumatic
33 perinatal event experiences. For example, increasing midwives' understanding about how to
34 manage rumination after a traumatic event could reduce distress or aid self-awareness about
35 when additional support is required.

36

37 *Perceptions of helpful or supportive strategies*

1 Midwives were generally able to access emotional and social support from their midwifery
2 colleagues but this was less prominently reported by midwives with high distress. Instead,
3 these midwives sometimes sought professional input from an external source. Where the
4 nature of this input was elaborated upon, midwives only described speaking with a counsellor
5 about their experience. The fact that several of these midwives remained symptomatic is
6 consistent with guidance from NICE (2005) that the provision of non-directive counselling in
7 the treatment of PTSD is contraindicated. Access to appropriate psychological assessment
8 and input for midwives experiencing PTS symptomatology following a traumatic perinatal
9 event is essential.

10
11 Whilst there were some instances of midwives with low distress reporting that support
12 received from their supervisor of midwives was helpful for them, some midwives perceived
13 contact from senior colleagues, managers or supervisors of midwives to be lacking, difficult
14 to access, or (when received) to have a punitive focus. Therefore midwives may have
15 important unmet needs in terms of accessing emotional support for events encountered
16 throughout their practice and current avenues of support (e.g., supervisors of midwives), are
17 not always perceived as helpful in this context.

18 *Reflections over time*

19
20 Midwives with high levels of distress cited low levels of staff and increasing demands within
21 the workplace as contributing to feelings of work-related stress, which is consistent with
22 previous findings with other maternity professionals (Beck & Gable, 2012). Therefore these
23 findings emphasise the contribution of a stressful working environment to feelings of difficulty
24 during (and following) adverse perinatal events.

25
26 Over a decade ago, Kirkham (2000) wrote about the 'culture of coping' in midwifery, where
27 midwives felt unsupported in their practice following adverse events. Findings from this study
28 confirm this observation, and that perceptions of a blame-focused environment may
29 contribute to difficulty following traumatic perinatal events.

30
31 Acceptance of the inevitability that some experiences will be perceived as traumatic was also
32 regarded as helpful by midwives. In the low distress group there was additional
33 acknowledgement for personal limitations as a midwife, and the likelihood of being distressed
34 following traumatic perinatal events. Focusing on the positive aspects of an adverse situation
35 is a strategy associated with resilience (Jackson et al., 2007). These findings parallel those
36 of Hunter and Warren (2013), who investigated UK midwives' perceptions of resilience in

1 their practice. Further research is required to identify ways of facilitating resilience in
2 midwives following exposure to trauma.

3

4 *Comparison between high and low distress groups*

5 Midwives with high levels of distress felt personally upset and isolated during events,
6 'punished' by other people following the event and that investigative procedures involved an
7 assessment of their general abilities as a midwife. This contrasts with midwives reporting low
8 levels of distress, who acknowledged the sadness of the event but did not feel personally
9 distressed, recognised that they were not alone in feeling shocked, and acknowledged that
10 investigative procedures were event-focused and not to apportion blame. Therefore there
11 was a greater level of personalisation identified in the appraisals formed by midwives with
12 high distress and generalization of the adverse responses.

13

14 A negative, global appraisal style and perceptions of unfair treatment or blame are implicated
15 in the development of PTS responses (Dalglish, 2004; Ehlers & Clark, 2000; Foa et al.,
16 1999). Therefore, the nature of processing style reported by midwives with high distress is
17 consistent with cognitive theory. Recognition of this trajectory provides a means of identifying
18 midwives who may be at increased risk of developing PTS responses following traumatic
19 perinatal events.

20

21 **Implications**

22 The midwifery profession in the UK is under increasing strain from rising birth rates, staff
23 shortages and a significant proportion of the midwifery workforce approaching retirement age
24 (ONS, 2014, RCM, 2013). There is an urgent need to understand aspects of midwifery
25 practice that could influence retention of the existing workforce, and findings from this study
26 highlight traumatic perinatal event exposure as an important component of this. PTS
27 responses, high emotional exhaustion and practising in an increasingly defensive manner
28 are also likely to negatively impact upon midwives' ability to provide compassionate care,
29 with implications for women's experiences of birth and postpartum wellbeing (Elmir et al.,
30 2010).

31

32 Supporting midwives in the provision of compassionate care is a global priority (ten Hoop-
33 Bender et al., 2014). Despite an emerging international interest in the impact of difficult
34 perinatal events on maternity professionals (e.g., Beck & Gable, 2012; Beck et al., 2015;
35 Leinweber & Rowe, 2010; Muliira & Bezuidenhout, 2015), there is a paucity of research
36 examining methods of reducing the likelihood that adverse psychological responses develop.

37 A pilot study with UK midwives, obstetricians and gynaecologists ($n=30$) indicated that

1 supervision from a clinical psychologist reduced PTSD symptoms following neonatal death,
2 stillbirth or miscarriage (Wallbank, 2010).

3
4 Findings from the present study contribute to existing literature by providing the first in-depth
5 qualitative study of UK midwives' experiences of workplace trauma. Midwives did not always
6 feel prepared to experience trauma, or supported in their workplace after a traumatic
7 perinatal event. Of those seeking external input to manage feelings, appropriate input was
8 not always provided. These findings are informative for the development of educational and
9 supportive interventions to prepare midwives for trauma exposure, support them in their
10 professional capacity, and to ensure the provision of appropriate psychological input.

11 **Strengths and limitations**

12
13 Whilst it was not the intention of this study to match respondents in the high and low distress
14 groups, midwives in both groups were similar in their demographic and professional
15 experiences, and had a similar extent of exposure to traumatic perinatal events. Due to
16 variations in the length of time between event exposure and the interview study, inferences
17 from those with low distress must be drawn tentatively (e.g., a longer length of time may
18 have aided the processing of trauma event information). The small sample size of this study,
19 recruited from an initially selective sample, limits generalisations of findings to all midwives in
20 the UK.

21 **Conclusions**

22
23 This study provides an in-depth analysis of midwives' experiences and perceptions of the
24 impact of encountering trauma whilst providing care to women. Event characteristics were
25 similar between midwives with high and low levels of resulting distress. However appraisals
26 of the impact and implication of events, and the experience of accessing support, differed
27 between groups. Midwives with high distress had a greater propensity to perceive all aspects
28 of personal and professional lives to be adversely impacted, and reported more difficulty in
29 accessing support from peers and senior colleagues. Findings indicate a need to consider
30 effective ways of promoting and facilitating access to support, at both a personal and
31 organisational level, for midwives following the experience of a traumatic perinatal event.

32 Consideration should also be given to how midwives can be appropriately prepared for this
33 aspect of practice during undergraduate education.

1

Table 1. Demographic and professional designation details

	High distress (n=16)		Low distress (n=19)	
	Mean (SD)		Mean (SD)	
Age	46.25 (9.26)		47.00 (4.37)	
Years Qualified	18.50 (10.95)		19.18 (8.92)	
Traumatic perinatal experiences				
Frequency witnessed events	8.06 (9.46)		8.61 (8.99)	
Frequency of accounts listened to	19.00 (13.09)		17.13 (24.30)	
	Median	Range	Median	Range
Time since event experience (years)	4	1-20	6	1-20
	N	%	N	%
Gender	16	100	18	95
Female				
Male	0	-	1	5
Education				
Bachelor's	7	44	5	26
Master's/ Diploma	3	19	6	32
Registered Midwife/ SCM	5	31	7	37
Currently in education	1	6		
Marital Status				
Single	2	13		-
Married/ Cohabiting	13	81	16	84
Widowed	1	6	3	16
Divorced/ Separated	0	-	19	-
Parity				
Nulliparous	2	13	0	-
Multiparous	14	87	19	100
Trauma History				
Personal trauma history (general)	10	63	10	53
Personal childbirth trauma history	5	31	7	37
Currently practicing clinically	15	94	19	100
Employer				
National Health Service (NHS)	15	94	17	90
University	-	-	1	5
Self Employed	1	6	-	-
Multiple	-	-	1	5
NHS Band (if applicable)				
5	1	6	-	-
6	10	63	13	68
7	3	19	5	26
Currently working as*:				
Hospital midwife	10	63	13	68
Community midwife	5	31	4	21
Integrated practice	2	13	4	21
Team manager	-	-	2	11
Midwifery Educator	1	6	1	5
Involved in care around*:				
Antenatal	4	25	4	21
Intrapartum	11	69	13	68
Postnatal	6	38	-	-
Community	8	50	5	26
Other (midwifery led care)	1	6	4	21

Table 2. Overview of sections, themes and inter-group differences between high (HH) and low (LL) distress groups. Group distinctions indicated in **bold**.

Section	Theme
1. Event characteristics	1.1. Sudden, unpredictable and uncontrollable events 1.2. Responding to the outcome and implication of the situation for the parents <ul style="list-style-type: none"> • Feeling upset at the outcome and having difficulty witnessing parents in distress (HH only) • Acknowledgement of the parents' loss and recognition of the implication (LL only) 1.3. Managing feelings to maintain a professional appearance <ul style="list-style-type: none"> • Maintaining a stiff upper lip (just carrying on) afterwards (LL only) • Struggling to carry on after the event (having to remain professional (HH only) 1.4. Feelings of isolation (HH only)
2. Initial responses and impacts	2.1. Emotionally distraught; feelings of shock and despair <ul style="list-style-type: none"> • Everybody was shocked by this (LL only) • It was like a personal bereavement (HH only) 2.2. Self blame and guilt 2.3. Feelings of vulnerability and judgement 2.4. Attempting to make sense of what happened 2.4. Feelings of vulnerability and judgement <ul style="list-style-type: none"> • Feelings of punishment, unfairness and vulnerability (practice under scrutiny) (HH only) • Acknowledgement that the investigation is not to apportion blame (LL only) 2.5. A permeating impact on professional life <ul style="list-style-type: none"> • Impact permeating personal life (HH only) 2.6. An enduring psychological impact
3. Helpful aspects and use of support	3.1. Taking steps to prevent a similar occurrence from happening again 3.2. Helpful strategies to manage responses in personal lives 3.3. Wanting to talk about it: accessing and receiving helpful support from peers <ul style="list-style-type: none"> • Being reassured (by colleagues) (HH only) • Gaining an objective perspective by talking through the event (LL only) 3.4. Perceived absence or inappropriateness of support <ul style="list-style-type: none"> • Not feeling acknowledged by senior colleagues (HH only) • Having to seek own (professional) help (HH only)
4. Reflections	4.1. 'Overcoming the impact': Gaining acceptance and the value of time <ul style="list-style-type: none"> • Acceptance of personal limitations (LL only) • It takes time, but positive subsequent experiences "dilute" feelings (HH only) 4.2. Working in the context of a stressful job <ul style="list-style-type: none"> • The job in general is causing stress (HH only) • Daunted by responsibility (LL only) 4.3. Events contradicting public perception of childbirth 4.4. Recognition of the need for change <ul style="list-style-type: none"> • Feeling unprepared for encountering traumatic perinatal events (HH only)

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