

‘Midwives Overboard!’ Inside their hearts are breaking, their makeup may be flaking but their smile still stays on

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1 **Abstract**

2 **Problem**

3 Midwifery practice is emotional and, at times, traumatic work. Cumulative exposure to this, in
4 an unsupportive environment can result in the development of psychological and behavioural
5 symptoms of distress.

6 **Background**

7 As there is a clear link between the wellbeing of staff and the quality of patient care, the
8 issue of midwife wellbeing is gathering significant attention. Despite this, it can be rare to find
9 a midwife who will publically admit to how much they are struggling. They soldier on, often in
10 silence.

11 **Aim**

12 This paper aims to present a narrative review of the literature in relation to work-related
13 psychological distress in midwifery populations. Opportunities for change are presented with
14 the intention of generating further conversations within the academic and healthcare
15 communities.

16 **Methods**

17 A narrative literature review was conducted.

18 **Findings**

19 Internationally, midwives experience various types of work-related psychological distress.
20 These include both organisational and occupational sources of stress.

21 **Discussion**

22 Dysfunctional working cultures and inadequate support are not conducive to safe patient
23 care or the sustained progressive development of the midwifery profession. New research,
24 revised international strategies and new evidence based interventions of support are
25 required to support midwives in psychological distress. This will in turn maximise patient and
26 public safety.

27 **Conclusions**

28 Ethically, midwives are entitled to a psychologically safe professional journey. This paper
29 offers the principal conclusion that when maternity services invest in the mental health and
30 wellbeing of midwives, they may reap the rewards of improved patient care, improved staff
31 experience and safer maternity services.

32

33 **Key Words:** Midwifery; Patient Safety; Health Services; Mental Health; Psychological
34 Distress; Midwives

35 **Summary of Relevance:**

36 **Problem**

37 There is potential for midwives to experience work-related psychological distress. This is of
38 salience, as poor psychological wellbeing in midwives is linked to poorer maternity care.

39 **What is Already Known**

40 There is a paucity of support for midwives, who could be at an increased risk of
41 psychological distress due to the fact that they are exposed to poor organisational cultures
42 and traumatic professional events.

43 **What this Paper Adds**

44 This paper illuminates the scale of work-related psychological distress within midwifery
45 populations. It also outlines the salient issues in practice, and highlights the need for
46 effective staff support for safer maternity care.

47

48 **Introduction**

49 Depression, burnout, anxiety and stress, account for one quarter of all episodes of sickness
50 absence in National Health Service (NHS) staff ¹⁻³. The Francis report demonstrates the
51 extent to which poor staff wellbeing directly relates to poor quality services ⁴. Poor staff
52 health can lead to an increase in medical errors⁵, infection rates¹, and mortality rates⁶. This
53 is not compatible with safe and effective patient care.

54

55 As with other health service staff, midwives are known to experience higher levels of stress
56 and trauma than the general working population due to the nature of their work relating to
57 human emotions, patient suffering and, in the developed world, relatively infrequent death⁷⁻
58 ¹³. Therefore, midwives in psychological distress may display behaviours that are out of
59 character, and experience symptoms of burnout, depression, secondary trauma, Post-
60 Traumatic Stress Disorder (PTSD) and compassion fatigue in line with other nursing
61 populations ¹⁴⁻¹⁶.

62

63 Much emphasis is placed upon providing support for the patients and carers who become a
64 part of a traumatic clinical incident. However, limited attention has been paid to the 'second
65 victim', the healthcare professional involved, who may experience similar levels of
66 psychological and emotional distress¹⁷⁻¹⁹. Many of the same symptoms can be identified in
67 patients, families and midwives during the aftermath of trauma. These include initial
68 numbness, detachment, depersonalisation, confusion, anxiety, grief, depression, withdrawal,
69 agitation, and flashbacks of the event²⁰. These symptomologies are not compatible with
70 quality patient care.

71

72 Recent position papers have set out clear visions for improved staff wellbeing ²¹⁻²³. Yet the
73 emotional trauma of caring often remains unrecognised, undervalued, and staff are often left
74 unsupported ²⁴⁻²⁸. This paper focuses on midwives' experiences of work-related

75 psychological distress. We refer to the concept of psychological distress as a general state
76 of maladaptive psychological functioning, which occurs in response to prolonged or acute
77 exposure to stressful occurrences^{29,30}. We further define it by its attributes of a perceived
78 inability to cope, a negative change in emotional status, actual and/or communicated
79 discomfort and/or harm³¹. Midwives have been known to suffer in silence whilst working in
80 cultures which may prioritise service and sacrifice above self-care^{28,32–36}. As such, it remains
81 important to collate an overview of current understanding and identify any opportunities for
82 change, and gaps for further research to explore.

83

84 **Background**

85 Midwives could be at an increased risk of work-related psychological distress due to the fact
86 that they are independent practitioners, working in an area of high litigation^{37,38}. Yet the
87 incidence of psychologically distressing episodes is sometimes seen as an inconsequential
88 and normal part of the job³⁹. Challenging work environments can also expose the midwife to
89 prolonged periods of stress^{40–42}. This is significant as a prolonged exposure to occupational
90 stress can result in significant physical symptoms as well as poor self-care, and may also
91 impact upon a midwife's family life^{43–45}. Midwives suffering psychological distress may also
92 be more likely to emotionally withdraw from their support network, patients and colleagues.
93 This both affects patient care and makes it even more difficult to identify those in need of
94 help³⁹.

95

96 Currently, there is a paucity of structured support designed to address the psychological
97 well-being of midwives³⁷. This has been identified as a missing response to the management
98 of adverse events around the world^{46–48}. In addition to a lack of support, some midwives may
99 experience ostracisation, bullying and inferences of incompetence, which may, in turn,
100 exacerbate their psychological distress^{49,50}. As midwives' experiences of witnessing

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101 traumatic events is under researched, appropriate support remains unlikely to be available or
102 provided⁵¹.

103

104 Healthcare guidance dictates the delivery of person centred care^{52,53}. Yet if midwives fail to
105 prioritise their own psychological wellbeing, their compassion for patients may deteriorate.
106 This is of concern, as compassion and empathy are both essential elements of good
107 maternity care, and are listed as key priorities for the NHS⁴. This warrants further attention
108 as patients and policy makers continue to demand accountability for the quality of healthcare
109 provided, in which cracks are beginning to appear^{54,55}.

110

111 The assumption that midwifery work is joyful and a privilege to be a part of, may not allow
112 midwives to acknowledge the emotionally demanding reality of their work^{56,57}. This is
113 concerning when psychological symptoms of traumatic stress can quickly overwhelm those
114 affected⁵⁸. Following any traumatic incident, midwives may begin to shield themselves from
115 any stimuli that serve as reminders to the incident, avoid activities which they used to find
116 pleasurable, experience cognitive deficits such as reduced concentration, and feel
117 emotionally detached from others⁵⁹. This dissociation is not compatible with quality maternity
118 care, yet healthcare professionals rarely seek help or do so only after years of suffering⁴⁸.

119

120 The most extreme consequence of psychological distress is death by suicide. UK healthcare
121 professionals have been identified as having high suicide rates^{37,60}. Yet a recent situational
122 analysis of suicide by clinicians involved in serious incidents within the NHS failed to identify
123 any sources of support, specifically designed for midwives³⁷. 28 doctor suicides were
124 reported between 2005 and 2013, all of whom were under investigation by the UK's General
125 Medical Council at their time of death. Some received diagnoses of alcohol-related illnesses,
126 depression, bipolar depression and substance misuse disorders⁶⁰. Similar data remains
127 unavailable for midwifery populations, and yet midwives have reported similar levels of

128 stress. Therefore the risk of death by suicide may be equally apparent in midwifery
129 professionals.

130

131 The NHS has committed to providing a positive working environment for staff and to promote
132 supportive cultures that help staff to do their job to the best of their ability^{22,61}. In many NHS
133 trusts, stress and mental health issues are now overtaking musculo-skeletal disorders as the
134 main reason given for sickness absence³, yet just 57% of these Trusts have a plan in place
135 to support the mental health of their staff^{23,62}. Sadly, occupational health departments may
136 not be adequate to support the clinical needs of midwives, nor be accessed when required⁶³.
137 This calls for the development of new strategies and innovations to drive remedial actions
138 forward into practice, as what is now needed may go beyond previous recommendations^{45,64}.

139 ***Categories of Psychological Distress***

140

141 Work-related psychological distress may occur as a result of hostile behaviour towards staff,
142 either from other staff or patients⁶⁵⁻⁶⁷, workplace bullying^{65,68}, poor organisational cultures²⁴,
143 medical errors⁶⁹, traumatic 'never events'⁷⁰, critical incidents³⁷, occupational stress⁷¹,
144 workplace suspension^{38,72}, whistleblowing⁷³, investigations via professional regulatory bodies
145 and employers^{60,74,75}, and/or pre-existing mental health conditions^{60,75}. This list is far from
146 exhaustive.

147

148 Midwives may experience different types of psychological distress in response to challenging
149 clinical events and/or work environments. 'vicarious compassion fatigue', 'vicarious
150 traumatisation' and 'secondary traumatic stress' are all terms used to describe the potential
151 emotional impact that working with traumatised families may have upon healthcare
152 professionals^{10,76}. These are a normal consequence of helping others over time, to deal with
153 an emotional, sometimes abnormal, and/or traumatising situation.

154

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155 In the most extreme cases, Post-Traumatic Stress Disorder (PTSD) can develop following a
156 traumatic event. Symptoms can include the display of reckless or self-destructive behaviour,
157 memory flashbacks, hypervigilance, emotional numbness and avoidance²⁰. However, the
158 risk of Acute Stress Disorder following an indirect, or direct traumatic event is far greater,
159 and can result in symptoms of shame, guilt, anger and self-doubt⁷⁷. Significantly, PTSD is
160 often accompanied by depression, substance abuse disorders, and/or other anxiety
161 disorders, which may result in a display of unethical behaviour^{77,78}. Should these symptoms
162 remain unmanaged, patient safety could be put at risk.

163

164 Those in psychological distress may also experience depression. Symptoms of major
165 depression include feelings of worthlessness, chronic fatigue, a sense of guilt, reduced
166 concentration and poor decision making²⁰. These symptoms may cause clinically significant
167 distress or impairment in areas of occupational functioning. This is pertinent to midwifery
168 populations as we begin to understand the co-morbidities of psychological distress and the
169 impact it may have upon a midwife's fitness to practise.

170

171 As health care professionals' emotional reserves run low, 'burnout' may eventually take hold.
172 Midwives have been identified as a group at risk of exhibiting high levels of emotional
173 exhaustion and burnout⁷⁹. Burnout is a syndrome consisting of emotional exhaustion,
174 depersonalisation and negative thinking towards others⁸⁰. Symptoms are closely associated
175 with psychological trauma, and occur when a midwife's emotional resilience becomes
176 depleted. In midwifery practice, burnout results in poorer patient care and increased staff
177 turnover²³. Saliently, 60%-70% of healthcare professionals admit to having practised at times
178 when they have been distressed to the point of clinical ineffectiveness, and as such are
179 more at risk of enacting unnecessary medical errors^{1,81,82}. These disclosures illuminate a
180 situation which is clearly incompatible with safe and effective clinical care.

181

182 As emotional stores run low, midwives may also exhaust their ability to care
183 compassionately. Compassion fatigue refers exclusively to those in the caring professions,
184 and weakens the capabilities of the midwife to provide effective care³⁹. Midwives will be
185 vulnerable to compassion fatigue, and yet they must continue to deliver emotional
186 interactions to ensure a healthy emotional journey for the families they care for ^{64,83}. This
187 suggests an urgent need to support midwives to remain emotionally responsive and clinically
188 effective in order for them to provide quality care.

189
190 Sustained psychological distress can result in adverse behavioural symptoms, which may
191 include drug and alcohol disorders ^{20,84–86}. Yet the vast majority of healthcare professionals
192 who develop substance abuse disorders are not doing so for recreational pleasure⁸⁴. The
193 use of substances becomes a symptom of mental ill-health, as the user employs
194 maladaptive coping strategies to medicate a deeper distress ⁷⁵. It will be important to
195 identify, remedy and understand the many origins and experiences of work-related
196 psychological distress in midwifery populations in order to ameliorate professional suffering
197 and improve the safety of midwifery care. A narrative literature review was chosen to do this,
198 so that the relevant literature in this field could be consolidated into narratives, which review
199 the state of psychological distress in midwifery populations from a contextual point of view⁸⁷.

200 **Methods**

201 The literature was reviewed narratively in order to gain a broader perspective with regards to
202 the aetiology, experiences, symptomology and epidemiology of midwives in psychological
203 distress.

204

205 ***Search Strategy***

206
207 AMED - The Allied and Complementary Medicine Database, CINAHL with Full Text,
208 MEDLINE and PsycINFO were searched simultaneously, using a combination of terms used
209 in tandem with the defining cohort of 'midwives or midwife' within the TI (Title) search field.

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210 Searches included 'midwives or midwife' and 'psychological distress', and 'bullying in nursing
211 workplace' and 'bullying in the workplace' and 'bullying in nursing' and 'traumatic stress', and
212 'vicarious trauma', and 'compassion fatigue and burnout', and 'secondary trauma', and
213 'depression and anxiety', and 'PTSD or post-traumatic stress disorder', and 'workplace
214 stress' and 'resilience' and 'Emotion Work' and 'secondary traumatic stress'. This resulted in
215 14 separate searches, which generated 264 results. 98 duplicates were then removed,
216 leaving 166 papers to review.

217
218 Searching was widespread in scope, in line with the ESRC Methods guideline for generating
219 Narrative Synthesis⁸⁸. Papers had to be written in the English language and focus upon
220 work-related psychological distress in relation to the aetiologies, experiences, symptomology
221 and epidemiology of midwives in psychological distress, rather than in relation to the women
222 they cared for or any other professional group. Papers were limited to those published after
223 the year 2000 in order to generate a more contemporary overview of current understanding.
224 Papers selected for inclusion were limited to cohort studies, systematic reviews, meta-
225 analyses, and randomised controlled trials in order to unite best evidence⁸⁹.

226
227 76 papers were primarily excluded as they related to issues affecting childbearing women
228 rather than midwifery populations. 25 articles were removed, as they were editorial or
229 discursive in nature. A further 36 articles were excluded, as they did not relate to the subject
230 of midwives in work-related psychological distress. 12 papers related to workplace
231 interventions, and although we considered these to be of general interest, they were
232 excluded from this review so that a focused depiction of psychological distress could remain
233 paramount. One study was rejected as it related to nurses providing care to labouring
234 women, and two studies were added through a snowballing of the literature, whereby
235 reference lists were assessed for absent papers⁹⁰. 30 papers were eventually selected for
236 inclusion.

237

238 The research team then went through the iterative process of reading and rereading these
239 papers, noting themes and narratives throughout a discursive process of review. Anonymous
240 peer reviewers also became a part of influencing the finalised report of findings.

241

242 **Limitations**

243 Midwifery is a nursing profession. As such, professionals who practise as midwives are
244 frequently referred to as obstetric nurses or nurse-midwives, and may be amalgamated
245 within nursing cohorts, or referred to as general healthcare staff⁹¹. Therefore, a large
246 number of studies may have avoided retrieval by omitting to identify their cohorts as
247 midwives.

248 **Results**

249 **Overview of studies**

250 The studies selected for review took place in Nigeria⁹², America⁵⁸, Ireland⁹³, the United
251 Kingdom^{25,51,94-99}, Australia^{44,100-103, 104}, France¹⁰⁵, Poland¹⁰⁶, Croatia¹⁰⁷, Israel⁵⁷, Italy¹⁰⁸,
252 Japan^{26,109}, Uganda^{7,110}, Turkey¹¹¹ and New Zealand¹⁰². Study designs included convergent,
253 parallel mixed-methods, critical literature reviews^{8,112-114}, online professional discussion
254 groups^{94,95}, individual and group interviews^{25,51,57,96,108,104} narratives¹¹⁵, diary-keeping¹¹⁵ and
255 questionnaires^{6,26,58,92,97,99,101-103,105-107,109,111,115-118}

256 **Findings**

257 The literature retrieved illuminates that distressed midwives may carry on working in
258 distress, and use this persistence as a maladaptive coping strategy. This dysfunctional
259 endurance may not allow them to recognise psychological ill health in themselves. Long
260 hours, the introduction of new technologies in healthcare, job security, emotion work, trauma
261 exposure, dysfunctional working cultures and a lack of career progression have become
262 strong predictors of work-related psychological distress in midwives^{112,113,116,119}. Additionally,

263 the overarching superhuman philosophy that midwives should be able to cope with anything
264 does nothing to promote healthy, or help seeking behaviours.

265

266 **Occupational Sources of Stress**

267 Midwives remain at risk of developing secondary traumatic stress as they care for
268 childbearing women⁸. Risk factors for the development of traumatic stress in midwives
269 include an increased level of empathy and organisational stress¹¹³. Secondary traumatic
270 stress in midwives is reported at high to severe levels as they engage empathetically with
271 the trauma experienced by those in their care⁵⁸. These high levels of distress mean that a
272 midwife's ability to professionally engage with childbearing women and their families may be
273 compromised. This may also make them more likely to leave the profession all together.
274 Within the labour and delivery rooms of the United States, midwives most frequently cited
275 neonatal demise/death, shoulder dystocia, and infant resuscitation as being the incidents in
276 which their secondary traumatic stress had originated⁵⁸. This becomes significant as specific
277 interventions of support are developed in response to the most salient adverse events.

278

279 Midwives report having difficulties in functioning professionally during the unexpected reality
280 of a stressful clinical situation⁵⁷. This may lead to distressing feelings of guilt, rumination and
281 diminished professional confidence. 33% of 421 UK midwives surveyed have been found to
282 develop symptoms of clinical posttraumatic stress disorder following a traumatic event⁹⁹.
283 These symptoms included feelings of fear, helplessness and horror. Following clinical
284 investigations and traumatic births, midwives in the United States expressed a need for a
285 safe forum to share their experiences with colleagues, as they had no place to talk and
286 unburden their souls⁵⁸. Some of these midwives lost their belief in the birth process,
287 developed PTSD, and many left the midwifery profession altogether. The development of
288 PTSD symptoms is associated with burnout, and as such, the exposure to trauma may
289 impact significantly upon the wellbeing of the workforce⁹⁹. This becomes significant as the

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290 world tries to recruit a high quality midwifery workforce in the face of a global shortage of
291 midwives ¹²⁰.

292

293 Upon providing ethically complex and emotive clinical tasks such as the Termination of
294 Pregnancy (TOP), many midwives report significant emotional distress^{105,108,121}. How the
295 midwife manages emotional midwifery work is crucial in determining the quality of patient
296 experiences, as the stressors involved in conducting a TOP are associated with the
297 development of compassion fatigue^{112,121}. Equally, the psychological distress experienced by
298 midwives caring for families experiencing stillbirth, neonatal loss and miscarriages remains
299 high, as midwives continue to provide emotionally intense and deeply empathetic care¹¹⁴.
300 This is significant as the demanding task of providing empathy may often conflict with the
301 midwives need to protect themselves psychologically, and yet empathy and compassionate
302 care have been identified as fundamental tenets of the nursing professions^{4,122}.

303

304 Midwives working within resource poor, developing countries experience traumatic incidents
305 and death more frequently^{123,124}. In a survey study of 238 midwives working in two rural
306 districts of Uganda, many have displayed moderate to high death anxiety (93%), mild to
307 moderate death obsession (71%) and mild death depression (53%)⁷. Furthermore, 74.6 %
308 of 224 midwives working again, in rural areas of Uganda, developed moderate or high death
309 anxiety following prolonged exposure to maternal death¹¹⁰. This becomes significant as the
310 midwifery profession looks to maintain a healthy workforce globally in order to make their
311 contribution towards achieving goal 4 and 5 of the Global Millennium Development Goals in
312 achieving safer childbirth¹²⁵.

313

314 Midwives who provide antenatal care to families with complex social needs have reported
315 cumulative feelings of frustration, inadequacy and vicarious trauma over time¹⁰⁴. This
316 emotional and stressful work, which often requires long working hours has led to some of

317 these midwives utilising unhealthy coping strategies and harmful daily drinking¹⁰². This is
318 significant as we begin to understand the consequences of cumulative exposure to complex
319 and emotive maternity work.

320

321 Student midwives also experience work-related psychological distress. As they narrate their
322 most distressing placement related event, their beliefs about the uncontrollability of thoughts
323 and danger, beliefs about the need to control thoughts, and rumination over that traumatic
324 incident were all significantly associated with posttraumatic stress symptoms¹¹⁷. Despite this,
325 student midwives have reported feeling unable to speak out and ask for help within
326 hierarchical midwifery workplaces¹¹⁵. This becomes significant as we seek to empower a
327 new generation of midwives to effectively manage their mental health whilst carrying out
328 demanding and emotional midwifery work.

329 **Organisational Sources of Stress**

330 Midwifery cultures are hierarchical, and this may lead to the subordination of midwives,
331 bullying, ineffective team working and a reduction in professional autonomy¹¹⁵. It has also
332 been proposed that midwives form elite 'clubs' in the workplace and exclude those of lesser
333 ranking¹¹⁵. As the obstetrician takes the most senior position within the hierarchical
334 structure, the medical takeover of birth could restrict the midwives ability to innovate and
335 develop optimal levels of confidence¹¹⁵. This dysfunctional working culture may not allow
336 midwives, or the midwifery profession to thrive, as midwives remain persistently worried
337 about workplace aggression and bullying¹¹⁹. Inhibited professional progression, bullying
338 and subordination are key predictors of psychological distress^{116,126,127}. This becomes
339 important as we begin to understand and address these predictors in order to construct
340 collaborative working cultures in maternity services, to ensure safer care for patients¹²⁸.

341

342 In one study of 58 Australian midwives, almost 30% of the sample experienced moderate to
343 high levels of burnout, and their levels of personal and work-related burnout were found to

344 be higher than any burnout related to giving care to women ¹⁰³. Midwives may experience
345 burnout as a result of dysfunctional working cultures, work stress, and poor job satisfaction
346 ¹¹¹. This suggests that the origins of burnout may be rooted within organisational sources of
347 stress, however more research in this area is required so that the origins of burnout in
348 midwives can be comprehensively acknowledged and defined.

349

350 Burnout, emotional exhaustion and depersonalisation levels have been found to be higher in
351 midwives than in general nurses and hospice nurse populations, yet the latter two
352 populations sometimes receive a higher level of support in the workplace ¹⁰⁶. This indicates
353 that the reality of burnout in midwives may not be adequately recognised. Should midwives
354 continue to receive inadequate support in comparison to other professional groups, they may
355 come to feel that they are a less valued profession. This is significant, as low morale does
356 nothing to ameliorate the challenges associated with recruitment and retention. This situation
357 may also fuel a midwife's belief that their own wellbeing remains inconsequential, which
358 does little to promote help seeking behaviours.

359

360 In a sample of 60 Croatian midwives, over three-quarters (76.7%) reported that their job is
361 stressful ¹⁰⁷. Another study has cited that 80–90% of 556 Japanese midwives have been
362 highly stressed by qualitative job overload, with one out of every three to five displaying a
363 psychological disorder¹⁰⁹. Those who express high levels of job satisfaction, and those who
364 perceive that others have a positive opinion about the midwifery profession are observed to
365 have lower levels of work-related stress and burnout ¹¹¹. This may indicate that raising the
366 professional profile of midwifery and placing more value upon midwives in practice should
367 play a part in any strategy designed to remedy psychological distress in midwifery
368 populations.

369

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370 The culture that student midwives observe is sometimes spiteful and cruel⁹⁸. They also
371 observe a lack of care towards themselves and other midwives in a culture permissive of
372 bullying⁹⁷. The reality is that workplace aggression and bullying from both staff and patients
373 has been seen as a frequent occurrence within the maternity workplace¹⁰¹. This becomes
374 significant as we nurture and recruit the new generation of midwives to become high quality
375 professionals for the future advancement of maternity services. Such disruptive working
376 cultures in maternity services also threaten patient safety⁶⁷.

377

378 Student midwives may also feel despondent upon the realisation that childbearing women do
379 not get the care that they expect due to organisational pressures and excessive workloads
380⁹⁸. Sadly, they understand why midwives may not want to come into work as they too see the
381 stresses of the job. Some midwifery students who identify with these feelings of stress
382 display unhealthy coping strategies such as excessive smoking, drinking or eating⁹⁸. This
383 introduction to the midwifery profession is not conducive to a positive inaugural experience,
384 and may have serious implications for future retention and recruitment strategies, as new
385 students in training may assume some of the negative perspectives and behaviours
386 communicated via their qualified mentors¹¹⁵.

387

388 Emotion work (emotional work) can be defined as the emotional regulation required of the
389 employees in the display of organisationally desired emotions¹²⁹. Emotion work remains less
390 understood as a concept in midwifery work. Yet challenging models of midwifery care, high
391 expectations, working intimately with women in pain, and managing the emotions of other
392 staff all place emotional burden upon the midwife¹¹². Negotiating inter-collegial conflict in UK
393 midwifery is a major source of emotion work, which is likely to exacerbate workforce attrition
394 and psychological distress⁹⁶. Interactions with colleagues and healthcare organisations
395 requires effective emotion management. This is significant as we begin to understand the

396 contradictory ideologies that present in midwifery practice, and the conflicts between ideals
397 and practice, which often result in frustration, psychological distress and anxiety ⁹⁶.
398
399 When a traumatic birth occurs, midwives find it difficult to work between the medical model
400 of care and the midwifery model of care as turf wars continue between midwives and doctors
401 ⁵¹. Midwives value the compassionate support given from their obstetric teams, yet many
402 feel betrayed and abandoned in an unsupportive, 'toxic' and unsafe working environment ⁵⁸.
403 It will be important to understand the nature of these tensions in practice in order to ensure
404 safe care for women, remedy low morale and improve staff retention rates ^{67,130,131}. Midwives
405 continue to report feeling bullied, undermined and intimidated because of the power
406 imbalances currently at play ^{51,96}. Interpersonal conflict has been positively correlated with
407 hostility, depression, anxiety, fatigue and physical complaints in midwifery professionals ¹⁰⁹.
408 As such, the origins of tension in the work place requires further attention before these
409 maladaptive cultures present further concerns in relation to effective collaborative working,
410 patient safety and staff wellbeing.

411

412 **Discussion**

413

414 The findings of this review illuminate a global and contemporary picture, where midwives are
415 suffering in work-related psychological distress and yet at times, carry on working
416 regardless. Some are frustrated when they cannot practice to the best of their ability due to
417 organisational inadequacies and obstructive working cultures. A multitude of organisational
418 pressures and features of emotional work have been identified as predictors of psychological
419 distress in midwifery professionals. In addition to the clinically significant impacts of direct
420 trauma exposure, inter-professional conflicts, bullying and unsupportive organisational
421 cultures are repeatedly highlighted as threats to the midwife's psychological wellbeing.
422 Midwives working within rural areas of developing countries, and those caring for women
423 with complex social needs may present with specific symptomologies which relate to their

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424 particular area of midwifery practice. In any case, this review has highlighted that midwives
425 in psychological distress often feel that sources of support are inadequate, and that there is
426 nowhere go to unburden their distress.

427
428
429 Midwives are faced with a multitude of workplace pressures which show no sign of
430 alleviating. Increased population growth, midwife shortages, a rising birth rate and increased
431 numbers of complex births have become part of the modern realities of midwifery^{120,132} Yet in
432 addition to these pressures, toxic, hierarchical, time pressured and unsupportive workplace
433 cultures only serve to reverse any gains made in supporting midwives in psychological
434 distress^{67,96,115,133}. These pressures may also result in midwives further neglecting their own
435 wellbeing. Effective clinical mentorship, clinical supervision, the reorganisation of maternity
436 care models, wellbeing strategies, positive leadership and the creation of positive working
437 cultures, where maternity staff feel valued and motivated to drive the midwifery profession
438 forward have all been suggested as ways in which to address these issues within the
439 midwifery workforce^{35,103,134–138}. Midwifery cultures may benefit from further research in this
440 area, as new proposals for change are required.

441
442 Midwives remain unsatisfied with the support programmes and management interventions
443 currently on offer¹⁰¹. This presents future research, healthcare leaders and policy makers
444 with new opportunities to develop effective, evidence based interventions designed to
445 support midwives in work-related psychological distress. Midwives often seek out their own
446 effective coping strategies, access support, develop self-awareness, reflect, vent, positively
447 re-frame events, cultivate a professional identity and employ self-distraction techniques in
448 order to increase their own resilience towards workplace adversity^{7,94,139}. However, more
449 research will be required in order to evaluate which strategies may be most effective. There
450 may also be an opportunity to turn new, online visions of support into practice.

451

452 Future interventions should predominantly focus upon placing more value on midwives and
453 empowering the midwifery profession to resolve professional conflicts. They should also help
454 midwives to recognise that they are not alone and provide safe platforms of support where
455 midwives can share their experiences with colleagues and unburden their distress⁵⁸.

456 Proactive support should focus upon those midwives engaged in situations most frequently
457 associated with distress. Ultimately, the shared goal should be the repudiation of
458 psychologically unsafe workplace cultures and the provision of appropriate psychological
459 support.

460

461 Midwives are entitled to a psychologically safe professional journey, and caring for them is
462 not an optional issue, it is an ethical one. As evidenced by this review, midwives are likely to
463 benefit from a sound work-life balance, autonomy, models of maternity care that maximise
464 their emotional wellbeing, sensible working hours, psychological support, professional
465 respect, safe platforms where midwives can unburden their distress, and processes to deal
466 with dysfunctional working cultures and bullying the most^{34,58,140}. New guidance, and the
467 development of novel interventions tailored to the needs of midwives have the opportunity to
468 turn this vision into practice.

469

470 **In order to protect and empower our valuable midwifery workforce to provide**
471 **excellent quality care, forthcoming international initiatives could:**

- 472 • Acknowledge the emotional consequences of midwifery practice.
- 473 • Promote the need to prioritise self-care and inter-professional support ^{141,142}
- 474 • Acknowledge the need to prioritise the emotional wellbeing of midwives ⁴⁵
- 475 • Promote psychologically safe working cultures ^{41,143}.
- 476 • Explore alternatives to discipline, which include non-punitive and non-blame-focused
477 approaches towards:

478 1. Medical error ¹⁷

- 479 2. Concerns raised by healthcare staff⁷³
- 480 3. Behavioural symptoms displayed whilst staff are unwell ^{46,48,63,75}.

481 **Conclusions**

482 This narrative review of the literature demonstrates that globally, there is not enough
483 attention assigned to the seriousness and prevalence of work-related psychological distress
484 in midwifery populations. Midwifery is seen as a pleasurable and privileged job by society
485 and by midwives themselves ⁵⁶. Yet the needs of those in psychological distress have not
486 been understood, prioritised or comprehensively acknowledged. In the future, it will be
487 important to identify the causes of problematic working cultures in order to reverse the
488 adverse consequences sometimes seen as part of the problem when catastrophic failings
489 within maternity services occur ¹⁴⁴.

490

491 Exposure to trauma and psychologically distressing events could adversely affect the
492 wellbeing of midwives, the care provided to women and contribute to adverse climates in
493 healthcare ¹¹³. Future research has the opportunity to explore and develop evidence-based
494 solutions to support midwives in work-related psychological distress. Further research may
495 also generate a deeper understanding in relation to the aetiologies, experiences,
496 symptomology and epidemiology of midwives in psychological distress. This will be
497 significant, as in facilitating psychologically safe professional journeys for midwives, we will
498 in turn augment the quality and safety of maternity services^{23,67,145–149}.

499

500 Midwifery care aims to support optimal outcomes in childbearing⁵³. If, when caring for
501 women, the potential consequences for midwives are ignored, we risk their capability to
502 provide midwifery care to the high levels they aspire to. This threatens the very eminence of
503 midwifery as a profession. So as the gargantuan 'Maternity Service Ship' sails on, proudly
504 flying the flag of being 'with woman', look out for those who have been left behind, silently
505 shouting 'Midwife overboard'.

506

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511

References

- 512 1. Boorman S. Health and well-being of the NHS workforce. *Journal of Public Mental Health*
513 2010; **9**(1): 4-7.
- 514 2. Boorman S. The Final Report of the independent NHS Health and Well-being review,(2009).
515 Department of Health. *NHS health and well-being review—the government response 2009*; .
- 516 3. NHS Employers. Reducing sickness absence in the NHS using evidence-based strategies.
517 Summary report. 2014; .
- 518 4. Francis R. Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry Executive
519 summary. *The Stationery Office. London 2013*; .
- 520 5. Harrison R, Lawton R, Stewart K. Doctors' experiences of adverse events in secondary care: the
521 professional and personal impact. *Clin Med* 2014; **14**(6): 585-90.
- 522 6. Keogh B. Review into the quality of care and treatment provided by 14 hospital trusts in
523 England: overview report. NHS; 2013.
- 524 7. Muliira RS, Bezuidenhout MC. Occupational exposure to maternal death: Psychological
525 outcomes and coping methods used by midwives working in rural areas. *Midwifery* 2015; **31**(1): 184-
526 90.

MIDWIVES IN PSYCHOLOGICAL DISTRESS

- 527 8. Leinweber J, Rowe HJ. The costs of 'being with the woman': secondary traumatic stress in
528 midwifery. *Midwifery* 2010; **26**(1): 76-87.
- 529 9. Thomas RB, Wilson JP. Issues and controversies in the understanding and diagnosis of
530 compassion fatigue, vicarious traumatization, and secondary traumatic stress disorder. *Int J Emerg*
531 *Ment Health* 2004; **6**(2): 81-92.
- 532 10. Klein M. The stork and the phoenix: birth, burnout and rebirth. *Midwifery Today Int Midwife*
533 2009; **(92)**(92): 44,6, 67.
- 534 11. Clarke J, Mander R. Midwives and loss: the cost of caring. *Pract Midwife* 2006; **9**(4): 14-7.
- 535 12. Kirkham M. Traumatized Midwives. *AIMS Journal* 2007; **19**(1).
- 536 13. Kenworthy D, Kirkham M. Midwives Coping with Loss and Grief: Stillbirth, Professional, and
537 Personal Losses. Radcliffe Publishing; 2011.
- 538 14. Wilkinson S. How nurses can cope with stress and avoid burnout: Stephanie Wilkinson offers a
539 literature review on the workplace stressors experienced by emergency and trauma nurses. *Emergency*
540 *Nurse* 2014; **22**(7): 27-31.
- 541 15. Rice V, Glass N, Ogle K, Parsian N. exploring physical health perceptions, fatigue and stress
542 among health care professionals. *Journal of multidisciplinary healthcare* 2014; **7**: 155.
- 543 16. Clarke E. Toasted, Fried or Frazzled? Burnout and stress in midwifery practice. *MIDWIFERY*
544 *MATTERS* 2013; (139): 15-6.
- 545 17. Wu AW, Steckelberg RC. Medical error, incident investigation and the second victim: doing
546 better but feeling worse? *BMJ Qual Saf* 2012; **21**(4): 267-70.
- 547 18. Wu AW. Medical error: the second victim. The doctor who makes the mistake needs help too.
548 *BMJ* 2000; **320**(7237): 726-7.

MIDWIVES IN PSYCHOLOGICAL DISTRESS

- 549 19. Denham CR. TRUST: the 5 rights of the second victim. *Journal of Patient Safety* 2007; **3**(2):
550 107-19.
- 551 20. DSM-5 American Psychiatric Association. Diagnostic and statistical manual of mental
552 disorders. *Arlington: American Psychiatric Publishing* 2013; .
- 553 21. Black C. Why healthcare organisations must look after their staff. *Nurs Manag (Harrow)* 2012;
554 **19**(6): 27-30.
- 555 22. Department of Health. Health Sector Staff Wellbeing, Service Delivery, and Health Outcomes.
556 A Compendium of Factsheets: Wellbeing across the Life Course'. 2014 2014; .
- 557 23. The Royal College of Physicians. Work and wellbeing in the NHS: why staff health matters to
558 patient care. 2015; .
- 559 24. Wilkinson E. UK NHS staff: stressed, exhausted, burnt out. *The Lancet* 2015; **385**(9971): 841.
- 560 25. Hunter B. Conflicting ideologies as a source of emotion work in midwifery. *Midwifery* 2004;
561 **20**(3): 261-72.
- 562 26. Mizuno M, Kinefuchi E, Kimura R, Tsuda A. Professional quality of life of Japanese
563 nurses/midwives providing abortion/childbirth care. *Nurs Ethics* 2013; **20**(5): 539-50.
- 564 27. Kirkham M. The midwife-mother relationship. Palgrave Macmillan; 2010.
- 565 28. Calvert I, Benn C. Trauma and the Effects on the Midwife. *International Journal of Childbirth*
566 2015; **5**(2): 100-12.
- 567 29. Abeloff M, Armitage J, Lichter A, Niederhuber J. Clinical Oncology. New York, NY: Churchill
568 Livingstone. 2000; .

MIDWIVES IN PSYCHOLOGICAL DISTRESS

- 569 30. Ryrle I, Norman I. The origins and expression of psychological distress. *The Art and Science of*
570 *Mental Health Nursing: A Textbook of Principles and Practice*. Open University Press, Maidenhead
571 2004; : 3-34.
- 572 31. Ridner SH. Psychological distress: concept analysis. *J Adv Nurs* 2004; **45**(5): 536-45.
- 573 32. Deery R, Kirkham M. Supporting midwives to support women. In: Page L, McCandish R,
574 editors. *The new midwifery: science and sensitivity in practice*. . London: Churchill-Livingston; 2006.
- 575 33. Kirkham M. The culture of midwifery in the National Health Service in England. *J Adv Nurs*
576 1999; **30**(3): 732-9.
- 577 34. Prowse J, Prowse P. Flexible working and work–life balance: midwives’ experiences and
578 views. *Work, Employment & Society* 2015; : 0950017015570724.
- 579 35. Dixon-Woods M, Baker R, Charles K, et al. Culture and behaviour in the English National
580 Health Service: overview of lessons from a large multimethod study. *BMJ Qual Saf* 2014; **23**(2): 106-
581 15.
- 582 36. Kirkham M, Stapleton H. Midwives' support needs as childbirth changes. *J Adv Nurs* 2000;
583 **32**(2): 465-72.
- 584 37. Strobl J, Sukhmeet S, Carson-Stevens A, McIldowie B, Ward H, Cross H, Madhok R. Suicide
585 by clinicians involved in serious incidents in the NHS: a situational analysis. . *NHS Clinical leaders*
586 *network* 2014; .
- 587 38. Anderson A. Ten years of maternity claims: an analysis of the NHS Litigation Authority data–
588 key findings. *Clin Risk* 2013; **19**(1): 24-31.
- 589 39. Wallbank S, Robertson N. Predictors of staff distress in response to professionally experienced
590 miscarriage, stillbirth and neonatal loss: A questionnaire survey. *Int J Nurs Stud* 2013; **50**(8): 1090-7.

MIDWIVES IN PSYCHOLOGICAL DISTRESS

- 591 40. Mollart L, Skinner VM, Newing C, Foureur M. Factors that may influence midwives work-
592 related stress and burnout. *Women and Birth* 2013; **26**(1): 26-32.
- 593 41. Campling P. Reforming the culture of healthcare: the case for intelligent kindness. *BJPsych*
594 *Bulletin* 2015; **39**(1): 1-5.
- 595 42. Holmes D. Mid Staffordshire scandal highlights NHS cultural crisis. *Lancet* 2013; **381**(9866):
596 521-2.
- 597 43. Kordi M, Mohamadirizi S, Shakeri MT. The relationship between occupational stress and
598 dysmenorrhea in midwives employed at public and private hospitals and health care centers in Iran
599 (Mashhad) in the years 2010 and 2011. *Iranian Journal of Nursing & Midwifery Research* 2013;
600 **18**(4): 316-22.
- 601 44. Mollart L, Newing C, Foureur M. Midwives' emotional wellbeing: impact of conducting a
602 structured antenatal psychosocial assessment (SAPSA). *Women Birth* 2009; **22**(3): 82-8.
- 603 45. Copp E, Morton N. Attention: calm and relaxed midwives at work! *Pract Midwife* 2011; **14**(4):
604 21-3.
- 605 46. Austin D, Smythe E, Jull A. **Midwives' well-being following adverse events – what does the**
606 **research indicate?**. *Journal of the New Zealand College of Midwives* 2014; **50**: 19 - 23.
- 607 47. Seys D, Scott S, Wu A, et al. Supporting involved health care professionals (second victims)
608 following an adverse health event: a literature review. *Int J Nurs Stud* 2013; **50**(5): 678-87.
- 609 48. Ullström S, Andreen Sachs M, Hansson J, Øvretveit J, Brommels M. Suffering in silence: a
610 qualitative study of second victims of adverse events. *BMJ Quality & Safety* 2014; **23**(4): 325-31.
- 611 49. Cresswell K, Sivashanmugarajan V, Lodhi W, Yoong W. Bullying workshops for obstetric
612 trainees: a way forward. *The clinical teacher* 2015; **12**(2): 83-7.

MIDWIVES IN PSYCHOLOGICAL DISTRESS

- 613 50. Carter M, Thompson N, Crampton P, Morrow G, Burford B, Gray C, Illing J. Workplace
614 bullying in the UK NHS: a questionnaire and interview study on prevalence, impact and barriers to
615 reporting. *BMJ Open* 2013; **3**(6): e002628.
- 616 51. Rice H, Warland J. Bearing witness: Midwives experiences of witnessing traumatic birth.
617 *Midwifery* 2013; **29**(9): 1056-63.
- 618 52. Richards T, Coulter A, Wicks P. Time to deliver patient centred care. *BMJ* 2015; **350**: h530.
- 619 53. Officers UCN. Midwifery 2020 Delivering Expectations. *London: Department of Health* 2010;
620 .
- 621 54. Collins KJ, Draycott T. Measuring quality of maternity care. *Best Practice & Research Clinical*
622 *Obstetrics & Gynaecology* 2015; .
- 623 55. Quality Watch. Cause for concern: Quality Watch annual statement 2014. 2014; .
- 624 56. Knapp R. Where there was love... Compassionate midwifery as protection against trauma. . *The*
625 *Practising Midwife* 2015; **18**(4).
- 626 57. Halperin O, Goldblatt H, Noble A, Raz I, Zvulunov I, Liebergall Wischnitzer M. Stressful
627 childbirth situations: a qualitative study of midwives. *J Midwifery Womens Health* 2011; **56**(4): 388-
628 94.
- 629 58. Beck CT, LoGiudice J, Gable RK. A Mixed-Methods Study of Secondary Traumatic Stress in
630 Certified Nurse-Midwives: Shaken Belief in the Birth Process. *Journal of Midwifery & Women's*
631 *Health* 2015; **60**(1): 16-23.
- 632 59. Horowitz MJ, Reidbord SP. Memory, Emotion, and Response to Ttauma. *The handbook of*
633 *emotion and memory: Research and theory* 2014; : 343.

MIDWIVES IN PSYCHOLOGICAL DISTRESS

- 634 60. General Medical Council (GMC). Doctors who commit suicide while under GMC fitness to
635 practise investigation: Internal review . 2015; Available at: [http://www.gmc-
uk.org/Internal_review_into_suicide_in FTP_processes.pdf_59088696.pdf](http://www.gmc-
636 uk.org/Internal_review_into_suicide_in FTP_processes.pdf_59088696.pdf). Accessed 08/05, 2015.
- 637 61. Department of Health. Policy paper Healthy Staff, Better Care for Patients: Realignment of
638 Occupational Health Services to the NHS in England . 2011; .
- 639 62. The Royal College of Physicians. Implementing NICE public health guidance for the
640 workplace: a national organisational audit of NHS trusts in England, round 2. 2014; .
- 641 63. Munro R. Sick day scrutiny. *Nurs Stand* 2011; **25**(18): 24-5.
- 642 64. Wilkinson E. UK NHS staff: stressed, exhausted, burnt out. *The Lancet* 2015; **385**(9971): 841.
- 643 65. Demir D, Rodwell J. Psychosocial antecedents and consequences of workplace aggression for
644 hospital nurses. *J Nurs Scholarsh* 2012; **44**(4): 376-84.
- 645 66. Woodrow C, Guest D. Workplace Bullying, Patient Violence and Quality of Care: A Review.
646 *NIHR and King's Patient Safety and Service Quality Centre (PSSQ) Workforce Programme, Working
647 Paper* 2008; **1**.
- 648 67. Veltman LL. Disruptive behavior in obstetrics: a hidden threat to patient safety. *Obstet Gynecol*
649 2007; **196**(6): 587.e1,587.e5.
- 650 68. Carter M, Thompson N, Crampton P, Morrow G, Burford B, Gray C, Illing J. Workplace
651 bullying in the UK NHS: a questionnaire and interview study on prevalence, impact and barriers to
652 reporting. *BMJ Open* 2013; **3**(6): e002628.
- 653 69. Wu A. Medical error: the second victim. The doctor who makes the mistake needs help too. .
654 *British Medical Journal* 2000; **320**: 726-7.
- 655 70. Harrop-Griffiths W. Never events. *Anaesthesia* 2011; **66**(3): 158-62.

MIDWIVES IN PSYCHOLOGICAL DISTRESS

- 656 71. Lindberg I, Christensson K, Öhrling K. Midwives' experience of organisational and
657 professional change. *Midwifery* 2005; **21**(4): 355-64.
- 658 72. Hood L, Fenwick J, Butt J. A story of scrutiny and fear: Australian midwives' experiences of an
659 external review of obstetric services, being involved with litigation and the impact on clinical
660 practice. *Midwifery* 2010; **26**(3): 268-85.
- 661 73. Francis R. Report on the Freedom to Speak Up review. *The Stationery Office. London* 2015; .
- 662 74. Edwards N, Murphy-Lawless J, Kirkham M, Davies S. Attacks on midwives, attacks on
663 women's choices. *AIMS Journal* 2011; **23**(3): 3-7.
- 664 75. Brooks SK, Del Busso L, Chalder T, et al. 'You feel you've been bad, not ill': Sick doctors'
665 experiences of interactions with the General Medical Council. *BMJ Open* 2014; **4**(7): e005537,2014-
666 005537.
- 667 76. Naturale A. HOW DO WE UNDERSTAND DISASTER-RELATED VICARIOUS TRAUMA,
668 SECONDARY TRAUMATIC STRESS, AND COMPASSION FATIGUE? *Vicarious Trauma and*
669 *Disaster Mental Health: Understanding Risks and Promoting Resilience* 2015; : 73.
- 670 77. National Institute of Mental Health (NIMH). What is post-traumatic stress disorder, or PTSD?
671 2015; Available at: [http://www.nimh.nih.gov/health/publications/post-traumatic-stress-disorder-
672 ptsd/index.shtml](http://www.nimh.nih.gov/health/publications/post-traumatic-stress-disorder-ptsd/index.shtml). Accessed 08/05, 2015.
- 673 78. Kouchaki M, Desai SD. Anxious, threatened, and also unethical: How anxiety makes
674 individuals feel threatened and commit unethical acts. 2014; .
- 675 79. Borritz M, Rugulies R, Bjorner JB, Villadsen E, Mikkelsen OA, Kristensen TS. Burnout among
676 employees in human service work: design and baseline findings of the PUMA study. *Scand J Public*
677 *Health* 2006; **34**(1): 49-58.

MIDWIVES IN PSYCHOLOGICAL DISTRESS

- 678 80. Yoshida Y, Sandall J. Occupational burnout and work factors in community and hospital
679 midwives: A survey analysis. *Midwifery* 2013; **29**(8): 921-6.
- 680 81. Romani M, Ashkar K. Burnout among physicians. *Libyan Journal of Medicine* 2014; **9**(1).
- 681 82. National NHS Staff Survey Co-ordination Centre. NHS staff survey for England. 2014; .
- 682 83. Hunter B. The heart of the job: emotion work in midwifery. *ESSENTIALLY MIDIRS* 2011; **2**(2):
683 17-21.
- 684 84. Merlo LJ, Singhakant S, Cummings SM, Cottler LB. Reasons for misuse of prescription
685 medication among physicians undergoing monitoring by a physician health program. *J Addict Med*
686 2013; **7**(5): 349-53.
- 687 85. Cleary M, Horsfall J, Baines J, Happell B. Mental health behaviours among undergraduate
688 nursing students: Issues for consideration. *Nurse Educ Today* 2012; **32**(8): 951-5.
- 689 86. Dorrian J, Paterson J, Dawson D, Pincombe J, Grech C, Rogers AE. Sleep, stress and
690 compensatory behaviors in Australian nurses and midwives. *Rev Saude Publica* 2011; **45**(5): 922-30.
- 691 87. Green BN, Johnson CD, Adams A. Writing narrative literature reviews for peer-reviewed
692 journals: secrets of the trade. *Journal of Chiropractic Medicine* 2006; **5**(3): 101-17.
- 693 88. Popay J, Roberts H, Sowden A, et al. Guidance on the conduct of narrative synthesis in
694 systematic reviews. *A product from the ESRC methods programme. Version* 2006; **1**.
- 695 89. Sackett DL, Straus SE, Richardson WS, Rosenberg W, Haynes RB. How to practice and teach
696 EBM. *Edinburgh: Churchill Livingstone* 2000; .
- 697 90. Choong MK, Galgani F, Dunn AG, Tsafnat G. Automatic evidence retrieval for systematic
698 reviews. *J Med Internet Res* 2014; **16**(10): e223.

MIDWIVES IN PSYCHOLOGICAL DISTRESS

- 699 91. Faucher MA. Most labor and delivery nurses experience secondary traumatic stress. *J*
700 *Midwifery Womens Health* 2013; **58**(1): 114-5.
- 701 92. Afolayan JA, Dairo BA. Stress in the workplace of Nurses and Midwives in Nigeria. *Journal of*
702 *Behavioural Sciences* 2009; **19**(1-2): 1-21.
- 703 93. Begley CM. 'Great fleas have little fleas': Irish student midwives' views of the hierarchy in
704 midwifery. *J Adv Nurs* 2002; **38**(3): 310-7.
- 705 94. Hunter B, Warren L. **Midwives' experiences of workplace resilience.** *Midwifery* 2014; **30**(8):
706 926-934.
- 707 95. Hunter B, Warren L. Midwives' experiences of workplace resilience. *Midwifery* 2014; **30**(8):
708 926-34.
- 709 96. Hunter B. Emotion work and boundary maintenance in hospital-based midwifery. *Midwifery*
710 2005; **21**(3): 253-66.
- 711 97. Gillen P, Sinclair M, Kernohan G, Begley C. Student midwives' experience of bullying. *EVID*
712 *BASED MIDWIFERY* 2009; **7**(2): 46-53.
- 713 98. Davies S, Coldridge L. 'No Man's Land': An exploration of the traumatic experiences of student
714 midwives in practice. *Midwifery* 2015; .
- 715 99. Sheen K, Spiby H, Slade P. Exposure to traumatic perinatal experiences and posttraumatic
716 stress symptoms in midwives: Prevalence and association with burnout. *Int J Nurs Stud* 2015; **52**(2):
717 578-87.
- 718 100. Farrell GA, Shafiei T. Workplace aggression, including bullying in nursing and midwifery: a
719 descriptive survey (the SWAB study). *Int J Nurs Stud* 2012; **49**(11): 1423-31.

MIDWIVES IN PSYCHOLOGICAL DISTRESS

- 720 101. Hutchinson M. Around half of nurses and midwives report workplace aggression in the past
721 month: 36% report violence from patients or visitors and 32% report bullying by colleagues. *Evidence*
722 *Based Nursing* 2014; **17**(1): 26-7.
- 723 102. Schluter PJ, Turner C, Benefer C. Long working hours and alcohol risk among Australian and
724 New Zealand nurses and midwives: A cross-sectional study. *Int J Nurs Stud* 2012; **49**(6): 701-9.
- 725 103. Jordan K, Fenwick J, Slavin V, Sidebotham M, Gamble J. Level of burnout in a small
726 population of Australian midwives. *Women and Birth* 2013; **26**(2): 125-32.
- 727 104. Mollart L, Newing C, Foureur M. Midwives' emotional wellbeing: impact of conducting a
728 structured antenatal psychosocial assessment (SAPSA). *Women Birth* 2009; **22**(3): 82-8.
- 729 105. Garel M, Etienne E, Blondel B, Dommergues M. French midwives' practice of termination of
730 pregnancy for fetal abnormality. At what psychological and ethical cost? *Prenat Diagn* 2007; **27**(7):
731 622-8.
- 732 106. Kalicińska M, Chylińska J, Wilczek-Różycka E. Professional burnout and social support in
733 the workplace among hospice nurses and midwives in Poland. *Int J Nurs Pract* 2012; **18**(6): 595-603.
- 734 107. Knezevic B, Milosevic M, Golubic R, Belosevic L, Russo A, Mustajbegovic J. Work-related
735 stress and work ability among Croatian university hospital midwives. *Midwifery* 2011; **27**(2): 146-53.
- 736 108. Mauri PA, Ceriotti E, Soldi M, Guerrini Contini NN. Italian midwives' experiences of late
737 termination of pregnancy. A phenomenological-hermeneutic study. *Nurs Health Sci* 2015; **17**(2): 243-
738 9.
- 739 109. Sato K, Adachi K. Occupational stress experienced by Japanese midwives. *British Journal of*
740 *Midwifery* 2013; **21**(11): 801-6.

MIDWIVES IN PSYCHOLOGICAL DISTRESS

- 741 110. Muliira R, Sendikadiwa V, Lwasampijja F. Predictors of Death Anxiety Among Midwives
742 Who have Experienced Maternal Death Situations at Work. *Maternal & Child Health Journal* 2015;
743 **19**(5): 1024-32.
- 744 111. Oncel S, Ozer ZC, Efe E. Work-related stress, burnout and job satisfaction in Turkish
745 midwives. *Social Behavior and Personality* 2007; **35**(3): 317-28.
- 746 112. Hunter B. Emotion work in midwifery: a review of current knowledge. *J Adv Nurs* 2001;
747 **34**(4): 436-44.
- 748 113. Sheen K, Slade P, Spiby H. An integrative review of the impact of indirect trauma exposure in
749 health professionals and potential issues of salience for midwives. *J Adv Nurs* 2014; **70**(4): 729-43.
- 750 114. Wallbank S, Robertson N. Midwife and nurse responses to miscarriage, stillbirth and neonatal
751 death: a critical review of qualitative research. *EVID BASED MIDWIFERY* 2008; **6**(3): 100-6.
- 752 115. Begley CM. Great fleas have little fleas': Irish student midwives' views of the hierarchy in
753 midwifery. *J Adv Nurs* 2002; **38**(3): 310-7.
- 754 116. Afolayan JA, Dairo BA. Stress in the workplace of Nurses and Midwives in Nigeria. *Journal*
755 *of Behavioural Sciences* 2009; **19**(1-2): 1-21.
- 756 117. Bennett H, Wells A. Metacognition, memory disorganization and rumination in posttraumatic
757 stress symptoms. *J Anxiety Disord* 2010; **24**(3): 318-25.
- 758 118. Farrell GA, Shafiei T. Workplace aggression, including bullying in nursing and midwifery: A
759 descriptive survey (the SWAB study). *Int J Nurs Stud* 2012; **49**(11): 1423-31.
- 760 119. Farrell GA, Shafiei T. Workplace aggression, including bullying in nursing and midwifery: a
761 descriptive survey (the SWAB study). *Int J Nurs Stud* 2012; **49**(11): 1423-31.

MIDWIVES IN PSYCHOLOGICAL DISTRESS

- 762 120. Oulton JA. The global nursing shortage: an overview of issues and actions. *Policy Polit Nurs*
763 *Pract* 2006; **7**(3 Suppl): 34S-9S.
- 764 121. Mizuno M. Confusion and ethical issues surrounding the role of Japanese midwives in
765 childbirth and abortion: A qualitative study. *Nurs Health Sci* 2011; **13**(4): 502-6.
- 766 122. The Nursing and Midwifery Council (NMC). The Code: Professional standards of practice and
767 behaviour for nurses and midwives. 2015; .
- 768 123. World Health Organization, UNICEF, United Nations Fund for Population Activities. Trends
769 in Maternal Mortality: 1990 to 2010: WHO, UNICEF, UNFPA, and The World Bank estimates.
770 World Health Organization; 2012.
- 771 124. Oestergaard MZ, Inoue M, Yoshida S, et al. Neonatal mortality levels for 193 countries in
772 2009 with trends since 1990: a systematic analysis of progress, projections, and priorities. *PLoS Med*
773 2011; **8**(8): e1001080.
- 774 125. Poverty E. Millennium development goals. *United Nations*. Available online:
775 <http://www.un.org/millenniumgoals/> (accessed on 23 August 2011) 2015; .
- 776 126. Schluter PJ, Turner C, Huntington AD, Bain CJ, McClure RJ. Work/life balance and health:
777 the Nurses and Midwives e-cohort study. *Int Nurs Rev* 2011; **58**(1): 28-36.
- 778 127. Skinner N, van Dijk P, Elton J, Auer J. An in-depth study of Australian nurses' and midwives'
779 work-life interaction. *Asia Pacific Journal of Human Resources* 2011; **49**(2): 213-32.
- 780 128. Prosser-Snelling E. Safer Births Through Better Teamworking. *The Health Foundation* 2015; .
- 781 129. Zapf D, Vogt C, Seifert C, Mertini H, Isic A. Emotion work as a source of stress: The concept
782 and development of an instrument. *European Journal of work and organizational psychology* 1999;
783 **8**(3): 371-400.

MIDWIVES IN PSYCHOLOGICAL DISTRESS

- 784 130. Johanson R, Newburn M, Macfarlane A. Has the medicalisation of childbirth gone too far?
785 *BMJ* 2002; **324**(7342): 892-5.
- 786 131. Reiger K. Domination or mutual recognition? Professional subjectivity in midwifery and
787 obstetrics. *Social Theory & Health* 2008; **6**(2): 132-47.
- 788 132. The Royal College of Midwives. State of Maternity Service Report. 2011; .
- 789 133. Fenwick J, Hammond A, Raymond J, et al. Surviving, not thriving: a qualitative study of
790 newly qualified midwives' experience of their transition to practice. *J Clin Nurs* 2012; **21**(13-14):
791 2054-63.
- 792 134. West M, Dawson J, Admasachew L, Topakas A. NHS staff management and health service
793 quality. *London: Department of Health* 2011; .
- 794 135. Blake H, Zhou D, Batt ME. Five-year workplace wellness intervention in the NHS. *Perspect*
795 *Public Health* 2013; **133**(5): 262-71.
- 796 136. Wallbank S. Effectiveness of individual clinical supervision for midwives and doctors in stress
797 reduction: findings from a pilot study. *EVID BASED MIDWIFERY* 2010; **8**(2): 65-70.
- 798 137. Sandall J, Soltani H, Gates S, Shennan A, Devane D. Midwife-led continuity models versus
799 other models of care for childbearing women. *Cochrane Database Syst Rev* 2013; **8**(8).
- 800 138. Newton MS, McLachlan HL, Willis KF, Forster DA. Are caseload midwives more satisfied
801 and less burnt out than standard care midwives? Findings from two cross-sectional surveys conducted
802 in Victoria, Australia. *BMC Pregnancy & Childbirth* 2014; **14**(1): 463-91.
- 803 139. Warren L, Hunter B. Reflecting on resilience in midwifery. *Pract Midwife* 2014; **17**(11): 21-3.
- 804 140. Scott A, Witt J, Duffield C, Kalb G. What do nurses and midwives value about their jobs?
805 Results from a discrete choice experiment. *J Health Serv Res Policy* 2015; **20**(1): 31-8.

MIDWIVES IN PSYCHOLOGICAL DISTRESS

- 806 141. Wickham S. Caring for ourselves. *Pract Midwife* 2014; **17**(11): 37-8.
- 807 142. Byrom S. Feeling the pressure: what can we do? *Pract Midwife* 2014; **17**(2): 46-.
- 808 143. Holland M. Intelligent Kindness: Reforming the Culture of Healthcare. *The Psychiatrist* 2012;
809 **36**(10): 399-.
- 810 144. Kirkup B. The Report of the Morecambe Bay Investigation. 2015; .
- 811 145. Illing J, Carter M, Thompson N, et al. Evidence synthesis on the occurrence, causes,
812 consequences, prevention and management of bullying and harassing behaviours to inform decision-
813 making in the NHS. 2013; .
- 814 146. Longo J. Combating disruptive behaviors: Strategies to promote a healthy work environment.
815 *OJIN: The Online Journal of Issues in Nursing* 2010; **15**(1).
- 816 147. Haigh R. The quintessence of a therapeutic environment. *Therapeutic Communities: The*
817 *International Journal of Therapeutic Communities* 2013; **34**(1): 6-15.
- 818 148. Downe S, Finlayson K, Fleming A. Creating a Collaborative Culture in Maternity Care. *The*
819 *Journal of Midwifery & Women's Health* 2010; **55**(3): 250-4.
- 820 149. King TL, Laros RK, Parer JT. Interprofessional collaborative practice in obstetrics and
821 midwifery. *Obstet Gynecol Clin North Am* 2012; **39**(3): 411-22.
- 822