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Published in:
Birth: Issues in Perinatal Care

Document Version:
Publisher's PDF, also known as Version of record

Queen's University Belfast - Research Portal:
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Download date: 31. Aug. 2023
SYSTEMATIC REVIEW

The impact on midwives and their practice after caring for women who have traumatic childbirths: A systematic review

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Abstract

Background: Women’s birth experiences can range from positive and satisfying to negative and traumatizing. Midwives caring for women can also be exposed to these traumatic childbirth experiences. There is a paucity of research on the impact these experiences have on midwives and their practice. The PEO framework guided the research review question.

Methods: Seven electronic databases were systematically searched. The quality of each included study was assessed using the tool appropriate to the study’s methodological approach; Critical Appraisal Skills Program (CASP) criteria and the Mixed Methods Appraisal Tool (MMAT) Version 2018. The Consolidated Criteria for Reporting Qualitative Research (COREQ) tool was utilized to assess reported findings. Confidence in the Evidence from Reviews of Qualitative research (CERQual) was used to grade the confidence in the evidence of the qualitative research. Data were thematically analyzed to formalize the identification and development of themes.

Results: A total of 12 studies were included. Synthesis of the evidence generated one overarching theme, “Midwives, the forgotten victims”, and three themes describing the essences of midwives’ experiences: “Bruised and battered but still smiling”; “Wearing armour to protect my soul”; “Members of my team are holding me up, others are pulling me down”.

Conclusions: Midwives expressed feelings of shock, fear, responsibility, and powerlessness which may contribute to some experiencing serious mental illness. They reported a shaken belief in the normal physiologic birth process which consequently led to more defensive practice. Research is needed to identify high-quality interventions to support midwives after these events. This systematic review protocol was registered on the International Prospective Register of Systematic Reviews (PROSPERO; Registration CRD42021252033).


1 | BACKGROUND

Labor and birth constitute a significant life-changing event for a woman and her family. For many years, maternity healthcare providers focused mainly on the physical health and well-being of the mother and her baby. However, the importance of a mother’s emotional health and a positive childbirth experience has rightly gained increasing attention in research and in clinical practice; nevertheless, further implementation of research evidence is necessary.

While many women and birthing people view their experience of care as positive and empowering, childbirth can be a negative and traumatizing event. A traumatic childbirth experience can result in both short- and long-term health and well-being consequences for the woman and her family. It is also important to consider the effects of participating in and/or witnessing a traumatic birth from the perspective of the midwife/midwives caring for the family. The term midwife is used throughout this systematic review; however, some studies included maternity care providers who were nurses or nurse-midwives.

Fear of childbirth, unnecessary interventions, unexpected mode of birth, and labor and birth complications have been associated with a traumatic childbirth. Interestingly, ineffective interaction between women and maternity healthcare professionals has a stronger influence on birth trauma than medical intervention or mode of birth. For example, a perceived lack of control and involvement in decision-making and feelings of disrespectful care, disconnection, helplessness, and loss of dignity can contribute to traumatic experiences.

Emotional support for women can protect against a potentially negative birth experience, irrespective of the level of medical intervention. Thus, the woman-midwife interaction is vital in reducing birth trauma experiences. Midwives provide uniquely intimate support comprised of intense empathy, however, this may challenge the normal and often protective professional/client boundaries. This unique role can put midwives in a vulnerable position of suffering emotional distress and increasing their risk of “compassion fatigue.” Furthermore, midwives can experience moral distress when women and birthing people experience disrespectful interactions which violates their values of midwifery and professional conduct.

A traumatic birth, from the perspective of midwives has been described as an event involving death, injury, emergency, or interpersonal disrespect. Midwives may suffer from feelings of guilt, fear, powerlessness, responsibility, doubt, vulnerability, and reduced professional confidence after these events. Furthermore, increased workloads, staff shortages, and long hours often mean that midwives are unable to process and overcome these emotions, leaving them vulnerable to Secondary Traumatic Stress (STS), Post-Traumatic Stress Disorder (PTSD), compassion fatigue and burnout. These consequences shape the phenomenon, the “second victim”, introduced by Wu. This term refers to the healthcare professionals victimized by unanticipated adverse patient-related incidents who are personally and/or professionally affected. Midwives can suffer from flashbacks, extreme tiredness, fearfulness, and a destruction in their belief in the physiology of childbirth. This shattered belief can damage midwives’ confidence, and increase fear of causing pain or death, receiving criticism or litigation. Midwives can cease to view labor and childbirth as physiological, resulting in increased vigilance, risk management and the use of unnecessary interventions.

Alternatively, some midwives may experience positive personal and professional growth. While personal characteristics, such as inner strength can influence this, Gruenberg found midwives can manage the impact of witnessing a traumatic event when they are given the opportunity to talk to a sympathetic listener. Healing can begin with a safe, supportive, and non-judgmental environment which encourages debriefing. This facilitates reflection and learning—tools which can help diminish feelings of self-blame and incompetence. Consequently, midwives can become reflective rather than defensive practitioners, which Elmir et al. and Toohill et al. believe improves midwives’ communication, confidence, and ability to maintain positive interactions.

Witnessing and/or being involved in traumatic childbirth events can become embedded in the midwife’s role. Systematically reviewing the related empirical evidence is essential for understanding the impact on midwives and their practice to learn how midwives can support each other after these events and to improve the quality of midwifery care and women’s childbirth experiences.

2 | METHOD

A systematic review was undertaken to identify and synthesize relevant research evidence to inform and guide midwives and maternity healthcare professionals in both
clinical practice and policy formation on the impact on midwives and their practice after caring for women who have traumatic childbirth.

2.1 Search strategy

A systematic search strategy was developed with the assistance of an expert subject librarian. A brief scoping review of research on birth trauma was conducted prior to formulating the search strategy to identify common terminology. The PEO (population, exposure, outcome) framework for qualitative studies was utilized to formulate the research review question: P: midwives, E: traumatic childbirth, O: impact and practice – What is the impact on midwives and their practice after caring for women who have a traumatic childbirth?

Systematic searches were conducted on seven bibliographic databases: Cinahl plus, Medline, EMBASE, Maternity and Infant Care, Scopus, PsycINFO and The Cochrane Library. An inclusion timeframe from January 1, 2010 to June 28, 2021 was chosen to allow for a manageable number of relevant articles. The search terms as illustrated in Table 1 were combined using AND and OR and were adapted to the requirement of each database.

2.2 Eligibility criteria

Only full-text articles published in peer-reviewed journals were included. The search was restricted to studies written in English as interpretation services were not available. Qualitative and mix-methods studies involving qualitative data describing practicing registered midwives’ perceptions/experiences of how caring for women who have traumatic childbirth experiences impacted them and their practice were included. Studies examining the experience of traumatic childbirth from the perspective of women, birthing people, partners, student midwives, and other maternity care providers were not included.

2.3 Data extraction

Following detailed systematic review of the databases, titles and abstracts of all retrieved articles were initially screened by JB with supervision and guidance by FAK and MH. Full-text articles were retrieved for further screening, and back chaining of their reference lists was undertaken. Studies were then read in their entirety and screened using the eligibility criteria.

2.4 Quality assessment of included research

Included studies underwent quality assessment by the research team. The tools utilized to assess the quality of evidence depended on each study's methodological approach. The Critical Appraisal Skills Program (CASP) tool was used for studies that used a qualitative design (Table 2), as endorsed by the Cochrane Qualitative and Implementation Methods Group. The Mixed Methods Appraisal Tool (MMAT) Version 2018 enabled the appraisal of the mixed methods studies (Table 3). Each study was assessed by the Consolidated Criteria for Reporting Qualitative Research (COREQ) tool (Table 4). Finally, the CERQual (Confidence in the Evidence from Reviews of Qualitative Research) approach was used to assess confidence that findings from qualitative research represent the phenomenon of interest (Table 5). No studies were excluded after quality assessment.

3 RESULTS

The systematic search of the databases identified 1232 articles. Following deduplication, 613 articles were screened; 593 articles did not meet the inclusion criteria, leaving 20 studies. Back chaining of these reference lists identified a further 15 for full-text assessment. A total of 12 studies were found to meet the aims and criteria for

<table>
<thead>
<tr>
<th>Population AND</th>
<th>Exposure AND</th>
<th>Outcome</th>
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<tbody>
<tr>
<td>Midwife OR</td>
<td>Traumatic childbirth OR</td>
<td>Care OR</td>
</tr>
<tr>
<td>Midwifery OR</td>
<td>Traumatic birth OR</td>
<td>Practice OR</td>
</tr>
<tr>
<td>Midwives OR</td>
<td>Birth trauma OR</td>
<td>Philosophy of care</td>
</tr>
<tr>
<td>Midwi* OR</td>
<td>Complicated delivery OR</td>
<td></td>
</tr>
<tr>
<td>Nurse midwife OR</td>
<td>Obstetric labour complications OR</td>
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<tr>
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<td>Obstetric labor complications OR</td>
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<tr>
<td>Nurse Midwi* OR</td>
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</tbody>
</table>
In this systematic review, 6 from the database search and 6 from the back chaining. A research PRISMA Flow chart (Figure 1) outlines this process. For each study, a data extraction matrix was completed (Table A1 in Appendix).

### 3.1 Data analysis

Thematic synthesis as reported by Thomas and Harden was undertaken to analyze the data obtained from the included papers. Coding was conducted primarily by JB and reviewed by FAK and MH with agreement by consensus. Data from each of the individual studies were coded line by line using verbatim text from each study. Similarities between the codes were identified to aggregate them into descriptive themes capturing the meaning of the original data. Finally, patterns, similarities and differences within the descriptive themes were explored and interpreted in relation to the review question to generate analytical themes.

### 3.2 Description of included studies

The 12 included publications dated from 2011 to 2021. Four studies were conducted in Australia, two in the United States, and one from the following countries: Turkey, United Kingdom, Israel, and the Netherlands and Flanders. Two of the studies recruited participants from the Association of Women’s Health, Obstetrics and Neonatal Nurses (AWHONN) which serves the United States and Canada. Three studies focused on specific traumatic events, such as shoulder dystocia, vasa praevia, and perinatal loss whereas the remaining nine studies reported on any event perceived as traumatic by the midwife.

Eight studies utilized qualitative approaches, with a descriptive mode of inquiry. Seven qualitative studies collected data through interviews. Puia et al. conducted a qualitative content analysis on data from the study by Beck and Gable. Four studies utilized a mixed method design with qualitative methods to elaborate on findings. For data collected through interviews, the participant numbers ranged from 9 to 35. The sample size of the mixed methods studies ranged from 24 to 473.

### 4 RESULTS

Midwives experienced births as traumatic when disrespectful treatment toward women and birthing people occurred, poor care practices were undertaken or obstetric
emergencies such as shoulder dystocia or maternal death occurred. Only Toohill et al. 32 acknowledged midwives’ personal birth trauma experiences; these midwives had a desire to provide extra care, compassion, and empathy to women.

The overarching theme from the synthesis of evidence was, *Midwives, the forgotten victims*, with three related themes as described below. Each study highlighted the range of intense emotions experienced by midwives during a traumatic childbirth event and how they struggled to deal with the aftermath, both personally and professionally. This was exacerbated by the lack of support provided by their employer, and in some cases, a hostile working environment.

### 4.1 Theme 1: Bruised and battered, but still smiling

The theme “bruised and battered, but still smiling” describes the often unpredictable nature of a traumatic childbirth and the initial emotional and physical responses experienced by midwives, at the same time the need to maintain their professionalism.

Midwives described the chaotic and urgent nature of traumatic experiences which required quick responses, often intensifying their emotions.25,46 Initially, midwives experienced shock and despair at recognizing an obstetric emergency, which for some also affected them physically.20,25 After the realization of an unexpected event, midwives spoke about high levels of fear and anxiety,27 as they desperately attempted to manage the situation and prevent adverse outcomes.27

Midwives felt scared and guilty due to the potential negative physical and emotional influence a traumatic childbirth could have on the families. When an adverse outcome occurred, midwives were overcome by deep sadness and felt they had “let the woman down.”20,23,25,28,45,46,49 This caused midwives to question their practice, doubting whether they were responsible by either action or inaction.20,28,32 Birth trauma caused by inadequate care also made midwives feel powerless and helpless. They expressed frustration and feelings of “failure to protect” women and birthing people when they were unable to speak up and advocate for them.22,28,32,48

Regardless of the emotional reactions experienced by midwives, they had a professional responsibility;20 “… your responsibility is to look after them... you hold it in...
all the time you’re at work.²⁰ Intense workload and long working hours can make it challenging for midwives to find time to reflect. This lack of psychological support and time to process can even cause midwives to normalize the event.²³

The personal influence of the events on midwives was long-lasting. Due to the ambiguous nature of many traumatic experiences, a period of rumination was common. Many midwives experienced the trio of symptoms of PTSD: intrusion, arousal, and avoidance. Midwives were haunted by details of the event as they psychologically re-lived each aspect repeatedly.²⁰,²²,²³,⁴⁵,⁴⁶,⁴⁸

### 4.2 Theme 2: Wearing armor to protect my soul

The theme “wearing armour to protect my soul” focuses on the influence a traumatic childbirth can have on midwives’ practice. From these experiences, some
TABLE 5  CERQual assessment of the confidence in the qualitative findings.

<table>
<thead>
<tr>
<th>Summary of review findings</th>
<th>Studies contributing to the review finding</th>
<th>CERQual assessment of confidence in the evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bruises and battered but still smiling - the impact traumatic experiences had on midwives</td>
<td>Goldbort et al., 2011; Halperin et al., 2011</td>
<td>Low confidence</td>
</tr>
<tr>
<td>Unanticipated and chaotic events – Unanticipated events, often sudden required urgent thinking and action from midwives to manage an unfolding traumatic event to deliver a baby safely and ensure the wellbeing of the mother is not compromised. Midwives described these events as ‘chaos’ which intensified their emotions during these situations</td>
<td>Halperin et al., 2011; Javid et al., 2018; Sheen et al., 2016</td>
<td>Moderate confidence</td>
</tr>
<tr>
<td>Shock and fear – Initially midwives may have feelings of shock and despair at recognising an obstetric emergency, which for some also affected them physically</td>
<td>Halperin et al., 2011; Javid et al., 2018; Sheen et al., 2016</td>
<td>Moderate confidence</td>
</tr>
<tr>
<td>Fear and anxiety – After the realisation of an unexpected event, midwives spoke about high level of fear and anxiety</td>
<td>Minoee, et al., 2021; Fontein-Kuipers et al., 2018</td>
<td>Low confidence</td>
</tr>
<tr>
<td>Scared – Midwives felt scared during traumatic childbirth due to the potential negative physical and emotion impact it could have on women</td>
<td>Cankaya et al., 2020; Halperin et al., 2011; Javid et al., 2018</td>
<td>Moderate confidence</td>
</tr>
<tr>
<td>Sadness – When experiences result in adverse outcomes, midwives experience deep sadness</td>
<td>Beck et al., 2015; Halperin et al., 2011; Javid et al., 2018; Puia et al., 2013; Rice and Warland, 2013</td>
<td>Moderate confidence</td>
</tr>
<tr>
<td>Feeling for the woman – Midwives were emotionally affected by the traumatic birth they witnessed because they were, ‘feeling for the woman’. Empathy for the woman’s experience influenced the way they interpreted the traumatic birth and also meant the midwives themselves felt traumatised by what the women went through. Furthermore, midwives perceived the event more difficult when they had a relationship with the mother</td>
<td>Halperin et al., 2011; Javid et al., 2018; Rice and Warland, 2013; Sheen et al., 2016</td>
<td>Moderate confidence</td>
</tr>
<tr>
<td>Maintaining a professional appearance – Regardless of all these emotional reactions, midwives have to manage their feelings to maintain a professional appearance</td>
<td>Sheen et al., 2016</td>
<td>Low confidence</td>
</tr>
<tr>
<td>Normalising event – Intense workload and long hours can make it challenging for midwives to have time to think about traumatic delivery and might cause them to normalise the event</td>
<td>Cankaya et al., 2020</td>
<td>Low confidence</td>
</tr>
<tr>
<td>Responsibility, guilt and self-blame – Feelings of responsibility, guilt and self-blame were emotions felt by midwives after witnessing a traumatic childbirth</td>
<td>Cankaya et al., 2020; Javid et al., 2018; Puia et al., 2013; Rice and Warland, 2013; Sheen et al., 2016</td>
<td>High confidence</td>
</tr>
<tr>
<td>Powerlessness and helplessness – When women experienced unnecessary trauma due to inadequate care, midwives reported feelings of powerlessness and helplessness. They expressed frustration and feelings like they had ‘failed’ to ‘protect’ women because they were unable to speak up and advocate for them</td>
<td>Beck and Gable, 2012; Beck et al., 2015; Puia et al., 2013; Rice and Warland, 2013; Toohill et al., 2019</td>
<td>Moderate confidence</td>
</tr>
<tr>
<td>Long-lasting – The personal impact of the events on midwives was long-lasting. Due to the ambiguous nature of many traumatic experiences, a period of rumination was common. Many midwives experienced the trio of symptoms of PTSD: intrusion, arousal, and avoidance. Midwives were haunted by details of the event as they relived each aspect over and over again in their minds</td>
<td>Beck et al., 2015; Sheen et al., 2016; Cankaya et al., 2020; Beck and Gable, 2012; Goldbort et al., 2011; Javid et al., 2018; Halperin et al., 2011</td>
<td>High confidence</td>
</tr>
</tbody>
</table>

(Continues)
### Summary of review findings

**Wearing an armour to protect my soul – the impact traumatic experiences had on midwives’ practice**

- **Improved practice** – Some midwives felt they improved their practice due to their traumatic experience. Midwives reported learning about themselves, their management of care or their professional behaviour from these events. The event contributed to or advanced their development of being (or becoming) a midwife and a reflective practitioner.
  
  Studies contributing to the review finding: Cankaya et al., 2020; Fontein-Kuiplers et al., 2018; Goldbort et al., 2011; Rice and Warland, 2013.
  
  CERQual assessment of confidence in the evidence: Moderate confidence

- **No longer evidence-based practice** – Traumatic childbirth experiences caused midwives initial passion towards birth to gradually convert to caution. Their belief in the birth process was shaken. Midwives became more cautious with the language they used, from encouraging statements to more tempered ones. Additionally, midwives expressed cautiousness in their practice. Hypervigilance and prophylactic intervention were common alterations to midwives’ practice. This was expressed to prevent the recurrence of a traumatic experience to protect both the midwives themselves and the mother/newborns or they felt less confident in their practice.
  
  Studies contributing to the review finding: Beck et al., 2015; Cankaya et al., 2020; Fontein-Kuiplers et al., 2018; Minooee et al., 2021; Sheen et al., 2016.
  
  CERQual assessment of confidence in the evidence: Moderate confidence

- **Litigation** – Midwives also feared litigation which exacerbated their defensive practice.
  
  Studies contributing to the review finding: Beck et al., 2015; Cankaya et al., 2020; Toohill et al., 2019.
  
  CERQual assessment of confidence in the evidence: Moderate confidence

- **Change in career** – Some midwives contemplated leaving their clinical role or the profession completely.
  
  Studies contributing to the review finding: Beck et al., 2015; Beck and Gable 2012; Minooee et al., 2021; Sheen et al., 2016; Cankaya et al., 2020.
  
  CERQual assessment of confidence in the evidence: Moderate confidence

**Members of my team are holding me up, others are pulling me down - different factors which soothe or worsen the traumatic experience**

- **Unsupportive working environment** – An unsupportive work environment and lack of emotional understanding from colleagues added to the burden of trauma relating to the birth. This made midwives feel abandoned, betrayed, and lonely and created a hostile working environment which was toxic and unsafe.
  
  Studies contributing to the review finding: Minoee et al., 2021; Beck et al., 2015; Sheen et al., 2016; Rice and Warland, 2013.
  
  CERQual assessment of confidence in the evidence: High confidence

- **Supportive obstetric team** – A supportive obstetric team and speaking to colleagues, particularly those who had had similar experiences were invaluable for midwives to cope following a traumatic experience. They provided emotional support and reassurance and helped them gain an objective perspective.
  
  Studies contributing to the review finding: Beck et al., 2015; Fontein-Kuiplers et al., 2018; Minoee et al., 2021; Sheen et al., 2016.
  
  CERQual assessment of confidence in the evidence: Moderate confidence

- **Professional support** – Furthermore, professional support and formal debriefing sessions provided staff involved in a traumatic childbirth an opportunity to share their thoughts and feelings and reflect on the event.
  
  Studies contributing to the review finding: Beck and Gable 2012; Cankaya et al., 2020.
  
  CERQual assessment of confidence in the evidence: Low confidence

- **Personal lives** – Midwives were less likely to share with non-midwife friends and family because they did not always possess the same understanding that they needed. This could either enhance or deteriorate the relationship. This demonstrates that midwives’ personal lives were impacted.
  
  Studies contributing to the review finding: Fontein-Kuiplers et al., 2018; Halperin et al., 2011.
  
  CERQual assessment of confidence in the evidence: Low confidence

- **Coping strategies** – Midwives reported implementing coping strategies. Some midwives found that prayer was an essential component of getting through and coping after a traumatic childbirth. Midwives also valued training exercises using stimulation to practice emergency situations helping them to feel prepared. Permission to take time off was also considered to be beneficial.
  
  Studies contributing to the review finding: Beck and Gable, 2012; Cankaya et al., 2020; Sheen et al., 2016; Halperin et al., 2011.
  
  CERQual assessment of confidence in the evidence: Low confidence
midwives felt their skills improved, for example, taking a more detailed medical history or informing the doctor in high-risk situations. Furthermore, midwives reported learning about themselves, their management of care or their professional behavior from these events. The event contributed to or advanced their development of being (or becoming) a midwife and a reflective practitioner.

Unfortunately for some, the change in their practice did not reflect evidence-based practice. Traumatic childbirth experiences caused midwives initial passion for birth to gradually convert to caution. Their belief in the normal physiological birth process was shaken. Midwives became more cautious with the language they used, from encouraging statements to more tempered ones. Hypervigilance and prophylactic intervention (routine episiotomy and oxygen initiation immediately after birth) were common alterations to midwives’ practice, to prevent the recurrence of a traumatic experience and/or to protect themselves and women. Midwives also feared litigation which exacerbated their defensive practice. With a heightened sense of fear and stress, every birth became a potentially traumatic event. Some midwives contemplated leaving their clinical role or the profession completely; “I thought a lot about quitting midwifery.”

### Theme 3: Members of my team are holding me up, others are pulling me down

The theme “members of my team are holding me up, others are pulling me down” encompasses a variety of factors that either soothe or worsen the traumatic childbirth experience.

An unsupportive work environment and lack of emotional understanding from colleagues added to the burden of a traumatic childbirth. This made midwives feel abandoned, betrayed and lonely, creating a hostile working environment which was toxic, unsafe and encouraged a blame culture. Furthermore, midwives reported that they felt judged or criticized about their clinical competence by colleagues or team leaders, affecting collaborative relationships. When there was contact with a senior colleague, midwives felt that the focus was to determine what went wrong rather than to support them. Study participants highlighted that even if the outcome of a birth was favorable, it could still be traumatizing.

A supportive obstetric team and speaking to colleagues, particularly those who had had similar traumatic childbirth experiences were invaluable for midwives, enabling them to cope: “Once you’ve talked to somebody about it properly, it’s as if a weight is just lifted off your shoulders.” Colleagues provided emotional support and reassurance, helping them gain a more objective perspective. Midwives also valued training exercises using simulation to practice emergency situations. Permission to take time off was also considered to be beneficial.

### DISCUSSION

#### 5.1 The midwife-woman relationship and continuity of care

Being “with woman” is the central construct of midwifery philosophy and practice. Several studies show that a trusting relationship between the woman and her midwife is an important aspect for a positive childbirth experience. Women and birthing people benefit from a consistent, continuing connection with a midwife throughout their pregnancy and birth journey. Continuity of care has shown to reduce medical interventions, improve neonatal outcomes and enhance maternal satisfaction. Rice and Warland suggest that there is a “cost of caring” when “being with” the woman during her pregnancy and birth journey. Midwives are vulnerable to STS, compassion fatigue and burnout due to the highly
empathetic relationship. Conversely, both Rice and Warland\textsuperscript{28} and Minooee et al.\textsuperscript{27} emphasized that follow-ups and continued contact with women helped midwives cope and begin the healing process.

### 5.2 Organizational stress

Long hours, increased workloads, staff shortages, and hostile working environments aggravated the emotional toll from witnessing or being involved in a traumatic birth. Irrespective of traumatic birth experiences, several studies have acknowledged how these issues can increase the symptoms of compassion fatigue, moral distress, PTSD and burnout.\textsuperscript{50,58-62} Traumatic birth experiences and work-related stress have implications for the efficiency of maternity services.\textsuperscript{63} Burnout has been associated with increased sick leave and staff turnover.\textsuperscript{57,64} It is important to prevent attrition from the midwifery workforce at a time of extreme staff shortages as continually emphasized in the State of the World's Midwifery 2021\textsuperscript{65} and 2014 report.\textsuperscript{66} It is vital to be attentive to the working environment of midwives to ensure a healthy, motivated midwifery workforce continues to provide high-quality...
care. It is evident from the included studies and wider literature that exposure to traumatic childbirth alone can make midwives contemplate leaving their career even in the absence of other job-related stressors.

5.3 | Blame culture

Furthermore, findings revealed that a blame culture intensified the influence traumatic births had on midwives. The Schroder et al. study concurred with this systematic review; fear of being blamed by women, colleagues or official authorities was a major concern, even when there was no culpability, and an outcome was deemed unavoidable. This is despite the report “To Err is Human” (2000) which proclaimed the need to transform healthcare culture, replacing blame culture with a just culture. A just culture promotes disclosure and learning after an adverse event and can be implemented in obstetrics and midwifery in such a way that errors are identified and corrected via perinatal audits, obstetric skills training, or psychological support. However, restricted budgets and limited knowledge on how to support healthcare professionals after adverse outcomes remains a challenge. This systematic review further emphasizes how midwives do not have appropriate support. Midwifery managers have a duty of care to support the well-being of their colleagues and employees. It is essential that they acknowledge the culture within the workplace and work to create and implement policies and strategies to shift the culture of blame to one of support and growth.

5.4 | Support and training

Supporting midwives after a traumatic childbirth experience is paramount in preventing the manifestation of significant mental health symptoms. However, this systematic review revealed a sharp contrast between the support needed by midwives and the support received; management continue to disregard the well-being of midwives despite the literature repeatedly emphasizing the importance of it. Improving professional psychological support is essential for reducing the long-term mental health influence on midwives who are frequently exposed to birth trauma. This could be facilitated by providing the opportunity to support colleagues or by raising awareness of existing support services. Alternatively, Pezaro et al. found interventions such as mindfulness programs, work-based resilience workshops partnered with mentoring programs, and clinical supervision supported the psychological well-being of midwives. However, there was a lack of high-quality interventions designed specifically to support midwives; future research should prioritize an evidence-based approach.

Furthermore, a more nuanced understanding of contributing factors and strategies to cope with the influence of traumatic birth events may help to shift midwives’ perceptual, cognitive, and behavioral responses and reduce the likelihood of STS and PTSD. Obstetric emergency training programs, such as Practical Obstetric Multi-Profession Training (PROMPT) and Advanced Life Support in obstetrics (ALSO) help midwives feel prepared when an emergency happens, thus reducing anxiety and feelings of inadequacy, self-blame, and responsibility. In addition, these courses have been shown to facilitate communication, leadership, decision-making, and collaborative working which are key to successful outcomes.

5.5 | Shaken belief in normal physiological birth

Many midwives indicated that they had a shaken belief in the normal physiologic processes of birth. Research by Dahlen and Caplice found that the top fears of midwives included death of a baby or mother, missing something that causes harm, obstetric emergencies and being the cause of a negative birth experience. Defensive practice has also arisen due to the fear of litigation. This heightened fear may hinder the normal physiologic birth process as midwives increase their use of interventions with subsequent short- and long-term health effects for the baby, women, and birthing people. Additionally, the midwife–woman relationship is also threatened as the focus is on self-protection rather than clinical care. Ultimately, care is compromised as it is no longer evidence-based and midwives struggle to build empathetic relationships.

5.6 | Limitations of the review

Although a thorough and comprehensive search strategy was implemented, it is possible that relevant papers were unintentionally excluded. Additionally, as interpretation services were not available, only papers published in English were included.

6 | CONCLUSION

Due to the nature of their work, midwives encounter traumatic childbirth experiences frequently. It is evident from midwives’ accounts, that these events influence their personal and professional lives. Feelings of shock,
fear, anxiety, sadness, guilt, self-blame, responsibility, and powerlessness sometimes overwhelm them. Pressures within the workplace, such as staff shortages and increased workloads, can mean midwives have to process their emotions outside of work, enabling trauma to overflow into their personal lives.

Yet, support from colleagues helped mitigate these feelings. Organizational support should be facilitated to help midwives reflect on their experiences in a safe space. This is vital as the personal influence appears to be long-lasting. When midwives are supported by their place of work, they become reflective leading to improved women-centered care. However, when there is a lack of support and a hostile working environment, midwives can struggle to deal with their feelings resulting in symptoms of PTSD. This can cause them to deliberately avoid a situation associated with the traumatic event and become hypervigilant. Defensive practice is likely to increase the rate of “just in case” interventions, and these are additionally exacerbated by the fear of litigation; a vicious cycle ensues.

In conclusion, midwives are often the forgotten victims after a traumatic childbirth experience. If midwives are supported and cared for, they will strive to provide women-centered, evidence-based care and to create positive birth experiences for women, birthing people, and their families.

DATA AVAILABILITY STATEMENT
Data sharing is not applicable to this article as no new data were created or analyzed in this study.

REFERENCES


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**How to cite this article:** Bingham J, Kala FA, Healy M. The impact on midwives and their practice after caring for women who have traumatic childbirths: A systematic review. *Birth.* 2023;00:1-24. doi: [10.1111/birt.12759](https://doi.org/10.1111/birt.12759)
## APPENDIX 1

### TABLE A1 Data extraction matrix.

<table>
<thead>
<tr>
<th>Authors and year</th>
<th>Title</th>
<th>Country of origin</th>
<th>Population group and size</th>
<th>Methodology</th>
<th>Outcome assessed</th>
<th>Results</th>
<th>Key conclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cankaya, Aksoy,</td>
<td>Midwives’ experiences of witnessing traumatic hospital birth events:</td>
<td>Turkey</td>
<td>29 midwives, who work in</td>
<td>Descriptive qualitative</td>
<td>To investigate in detail the traumatic birth experiences of midwives in the</td>
<td>Three main themes</td>
<td>Midwives need to feel valued and supported by their institutions in coping with</td>
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<tr>
<td>and Yilmaz (2020)</td>
<td>A qualitative study</td>
<td></td>
<td>labour and birth rooms</td>
<td></td>
<td>the delivery rooms, and their attitudes, reactions, and coping strategies</td>
<td></td>
<td>emotional stress. Therefore, performing clinical inspections by experienced</td>
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<td>or specialist midwives may serve as a supporting framework for reducing</td>
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<td></td>
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<td>defensive interventions</td>
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</tbody>
</table>

(1) Psychological impact  
(2) Defensive practice  
(3) Expectations in terms of support from the hospital  

After a traumatic birth, midwives experienced highly emotional exhaustion in the form of sadness, flashbacks, guilt, fear and empathy and, they performed an increasingly defensive practice. During the interviews, 19 midwives needed psychological support. Midwives explicitly stated that they were not prepared enough for traumatic events and the most traumatic births were simply ignored in their workplace. Eventually, it was determined that midwives received support mostly from their colleagues in case of a traumatic birth.
<table>
<thead>
<tr>
<th>Authors and year</th>
<th>Title</th>
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<th>Results</th>
<th>Key conclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minooee, Cummins, Fourer and Travaglia (2021)</td>
<td>Catastrophic thinking: Is it the legacy of traumatic births? Midwives' experiences of shoulder dystocia complicated births</td>
<td>Australia</td>
<td>25 Australian midwives who had experiences at least one case of shoulder dystocia (SD)</td>
<td>Descriptive qualitative</td>
<td>To explore the impact of SD, as a birth trauma, on midwives' orientation towards normal birth and on their clinical practice and the factors which may deteriorate or improve the experience of SD</td>
<td>Three main themes</td>
<td>Shoulder dystocia is a birth emergency that midwives will inevitably experience. Involvement in such births can potentially direct midwives towards a ‘worst case scenario’ mentality and affect the way they provide care for women in the future</td>
</tr>
</tbody>
</table>

(1) An unforgettable birth; a wake-up call
(2) From passion to caution
(3) Factors worsening the experience
Factors soothing the experience

Fear, anxiety and doubt about their professional competence were the most common feelings experienced by midwives after SD. For many, the first exposure to SD left them contemplating their previous attitude towards normal birth. Disturbed orientation of normal birth shifted midwives towards hypervigilance in practice. Not having effective relationships with women and receiving poor support from colleagues were perceived to worsen the traumatic experience, whereas working in a midwifery continuity of care model and the sense of being appreciated improved midwives' experience after the trauma
<table>
<thead>
<tr>
<th>Authors and year</th>
<th>Title</th>
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<th>Results</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Rice and Warland (2013)</td>
<td>Bearing witness: Midwives experiences of witnessing traumatic birth</td>
<td>Australia</td>
<td>10 past or current registered midwives who had work with birthing women</td>
<td>Descriptive qualitative</td>
<td>To explore the experiences of midwives witnessing traumatic birth</td>
<td>Three main themes</td>
<td>It was anticipated at the outset of this research that midwives might be putting themselves at risk due to the highly empathetic nature of their relationship with women, unexpectedly, feeling ‘stuck’ between two philosophies was reported as a main source of difficulty for midwives when witnessing traumatic birth. The identification that midwives reported symptoms of secondary traumatic stress and vicarious traumatisation was not unexpected. However, they were not necessarily being traumatised by common obstetric emergencies but rather by witnessing medical interventions which they considered the woman did not want. Maternity units and professional bodies need to be aware of the possibility that midwives may experience witnessing some births as traumatising and may require support to cope with the aftermath of such an experience.</td>
</tr>
</tbody>
</table>

(1) Stuck between two philosophies – emotional distress from feeling ‘stuck’ between wishing they could practice according to their midwifery philosophy, and the reality of working within a medical model of care
<table>
<thead>
<tr>
<th>Authors and year</th>
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</thead>
<tbody>
<tr>
<td>Toohill, Fenwick, Sidebotham, Gamble, and Creedy (2019)</td>
<td>Trauma and fear in Australian midwives</td>
<td>Australia</td>
<td>Quantitative – 249 midwives</td>
<td>Mixed methods</td>
<td>(1) Determine prevalence of birth related trauma and fear in midwives and associations with midwives' confidence to advise women during pregnancy of their birth options and to provide care in labour</td>
<td>The majority of midwives (93.6%) reported professional (85.4%) and/or personal (41.6%) traumatic birth experiences</td>
<td>High fear was associated with lower confidence to support childbearing women. Fear and trauma in midwives warrants further investigation to better understand the impact on professional practice</td>
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<td></td>
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<td>Qualitative – 170 midwives</td>
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<td>(2) Describe midwives' experiences of birth related trauma and/or fear</td>
<td>Reasons for personal trauma included experiencing assault, intervention and stillbirth. Professional trauma related to both witnessing and experiencing disrespectful care and subsequently feeling complicit in the provision of poor care. Feeling unsupported in the workplace and fearing litigation intensified trauma</td>
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<td>Authors and year</td>
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<tr>
<td>Beck, LoGiudice, and Gable (2015)</td>
<td>A Mixed-Methods Study of Secondary Traumatic Stress in Certified Nurse-Midwives: Shaken Belief in the Birth process</td>
<td>United States of America</td>
<td>Quantitative – 473 Certified Nurse-Midwives (CNMs)</td>
<td>Convergent, parallel mixed methods</td>
<td>To determine the prevalence and severity of Secondary Traumatic Stress (STS) in CNMs and to explore their descriptions of experiences attending traumatic births</td>
<td>29% of the CNMs reported high to severe STS, and 36% screened positive for the Diagnostic and Statistical Manual of Mental Disorder, Fourth Edition diagnostic criteria for PTSD due to attending traumatic births. The top three types of traumatic births described by the CNMs were fetal demise/neonatal death, shoulder dystocia and infant resuscitation</td>
<td>Nursing and midwifery professionals need to be alerted to the negative impact that traumatic births can have, not only on the clinician’s themselves but also on the workforce of these professions when clinician deliberate changing careers</td>
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<td></td>
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<td>Qualitative – 246 CNMs</td>
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<td>Content analysis revealed six themes</td>
<td>(1) Protecting my patients: agonizing sense of powerless and helplessness</td>
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<td>(2) Wreaking havoc: trio of posttraumatic stress symptoms</td>
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<td>(3) Circling the wagons: it takes a team to provide support...or not</td>
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<td>(4) Litigation: nowhere to go to unburden our souls</td>
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<td>(5) Shaken belief in the birth process: impacting midwifery practice</td>
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<td>(6) Moving on: where do I go from here?</td>
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<td>Authors and year</td>
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<tr>
<td>Fontein-Kuipers, Duivis, Schamper, Schmitz, Stam, and Koster (2018)</td>
<td>Reports of work-related traumatic events: A mixed-methods study</td>
<td>Netherlands and Flanders</td>
<td>Quantitative – 106 midwives who practised or who had practised in the Netherlands and Flanders</td>
<td>Sequential explanatory mixed methods – questionnaire and semi-structured interviews</td>
<td>To investigate accounts of midwives about work-related events, being experiences as traumatic, in order to categorize (i) the types of events, (ii) midwives’ responses to the events, and (iii) to explore their experiences of the aftermath of the event on professional and personal life</td>
<td>Various work-related traumatic events: witnessing birth trauma/complications (34%), death (28.3%), (mis)management of care (19.8%), events related to the perceived social norm of maternity services’ practitioners (9.5%), events related to environmental and contextual issues (5.6%) and to (mis)communication (2.8%). Participants still experienced the influence of work-related events in day-to-day practice and still experienced the effects in their personal life</td>
<td>Various work-related traumatic events can impact on midwives’ professional and/or personal life. Although not all midwives reported experiencing (lasting) effects of the events, the impact was sometimes far-reaching. Therefore, midwives’ experiences and impact of work-related traumatic events cannot be ignored in midwifery practice, education and in supervision or mentoring</td>
</tr>
<tr>
<td>Halperin, Goldblatt, Noble, Raz, Zvulunov, Wischnitzer (2011)</td>
<td>Stressful childbirth situations: a qualitative study of midwives</td>
<td>Israel</td>
<td>18 midwives employed in six labour and delivery units in Israeli hospitals</td>
<td>Qualitative</td>
<td>To explore clinical life-threatening childbirth situations and their impact on midwives – functioning professionally in an unexpected reality; emotional reactions; physical reactions and long-term effects</td>
<td>(1) Reactions to stressful childbirth situations and their impact on midwives</td>
<td>Stressful childbirth situations can have long-term impact on midwives’ professional and personal identities. Midwives need to feel support and valued in order to deal with emotional stress. Incorporating clinical supervision by experiences midwives can serve as a supportive framework for other midwives</td>
</tr>
<tr>
<td>Authors and year</td>
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<tr>
<td>Goldbort, Knepp, Mueller, Pyron (2011)</td>
<td>Intrapartum Nurses’ lived experience in a traumatic birthing process</td>
<td>United States of America</td>
<td>Nine intrapartum nurses from Indiana’s AWHONN (Associations of Women’s Health, Obstetric and Neonatal nurses)</td>
<td>Descriptive qualitative</td>
<td>To describe the essence of nine nurses’ participation in an unexpected/traumatic birthing process to ascertain what impact this experience had on the nurse</td>
<td>One overarching theme – from behind closed doors</td>
<td>Intrapartum nurses in this study demonstrated that the impact of an unexpected event can be emblazoned on one’s memory for many years, with an immediate response of secondary traumatic stress disorder symptoms</td>
</tr>
<tr>
<td>Sheen, Spiby, Slade (2016)</td>
<td>The experience and impact of traumatic perinatal event experiences in midwives: A qualitative investigation</td>
<td>United Kingdom</td>
<td>35 midwives who had experienced a traumatic perinatal event defined using the Diagnostic and Statistical Manual of Mental Disorders (version IV) Criterion A for posttraumatic stress disorder</td>
<td>Qualitative interview design</td>
<td>To investigate midwives’ experiences of traumatic perinatal events and to provide insights into experiences and responses reported by midwives with and without subsequent posttraumatic stress symptoms</td>
<td>Four main themes</td>
<td>Event characteristics were similar between groups and involved severe, unexpected episodes contributing to feeling ‘out of control zone’</td>
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</tbody>
</table>

**TABLE A1** (Continued)
<table>
<thead>
<tr>
<th>Authors and year</th>
<th>Title</th>
<th>Country of origin</th>
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<tbody>
<tr>
<td>(1) Event characteristics</td>
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<td></td>
<td>Emotional upset, self-blame and feelings of vulnerability to investigate procedures were reported</td>
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<tr>
<td>– sudden, unpredictable and uncontrollable events; managing feelings to maintain a professional appearance</td>
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<td>(2) Initial responses and impacts</td>
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<td>High distress midwives were more likely to report being personally upset by events and to perceive all aspects of personal and professional lives to be affected. Both groups valued talking about the events with peers but perceived support from senior colleagues and supervisors to be either absent or inappropriate following their experience</td>
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<tr>
<td>– emotionally distraught, feelings of shock and despair; self-blame and guilt; permeating impact on professional life and an enduring psychological impact</td>
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<td>(3) Helpful aspects and use of support</td>
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<tr>
<td>– taking steps to prevent similar occurrence from happening again; helpful strategies to manage responses in personal lives; wanting to talk about it; accessing and receiving helpful support from peers; absence or inappropriateness of support</td>
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<tr>
<td>(4) Reflections</td>
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<tr>
<td>– 'overcoming the impact'; working in the context of a stressful job; events contradicting public perception of childbirth; recognition of the need for the change</td>
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<td>Authors and year</td>
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<tr>
<td>Javid, Hyett, Homer (2018)</td>
<td>The experience of vasa praevia for Australian midwives: A qualitative study</td>
<td>Australia</td>
<td>20 midwives agreed to participate in the study. Of those 12 had cared for women who had a neonatal death, near-miss or both neonatal death and near-miss. The focus of the paper was on the experience of these 12 midwives</td>
<td>Descriptive qualitative</td>
<td>To investigate the experience of Australian midwives caring for women with undiagnosed vasa praevia during labour and birth</td>
<td>One over-arching theme – ‘devastating and dreadful experience’ for midwives</td>
<td>Caring for women who experienced ruptured vasa praevia had a profound impact on the emotional and professional well-being of midwives even when the baby survived. Midwives should be supported and adequately prepared to cope with traumatic events</td>
</tr>
<tr>
<td>Beck, and Gable (2012)</td>
<td>A mixed methods study of secondary traumatic stress in labor and delivery nurses</td>
<td>America and Canada</td>
<td>Quantitative – 464 labour and delivery nurses from the membership of the Associations of Women's Health, Obstetric and Neonatal nurses (AWHONN)</td>
<td>Mixed methods – convergent parallel design</td>
<td>Determine the prevalence and severity of secondary traumatic stress in labour and delivery (L&amp;D) nurses and to explore nurses' descriptions of their experiences attending traumatic births</td>
<td>35% of the L&amp;D nurses reported moderate to severe levels of secondary traumatic stress</td>
<td>Nurses need to consider the possible impact their work may be having on them and take preventative measures to address their current symptoms</td>
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<td></td>
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<td>Qualitative – 322 AWHONN labour and delivery nurses</td>
<td></td>
<td>Six themes emerged</td>
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<td></td>
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<td>Mean age – 46.7</td>
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<td>(1) Magnifying the exposure to traumatic births</td>
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<td></td>
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<td>Mean years of experience – 20.77</td>
<td></td>
<td>(2) Struggling to maintain a professional role while with traumatized patients</td>
<td></td>
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<tr>
<td>Authors and year</td>
<td>Title</td>
<td>Country of origin</td>
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<tr>
<td>Puia, Lewis, and Beck (2013)</td>
<td>Experiences of obstetric nurses who are present for a perinatal loss</td>
<td>America and Canada</td>
<td>464 cases were included in the parent study; 150 cases included either fetal or infant death. Of those, 91 cases had rich description</td>
<td>Secondary qualitative analysis</td>
<td>To discover the impact of perinatal loss on obstetric nurses</td>
<td>Six themes emerged for perinatal loss</td>
<td>Perinatal loss can have a lasting effect on nurses, and thus continued support may be needed</td>
</tr>
</tbody>
</table>

(1) Getting through the shift
(2) Symptoms of pain and loss
(3) Frustations with inadequate care
(4) Showing genuine care
(5) Recovering from traumatic experience
(6) Never forgetting