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Bearing witness: Midwives experiences of witnessing traumatic birth

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ABSTRACT

Background: traumatic birth is a phenomenon that has been identified in women's birthing experiences, yet there has been no primary research conducted into midwives experiences of witnessing traumatic birth. Traumatic stress from witnessing and working with traumatised clients has been identified in other caring professionals such as nurses, social workers and emergency department personnel. This includes evidence of posttraumatic stress disorder, secondary traumatic stress, vicarious traumatisation and compassion fatigue. A distinct gap in the literature about midwives experiences of witnessing traumatic birth and the effects of working with potentially traumatised women formed the basis for this research.

Research design and method: a descriptive qualitative study was used to explore midwives experiences of witnessing traumatic birth. The aim of this research was to enable midwives to describe their experiences and to determine if they are at risk of negative psychological sequalae similar to those in other caring professions. Ten currently or previously Registered Midwives with varying amounts of experience were interviewed, and transcripts of those interviews formed the raw data for the study. The data were independently thematically analysed by the two authors to identify common themes used to describe the experience of witnessing traumatic birth.

Results: 'Stuck between two philosophies', 'What could I have done differently', and 'Feeling for the woman', emerged as the main themes from the research. The participants described their 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. Feelings of responsibility for women and babies' outcomes, and repeatedly questioning what they could have done differently to prevent a traumatic birth was also reported. Feeling for the woman emerged as a major factor in midwives' experiences of witnessing traumatic birth.

Conclusions: as far as we can determine this is the first study to explicitly examine the phenomenon of midwives witnessing traumatic birth from the midwives point of view. While it was anticipated that midwives might describe being emotionally distressed by their experiences, the extent of their empathy and feelings of being stuck between two philosophies provide new knowledge into what affects midwives when working with birthing women. Further research into these areas is warranted. Better understanding of how witnessing traumatic birth impacts on midwives and what kind of support after these experiences is required to ensure midwives are equipped to cope when witnessing traumatic birth.

Introduction

Midwives have been described as the 'guardians of normal birth' (Fahy et al., 2008) and while they most often witness positive and uplifting births, they may also witness traumatic and distressing events when caring for birthing women. Although there is little reported research on the phenomenon of midwives witnessing traumatic birth, there is a plethora of evidence describing the effect of experiencing a traumatic birth for women (e.g. Beck, 2004a; Ayers, 2007) and an appropriate midwifery response (Gamble et al., 2006; Gamble and Creedy, 2009). Midwives attend birth and so it is reasonable to assume that they witness traumatic birth, when it occurs (Leinweber and Rowe, 2010).

Other literature suggests that caring for traumatised populations carries the risk of causing emotional stress in caring professions such as nursing, social work, and mental health health-care professionals (Austin et al., 2009; Devilly et al.,

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2009; Newell and MacNeil, 2010). Although midwifery shares some commonalities with these professions, it is the distinct relationship with their clients, childbearing women, that is a defining feature of midwifery (Hunter et al., 2008). The close woman–midwife relationship is core to midwifery work (Lundgren and Berg, 2007). The very nature of the midwives' role, that is, to be 'with-woman' (Carolan and Hodnett, 2007), may put midwives at risk of suffering emotional distress especially when witnessing traumatic birth.

There is very limited research concerning the effects that witnessing traumatic births may have on midwives. Just one paper has been published regarding the cost of the close midwife–woman relationship when midwives witness traumatic birth, this was a review of the literature on traumatic stress in caring professionals. Their results suggested that midwives may be at risk of experiencing secondary traumatic stress due to being 'with woman' (Leinweber and Rowe, 2010).

The primary aim of this research was to explore the experiences of midwives' witnessing traumatic birth.

Literature review

Due to the lack of primary research into midwives experiences of witnessing traumatic birth, pertinent literature on traumatic stress in caring professions is briefly reviewed.

Caring professions and emotional stress

Caring professions today recognise that compassion and empathy are essential components of their work (Sabo, 2006). Leinweber and Rowe (2010) explain how caring is now understood to be a holistic practice, requiring the carer to be both physically and mentally present. These components of caring work are present in many professions, for example, Bride et al. (2007) explain how it is essential that social workers take on some of their clients' psychological trauma in order to aid in their healing from traumatic events. It has been found that this close involvement with clients may put caring professionals at risk of developing traumatic stress responses (Wilberforce et al., 2010).

This personal emotional investment can lead to negative effects suffered by health-care professionals, termed 'the emotional costs of caring' (Leinweber and Rowe, 2010). This term can be used to describe the various concepts within the literature that pertain to the issue of emotional stress in the caring professional. These concepts include posttraumatic stress disorder, compassion fatigue, secondary traumatic stress, and vicarious traumatisation (Sabo, 2006; Austin et al., 2009; Devilly et al., 2009; Newell and MacNeil, 2010; Showalter, 2010).

A commonly acknowledged negative outcome of experiencing a traumatic event is Post Traumatic Stress Disorder (PTSD). The American Psychiatric Association defines PTSD in the revised fourth Diagnostic and Statistical Manual of Mental Disorders (DSM IV-R) as an anxiety disorder that causes disturbances to a person's life, and may affect social, occupational or other aspects of their life (American Psychiatric Association, 2000). It was not until the release of the DSM IV, that it was recognised that traumatic Childbirth could be a triggering event for PTSD. Since the DSM IV criteria change there have been a number of studies reporting childbirth as an event which could trigger PTSD. (e.g. Creedy et al., 2000; Olde et al., 2006; Zaers et al., 2008) However, caring professionals witnessing someone else's trauma still may not usually meet PTSD criteria (Laposa et al., 2003) rather this kind of caring has been recognised as a potential trigger for secondary traumatic stress.

Secondary Traumatic Stress (STS) is closely associated with PTSD, and is a term used to describe emotional distress in caring professionals and presents with much the same symptoms as PTSD (Beck, 2011). The main distinction between PTSD and STS is that people suffering from STS suffer stress as a result of having developed an empathetic relationship with their clients, and bearing witness to their clients' experiences of trauma (Baird and Kracen, 2006; Newell and MacNeil, 2010).

While STS pertains to the symptoms the carer experiences from empathising with a client's trauma, vicarious traumatisation is the term used to describe the internal changes a person experiences as a result of bearing witness to another person's trauma, as identified by the seminal research conducted by Figley (1995), and supported in subsequent research on emotional stress in caring professionals (e.g. Newell and MacNeil, 2010). These internal changes have been described as transformations of the caring professional's worldview, self-identity, and professional identity (Sabin-Farrell and Turpin, 2003) that have been brought about by repeated exposure to traumatised populations. In particular, it has been identified that the sufferer's conceptualisation of safety, trust, and control are noticeably altered (Figley, 1995; Sabin-Farrell and Turpin, 2003).

Compassion fatigue is a type of emotional stress that is less dedicated to a particular incident, instead, it is due to the general fatigue, strain and stress that caring professionals may experience from dealing with trauma, illness and death in their day-to-day work (Austin et al., 2009; Meadors et al., 2009). The symptoms of compassion fatigue include exhaustion, loss of compassion and empathy, and reduced vitality and energy (Thomas and Wilson, 2004). A common theme occurring through all of these types of traumatisation is addressed by Figley (1995), who stated, 'there is a cost to caring. Professionals who listen to clients' stories of fear, pain and suffering may feel similar fear, pain and suffering because they care' (p. 1).

Woman–midwife relationship

The term 'midwife' is derived from middle and old English and literally means 'with (mid) woman (wife)'(Harper, 2011). Although all caring professions hold empathy and compassion as core values (Figley, 1995; Sabo, 2006), the close relationship between women and their midwives, at times described as more of a friendship (Walsh, 1999), means that midwives are involved in a highly empathetic relationship with their clients. It is this kind of highly empathetic relationship that research has found increases the caring professional's risks of emotional stress due to witnessing or caring for traumatised populations (Thomas and Wilson, 2004; Austin et al., 2009; Showalter, 2010). Although limited literature exists examining the outcomes of this highly empathetic relationship between midwives and women, it is possible to hypothesise that this professional–client relationship could give rise to emotional effects on the midwife especially when they bear witness to traumatic birth

Methods

This study was undertaken using a descriptive qualitative approach. This approach was ideal for a preliminary exploration of the nature of a phenomenon (Crotty, 1998). The research question was 'What are midwives' experiences of witnessing traumatic birth?'

Recruitment

Participants were self-selected through the method of 'snowball' sampling. This sampling method involves using human