Midwives experience psychological distress because of their work or working culture. Initiatives must tackle this to optimise the wellbeing of staff and patients.

Addressing psychological distress in midwives

In this article...
- The causes of psychological distress experienced by midwives
- How that distress can manifest itself
- Benefits to be gained by addressing the issue

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Abstract
Pezaro S (2016) Addressing psychological distress in midwives. Nursing Times; 112: 8, 22-23. Evidence shows midwives may experience psychological distress resulting from their work and working cultures. They may continue to work when they do not feel well enough, which is not conducive to providing high-quality maternity care. This article critically analyses 30 papers that show the occupational and organisational sources of stress highlighted by midwives in 14 countries.

Depression, burnout, anxiety and stress, account for a quarter of all episodes of sickness absence in NHS staff (Boorman, 2009). However, some staff still attend work, despite not feeling well enough to perform their clinical duties effectively (NHS Employers, 2014).

The emotional traumas associated with healthcare work often remain unrecognised, and staff are often left unsupported (Wilkinson, 2015). It is vital to highlight the experiences and support needs of staff in psychological distress, as there is a clear correlation between staff health and the quality of patient care (Francis, 2015; Royal College of Physicians, 2015).

Midwives in psychological distress may be at high risk of psychological distress due to the nature of their work (Boorman, 2009). However, some staff still attend work, despite not feeling well enough to perform their clinical duties effectively (NHS Employers, 2014).

Midwives experience psychological distress because of their work or working culture. Initiatives must tackle this to optimise the wellbeing of staff and patients.

Causes of psychological distress
Causes of psychological distress in health professionals include:
- Hostile behaviour, either from other staff or patients;
- Workplace bullying;
- Poor organisational cultures;
- Medical errors;
- “Never events” or critical incidents;
- Workplace suspension;
- Whistleblowing;
- Occupational stresses;
- Investigations by professional regulatory bodies and employers;
- Pre-existing mental health disorders.

Box 1 outlines the various categories of distress experienced by midwives, along with the associated symptoms; the most severe consequence is death by suicide. These initial findings and symptomologies are clearly incompatible with a psychologically safe professional journey, nor safe and effective clinical care.

Initial findings from the literature indicated that the frequency of psychologically distressing episodes in midwifery practice can be seen as an inconsequential and standard part of the job. There is an assumption that midwifery is always a privilege, which may not allow the profession to fully appreciate the emotionally challenging nature of the work. This was reflected in the additional discovery that there is currently a paucity of structured support for midwives (Austin et al, 2014).

Box 1: Categories of distress experienced by midwives

1. Hostile behaviour, either from other staff or patients
2. Workplace bullying
3. Poor organisational cultures
4. Medical errors
5. “Never events” or critical incidents
6. Workplace suspension
7. Whistleblowing
8. Occupational stresses
9. Investigations by professional regulatory bodies and employers
10. Pre-existing mental health disorders

It is vital to support the needs of healthcare staff in psychological distress.
BOX 1. CATEGORIES OF DISTRESS

Categories of distress

- Occurrences of post-traumatic stress
- Post-traumatic stress disorder
- Acute stress disorder
- Depression
- Burnout/fatigue
- Compassion
- Vicarious traumatization

Associated symptoms

- Substance abuse
- Display of adverse behaviours
- Chronic fatigue
- Feelings of guilt and despair
- Emotional exhaustion or numbness
- Depersonalisation
- Negative thinking towards others
- Reckless or self-destructive behaviour
- Flashbacks
- Hypervigilance
- Avoidance
- Poor concentration/decision making

Findings unite the comparable and variable concerns of midwives across the globe, suggesting that their needs and experiences may be analogous in a variety of settings, with the exception of some midwives in resource-poor settings.

Next steps

Healthcare leaders are urged to give immediate attention to the seriousness and prevalence of work-related distress within midwifery. The emotional consequences of the work need to be acknowledged, and initiatives put in place to prioritise:

- Self-care;
- Psychologically safe working cultures;
- Midwives’ emotional wellbeing;
- Interprofessional support.

Additionally, healthcare leaders are encouraged to explore non-punitive and non-blame-focused approaches towards medical error and behavioural symptoms displayed while staff are unwell.

Future research is required to explore and develop new, evidence-based solutions to support midwives in work-related psychological distress (Pezaro et al., 2015). This supports the aim of ensuring the NHS “sets a national example in the support it offers its own staff to stay healthy”.

Conclusion

Healthy midwives are essential for high-quality maternity services. This requires new, evidence-based approaches to support midwives in distress.

Pezaro and Clyne (2015) are undertaking new research to inform the development of an online intervention to support midwives in work-related distress. Further conversations and debate on these issues in the pursuit of real change are invited.

This article is a summary of: Pezaro S et al (2015) “Midwives Overboard!” Inside their hearts are breaking, their makeup may be flaking but their smile still stays on Women and Birth: doi:10.1016/j.wombi.2015.10.006. To contribute your views to the research, contact Sally Pezaro via Twitter at @SallyPezaro

References


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While other professions may receive a higher level of support (Kalicińska et al., 2012). Ultimately, the indication was that midwives are undervalued.

The sources of distress can be separated into occupational and organisational causes. Although infrequent, the occurrence of obstetric emergencies remained a key source of occupational traumatic stress for midwives in first-world countries. Additionally, as they are required to perform ethically complex procedures and emotional work, as well as caring for families with complex social needs, there was evidence of their experiencing compassion fatigue and distress. Organisationally, midwives frequently highlight toxic, hierarchical, bullying cultures, where midwives are often unkind towards each other (Farrell and Shafiei, 2012; Afolayan and Dairo, 2009; Begley, 2002). The resulting job stressors were seen to go on to perpetuate unhealthy cultures for students to experience, and in some cases, emulate.

Findings remained consistent across the studies; various cohorts of midwives worldwide experienced high levels of:

- Secondary traumatic stress;
- Compassion fatigue;
- Burnout;
- Emotional distress;
- Feelings of inadequacy and frustration;
- Occupational distress.

The only significant differences found were in midwives practising in resource-poor countries, where maternal and neonatal death are more frequent than in the developed world (World Health Organization et al., 2012). These midwives tended to experience the distinctive distress of death anxiety, death depression and death obsession (Mulíra and Bezuñenhou, 2015; Mulíra et al., 2015).

These findings unite the comparable and variable concerns of midwives across the globe, suggesting that their needs and experiences may be analogous in a variety of settings, with the exception of some midwives in resource-poor settings.

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