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Midwives’ Experience of Traumatic Birth in Cyprus

Eleni Hadjigeorgiou, Ioanna Koliandri and Eva Josephidou

Abstract

In the twenty-first century, research evidence justifies that maternity health professionals, particularly midwives, may experience a birth as traumatic. Childbirth in Cyprus is highly medicalized and midwives as advocates of normal birth, face enormous difficulties to fulfill their professional role. Therefore, identified as crucial to finding more about midwives’ experience providing perinatal care in Cyprus. A study was carried out to explore midwives’ experiences of traumatic childbirth in Cyprus and how this affects their personal and professional life. Qualitative design approach was used based on Husserl’s phenomenological approach. Following ethical approval, data were collected through semi-structured interviews with a purposive sample of midwives (N = 14) from September until December 2021. Data were analyzed using Coaizzi’s method and analysis revealed three main themes with subthemes: (1) The nature of traumatic events, (2) Consequences of traumatic experience, and (3) Dealing with traumatic events. Some midwives become defensive and careful, in order to avoid a similar traumatic experience in the future, while some of them develop symptoms of post-traumatic stress disorder (PTSD). Midwives in Cyprus experience traumatic events during childbirth that negatively affect their professional and personal life with long-term effects. Collegiality is important to deal with traumatic events. More awareness must be created during basic and continuing education about decision-making power and problem-solving.

Keywords: midwives, midwifery care, traumatic labor, traumatic birth, perceptions, experiences

1. Introduction

Midwives care for two human beings at the same time and any complication to the mother or the newborn incur uncompensated lesion of the family and community health and prosperity [1]. Midwives providing care during labor and childbirth experience various emotions, such as joy, happiness, and gratitude, sometimes it can lead to sadness and anxiety in the cases midwives are present during traumatic childbirth [2]. The birth process frequently exposes midwives to trauma, which can result in burnout, unmet care, emotional exhaustion, worsening of interpersonal relationships, rise in conflict, dejection, and other problems of a similar nature [3]. A traumatic experience during childbirth can cause stress to health professionals who
consequently might develop post-traumatic stress [4]. The symptoms of midwives who have gone through traumatic experiences, however, do not necessarily meet the criteria for PTSD symptoms, even though the concurrent symptoms can have an impact on a person's psychological health [5]. Midwives and pregnant women often develop a special and unique bond, as midwives “coach” pregnant women and support them to have a normal birth and a positive birth experience [4].

There have been numerous research looking into the connection between post-traumatic stress disorder symptoms and midwives’ exposure to stressful occurrences during childbirth (PTSD). Sheen et al. [6] conducted research on the relationship between burnout and midwives’ exposure to traumatic prenatal events and post-traumatic stress symptoms. From the 421 participants, it was found that the prevalence of PTSD symptoms is at 32% among midwives (n = 138) who reported having experienced a traumatic birth event. Similarly, in Australia, 17% of midwives (n = 102) who witnessed a traumatic birth trauma met criteria for probable PTSD out of the 687 participants [7]. Exposure to a traumatic birth can affect midwives’ professional and personal lives but also their mental/psychological health [8].

Previous literature suggests that post-traumatic stress symptoms in midwives have been linked to negative effects on their interactions with women, their ability to care for them, and their ability to make clinical decisions [7]. Halperin et al. [9] identified that midwives often identify traumatic events as a failure, which causes them despair while it can have long-term effects on their mental well-being. It has been found that these events can lead to reduced levels of confidence and an increased tendency to practice defensively [10]. Furthermore, it was identified that the presence of a doctor at a traumatic event could create feelings of degradation in midwives regarding their ability to manage the situation, adding to the stress they experience from the event itself [11]. Innovative strategies are needed to support and assist midwives to cope with traumatic events and at the same time to realize their value and contribution to the care of women [8, 9]. The effects of traumatic occurrences on midwives worldwide include PTSD, compassion fatigue, secondary traumatic stress, and vicarious traumatization [12–15].

In Cyprus, the cesarean section rate is 53.6% in 2018 and 61% in 2022 [16]. Midwives in Cyprus were unable to support and promote physiological birth [17] as they have limited influence on public health policies in relation to the provision of prenatal, intranatal, and postnatal care [18]. Thus, many midwives in Cyprus experience immense stress regarding the medicalization of childbirth, which concludes in facing difficulties in conducting normal childbirth and advocating for women's childbirth rights [17].

The aim of this study was to explore midwives’ experiences of traumatic childbirth and how it influenced their personal and professional life.

2. Methodology

Qualitative, descriptive study uses a phenomenological approach according to Husserl’s phenomenological approach. The current approach was used because it allows one to gain complete understanding of a topic through truthful reporting and first-hand knowledge. According to Husserl’s phenomenological design, the researcher strives for objectivity and to set aside their personal perceptions [19].
2.1 Sample

A purposeful sample of participants was recruited following careful consideration of the need to select midwives; a sample size that would generate quality data. The priority was to achieve depth of data conducive to the production of high-quality findings. The sample consisted of 14 midwives that were recruited from public hospitals and private maternity clinics in Cyprus. The inclusion criteria for participation in the study were: (1) being able to speak and/or understand the Greek language, (2) having at least 5 years’ experience in the birth room, (3) being registered as a midwife, and (4) having experienced at least one traumatic birth.

2.2 Ethical issues

Ethical approval was obtained from the Cyprus National Bioethics Committee (ΕΕΒΙΦΕΓΙ/2019/81). All participants completed a consent form containing the assurances for confidentiality, voluntary participation, and their right to withdraw from the study at any stage of the research without any penalty. The participants were assured of their anonymity and privacy while codes were used for each one of them (i.e. Midwife 1, Midwife 2) for data analysis and also for the presentation of the data.

2.3 Data collection

Data collection was achieved through semi-structured one–one interviews with an interview guide developed from relevant literature. The interviews were conducted by one experienced researcher for the consistency of the interviews at a convenient time and place chosen by the participant. A pilot study was carried out with two midwives to evaluate the interview guide in terms of understanding the questions and if they were appropriate. All interviews were face-to-face, where midwives consented with their written permission to participate and for the interviews to be recorded. In addition, it was requested to complete a demographic questionnaire.

2.4 Data analysis

Data analyzed using the Colaizzi method were recognized as the best method for Husserl’s phenomenology [20]. Firstly, all the transcribed interviews were read and reread to make sense of them as a whole in order to extract significant statements. The phrases or sentences that directly pertain to the investigated phenomenon were identified. Following is the process of giving meaning to those statements. During this process, pertinent quotes are broadly categorized, where subsequently themes are generated on multiple statements that convey similar meanings. A summarized description of everything generated during the analysis was done so that there is an identification of the fundamental structure of the phenomenon. Lastly, rigor of the data was ensured through discussions with experts and independent reviewers.

2.5 Reflexivity and trustworthiness

A reflective diary was kept by the main researcher during the data collection carefully self-monitoring the impact of biases, beliefs, and personal experiences of the research [21] to ensure rigor and trustworthiness. In addition, COREQ checklist
was used to ensure the credibility, trustworthiness, and quality of the study. Data trustworthiness was based on credibility, transferability, dependability, and confirmability. Credibility was established by two authors who had prolonged engagement with the participants and their professional experience. The first author was trained in qualitative methodologies and had 25 years of expertise. To get to an agreement, the authors additionally double-checked and discussed the analysis findings. The interviews were recorded on tape, which increased the dependability of the data by providing a comprehensive and exact account of each participant’s responses. Making note of participant quotations to support the findings contributed to ensuring confirmability, which established that themes and categories accurately reflect the participants’ experiences and perspectives. Auditability was established by maintaining an audit trail to record the context and background of the study, evaluation of the findings, decisions made, and actions taken during the whole research process.

3. Results

3.1 Demographic findings

In terms of the characteristics of the sample, all 14 participants were permanent residents of the Cyprus Republic working in public hospitals (8) and six private maternity departments. Demographic characteristics of the participants are presented in Table 1.

From the in-depth analysis of the data, three themes emerged: (1) The nature of traumatic events, (2) Consequences of traumatic childbirth, and (3) Dealing with traumatic events. Themes and subthemes are shown in Table 2.

3.2 The nature of traumatic events

The traumatic events experienced by midwives in the birth room are related to the risk to the mother and the newborn life. The description of the midwives’ experiences referred to traumatic events related not only to the mother’s life and newborn but also to the medicalization of birth, where complications arose that endangered the life of the mother and the fetus/newborn.

3.2.1 Traumatic events related to mother’s life

Midwives’ descriptions revealed that when the mother’s life was in danger, those events remained vivid in their minds; consequently, having flashbacks and nightmares. The description suggests that these kinds of traumatic events are imprinted in their mind; specifically, a midwife’s pain was captured in the case of the loss of a mother.

“I cannot forget the death of a woman with amniotic fluid embolism; suddenly she had seizures and after death … we did a cesarean section, but the mother died, and the baby came out alive.” (Midwife 3)

Midwives mentioned that heavy bleeding during labor and birth, was the one of the most traumatic events for them and it was perceived as a traumatizing moment for them.
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3.2.2 Traumatic events related to newborn’s health

Some midwives reported traumatic events related to the newborn’s health complications and/or death. One midwife had described the agony she had experienced, to keep the newborn alive, but the newborn passed away the next day.

“...mother has a massive bleeding ... I had never seen such hemorrhage in the many years I have been working” (Midwife 4)

“An uncontrollable bleeding had started, where ... it was very shocking (embarrassing smile), I had never seen so much blood ... the woman was in the operating room and the blood dropped ... on the floor.” (Midwife 6)

Table 1.  
Socio-demographic characteristics of participants.

<table>
<thead>
<tr>
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<td>11–20 years</td>
<td>6</td>
</tr>
<tr>
<td>5–10 years</td>
<td>4</td>
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</table>

3.2.2 Traumatic events related to newborn’s health

Some midwives reported traumatic events related to the newborn’s health complications and/or death. One midwife had described the agony she had experienced, to keep the newborn alive, but the newborn passed away the next day.

“The baby was born alive but in bad condition ... the next day he/she died. I felt guilty, I blamed myself.” (Midwife 7)

Similarly, another midwife reported the death of the newborn that was imprinted in their mind and explained that it was due to severe and sudden bleeding.
“I cannot forget the death of a baby; the mother came to the hospital with a sudden hemorrhage, we could not save the baby.” (Midwife 11)

3.2.3 Traumatic events related to medicalization of birth

Midwives strongly pointed out the fact that in some cases during labor and birth, they did not offer evidence-based care to the mother as they were afraid to create conflict with the obstetrician. A midwife gave a vivid description of a disagreement with the obstetrician as he wished to expedite the birth and made interventions to speed up the birth.

“Obstetrician told me that he will make a “milkshake of drugs”, I will put that in the woman’s vein and by the end the cervix will be dilated very easily, and birth will finish easily... it was a traumatic experience because I was next to the woman...and by the end she had Vacuum extraction.” (Midwife 13)

Vacuum extraction was also described by some midwives as a traumatic experience for mothers’ and babies’ health. Specifically, they explained a certain event where the suction cup of the vacuum extraction was used several times does not feed well and does not facilitate the birth of the baby.

“The doctor tried several times to apply the suction cup on the baby head and pull it out; we tried to stop him, but he would not hear. The poor woman was screaming in pain...” (Midwife 12)

In addition, midwives mentioned that some obstetricians’ behavior in their opinion was unprofessional. A certain event was described by a midwife in which she was present where misconduct took place. The authority of the obstetrician was imposed rather than the midwife’s opinion and mother’s wishes.

“He put her to bed, the woman cried from the pain, she was telling him: I’m in pain do not touch me and he continues and asks her to push...” (Midwife 13)

“The woman said to us that she wishes to have no intervention during labor, no oxytocin, no epidural but the obstetrician convinced her to start Oxytocin and have...” (Midwife 12)
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an epidural. I could not react; I stay speechless but then I felt so disappointed with herself.” (Midwife 7)

3.3 Consequences of traumatic childbirth

3.3.1 Short-term psychological effects

The most prominent effect of being present at a traumatic birth was psychological, through the traumatic experience, midwives had short-term psychological effects. Many of the symptoms were related to PTSD symptoms but none of them were diagnosed with PTSD by a professional. Specifically, it was reported that they felt “numb,” a state of constant vigilance to surroundings (hyperarousal), had negative beliefs about themselves, had dark moods, felt very nervous, had tachycardia, and were frustrated. Some midwives felt very bad because they did not react to situations that caused trauma to women or new-born and they remained speechless. Some of the midwives reported being present at events where obstetric violence took place and subsequently their stress increased.

“I felt a lot of remorse, I did not want to talk about it, I did not want to listen, I did not want to talk about it, I did not sleep at night, I felt very bad, because if I felt that I could not do what I want to help that baby.” (Midwife 8)

“Most of the time I find myself coming home, with stress, I reflect on the event to see what went wrong… I recognise obstetric violence and that causes me more stress.” (Midwife 2)

Midwives develop somatic symptoms such as tachycardia, headaches, and sleep disturbances/nightmares and felt very bad and guilty as they did not protect women, which affected their morale and made them feel weak, sad, and fearful.

“I was praying, I felt bad as I was discussing the incident with my husband.” (Midwife 11)

“I felt bad, I felt guilty, I could not protect the woman.” (Midwife 12)

“A lady admitted with placenta praevia. We took her to the theater for cesarean section, we saved the mother but not the baby. I could not forget that scene and after that, I had sleep disturbances.” (Midwife 8)

“The baby was born but I had a headache and slowly - slowly, now I have tachycardia.” (Midwife 4)

3.3.2 Long-term psychological effects

Long-term effects of traumatic events such as flashbacks, depression, low esteem, and thoughts of leaving the birth department to be away from childbirth were reported by midwives. Midwives were stressed out and reported not feeling well for years, while others mentioned experiencing depressive symptoms.
"For years ... I felt very bad... I think I was in the early stages of depression. I always had that incident in my mind." (Midwife 4)

"I work for many years in the birthing room but after traumatic events, I feel so stressed that make me feel sick." (Midwife 7)

"That scene of women crying in pain after vacuum extraction, stay in my mind and made me feel so miserable, I found myself to prefer to stay at home doing nothing, I cannot describe my feelings." (Midwife 10)

Furthermore, two midwives could not forget traumatic events that occurred when they were students, doing their internship in the hospital. They felt that as students they could not react, but this experience remained in their minds. Specifically, they stated that they had nightmares.

"I had bad dreams; I remember everything very well and that affected my professional life." (Midwife 13)

"I was in the birth room and the woman was fully dilated and the obstetrician shouted to her to push and push... and one of my colleagues - a midwife went next to her pushed her uterus without informing her and said "I help you I help you". After that I had nightmares ..." (Midwife 7)

"After I saw the baby come out after cesarean section dead, I felt so bad that I could not sleep. I had nightmares." (Midwife 4)

3.3.3 Implications on professional life

The implications for professional life were many. Descriptions suggest that midwives blame themselves, they feel guilty and have constant fear of future errors and feelings of inadequacy, loss of confidence and entering a vicious cycle with increased odds of future self-perceived errors, have been shown to be consequences of being involved in a severe event and the event lowered their self-esteem, their care. Some of them wanted to take sick leave and be away from their work while others mentioned that they changed their place of work and prefer to work in a nursery. Some midwives reported that they felt alone, while they had experienced a traumatic event, they were afraid to discuss the whole event with their colleagues because they were afraid of the criticism. Specifically, one midwife mentioned that she was present in a difficult birth and that neonate suffered a lot and she went home and continuously had this event in their mind.

"I went home and I have in my mind the whole event continuously, the poor baby suffers .. I have it now in front of my eyes ... the ventouse." (Midwife 7)

Some midwives opined that there are changes in maternity care and in the passing years their role and work culture were affected negatively. Midwives’ autonomous role to create special relationships with women and advocate for their childbirth rights got lost. Obstetricians wish to be present during normal childbirth and if everything went well, they get all the credit from the system, from the relatives, and the contribution of the midwife. But at the same time if something goes wrong, then they blame the
midwives. In this way, midwives are forced to change their clinical practice so that they are in line with the mindset of doctors.

“Sometimes during labor and birth, there is a very high level of stress ... if something goes well during the birth, okay, all credits went to the doctor, if something goes wrong, it is the midwife’s fault ...” (Midwife 2)

Some descriptions reflected the work environment where midwives felt that there was no adequate coordination or support and not working as a team, which often led to missed care.

“The work culture where we as midwives worked more as a team no longer exists .... There is a lack of coordination, due to bad management. we have no leaders.” (Midwife 14)

In contrast, some midwives emphasized that the support they receive from other midwives helps them to feel better.

3.4 Dealing with traumatic events

3.4.1 Colleague support and/or family support in dealing with traumatic events

Support in dealing with traumatic events came either from their colleagues and/or their family. After the event, some of the midwives shared with their colleagues their feelings, thoughts, and concerns and discussed with them the event and their reactions.

“I had support from other midwives, listened to me because ... listening is a kind of support, then they advised me ... they helped me a lot just talking ...” (Midwife 13)

Midwives reported that after experiencing a traumatic event they found family support beneficial. Midwives refer to their spouse or partner support.

“I discussed the event with my husband ...he helped me.” (Midwife 11)

3.4.2 Personal characteristics

Midwives react to traumatic events in many ways according to their personalities and they refer to personal characteristics that helped them deal with traumatic events. An experienced midwife based on her expertise.

“When I saw a lot of blood on the bed I said to myself you know what to do and you must do it ... , think, concentrate on your knowledge ...” (Midwife 1)

Midwives became stronger and learned how to react to similar events, pay attention to the smallest details, acted more autonomously, and became more accountable.

“Traumatic events help me to pay more attention to some details during midwifery care. I will improve my skills to be able to cope with something similar in the future ...” (Midwife 5)
“That event gives me strength… If I have to deal with the same situation again, I will try to think better, a strength comes inside me now.” (Midwife 2)

4. Discussion

This study explored midwives’ experiences of traumatic birth while identifying the implications on their personal and professional life. Midwives had described the various traumatic events they experienced, which entailed exposure to emotionally demanding situations, how their lives were affected, describing their reactions and feelings. Cope mechanism with a traumatic event developed, while some midwives mentioned that nothing could help them and had partially changed their place of work and clinical practice. A traumatic perinatal event was defined as occurring during labor or shortly after birth when the midwife perceived the mother or her infant to be at risk and they (the midwife) had experienced fear, helplessness, or horror in response [22].

PTSD is characterized by involuntary and distressing recollections of the traumatic event (e.g., flashbacks and intrusive imagery), avoidance of reminders (people, places, and thoughts) of the event, heightened arousal (where concentration and sleep can be disrupted), and alterations to worldview beliefs and affective states (e.g., guilt, fear, or shame). The psychological effects on midwives are important for their mental health. Midwives exposed to a traumatic birth develop symptoms of post-traumatic Stress disorder (PTSD) [23, 24]. PTSD did not emerge in our interviews but high levels of stress and in one case symptoms of depression were prevalent in the midwives. Halperin et al. [9] reported the long-term effects of traumatic births on midwives where they dealt with guilt and nightmares regarding the traumatic event, which was consistent with the findings of our study. The fear, stress, and guilt led women to believe that the traumatic events women experienced were their fault [22].

The effects of abusive care were discussed in detail by midwives, including bodily integrity violations, unnecessary roughness, witnessing or participating in procedures that were not in the woman’s or the baby’s best interests, and general interpersonal disrespect in which the woman’s dignity was disregarded or her wishes were ignored [25]. This also consisted in the current study, descriptions of abusive care and the authority figures that affected the midwives. Cankaya et al. [26] identified that midwives tried to be more defensive and careful, so they would avoid a similar traumatic experience in the future. Also, it was pointed out that, sometimes due to management, coordination and communications problems occurred, where most of the time obstetricians had no consequences for their actions. As a result, midwives changed their care, and they did not react if interventions occurred during childbirth. Traumatic events were associated with emotional distress in midwives, specifically, feelings of worry, guilt, anger, and horror regarding the event the pregnant women experienced under their care [7].

It has been observed that long-term effects on midwives’ personal lives are consistent with other studies; some of the midwives reported experiencing feelings of guilt and having nightmares about the traumatic event they experience while others tried to avoid any situations that would put them in the same position [9, 27]. In certain cases, there were immediate effects that affected their personal life such as stress, fear, and sadness because they felt responsible for the event [22].

The support from their co-workers, family, and friends was of important value for the midwives and had a vital role in adapting resilience in the
workplace. Another factor effective in resilience was the sense of usefulness and reassurance. Halperin's study [9] justified that emotional support by coworkers and family were essential for their emotional well-being, to cope with the traumatic event but also in reaffirming their professionalism. Specifically, family support was the most important support system [26]. In contrast, in some cases, the events were criticized by their coworkers, which made it more difficult for them to process [28].

Furthermore, another factor that contributed to dealing with the traumatic experiences was the additional information given, as well as the education of the midwives, on issues that they felt had gaps. This factor was shown through the study of Wahlberg et al. [2] that it is important since midwives need training to increase their resilience on an individual and professional level. It is important to have multidisciplinary professional meetings, in which midwives can discuss their traumatic experiences and have therapeutic discussions with them. Professional support should be provided to midwives to deal with traumatic experiences, recognize and understand the impact of psychological trauma, and have the appropriate support to provide quality perinatal care [26].

5. Conclusion

Midwives living in Cyprus experience many traumatic events, significant ones being bleeding before or after childbirth, death of the mother, and the death of the newborn and unnecessary interventions. It has also become evident that vacuum extraction and the medicalization of childbirth and lack of support affect the mental health of midwives. Midwives following the experience of a traumatic perinatal event need effective support at both a personal and organizational level.

Regarding the effects of midwives after the traumatic experiences, they had a significant impact on both their personal and professional lives. They pointed out that the short psychological effects they had were related to the fear they felt after the traumatic event, and they considered themselves responsible for it. Long-term effects were reported such as symptoms of depression and high levels of stress and PTSD, which was distressing to the midwives. The study showed that midwives, experiencing a traumatic experience in the birth room, forced themselves to change their place of work and clinical practice. Factors that contributed positively to coping with these events were the mutual support from other midwives and their families.

The consequences of traumatic births on midwives affect their professional and personal life. It should be feasible to seek professional help when experiencing these kinds of events to share their worries and experiences with suitable care and therapy. Educational programs and seminars are needed not only to educate midwives but also to empower them to help improve the outcomes of traumatic events. Most importantly, multidisciplinary intervention groups should be implemented where midwives could share their experiences and discuss their worries with other coworkers to help them recognize that they are not alone. It is vital for the health systems to provide counseling or multidisciplinary meetings where they can discuss responses to trauma in a nonjudgmental way and provide them with information on how to access support if desired or needed. Conclusively, there is an urgent need to facilitate development of health professionals that feel confident and competent in providing the right evidence-based perinatal care.
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I acknowledge the generosity of midwives in Cyprus for their time and willingness to share with us their experiences from a traumatic birth.

Conflict of interest

The authors declare no conflict of interest.

Notes/thanks/other declarations

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References

[1] Leinweber J, Rowe HJ. The costs of ‘being with the woman’: Secondary traumatic stress in midwifery. Midwifery. 2010;26(1):76-87
[14] Newell JM, MacNeil GA. Professional burnout, vicarious trauma, secondary traumatic stress, and compassion


