ARTICLE

# MIDWIVES' EXPERIENCES OF STRESS DUE TO EMERGENCY CHILDBIRTHS IN A NAMIBIAN REGIONAL HOSPITAL

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## ABSTRACT

Midwives throughout the world experience excessive stress when dealing with emergency childbirth situations. Complications may occur during labour and delivery, leading to the lives of both mother and baby being threatened. The midwife is usually the professional who has to cope with the emergency and who must be able to think clearly and act appropriately. The study is significant due to the description of the different emotions experienced during emergency childbirth situations. The purpose of the study was to determine how midwives working in a Namibian regional hospital experienced stress when exposed to emergency childbirth situations. The study design was qualitative, explorative, descriptive and contextual. Ten midwives who had experienced emergency childbirths were purposely selected to participate. Data were collected using in-depth individual interviews until saturation occurred. The interviews were audio-taped and transcribed verbatim. Content analysis was used to identify themes and sub-themes. Trustworthiness was ensured. The findings indicated that midwives were exposed to unique stressors, which compromised their ability to cope. The participants described experiencing a variety of emotions such as anxiety, panic, sadness, relief, joy, guilt and self-blame during and after the crisis. They felt frustrated and angry when they could not render quality maternity

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care due to staff or equipment shortages. They felt that the excessive stress they experienced could lead to them to experience burnout. It was recommended that midwives experiencing excessive stress should be formally debriefed after each incident and in-house support should be arranged. Stress management workshops should be presented annually.

**Keywords:** anxiety; stress; emergency childbirth; midwives

## INTRODUCTION AND BACKGROUND

Midwives throughout the world experience stress when dealing with emergency childbirths where the lives of both mother and baby are threatened (Hood, Fenwick and Butt 2010,269). Dealing with midwifery emergencies could cause a midwife to experience emotional trauma that may include anxiety, anger, sadness and uncertainty (Ross and Deverell 2010,400). The stress they experience due to an emergency childbirth can have a long-term impact on a midwife's professional and personal life (Halperin, Goldblatt, Noble, Raz, Zvulunov and Wischnitzer 2011,391). It may leave midwives feeling depressed, with a low morale and questioning their midwifery skills. They may lose confidence and experience fear when working with patients. Uncertainty about their skills may lead to compromised patient care, which may lead to more adverse outcomes (McCool, Guidera, Stenson and Dauphinee 2009,1003).

It is widely accepted that people in health professions are particularly vulnerable to stress and burnout (Ross and Deverell 2010,405). Yoder-Wise (2011,844) states that midwives need to know how to cope with stress as it usually recurs and is a reality in their profession. Due to poor stress management, midwives may also experience mental discomfort such as unhappiness, anxiety or depression. Midwives' physical health may be affected, causing problems such as hypertension, heart disease and diabetes (Yoder-Wise 2011,555). Stress can negatively affect other aspects of the midwife's life, such as increased friction at home or unhappiness in the work place. It may also adversely affect the midwives' image of the midwifery profession, causing them to question if they chose the right profession (Ross and Deverell 2010,405).

When work-related stress is not managed effectively, it may lead to burnout, which in turn may cause the midwife to lack motivation or to fear working in a maternity ward. Patient care may be compromised as some midwives become apathetic, losing empathy with their patients, ignoring them, shouting at the labouring women, or using abusive language (Ross and Deverell 2010,400; Yoder-Wise 2011,561). Such behaviours eventually compromise team unity/spirit, which in turn may lead to poor work performance, maternity services that are not woman-friendly and women seeing the maternity ward as a place where they are treated in a rude and unfriendly manner (Reid 2007,9). This may increase cases of childbirth complications as mothers may become stressed. Due to the excessive stress midwives

experience, some may resign or request transfers out of the maternity unit, leading to high rates of staff turnover and shortages of experienced staff to deal with obstetric emergencies (Pugh, Twigg, Martin and Rai 2013,497).

## STATEMENT OF THE RESEARCH PROBLEM

The context in which the study took place is a regional state hospital in Namibia with a large maternity ward that accepts referrals from the outlying areas, which include the surrounding district hospitals, health centres or clinics. Specialised services are available at the hospital in the form of an obstetrician, a pediatrician and three specialist midwives. The midwifery ward consists of a labour room that can accommodate eight patients, a delivery room with only two beds, a post-natal unit with 50 beds and a neonatal and sick baby unit that can care for 35–40 babies. According to hospital administration, bed occupancy oscillates between 60–80% with nearly 6 000 deliveries a year. This means that approximately twenty or more deliveries are conducted per day. Approximately 1 300 patients a year are referred, most from the outlying hospitals or clinics, and another 1 300 patients present with complicated pregnancies. Referrals consist of women with pregnancy-related problems or complicated labour. Pregnancy-related problems include conditions such as being anaemic or hypertensive, multiple pregnancies, an increased risk of haemorrhaging after delivery, or infections such as HIV. Complicated labour refers to women who are already in labour and presenting with complications such as prolonged labour, cephalo-pelvis disproportion, malpresentations, obstructed labour, uterus rupture, convulsions due to hypertension, hemorrhage and/or fetal distress. Due to distances or transport problems, women may arrive at the hospital with little time for midwives to prepare for the delivery of the baby. The midwife is often the first health professional on the scene and therefore has to be able to deal with any of these emergencies. They reported that having to deal with childbirth emergencies on a regular basis caused them to experience excessive stress. They reported that they were exposed to a high workload, that they were responsible for both mother and baby and had to be able to deal with any kind of emergency at the “drop of a hat”.

The researcher, an advanced midwife, noticed that the midwives who had been exposed to emergency childbirths tended to present with stress. They described physical symptoms they experienced such as headaches, palpitations, hypertension, feeling very tired and unable to sleep well. They also reported mental symptoms such as an inability to concentrate, feeling depressed and anxious. The ward has a high turnover rate of staff (31%) and has difficulty recruiting new staff. Midwives leaving the ward reported that they prefer not to work there as they experienced constantly dealing with emergencies as very stressful. The staff reported that the stress influenced both their professional as well as their private life.

## THE OBJECTIVES OF THE STUDY, ASSUMPTIONS AND RESEARCH QUESTIONS

The purpose of the study was to determine how midwives working in a Namibian regional hospital experience stress when exposed to emergency childbirth situations. The question that guided the research was: 'What are the experiences of midwives working in a midwifery ward when dealing with emergency childbirths?'

## CONCEPT CLARIFICATION

**Anxiety** is defined as a complex blend of unpleasant emotions and cognitions that is more oriented to the future than the present (Butcher, Mineka and Hooley 2013,172). Mild anxiety includes experiencing unease and discomfort while severe anxiety refers to terror or dread (Kniesl and Trigoboff 2014,87). Stress, on the other hand, is described by Hornby (2010,1477) as pressure or worry caused by problems in a person's life. Kniesl and Trigoboff (2014,82) refer to stress as a broad class of experiences where a demanding situation may negatively influence a person's resources or coping abilities.

**Emergency childbirth** refers to obstetric emergencies that require immediate attention, since a delay in management or treatment may cause foetal or maternal morbidity and mortality (Cronje, Cilliers and Pretorius 2011,220).

**A midwife** is the 'professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births and to provide care for the new-born infant. Such care includes preventive measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care, or other appropriate assistance, and the carrying out of emergency measures' (defined by the International Confederation of Midwives in Fraser and Cooper 2009,5).

## RESEARCH METHODOLOGY

Brink, Van der Walt and Van Rensburg (2012,96) state that the best research design is the one that is most suitable to the research problem and purpose. A qualitative, explorative, descriptive and contextual study was used in this project. Qualitative studies tell the story of the participant in words (Cresswell 2013,249). Exploratory studies help the researcher gain insight into a situation where there is little information, or when limited research has been conducted (LoBiondo-Wood and Huber 2010,198). Although similar studies were conducted around the world, no such study had been conducted in Namibia. The study was contextual, as it took place in a specialist midwifery ward where midwives had to deal with problem pregnancies or complicated labour on a continuous basis.

## The research population

The target population consisted of 36 midwives who worked at a maternity ward of a Namibian regional hospital. The research sample consisted of 10 midwives who met the inclusion criteria, which stated that the participants were registered with the Namibian Nursing Council as midwives, had to have worked in the field of midwifery for the period of at least three years, were currently employed to work in the maternity ward, and had to have dealt with at least one emergency childbirth. A sample was selected conveniently and purposively (Polit and Beck 2012,517). All the participants who met the inclusion criteria were invited to participate and names were selected from the individuals who indicated a willingness to participate. All participants were female, had ages ranging from between 28 to 57 years, and had worked in midwifery for periods ranging from three to 30 years. Two participants had an additional qualification in advanced midwifery and neonatal nursing science. Four of the participants also had a bachelor's degree of nursing management qualification.

## Data collection procedure

Data were gathered during February 2014 using in-depth individual interviews. The interviews took place in an office where privacy and confidentiality could be ensured. Each participant was asked a question, 'How was it for you to be involved with emergency childbirth situations? Tell me about the stress you experienced.' Follow-up questions were used to clarify the meaning of their descriptions. Each interview lasted between 30–60 minutes and was conducted during the participants' off-duty time to minimise inconvenience to the maternity ward. A variety of interview techniques were used to obtain in-depth information (LoBiondo-Wood and Haber 2010,275). All the interviews were audio-taped and transcribed verbatim, ensuring that no information was lost. Data saturation was achieved after the tenth interview, when no new information was revealed (Gerrish and Lacey 2010,22). During the interviews the researcher kept field notes regarding the body language of the participants.

Rigor was ensured using Guba's model of trustworthiness (Lincoln and Guba 1985, cited in Polit and Beck 2012,584), using strategies such as triangulation (using more than one source of data such as interviewing, field notes and literature), member checking by asking participants to read their own interviews and comment on it, purposive sampling that ensured that the best sources for information were utilised, and detailed descriptions of the methodology and findings were given to ensure rich data. An independent coder was used to ensure objectivity of the findings by each person coding independently and having a consensus discussion afterwards to identify the final themes and sub-themes. A pilot study was done to ensure that the interviewing technique and the questions asked delivered the required information (De Vos *et al.* 2011, 237).

## Data analysis procedures

Data analysis is a mechanism for reducing and organising data to produce findings that need interpretation by the researcher (Creswell 2013,182). The data were analysed according to Tesch's method of content analysis (Tesch 1990,142–145, cited in Creswell 2013,186). This meant that the researcher read through all the transcriptions carefully, making notes of ideas that came to mind in the margins of the interview. Words and phrases that indicated meaning were underlined and categorised into topics. Similar topics were grouped together to form themes and sub-themes. Descriptive wording for the topics was identified and this was converted into categories. The researcher also attempted to draw correlations between the categories to indicate relationships.

## Ethical considerations

The permissions to conduct the study were obtained from the Permanent Secretary of the Ministry of Health and Social Services in Namibia, the Regional Health Director, the Medical Superintendent and the Nursing Service Manager of the hospital concerned. Ethical clearance was obtained from university structures (H13-EA-NUR-017). Written informed consent was obtained from the study participants. They were informed that participation was voluntary, that they had a right to withdraw from the study without penalty and that confidentiality and anonymity of the reported findings would be ensured (Burns and Groove 2011,123). The researcher, who is a colleague of the participants, arranged for an independent interviewer without a connection to the hospital to conduct the interviews. This was done to prevent a conflict of interest and to maintain confidentiality. The researcher ensured that the transcribed data were given to the independent coder without any biographical information. During and after completion of the study, the research information was kept safe in a locked cupboard (De Vos *et al.* 2011, 408). Privacy was maintained in this study by conducting the interview in a hospital office, which was situated away from the midwifery setting and free from disturbances and manipulation.

# DISCUSSION OF RESEARCH RESULTS

Rich data were obtained from the interviews. Three themes with sub-themes were identified, which included a description of the emotions experienced by the midwives that included verbalisations of excessive stress being experienced. The emotions may have been a result of often having been exposed to excessive stress. A second theme dealt with the factors in the working environment causing stress, and the last theme dealt with the midwives' need for support. For the purpose of this article, only theme one, where the participants described their emotional experiences, will be discussed.

## Theme: Midwives experienced mixed emotions about dealing with emergency childbirth situations

The participants who had been exposed to excessive stress during childbirth described that they experienced both positive and negative emotions. Positive emotions referred to happiness, joy and compassion, which were experienced when the emergency childbirth had a positive outcome and both mother and baby were healthy. Negative emotions referred to anxiety, panic and frustration experienced during the emergency, while guilt, anger and sadness were often experienced when the outcome was in the balance or when the patients were not doing well. Fraser and Cooper (2009,12) point out that while childbirth is usually associated with joy for all those involved, sadly this is not always so. According to Macdonald and Magill-Guerden (2011,954), stress can be experienced both physically and emotionally. The emotional experiences will now be discussed.

### Sub-theme 1: Midwives shared in the happiness and joy experienced by the mother and family

Participants described experiencing excessive stress during a complicated confinement, which turned into feelings of happiness and relief when the baby was safely delivered or the mother's condition stabilised. Midwives reported feeling satisfied when they saw a mother leave the maternity ward with her family and a healthy newborn baby. One participant added that knowing that the maternity care she rendered to the women during delivery was beneficial, relieved her work-related stress. Another participant described her feelings after assisting the newborn who arrived safely as follows:

> "I was happy and excited, because I can see that I did a good job as I saved the baby's life …. When I knocked off I went home feeling happy and relieved."

The midwives reported that their morale was enhanced and their tension relieved when emergency childbirth resulted in good outcomes. The positive emotions they experienced alleviated the stress caused by the complicated childbirth and increased their work satisfaction.

### Sub-theme 2: Midwives reacted with anxiety, fear and panic when a patient's condition deteriorated

When a midwife became aware of a compromised delivery, where either the mother's or baby's life was threatened, her levels of stress would immediately escalate, sometimes leading to experiences of severe anxiety and panic. This is illustrated by the following two quotes by participants:

> She was bleeding heavily despite being on the blood transfusion. It was during the night. I started to panic. She started with difficult breathing … then gasping. The doctor transferred her to intensive care unit … She was just gone, she died.

> I continued resuscitating the baby … I became panicked because the mother of the baby was looking at me. She could see her baby was not doing well as it never cried … I became more panicky and felt anxiety. I was shivering and could not even hold the ambu-bag. There wasn't another midwife to help.

In both these life-threatening situations, the midwife experienced excessive stress but still continued to try to rectify the crisis. The participants reported that having to handle an emergency alone caused them high levels of stress. Having another midwife present to continue with the resuscitation may have lessened the stress. Stress was sometimes caused by uncooperative patients who did not respond to the midwife's instructions, such as allowing the midwife to check vital signs, or to get the patient onto the bed. Midwives felt anxious as this resulted in them not being able to assess the patient's or baby's condition or having to deliver a baby while the mother was lying on the floor.

> She was not cooperating, as she was standing around or rolling on the floor during her first stage of labour. I could not put her on the fetal monitoring machine and that day I was alone at the assessment room … I delivered the baby on the floor, a very tired baby.

The aftermath of a complicated delivery may cause further concern for the midwives who have to write an incident report without compromising themselves. The reaction of the hospital's management may exacerbate their stress as they felt that management may not support them and will leave them to their own devices.

> "Before any investigation had been done, they are already blaming you. Before they looked at the whole story … the community is blaming us … I am scared to wear my epaulettes in the shopping centre."

Midwives reported that the community's reaction to the death of a patient or a baby caused them stress. The stress was exacerbated by the media who betrayed them negatively, causing the community to call them "baby killers".

### Sub-theme 3: Midwives felt sadness at the loss of a mother or baby

The participants described experiencing sadness at the loss of a mother or baby. They shared in the family's grief and felt compassion when confronted with a grieving spouse or grandparent. The sadness was enhanced when they had to break the news to excited family members when a mother died unexpectedly, or where there was no baby to take home. Participants reported that a perinatal death affected their emotions deeply as it was difficult to pass on the message of the death to the relatives. They often personalised the experience, as illustrated by the following quotations:

> The woman started crying … I couldn't hold my tears, we cried together. I knew very well that it was not right but I couldn't … It was very sad. I am a mother myself and I just put me in her socks.

> The aunty arrived two hours later after she got transport. I felt sadness and compassion when I looked at her as she carried the bag full of the deceased's and the baby's clothes, hoping her niece was still alive. I accompanied her to intensive care unit to receive the death message.

Some of the participants revealed that they could not forget what happened and took their negative emotions home with them. They feared that those sad memories could affect their psychological well-being.

### Sub-theme 4: Detrimental working conditions in the ward caused the midwives to experience anger and frustration at not being able to do their jobs well

The participants explained that they experienced frustration when they were expected to give good quality care to patients while there was not enough staff to look after many patients. Sometimes the midwife had to deal with a large number of patients and only a few nurses to help in taking care of them.

> "I wanted to help the woman but I cannot divide myself to give the care to two patients at the same time."

The participants had to deal with very ill patients while there was a lack of equipment, such as not enough monitoring equipment or beds for the labouring women. They also experienced electricity failure that caused equipment such as lights not to work.

> "The baby was born with a low Apgar [score] but there was no electricity in the ward. It was difficult to use the suction machine and to give oxygen … I was very angry … frustrated."

Knowing what to do in a crisis but being unable to implement the solution because they did not have access to equipment increased their stress and caused them to experience frustration and anger.

### Sub-theme 5: Questioning their actions may lead to guilt and self-blame

The participants reported feeling guilty and tended to blame themselves following the death of a mother or baby. Their feelings are illustrated by the following quote:

> All midwives want to succeed during emergency childbirth situations. Nobody wants to lose the life of mother or baby … Such cases cause a lot of stress and we blame ourselves for not being able to succeed to save the life. I felt guilty because of such deaths.

The participants questioned their own actions as well as their abilities and skills after losing a patient.

## DISCUSSION OF RESULTS

Midwives enter the profession wanting to help women during pregnancy and birth. They foresee working in an environment where patients and families experience joy at the birth of a normal, healthy baby and where sadness and stress are seldom experienced. During times of stress, the rewards of patient appreciation, the joy of seeing a healthy newborn baby or seeing the relief brought on by the judicious use of medical science may comfort the midwives exposed to excessive stress (Yoder-Wise 2011,557). Macdonald and Magill-Guerden (2011,954) state that the losses associated with childbirth might cause midwives to develop negative feelings about themselves and their work, causing them to see themselves as failures. Midwives' emotions are affected in a significant manner when managing emergency childbirths that are followed by the loss of life (Robins 2012,27). These experiences may lead the midwives to experience excessive stress, which may lead to burnout. This may cause an experienced midwife to decide to transfer out of the midwifery unit rather than exposing herself to the repeated experiences of stress.

Midwives reported a mixture of emotions such as frustration, anger, guilt and self-blame, which may be a consequence of excessive stress. The stress may rob the midwife of quality of life and contribute to unhappiness. Butcher, Mineka and Hooley (2013,172) state that the midwife experience a complex blend of unpleasant emotions and cognitions that is more oriented to future functioning than what happened in the past. However, it is past exposure to stress that is at the basis of the midwife's unhappiness. They worry about possible repercussions or future threats of danger and humiliation. They are unable to predict a future for themselves as they doubt their own ability.

The midwives also reported that during a childbirth emergency they may experience panic. According to Kniesl and Trigoboff (2014,133), panic can be described as an experience of intense terror where details may be enlarged, scattered or distorted. Logical thinking and effective decision-making may be compromised. They may also experience physical manifestations of stress such as palpitations, rapid breathing, cold sweat or hot flushes, sensation of horror, nausea and a dry mouth (Melgosa 2011,96). This may cause the midwife not to think clearly during the emergency, leading to mistakes.

## CONCLUSIONS

The midwives in this study experienced mixed emotions related to dealing with emergency childbirth situations. At times they felt happy and relieved at having been able to deal with an emergency childbirth effectively. However, when things went wrong, they experienced negative emotions, which lead to excessive stress. Ross and Deverell (2010) describe burnout as a state in which the person experiences emotional exhaustion, feels depleted emotionally and spiritually, has a low self-

concept, and tends to be suspicious and see work as a drudge. Yoder-Wise (2011) lists the symptoms associated with burnout as being stressed, worried and anxious or feeling depressed. More emotions include being irritable, angry, impatient and feeling emotionally depleted. These emotions may give rise to low self-esteem. The midwives in the study experienced some of the same emotions, which included anxiety, fear, panic, sadness, anger, frustration and guilt. They mentioned feeling so overwhelmed and stressed that some of them just wanted to leave the midwifery profession. They needed to know how to cope effectively with the stress and to feel supported by colleagues, management or even have access to a counsellor. Instead they reported being unable to cope with the amount of stress they were exposed to. One can conclude that the excessive stress was putting their physical and mental health at risk, and causing them to be at risk of developing burnout.

## RECOMMENDATIONS

Counselling done by a mental health professional should be provided to midwives who are stressed and/or emotionally affected by an emergency childbirth that has had adverse outcomes. These midwives should be offered debriefing as soon as possible after the event. All midwives should also be encouraged to attend an annual, in-service education workshop, teaching them stress management skills as well as assertiveness and self-esteem development. Midwives' confidence in being able to manage obstetric emergencies should be developed by encouraging them to attend in-service programmes focusing on midwifery issues. A further need expressed by the participants was for training in writing incident reports.

Midwives' confidence in their ability to manage any emergency may be boosted if guidelines and protocols that describe the management of emergency childbirths are readily available in labour units. Posters displaying steps to follow in a specific situation can be displayed on walls where the midwife can follow the steps with only a glance at the wall. This will boost the midwife's confidence in her ability to manage emergencies.

## LIMITATIONS OF THE STUDY

Since qualitative research studies are contextual, it is difficult to make generalisations to other similar situations or settings. The study only included female midwives who were working in the maternity ward of one public regional hospital and did not include the midwives who were working in maternity wards in the private sector or in the surrounding community.

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