Understanding Stress and Burnout in Birth Suite Midwives

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Abstract

Perhaps due to the perception of midwifery being an inherently pleasurable pursuit, there has been limited research of the stress and burnout midwives may experience. However, with evident difficulties in recruiting and retaining midwives, this is an area that requires research. Therefore the stress and burnout experienced by midwives who work in birthing suite was explored in terms of their coping style and levels of social support and assessed in terms of the levels of stress, burnout and compassion fatigue experienced.

A mixed methods design was used with the initial phase being qualitative and a second quantitative phase. The qualitative phase was carried out within a phenomenological framework using a purposive sample of ten midwives with birthing suite experience. The interviews followed a semi-structured format using open-ended questions. The aim of this phase of the study was twofold. Initially the data were analysed to gain an insight into the essence of the stress being experienced. Further to this, data obtained facilitated the development of the *Diary of Stressful Events*. The initial analysis revealed thirty one constituents to be the essence of the stress experienced by birthing suite midwives. These constituents related to the areas of stress, debriefing, support, communication and bereavement care. The overarching conclusion drawn from the analysis was that the midwives' stress was underpinned by any challenge to their sense of control where control is synonymous with adequacy, competence, confidence and being able to manage.

The second phase was quantitative with the aim of assessing any relationships found between measures of stress, burnout, social support and coping. A longitudinal design was used with data collection occurring over a twenty four week period. There was also a cross-sectional element with a series of scales completed at the beginning of data collection. The final sample of thirty one midwives was drawn from an outer-suburban 'level two' hospital and an inner-suburban 'level three' hospital. The longitudinal component of the study required completion of the *Diary of Stressful Events, Perceived Stress Scale (PSS),* and the *Professional Quality of Life –R III (ProQOL-R III),* while the cross-sectional component included a demographic questionnaire, *Maslach Burnout Inventory (MBI), Social Provisions Scale (SPS),* and the *Coping Inventory for Stressful Situations (CISS).* It was found that the key components of the stress experienced related to a challenge to the midwives' sense of control, a lack of supervisor support and their workload. The provision of bereavement care was found to increase burnout while concurrent compassion fatigue also existed. The findings have implications for the management of staff / women ratio and staff skill mix, reducing unpredictability through clear work plans and protocols, training for bereavement care and provision of workplace support.

Student Declaration

"I, Lynette Mary Walpole, declare that the PhD thesis entitled Understanding Stress and Burnout in Birthing suite Midwives is no more than 100,000 words in length including quotes and exclusive of tables, figures, appendices, bibliography, references and footnotes. This thesis contains no material that has been submitted previously, in whole or in part, for the award of any other academic degree or diploma. Except where otherwise indicated, this thesis is my own work".

Signature

Date

Acknowledgements

My experience of completing this thesis would suggest a paradoxical situation is formed with regard to the relationship you have with those around you. On the one hand, particularly during the endeavour of writing, there can be an increasing sense of isolation. On the other hand, there is the realisation that many people have played a supportive role that has been integral to arriving at the point where there is a completed thesis.

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Table of Contents

Phase One: Elucidation and Discussion of Constituents

CHAPTER 9   146

Phase Two: Discussion

CHAPTER 10   192

Conclusion of Qualitative and Quantitative Findings

List of Tables

Glossary

Accrued stress: is associated with the notion that repeated exposure to a particular stressor will lead to an accumulation of stress in relation to that stressor

Aggregate stress: indicates the overall amount of stress experienced across a given period of time

AUM: Associate Unit Manager, a term used to signify those staff members that fulfil the role of the Unit Manager / Nurse Unit Manger in their absence

Birth Centre: a place where women / couples choose to birth that is akin to a homebirth / in an environment that is not 'medicalised', but where there are often the facilities of a hospital available if required

Code Blue: a term used to describe any medical emergency where resuscitation may be required or instituted (e.g. cardiac arrest, respiratory arrest)

Delivery suite: an outmoded term used to describe a birthing suite, an area where women in the process of birthing of cared for

FDIU: fetal death in utero, the baby has died prior to being born

Fetal distress: a term used by midwives to describe a situation where the baby's vital signs do not fall within the prescribed normal range. This is more likely to be seen during the labour process

Global stress: a term used in relation to the Perceived Stress Scale that refers to the measure of stress a person has experienced in their life in general

Graduate midwife: a person who having achieved the standards required to register as a midwife is in her for 12 months of post training employment

Level 2 hospital: a teaching hospital that does not have the fulltime academic staff, and in the instance of a maternity hospital the neonatal nurseries do not have the capacity to care for babies of less than 32-34 weeks gestation

Level 3 hospital: a teaching hospital that has academic departments headed by a professorial or associate professorial appointee based at the hospital full-time with a further two or more senior academic appointees per department and an established undergraduate and postgraduate teaching program that also demonstrates significant research activity

MBI: Maslach Burnout Inventory, a commonly used measure of burnout

Midwifery supervisor: a hospital staff member employed to oversee and ensure the smooth running of the clinical areas

MMPI-2: Minnesota Multiphasic Personality Inventory, used clinically to assist with the diagnosis of mental disorders and the selection of appropriate treatment methods

MTS: 'Mid-trimester service', the name used to describe the hospital clinic responsible for providing care to those women seeking a late termination

MTT: mid-trimester termination, a termination carried out after the 14th week of pregnancy and generally prior to 22 weeks of gestation

NEO-five factor: an inventory used to measure the five domains of personality (neuroticism, extraversion, openness to experience, agreeableness, and conscientiousness)

NUM: nurse unit manager, a term synonymous with 'Charge Nurse' it is used to describe the person with the administrative responsibility for the ward

Operalisation: a commonly used psychological term describing the process whereby an abstract psychological construct (midwives' stress) is translated into a more specific and concrete construct that is observable and measurable

Primigravida: a woman who is in her first pregnancy

Private client: a woman who has selected to pay to see an obstetrician of her choice as compared to being cared for on the public health care system

Prolapsed cord: a situation that arises when the umbilical cord is able to descend into the vagina in front of the baby's head when the membranes ('bag of waters') rupture

PSAs: Patient Services Attendants are staff employed to ensure the women's meals are given to them and the rooms are cleaned between women.

Registered midwife: a midwife who has completed 12 months of work following completion of her training

"Snapped cord":   a term used by midwives to describe the circumstance where they cord has detached from the placenta, this usually occurs as delivery of the placenta is being attempted

Subjective stress: the stress reported by the midwives as they completed the Diary of Stressful Events

UM: Unit Manager, the term used to describe the midwife charged with the administrative responsibility of the ward (NUM).

Chapter 1

INTRODUCTION

As a person who has worked as a midwife since 1982, predominantly in birthing suite, the idealised perception of a midwife seems to one of a very caring, empathic person who is knowledgeable, supportive and able to provide a high level of care. This perception is combined with the notion that in a developed country such as Australia the population expects that all health services will be of a high standard. For this to be so there is an imperative to constantly develop and grow in all areas of health care delivery. As a result of this, midwifery is subtly, but constantly, evolving and developing to suit the needs of the clients. Therefore, along with any inherent stress that the work of a midwife may entail the requirement to change and implement new practices is just one of the many stressors experienced by midwives. It is with this knowledge in mind and after undertaking studies in psychology that I developed an interest in understanding the stress experienced by midwives, particularly those with birthing suite experience.

In the following pages of this introduction I will endeavour to provide an overview of the midwife working in birthing suite, the nature of the work undertaken in that role, the difficulties encountered and place that in the context of the current employment climate.

A commonly held, but inaccurate perception of the Australian midwife, suggests that it is an inherently pleasurable and satisfying sub-speciality of nursing. Further to this, the work "usually has a happy, positive outcome", and is without any of the hazards, adversity, distress or anguish often associated with nursing. This perception may explain why Carlisle, Baker, Riley and Dewey (1994) found that there is little research on stress specific to midwives, a view supported by Mander (2001) when she offered an explanation as to the scarcity of research regarding burnout in midwives. This is against a background where the there are now opportunities for Australians to train specifically as a midwife and without the need to have undertaken nursing training. Also, the work of the midwife varies greatly from that of a nurse in that it necessitates them frequently forming a very intimate and cogent relationship with the women in their care.

In the instance of the midwife who works in a birthing suite, this occurs in circumstances where one-to-one care is required, which gives impetus to the development of a relatively short, but intense relationship. In a nursing context, the nature of the relationship has been recognised and described in terms of the degree of closeness a patient may experience. It is seen as qualitatively different when compared to that experienced with the medical staff; the time the nurse (or midwife) spends at the bedside generated a deeper bond when compared to the comparatively short time spent with the doctor (Campbell-Heider & Pollock, 1987).

1

While it is acknowledged that all areas of midwifery care are of equal significance, it is the period of labour and childbirth that is seen as the most critical. It is the period of time when the woman is most dependent on the midwife and one where the midwife understands that serious events can occur very quickly, and that she may be required to act skilfully, confidently and quickly and sometimes without the opportunity for consultation (Waldenström, 1997).

Clift-Matthews (2006), in her British Journal of Midwifery editorial, posed the question as to how modern midwives cope. She depicted the modern midwife as someone who has a complex role to fulfil, is required to keep abreast of the latest developments, all while often working long hours and being a parent themselves. As she so succinctly described it, midwives not only act as expected with regard to providing information for the usual concerns of pain relief and feeding issues, or the provision of antenatal care and advice and facilitating wishes that ensure the optimum birthing experience, but she also noted that the women who come under their care can present with a complex array of issues. The issues that may require management can range from teenage pregnancy through to being an elderly primigravida, from domestic violence to substance abuse, from being affected by diabetes to cancer. All of these women also need to be managed in a culturally sensitive manner that may involve them not speaking the same language, thereby adding another layer of complexity. While now recognising the possibility for a sometimes high level of complexity in the work of midwives, as McCreight (2005) suggested, the very nature of the work of midwives and nurses means that they will also encounter emotional and stressful situations.

The manner in which these emotional and stressful situations are experienced within the bounds of this intimate relationship may be more complex than initially apparent. There is the notion of midwives belonging to a caring profession that brings with it a set of expectations with regard to society's vision of a midwife and the expectations of those who become a midwife. Within this spectrum and with particular regard to emotion, it is of value to consider the perspective of Hochschild (1979) who detailed the role of social rules in governing the manner in which people act according to a situation. For example, the social rules of society and midwifery direct that a midwife should feel joy with each birth and sadness with a perinatal bereavement (i.e., where a baby has died in the time prior to or immediately following the birth).

Hochschild's (1979) theory posits that a midwife may find herself in a situation of trying to align her innermost emotions with her 'social rule' actions and physiognomy, suggesting that the individual "is conscious of a moment of 'pinch', or discrepancy" (p.562). This is the 'emotion work' whereby the midwife would attempt to change the degree or quality of her inner emotion to free her of any dissonance she may be experiencing between her projected emotion and her actual inner emotion. For example, for a midwife this would require her to not only express but always feel an inner joy when a

baby is born or to conversely feel a deep inner sadness when there is a perinatal bereavement. This may be irrespective of any reservations she has about the future for that child, or that she may have assessed the bereavement as sad, but inevitable or any other such feelings that may moderate her emotion. Therefore, in outwardly adhering to the social rules, an inner dissonance may exist, putting the midwife at odds with the aforementioned perception of there being little or no adversity or anguish associated with her role at not only a superficial level, but also at a deeper intrapersonal level.

With further regard to the commonly held perception of there being little adversity or anguish, there are studies (Hunter, 2001; Mander, 2001, 2005, 2009; Moulder, 1998) which support the notion that midwives often suffer grief and sometimes fear when dealing with the loss of a baby and they experience difficulties managing the associated emotional distress. This notion also sits well within Hochschild's (1979) theory of 'emotion work' from the perspective that as professionals, midwives have an image to uphold that they will be empathetic but commonly see it as inappropriate to display any personal feelings of grief.

Further to the situation of perinatal bereavement, Powell (1997) suggested that newer practices regarding pregnancy loss might be a source of stress. There is less understanding of the stress midwives may encounter specific to caring for those who have experienced a perinatal bereavement. Defey (1995) noted that a neonatal death or stillbirth in the third trimester "sometimes affects staff as strongly as it does parents" (p104).

While there is a body of research that explores work stress as a concept, and there is a specific body of research that explores stress in nursing, there is a paucity of research with regard to the work of midwives, the stress they may experience, the origins of that stress, and the effects and outcomes of it. Similarly, and not unexpectedly, there is limited understanding of the coping mechanisms employed by midwives to manage the stress they experience, or the levels of burnout that may ensue. For example, the area of perinatal bereavement as it affects the midwife has only recently become the subject of research. Moreover, when addressing the specific issue of staff grief related to perinatal bereavement, it was necessary to draw on the findings from other areas of research, for example where it had involved doctors, oncology nurses or medical students (Mander, 2009).

In considering the effects of perinatal bereavement and also the many other traumas that a pregnant woman may experience, the spectre of midwives experiencing compassion fatigue becomes apparent. Compassion fatigue is a condition that can arise rapidly as a result of empathically managing the trauma of others (Figley, 2002). While this may not be as predominant in midwives when compared to those who work with war veterans or disaster survivors, there is still a need to ascertain if this is a condition that afflicts midwives and to build on any existing research in this specific area.

While it is necessary to develop an understanding of the nature of the stress experienced, how it is experienced and what its various components are, there is also a need to gain some insight into some of the factors that may buffer, ameliorate or mitigate against the effects of stress and burnout. An example of one such factor is social support, which is considered important in protecting people from the effects of stress (Cobb, 1976). Social support networks may include family, friends and colleagues and serve to provide a sense of belonging, and also instrumental and emotional support, integral to the coping process. In endeavouring to develop an understanding and insight into these issues it is hoped that some information will be derived that is useful in maintaining the overall health and wellbeing within this group of health care professionals. The knowledge provided to health care organisations will offer greater insight into the difficulties midwives face. This will make it possible for them to care for the members of this important workforce sector as they expect them to care for their clients. In relation to doctors, Huggard (2003) suggested that if these issues were addressed appropriately then the health care workers would be able to continue giving in an empathic manner. Importantly, this would provide a platform from which beneficial therapeutic relationships that enhance the lives of both the carer and those in their care can be forged.

The imperative to provide this knowledge is done with an awareness that there are continued pressures being experienced in the health care sector as a result of the recruitment dip in the early to mid-1990s (Preston, 2009). This provided the impetus for a warning from the Australian Peak Nursing and Midwifery Forum with estimates suggesting that by 2010 there will be a national shortage of 19,000 nurses and midwives in Australia (Cook, et al., 2008).

Stress is recognised as integral in the development of burnout, and as Harris (1989) wrote in relation to American nurses "the costs of burnout (in nursing) are staggering both financially to the institution and humanly to the patients, as well as the nurses themselves" (p. 17). She further noted that nurse turnover rates exceeded those of women employed in other fields. Current research supports the notion of a "debilitating cycle" where insufficient staffing results from stress-related absences due to the increased stress created by staff shortages (Button, 2008).

The purpose of this study therefore is to extend our knowledge of the stressors affecting Australian midwives who work in Birthing Suite. It is an area of limited research, and due to the current issues facing the midwifery workforce in Australia it is timely to gain an insight into these stressors. Also, in acknowledging the role of the midwife in the provision of perinatal bereavement care, there is an opportunity to recognise and record the incumbent difficulties of this task.

Study format
Given that the study was carried out in two phases an overview of the arrangement of the thesis and methodology for the complete study is now provided with more detailed descriptions of the method

employed for each phase provided at the commencement of Chapters 3 & 7, with Chapter 6 providing some introductory comments and the hypotheses for the second quantitative phase of the study.

For both phases of the study, a group of midwives employed at two Melbourne metropolitan obstetrical units were surveyed. All of the midwives held either full-time or part-time birthing suite positions. The elements selected to be explored (broadly categorised as organisational, personal, and social) are considered to contribute to burnout in midwives and provided a framework for the analysis. After an initial qualitative phase, a quantitative approach was adopted with a focus on considering the relationships and interactions of demographic, social support and personality factors.

Due to limited previous research specific to the area of stress and burnout in midwifery it was considered some knowledge explicit to midwives was necessary to facilitate the quantitative assessment of their stress, hence the adoption of a qualitative approach. Therefore, the aims of the first phase were twofold in that initially it was necessary to glean information from the data collected to develop a tool that would be used to collect quantitative data. Following this the focus of the first phase was to provide an in depth description of the factors revealed as being inherent in the development of stress in birthing suite midwives.

The second phase of the study had a quantitative focus where the data collection was of a prospective longitudinal nature. The aim of this phase was also twofold because initially it was an opportunity to gain knowledge of the stress rating given by midwives to the various events that occur in their daily work lives. Also, as in the first phase, there then followed a more in depth assessment where the selected elements of interest (e.g., burnout, coping, compassion fatigue, social support) were measured and analysed.

Phase One: a qualitative approach

A qualitative approach was required for the first phase to enable the discovery of those stressors considered most pertinent to the development of stress in birthing suite midwives. Drew, Hardman and Hart (1996) argued that a qualitative methodology provides the opportunity for identification of undiscovered areas, and the gathering of richer information. There is also the potential for the socially constructed nature of reality to be emphasised (Highlen & Finley, 1996).

The initial research strategy was an *ecological* one aimed at discovering how environmental circumstances influence the achievement of the participants' goals (Highlen & Finley, 1996). A semi-structured interview was developed to collect the qualitative data. Following ethics approval from the proposed institutions, a stratified purposeful sample of ten participants was used which allowed for the selection of information-rich cases that had the characteristics of particular subgroups of interest,

allowing comparisons to be made (Patton, 1990). As Ackroyd and Hughes (1992) elucidate, by adopting such an approach researchers are not restrained to what they observe or experience.

The interview was formatted with the specific, routinely asked questions of a demographic nature to be asked as the dialogue unfolded or at the conclusion of the interview. A list of open-ended questions (Appendix A) was employed, but there was also the freedom for the interviewer to probe beyond these (Ackroyd & Hughes, 1992). The use of this format ensured that those stressors cited in the relevant nursing and midwifery literature (Carlisle, et al., 1994; Hundley, et al., 1995; Lewis, 1995; Mackin & Sinclair, 1998, 1999; Sandall, 1997) were included to be explored while there was also an opportunity for other unknown stressors to be revealed.

The advantages of this approach in the context of the proposed study were that the participants were able to reflect and reveal past cases while providing detailed descriptions of those cases (Drew, et al., 1996). It was also less costly in time and effort to administer when compared with unstructured interviews or focus groups and the data collected is more straightforward to code and process (Ackroyd & Hughes, 1992).

As Betz (1996) specified, the development of an appropriate scale can be drafted from the information gathered. On this basis the interviews were transcribed and then read to gain a global sense of the information contained within them. Throughout the reading of each transcript a note was made of any events nominated as stressful. This resulted in a list of 25 items that were able to be logically grouped into six categories. This information formed the basis of the 'Stress Diary' used in Phase Two (Appendix G). Its function was to enable the midwives to record on a shift by shift basis the stressful events they experienced while rostered to birthing suite.

Phase Two: a quantitative approach

The collection of quantitative data was both cross-sectional and longitudinal in nature. With regard to the longitudinal data collection, it was determined that this would be most appropriate because it has the following advantages of:

1. greater precision in the timing and measurement of experiences and resultant outcomes
2. the possibility of studying the process by which a risk variable leads to different outcomes
3. the subdivision of outcomes according to predetermined parameters
4. the study of change in individual subjects as a result of exposure to a risk variable; and
5. the possible analysis of indirect causal chain mechanisms (Rutter, 1988).

Prospective data collection also eliminates the biases of a retrospective study. Rutter (1988) elucidated, retrospective recall lead to a reconstruction of events, or difficulty in recalling some cognitive attributes

and behavioural patterns. The prospective study is also a classic longitudinal study that has the aim of understanding the causes of a particular behaviour pattern or disorder (Robins, 1988).

Therefore, the prospective longitudinal aspect of this phase was achieved by having the participating midwives maintain a record of the stressful events they encountered during each shift they worked. This was done over a continuous twenty four week period. At the end of each four week period when a new diary was issued, the midwives were also issued with two questionnaires (Perceived Stress Scale and the ProQOL [Professional Quality of Life]), which they completed and returned along with the diary. The Maslach Burnout Inventory was also administered at the beginning and end of the twenty four week data collection period.

The cross-sectional data was collected to explore the social and personal factors that had been researched in relation to stress in nurses, and was done with a view to gaining an understanding of any associations or implications as they affected midwives. To achieve this, a battery of scales was administered at the beginning of the data collection period. In addition to a form with the pertinent demographic questions, the package of scales included a) the Maslach Burnout Inventory, b) the Coping in Stressful Situations Scale, and c) the Social Provisions Scale.

Chapter 2

LITERATURE REVIEW

Introduction

The initial aim of the literature search was to discover any reference to midwives in relation to the areas of stress, burnout, coping, compassion fatigue and social support in the ten years prior to the initial search carried out in the year 2000. The initial plan was to focus on research carried out in the Australian setting. The data bases of Academic Search Premier, CINAHL, Medline and Psycarticles and Psycinfo and were searched using the terms Australia, Australian, midwife, midwives and midwifery in conjunction with the terms stress, burnout, coping, compassion fatigue, vicarious traumatisation, secondary traumatic stress and social support. This returned just two papers, therefore the terms Australia and Australian were eliminated, but because this still yielded a very low number of returns, it was decided to include the terms nurse and nursing. This decision was taken on the basis that like nurses, the midwife participants for this study would be working in a hospital setting. While it is recognised that there are inherent differences in the nature of the work in either group, there are also some parallels and it was therefore reasonable to draw on this body of work to inform the current research. It was also felt that the paucity of research in relation to these matters as they affected midwives highlighted the need for the current research to occur.

Stress

The concepts of stress and burnout are inextricably linked, with some viewing burnout as arising out of stress and others conceiving of it as a form of 'work stress'. The concept of stress is of longer standing and has been widely researched from several perspectives. A widely used concept of stress has coping as an integral part of the stress process (Folkman & Lazarus, 1980; Lazarus, 1966).

Stress is a subject that has been broadly researched. It is generally accepted that the various definitions of stress fall into one of three categories: stress as stimulus (engineering), stress as response (predominantly physiological), or stress as a stimulus-response interaction (predominantly psychological), but no one single definition is universally accepted. This may relate to the context in which stress has been studied. Singer and Davidson (1991) described stress research as falling into two broad categories. The first was proposed during the 1930's by Selye (1956) and is an essentially physiological model where the organism is seen as reactive and cognitions are given little significance. The second category evolved some thirty years later and stress is defined as the outcome of interactions between the organism and the environment.

While Selye may be popularly known as the "father of stress" (Maslach, 1986), the stress model proposed by Lazarus has been accepted and used extensively in stress research. It is human focussed

and uses psychological measures to evaluate the subjects' stress appraisal. Central to this approach is the consideration given to cognitions. Adopting a phenomenological stance, Lazarus (1966) proposed that the person and the environment are in an ongoing relationship of reciprocal action mediated by *appraisal* and *coping*, where stress occurs when there are demands on the person which tax or exceed their power to adjust. In later writings Lazarus (1993) added a third cognitive action, or *reappraisal*, which denotes the feedback process inherent in the *transactional model*. Although this is a model that Hobfoll (1989) considers incomplete because the goal of coping is not specified. This is the crux of Hobfoll's theory of 'conservation of resources', where the focus is on the individual's management of their resources. Specifically, when confronted by stress they seek to minimise the net loss of resources. Additionally however, when not faced by stress, they endeavour to offset future losses by developing surplus resources.

In understanding the mechanism of stress we gain an insight into why an individual may respond in a variety of ways, but our understanding of what is normal and abnormal has not been informed. As may be expected, defining what is normal and abnormal is a difficult and sometimes fraught task because standards of normality and abnormality are culturally defined (Parkes, 1997).

Various studies have identified nursing as a stressful occupation (Gray-Toft & Anderson, 1981; Tyler & Cushway, 1992, 1995; Tyler & Ellison, 1994), or suggested that stress is endemic to the nurses' environment (Wheeler & Riding, 1994), but there is limited evidence of research that specifically focuses on midwives' stress.

With regard to the origin of stress experienced by nurses, this is an area that has been well researched. An integrative review of the literature from 1985 until 2003 was carried out by McVicar (2003) with the aim of determining if there was commonality of sources of workplace stress, were these changing and were any recent organisational interventions effective in the reduction of stress. As a result of the search over 100 papers and texts were consulted and twenty one were found to detail the main sources of stress for nurses. As a result, it was determined that there were six main themes with regard to workplace sources of stress. These were *workload, leadership / management issues, professional conflict, emotional demands, shift work* and *lack of reward* with the suggestion that shift work and lack of reward are becoming more significant factors. It was further suggested that the ranking of these will vary according to both the perception of the individual and to the area of practice. This notion was an area of focus for Guppy and Gutteridge (1991) in attempting to determine the levels and sources of stress as it impacted on job satisfaction.

While the study of Healy and McKay (2000) was conducted with the aim of determining if there was an association between coping styles and mood disturbance and was included in the review carried out by

McVicar (2003), particular note is made of it because it was an Australian study. Using the Nursing Stress Scale (NSS) they found that *workload* was perceived as creating the highest stress in nurses, a finding that concurs with that of Tyler and Cushway (1995). The components of the workload sub-scale of the NSS indicates there were issues to do with the actual workload, inadequate staffing levels and not being able to complete all tasks in a timely manner.

When attempting to redress the situation with regard to the stress experienced by midwives, Carlisle et al (1994) located just seven articles for the period 1985 to 1990, using the search terms midwifery, stress and environment. In the years since 1990, stress research pertinent to midwives and midwifery remains limited, and is more frequently included as a part of research into nurses (Carlisle, et al., 1994; Wheeler & Riding, 1994). This is particularly evident in Australia where Lambert and Lambert's (2001) review revealed that there had only been four studies carried out and of these none involved midwives. With respect to the other studies reviewed, the main focus had been on work environment factors with work overload, lack of support, lowered job control and concerns of staff quality/nursing care quality predominating as the factors contributing to or being correlated with role stress. Where there had been a study of a particular group of nurses more specific factors had been revealed, such as a sense of being marginalised when working on remote Aboriginal settlements or concern regarding the legal implications in the role of an intensive care nurse.

The limited work carried out specific to midwives includes that of Mackin and Sinclair (1998, 1999), who suggested that the transactional theory of stress complements the notion of occupational stress as a multidimensional phenomenon. They specifically investigated the stress of birthing suite midwives in Northern Ireland. Stress was highlighted as impacting on midwives' physical and psychological wellbeing. They also identified a number of sources of stress for this group, highlighting the prominence of stillbirth and caring for those having a termination of pregnancy within this realm.

In more recent times Mander (2000, 2005, 2006, 2009) has also considered the impact of a perinatal bereavement from the perspective of the midwife. As a result of her work in researching the impact on women relinquishing a baby for adoption and also the experience of perinatal bereavement, she came to the conclusion "that the personal costs to the researcher may be great" (2000, p.37) and by implication so could the effect on the midwife providing care to a bereaved mother. In providing an anthropological perspective as to why in much of the literature there is limited attention given to the effect on the researcher, Mander considers some of the recommendations that have been made and extrapolates these to encompass the midwife caring for a grieving mother.

Burnout
The body of work in relation to burnout is set predominantly within the people-oriented, care giving professions. While no single definition exists for burnout, it will be demonstrated that researchers agree

that there is an unfavourable internal psychological reaction to the work environment, and that burnout is particularly relevant to nursing.

Within the domain of occupational stress, as described by Cooper and Payne (1978), falls the phenomenon of burnout. Maslach (1986), a major contributor to our knowledge of burnout, suggests that burnout is a type of job stress. While Freudenberger (1974) can be attributed with first using the term in the psychological literature, it is Christina Maslach who has become synonymous with the term. A paper delivered to the American Psychological Association (Maslach, 1973) marks the beginning of her extensive work in the area. Maslach and Jackson (1984a) detailed how their study of burnout grew out of work on emotion and the way in which people interpret and understand their own emotional states. The theoretical stance relied upon was of both the organisational and social psychological perspective. Maslach (1982) and Maslach and Leiter (1997, 2004) described three dimensions of burnout:

Exhaustion dimension – previously known as emotional exhaustion, and typified by a lack of energy and willingness to face the world along with feelings of debilitation and fatigue, it is the first reaction in the course of burnout

Cynicism dimension – previously referred to as depersonalisation, is where an individual will distance them self from colleagues, develop a negative outlook, become irritable, suffer a loss of idealism and become indifferent to the world around them.

Inefficacy dimension – previously described as personal achievement, is where there is a growing sense of inadequacy, a sense of being overwhelmed or inability to cope with reduced productivity and lowered morale.

The development and change in these dimensions of burnout have had various theoretical explanations posited over time. While a phase model has been proposed, an alternative process model whereby the development of one dimension precipitates the subsequent development of the others has the stronger empirical support from both cross-sectional and longitudinal data. This process model suggests that the exhaustion dimension precipitates the cynicism dimension, which in turn leads to inefficacy (Maslach & Leiter, 2004). Researchers using the Maslach Burnout Inventory (MBI) have accepted that aggregation of the three scores for each dimension is meaningless, with the exhaustion dimension consistently viewed as being central to burnout and as predicting the other two components in longitudinal studies (Shirom, 2010). This is generally supported by the work of Diestel and Schmidt (2010) who drew on longitudinal data from two German samples to test five models of burnout that have been proposed in the literature. Employing structural equation modelling, their findings demonstrated that the exhaustion dimension is longitudinally associated with the cynicism dimension. Further to this, the inefficacy

dimension is longitudinally predicted by the emotion and cynicism dimensions. There research generally supported the initial model proposed by Maslach (1982) that indicated emotional exhaustion as the beginning point of burnout, which precipitated cynicism that in turn led to a diminished sense of personal accomplishment.

This multidimensional conception of burnout is very popular in the literature, perhaps due to the common use of the Maslach Burnout Inventory (MBI). Other definitions have been proposed (Cherniss, 1980; Pines, Aronson, & Kafry, 1981), while Iacovides, Fountoulakis, Moysidou and Ierodiakonou (1997) suggested that burnout is a clinical syndrome with neurotic features rather than a psychological reaction, a position not too dissimilar to Piedmont (1993) who argued that enduring qualities of the individual, or more specifically their personality is reflected in the long-term stability of burnout scores. This is countered by the notion that burnout is a result of care giving over a long period that ultimately erodes our capacity to cope with distress, draining our resources and leading to disillusionment and cynicism. It is seen as an unavoidable occupational hazard that is cumulative, may become permanent if not recognised, but modifiable if acted upon (Papadatou, 2009).

Maslach and Leiter (2004) identify six domains that encapsulate the risk factors for burnout. These are workload, control, reward, community, fairness and values. Not surprisingly workload is a commonly discussed source of burnout. It relates to people having to do too much in too little time and without adequate resources. It has been consistently related to the exhaustion dimension which arises when there has been chronic overload and no opportunity for recovery. It does not occur as a result of an acute crisis or demanding event where there is then an opportunity to restore balance.

When an individual has a sense that they are able to influence decisions, access necessary resources and have some professional autonomy, they feel they have some control. If there is role ambiguity as typified by unclear or conflicting directions there is increased burnout, but it is not as consistent in predicting burnout as role conflict which occurs when there are conflicting demands or incongruent values. The effect of exhaustion can be offset by active participation in organisational decision making which in turn leads to a rise in efficacy. The inefficacy dimension is also influenced by the rewards gained, whether that is monetary, social or intrinsic. Where the work and worker is valued, efficacy is high and is just as important as material rewards (Maslach & Leiter, 2004).

The notion of social support in any form can be linked to the domain of community where it is associated with greater engagement. More specifically, research suggests that supervisor support is linked to the exhaustion dimension and colleague support related to the inefficacy dimension. Linked to community is the concept of fairness in any decision-making process. When people feel heard and involved in such processes they are supportive of the decisions made and less susceptible to burnout.

Also, if there is a mismatch of organisational and personal values, all three dimensions of burnout will be affected (Maslach & Leiter, 2004).

There have been many studies that have looked at factors related to burnout in nurses. Duquette, Kerouac, Sandhu and Beaudet (1994) undertook a literature review of 300 documents on nursing burnout in an effort to better understand the interactions between the personal and environmental factors that contribute to burnout. The analysis revealed five variables concerning organisational stressors, seven sociodemographic factors, and three buffering factors.

A different approach was adopted by Demerouti, Bakker, Nachreiner and Schaufeli (2000) in developing a model of burnout among German nurses. They categorised working conditions in terms of *job demands* which related to workload and time pressure, and *job resources* which related to task variety, performance feedback, participation in decision making and job control and social support. Their findings suggested that in relation to job demands some reorganisation of workload to reduce demanding contacts with patients, and a reduction of time pressures would minimise burnout. With regard to job resources, it was considered important to increase the nurses' participation in decision making processes, for supervisors to provide performance feedback, and for there to be some congruence between workload and rewards.

There is a body of research with a focus on burnout that includes a variety of settings in diverse countries (Costantini, Solano, Di Napoli, & Bosco, 1997; Duquette, et al., 1994; Eastburg, Williamson, Gorsuch, & Ridley, 1994; Iacovides, et al., 1997; Leiter & Maslach, 2009; Lin, St John, & McVeigh, 2008; Mallett, Price, Jurs, & Slenker, 1991; Narumoto, et al., 2008) and apart from Duquette et al, all of these utilised the MBI. All found a moderate degree or more of burnout in a significant proportion of those surveyed. Another more recent study involving Australian nursing students, found that at the end of their Bachelor degree, a significant proportion were "in a dangerously fatigued state" (Rella, Winwood, & Lushington, 2008, p. 895). Such findings have implications for the retention of newly graduated nurses and have relevance to midwives who undertake a similar training schedule.

Of burnout studies that have directly related to midwives and midwifery practice, there is the work of Bakker et al (1996) which examined the effect of workload on burnout in a group of independently practicing Dutch community midwives. They concluded that policies to reduce burnout for midwives must consider specific work-related factors with an emphasis on personal resources. In a similar vein is the work of Sandall (1997) who also looked at burnout in midwives who provide community based care. A feature of this study was to ascertain what effect the provision of continuity of 'carer' had on midwife burnout levels, while in an ongoing longitudinal study of Danish human service workers, where the

Copenhagen Burnout inventory has been employed, baseline data found that midwives were high on both work and client related burnout (Borritz, et al., 2006).

Coping

The notion of coping is inextricably linked to the stress process. Folkman and Lazarus (1980) proposed that both the regulation of emotion (emotion-focussed coping) and the alteration of the person-environment relationship (problem-solving coping) needed to be considered jointly for a more complete definition. Subsequent research using this dichotomy centred on such things as establishing whether general personality characteristics influenced the coping process (Fleishman, 1984), differences in gender (Hamilton & Fagot, 1988), and the role of individual differences, environmental factors and situational characteristics (Parkes, 1986) . Roth and Cohen (1986) identified the long-standing concepts of approach and avoidance coping as crucial processes both when anticipating future stressful events, and also when recovering from trauma. Within the various formulations of approach – avoidance coping, they suggest that the formulation proposed by Lazarus has a focus on the individual style of coping, compared to the work of Horowitz (1976) who specifies a universal process.

Endler and Parker (1990) were the first to develop a more complete measure of coping, the Multidimensional Coping Inventory in which three types of coping (task oriented, emotion oriented and avoidance oriented) were identified. Endler and Parker (1994) then went on to develop and validate the multidimensional Coping in Stressful Situations (CISS) scale with the added subscales of distraction and social diversion for avoidance oriented coping. Of some interest in the validation process was confirmation that task-oriented coping was negatively related to psychiatric symptomatology, depression, and social symptomatology as measured by the Basic Personality Inventory (BPI). Conversely, there were positive correlations between these three dimensions and emotion oriented coping. They also suggest that there are gender differences in the relationship between coping and depression (1990, 1994), and that there were mean differences between gender groups with women scoring higher on emotion oriented and avoidance oriented coping, as distinct from males who scored higher on task-oriented coping (1990). Further to this, subsequent research has confirmed inter-correlations of the CISS with the MMPI-2 (Endler, Parker, & Butcher, 2003), and with personality factors of the NEO-five factor inventory while also placing the scale conceptually within the process-oriented transactional model of stress (Cosway, Endler, Sadler, & Deary, 2000). More recently when evaluating the psychometric properties of the CISS and confirming the stability of its factor structure, Rafnsson, Smari, Windle, Mears and Endler (2006) also found that women scored significantly higher on emotion and avoidance oriented coping as well as on the avoidance dimension subscales of distraction and social diversion.

Within the occupation of nursing, coping research has attempted to establish if coping has a main effect or buffering effect in the stress process (Boumans & Landeweerd, 1992), if there is a relationship between the perception of stress and the utilisation of adaptive and maladaptive coping responses (Lewis & Robinson, 1992), resistance to stress in terms of either using approach or avoidance coping measures (Boey, 1998) and more recently any interactions between problem focussed versus emotion focussed coping and psychological health (Button, 2008), and the actual coping strategies employed (Lim, Bogossian, & Ahern, 2010). Specific to the area of birthing suite is the exploratory work of Mackin and Sinclair (1998, 1999) who examined birthing suite midwives' perception of stress and its effect, identifying some coping strategies and sources of support. Their aim was to explore the midwives' perception of stress while working in the labour ward.

There has been much work in the realm of nurses' stress and coping with issues of death and dying in areas such as hospice work, AIDS care, and intensive care. However the area of perinatal death has, until very recently, had limited coverage, Defey (1995) being one of the few to focus on helping health care staff cope with a perinatal loss. In identifying that the work of mental health staff could be more effective if nursing and medical staff in Uruguay changed their practices in relation to caring for those women experiencing perinatal bereavement, the effect of providing this care was not central to the paper. In more recent times it has been posited that there are three primary reasons for midwifery staff experiencing difficulty in coping with perinatal death (Mander, 2006). These relate to the untimely nature of the death, the sense that it is a failure to perform the role of a midwife as expected, and it is an area that midwives are neither trained in nor have knowledge in.

Compassion fatigue

The notion of compassion fatigue as it is recognised today can be attributed to Charles R. Figley. It began in 1971 when he began working with Vietnam Veterans (Figley, 2002). It is not surprising then that there is a body of literature where the impact of caring for the traumatised centres on therapists or counsellors. However, it is a notion that has also been discussed in terms of the family doctor (Benson & Macgraith, 2005; Pfifferling & Gilley, 2000), community workers (Forster, 2009), nurses (Joinson, 1992; Sabo, 2006) and midwives (Leinweber & Rowe, 2010).

While the term 'compassion fatigue' is in common use, there are several other terms such as *vicarious traumatisation, secondary traumatic stress* and *empathy fatigue* that have been used to convey a similar meaning. While it could be argued that this has lead to a lack of clarity in the literature with regard to the exact meaning and implication of these various terms, Baird and Kracen (2006) suggest *vicarious traumatisation* refers to the change of outlook experienced by a professional who has been exposed to the traumatic material of their clients. This change, which occurs with prolonged exposure to trauma, is typified by changes to cognitive schema of intimacy, trust, safety, self-esteem and control (Saakvitne &

Pearlman, 1996). This is compared with *secondary traumatic stress,* which is in fact a set of psychological symptoms aligned with those of post-traumatic stress disorder (Bush, 2009; Figley, 1995). The term *empathy fatigue* was used to underscore the importance of empathy as a tool for rehabilitation counsellors (Stebnicki, 2000). With this information, the conclusion can be drawn that compassion fatigue is the culmination of experiencing vicarious trauma and symptoms of secondary traumatic stress.

In understanding and defining compassion fatigue, it is the work of Figley (2002, 1995) that has predominated. While working with Vietnam Veterans, Figley initially conceived of compassion fatigue as a form of burnout experienced by therapists. It was typified by episodes of sadness, depression, sleeplessness and general anxiety. The therapists linked these symptoms to working with those affected by trauma. Figley hypothesized that as a result of the combined effect of their empathy for the client, and their exposure to a traumatic event, compassion fatigue was a natural consequence of such work.

Figley (2002) made the point that the 1980 edition of the Diagnostic and Statistical Manual of Mental Disorders (3rd ed.) contained the diagnosis of PTSD for the first time. This made provision to make a diagnosis for the individual who had been traumatised by having been directly in harm's way or by bearing the distress of those who had been. With the recognition of PTSD Figley (1995) made the distinction between it and Secondary Traumatic Stress (STSD), which he described as a syndrome with symptoms aligned with PTSD. The distinction he made was that the symptoms of STSD were the result of "knowledge about the traumatizing event experienced by the significant other" and "is a function of bearing witness to the suffering of others" (2002, p. 1435). He further distinguished it from notions of both burnout and countertransference. Countertransference is described as an over identification with the client which is not exclusively associated with trauma, empathy or suffering, while burnout was described as a more gradual process whereby feelings of emotional exhaustion, cynicism, inadequacy and ineffectiveness progressively overwhelm the caregiver. This is contrasted with the more acute onset of compassion fatigue, but significantly burnout is considered a risk factor for compassion fatigue (Figley, 1995).

More recently while discussing compassion fatigue in relation to psychotherapists, Figley (2002) made the point that while on the one hand their role as a professional helper requires them to be objective and analytical, on the other hand they have to see the world as their clients do. He contends that this ability facilitates the therapist in appropriately adjusting their services to meet their client's requirements. Furthermore he reasons that this ability is underpinned by them being compassionate and empathetic, but it is the act of being compassionate and empathetic, or *to bear suffering*, that causes therapists to suffer. In a relatively short time this can lead to a reduction in their capacity or interest to suffer for their clients. At this point they will experience compassion fatigue which can be typified as a 'loss of

self' (Bush, 2009). In elucidating on vicarious traumatisation, compassion fatigue and burnout in relation to care provision in death situations, Papadatou (2009) reasons that they are all a product of the relationship that develops between the carer and the client.

The majority of research into compassion fatigue has a focus on its development, effect or management in counsellors or therapists in one of the many fields where they see traumatised individuals, and it has been noted that there has been a limited number of studies where the focus has been on formal caregivers such as child protection workers or nurses (Adams, Boscarino, & Figley, 2006). Recently there has been some work done regarding its implications for both nurses and midwives. Of particular relevance is the work of Leinweber and Rowe (2010) who in their review of the literature aimed to consider the evidence of traumatic stress in health professionals and more particularly to examine if there were aspects of midwifery practice that occurred at a cost to the midwife.

The review considered studies that included hospice nurses, paediatric nurses, emergency nurses, and nursing students as well as some other allied health professionals such as ambulance personnel and social workers. As has been previously suggested however, there is some difficulty in extrapolating sound conclusions due to the distress being conceptualised as either PTSD or compassion fatigue, which has resulted in an array of assessment methods being adopted. What is of significance is the connection that is drawn between the nature of the relationship the midwife forms with those for whom she cares and the development of 'traumatic stress'. The argument is made that the high level of reciprocity and mutuality characterising the midwife woman relationship is the equivalent of a high degree of empathic identification, and it is this factor that underpins compassion fatigue (Leinweber & Rowe, 2010).

As a demonstration of how midwives in Australia may be impacted by vicarious trauma (a precursor to compassion fatigue) there was a study conducted to assess the emotional well being of midwives required to carry out a 'Structured Antenatal Psychosocial Assessment' (SAPA) (Mollart, Newing, & Foureur, 2009). Their findings suggested that there was a cumulative emotional effect arising from repeated exposure to stories of domestic violence, childhood trauma, substance abuse and other social issues, which is similar to the findings of McKosker-Howard, Kain, Anderson and Webster (2005). While these were midwives in an antenatal setting, it can be argued that midwives carrying out their duties in birthing suite will be subjected to similar stories and instances of trauma and bereavement while in a unique professional relationship. The need to understand if this is a factor in the working life of the birthing suite midwife is highlighted by the notion that compassion fatigue takes a toll not only on the personal level of the professional, but also in terms of the workplace through decreased productivity, increased sick leave and higher turnover rates (Pfifferling & Gilley, 2000).

Due to the lack of clarity caused by the interchangeable terms used, it is understandable that there has been uncertainty with regard to what is being assessed or measured by the various scales in current use. To overcome this, a study of social workers living in New York City following the World Trade Centre attacks was undertaken (Adams, et al., 2006). While they found that the revised 30 item scale developed by Figley measured multiple underlying factors, two reliable scales that unambiguously demonstrated the difference between secondary trauma and burnout were found when items not consistent with secondary trauma and burnout were eliminated. The authors note several limitations to their study, one of which relates to the evolutionary conceptualisation of compassion fatigue and the view of Stamm (2000) who considers it appropriate to measure both compassion fatigue and compassion satisfaction. It was argued that exposure to traumatic stories does not guarantee a negative effect, but a scale that focuses on the negative symptoms could create a response bias. To this end a scale (ProQOL) was developed that measures both these constructs plus burnout (Stamm, 2005).

A study to determine the relationship between the three variables of the ProQOL (compassion fatigue, compassion satisfaction and burnout), and provider and setting characteristics revealed that females were at higher risk of compassion fatigue. Also those with specialised training in trauma work reported higher levels of compassion satisfaction (Sprang, Clark, & Whitt-Woosley, 2007). While the subjects for this study were mental health providers, it is of significance for midwives where females predominate and where there training does not include training relevant to the trauma they may have secondary contact with.

The issue of accurately assessing the consequences of caring work is one addressed by Sabo (2006). In discussing the implications of caring work on the health of nurses, Sabo highlights the limitations of the instruments currently available. Also, in considering the conceptualisation of empathy, the trait that underpins the development of compassion fatigue, she argues that it is necessary to consider more deeply the role of burnout in the development of compassion fatigue. Along with the notion of compassion satisfaction (Stamm, 2000), Sabo suggests that there may be certain individual qualities such as resiliency, hardiness and social support at play, that are protective of the carer.

Social support
The construct of social support is also not without some controversy and ambiguity. Sarason, Sarason and Pierce (1990) contended that "characteristic personality patterns, relatively enduring social ties, developmental histories and situational demands combine to produce the effects that, in the simplified world of a few years ago, we might have attributed to that amorphous entity, social support" (p.1). As this quote suggests, social support is a multidisciplinary area that has been researched from several perspectives, an outlook supported when studying the development of the *Social Support Questionnaire* (Sarason, Levine, Basham, & Sarason, 1983).

While the papers of the epidemiologist Cassel (1976), and the medical doctor Cobb (1976) are considered seminal in any discussion of social support, the work of Weiss (1974), who described six provisions derived from social relationships is worthy of consideration when investigating adaptation to stress. The provisions he discerned were *attachment* (sense of security and place), *social integration* (companionship and exchange of services), *opportunity for nurturance* (assisting others), *reassurance of worth* (recognition of competence), *reliable alliance* (commitment from others in times of stress) and *guidance* (advice and emotional support).

Cassel (1976) emphasised the buffering effect of social support on stress within the context of the social environment generally, and the individual specifically. He recognised that for disease prevention, it was more effective to strengthen the individual's social supports rather than trying to limit their exposure to stress. Cobb (1976) also saw social support as a buffer used in times of crisis, and not as an agent of improved adaptation. He proposed that the buffering effect was achieved because social support meant that individuals felt cared for, believed they were loved, esteemed, and valued, and that they belonged to a reciprocal network which provided the basis for providing protection from disease, accelerated recovery from illness, and generated greater compliance with 'doctors orders'.

Some within the field of community psychology followed up the earlier work of sociologists where some studies had suggested that stressors were more common in economically disadvantaged groups. The community psychologists had witnessed individuals without supportive networks, not coping effectively, but being supported by professionals and para-professionals (Sarason, et al., 1990). Auerbach and Kilman (1977) and Whitcher and Fisher (1979) were able to demonstrate that this emotional support was beneficial to health. Sarason et al (1990) also elucidated the role of child development. Child development provided the basis of the concept that social support is a personality variable with its source in early close relationships. They made the point that this notion arises particularly from attachment theory as proposed by Bowlby(1979) in the early 1970's.

This history of the foundations of social support suggests it is necessary to consider which concept of social support is to be utilised, and then match an appropriate measurement technique, something that Holahan and Moos (1983) considered initially resulted in a somewhat *ad hoc* development of measures suited to the needs of particular studies. The three major methodological approaches used in social support research, as defined by Sarason et al (1990) include: (a) the mapping of social networks, (b) the assessment of support available to individuals in their daily lives, and (c) estimating the perception of the amount of support available to the individual. In terms of operationalising and measuring social support, Thoits (1982) concluded that it could be done in relation to its function or its structure. Cohen and Wills (1985) concurred with this, judging that support measures typically assess the function of the social support or the network structure within which it occurs. House and Kahn (1985) also identified

function and structure plus quantity of social relationships as important properties of social support, concluding that quantity of social relationships measures were reliable and stable. In this vein, various patterns of relationships were found between the type and scope of social support when studying the buffering effect of social support in the stress – burnout relationship (Koniarek & Dudek, 1996).

In reviewing multidimensional models of social support to develop a model with the potential to match the characteristics of any given stressful event to specific beneficial forms of social support, Cutrona and Russell (1990) concluded that Weiss's (1974) theoretical conceptualisation had inspired the greatest number of measurement scales. In this realm, they further contended that the factor structure of their *Social Provisions Scale* was found to correspond to the six dimensions described by Weiss and support the notion that social support is a multidimensional construct. In relation to the Social Provisions Scale, Wills and Shinar (2000) point out that there are both functional and structural areas of support represented, but instrumental support is not well represented. Further to this, because there is high subscale correlations that may lend it to measuring a higher-order construct of perceived support, this same feature may prevent it from detecting effects for any individual function.

The complexity of assessing social support is further highlighted by research that has focussed on the interaction effect of various factors. An example of one aspect to be considered was explored by Cutrona, Cohen and Igram (1990). In a study of university students the interaction of context with situation was explored where it was found that whether the support was offered spontaneously or requested, whether it was consistent with what was required, and the nature of the relationship with the person providing the support significantly affected the perceived supportiveness of the behaviour. A more recent study considered the potential of social support to combat the stress associated with variable workloads, which in turn resulted in diminished productivity (Hauck, Snyder, & Cox-Fuenzalida, 2008).

There exists a series of findings supporting the significance of individual dimensions as described by Weiss with regard to the experience of stress. The reassurance of worth dimension has been negatively associated with perceived stress (Cutrona & Russell, 1987a; Varvel, et al., 2007), especially when provided by workplace supervisors (Constable & Russell, 1986). In conjunction with reassurance of worth, Varvel et al. also found that reliable alliance and social integration were also negatively associated with perceived stress. Similarly with regard to burnout in military nurses, personal achievement was significantly predicted by social provisions (Cutrona & Russell).

Within the realm of nursing, an early study looked at the relationship of social support and the work environment on burnout in U.S. army nurses (Constable & Russell, 1986) and found that lack of supervisor support was a significant predictor of emotional exhaustion on the MBI, indicating the

buffering effect of this form of social support. Mallett et al (1991) compared the incidence of burnout in American hospice and critical care nurses in terms of their perception of the quantity and quality of social support available to them. They found significant but low negative correlations between burnout and the number of support persons, and the nurse's satisfaction with that support. McIntosh (1991) adopted a similar approach when identifying and investigating the properties of social support in a group of American general nurses. The divergent conclusion that increased numbers of providers can neutralise the positive impact of social support was made. It was found that there was a significant negative correlation between emotional exhaustion and the amount and adequacy of support. An incidental finding suggested the amount of supervisory support to be significant in moderating stress effects. A recent study of Jordanian nurses supports the notion of the moderating effect of social support, finding an interaction between job stress and the support of co-workers and supervisors (Abualrub, Omari, & Abu Al Rub, 2009).

Eastburg, Williamson, Gorsuch and Ridley (1994) sought to include personality factors in their study of social support and burnout in Californian nurses. Their results suggested that extraverted nurses were more sensitive to variations in peer support than were introverted nurses, and required more peer support if they were to avoid the burnout dimension of emotional exhaustion. Further to these approaches, Tyler and Cushway (1995) studied stress in a group of English nurses in terms of coping and social support. They concluded that the more social support the nurses had within the organisation, the better they felt. However those without social support were not more reactive to stress, concluding that social support does not ameliorate the occupational stress of nurses.

In exploring the interactions of social support and coping style on the relationship between occupational stress and health, Button (2008) found social support had a reverse buffering effect on the psychological health of nurses. For low levels of social support with high levels of work-related stress, psychological health was good but if the stress was low poorer psychological health was experienced. High levels of social support with high work stress saw the psychological well being of the nurses being compromised while low job stress was associated with better psychological health.

The present

While the various domains touched on in this literature review have all been well researched in the past, it has been demonstrated that their significance to midwifery practice is less well documented. The present study aims to address this gap in the literature. Additionally, throughout the literature review, there have been many examples where two or more of the factors being considered in this study have been central to a previous study. However they have not been considered in combination with a view to understanding stress and burnout as it affects midwives in birthing suite.

It is envisaged that a more holistic understanding of midwives' stress and burnout will create opportunities to modify those workplace practices demonstrated as contributing to stress and burnout, while also providing an insight into those variables that may increase resistance to, or buffer stressful events. Such modifications would aid in facilitating rectification of some of the issues surrounding recruitment and retention of midwives, with the retention of experienced midwives ensuring that knowledge is passed on while minimising the deskilling of this professional group.

It can be proposed that the longer-range significance of the study would be the effect on the care of childbearing women. The establishment of a less stressed, more experienced group of midwives who want to remain in the profession will facilitate improved care of women. The findings should also provide midwives with greater knowledge and insight into those elements of their personal lives that may impinge on their wellbeing, providing them with information that would allow them to make beneficial adjustments affecting both them and their families.

Summary

The first aim of any literature review is to place the current study in terms of the past research. In achieving this aim this literature review has served a twofold purpose. The initial goal was to explicate the various domains of interest from the perspective of their history and how they have evolved. This in turn provided an opportunity for it to be clearly defined as to how the concepts within these domains were considered and operationalised.

The second goal of this literature review was to introduce the relevant research in each domain in terms of how these related to midwives and midwifery. What became clearly obvious is that this is an area of limited research. It was on that basis that it became necessary to use nursing as a corollary and to also incorporate other fields of employment.

Although the research of midwives and midwifery was limited, requiring the research of nurses and nursing to be included, it remained significant from the perspective that the research informed both phases of the study. In the qualitative phase it informed the development of the potential questions to be included in the semi-structured interviews. While for the quantitative phase, it provide the background information required to develop the hypotheses. This is particularly evident from the perspective of the instruments selected for use in the quantitative phase.

Chapter 3

PHASE ONE: METHOD

Introduction

The two major objectives of the first phase of the study were to explore midwives experience of stress when working in a birthing suite setting, and to inform the second phase of the study with regard to the use or development of an appropriate tool to measure the stress experienced by midwives as they worked in birthing suite. Both of these objectives were pursued using a qualitative approach.

The function of a qualitative methodology as compared to a quantitative methodology is to have to hand data that is emic as opposed to etic, which as suggested by Babbie (1998) makes it richer in meaning and gives greater detail. This theme is supported by Giorgi (1985a) when arguing the validity of descriptive psychology, where the phenomena 'as lived and experienced' is more truly represented than when quantification is attempted. The richness and detail of the data will then, as Highlen and Finley (1996) suggested, have the potential for the 'socially constructed' nature of reality to be emphasised. Denzin and Lincoln (1998a) concurred with this concept when writing that qualitative researchers "seek answers to questions that stress how social experience is created and given meaning" (p.4).

In addition to this, qualitative investigators have argued that their attention is directed to the specifics of particular cases and the giving of more idiographic explanations (Babbie, 1998; Denzin & Lincoln, 1998a), suggesting that the individual or unique events can be confronted. This is a notion supported by Harmon (1991) who suggested "We do not learn about reality from controlled experiments but rather by identifying with the observed" (p. 53). Therefore the initial aim of discovering the meaning of stress for a group of individuals in their role as midwives working in birthing suite, identifying the individual or unique aspects of that experience, and gaining greater insight into that experience, were to be met by adopting a qualitative methodology.

Selecting a strategy

With this decision, a fitting strategy with an approach and method for collecting and analysing the material collected had to be determined. Denzin and Lincoln (1998b) have observed that each strategy available to the researcher is associated with a complex literature that details its history, exemplary works, and preferred systems for data collection and analysis when employing that strategy. In addition, when comparing five qualitative inquiry and research designs, Creswell (1998) suggested that there are a 'baffling number' of qualitative traditions to select from. One of his stated aims was to provide clarification and comparison of approaches to facilitate the design of more rigorous and sophisticated studies. When explaining his choices for review, some of the major selection criteria related to popularity and frequency of use, use of systematic procedures of inquiry, and the availability of recent

texts illustrating procedures. His selections were biography (originating from the humanities and social science), phenomenology (psychology and philosophy), grounded theory (sociology), ethnography (anthropology), and case studies (social sciences and evaluation research). The comparison also provided the basic knowledge that led to the selection of the strategy deemed the most useful in relation to the aims of the study.

Morse (1998) explained that the usefulness of the results will be determined by the strategy chosen. Each strategy has its own perspective that will better depict particular aspects of reality, and some strategies are designed for particular types of data. She also suggested that the researcher must be competent in recognising the restrictions on the types of data that can be collected in their endeavour to achieve their research aim(s).

An appropriate beginning point for selecting one strategy over another is to consider the purpose of the study, the nature of the research questions, and the skills and resources available to the researcher (Janesick, 1998; Morse, 1998). The purpose of the study is determined by asking such questions as 'does the research aim to determine the meaning, nature, or process of a phenomenon?' The answer will ascertain if the best suited method is phenomenology, ethnography, or grounded theory. In wanting to gain an insight into the meaning of stress for midwives working in birthing suite, and considering the skills and resources available, it was appropriate to conduct this phase of the study within a phenomenological paradigm.

When the term phenomenology is used, it is prudent to clarify the context within which it is employed. Phenomenology as a philosophy, in which the focus has been on describing the general characteristics of experience, is attributed to Edmund Husserl (Polkinghorne, 1989). It was Van Kaam in 1959 who operationalized phenomenological research in psychology (Moustakas, 1994), while Polkinghorne advised that it was Giorgi who first coherently described an actual program of scientific research founded in phenomenological psychology. Polkinghorne further elucidated that phenomenological psychology was a psychology that drew on the insights of phenomenology, and was not a subfield of philosophy. While phenomenological psychology typically investigates structures that are general for groups of people, with an emphasis on the descriptions from the research subjects, the practice of self-reflection is paramount to philosophical phenomenology.

A central tenet of psychology has been the examination of conscious experience. Where phenomenological psychology varies from traditional mainstream psychology is in its belief that behaviour is not only a learned response to stimuli, but is also the expression of a meaningful experience. It posits that our locus of knowledge emanates from these lived experiences, and therefore research within phenomenological psychology aims to clearly and precisely describe the meaning of the

conscious experience (Polkinghorne, 1989). Creswell (1998) distinguished between the sociological approach where group experiences have been the focus, as opposed to a psychological approach where individual experiences have been central. The psychological approach is commonly linked to the 'Duquesne Studies in Phenomenology', and is predominantly attributed to the work of Van Kaam, Giorgi and Colaizzi (Ehrich, 2005).

Ehrich (2005), drawing on the work of Giorgi, summarises the aims of phenomenological psychology. It was determined that adopting the methodology as described by Giorgi with its aim of producing accurate descriptions of human experience, predominantly through utilisation of others' descriptions which are systematically and rigorously analysed in what Ehrich argues is an empirical manner, would best fulfil the objective of gaining a deeper insight into the birthing suite midwife's experience of stress. This was done after considering the critique offered by Paley (1997) with regard to the use of Husserlian phenomenology in nursing research who argues that nursing research is unable to fulfil the basic criteria of Husserlian phenomenology. As argued by Giorgi (2000), Paley has not distinguished philosophical phenomenology from scientific phenomenology. Giorgi recognises that there have been deficiencies in some of the nursing research, but argues that the position adopted by Paley is counterproductive toward motivating nurses to do better phenomenological research. In this vein Giorgi argues that scientific research can be done based upon a phenomenological philosophy.

Data collection
Moustakas (1994) suggests that the first challenge of any phenomenological investigation is to have a topic and question that is significant at both a personal level and at the wider social level. Therefore, from the starting point of having an appropriate question as defined by Moustakas, it was determined that interview would be the preferred method of data collection. While Giorgi (1997) suggests that either straightforward description, interview, or a combination of the two is an appropriate method for collecting the verbal data required in a scientific phenomenological method, it was decided that interviews have the advantage of being flexible and adaptable with regard to the information that can be elicited, and potentially provide data that is rich and illustrative of the phenomena. In addition, face to face interviews permit responsive modification of questions. This assists in following-up interesting responses, pursuing underlying motives, and pursuing non-verbal cues as deemed appropriate (Robson, 1993).

Remaining mindful of the aims of the first phase of the study and counter to the traditional phenomenological practice of carrying out unstructured, open-ended interviews, a semi-structured interview schedule with open-ended questions was devised. This was done with the endeavour of eliciting an extensive account of each midwife's experience of stress in birthing suite while providing information essential to the second phase of the study. This fits with the notion expressed by Giorgi

(1997) that the questions are generally broad and open-ended and that there is the opportunity for the subject to express their perspective extensively. Moustakas (1994) also suggests that a series of questions with the purpose of prompting a detailed account of the experience may be formulated and used as required in a phenomenological study.

The questions formulated arose from the literature with regard to stress within nursing and midwifery and not from within the area of previous phenomenological research. There was also a focus on eliciting information with regard to the selected elements of interest pertinent to the second quantitative phase of the study, as they affected the midwives experience of stress. The aim of the interview guide, used solely by the researcher, was to provide a reminder of the subject areas to explore, probe, and ask questions to illuminate those predetermined areas. The questions were not asked verbatim. Therefore, whilst the interviews were conversational in style, a series of prompts were employed to ensure that information central to the second phase of the study was obtained. Consequently each interview had an individualised format that was the product of an interaction between the unfolding story of the midwife and the requirements of the entire study.

Sampling

Having determined the method of data collection, it was necessary to determine the method of sampling and the number of interviews that would be appropriate. Purposeful sampling is a technique typically employed in qualitative methods as it permits the selection of information rich cases (Patton, 1990; Polkinghorne, 1989). When selecting participants for a phenomenological study, there are several criteria that must be met. They must have experienced the phenomenon, and have the capacity to provide comprehensive descriptions of that experience. In addition, a full range of variation of descriptions of the phenomenon is desirable to determine its essential structure (Polkinghorne, 1989). Therefore a stratified sample was selected. This ensured that there were representatives from across the ranges of experience and expertise. Some midwives held supervisory or administrative roles, others were recently graduated, and some were employed full-time, others part-time and some no longer worked in birthing suite, thereby depicting an extensive range of subgroups of birthing suite midwives (Kuzel, 1992). An advantage of the stratified purposeful sample is that major variation can be captured, but a common core may still be identified in the analysis (Patton, 1990).

In qualitative research, determining the number of participants to be included in the process can be problematic. The commonly espoused strategy of sampling to the point of redundancy or saturation provides a more convincing explanation of events, but has implications with regard to sample size. While there are no well-defined rules and many ambiguities (Patton, 1990), experience suggests that 6-8 'data sources' will suffice for a homogenous sample, and 12-20 when attempting to achieve maximum variation (Kuzel, 1992). This compares with Creswell's (1998) example of 10 when discussing the

format for a phenomenological study. In conjunction with this consideration are the more pragmatic considerations of what resources are available and what constraints are being faced (Patton, 1990). Therefore, while considering the need to inform the second phase of the research, the decision was made to carry out ten (10) interviews.

Ethics

Ethics approval for Phase One of the study was applied for through the Victoria University Human Research Ethics Committee. Approval was gained to carry out up to ten face to face interviews drawn from a representative cross section of midwives with birthing suite experience as detailed in the next section.

With regard to the risks identified it was believed that personal and ethical issues may be recalled by participants. Furthermore, it was considered that discussing issues and situations that had been stressful in the past may possibly rekindle the stress experienced at the time, or in discussing the circumstances of perinatal loss and mid-trimester termination, some difficult ethical issues may be raised. To prepare for such eventualities, a clear indication of the probable content of the interview was given as part of the recruitment process. Also, all midwives were informed in the plain language statement that they had the right to cease the interview and withdraw from the study at any time, none of the midwives elected to terminate interviews and/or withdraw from the study, and no complaints were registered.

Recruitment

It was determined that a purposeful sample would best suit this phase of the study. A purposeful sample is one that is collected from information rich cases, making them suited to an in depth study. Also, to ensure that a variety of work circumstances and conditions would be reflected in the sample, a stratified approach to recruitment was adopted. Traditionally a 'stratified purposeful' sample facilitates the comparison of subgroups, however in this study participants were selected based on a stratification of their experience and roles in the birthing suite and hence provided a good representation of roles and various levels of experience. The range of experiences sought and found included more recently graduated midwives to those in senior management positions, some worked fulltime some part-time, some no longer worked in birthing suite, others no longer worked in a hospital setting, and also included a diverse range of age groups and personal situations.

Two procedures to recruit midwives were employed. The initial procedure employed involved approaching six prospective midwife participants known to the researcher but with whom she did not have a working relationship. Contact was either made via a telephone call or they were approached in person. They were provided with a verbal outline of the objectives and requirements of the overall study. All of the midwives approached demonstrated an interest in participating in the first phase, and were then provided with a more detailed description of the aims of the first phase of the study and what

their involvement would entail if they consented to participate. They were also given the opportunity to ask questions and clarify any points of interest or concern. If they expressed interest in participating they were given a copy of the plain language statement (Appendix B) to read and the consent form to complete (Appendix C). Upon receiving the completed consent form arrangements were then made for the interview to be carried out at a mutually convenient time and location. The midwives approached, and who all agreed to participate, had a range of experiences from the perspective of years worked, position held, place of employment and hours worked per week.

The second procedure used for recruitment required the researcher to arrange a series of information sessions for the birthing suite staff of the outer suburban hospital to attend. At these sessions the background to the research, its aims, objectives, and methodology were explained and the opportunity for questions to be asked was given. Upon completion of each session, plain language statements and consent forms as approved by the hospital's ethics committee were made available to all attendees. Included with the plain language statement and consent form was a form with provision for recording the name, address and contact number of those wishing to participate and a reply paid envelope. Upon receipt of a completed form, the researcher contacted the prospective midwife participant, arranging to meet them at a mutually convenient time and location. All four respondents to this method of recruitment met the criteria for inclusion in the purposeful stratified sample. The final sample consisted of ten midwives who were working or had worked in birthing suite. Their age range was from the mid thirties to mid fifties and they held positions ranging from graduate midwife to unit manager.

Interviewing
The aim of the interviews was to be twofold. In the first instance they were to be used to describe the experience of birthing suite midwives. In the second instance they were to be used to inform the researcher in constructing an instrument to assess stress in birthing suite midwives. All of the interviews were audio-taped with the midwives' permission.

At the beginning of the interview, in endeavouring to establish a conversational style, the initial question was non-controversial and tailored to encourage description (Patton, 1990). After a brief introductory description of the aims of the research and the focus of the interview, the first question asked the midwife to describe their understanding of stress and what they recognised as stress. Subsequent questions focussed on workplace conditions, interactions with the clientele, coping strategies while at work and when away from work, their perception of themselves as individuals, and their support networks and what they gain from those supports. Where possible, demographic questions were unobtrusively woven into the conversation to ensure the midwife was not conditioned to provide short answers to tedious inquiries which also assisted in maintaining a conversational flow. If an opportune moment had not presented itself to ask a particular demographic question or questions, these

were followed up at the end of the interview (Patton, 1990). While the interviews were all individualised interactions, all interviews had been aided by the use of an interview guide to assist in making them as precise and detailed as could be expected. Reference to the guide ensured that those areas identified as areas of interest to the study were included in the dialogue.

Data management
At the completion of each interview, the midwife was assigned a code name known only to the researcher. The interview was then transcribed verbatim by the researcher, which became the starting point for the analyses. Giorgi (1997) pointed out the holistic approach of phenomenology which requires the researcher to gain a global sense of the data through reading all of the data, without developing themes, but as the activation point for discerning the meaning of what has been recorded. It is also the point at which the researcher gains an understanding of the language of the describer (Giorgi, 1985a). Following the completion of the transcription process, the audiotapes were stored securely by the principal supervisor.

Data analysis
Although the human scientific phenomenological method as described by Giorgi (1997) is the method of choice, it is worth noting the four key stages that Husserl described as necessary to complete a phenomenological analysis. Moustakas (1994) describes these stages as 'Epoche', 'Phenomenological Reduction', 'Imaginative Variation' and 'Synthesis of Meanings and Essences'.

Epoche, a term used by Husserl, referred to a freedom from suppositions. It's a process whereby the researcher acknowledges and puts aside their preconceived notions, judgements and knowledge of the subject. Giorgi (1997) describes this as the first part of the phenomenological reduction whereby it is the requirement of the researcher to focus their full attention on the phenomenon as it presents itself to their consciousness. This is achieved by 'bracketing' all knowledge they have of the phenomenon. 'Bracketing' is a process where the researcher will be aware of and recognize any knowledge, either theoretical or personal, they have of the phenomenon. This in turn facilitates the unveiling of any prejudices and biases which can be understood and set aside, enabling a new, fresh and naïve position to be adopted as they study, describe and analyse the phenomenon. Giorgi sees this as the second part of the phenomenological reduction.

Giorgi (1997) describes these as attitudinal perspectives devised by Husserl with the aim of having the researcher consider the phenomenon as it appears, in isolation and without association or influence from other similar experiences. This limits the researcher to the experiential claims within the data and maintaining them within the phenomenal realm, ensuring some rigour in the description of the phenomenon in question.

The next stage of 'imaginative variation' involves considering all possible variations of structure. The aim of this stage is to arrive at a structural description that incorporates the underlying and precipitating factors that account for what has been experienced. This is achieved by imaginatively integrating the common aspects of the diverse experiences while reflecting on and examining the different possibilities (Moustakas, 1994). The significance of this stage is detailed by Giorgi (1997) when he points out the alternatives to description, such as interpretation, explanation or construction. Through the use of 'imaginative variation' the researcher 'imaginatively' subtracts one feature of the described phenomenon to determine if this 'variation' of it is essentially changed or if it remains intrinsically intact and the removed feature is incidental to the structure of the phenomenon. The description of the essential aspects of the phenomenon delivers the essence of it.

The final step of synthesizing meanings and essences requires 'intuitive integration' of the fundamental textural and structural descriptions. This culminates in the production of a 'unified statement of the essences of the experience of the phenomenon as a whole (Moustakas, 1994p. 100). Giorgi (1997) pointed out that this provides a philosophical phenomenological analyses.

While Polkinghorne (1989) suggested that the translation of the philosophical perspective into a functioning research methodology was continuing, concurring with Giorgi's (1985a) assessment that a "genuine phenomenological psychology does not yet exist…", it may be argued that progress has been made in this area. This is despite the thoughts of Giorgi (2006) who in his article clarifying the problems associated with undertaking phenomenological research, is drawn to conclude that "scientific phenomenological research has not as yet come of age" (p.360). He argues that while the social scientists of today are using the phenomenological method to study experiential phenomena, they continue to be deeply rooted in empiricism and there have not yet been the discussions required to determine how to mediate between the fundamental concepts of philosophical phenomenology and the requirements of sound scientific research.

Giorgi (1997) in critiquing an article by Klein and Westcott, had addressed many of the issues surrounding the dilemma of mediating between philosophical phenomenology and sound scientific research. In the article he details some of the key aspects of the phenomenological approach, the philosophical phenomenological method and the modifications of the philosophical method for scientific analyses, going on to describe the concrete steps of the human scientific phenomenological method.

The point is made that it is apparent that all qualitative methods require a minimum of five basic steps. There is the collection of verbal data, the subsequent reading of the data followed by reduction of the data into units appropriate to the method being employed. These are then organised or expressed from a

disciplinary perspective from which a final summary of the data can be created. Giorgi (1985b, 1986, 1997, 1985a) describes a 'psychological phenomenological' method that consists of these five basic steps, and it was this method that guided this phase of the study. The particular nuances of the method of qualitative analysis established by Giorgi and used for this phase of the study are described in the following section.

THE HUMAN SCIENTIFIC PHENOMENOLOGICAL METHOD

Preamble

Giorgi (2000), in defending the notion of the *scientific phenomenological method* makes the point that the knowledge gained meets the criteria for being scientific. In summary he states that this method produces knowledge that is general, methodical, critical and systematic, and importantly it is replicable. The method also involves description, reduction and the search for invariant meanings within a specific context, all of which is done from a 'Husserlian perspective'.

The first two steps described by Giorgi (1985b, 1986, 1997, 1985a), the collection of verbal data and the initial reading of the transcript have been described in the previous chapter in 'Interviewing' and 'Data Management' respectively and meet the criteria as set out by Giorgi in his 1997 article that describes the modifications to the philosophical method to render it as a scientific analysis. Therefore, the descriptions were obtained from others 'from the perspective of the natural attitude' because it cannot be expected that everybody in the real world is able to enter an attitude of phenomenological reduction. Furthermore, it is required that each description is in personally chosen 'everyday language', and not be theory laden or explanatory (Giorgi, 1993).

Global understanding

The reading at the completion of the transcription process to ensure accuracy in transcription initiated the process of gaining a global sense of the description. Each interview was read as an individual entity. While smaller transcripts can require just one reading, with a longer or more complex text the researcher will find it necessary to read the text several times to gain an understanding of the whole. Such was the requirement of this study.

The initial reading assisted in ascertaining how the various parts were constituted. There was then a second, slower reading of the same data where the aim was to identify transitions in the meaning of the description of stress from a psychological perspective. To accomplish this stage and the following stages the researcher entered into "the attitude of the phenomenological reduction" to facilitate encountering the phenomenon freshly or naively and to experience it directly as a concrete description (Giorgi, 1993). This then made it possible to produce a description of it as experienced by the subject (Giorgi, 1997).

The phenomenological reduction was achieved as a two stage process as described above by initially 'bracketing' prior knowledge and experiences, thereby facilitating the adoption of a naïve position that allows pertinent meanings to be intuited and also allow unanticipated meanings to be revealed. Giorgi (2000) elucidates that the subject provides concrete descriptions of specific situations from their perspective (the natural attitude), and that it is incumbent upon the researcher to recognise and put to

one side any previous knowledge of the phenomenon while also withholding any existential claims. This is not a transcendental reduction but a psychological phenomenological reduction. The resultant description is then only of the aspects given to the researcher and is not based on their past knowledge of the phenomenon or any inferences they have drawn.

In the process of 'bracketing', the effectiveness of the concurrent practice of listing all of the assumptions the researcher has in relation to the phenomenon in question in an endeavour to eliminate their presence in the analysis is considered dubious. It is argued that such a procedure may lock the researcher into their listings, rather than make them free of them. Reflecting on potential biases a priori does not ensure that such biases will not be present during the analysis and it is therefore necessary to recognize and be aware of the biases in the process of analysis (Giorgi, 2006).

Discerning meaning units

Having entered into the attitude of the phenomenological reduction, the second reading commenced. Where a transition in the meaning as it applied to the study was identified, it was marked and without any further examination or consideration the reading was continued until the next transition in meaning occurred. This gave rise to a series of spontaneously discriminated meaning units (Giorgi, 1985a) pertinent to the stress experienced when working in birthing suite, as expressed in the subject's own language (Appendix H).

While it was necessary for the researcher to achieve an awareness of the relevance of the subject's own words to the phenomenon of stress when working in birthing suite, it must be noted that the 'attitude and set' of the researcher will determine the overall form or guise of the meaning units. In this instance the attitude or perspective is 'psychological', and the set is 'midwives' stress'. As Giorgi points out, the meaning units are not inherently essential elements of the text, but in fact are context laden constituents, the context determined by the direction and purpose of the study.

Transformation of meaning units

In what Giorgi (1993) has described as 'the heart of the method', the meaning units were probed to discern what they revealed about the stress experienced by the subject when working in birthing suite. This resulted in a description of the psychological dimensions of the stress experienced, thus transforming the subject's lived experience into a direct psychological expression. An essential component of this stage was the use of 'free imaginative variation' which Giorgi (2000) suggests allows the phenomenologist to arrive at higher level and more invariant meanings, or the 'essences'.

Free imaginative variation entailed exploring each meaning unit and metaphorically unpacking its components, removing them one by one to determine which were essential to the meaning of stress. Therefore, in transforming "the subject's everyday expressions into psychological language with

33

emphasis on the phenomenon being investigated" (Giorgi, 1985a, p. 17), the essence of the true meaning within each meaning unit was arrived at by imaginatively altering the facts of the description presented and ascertaining if that alteration had modified the meaning, thereby uncovering the invariants of the phenomenon (Appendix H).

Determining the structure

The final stage of the analysis had as its endpoint the production of a statement expressing the essential constituents of stress as experienced by midwives who had worked in birthing suite. This was achieved by considering all of the transformed meaning units and selecting those that were essential to the development of the phenomenon.

The first step in achieving the endpoint was employed purely to organise the data in a more manageable way. It must be noted that it is not included as a routine part of the *human scientific phenomenological method* as described by Giorgi, but it was required because a large volume of data had been created via the ten in depth interviews that were to be analysed. In keeping with the phenomenological method however, free imaginative variation was employed in creating the *descriptive categories* for the transformed meaning units. The descriptive categories were also then considered to be appropriate headings under which the structure of the phenomenon could be discussed.

To this end each meaning unit was examined to arrive at a broad descriptive categorisation that represented a distillation of the meaning unit. When each meaning unit had been allocated to a descriptive category, and continuing to adhere to the notion of imaginative variation, the meaning units within each descriptive category were considered to reveal its *constituent* or what was truly essential about it. Giorgi and Giorgi (2003) argued that delineation of the structure in this manner aids in deepening the understanding of the situated experience. It not only provides psychological understanding of empirical details, but also provides a generalisation of the key psychological factor that belongs to the experience. Therefore although there is multitudinous detail where the empirical information for each midwife may be very different, the essential constituents are revealed.

The constituents considered defining for the phenomenon were included and those facets of the experience considered non-essential or contingent on other facts were not included as part of the structure. With the essential constituents revealed it became possible to describe them and their variations. While there are no perfect descriptions, the aim was to have an adequate description which from a psychological perspective yielded the distinctive structures of the phenomenon under investigation. These structures are to be considered as general or typical and not as universal (Giorgi & Giorgi, 2003).

Qualitative validity

In discussing the scientific phenomenological method, Giorgi (2000) states that it involves description, reduction and the discovery of essential structures using a method that follows the scientific standards of being general, methodical, critical, systematic, and that it is replicable. To this end, the supervisors of this research adopted the scientific phenomenological approach and analysed a sample of the interviews. They were able to replicate the findings of the author through the discovery of similar essences.

Giorgi (2006, p. 9) argues that "the goal of phenomenology is to arrive at a structural understanding of specific and concrete experiences by being fully and critically present to situations". He further argues that it is not practical to eliminate subjectivity because the world and subjectivity are reciprocally related and that in fact the aim of phenomenology is to use and clarify subjectivity when correct knowledge is attained.

While triangulation of results is a concept used in other fields of qualitative research, Giorgi (2006) views the use of judges in any form with respect to phenomenological results as misguided. Giorgi comments on two commonly used practices where either a colleague in the field of study reviews the descriptions or the findings are presented to participants to verify and any corrections suggested are adopted. Giorgi suggests the first strategy is driven by empirical considerations and not phenomenological ones, while the second strategy is considered untrustworthy. He explains that the phenomenological attitude adopted by the researcher produces eidetic findings that require checking through the use of phenomenological procedures, which cannot be assumed to be part of the participants' armoury. Also, because the aim of the research is to obtain knowledge of the meaning of the experience, but the participant may not have thought about the meaning. It cannot be assumed that the' experiencer' is also the best judge of the meaning of the experience.

Chapter 4

PHASE ONE FINDINGS: ESSENTIAL CONSTITUENTS

Preamble

In this section an outline of the main features of each constituent considered essential in the development of stress in midwives working in birthing suite will be given. In the following chapter these essential constituents will be discussed in greater detail. That discussion will provide a more detailed description of each constituent and will be supported by the inclusion of appropriate examples and quotations from the interviews.

With regard to the identified *constituents*, these were arrived at with the aid of imaginative variation (Giorgi, 1985a). Each meaning unit was examined and explored to reveal what was central to the statement. While it will be apparent that some of the constituents revealed had links to other constituents, it will also be apparent that they were not contingent upon them and were in fact essential to how the phenomenon was experienced.

For the purposes of organisation a majority of the constituents were descriptively categorised. The descriptive categories settled upon are *stress, debriefing, support, communication & bereavement care* and it is under these headings that the essential constituents revealed have been arranged. There are also two constituents, *personal qualities* and *introspection,* which are not categorised.

Non-categorised Constituents

Personal qualities

This constituent arises in part from the responses given by the midwives when they were prompted to consider the characteristics they believe a midwife requires. However the more noteworthy revelations were made in conversation as they discussed how they managed different situations or when they discussed the important features of their daily lives. This is considered to be a core constituent as it provides an insight into the nature and principles of the midwives interviewed.

Introspection

Introspection is when an individual looks inwardly at their mental experiences, which could be considered a "personal quality" that some midwives have. However of interest is not that this quality exists, but how it is used and what benefits are gained, particularly in relation to the midwives' ongoing mental processes. It is this that distinguishes it from the reflective process linked to stress management that takes place post crisis.

Categorised Constituents

As previously explained, to arrive at the descriptive categorisations as finally selected the transformed meaning units within each interview were read and with the aid of imaginative variation, a categorisation was arrived at. These categorisations were deliberately broad in keeping with the notion of them being an organisational tool only of the description and not as an essential component of the structure.

Stress:

The first categorisation to be analysed pertains to the predominant area of interest for this research project. At the beginning of each interview and after a brief explanation of the purpose of the interview was given, each midwife was asked what she personally recognised or would describe as stress. While many spoke of the reaction they had when stressed and gave examples of incidents that evoked these reactions and how they managed the associated stress, a constituent that became apparent related to the notion of control and the sense of control they had.

Sense of control

It is this constituent that underpins what stress was for the midwives. While birthing suite is acknowledged as being a dynamic work environment, it was not this *per se* that engendered a sense of stress but more the sense that events may become overwhelming. Therefore while control is frequently used in the context of having the discretion to make a choice or the authority to make decisions, in this instance control is synonymous with adequacy, competence and confidence and being able to manage.

It is in this context that the potential to or the sense of losing control that characterises stress for the midwives was often manifested as a diminution in job satisfaction which stemmed from not maintaining a level of care that they considered satisfactory. This in turn engendered high levels of self reflection (as described in the *management* constituent) with the focus being on how their practice may be improved in similar circumstances. Thus, self-reflection was an element that assisted them in maintaining their sense of control.

Genesis

This relates to the causes or origins of the stress experienced and the events or situations that acted as a stressor. Perhaps unsurprisingly the major stressors for the midwives in the birthing suite related directly to the work as it was carried out. This involved such things as their interactions with the various groups of people encountered (doctors, students, support people, the women in their care and colleagues), the nature of the work (emergencies, difficult labours and births) and lack of staff or adequate support. Also when considering their interactions, particularly in relation to the partners and

support people of the women and somewhat more commonly than may have been anticipated, the issue of abuse was raised.

These issues also interact with another group of stressors relating to staffing support. This related to having an appropriate skill mix and the staff being supportive of their colleagues when required which was also linked to how they experienced the autonomy afforded midwives. The onus of responsibility that accompanies the autonomy of caring for women during labour and birth weighed heavily on the midwives.

Role stress

Another frequently mentioned stressor centred on the timely completion of all tasks. These tasks were mainly to do with the care of the women or were of a managerial nature. The timely completion of tasks linked in with 'role stress' which refers to the stress arising from the midwives position or role. For those with a managerial role there was frequently tension between fulfilling their managerial tasks while also fulfilling a clinical role. For those with a predominantly clinical role the responsibility and distraction of mentoring students was an example of their 'role stress'.

Reactions

These are the manifestations of the midwives stress and commonly it was how the midwife recognised she was stressed. In some situations, such as emergencies where quick responses were required, the recognition of their reactions and their stress was retrospective. This situation was commonly described as 'positive stress' and was differentiated from the stress experienced when their sense of control had been challenged by assorted other events or situations. The midwives variously described physical, cognitive or emotional reactions and consistently spoke of the need to contain these reactions where possible because of the negative effect they may have on both colleagues and those in their care.

Management

There were various measures taken by the midwives to counter and manage the stress being experienced. This constituent includes both the immediate and later measures taken by the midwives to minimise the effects of the stress experienced and incorporates the effectiveness or outcomes of the measures employed and how their effectiveness could be undermined.

Support resources

A constituent central to the level of stress experienced, it is based on the resources that have the greatest impact in determining this. These resources where generally of a more material nature and were important in buffering or ameliorating the stress that may be experienced. The affect of these on the midwife depended on her role in birthing suite, but the resources most frequently mentioned centre on the nexus of 'women-staff' ratios and skill mix.

Debriefing:

The term debriefing may connote a formalised psychological procedure, but it is used here in reference to the usually informal discussions the midwives instigated following any event they considered stressful. It is the term the midwives themselves used to describe any situation where they felt the need to talk about an incident. Therefore, the constituents analysed within this categorisation relate to what the midwives hoped to gain from debriefing, why they chose who they chose to debrief with, those factors that inhibited them from debriefing and the nature of the debriefing sought whether that was informally with colleagues or formally with a counsellor.

Purpose and meaning

The midwives described the purpose of debriefing as having two levels. The more apparent purpose was at the intrapersonal level, but debriefing also functioned as part of the process that maintained and educated all midwives. At the intrapersonal level the purpose was focussed on managing and dissipating the stress that had been experienced. They sought reassurance that their actions were appropriate which meant that their self-esteem was either restored or maintained, or there was the opportunity to discuss emotive issues and derive emotional support. As mentioned previously, there is a link between *Purpose and meaning* and *Debriefer selection parameters* with it being mentioned that some friends are able to restore self-esteem while colleagues have knowledge that allows them to provide an accurate and respected perspective on events. With regard to the process of education and maintaining the wellbeing of staff, the debriefing process is an opportunity for senior staff to discuss with junior staff the events as they unfolded and for all staff to increase their knowledge and develop strategies for future events.

Debriefer selection parameters

It was found that there were individual parameters used to select who it was considered most appropriate to debrief with in any given circumstance. While links can be made between this constituent and the constituents of *Purpose and meaning* and the *Constraints* constituent, it is not absolutely contingent upon these. A consistent theme of the thoughts around who was considered appropriate related to the insight that may be provided and issues of trust, respect and honesty. While there was not always an expectation of change it was mentioned that by selecting a colleague there was the possibility to muse over events which provided some prospect of resolving any issues. This is consistent with the notion of seeking someone with insight and ties in with a perception that there are some issues better not discussed with lay persons. In this vein there was the notion of keeping some of the more distressing and controversial realities of being a midwife 'in house', the sense that the lay public lacked understanding of the minutiae of their work and the perception that some of the midwives' behaviours and reactions could be judged as inappropriate.

Constraints

It was revealed that there are inhibitors to the debriefing process and as suggested previously, in some instances this can play a role in who is selected to debrief with but more particularly it determines the depth of the revelations made and the discussion that can be had. Of particular concern was what was perceived as appropriate to reveal to the person chosen to debrief with. Therefore although the selection parameters did not always determine somebody as inappropriate to debrief with, there was the possibility of withholding information from the person chosen for a variety of reasons which altered the nature of the debriefing received.

Succouring debriefing

Here the debriefing is informal and immediate. It may occur as a shift unfolds, immediately at its conclusion with colleagues or immediately following it with friends and or family. It can be correlated to the dynamic nature of birthing suite where it is seen as integral to the process because of its immediacy. It is seen to restore equilibrium, facilitate unburdening and possibly provide constructive feedback.

Prescient debriefing

In this instance the debriefing is usually confined to peers who have the advantage of understanding the work environment and therefore do not require any lengthy explanations regarding policies, procedures, protocols and the issues involved. This fore knowledge facilitates a candid conversation requiring little detailed explanation and is one that does not become ghoulish, which is considered to contain the possibility of compounding the stress experienced. Instead a shared perspective offers support while practical and beneficial feedback is supplied. This nature of debriefing is sought when events require more than the simple unburdening process of the *succouring debriefing.*

Formal debriefing

This includes all those situations where a trained counsellor is employed to discuss events either as a group or individually. These situations may be at the behest of the hospital or sought privately. For those who undertook private counselling it was either suggested by a superior or as the sequel to exceptional circumstances. The hospital initiated involved group debriefing following a significant incident. The experience of any formal debriefing was variously reported as providing non-judgemental debriefing, being without cross-examination and one where emotions were normalised.

Support:

The notion of support is one that was explored in the interviews. To this end, if the midwife had not included the notion of support in their response, prompting questions were asked to elicit a response. The prompts focussed on who they turned to for support, what it was that they were seeking or hoped to

gain and their perception of the availability of support and how beneficial it was. It is interesting to note that in all but one interview the notion of support was raised by the midwife. However it must also be noted that this did not preclude some clarifying questions in the areas of interest being asked.

Support structure

While a simple catalogue of the various sources of support midwives availed themselves of could be done the more noteworthy aspect is that when a midwife spoke of support, it was always with reference to the levels of support provided from the various sources in their work environment. Within this realm the support of peers was mentioned most frequently and was central to the support structure. Underpinning the general effectiveness of this was the support or lack of support from supervisors / 'management' and as a conduit to this the support was the Unit Manager, whose support as an empathic listener who reacted to their more material needs was also evident. Additional to this 'superstructure' was the notion of professional counselling as an option, particularly if other sources were inadequate, and the valued support that was received from family and friends.

Characteristics

The significance of this constituent rests in the nature of the support that was derived from the various sources. The support of colleagues was spoken of most frequently, and this was in terms of guidance provided, physical assistance in stressful situations, reassurance, collegiality and camaraderie. When speaking of the support of family and friends it was more frequently in terms of emotional support

Aims and outcomes

While this constituent is linked to the *Structure* and *Characteristics* constituents, it is as its sequel to them, describing what the midwives were seeking in a concrete way, determining if this was achieved and the sequel if the original aim was not gained.

Sustenance

This constituent refers to the valued sources of support which provided the midwives with the impetus to continue and gave a sense of value, a figurative 'arm around the shoulder' type of support. In all cases this support predominantly came from midwife colleagues. In relation to other sources such as friends and family their support was supplemental to that of any colleague; a sentiment that was also repeated with respect to the gratitude expressed by women.

Colleague advocacy

This constituent's significance lies in the thoughts and actions of the midwives which were the genesis for the support that was provided. It is a constituent that has ties with *Sustenance* because it spawns the intrinsic qualities of the support that is esteemed by other midwives. The notion of colleague advocacy

was undermined by a lack of resources or in those instances where there was any covert questioning of the midwife's actions by other colleagues.

Corporate advocacy

This refers to any form of advocacy that is outside of that provided by midwife colleagues but includes the peer support program which had the imprimatur of management. With regard to the more formalised support programs there was a dichotomy of experiences reported. On one hand there was an inadequate peer support program and inadequate access to professional counselling, while on the other the support around bereavement care was exemplary.

Bereavement care:

Whilst bereavement care was one of many possible sources of stress mentioned in the preamble to each interview, there were no specific questions asked in relation to this category. The constituents revealed in this category concern the impact providing this care has on the midwives, the effect of the women's expectations, what procedures and supports are in place, some of the personal issues that come into play and the moral and ethical considerations the midwives make.

Morality and ethics

While personal moral judgements are made with regard to the termination of a pregnancy, the midwives have a particular notion of the moral principles they consider need to be upheld. This acts in concert with the ethical considerations pursuant to their conduct in relation to the rules recognised as appropriate to their profession. The morality and ethics constituent encompasses the midwives judgements, notions and conduct and the juxtaposition of these to her personal values and beliefs. This constituent has ties with the following constituent of *Women's expectations.*

Women's expectations

The patients have their expectations as to how events should unfold and this constituent considers the nature of these expectations, how these marry with the expectations of the midwives and what effect all of this has on the midwives. In some instances the expectations of the patient have challenged the moral judgements and ethical perspectives of individual midwives.

Personal issues

Some of the midwives have had a personal experience of perinatal bereavement and this constituent reflects on their experience of caring for others in a similar situation.

Emotional impact

This constituent involves how providing bereavement care impacts emotionally on the midwife, what the triggers for any emotional impact are and any relationship they may have with the midwife's personal beliefs.

Procedures and support

A process to facilitate the appropriate care of those facing a perinatal bereavement had been developed by various stakeholders. The procedures and protocols arising from that work and currently in place are considered in terms of how they support the bereaved, the consequences for the midwives and the support provided for the midwives.

Stoicism

This was a trait evident in many of the midwives and was inextricably linked to how they coped with bereavement situations and the resultant emotional impact. Typically they spoke of the need to accept the situation at hand and 'move on'. For those midwives not able to do this the emotional impact was greater with the probability of more devastating personal consequences.

Communication:

While in the initial literature review of stress as it related to nursing (as distinct from midwifery), communication with either colleagues or in dealing with the 'bureaucracy of the hospital were areas that had been researched previously but it was not a focus in the interviews. Therefore the constituents found in this category arise from comments made by the midwives in their general discussion of stress in birthing suite. The most universal constituent discerned within this category pertained to the women's rapport with the others found relating to the communication skills that individuals have or lack, the barriers that exist with regard to effective communication, the integrity shown by the communicator and the nature of the communication as it pertains to staff and to patients.

Women's rapport

Developing a good rapport with those in their care is seen as integral to providing optimum care and is something that is strived for. Within this constituent the difficulties associated with developing and maintaining good rapport are the main feature and the style used to develop and maintain that rapport.

Skills

Several observations made by the midwives pointed to the notion that while effective communication skills were very important to engender a sense of inclusion and more efficient and effective work practices there was a general lack of communication between departments and across disciplines and also sometimes destructive communication between colleagues.

Barriers

The barriers to good communication fall within two broad domains. The first relates to the variety of personality types that have to be accommodated and the responses that are accordingly anticipated, while the second is focussed on the thoughts and ideas that each individual will have as to what they consider to be the most appropriate management of each case.

Integrity

This is a constituent discussed by only a few in more senior or managerial positions. It relates to the need to maintain ones personal integrity and not demean colleagues, and also to remain impartial in all private discussions with staff.

Elucidatory communication

Once again this constituent surfaced in discussions with more senior staff and is seen by them to be important in the context of supportive education for staff and more particularly the junior staff. It could be seen to be a precursor of the debriefing process but is readily distinguishable from it. While it may be a catalyst for personal reflection, it is the imparting of knowledge and wisdom through the revisiting of events either in a case management format or as a one on one dialogue that allows questions to be asked, answered and argued.

Chapter 5

PHASE ONE: ELUCIDATION AND DISCUSSION OF CONSTITUENTS

Preamble

In the previous chapter the essential constituents that had been identified via the use of imaginative variation were catalogued. While many of the constituents were readily distinguished from all others, the similarity of some constituents was highlighted. Where there was some similarity the distinguishing features of each constituent were clearly defined and a clear differentiation between constituents made. This resulted in a list of distinct constituents where it was apparent that there was the possibility for some underlying interactions. Importantly it was also apparent that each constituent was not contingent on another.

The purpose of this chapter is to discuss the variations within each constituent and thus provide an in depth description of each in the tradition of Giorgi (Giorgi & Giorgi, 2003). Throughout this discussion direct quotations from the interviews will be provided for exemplification. Thus an insight into the essence of what constitutes stress for midwives who work in birthing suite will be elucidated.

To maintain the anonymity and confidentiality of the participants, pseudonyms have been used throughout. These names were selected at random from a book of girls' names, ensuring that none of the participants were used. While a brief description of each participant is often provided to provide the reader with a deeper understanding of the comments, in this instance it was considered that even the briefest of descriptions risked breaching the anonymity and confidentiality of the participants.

In completing an elucidation of each constituent, a search of the current literature was carried out using the constituent names and the descriptive categories as the search terms. Any information relevant to the constituent that was found was included in the discussion. It must be noted that while the phenomenological method of analysis revealed thirty constituents, not all of these were found to be the focus of research or review, particularly with specific regard to midwives or nurses. With this in mind it was reasoned that a pragmatic approach was justified and should be adopted with regard to the manner of the literature search and the inclusion within the elucidation and discussion of anything found. Therefore where there was a body of literature available within the realm of the constituent any works that summarised the essential literature pertinent to the constituent or provided an overview of the body of work to this point was sought. The literature found fell broadly into two categories, either being an edited book with chapters by experts in the field or articles where a literature review had been carried out to compare and contrast findings.

Having located these 'foundational' articles the search then focussed on locating the most recent studies published. The initial search included the terms *midwife* and *midwifery* to ensure that all works with a

focus on this very specific group were located. If this yielded no result the search was adjusted and used the terms *nurse* and *nursing*, which in turn was broadened to include any research and knowledge in the area. The literature included in the discussion reflects the results of this approach.

Non-categorised Constituents
Personal qualities

As previously mentioned, when interviewed the midwives were asked to consider what characteristics they thought the most important for a midwife to have. This general question was posed to elicit if there was a common notion of what was required to be a midwife. Within this realm, when the question was asked, the more common response centred upon them being a caring person. The following excerpts highlight this point.

> *I'm a caring person. A caring person; but my husband said I'm really most happy when I am caring for people…… (Barb)*
>
> *I think I'm quite a caring person…… (Erin)*
>
> *Caring, a good listener, willing to help people …… (Faye)*
>
> *I would see myself being less academic and more towards the nurturing, caring sort. (Gill)*
>
> *I feel that I'm quite caring and sort of care for women how I want to care for my family. (Helen)*

While such responses would perhaps not be unexpected from a nurse or midwife they also included the need to display empathy and compassion, to be a good listener and communicator and to maintain a sense of humour. These qualities parallel the findings of Nicholls and Webb (2006) in their integrative review of thirty three research papers. While they concluded that having good communication skills made the greatest contribution to being 'a good midwife' and the other personal attributes of being compassionate, kind and supportive also made major contributions, the midwives interviewed for the current study also revealed other noteworthy characteristics not revealed in prior research.

When the midwives discussed their work and their approach to it, the main thrust of what was said suggested they knew of and accepted the challenges of it and while being committed and disciplined with regard to their work, they were independent thinkers who also understood the requirement to be part of a team. There was also the notion of growing into the role and accepting greater responsibility as experience was gained. The following quote from a registered midwife who worked part-time encapsulates the thoughts of the other midwives interviewed.

As I think of the people I work with in delivery suite, I think you have to have a strong personality. They are determined people who will not be pushed around. They are not submissive, sure of what they are doing, and very independent but not loners because they work very well with others. They enjoy taking responsibility and enjoy a challenge, but that is when I am thinking of the AUM's. (Monica)

I think we learn from our experiences. We see it as our responsibility to see that things are done correctly and will change our practice to ensure they are. I am not infallible, so I'm happy to be told, to learn, but I enjoy the challenge. (Chris)

Introspection

Of the midwives interviewed the majority spoke of how they reflected upon various events to process them. Incorporated into this was a process of self observation whereby the midwife would consider her own thoughts and feelings.

....having been unsuccessful at positions I have applied for, and you know when you're knocked back a couple of times, you think "Oh why?", but over the time if you are honest and recognised and acknowledge your faults... (Barb)

Then I was ready to take more responsibility, not move on any more. (Erin)

In each instance the acknowledgement facilitated a deeper understanding of herself as an individual and allowed her to grow. This notion has some correlation with the findings of Vinje and Mittelmark (2007). They conducted a qualitative study of Norwegian community nurses to explore the role of job engagement in burnout. One of the conclusions drawn was that those who were able to make changes in themselves and their situations while maintaining meaningfulness in their work participated in 'deep stocktaking'. Such nurses had developed a talent for introspection which was coupled with an enduring habit of reflection. As they rightly point out however, their sample was drawn from the 'survivors' and there may be a paradox in that high job engagement can also have a negative effect that contributes to nurses leaving. This may be an explanation in the circumstance where a midwife who was seemingly enmeshed in her role did not gain the deepest understanding until she disengaged from her role ... *and sometimes you don't realise that you have a problem, because you are coping, or you presume you're coping (Faye.)*

With these two constituents we are given an insight into the core of the midwives' thinking. While it could be anticipated that they would consider themselves as caring individuals, it is revealing to contemplate them as people who are not submissive, but independent thinkers who anticipate and enjoy challenge. When this is coupled with an ability to look inwardly not only at their practice but also at the

ramifications of their role as a midwife, we are provided with an impression of a midwife that can be used to underpin our understanding of how midwives experience stress when working in birthing suite.

Categorised Constituents
Stress:

<u>Sense of control</u>

The constituent 'sense of control' underpins the stress experienced by the midwives. While the notion of control as authority has a role in the stress experienced by the midwives, the essence of the stress experienced is synonymous with the more abstract meaning as it pertains to feelings of adequacy, competence and confidence and the ability to manage.

In the context of the workplace, control is a term that can have many meanings depending on the context within which it is used. In terms of this study, control is associated with the midwives having a 'sense of control' and not as it has been considered in prior theories of stress where it is central to the work-stress model (Karasek, 1979) and the appraisal component of the transactional theory of stress (Lazarus & Folkman, 1984, 1991).

The transactional model of stress as described by Lazarus (1993) is a process of appraisal, coping and reappraisal. It is the appraisal of control that is deemed an important factor in influencing coping behaviour and it is from this perspective that control as a variable has been considered with Lazarus (1999) considering primary appraisal, secondary appraisal, situational emotions and coping behaviour as the salient components of the transactional theory of stress.

In their work on the appraisal of workplace stress Troup and Dewe (2002) suggest however, it is important to consider control not as a one-dimensional factor but to also consider what the individual expects to have control over and to what degree. They examined control as a multifaceted construct consisting of task control, predictability, self-control and general control.

Troup and Dewe (2002) ask us to consider control in terms of its significance to the individual and what it is the individual considers it is that they have control over. They measured some situational aspects of control and then examined the relationship between those situational aspects and other aspects of the appraisal process with the aim of gaining an insight into the individual's perception of those factors important in gaining a sense of control and to identify the meaning given to the type of control gained. They found that a sense of control is derived from four components. These components are *predictability* (having knowledge of events), *task control* (completion of duties), *self-control* (remaining calm) and *general control* (professional decisions responsibly made).

In endeavouring to ascertain the conditions that would empower midwives, Matthews, Scott, Gallagher and Corbally (2006) used the *Understanding of Empowerment Scale* to survey ninety-five practising Irish midwives. The completed questionnaires were factor analysed using Principal Axis Factoring which revealed the conditions of *control, support, recognition* and *skills* as being central to the empowerment of midwives. While the four factors listed explained 53.8% of the variance, it is worthwhile noting that the factor *control* explained 29.69% of the variance.

In keeping with the notion of Troup and Dewe (2002) that it is important to understand what it is the individual strives to have control of, there is an array of issues within the workplace over which the primary appraisal by midwives recognises that they have little or no control, such as staff numbers, the skill set of staff or women numbers:

> *Yes, having no control over, or not having a lot of control over other staff, having the amount of staff or the level of expertise you need, lack of control, lack of resources possibly, lack of... well when you talk about control and there's and influx of patients and not having any control over ..., you know we might not have the staff but we don't, we can't say no. (Anne)*

While it can be argued that it is a stressful situation where the authority to manage events as they unfold is constrained by other factors, in keeping with the transactional model of stress it is the perception of having events overwhelm them and not being able to anticipate what the outcome may be that is alarming for the midwives, as depicted by the statement; *Stress is where I feel like I'm not coping. There is a sense of being overwhelmed by events and having a loss of control in the circumstances (Chris).* In terms of the research carried out by Troup and Dewe (2002) this would relate to 'predictability' or being able to anticipate events or potential problems, feeling certain of the outcome or responding appropriately. Along with maintaining a sense of self control, predictability was moderately important in giving a sense of control.

Importantly however this situation is exacerbated if there is a sense of not controlling situations when there is an expectation too, leading to a sense of inadequacy, *I felt like I wasn't managing. Felt like I wasn't performing my role as an AUM (Gabbi).* This is more in keeping with the 'task control' component which focuses on meeting deadlines, organizing your own workload, setting priorities and managing your own time (Troup & Dewe, 2002). This was not found to be an important component in their study, but 50% of the incidents reported upon as stressful related to interpersonal conflict where, as they suggest, it is reasonable to suggest task control would not be a factor.

The significance of maintaining a sense of control is reflected in its effect on the midwives self-esteem and her job satisfaction. As the midwife gains mastery over various situations her confidence increases

and self-reliance is engendered. *The first time things can be a little anxious for you, but once you get through it, you think it was fine and that you will be able to do it next time (Irene),* and if her sense of control has remained intact she is more able to reflect on her day's achievements in a positive light that provides greater job satisfaction, *... and at the end of the day, if you can look back and say that you gave her all I could give and nothing more, then you've done your job (Gabbi).* This reflects the positive correlation found by Troup and Dewe (2002) between feeling 'accomplished and fulfilled' and the importance of having a sense of task control and predictability.

A study carried out in Ireland by Matthews, Scott, Gallagher and Corbally (2006) to determine those factors or conditions considered necessary for the empowerment of midwives settled on four factors. The factor that explained the greatest percentage of the variance at 29.69% was named 'Control' and pertained to 'having control over my practice', 'being adequately educated to perform my role', 'having access to resources for staff education and training', 'being able to say no when I judge it to be necessary' and 'having access to resources for patients'. While some of these are broad statements open to varying interpretations, it can be argued that they align with the notion of midwives wanting to take responsibility for work for which they have been adequately prepared in conjunction with having the facilities to do so. The provision of training, knowledge and appropriate resources facilitates midwives in responding appropriately and provides an element of predictability, while being able to take responsibility for their practice engenders a greater sense of accomplishment and fulfilment. Therefore it can be suggested that the factors described by Matthews et al encapsulate the basis and significance of what it is for a midwife to have a sense of control.

Genesis

In the current study of midwives it can be argued that the majority of incidents described fall broadly within those categories detailed by McVicar (2003) but there are some points of difference to be made between the experience of nurses and that of the midwives and these will be detailed. There are also some additional categories to be considered. These pertain to issues surrounding the autonomy afforded and expected of midwives and the more troublesome category related to the level of abuse reported by the midwives.

In the current study the issue of *workload* was mentioned directly on only a few occasions and these were in reference to the onerous amounts of 'paperwork' and in management situations where deadlines have to be met or the constant demand of managing staff issues (either of a personal nature or staffing the ward) created a sense of pressure and overload. This was further exacerbated when required to carry out both a management and a clinical role.

Another expression of workload centred on the stress created from an inability to complete tasks in a timely manner and to a self-imposed standard. For the clinical midwife this occurs while also recognising that there is not an expectation to complete everything by shifts end:

> *You're not performing as expected, and that doesn't mean doing everything in an eight hour shift because it's a twenty four hour care environment. But there are certain things that should be done and you know that you just can't get them all done. You go home feeling a bit dissatisfied (Irene).*

This compares with those in a managerial position where dissatisfaction also arises from not completing work to one's satisfaction. This is seen to arise from dividing time between both the clinical and management roles creating a sense of never having the time to fully complete a task, thus being denied the sense of a job well done:

> *(In a previous position) I would leave each day knowing I had completed my job and done it well. In this job you have to get used to never completing your job because you cannot be 100% management or clinical. You give half to both, which leaves you feeling like you haven't done a good day's work. I'm not sure it it's really stressful, but it's disheartening (Denise).*

It has been suggested that where there is inadequate staffing, the basis for the sense of work overload and the inability to provide all the care needed, nurses experience moral distress (Corley, 2002).

One of the more commonly revealed areas to cause distress for the midwives is in keeping with the findings of McVicar (2003) and relates to *professional conflict*, an area of interest to Tabak and Koprak (2007) who found that the manner nurse's chose to resolve conflicts with physician colleagues correlated to the level of stress experienced, and that more senior, more experienced nurses were likely to use self-assertive tactics of 'integration' and 'dominance' rather than obliging avoidance approaches.

In the current study professional conflict arose with obstetric staff, ancillary staff (social workers) and midwife colleagues. With regard to midwife and obstetric staff conflict, the reasons varied according to the experience of the obstetric staff. In relation to the junior or resident doctors there were issues of power and or control, their inexperience and professional antipathy in a situation where the midwives oversaw much of their work. Therefore the more experienced midwives were in the situation of having to respectfully guide and direct them, this perhaps in line with the notion of 'integration' and 'dominance' (Tabak & Koprak, 2007). Interestingly this created discontent for both professional groups and if the junior doctor chose not to consider the advice of the midwife there was the potential for it to impact on both the childbearing women and their more senior colleagues:

It can be difficult with the attitude some junior doctors have because you create this
conflict. I had two conflict situations with junior doctors in an hour. I suggested
that it isn't usually done that way, or it's done another way. They wouldn't consult
the registrar, went ahead with it and that impacts on the woman. You then explain
that it's not the right way. These are situations they have never seen before and that
you have experienced many times over. They don't seem to be able to grasp the
possible consequences of their actions (Erin).

This situation was sometimes overlaid by apparent apathy on the part of junior doctors:

… what experience have they had, you get some that are fantastic, that will want to
learn, there's others that are not really too interested, they're just doing it because,
yeah, they have to do it to do whatever they are going to do in life… (Helen).

Much of the conflict with more senior obstetric staff related to care decisions they took in conjunction
with the childbearing woman that the midwife was then required to execute, particularly in the area of
managing mid-trimester terminations. This source of conflict will be described in more detail when the
area of bereavement care is discussed. What is of interest is that the brief mention of professional
conflict with ancillary staff is couched in similar terms to that of the more senior obstetric staff. The
midwives were responsible for instituting and maintaining a care plan for which they had no input and
which they often found problematic, especially in the more complex cases. In discussing the case of a
handicapped women Faye recalled:

The social work department and the carers had written a plan for her regarding
what had to be done with her. I suppose in those cases I get upset with that because
they write a plan, but they're never actually there when it's coming to pieces. She
had a piece of paper that was more about anger management. When she was
getting angry you had to hold this piece of paper and say "What number are you?"

The reason for conflict between midwife colleagues was broad and included differences in scope of
experience and knowledge, opinions of appropriate care and models of care, issues of change
management, issues of personality and varying communication styles. While issues of communication
will be discussed in more detail when the essential constituents as they relate to this area are explored,
the notion of miscommunication in any form can evolve into a source of unnecessary stress involving all
staff. Helen recalls the consequences of miscommunication between colleagues she has witnessed:

*Upsetting them, sometimes you upset them by things that you do and you don't
really want to upset them, but they are upset. Maybe you have said a word or
something that they are not happy with what you said, things like that, and that's
pretty stressful. It has not actually happened to me but it has happened to other
midwives that said or done things and they've complained, and I think that can be a
problem.*

While not communicating with a senior midwife may be the catalyst for some frustration, it is the
sequence of events that unfold should a junior midwife not consult with her but instead directly involve
the doctors leading to intervention and medicalisation of what was assessed as a normal situation in a
well person that is contentious and is possibly linked to the previously discussed antipathy that can exist
between junior medical and senior midwifery personnel:

*... whilst I think we have the same, we wish to have the same outcomes, a healthy
mother and a happy baby, I do think that we come at it from very different sides,
and we were taught that there are well people doing normal things, and whilst you
have to recognise the abnormal, the normal is so vast that ... but that, I don't know,
they tend to turn it into a medical thing; quite frustrating (Barb).*

Another example of differences in experience and models of care is highlighted by the recollection that
a senior midwife was perceived as being condescending toward the women because of her manner, a
manner originating from a far more rigid training regime where certain formalities were expected, a
training based in following instruction with little or no question. This compares with midwives today
who are seen to be more self-assured and assertive and as individuals are willing to exercise their right
not to participate in some procedures which has the effect of deflecting greater pressure onto colleagues.
Birthing suite is also seen as being insular, having limited contact with midwives in other wards which
cultivates the rise of some dominant personalities, leading Gabbi to question the motives of some
colleagues when espousing the value of woman centred care:

*The midwives in delivery suite are quite proactive about woman centred care,
ostensibly, but I don't know that they grasp the concept. I think some of them are
very interested in midwives' centred care. Typified by not wanting to supervise a
student because they wish to do a delivery, you constantly work with that.*

Further to this, those midwives following the 'Caseload' model of care found that they derived support
from their immediate colleagues working in the caseload model, but the support and cooperation of
birthing suite staff was not as reliable. This situation may in part be aligned with the findings of Hunter
(2004) who suggested that those working in a hospital environment (birthing suite) had a task oriented

focus ensuring they met service needs while those with a more community based orientation (caseload) had a more individualised less task oriented focus. Thus these two groups of midwives have fundamentally different points of view and ideals.

In the current study, from a management perspective some midwives were seen to have challenging attitudes requiring carefully considered strategies to encourage them while maintaining the appearance of treating all staff equally. These efforts were not accepted as true and valid and a concerted effort was required to gain trust and respect, thereby diminishing the initial disquiet and personal upset incurred as a result of any negative reactions:

> *It doesn't always happen and there are the ones where you think what haven't I done, what haven't I put into this one, because as I said before I try to deal with everybody the same way. Some of them are challenging, more challenging than others and some of them don't want to listen ... (Barb).*

An interesting perspective of the work of the nurse or midwife that has been considered by some is the 'emotion work' that they perform. It is argued that the quality of the relationship that develops between the midwife and the woman plays a significant role in determining the experience of childbirth for the woman (Hunter, 2001). While there has been a focus on service provision and outcomes for the women, there has been little consideration given to the effect of this aspect of caring provided by the midwives. In an effort to redress this situation, Hunter undertook an integrative literature review to facilitate a discussion of both sociological and nursing research that considered the theoretical aspects of managing emotion at work and its application to midwifery work.

In drawing on the work of Hochschild, Hunter (2001) explored the notion of 'emotional labour' which it is contended is ultimately performed at some personal cost to the worker. Further to this, it is a gendered concept where the perception is that it is a natural female skill. It is argued that this gendering of emotional labour has resulted in its invisibility and undervaluing within the workplace. Hunter argued that there are several key features of contemporary midwifery that underpin the sources of emotion for a midwife. These key features are the emphasis on continuity of care where the aim is to offer greater control, continuity and choice for the women, the high levels of expressed emotion, the intimacy and undeclared sexuality of the work with the accompanying physical contact, working with women in extreme pain and the division of labour or more particularly 'who has the control?'

To ascertain how a range of midwives experienced and managed this 'emotional labour' Hunter (2004) carried out a qualitative study of student midwives and registered midwives in both a hospital setting and a community setting in South Wales. The primary source of the emotion work was unexpected and related to contradicting ideologies of midwifery. Where these intersected the conflicting practice

ideologies underpinned the subsequent emotion work that stemmed from the dissonance experienced. On the one hand there were midwives adopting a pragmatic approach to satisfy the requirements of the standardised care of an institution while on the other there were midwives who sought to provide individualised, woman-centred care and who held strong beliefs in the normal physiology of birth. For the midwives in a hospital setting, their work was emotionally rewarding when their tasks were finished and they were recognised by their peers. This compared to the community based midwives who saw greater significance in developing a relationship with the woman and her family. Not only was this important in facilitating a complete assessment of the woman's wellbeing, but it was this relationship that sustained her emotionally.

From this same sample, Hunter (2005) looked particularly at the hospital based midwives and concluded that the more junior midwives adopted and were advocates of the 'with woman' approach while the senior midwives were seen to be 'with institution' and operated on an informal reward and punishment system to maintain their status positions within the hierarchy. The significance of this relates to its effect on the emotional wellbeing of an important section of the midwifery community and its implications for staff retention as well as the quality of care provided.

Therefore the point made is that there are many aspects of midwifery work that have the potential to create great emotion but in the main this has not been fully explored from the perspective of the impact it has on the midwife (Hunter, 2001), while later work suggests the basis of the emotion was a conflict in ideologies of midwifery practice resulting in senior and junior midwives competing to hold sway and practice in their preferred manner (Hunter, 2004, 2005).

In the current study it is perhaps understandable that an important source of stress arose from the midwives' interactions with the women, their partners and their support people. It is possible that some of this stress can be aligned with the findings of McVicar (2003) in that it relates to 'the emotional cost of caring'. Williams (2001) reasons this is something that has increased over the last twenty to thirty years as a result of nurses moving from maintaining an aura of professional detachment to the embracing of the more holistic approach of building a 'nurse – patient' relationship.

With regard to midwives, Hunter (2001) sees the 'midwife – patient' relationship as central to the women's experience of childbirth and as she suggests there is the likelihood that the experience will be an intimate and emotionally charged one. A feature of the relationship revealed in the current study is the understanding and compromise afforded the woman by the midwives. When demanding and difficult behaviours occurred they were rationalised as part of the labour process and only those seen as extreme or unreasonable, such as requests not to carry out routine fetal monitoring were considered unreasonable and a stressor:

We had an incident recently where a woman decided to have a hypno-birth. She had very strong ideas about what she wanted. We weren't allowed to use a Doppler, we weren't allowed to have coffee or talk about contractions. To my mind it shouldn't have been allowed to go that far. We have to use a Doppler, particularly if she is going to be on all fours and not cooperate with you using the Pinnard. You need a cooperative lady, but there are all those sort of issues (Gabbi).

Another area of interaction that has consequences with regard to the genesis of stress relates to the presence of support people at a birth. While there has been research within in this area, it has related to the effect for birthing women with any information regarding midwives arising as a result of this (Maher, 2004). On this basis Maher undertook a study to discover what the experience of midwives was in relation to the presence of support people in the birthing suite. A qualitative study of Australian midwives made some important findings. It was revealed that midwives sought to protect the woman from any negative consequences if there was tension between her and any support person whilst also endeavouring to not alienate the support person, they sometimes felt hindered in their work by ill-prepared support people, especially when they either had no clear role or there were large numbers of them and to provide guidance and support to the support person. Of particular significance was the revelation that all midwives had been in a situation where the support person had made the event more difficult with behaviours that had been either detrimental to the woman or in the instance of becoming aggressive, detrimental to the midwife.

The concept of aggression perpetrated against nurses has been more commonly researched in mental health settings (Duxbury, 1999) indicating many practice settings were ignored. Since Whittington and Whykes (1989) revealed that minor acts of aggression can leave nurses emotionally traumatized there has been greater awareness of and research into aggression in nursing. However in Australia its extent remains unknown due to only a limited number of studies with small samples sizes being carried out (Farrell, Bobrowski, & Bobrowski, 2006) and with the focus on psychiatric and emergency settings while minimal attention has been given to general inpatient settings (Hills, 2008). Although the work of Maher (2004) focussed on the midwives' experience of the presence of support people, it is significant that mention was made of 'aggressive partners' hampering their work.

While to some extent the principle of rationalising behaviours was extended to the partners and support people, *they're excited about the coming event, aware of her pain and that concerns them, so there is a whirlpool of emotion, there is anxiety… (Irene),* they were revealed to be a source of frustration, *support people can be inconsiderate, coming and going all the time without being supportive (Irene),* a sentiment also expressed by midwives in Maher's (2004) study. The midwives saw it as their responsibility to advocate for the woman, a responsibility that was magnified when having to mediate

between her wishes and expectations and the sometimes unreasonable wishes and expectations of the partner or support people. This situation is reflected in the experience of Irene:

> *Sometimes also their support people might not be as supportive as you might wish and try to take over the situation. Sometimes you suspect they are putting their wishes above those of the expectant mother, or forcing their wishes on that mother. You have to deal with that situation, you can't ignore it. You have to cope with it and work it out. You chat; find things out, gain their trust. But sometimes partners' demands can be unreasonable.*

Further to this it was also revealed that midwives felt that many support people were unprepared for the birthing process (Maher, 2004) and this is reflected in the current study where this lack of preparedness is revealed along with a lack of understanding of what a midwife can achieve, leading to various demands and the generation of more stress for the midwife:

> *When you are doing as much as you can, but as you know sometimes factors influence this. It could be that the woman is needing further analgesia and the anaesthetist is required to administer this, that his presence has been delayed for more urgent cases, and they do not understand that though you have done all you can … (Barb).*

In the interviews carried out by Maher (2004) she reported that all the midwives agreed they had experienced a situation where a support person had instigated some difficulty during a birth with one midwife remarking on the job being hampered by aggressive partners. The suggestion of aggression is also reflected in the experiences of the midwives in the current study.

The level and reason for the aggression can vary. A more common situation being one where a partner is adamant that his wife is not to have analgesia because of a birth plan they had formulated, placing the midwife in the testing position of needing to advocate for the woman while not wanting to further antagonise the partner:

> *I think you talk to someone about pain and they might say I don't want an epidural or whatever, I mean, you know, they get into very well established labour and they change their mind occasionally. And the partner or support person, you know, stands there and says, "You didn't want one", "You can't have one", "No, no, we're not going to have one" … (Anne)*

It appears that strategies are required particular to the birthing suite where the midwife may be required to advocate for the woman against the thoughts and wishes of her partner and family.

Other situations where interactions can be problematic include having to manage those with disabilities who may display challenging behaviours, people who have a drug or alcohol dependency who are needy and can behave irrationally while being vexatious and difficult to satisfy, or more severe incidents where the midwife feels a level of despair and an inability to contain the situation when physical and verbal family conflict is played out in the birthing suite, *I have been in the situation where an individual has behaved in a manner that has caused great anxiety for those witnessing the event, but I have felt useless because they have been unapproachable and violent (Chris)*. Such events create a nexus of escalating tensions between the staff, the woman and her partner.

While it is the inappropriate coping mechanisms of some of the clientele that is the catalyst for stress in the midwives and the knowledge that verbal aggression can escalate to physical aggression, it is a sense of concern for her wellbeing, the wellbeing of colleagues, the wellbeing of the new mother and what the future holds for the newborn that also generates stress. Also the midwives have the initial responsibility to diffuse or control difficult situations with minimal support while waiting for the aid of security staff when required. One midwife reported that the situation escalated to the point of requiring police intervention. Any of these situations are made more distressing for the midwives when they occur during the night shift because they have a greater sense of vulnerability.

A consistent theme expressed in the literature is that while what constitutes aggression or how it is conceptualised for research purposes is not clearly defined, those nurses who report instances of aggression, be it verbal or physical, suffer symptoms of burnout (emotional exhaustion, depersonalisation), job dissatisfaction, professional loss, anxiety, fear and resentment (Hills, 2008). In terms of retention of staff in the presence of declining numbers of midwives registered in the state of Victoria (McClelland & McKenna, 2008) it can be argued that this is an area that needs further research.

Another area where difficulties arise in interactions with the women, partners and support people, is a result of varying cultural and religious expectations and customs. On one hand there can be the perception of an apparent lack of both professional and personal respect for them as women:

> *I recently encountered a situation where the woman required specific treatment and all the advice for that treatment was coming from female doctors. The woman's husband would not accept this advice because it was not coming from a male doctor, but he did accept it following the shift change when a male doctor gave him the same advice. This is at odds with their normal expectation of having only female doctors care for their wives (Chris).*

In other circumstances there was a need to come to terms with a variety of social equity and social justice issues while also dealing with some firmly held beliefs that were seen to cause a fetal death:

I understood why she, as a refugee, had made the decision she had and the
circumstances behind it. Those circumstances raised a whole lot of other issues for
me. The helplessness of her situation, what we take for granted and that we would
never have to make that sort of decision (Chris).

As can already be gauged by the events discussed, the breadth of situations encountered in combination with the unpredictability of events makes birthing suite a very dynamic environment where stress cannot be avoided, but it is possible that not all of this stress is experienced as a negative. In fact it can be argued that midwives working in an environment such as birthing suite experience 'eustress', as described by Selye (Lazarus, 1993) the positive stress engendering positiveness and a healthy body/mind state that enables them to perform to their potential. It is an area where there is the potential to be engaged in a challenge at any moment and it is meeting and managing these challenges that initiates the fulfilment gained from birthing suite work:

An emergency situation such as a shoulder dystocia or PPH, or even where the
lady who is considered not to be in labour, but the head ends up in the bed, you get
that rush. It's a different sort of stress, you get that rush and it makes you act
(Denise).

For some a busy ward is seen as a positive stressor that encourages the qualities of good time management, forward planning, prioritising and oversight to be used effectively, which can be contrasted to quieter shifts where the impetus to complete all tasks is diminished:

……just have it in my head, planning ahead, looking at all the eventualities. I
actually find that I function properly, I function quite well… it's the quieter shifts I
tend to forget things. Not important clinical things you know, just a bit of
paperwork or something (Gabbi).

However for a midwife who finds these daily challenges do not fall within the realm of eustress but in fact cause 'distress', the negative stress engendering negativeness and a disturbed body/mind state (Lazarus, 1993), then that midwife will not be comfortable and be less likely to consistently perform to expectations within the birthing suite environment.

Within birthing suite there are recognised challenges that will potentially confront a midwife at any moment and in this vein there is in the mind of midwives a scale of stressful events that is pertinent to the area. As suggested by Denise - s*ituations such as a prolapsed cord will cause greater stress than a 'snapped cord'.* While a labour that does not proceed as anticipated may cause some mild stress, an experienced midwife will use her knowledge and expertise developed over time to recognise any variation from normal and have the confidence to manage it competently. However in situations where

there is a more imminent threat to the well being of the mother or baby, for example a post partum haemorrhage or fetal bradycardia, this is registered as 'very stressful', but there is a sequential process that has to be followed as inner reserves and knowledge are drawn on to respond appropriately:

> *Deep down you realize what's happening and you have to deal with it sequentially, you just get on and you just do it, and yes you do need help, but you are still the first person there and you've got to act on what you are actually observing, and I think that is a big example (fetal bradycardia), another one is postpartum haemorrhage, that's a really good example too, where you have got to deal with it very promptly to prevent further deterioration and I think that is another good example of stress (Helen).*

However when there is a continuous flow of the more high risk, complicated or difficult cases with little respite offered through a balance of normal births there can be a cumulative effect in the most experienced midwife leading to an element of distress – *it was a series of events, the straw that broke the camel's back (Faye).*

For those who find birthing suite is not an area where they experience eustress, that is a sense of achievement, fulfilment and personal gain when placed in stressful situations, all aspects of a labour and birth create in turn an element of concern or distress which is replaced by solace when the outcome is normal. These feelings of concern are exacerbated if the midwife has limited experience in the area or if the pregnancy or labour is not within the parameters of 'normal' such as with twins or a forceps birth. Therefore while they may not have experienced any major calamity, some 'nerve wracking' moments will have occurred where there has been a realisation that an outcome may be less than optimal:

> *I haven't had any huge things happen to me in labour ward. I mean I've had frights and that of course. I was in the birth centre and a lady delivered and I was there on my own. The other person had gone off somewhere and the baby was flat. I had just walked in to relieve and all of a sudden this baby was born, and that was sort of ……… I really needed help. So I suppose that was a bit nerve wracking at the time. But it all turned out okay (Julie).*

While gaining experience in birthing suite anxiety is created in knowing that one may be faced with a novel situation where there is the expectation to still respond appropriately and any disruption to the smooth flow of the process is magnified. Even after gaining experience and being well drilled in the procedures, this notion of wanting a smooth flow of events remains:

> *You know you need to be on the ball, act quickly, keep good documentation, hope*
> *all the equipment is right. I remember taking a woman for an emergency 'Caesar'*
> *and the oxygen mask fell off. It was only a small thing, but in the whole process you*
> *want things to go smoothly (Irene).*

This may be linked to the expectation that a certain level of expertise will be achieved and maintained with regard to many procedures irrespective of how frequently they are performed. Another additive is the recognition that a midwife has much autonomy that creates an added onus of responsibility and accountability. This will result in an intrapersonal revisiting of some events many times over when it is considered a wrong decision may have been made.

Despite many years of experience novel situations arise that may cause stress for the midwife. While the novel situation that requires management of itself may not be unduly stressful, it can be its management in concert with ensuring the fulfilment of the woman's preferred outcomes while reconciling any intrapersonal dissonance that may be creating an internal tension. This internal tension does not hinder the midwife's ability to provide the expected or required care, but can prompt lingering emotional introspection:

> *I remember one girl who had hidden her pregnancy from everyone and denied it to*
> *her mother when she had asked …......she didn't want to look at it, didn't want to*
> *touch it …… she wanted it taken straight out of the room and never wanted to see it*
> *again. I found it very alien really. I knew her situation, but it just seemed alien, so*
> *foreign really to what you are used to doing (Irene).*

Further to this, in some instances the expectations of the parents can be unrealistic and difficult to reconcile or support, such as where they have an expectation that their extremely premature child will be salvaged. Any dissonance experienced by the midwife is compounded by the tacit understanding that she will care for that case in subsequent shifts across the duration of the woman's stay in the birthing suite.

An overarching tenet of care is that the midwife will to the best of her ability provide the birthing experience the parents wish for. When there is success in this endeavour there is a reward of satisfaction in having done her job well. However while she may technically do her job well there can be extreme frustration generated through an unwillingness by some parents to acknowledge the facts or through maintaining a dogmatic adherence to their preferred birth plan. This can occur despite the best efforts of the midwife who will have provided detailed explanations in an endeavour to keep the couple informed of the reasons behind any need to change a plan or why their plan is no longer feasible.

Subsequent meetings with those parents where the outcome was not a desired one either because their expectations were not met or the baby has succumbed become problematic for the midwife.

In discussing the various stressors many of the midwives also mentioned the support they had or felt they required but was not there which added to the burden of stress experienced. At the Meta level this was linked to the general shortage of and retention of midwives which makes it difficult to share the workload appropriately and evenly:

> *Stress is having too many patients with not enough staff and a lot of inexperienced*
> *staff to provide good care that they expect to give and the patients and their*
> *relatives demand to have but the current climate makes it difficult to meet these*
> *demands (Erin).*

and in other instances it was related to the fact that ancillary services are only readily available during business hours, meaning that there are many hours of the day where it is difficult to access the required supports – *We should be able to lift the phone and get appropriate assistance – social worker if that is indicated (Erin).*

At the more micro level the discussion focused on issues involving personality types and the communication skills of those with whom they were working. Some staff members were portrayed as inherently unsupportive or dismissive or as being deficient in relation to their communication skills – *Your stress increases when you have a situation of concern and you are concerned about the reaction of certain people. That increases your stress level (Irene).*

There was some mention of discrepancies in the outlook or agendas of different departments and wards that also create some tension. This can arise from a lack of understanding or awareness of the various demands of any given area or the different values and practices that may be adhered to by staff. The result of these discrepancies are various and include feelings of work overload when a particular task is requested for completion 'ASAP' by another department, or there is a need to spend some time in carefully explaining to a woman why something that was thought to be possible is no longer possible, or the need to advocate for a woman in a range of circumstances:

> *I had a woman and baby with an interesting condition and it was distressing*
> *because she was in a cubicle with a curtain across the door that kept getting flung*
> *back, and it was open to the rest of the world. I had people wanting to come in and*
> *watch, not liking it when I refused them entry (Faye).*

Apart from the issues directly related to their work, a majority of the midwives had experience of a work / home / family nexus that fed into the genesis of their stress. As Bellavia and Frone (2005) report

in their review of 'work-family conflict' this conflict can occur in two directions, and this was the case for the midwives interviewed. While much of the conflict for the midwives was expressed as *work to family conflict*, that is managing shiftwork in terms of the family and family commitments (breast feeding, attending children's school functions or extracurricular activities), managing the expectations of extended family who lack an understanding of the inconveniences of shiftwork (particularly night duty) and managing the stress they may be experiencing without letting it impinge on family life, there were also midwives who revealed *family to work conflict* by expressing concern at not being able to attend in-service training or being restricted in the number of shifts they were able to work because of family commitments. This suggestion is consistent with the research reviewed by Bellavia and Frone and in terms of outcomes for midwives it appears that whilst either form of conflict predicts lower levels of job satisfaction, *work to family conflict* is a better predictor of job turnover, intentions to quit and lower levels of organizational commitment. This is contrasted with *family to work conflict* which sees employees requesting greater work flexibility.

Role stress

In their discussion of role stress Beehr and Glazer (2005) suggest that it arises from the demands, constraints and events within the work environment that influence the individual's role fulfilment and that it is associated with either the individual's perception of the expectations others have or their own perceptions of what their work behaviours should be. This is in contrast to the more general conception proffered by Lambert and Lambert (2001) as compatible with the definitions used around the world in their review of role stress on nurses. It is suggested that role stress/strain occurs when the expected characteristics for a role vary from the actual outcomes.

In considering midwives, each of whom may have a perception of what they want to achieve as a midwife, it can be argued there is a 'collective perception' and expectation of what it is to be a midwife. Paramount in the formation of this 'collective perception' is the definition of a midwife as adopted by the Australian College of Midwives (ACM), with particular emphasis on that part which states that:

> *The midwife is recognized as a responsible and accountable professional who works in partnerships with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife's own responsibility and to provide care for the newborn and infant (ACM, 2005).*

The notion of a 'collective perception' aligns with the view that "a person's role is based on inferences made from other's expectations for attitudes and behaviours" (Beehr & Glazer, 2005, p. 10)

As an AUM or UM it is accepted that they bear a greater load of responsibility, however any strain they experience is amplified when a RM does not fulfil the 'collective perception' of what it is to be a midwife:

> *The stress of staff not taking responsibility for themselves and certainly some staff members are happy handing over their responsibility to you, asking 'What should I do about this?' 'What should I do about that?' and they often think they're supposed to call the doctor all the time instead of acting as a midwife. And what the doctor thinks should be done are sometimes quite different from what I think should be done in terms of care and people don't seem to take responsibility for their action and that's what a being a midwife is really (Anne).*

This quote highlights not only the strain associated with being in a managerial position but also the stress that may arise when the RM being spoken of comes to the realisation she is not fulfilling the 'collective expectation' of what it is to be a midwife.

In their review of past research into 'Organizational Role Stress' Beehr and Glazer (2005) discuss the concept of 'role overload'. When it is considered as a distinct construct it is seen to be due to an incompatibility between work demands and the time available to satisfy those demands. While a case can be made to suggest all midwives experience 'role overload', it is the midwives with a managerial role in particular who have this experience. This is due to the need to often fulfil not only a managerial role but to also play a clinical role.

Further to the notion that it is the perception of other's expectations that instigate our experience of role stress (Beehr & Glazer, 2005) a unit manager may experience a unique tension in that role because her focus is often divided across several levels simultaneously. The complexity of her role is not always appreciated by many of the staff and is complicated by her perception that she is judged as lacking in organisational skills. This perception stems from the management role having precedence, a reality not appreciated by all birthing suite midwives who expect her to be available to fulfil a clinical role as required. Other factors additive to perceptions of expectations include requests from other departments for assistance from her or one of the birthing suite midwives to complete various tasks (assistance with audits, data gathering exercises) that increase her workload, the need to maintain clinical skills and be abreast of latest developments, a requirement to be inclusive of all staff and know them both in the personal sense and at the level of their clinical competencies in a situation of constant rotations.

The need to be focussed in several directions is repeated for the AUM's where they find they are unable to approach their work methodically but must balance appropriately attending to the needs of the staff and the people they are caring for. An internal tension arises in senior midwives because they cannot

reconcile their inability to provide optimal care due to the demands of their seniority. Ultimately their sense of adequacy and thus their sense of control are challenged, the constituent determined as underpinning the stress experienced by birthing suite midwives, resulting in diminished job satisfaction because of the perception that they have not performed to their expectations:

> *At the end of the shift you reflect on how unsupported the junior midwife was, and*
> *the woman in your care, and you go home feeling that you've not really achieved*
> *much. You feel it's not a job well done, there is little job satisfaction and you are*
> *unfulfilled (Erin).*

Incorporated into this constant balancing act is the ad hoc need to undertake a variety of tasks and roles to ensure the smooth operation of the area. This can include the need to work with 'domestic services' to have beds and rooms cleaned expeditiously, maintaining oversight of unfolding events to ensure junior doctors and midwives do not make any grave mistakes, managing interactions with more assertive and sometimes aggressive staff members or discord between departments, all while taking some responsibility for the actions of others. Additive to this common situation can be the knowledge that legal consequences are pending for a past case with an attendant need to be discreet and understand the legal requirements. A counterpoint to this is a description of the role stress for those with any managerial responsibilities was given by one who took a 'sabbatical' from birthing suite to work in a caseload model of care:

> *When I go to work I don't have to worry about anyone else. I have my client to care*
> *for, and I cared for her and go home when I've finished. I don't have to be*
> *worrying about the other rooms. I stay in my room and I don't have to worry about*
> *the other staff and cooperation. Sometimes I need help with something, but it's*
> *usually a transient thing. I don't have to worry about anything else that's going on.*
> *I can just do what I have to do (Gabbi)*

The registered midwives interviewed presented as having a preference not to work in-charge, although many found that they had been required to work in charge at different times when their preference not to work in-charge was overridden by a necessity to cover a period where an appointed person was not available. The effect of this was to give them a greater appreciation of the role:

> *Sometimes I look at the skill mix for the shift and there is one person at the tip with*
> *all the skill. I think it must be awful for that person who is in-charge. When I am*
> *occasionally in-charge I think times must be tough (Barb).*

Some midwives attempted to restrict their level of responsibility by being content with a RM or CNS grading because of a perception that with each promotion a greater personal commitment was required,

and this was not compatible with a commitment to family. This strategy was not always effective for them however because years of experience was accompanied by the notion and expectation that extensive skills would have been acquired which equated with a belief that greater responsibilities with respect to workload and case load could be taken on:

> *When you're there for a certain amount of time, and you gain more experience and*
> *become more senior, more things are expected of you. You are expected to cope*
> *with certain situations (Irene).*

For those midwives working at the level of RM or CNS, a source of 'role overload' for them is the requirement to fulfil the function of teacher/preceptor/mentor for the various students and new staff while also carrying out their clinical role. While this role can be rewarding and create little stress if the student is confident, involved and enthusiastic – *If you have a great student midwife who is confident, eager to try things, that's good (Irene),* but if they lack initiative and require constant direction and there is the responsibility to provide adequate support while ensuring they become independent and manage events appropriately is not only time consuming but emotionally demanding:

> *…… stressful working with junior staff who are not too sure what is happening,*
> *they are learning, particularly students. You are trying to observe what they are*
> *doing plus do your own job as well. That's pretty difficult, you are trying to give*
> *them independence yet you are trying to observe that they are doing it in the*
> *correct manner, and that's difficult (Helen).*

While the role stress discussed above may have nuances that are particular to midwives, a role stress that is consistent with previous research as reviewed by Lambert and Lambert (2001) involving nurses around the world is the difficulties associated with shift work. Of particular concern to the midwives interviewed was the problem of not sleeping well between 'short changes', a situation exacerbated by a busy shift or one where a critical event had occurred:

> *That's a hard one (finishing an evening shift). I don't sleep at all. We had a really*
> *particularly busy shift on Tuesday night and the last hour was really like "Phew,*
> *full on", and none of us slept. We all went into work yesterday with our eyes*
> *hanging out of our heads because none of us slept, we couldn't switch off. There*
> *was nothing nasty, everything was a good outcome and everything, but our minds*
> *were still working overtime. You can't switch off if you have a busy shift (Helen).*

<u>Reactions</u>

The majority of the reactions described by the midwives are typical short-term symptoms or features of stress that were one of either a physiological, emotional, cognitive or behavioural response. While the

dynamic nature of birthing suite may suggest that physiological responses would predominate, in fact the most commonly described reactions were of an emotional nature.

It is an unfortunate reality that many of the emotions aroused by stress are negative and have associated affective responses that are detrimental, whether these are manifested as anxiety, depression, tension, sadness, frustration or somatic symptoms such as headache and sleeplessness. When asked to describe what they considered stress to be or how they recognised it, the midwives' spoke of people being tired and disinterested in work, there were expressions of feelings of anxiety, irritability, frustration and lethargy while some mentioned developing headaches or rashes. All of these were noted by the midwives to be negative either personally or with regard to their output or effectiveness at work:

> *But I do know of all that, there comes a time when one… if you just push yourself too much and then you stop, you certainly feel that it's just not working and you get slight 'hiccups'. It really drags you down, literally, because you have been pushing yourself all the time (Barb).*

Of interest is the fact that for some the stress had passed before it was recognised. This was in relation to both general events as they occurred in birthing suite:

> *To identify that I'm stressed it's more often than not retrospective. If I look back over an hour, I might have been raising my voice, getting upset about something I don't usually get upset about, or feeling like I'm not coping, that I'm one step behind the eight ball (Denise)*

and the physiological reactions triggered by a crisis or emergency event:

> *You don't feel stressed at the time, you just do it and then it's after the events that you realise that yes you were stressed, that adrenaline has certainly built up. And that happens to me. I don't realise at the time, I just do it and then after my heart is racing. Yes you feel that tremor, you realise you are breathing faster; you can feel it (Helen)*

while other midwives immediately recognised their emotional stress response and where it arose from – *When I am stressed I am aware that I become very irritable with everyone as I am unable to achieve what I want to (Erin).*

When revealing their reactions to the stress being experienced, the midwives displayed an awareness of the effect this had on both their colleagues and those in their care. In acknowledging their displays of emotion there was a realisation that such visible evidence of stress was seen more commonly than thought ideal with these manifestations affecting colleague perceptions of and interpersonal interactions

with the individual. Further to this, a physiognomy suggesting stress was considered detrimental by inducing stress in those around them while also adding to a sometimes escalating process where the stress experienced by one midwife fed off the apparent stress of another. The recognition of such implications activated strategies for some to regulate that response – *I'm very much aware, and I'm aware of the people around being aware of my irritability. It doesn't do any good so I sit down and count to ten and get past it (Erin).*

Although conceding that emotional reactions to stress had an adverse effect, some midwives justified these reactions. Some considered it was not unreasonable to become agitated, frustrated or irritable when caring for 'difficult women' such as those with a drug dependency or where the midwife's expertise and assistance had been sought and was then disregarded. In that context, anxiety regarding the outcome of the baby was seen to justify any emotional reaction. For others, emotional reactions were seen as a valuable release of tension, or because of an expectation and acceptance that midwives would show some reaction in circumstances where a task oriented ethos was paramount. In fact there were situations where some emotional reactions were thought to be of benefit because a necessary sense of urgency was imparted, albeit at the expense of an individual's feelings – *If there is a life at stake I don't mind if some toes are stood on (Denise).*

While an emotional reaction was often manifested as a visible response to stress, various emotions were bound to that reaction. As part of the coping mechanism, these emotions were processed by the midwife. In a situation where the midwife felt overwhelmed by events but her concerns were validated by colleagues, cognitively any sense of inadequacy is quickly assuaged. However where the midwife disassociated from events and avoided the emotional content, when she faced it again the emotion was found to lie just beneath the surface – *I hadn't thought about them in between my shifts, and I hadn't come back and looked up the book to see the outcome. Then when I saw her I was very sad for her and her husband (Chris),* thereby prolonging the duration of the reaction.

While the cognitive aspect of midwives' reactions will be discussed more extensively in relation to the appraisal and management of stress, it is worthwhile considering the instinctual midwife reaction of reflection. It seems to be a habitual reaction for a midwife to reflect on her practice, particularly where events have been outside the realm of 'normal' (have deviated from an expected path). The perception that each individual midwife needs to stringently review her practice can institute long periods of reflection, ensuring that troublesome events remain in their consciousness for extended periods:

> *I find that difficult deliveries stay with me a rather long time. I go home and stew about it, wondering if I could have done something differently. I really look at my practice; consider what I might have missed, when I called the doctor … … (Erin).*

68

This means that the stress was taken home where the manifestations of the reaction impacted on family, friends and shaped the ongoing well being of the midwife. While reflection was considered to provide insight into the reasons for the reactions of all those involved, there was an associated depletion of energy and strength, especially if sleep patterns were disturbed in the process.

The physiological response, commonly known and described as the *fight or flight response*, was often associated with having a positive effect where it was seen to activate an appropriate response in terms of the actions required to manage an emergency situation – *When you see a situation and you realize that you have got to deal with that situation, you deal with it ... ... (Helen).* The sequel to this is a euphoric release when the crisis has passed – *You are sort of on a bit of a high, I find that. It's an automatic response and it's only after that you do realize that 'Gosh, thank goodness that's all over with' (Helen).*

Cognitively, the midwives would query how they were going to cope with any given situation. While stress was being recognised because of an internal sense of heightened vigilance, agitation and an inability to relax, there was an increased caution in observing events and in any decision making processes, which were perceived as remaining clear. This was more apparent in those who felt experienced in the area and who identified that an appropriate response required understanding and forethought:

> *I guess I would stop and think what was happening for me in my head. Why is it creating stress? If it was something I knew I had to deal with anyway, it is not having control over that. I think it through (Gabbi).*

This response can be contrasted to someone who may happily work in charge in other areas of the hospital but prefers not to when in birthing suite because when she does it results in both a physical and particularly a mental exhaustion:

> *……it's very stressful and I would have been exhausted at the end of the day , both physically and mentally, mainly mentally. I would have been glad the shift was over. I don't feel the need to be in charge in delivery suite at all. I don't mind being in charge in other areas. Out of all the areas of midwifery, delivery suite is the most stressful for me.*

It can be argued that these two responses typify the notion of eustress and distress for midwives and was identified by Gabbi when she said:

There are different sorts of stress. There is positive stress and negative stress.
Positive stress is something that stretches you. You work harder, you strive for
something ……… you feel like you have contributed to whatever is occurring and
you don't feel any adverse emotion ……… With negative stress I think it impacts on
your emotions and affects your ability to work ……… I often get headaches. It's not
usually until after the event I feel my heart racing and I feel I haven't done the best
I could.

<u>Management</u>

The manner in which the midwives managed the stress they experienced can be broadly divided into the immediate management, or the steps they undertook whilst at work to minimise, control or modify the stress being experienced and the subsequent management, or what they did once away from work. The steps taken were dependent upon a set of beliefs they had. The beliefs ranged across such things as personal discipline and planning – … … *I say I discipline myself that I must do it. ……so the best thing is to do is just sit down and plan … (Barb),* individual behaviours as a manager – *you need to be able to take control and you have to take control (Erin)* or *To appear calm, logical, rhythmical is ideal (Denise),* and individual behaviours as a registered midwife ... … *it's no use getting angry at him (husband), he probably can't help the way he's behaving ... ... you just have to sort of keep calm ...(Julie),* personal development *I've been to lots of courses about managing stuff and stress and conflict ... I felt perhaps my interpersonal skills needed some help (Gabbi),* personal coping strategies – *If I need to I deal with things actively and then put them away (Chris),* and the work experience they have gained … … *that's an experience thing, some things can be left for a while, it doesn't really matter (Helen)*

When considering the management measures adopted, these can be further divided into the intrapersonal and the interpersonal. The intrapersonal is associated with the inwardly focussed measures the midwives adopted to maintain their well-being. The interpersonal are the more general measures taken to maintain the wellbeing of all in the most relaxed environment possible.

When considering the immediate management of any feelings of distress, one of the more common methods of managing such manifestations at the intrapersonal level was to take 'time-out'. This typically involved taking a short break from the ward whenever it was practicable to do so – *anyway, taking time out, if it's humanly possible, just five minutes in total I think can help. That's a method I've used for many years ... I seriously endeavour to do that …… (Anne).* For some this effect was gained by focussing on the care of the woman to the exclusion of all other events for a short period. In a more extreme situation where there had been a culmination of events and personal management strategies had failed, the 'ultimate time-out' was taken by accepting a position in another department:

There was a shift that came up downstairs in January, and so I sort of fell into this position. They were looking for new staff and I thought I would apply, I'll have a go and if it doesn't work out, I can always go back (Faye).

Another strategy employed at the intrapersonal level was to remain honest and frank with other staff despite any embarrassment that may ensue – *To manage that I would never pretend to know. I would be up-front in saying I don't know (Denise)*. Therefore, any mistakes were immediately admitted to, advice sought when knowledge was lacking, or recognition and admission that a situation was likely to become stressful. This allowed the midwife to take the appropriate steps to minimise immediate and potential stress.

Communicating with other staff for the purpose of problem solving and gaining reassurance as events unfolded was important at the intrapersonal level. An extension of this was debriefing with colleagues during, immediately following and subsequent to the shift, while any unresolved issues or client outcomes were followed up (often prior to their next shift) to gain closure:

I also have a network of friends who are nurses and midwives I can speak with openly and after dealing with the kids; I would be on the phone to a girlfriend if I was really upset. Also I would check with work to find out an outcome and close it (Chris).

The significance of being able to debrief informally with colleagues as the primary option for managing stress at the intrapersonal level was very apparent. As a function of being a shift worker some midwives encountered difficulties in being able to debrief with a trusted colleague when there had been an event on an evening shift, resulting in a sleepless night as events remained in consciousness with little chance of resolution. To minimise this and gain some sort of closure on an event before going home – *I would always seek closure on an event before going home. I couldn't go home without knowing what is happening (Erin).*

Continuing at the intrapersonal level and as an adjunct to the debriefing when away from the ward it was common for the midwives to reflect on events to better understand what had happened, to develop strategies to better manage any recurrences and to consider if and what other actions were required. Having done this distracting activities were then often pursued to counter the stress and for relaxation. While exercise provided some with time to reflect - *I suppose I'm going through, have I, did I do everything right? (Julie),* for many it provided an opportunity to focus on the activity and avoid all thoughts of any work events. Clubs and groups provided a similar utility where the focus of discussion aligned with the club's core purpose.

The activities the midwives participated in served to provide balance to their lives and the opportunity to distance them from the stress they were experiencing. These activities ranged from various forms of regular exercise to participating in book clubs, groups for handcrafts or gardening, or by making a conscious effort to unwind through listening to relaxing music or watching a favourite movie.

At an interpersonal level there was recognition that personal reactions will affect how others perceive and react to events – *Some staff can create an air of panic because of their actions, because of their stressed nature (Erin),* and in this vein having or adopting a professional persona was mentioned – *I put on a professional hat and maintain it for the shift (Gabbi).* To this is added the ability to communicate appropriately with all the people with whom there is contact – *So (patient) demands can be a bit tricky, but you learn to deal with them and talk to people* or *I would think my concerns over and confer with other staff members to get their opinion …(Irene).* In some instances it was deemed appropriate to delegate some tasks to other staff members or to seek their assistance – *any difficulties I have I run by the person in charge (Chris).*

While some midwives balanced work and family by taking a less stressful role - *I'm married with a couple of kids and have issues at home to deal with … so I'm very happy to come to work and just be the 'working bee'*(Chris), for some with family their stress arose from or was exacerbated by balancing the needs of family and work and family needs took from them the opportunity to manage their stress as desired, for others tending to the needs of family provided a diversion that assisted them in regrouping - *…… the routine is good too, sit and have the dinner and then think well now get back to it. No doubt that recharges me* (Barb).

For the midwife who took the 'ultimate time out' and no longer worked in birthing suite, she had considered stress leave as not valid, invoking the thought – *…"what a lot of poppy", you know, because to me it seemed like a cop-out (Faye),* found herself in the situation of leaving birthing suite and moving on in terms of job expectations but remaining emotionally static – *I'm (emotionally) just stationary at the moment. I'll regrow next year; I have to give myself time.* This followed a period prior to her departure she described as falling into an abyss where her coping skills became diminished but finding herself unable to avail herself of the available supports. This ran parallel with her notion of viewing work as one facet of her life, not the focus and was juxtaposed with an internal belief that to pursue a regular activity requiring a recurring day off or shift each week would be selfish, unhelpful and unfair in terms of the smooth functioning of the ward and her colleagues needs.

The support resources available impact most noticeably on the level of stress that is experienced for all midwives. The mode of the stress experienced in relation to the support resources available varies according to the role the midwife fulfils.

It is clearly understandable that when the ratio of women to staff is high the staff will feel under greater pressure, or when there is a preponderance of junior staff that lack experience and expertise there is a heightened sense that a situation may spiral out of control more readily. However, it is the mode of stress that is also significant in this process.

Central to providing good care is having sufficient staff with an appropriate skill mix and providing good care is integral to the midwife's self-actualisation. Adequate staffing levels provide the opportunity for appropriate oversight while sustaining a less demanding clinical role:

> *Personal satisfaction and a sense of fulfilment comes when you feel you have done*
> *a good job, which is more difficult to achieve if there is not adequate staff,*
> *adequate experienced staff, inexperienced doctors, then you can't provide good*
> *care (Erin).*

For the midwife who has the responsibility of being in charge when there is a higher ratio of junior staff to senior staff, there was greater difficulty in maintaining oversight, supervision and teaching. Such ratios curtailed discussion of care management issues, thereby limiting learning opportunities. While the lack of permanent staff requiring the use of bank and agency staff has in part been overcome by the advent of 'core staff' there remained a need for the senior midwife to maintain vigilant oversight. This was impaired when as a manager the midwife was required to also undertake a clinical load, making them less available to other staff. The availability of experienced staff can allay some of the stress experienced by more junior staff.

For the midwife who is less experienced and does not work in charge, the presence of available senior staff engenders a more relaxed persona, but when there is a perceived or real lack of support from more experienced midwives there are feelings of agitation. This is related to working with colleagues in whom you have confidence which provides a sense of security, reducing stress especially in emergency situations. Therefore junior staff are sustained and nurtured by the presence of senior staff – *It's good for me when there is at least one more experienced person on the ward I can go to (Chris).* However if there is the perception that an individual threatens your self-esteem, or if they have been dismissive or unsupportive in the past there is a disinclination to approach them for assistance. Witnessing such situations also gives rise to some disquiet in the other staff on for that shift.

The concept of what are appropriate support resources is multi-faceted and complex. The midwives' perception is that the hospital is resourced according to the numbers who present for care with little recognition given to the demands placed on staff due to the often complex needs of many women:

> *I don't think the hospital realizes what the clientele is actually like and has never really been looked at. We are dictated by the numbers of patients who will require this number of staff. We have needy clientele with many social issues who have to spend a lot of time with you, but this is not recognized. The needs of Mr & Mrs Average from Malvern is very different to Miss Smith, 13 year old from Broadmeadows (Erin)*

This is a situation exacerbated when unfolding events overwhelm available resources creating tensions and increasing stress for all staff.

An example of such tensions arising occurs when there is a lack of appropriate ancillary staff. While more senior staff see it as appropriate to fill the breech and perform any tasks as they deem necessary to maintain good care, more junior staff do not see it as their responsibility – *I know it's not our job to do PSA's work, but sometimes circumstances beyond our control mean there isn't one and we all need to work together (Erin)*. In such circumstances the provision of a clean room / bed is linked to providing good care by the senior midwife, which provides her with both personal and job satisfaction. On the other hand some staff view it as not part of their role and a requirement of the hospital to ensure the appropriate staff are provided.

Debriefing:

<u>Purpose and meaning</u>

The view of an experienced midwife interviewed for this phase of the study is that the purpose for debriefing is twofold. While it was considered particularly important for the junior staff to be able to discuss the more emotive events and issues, it was also thought to be educative to reflect on the progression of events as they had occurred, a sentiment reflected in the comments of Helen who agreed that there was both an element of seeking reassurance and seeking knowledge - *…but some people might say 'Oh, I would have done this', and you are saying 'Ah', gives you food for thought; maybe next time I'll try that one. So you can learn; it can be a learning exercise too.* Additionally clarity surrounding particular events and strategies for future experiences are also provided, supplementing the reassurance and knowledge gained.

There were situations where the midwife's self belief may have been challenged, but following a rational discussion with another or other midwives an essential ingredient in maintaining that self belief was provided:

I was working in delivery suite and I had the paediatrician; I think she was feeling
apprehensive about the outcome, and so she was very quick to abuse me and try
and blame me. I didn't think it was very helpful. I didn't think I'd done anything
wrong, and talking through it with others I don't think I had. The outcome would
have happened anyway. I started to feel that I hadn't done the right thing, but then,
thinking through it logically and talking through it, I had (done the right thing)
(Julie)

Interestingly however, the informal debriefing with peers was also seen as important in processing any mistakes that an individual may have made:

Part of the talking about a situation and debriefing is the diffusing and accepting of
responsibility for your actions, you don't expect colleagues to say you haven't
made a mistake (Denise)

While an element of discussing such situations with a peer may stem from a need to unburden and reduce the stress being experienced following a challenging situation, the more significant aspect arises from the need for and provision of non-judgemental listening and the restoration of some self-esteem. In some circumstances this form of support may have come from a trusted friend with whom the midwife had chosen to debrief.

The notion of unburdening is the other important purpose of debriefing and integral in maintaining the wellbeing of everybody. In some situations it was recognised that there was not a complete solution but that resolution could be achieved by talking through the issues rather than seeking improbable change. In fact apart from the emotional support gained from the empathic listening, for many midwives there was often no specific outcome expected from the informal debriefing process that they engaged in.

The fact that the midwives saw debriefing as an opportunity to not only unburden and gain some emotional support and restoration or maintenance of self-esteem, but also as an opportunity to reflect on their practice and to learn from the experience provides an insight in the logic of who they chose to debrief with.

An overarching characteristic of this debriefing is akin to what has been described in the field of counselling as 'peer collaboration'. This is where an equal and non-hierarchical relationship exists between colleagues who discuss their practice, facilitating learning while working toward a common goal (Barlow & Phelan, 2007). Similarly, in a qualitative study of novice nurse, Mangone and King (2005) concluded that formalised peer group debriefing sessions improved the novices' psychosocial experience while raising organisational awareness of the need to provide emotional as well as clinical support. These approaches can be contrasted to the more standardised techniques of debriefing and

crisis intervention where the aim is to minimise or prevent post-traumatic symptoms and sequelae (Busuttil & Busutill, 1997).

<u>Debriefer selection parameters</u>

Individual midwives expressed an array of reasons for selecting those that they chose to speak with or not speak with. For example, when senior midwives spoke to a colleague it was considered more prudent to choose one who shared a similar level of experience. It was also common for the distinction to be made between the role of family and the role of colleagues. The reasons for preferring a peer centred on their ability to provide erudite empathy, facilitating a highly valued but informal debriefing dialogue where the midwife felt listened too:

> *(other midwives) ...because they understand the problem, they would have gone through it themselves; they know exactly what you are going through, you are more comfortable because you don't have to set the situation up in their mind, step by step. You only have to say a few things, they say "Right" and it makes it easier for you (Irene).*

Where a family member had some experience or insight into the requirements of counselling, they were also considered appropriate as they were able to provide unconditional support, however a distinction was made between what could be told and how it was told when discussing events with peers versus family. The suggestion was that the perspective and humour adopted at work would not be understood and most probably misconstrued outside that environment:

> *Sometimes what I would say to my peers might be construed as harsh and judgemental about the couple that I'm working with …… um I wouldn't say it to everybody, we joke with it. Well I think it's because we've worked together … (Anne)*

A common assertion made by many midwives was that discussion of the more sensitive events and issues, such as a fetal death or mid-trimester termination, outside the circle of colleagues was taboo. This self-imposed censoring of these more sensitive issues was not only to protect the general population from some of the more unpleasant realities of the midwife's role, its effect on them as midwives and the responses engendered but also to protect themselves from any unwanted questioning and discussion regardless of any self-reproach they may feel:

There was this couple at work, they were in the MTS service and I was sort of at a stage where I was thinking 'I'm a bit over this'………… after the chaplain had been to see her, she came out and said "Oh look, I'm sorry, I've left that couple crying". So I go out and she is sobbing her heart out……um, you know I just didn't know this had happened, but in my head I'm saying "Yeah, yeah, just get on with it".

I obviously did all the right things and a week later we got this card and I was telling a friend about it and I said "You know, I'm a bit embarrassed with regard to this story. I didn't feel a thing after the baby was born. She was crying, the husband was just sitting there"………… but I wouldn't say that to a sister because they wouldn't understand (Anne)

It can be suggested that the content of any discussion with friends or family is largely dictated by the level of understanding they are likely to have of the work issues and environment. Each individual fulfils a role, with a partner and other family members providing stability, colleagues and midwife friends providing support and lay friends providing escapism. Where the emotions were concerned, it was considered more appropriate for a professional to be consulted as they were more able to provide greater insight into the feelings expressed. Interestingly for one midwife it was considered good policy not to discuss work events with family because while there was a lack of understanding, there was also an inherent need for some people to apportion blame:

I think it's very hard to talk to people who aren't nurses, they just don't understand. They don't understand how the whole system works, and how things could go wrong. And they would think that maybe you must have done something wrong, or someone has done something wrong for something to go wrong. I just think they don't understand that things just happen sometimes (Julie).

The role of the partner was seen as being a good or valued listener, a person with whom the midwife could 'offload' but one who didn't try to provide solutions as that was not the expectation or requirement. For those who were single it was seen as important to have a friend who could be contacted to discuss a 'bad day' with to provide the emotional support required. This is contrasted with the role of colleagues who may have had similar situations in their lives which created a bridge to sharing experiences and being comfortable in debriefing with on a range of work issues as well as personal issues. However the colleague considered ideal for debriefing with on significant work issues was perceived as having a particular set of characteristics that engendered trust and respect but significantly they were not expected to routinely bring about change. In this situation the opinion of the colleague was sought to provide an opportunity to muse over events and it was this factor that was

considered the most likely prospect of resolving any issues. When a colleague wasn't available to debrief with, a friend may have been used which provided an opportunity to talk and receive some sympathy, but there was not the intrinsic understanding of the deeper work related issues that comes with experience in the field, thus a significant constraint on the overall effectiveness of the debriefing process was effected.

<u>Constraints</u>

The reasons for debriefing exist at two levels; the first level relates to being able to unburden and to receiving emotional support while the second level relates to an ongoing experiential learning process. Therefore any constraints on the midwife's ability to debrief not only affected her emotional state but also her ability to process novel experiences. While the midwives may have been able to unburden with a partner or family member to minimise some of the emotional effects, when required these people rarely had the depth of understanding that allowed the midwife to engage in a deeper discussion that allowed the midwife to process her experience or issues effectively. In this manner the constraints on debriefing were not only influenced by who was available for the midwife to debrief with but also its immediate purpose in relation to the prevailing issue.

The reluctance expressed by most midwives to speak of work issues in depth outside their band of colleagues related to confidentiality which included not only confidentiality in relation to the women, but also the confidentiality of other staff members. As an example, the midwife manger had to remain cognisant of confidentiality on many issues, placing considerable constraint on which person she was able to effectively debrief with. This isolation was mitigated by talking to peers, but rather than debrief an exchange of ideas was sought in an endeavour to provide a solution through clarification of available strategies.

Constraints also occurred when some of the details were perceived as unsuitable and improper for others either to know about or to have to deal with. This could relate to a partner where there was a personal history:

> *I hold stuff back, partly because he doesn't understand, and because of our history,*
> *our personal experiences, I sort of protect him a little bit too (Gabbi)*

or family and friends:

> *Some sad situations we deal with people are not aware of, and really I don't want*
> *to make them, they don't need to know (Irene)*

There were also instances where a trust or a confidence had been betrayed – *I didn't feel it would be a problem in this relationship and it was. I trusted someone and they betrayed me (Gabbi)* – which created wariness in making disclosures to colleagues.

A factor for many pertains to being a single person and therefore not having an accessible 'sounding board' at all times. In some situations a simple 'unburdening' discussion was seen as necessary but if this followed an evening shift it became problematic:

> *Sometimes you don't want to have to make the effort of thinking who to ring and if they will be awake, or if you will be disturbing them. Sometimes you just want that person to be there rather than have things chewing around in your mind; a more immediate face to talk to would be good sometimes (Irene).*

While for those with a male partner the effectiveness of debriefing with them was mitigated by the inherent gender differences in communication style and the expression of emotion. Associated with this gender difference was the nature of the support where it was perceived that it became a problem solving exercise for the male where as the female simply wanted to unburden and was not looking for solutions.

With regard to the nature of debriefing three types were identified. It is apparent that reciprocal relationships exist between the three debriefing constituents already discussed and the nature of debriefing sought. The purpose of debriefing will determine the nature of debriefing that is sought, however if the selection parameters are compromised this will affect the opportunity to achieve that purpose. Also any constraints experienced will affect the meaning of the debriefing and the nature of it, while the selection parameters are inextricably linked with both the purpose and meaning and the nature of debriefing being sought.

Succouring debriefing

The dynamic nature of birthing suite sees day to day events unfolding in a manner that can cause emotions to fluctuate from one extreme to the other in quick-time. Such emotional lability can be disquieting and a sense of equilibrium was thought to be restored by debriefing with colleagues. A more immediate debriefing with colleagues facilitated better management of the emotional work stressors being experienced. This was seen as an accessible and informal process, often being done while completing some documentation or other work – *You can do it as you clean up the room, doing something constructive as you're talking, and sometimes it's easier that way (Irene).*

A key element of such debriefing is the immediacy it offers. Debriefing post event with colleagues was viewed as effective in dissipating the thoughts surrounding and event in all but the most intense situations. Because of the recognised need to be able to talk to someone who will listen after some

shifts the more experienced or senior staff understand the importance of the availability of such debriefing and see its benefits overriding such factors as the additional workload created by providing an opportunity for this form of debriefing:

> *... well, I suppose it does add to the burden but I don't see it as a burden, I think that it's a very, very important thing to do and well I know how it felt to me. I don't expect that everybody feels the same way as I do, as in okay you have to sit down and talk about it. But, the opportunity is there, and I suggest that they do need to talk to someone (Anne)*

While the opportunity to discuss events with other staff was an integral part of each shift, it was also important to speak with people with whom there was some rapport and understanding, therefore in some instances the debriefing was done with trusted friends or family after work. The reason for discussing the day's events was to debrief in an effort to feel better than when work finished. They were not seeking answers or wanting to face criticism, and while constructive criticism that did not demean but offered strategies for the future was seen as beneficial, the main function of this succouring debriefing was to facilitate the unburdening of some concerns and restore equilibrium.

Prescient debriefing

In some instances the more simple unburdening process of succouring debriefing was not sufficient to quell the anxiety being experienced. While, as with succouring debriefing, this form of debriefing may also be very immediate, it has a greater depth to it that requires insight and understanding from the debriefer. Therefore while a partner may be supportive, debriefing with them is problematic if they have no understanding or insight into the situations being spoken of, making it of little value to discuss some issues with them:

> *I have a partner who is not medical, so I don't actually discuss a lot with him. He doesn't understand a lot. I tell him it's been busy and he say okay and gives me a cup of tea. I wouldn't discuss anything as such; I'd be more inclined to discuss it with colleagues. Someone from work who can relate to you and what you have done, it's easier than speaking to my partner. He doesn't understand that deliveries can be difficult; he just thinks babies come, what could the problem be? (Erin).*

When friends or family do not share the outlook and perceptions of a midwife or have the fundamental knowledge of the midwife's work environment along with an understanding of the terminology used by them, only a rudimentary appreciation of the issues affecting the midwife can be gained. This is seen to preclude them from providing any support that the midwife discerns as beneficial. For this reason it was

seen as essential for optimal debriefing to occur that the debriefer had had experience in midwifery, thereby enabling an empathetic discussion that required minimal explanation.

The prescient debriefing experienced with colleagues or people with appropriate insight was considered advantageous from several perspectives. Despite differences in personality, coping styles and backgrounds, there was an empathy and understanding from colleagues that engendered a conversation that was more candid and free flowing compared to the more explanatory conversation required when discussing events with family. The advantage of this was to not compound the stress experienced by repeated explanation of details and the elimination of any interest in ghoulish minutiae. The requirement of candour was also relevant in the discussion of cases where moral and ethical issues were involved. Additionally, the colleague with whom the debriefing took place may also have witnessed or been part of the experience, providing an extra dimension to the support provided and another valid and valued perspective. The achievement of such debriefing can be related to the fact that it is initiated in response to a felt need by the midwives (Weiner, Caldwell, & Tyson, 1983).

Formal debriefing

The use of professional counselling came in two forms. There were those instances where the hospital arranged for debriefing in the form of critical incident stress management, or there were those instances where the midwife arranged to undertake professional counselling. Where the midwife arranged the counselling for herself, it was undertaken in what was often termed 'exceptional' circumstances. The nature of the exception varied, but the circumstances were such that the more usual prescient debriefing was considered inappropriate or ineffective. Interestingly for one midwife, the seeking of counselling was viewed as a coping failure and a 'downfall of my personality'.

The critical incident debriefing usually occurred within 48 hours of the event, but if the ongoing impact was such that there was continued distress, then further formal debriefing with an independent counsellor was sought. The opportunity for group debriefing facilitated by a psychologist was taken up by the staff as it provided a chance to discuss events as a group, and this combined with the impartiality of the psychologist was seen as a positive experience.

In a similar vein, when it was recognised that to move forward in an exceptional situation a midwife sought professional assistance and found the counsellor was able to offer non-judgemental debriefing without cross-examination. A perspective echoed by another midwife who in the first instance was directed by a senior staff member to seek professional counselling. Having adapted to the notion, the psychologist was seen as a serene person who facilitated an adjustment of perspective by normalising the emotion surrounding the events of concern - *… she helped to normalise it … … and as everything came out, I think I just levelled out and sort of got it all in perspective (Anne),* and the midwife

remarked that this was despite having a working relationship with the psychologist prior to counselling being sought.

Support:

Support structure

The most commonly spoken of source of support was that from colleagues and this was inextricably linked to the nature of the support received:

> *If I talk to a midwife friend they would reassure me, but then agree that I have*
> *made a mistake. My husband would not necessarily be interested in the significance*
> *of the mistake (Chris).*

The support of managers was also of significance to the registered midwives: *… … our unit manager is delightful and quite supportive, which is also important (Chris),* while for those midwives in management positions an important consideration was the appropriateness of the colleague selected to debrief. Also the relationships formed at work varied according to need and circumstances, but always within the context of the unit's professional hierarchy and its dynamic:

> *The good strong relationships I've developed have been with people who are*
> *outside the unit. I'm mentor to a lot of the students, so I develop relationships with*
> *them but they are professional relationships; also my NUM and other people who*
> *are at my level. I can't afford to develop close relationships with people who*
> *aren't at my level because of the dynamic of the unit (Gabbi).*

This was one factor that dictated who those in management positions could seek to use in their quest for support. While the support of staff was acknowledged it was not appropriate to discuss various issues with them, causing the role to be typified as a lonely position:

> *…… as you know it's a very lonely role, very lonely, but I am fortunate to have all*
> *the support. But there are staff issues which I need to talk to the Director about. I*
> *must afford people trust, I don't take my troubles home … … …. I won't divulge a*
> *confidence … … (Barb).*

This theme is continued by another manager who had no expectation of support from the hospital as an institution and had difficulty in assessing any feasible level of support from senior management. She felt her support was provided by a network of friends and on management issues from other unit managers.

The option to speak to a psychologist was mentioned by several of the midwives. While the notion of seeing a psychologist as an individual had credence: *I think that I would use the counsellor if my other resources were inadequate. If my colleagues weren't nurturing I would go to her. She has seen friends of mine and there have been good reports (Chris)*, it was more commonly discussed in terms of group debriefings that were arranged following a critical event: *In fact the supervisor, if there is any problem they always organize a group debriefing with the staff psychologist (Helen).*

In summarising the sources of support available to the midwives, it can be said various sources exist for midwives of all levels with each source having a tenor best suited to individual situations and preferences. The midwives draw on these sources as required with the predominant source being a colleague or peer:

> *I feel I have a pretty good support network that works for me. I am aware of an*
> *independent counsellor that is available to us but I have not felt the need to use her.*
> *I am aware of her debriefing the team as a group for some events, which I think is*
> *great. For my personal needs, I've been there several years, so I find that the team*
> *I work with know me very well and are a great support and I feel comfortable with*
> *them (Chris).*

But this was not the only source of support with many midwives able to elaborate on pastimes they pursued away from the work environment that were also considered beneficial sources of support; the function of these sources within the *support structure* were as a form of relief from any work issues which were in fact avoided or discontinued if their role as a midwife became common knowledge to others within the group or became a point of conversation.

Characteristics

When the support of colleagues was spoken of it was most frequently in terms of the guidance received, which while it was not always exactly what they may have wanted to hear was linked with the sense that these people could be relied upon in stressful situations, all of which was predicated on them being comfortable in their role in birthing suite. As an adjunct to this, colleagues and midwife friends were also valued for the reassurance they offered in terms of recognising and confirming the midwife's competence. The nature of the support therefore ranged from being task oriented or assisting in determining an appropriate course of action through to providing guidance and emotional support:

Well if you are having a problem with something and I just ring for a colleague to come in and give me some support, I just want moral support. I ring the bell or I'll go out and I'll say "Look, I need some support in here, can you come in please?" and I find that really, there are two of us then, we can both brainstorm or you can brainstorm and then think well what else can I do (Helen).

Another characteristic of the support derived from colleagues was the sense of belonging and camaraderie: *I do miss the bond of the girls in labour ward, and at the moment I'm not missing the deliveries; I'm not missing everything that goes with it (Faye).* However, while seemingly strong bonds can occur with colleagues who share a great camaraderie, as a source of support this may be transient, lasting only while the working relationship exists: *strangely enough the people you were probably very close to in that time, I don't see now. We try and get together but there's always something else on (Faye).* The nature of the support from managers toward the registered midwives was seen in various lights. For some it was their ability to be a good listener: *I had a lot of time for her and we would just talk about whatever. I felt she was a good listener (Faye),* while for others it was the directness of the response received *…… and she always gave it to me (the direct answer). Always gave it, which was so very, very good (Barb).*

When speaking of the support of family and friends, more commonly it was in terms of an emotional closeness that was the basis for any guidance or reassurances that were given. It was of interest to note that with seniority and for those in management positions it was the provision of support to others that provided a reciprocal sense of support. The notion of playing a nurturing role whereby they made themselves available to others or assisted in arranging more formalised support was considered as beneficial to themselves also.

Aims and outcomes

The overwhelming premise of seeking support from midwife colleagues was the receiving of compassion and reassurance from colleagues, particularly in a situation of high stress:

When I seek support (from colleagues), I am looking for reassurance. In the situation of a baby with severe shoulder dystocia who died, I wanted to be reassured that those things do happen, that you are not directly to blame and that you don't always have control; that what you did is okay (Chris).

 It was also important that colleagues recognised and acknowledged when an issue had been difficult and provided empathy and did not become judgemental should the midwife become distressed or emotional:

I think recognition of the fact that it has been difficult, that this has been a difficult issue for you and you need to talk to someone about it. I think it's just the basic recognition that this is really important. Without prejudice, so there's no judgement, and you're expressing your emotions or your distress about a particular issue, someone saying they understand (Gabbi).

A midwife also expected those senior to her to be approachable and supportive and if this was not forth coming there was a sense of agitation:

If I thought I wasn't being supported, if I thought I needed support from someone more senior, or (they) had been there longer, (were) more experienced, then I would get very agitated. At times you think you're not being supported (Julie).

With respect to those in senior positions, such as a Unit Manager, there was the added dimension of providing support that would aid in the development and growth of the registered midwives as midwives. This required finding the appropriate strategies for each individual to encourage their development: *I do try different ways of assisting each one and it can be frustrating, but one must try (Barb).* By having success with these endeavours and aiding in the development of junior staff a sense of pride was gained.

The support of colleagues could be either practical or comforting and if it was lacking that was disturbing because it was valued as the most beneficial, but where closure around an event could not be achieved then professional help would be sought. There was also evidence of the experiential rewards whereby the wisdom of past managers and confidantes who had provided varying types of much appreciated straight talking, encouragement or debriefing was drawn on to address current situations.

With regard to family and friends predominantly emotional support was sought along with practical support. What was gained from this support was a sense of stability. Therefore, the support of colleagues could be both problem focussed and emotion focussed, compared with the support of family and friends where the expectation was to receive emotion focussed support:

If I tell my husband I don't expect him to understand the situation, but would want him to cook tea and be nice to me, to take the kids away and let me be myself. If I speak to a friend who is a midwife, she would understand and reassure me. My work colleagues would reassure me and provide ongoing support by ensuring I wasn't faced with a similar situation in the immediate future. So there is physical and emotional support, and there is reassurance (Chris).

Sustenance

It could be suggested that the support within this category is integral to the midwives continuing in their role because it was these sources that provided the impetus for them to prevail in sometimes trying circumstances. While family members may have provided reassurance, the greater contribution was seen to come from friends and colleagues, which was also seen as more significant than any recognition or support offered by the women:

> *…… I didn't need them telling me I was good or bad. I felt supported by the team of midwives and feel respected by them. I have generally always felt supported by the midwives even when working an agency shift elsewhere (Chris).*

A characteristic arising from such buoying sources of support was that such a supportive environment facilitates effective communication, particularly in stressful situations, instilling confidence and minimising stress. Another characteristic of this support was that it crossed divides with a unit manager deriving comfort and support from staff encouraging her to take a break. In this light it may be considered the cement that bonds the midwives: *I don't see the stresses of work making you a social person, but I think when you need to you just socialise with people that know where you are coming from (Chris).*

Colleague advocacy

Colleague advocacy was identified at all levels of experience; the less experienced midwives were conscious of supporting their peers through offering assistance and sharing workloads while more experienced midwives displayed a deeper understanding of issues of burnout. In this vein, this constituent is typified by the expressed notion that it was necessary to provide staff with the opportunity to discuss the day's events while having an awareness of the needs and reaction of the individual. For midwives with more experience or in a management position, came a commitment to developing competent midwives not only because of an obligation too, but also in recognising the professional journey they had been afforded.

Functioning in the knowledge that staff could not be replaced created an imperative to protect everybody by ensuring that the workload was balanced according to the individual needs and capabilities of each person while also matching the needs of the women to the skills of the staff. While this responsibility fell on more experienced midwives and those who worked in charge, in other circumstances colleagues made attempts to share workloads evenly, particularly for exigent cases. It was recognised that some facets of care needed to be shared to provide an opportunity to recover from caring for the more difficult or more emotive cases. This was done while recognising that perceptions of what is stressful and the ensuing levels and tenacity of the stress experienced varies between individuals, as does the coping strategies employed. Therefore by facilitating some debriefing and reappraisal perceptions could be modified or adjusted over time:

The midwife who looked after the difficult homebirth case I spoke of earlier has sought me out every shift because it was distressing for her to have the partner running around naked, especially where there were Muslim women in the ward. She was initially very stressed, but now finds it incredibly amusing (Chris).

While the preceding discussion of *colleague advocacy* is predominantly focussed on the perceptions of more senior staff and those working in charge, the perspective of those receiving this support reveals its value. It was suggested that the consequences of stress are diminished when a midwife feels empowered to persevere and succeed with the support of colleagues. Advocacy from colleagues is seen to extend to the feedback that is given, which may be evaluative, supportive and sometimes negative. All of this is accepted as necessary for both professional and personal growth:

Professional critical appraisal of what you did is good for you professionally and personally. It might be that something that could have been done differently and something to think about for the future. It might be critical or supportive, but it's something you have to go through (Irene).

Several counterpoints to *colleague advocacy* were also identified. While colleagues were generally reported to advocate for each other, there were occasions when a midwife's actions were questioned by another, creating tensions and the possibility of self-esteem being diminished. Some midwives found themselves in the position of being trapped between advocating for those in their care and facing the ridicule of their colleagues and disappointed that the colleagues could not appreciate the logic of their actions but consoling themselves with the thought that these colleagues were not cognisant of all the facts.

Also in providing *colleague advocacy*, some midwives found themselves constantly involved in the care of the exigent cases thereby having little opportunity to heal emotionally:

I wasn't able to (renew myself). Even if you are not dealing with the patient having a mid-trimester, it was in the ward and you are dealing with the staff member that was doing it. I am the type of person, even though I wasn't in the room, I would go and ask if they were okay and if I could help, or go and stand with them while they took the photos (Faye).

Corporate advocacy

The impression gained in relation to *corporate advocacy* is that while *colleague advocacy* was in the main found to be appropriate and beneficial by the midwives, the formalised structures of support put in place by 'management' were frequently found wanting. This is exemplified by the ambivalence expressed regarding the effectiveness of the Peer Support Program in addressing the requirements for

midwives of various levels and expertise. It was a program aimed at providing immediate support for critical incidents but it was suggested that a lack of both suitably trained midwifery personnel and the continued backing from management had rendered it ineffective.

The availability of a psychologist on staff was acknowledged positively by most of the midwives interviewed with several having availed themselves of the service. For those who had spoken with the psychologist the experience was beneficial, although one midwife found it a *'one way thing'* in that she had an expectation that the psychologist would follow her up as a doctor may do. Upon reflection she then considered that this may have been a method and justification for not pursuing further counselling. Therefore while there was a demonstrated willingness by the midwives to seek professional help a lack of continued managerial support was seen as depleting a program they had initiated.

While the midwives were distanced from 'management', having little direct contact with them, the midwifery supervisors formed an interface between 'management' and staff. It is of interest to note that while the perception of the support offered by a unit manager was often positive, this could be contrasted with the perception of that offered by more senior midwifery supervisors which was frequently described as lacking in some way. This was particularly related to issues of staff-women ratios where a direct link to a *sense of control* can be made, the constituent determined as underpinning the stress midwives experience. While this situation was relevant to all shifts it resonated more when occurring on night duty:

> *There is also a lack of support on night duty. There is a lack of supervisor support.*
> *We can be stretched to looking after more labouring women than we have staff, and*
> *then be made to accept further labouring patients. It is also unsafe and you become*
> *frustrated because you cannot give decent care and there is no back-up (Erin).*

A situation compounded by a perception that management has an expectation for the midwives to function to the same level as on day duty without any of the ancillary supports available at that time:

> *I understand they (the patient and support people) are stressed, but in the middle of*
> *the night it's difficult. There are organisational issues; we should be able to lift the*
> *phone and get appropriate assistance – a social worker if that is indicated (Erin).*

Such situations led to the burden of responsibility falling on the midwives who achieve what they can with the resources available but do this harbouring the perception that there is a lack of concern for them, ultimately questioning if they were appreciated and leading to an undermining of their self worth while leaving them feeling undervalued.

One illustration of the dichotomy between *colleague advocacy* and *corporate advocacy* is reflected in the experience of a midwife who took a midwifery supervisor into her confidence and revealed some personal psychiatric health details to her. This was done in the context that it was thought inappropriate as a more senior member of birthing suite staff to discuss these issues with junior staff. In her role as a midwifery supervisor she broke that confidence, ostensibly out of concern for the ongoing smooth running of the institution. This has resulted in an ongoing distrust of 'management' and who can be spoken to because of differing agendas.

Bereavement care:
Morality and ethics

It would not be immediately apparent that the complexity of the issues that arise in providing bereavement care could be centred on morality and ethics. However with improved antenatal diagnosis of fetal abnormalities and an accompanying improvement in methods of termination, the option of mid-trimester termination is one that is frequently adopted thereby creating a uniquely fraught genre of bereavement.

While there was an acknowledged burden for the parents, there was also a burden for the midwives when providing this care. Just as there were moral and ethical considerations for the parents, so there were too for the midwives. As a consequence of the unique circumstances dictating the choices made by each couple, the midwife was posed with contemplating and reflecting on the morality and ethics of each case she was involved with. Such contemplation, while bringing the notion of morals and ethics into sharper focus, ultimately served to confound the midwives, particularly where the fetal abnormality was not incompatible with life:

> *The most difficult thing for me is the reason why she is doing it. I've never had to*
> *care for someone who is terminating due to a missing limb, but I think I might have*
> *a problem with that. I see it as an ethical issue, like some of the Down's children;*
> *it's not incompatible with life. It's not clear-cut; it's a grey area (Erin).*

The moral and ethical dilemma of a baby being terminated when the abnormality is not incompatible with life is one repeated as causing great distress for the midwives:

> *One occasion I found very distressing when I worked for another facility where a*
> *woman terminated the pregnancy because the baby had a cleft lip. I found that very*
> *distressing (Gabbi).*

This dilemma was countered by the expressed notion that until one is placed in the situation of having to make a difficult fertility choice one could not be sure of what choices they may make. However there

89

was a reiteration that the context of the mid-trimester termination does not diminish the difficulty and distress experienced by the midwife:

> *I don't even remember, I think the baby had a lesion, but I don't remember, yet it*
> *was one of those that when they're born it's there (but) it's not until they grow to*
> *full term that it's really obvious. They're all very hard and very sad (Faye).*

While there was not an absolute reluctance to care for those having a mid-trimester termination, the morality and ethics pertinent to each case created an ambivalence within some midwives. They may have queried the reason or logic for the procedure but accepted that the couple had made a choice to suit them and their circumstances. By accepting it as the right of the individual to make a choice the midwife deflected any deeper exploration of the moral and ethical considerations:

> *I don't mind looking after them. Maybe there's been a few that have been*
> *terminated that I've thought that I don't know if this is really appropriate for them*
> *to be terminated. But then I'm probably not really there to judge them. I'm just*
> *there to help them and I'm not living there life, so I can't really ……… so I'm*
> *happy to look after them. I try not to think about it (the reason for the termination)*
> *because obviously I don't really think we're here to be saying you shouldn't do this,*
> *shouldn't do that (Julie).*

Similarly a midwife experienced some disequilibrium when asked for reassurance by a woman in turmoil who had not resolved her dilemma and remained uncertain of her actions:

> *I've seen a lady in more turmoil than usual who asked me if she was doing the right*
> *thing and should she continue. That threw me because I felt like I was being asked*
> *to play God (Irene).*

The midwife was steadfast and quite clear in her role as one of facilitating a process after a choice had been made. She considered it as being completely inappropriate in the circumstance for her to be involved in any decision making by the woman and did not want to be included in her decision making process at that point:

> *It was quite distressing because she was asking me if she should do it and I thought*
> *it's not up to me at all. It's not my decision; it's nothing to do with me. I'm there to*
> *assist the lady, the family, partners, support people in the process, but I'm not the*
> *one to say yes or no. it's only happened once but was quite distressing (Irene).*

In her qualitative work that considered the experiences of Swiss midwives in caring for women having terminations after the 14th week for fetal abnormalities, Cignacco (2002) spoke of the conflict

experienced by midwives who had to care simultaneously for women at opposing ends of the antenatal spectrum. She describes this as a situation resulting from the increased utilisation of technology in obstetrics and reproductive medicine. She argues that this has been the basis for important changes in midwives' work conditions, ultimately creating a dissonance in their minds as they move between the role of midwife and abortionist, thereby removing the clear directive they once had on which to base and uphold their professional principle. The distress created by this dissonance is perhaps similar to the distress experienced in paediatric palliative care as described by Davies and colleagues (1996, as cited in Papadatou, 2009) whereby there is a *grief distress* arising from the impending bereavement, and a *moral distress* faced in resolving in their mind the dilemma of the validity of the chosen management.

In the current study, while the midwives contemplated the morality and ethics of various mid-trimester terminations, the personal morality and ethics of the midwives dictated that they felt an obligation to provide the best care possible. This required that they remain non-judgemental and not give any consideration to their personal opinions. As in the Cignacco (2002) study, some stress and distress arose in this process, particularly when personal values and feelings were challenged by the choices made. A unit manager suggested that the moral issues that arose were taken home to deal with but caused an underlying stress while at work. She suggested that the juxtaposition of varying management strategies for similar circumstances that ultimately resulted in very different fetal outcomes created a certain dissonance for her:

> *I've thought how can you do this? You can deliver the twenty three week*
> *termination in one room and the twenty four week full resuscitation in the next*
> *room. That is quite stressful (Denise).*

Denise had the expectation that all staff experienced a similar dissonance but whether due to repeated exposure or a reticence to confront the issues, they appeared relaxed about caring for those women having a mid-trimester termination. This can perhaps be explained by the afore mentioned morality and ethics of the midwives', which was underpinned by a belief that in providing care to the best of their ability they must remain understanding and outwardly non-judgemental:

> *I have difficulty reconciling that they won't hold the baby, but it doesn't affect my*
> *care in any way for the couple. I understand it's a difficult decision to make, but to*
> *not hold the baby until it dies and to expect me to do it, I find it quite hard (Erin).*

This position correlates to the midwives in the Cignacco (2002) study where when confronted with the ethical dilemma of the rights of the mother versus the rights of the baby, they chose to support the notion of the woman's right to self-determination. This principle is included in the overarching framework set out by the *Australian Nursing & Midwifery Council* in their 'National Competency

91

Standards for the Midwife' (ANMC, 2006) which mirrors the code of ethics adopted by the International Confederation of Midwives (1993).

Through all facets of care for any bereavement the complexities of the issues and the notion of the parent's wishes remained foremost in the thoughts of the midwives:

> *I tell you it's very stressful with the relatives but also it's very stressful with the paperwork – that you are doing the correct thing. And certainly you are handling the baby correctly and things like that because the smallest thing can upset them, and it can really change their outlook how they are going to grieve with this baby (Helen).*

There was a realisation by all midwives that while the baby is now given greater recognition than in the past, the parents ultimately only have tokens of their baby's being making it incumbent upon them to ensure that everything possible is done to recognise and record the baby's being. This, along with acceding to the wishes of the couple wherever possible was seen as the most moral and ethical response they could make.

Women's expectations

An overriding role of a midwife is to provide care that within reason accedes to the wishes of the mother and her partner. An adjunct to this is to advocate for those in her care and to provide relevant information that will allow an informed choice to be made. When there was an expectation for the midwife to be active in the choice selected this was avoided; when the expectation was in relation to proceeding with a termination of pregnancy considerable distress was created for the midwife:

> *I felt she wasn't ready at that time to go through with the process and felt she needed more time to discuss the situation with family or the doctors and I felt she was asking me to make a decision that's nothing to do with me (Irene).*

In the daily course of their work the notion of acceding to wishes not congruent with their own is one the midwives faced on a daily basis. However, when these wishes were in relation to a bereavement, there was an additional dimension of stress created. Such incongruence where the women's expectations challenged the midwives' ethical perspective or the moral judgements they had formulated created much angst for the midwives. If a midwife experienced any dissonance as a result of her expectations and beliefs and the couple's wishes being incongruent she not only relied on the moral and ethical perspective of acceding to the wishes of the bereaved to rationalise this, but would also act to satisfy her expectations to reduce the dissonance she was experiencing:

For a baby to be born alive and not be held by its mother, it just eats away at me. I
find it emotionally difficult. I've held babies until they have died when the mother
or father wouldn't (Erin).

However where the midwife's moral and ethical standards were compromised in meeting the wishes of the parents the midwife still experienced both anger and sadness in providing the care she considered appropriate for both the parents and the baby:

When the baby is dying it really saddens me. A woman asked me to hold her baby
once and I thought why can't you, why does it have to be me giving more of my
emotion to you. It makes me a bit angry. They have made a difficult decision, but
why do they want me to hold their baby? (Erin)

Another concern that arose for a midwife was the parents' perception of how their wishes and expectations had been met. There was an example of the parent's recollections being at complete odds to those of the midwife. While accepting that recollections and perceptions can vary, particularly in such fraught situations, the distress of this to the midwife was exacerbated because she had had her own experience of a fetal bereavement and new she would never have acted in the manner being suggested by the bereaved parents. The difficulty of supporting any parent expecting a poor fetal outcome is one where the midwife is required to have honed her empathic skills and will have the ability to intuitively understand the needs and desires of the parents as they occur from moment to moment.

Personal issues

For a small percentage of midwives they too had had a personal experience of perinatal bereavement. For these midwives their personal sentiments had to be balanced with the needs of the ward when there was a need to provide perinatal bereavement care. This meant they had to accept a share of the workload in relation to such cases, but as a result it was their perception that any stress they experienced was exacerbated by their personal experience. There was also a need to uphold the confidentiality of any staff member and to not use any information inappropriately; therefore when a less experienced midwife communicated details of a colleague's perinatal bereavement to a woman in a similar situation unwanted pressures were created:

There was a lack of confidence on the part of this midwife, she hadn't cared for
anyone in that situation before and she was trying to alleviate some of this
woman's distress. It was quite stressful coming on and being confronted with that
(Gabbi).

The midwife had been placed in a situation of not only having her confidentiality breeched but also of being unable to circumvent the expectation to provide that woman's care, something that she preferred to do only on those occasions when she felt emotionally strong enough too.

<u>Emotional impact</u>

Bereavement care was described as very stressful and emotional for all parties. The stress experienced by the midwives was quite separate from the adrenaline charged stress of an emergency situation and as Cignacco (2002) found with all 13 of the midwives she interviewed, they experienced a 'heavy emotional burden' that included feelings of sadness, anger, helplessness and contradictory feelings.

An indication of the impact of this constituent that conveys several of the feelings described in the previous paragraph was conveyed in one midwife's description of the nature of the stress she experienced. While she deemed it difficult to characterize, there was the notion that for the midwife too, it generated a grief reaction. This reaction had a fundamental component of ongoing introspection where the logic and justice of the outcome was questioned:

> *It's a grieving stress I think that sort of ………and you start questioning why this*
> *did happen. It's completely different. Why did this happen when an FDIU, say it's*
> *an FDIU, why did …… you know. And you know it's a beautiful couple and you say*
> *"Why? Why?" You are asking questions all the time to yourself…… (Helen).*

The concept of the midwife experiencing her own grief is also supported by Gardner (1999) who in a transcultural study of midwives in the US, England and Japan found that US nurses did not know how to express their own grief, English midwives experienced feelings of grief and insecurity and the Japanese midwives, while wanting to keep their feelings under control, found it difficult to manage their feelings of grief.

For another midwife with many years of experience who had taught herself to establish a protective barrier, the grief of the bereaved parents remained overwhelming. This was exemplified by her statement that she could readily recall the names of those bereaved parents she had cared for over the years which she contrasted with her inability to recall the names of those recently cared for with a live birth. A further example of the impact of a FDIU came from a midwife, who when reflecting on past events, recalled images of a dead baby dressed in a *'beautiful smocked frock'*. She ruminated on the fact that at the time she did not seeking professional counselling but in retrospect pondered the benefit that it may have had.

The relationship that developed between the midwife and the bereaved parents was also spoken of in terms conveying a degree of intensity not experienced in other birthing suite scenarios:

> *I mean, if you were to walk into a room and be introduced to a group of people and have to sit there for eight hours with them we wouldn't make the contact with them around a dinner table that you make with a couple going through the loss of a child that they desperately wanted and for some reason they can't have it. So it is very intense (Faye).*

This was exemplified in one midwife who had developed a good rapport and bonded with the bereaved family to the point where they asked her to attend the funeral. While this was not viewed as an impost it brought into focus the emotional difficulties of the situation. Further to this another midwife had formed a more enduring relationship in the knowledge that she may be discarded as the bereaved moved forward with their lives and came to view her more as a reminder of a past painful event.

For one midwife the emotional impact was such that she found it necessary to move away from birthing suite. Caring for those women having mid-trimester terminations was viewed as her downfall despite her best efforts to rationalise these events, deeming it as her role to care for those choosing this path without opinion or judgement. Over time her endeavours to provide empathic and nurturing care in these situations became detrimental to her well-being. The memories of providing such care continued to linger and when recalled evoked a strong reaction that reinforced the appropriateness of her decision to leave the birthing suite:

> *I had a really strange sensation the other day. I took a lady up to labour ward and we had to go into a room where the mid-trimesters were done a lot. She was allocated that room, so I wheeled her in there and felt like there were a hundred ghosts came to greet me. It was a really spooky feeling that came over my whole body, and I just thought "I'm glad I'm not still here" (Faye).*

Prior to making the decision to leave, the midwife experienced highs and lows across the shift as she endeavoured to be supportive of the bereaved when called upon to care for them. She had also reached a point where going to work was associated with grief. Moreover she had developed a sense that while the bereaved were supported she was not and in time, despite the support she gained from a stable home life, she suffered a sense of complete psychological exhaustion. This was exacerbated when having moved from the birthing suite she was required to care for another mid-trimester bereavement on the ante/postnatal ward:

> *Then I was in the ward and we had a sixteen week, I think inevitable abortion, and I was told I had to deal with it in the ward. I just sat there and cried. I could not stop myself from these emotions, and I rang the counsellor (Faye).*

95

While the decisions and events leading up to the birth could be bothersome for some, for others the events following the birth where found to be the most overwhelming. In remaining sensitive to the needs of the bereaved, there was ultimately a dead baby that had to be dealt with. This required the midwife to proceed with the more complex post birth management in a very discreet manner to ensure not only that confidentiality was not breeched, but also with an eye to the sensibilities of the other women.

There are many elements that make up the provision of bereavement care in the birthing suite setting. Some of these elements were used by the midwives to mitigate the emotional impact while other elements exacerbated it. An example of mitigation was the rationalisation that a FDIU was sudden and devastating for the woman where as the mid-trimester termination more often had a degree of choice and acceptance associated with it, making it less emotionally draining to care for. Also, in line with previous research, where there was evidence of a handicap that would result in severe handicap it was established that the midwives found the loss more manageable (Kaunonen, Tarkka, Hautamaki, & Paunonen, 2000; Walpole, 2002).

For another midwife, when caring for a woman having a mid-trimester termination, the process of birthing was less taxing because the baby was 'not at risk' and did not require monitoring, but found the empathy associated with supporting the parents exacerbated the emotional impact for her. For both these midwives the emotional impact was exacerbated when the baby being terminated was born alive. This created an awkward and emotional hiatus as everyone waited for the baby to die.

> *She didn't want to see the baby until it had died. She kept … … so I had to take the baby away and she kept saying to me "Is it dead yet?", and you know, five hours later I was still saying "No." So that was a very long day that one (Irene).*

Such a situation prompted one midwife to question the management strategy for all mid-trimester terminations:

> *They know these babies are going to die ultimately, so why don't they give them KCl before they deliver? (Erin).*

This is perhaps a reflection of the sense of control the midwife felt she was lacking and may be related to the sense of uneasiness created from carrying out what has been described as a mechanical procedure (Cignacco, 2002). Cignacco elaborates with the suggestion that midwives are expected to take joint responsibility for and implement a decision with which they have not been involved, and about which they have minimal information. Similarly, in the current study the expectation was that a series of choices and judgments made between the doctor and the woman were to be adhered to by the midwife.

This sometimes resulted in the midwife being placed in a trying and demanding situation that was very taxing emotionally:

> *...and then there was the baby who was meant to be twenty two weeks, but was*
> *much bigger and it actually cried, and it was moving. But the mother didn't want to*
> *hold it so I took it. I felt awful; she must have heard it but didn't acknowledge it. To*
> *have this baby ... have it cry ... feel it move in my arms ... (Julie).*

Further to this there was a sense that the complexity of the care had increased, placing a greater burden on the senior staff that were responsible for providing guidance to those learning. The need to discuss a case in depth and to provide detailed explanations created a greater involvement than preferred which was seen to reinforce the emotional impact. Additional to this could be the task of compiling a 'Memory Folder'. In those instances where it was technically difficult to obtain the hand and foot prints or suitable photographs, the emotional impact was intensified. Throughout all of these considerations however there remained the belief that the care of bereaved couples while upsetting and emotionally tiring was a task not to be avoided and one to be shared.

Procedures and support

With regard to the procedures that had been created and established with regard to a perinatal bereavement, the midwives acknowledged and understood them. The difficulty for the midwives arose from the fact that they felt they had little say in how the procedures were to be implemented and therefore there was no apparent consideration given to how this would impact on them. Further to this, while they comprehended and readily ensured that the appropriate supports were provided for the bereaved, there was a sense for some of them that they were not adequately supported:

> *As much as your bereavement folder is really good and the things that you're*
> *meant to go through and the support people ... the pastoral care were always there*
> *no matter what time you rang, they were fantastic. The people from the*
> *bereavement team were never there. They were just the people that sat there and*
> *made up this folder and said 'You do this' and 'You do that', yet I don't think any*
> *of them ever did it. They were more the sit at the desk and let's make this new*
> *program; yet they never put themselves in the situation. They never had to go*
> *through the dilemma with the lady. They never had to deliver ... ... they never had*
> *to hold the baby there with the head stuck for forty-five minutes because the parents*
> *don't want to see the baby. They didn't have to go through those issues, so they*
> *have no idea of what else is happening around that black and white print (Faye).*

It was the seeming anonymity of the creators of the bereavement care plan and their apparent lack of hands-on experience that created a credibility gap resulting in a sense of frustration and tension in some midwives. In acknowledging that there was probably little that could be changed, the feelings of frustration were compounded by their sense of control being challenged. This was typified by the apparently unstoppable increase in the number of mid-trimester terminations being offered and selected as the preferred course of management:

> *I mean the only change in your mid-trimesters that perhaps you could do is*
> *decrease the numbers. I know the Unit Manager has approached them several*
> *times to do that. The other departments that refer them on feel they're doing really*
> *good. Their numbers are going up and that is great for their area because it*
> *enables them to get more resources, but they are not thinking of where they*
> *ultimately go (Faye).*

Further to this, the midwife nominated to care for somebody having a mid-trimester termination had minimal understanding or insight into the process that had preceded their admission. This could lead to a sense that the procedure was being undertaken with undue haste creating anxiety and trepidation for that midwife. This trepidation was further exacerbated if the midwife was inexperienced and their lack of specific training became a concern as they felt ill prepared for the task:

> *Initially you don't know what to expect. You want to do the right thing for all*
> *involved, but it is difficult because you know it is not going to be a good outcome,*
> *whether the baby is expected to be alive or not (Irene).*

When there were staff shortages the probability of caring for several women with bereavements within a short time span was greatly increased. This was further compounded by the need to care for other taxing cases and could carry with it an overlay of personal issues away from work, thereby creating a situation of seemingly constant pressure. Those more likely to be required to carry the majority of the burden were those with experience, particularly where a case may have had additional complexity.

The previous experience can be contrasted with a midwife from another hospital where the mid-trimester terminations were not carried out in the birthing suite. With the inception of a 'perinatal loss team', who had the responsibility of providing the care for those undergoing a mid-trimester termination, the support for midwives in birthing suite caring for a woman with a perinatal bereavement had increased:

We actually don't do them in delivery suite. We go up from about twenty weeks in delivery suite and we don't get many below that. Usually when they have their routine eighteen week scan and we find there's a problem, they actually go to a ward and we have a team of midwives who specialize in that area. But if we do end up with and FDIU that goes to term, or beyond twenty weeks, we do care for them in delivery suite, but we have a lot of support from this team, this perinatal loss team. So there is usually somebody around that can give you support, and we can always get support from the health psychologist if need be (Helen).

The midwives' perception as a result was that the support for staff had improved greatly; rising from nothing to having a specialist team who provided expertise and support that was readily available.

It was apparent however that there was no formalised training of the midwives in this area; the burden of responsibility fell on the senior midwives who sometimes felt ill equipped to have that responsibility. In conveying the impression that the procedures and supports for training of midwives in this area were minimal the experienced midwives all accepted that it was important for them to support the more junior staff through educating them on the provision of bereavement care. It was recognised as counter-productive not to but it was also considered a burden that potentiated the stress and emotional impact they experienced. An outcome of this lack of training procedures was for the senior midwives to choose to provide the majority of the care themselves:

The midtrimesters are traumatic and my AUM's tend to look after them, meaning others don't get the experience. I've talked to them about it, suggesting its tough doing it all the time and they've been in tears. You have to delegate, which doesn't mean you are not being supportive. They say it's so time consuming – explaining the paperwork (Denise).

Further pressure arose from the tension of fulfilling both a clinical role and a management role. The pressure of performing both roles in conjunction with the vagaries of rostering resulted in difficulties with following up some staff and conspired to restrict effectiveness in all areas. Thus the more immediate support that may have been required was not always provided. Further to this, it was recognised by some that it was prudent to debrief or discuss the issues of termination of pregnancy for fetal abnormality with the individuals who had some knowledge of the issues as any discussion with a lay person may tend toward the ghoulish and compound any stress being experienced.

Where there is a lack of opportunity to debrief or a lack of support generally, the ramifications cannot be underestimated. For one midwife, where she concluded that there was not adequate recovery from one event to the next, it could be suggested that there is an additive effect of providing bereavement

care. The deprivation of an opportunity to debrief immediately with peers following a difficult case and the accumulated tension provoked a failure of her coping strategies:

> *...it was a very difficult case and this would have been where I would say my stress*
> *broke. I had succumbed to it. I don't think I ever took time off, but I just couldn't*
> *get the time out to talk about it at the end of the day and by the time I came back to*
> *labour ward it was already a couple of days old, and not necessarily the people*
> *that were there at the time. Yeah, go into an abyss ... to the bottom (Faye).*

<u>Stoicism</u>

There was an acceptance of the reality that there will always be fetal deaths and that this reality had to be managed. Part of the coping strategy was to stoically provide the best care possible in the most sympathetic and empathetic manner possible. Where it was established that there would be a poor fetal outcome an altered outlook and approach was adopted to achieve this:

> *You want to be supportive, but you have been use to looking forward to a positive*
> *outcome. So you have to develop a whole new line of thinking (Irene).*

An important factor in determining the way in which the midwives coped with providing bereavement care was dependent on the nature of the bereavement. With regard to mid-trimester terminations there was a need to come to terms with the service that was being provided and a need to become proficient in providing that care. The stress of managing terminations due to abnormalities had several aspects and it was suggested that there should be a place to be with the baby after the event, a significant aspect with regard to the midwife's ability to provide good care.

Experienced midwives had developed coping skills in line with their stoicism which enhanced their proficiency, thereby benefitting the women through the provision of better care. However, the more experienced midwives had also formulated a set of beliefs with regard to what they considered to be appropriate responses and actions and when the bereaved parents' responses were not congruent with these the midwife's endurance was challenged requiring her to take actions to minimise the incongruence:

> *I will ask them a few times if they want to see the baby, and I am happy when they*
> *do ……it gives me some relief (Erin).*

The complexity of issues that arose from providing bereavement care required some midwives to deliberate to allow them to organise their thoughts and consider what an appropriate course of action may be while also canvassing various colleagues' opinions:

*Just really kind of at work I put it in order in my brain. I just sit down in the quiet
room and I sit there, just think about what I am going to do and I actually chat with
my colleagues sometimes ...(Helen).*

By stoically attending to all aspects of the situation in such a manner the midwife felt reassured that she had taken all the right actions to ensure the wellbeing of all parties. An example of such stoicism is typified by Helen:

*... the baby was alive and I found that a very stressful – I had to accept that was
what she wanted and we dealt with that. But I had to sit down and have a quiet time
to myself and think about how I was going to do it. I had time on my hands, it was
not that it was just straight away; I had to think and I had to just do it, I had time to
think.*

A further example of the stoicism displayed by the midwives involved the completion of a well presented 'Memory Folder'. While this was usually a source of satisfaction to many of the midwives, if the fetus was macerated it was technically more difficult to achieve:

*You like to have a nice little memory for the parents to either take home then or
come back to when they're ready. If you can't get a reasonable footprint or
handprint it makes it a bit harder for you to think 'I've done the best I can' (Irene).*

While the procedures and supports available to the midwives may not have been adequate, this was compounded with the addition of the pressures of daily family life and their stoicism:

*I suppose then I had to go out of the room, shut off my emotions and go to the next
thing. I probably should have sat there and cried for half an hour. I should have
gone for a drink with the girls, but I was already late for something (Faye).*

Communication:

In answering the question "What makes a good midwife?" Nicholls and Webb (2006) reviewed both quantitative and qualitative articles that had drawn on the experiences and views of antenatal and postnatal woman, their partners, nurses, student midwives and midwives. In an integrative review of thirty three papers published during the period between 1993 and 2006, the common theme across all was the need for good communication skills.

The constituents discerned within this category pertain mainly to communication between peers and work colleagues and highlight the influence of personality and personal standards. A separate but important constituent differentiated as significant to the midwives concerned building a relationship with those in their care.

<u>Client rapport</u>

As described elsewhere, the work of a midwife involves her providing care through a very personal and emotional time, with an intrinsic element of her work reliant upon having a good rapport with those in her care. Not only does having a good rapport make her personally more comfortable, it also facilitates her work (Xu, 2009).

A study of labouring women found that women undertook 'emotion work' to relate to the midwives, requiring the midwives to be intuitive and sensitive (John, 2009), something reflected in the current study where the midwives saw each person as an individual and endeavoured to understand their personality in the process of developing rapport. This was more usually done without the advantage of a prior meeting and the associated insight that may provide. Various techniques or strategies are used to assist in building rapport and trust:

> *...I talk to them at their level, I don't talk down to them, I don't shout at them, I talk quietly to them and I try to be friendly and let them sort of be able to talk with me if they feel like they want to (Helen).*

> *The patients often think about things that may seem ridiculous, but they need to be addressed. You need to talk to them, maybe have a bit of a laugh, a joke. That helps break the ice and for them to feel more relaxed and trust you, bond with you (Irene).*

Of course some difficulties are encountered because of the dynamic circumstances of the situation and frequently there are two individuals to interact with resulting in variable experiences:

> *...some of them are really easy, you just get in there and you just feel so comfortable with a couple, and another couple you're saying …… oh I don't know … well it might just be one of them that you just can't get on with (Helen).*

While the interactions between those being cared for and the carer are less formal than in the past it is recognised that the more relaxed approach requires discretion and good judgement in its application:

> *It is quite different, but of course one must be very careful and you judge your patient in a way to know the ones that you can act in this way with (Barb).*

As with any communication, barriers and difficulties were encountered by the midwives. Developing rapport and the timing of meeting the woman were crucially juxtaposed with it being very difficult to create good rapport when the woman was in the late stage of labour and her partner was feeling anxious.

If information not to the liking of the woman or her partner had to be conveyed, or in circumstances where the midwife was not able to comply with a couple's more dogmatic wishes not only was it difficult to develop rapport but any rapport that had been established could evaporate.

The issue of cultural differences was another difficulty noted. While the midwives understood and accepted the norms for many cultural groups and made provision to accommodate them, there was some tension that related to issues of gender. The presence of a male was sometimes seen as counter-productive to any endeavours to build rapport with the woman:

> *The women appreciate you and you can build a good rapport with them. But when the men are in the room there can be a tension that sometimes makes it uncomfortable (Chris).*

While issues of personality sometimes had a significant bearing on developing rapport, the issue of taking over from another midwife was also significant:

> *Well certainly personality things with your patients …… sometimes you just don't seem to get along with them, or you might follow a certain midwife and it takes a while before you actually hit it off with them (Helen).*

This was a situation faced by all midwives; since admission or over the previous shift, the couple had developed a rapport with another member of staff and then grieved for that loss. As suggested in the following quote, there is a period of stress for the midwife as she works to develop rapport with a woman who has bonded to the midwife from the previous shift:

> *…it takes about an hour or two if things … when you've got a women that's been in delivery suite and when suddenly you take over their care. It takes a couple of hours before they start feeling comfortable with you and you feel comfortable with them. Sometimes it's less than that, sometimes it's more. I find that can be quite stressful (Helen).*

Significant in the midwives experience of developing a good rapport with those in their care is her experience and perception of events as it affected them. It is wholly different to that of the family's who has not shared the experience and is relevant to the ongoing stress and tension the midwife feels:

You've made a connection yes. Because we have been in ... actually in that
environment and we know that family, where as it's like if you are talking about
something, maybe a pop star that some disaster has happened in their life, yeah,
it's a disaster, but it's happened to them and you don't really know them. But if you
know them, you've met them, you've been talking with them and dealt with them,
it's different, it's a different thing completely (Helen).

Skills

The ability to communicate effectively is relevant to all areas of life, but its relevance when working in high stress situations is greatly magnified. When there was a lack of adequate communication, whether that was woman to staff, staff to woman or staff to staff, tension was generated:

The basic communication didn't occur between the woman and her carers in the
first place. This involves the midwives alerting them to the possibility that things
may change or it may be difficult to meet all expectations. Then it is a lack of
communication between the Birth Centre midwives and the midwives in delivery
suite. That there is not some advance warning of the woman's needs, what may
happen if she is transferred out. None of that happened and she was just
transferred (Gabbi).

While such instances of inadequate and ineffective communication created unnecessary stress for all those involved the midwives in charge of each shift relied upon the communication skills of the staff to keep them informed of unfolding events. If there was a lack of effective communication their ability to manage the ward effectively and safely was impaired, exacerbating the stress they were experiencing:

Going back to the issue of people not informing of what's going on and they go and
call the doctor and they could institute ... institute, say put up syntocinon or
something, that sort of thing (Anne).

As a manager or for those with in charge responsibilities, communication with staff was seen as needing to be inclusive of them when assessing the ward situation to assist them in refocussing and prioritising. When the midwives were communicated with in this way a sense of inclusion was engendered, or conversely felt excluded when not included in conversations relevant to someone in their care:

She presumed I'd know what was going on, which I did 99%, but I think she should
have communicated her thoughts with me as well as the doctors outside the room
(Irene).

In an area of high stress such as birthing suite tensions can rise and lead to confrontation. The ideal management of such situations was seen to involve neutralising strategies where and when possible, but the immediacy and dynamic nature of birthing suite often curtailed implementation of such strategies. This frequently resulted in a less than ideal resolution. Of concern to a more senior manager was the associated evidence of 'horizontal violence' which she saw as being exacerbated by a lack of recognition by its perpetrators:

> *...that these people there certainly are guilty of giving horizontal violence. Cannot*
> *see it in themselves, and it is sad because we as people must be able to make*
> *decisions about our involvement with and all people who deal out horizontal*
> *violence (Barb).*

In developing their communication skills the midwives drew on past experiences and any knowledge gleaned from interacting with a variety of people over time. While each midwife had her own manner of communication, all required the skill to develop a rapport with those in their care. The relationship and rapport they developed with the woman, her partner and any support people had to strike a balance of affability with responsibility:

> *I try not to overrule them with rules and regulations, just let them know of the*
> *essential things and why we need to do various things so they, and their support*
> *people, feel supported and reassured and see you as approachable (Irene).*

Barriers

The major barrier to effective and comprehensive communication was not associated with any technology or knowing who to communicate with, but was predominantly related to the personality of the individual:

> *You know the avenues of communication and methods of communication, but*
> *everyone has a different personality, so you might think of the reaction of that*
> *person when you contact them (Irene).*

While there was a realisation that it was necessary to communicate with the appropriate people regardless of any concerns regarding personal feelings, the personality of the individual was a factor for the midwives when determining who to approach. Therefore, while it was realised that it was preferable for all staff to be approachable there was an understanding and acquiescence in accommodating the common reactions of some individuals.

Communication was recognised as a complex matter but with much of it dependent on the personality of the individual. It was this factor that governed how each individual reacted and accordingly the

interpretation of those reactions by others. This is typified in a circumstance where a midwife was caught in a stressful situation and experiencing difficulty in communicating with a colleague, this precipitated an emotional response that she considered inappropriate and of a regrettable nature. This notion was related to the perception of those behaviours that accommodated the woman's personality style and personal preferences as part of the overall notion of projecting a professional appearance and persona.

While personality differences predominated as a key barrier to effective communication, another important factor was differing personal opinions. Although all parties had the same aim, the individual approaches in association with varying levels of experience and personal opinion provided a constant source of friction and conflict. This was seen to inhibit more thorough and inclusive communication:

> *...we all want the same thing but we come at it from different views. And there's*
> *conflict with other midwives, and conflict with the medical staff and how we*
> *achieve that outcome leads to conflict all the time really (Anne).*

Added to this was the principle of not intruding on a colleague's domain:

> *They wouldn't come in because that's not what we do. We try not to invade other*
> *people's territories (Gabbi).*

However the most absolute example of a variance in personal opinion and personality acting as a barrier to communication was expressed by a Unit Manager when discussing interpersonal interactions with staff:

> *...but you see, sometimes people don't want to hear what you say... (Barb).*

<u>Integrity</u>

The issue of how personal information gained through discussions with colleagues is managed and used can raise many issues. When a more senior staff member with a management role discussed the communication they had with other staff it was apparent she recognised a need to be judicious in the management of any information gleaned from a confidential conversation. Attending to the personal and professional issues raised by staff was not seen as an onerous task and was one underpinned by a need to remain true to her personal principles:

> *Of course they find that sometimes they're not able to handle colleagues they work*
> *with, but then I'm privileged they come to me and that's because I have to be equal*
> *to everybody (Barb).*

This notion contrasted with the experience of one of the midwives who had experienced an accumulation of psychological distress associated with a recent personal reproductive loss which resulted in a short period of suicidal tendencies. Feeling distressed at the time, the information was divulged in a confidential discussion between two peers. When the peer moved into the role of Director of Nursing, the information was subsequently recorded in a staff appraisal by her and was then used to the midwife's detriment. While such a breach of trust can cause distress and harm to the individual, distress is also experienced when the individual's best efforts are demeaned by hurtful statements:

> *I attend events that I feel my presence must be seen at for the good of the unit. But*
> *for people to embarrass one, you might say, at a meeting by saying "Oh of course*
> *you don't know" ………people have always got their own personal reason for*
> *doing this … (Barb).*

Elucidatory communication

While such communication may initially be thought to be synonymous with debriefing it in fact serves a very different purpose. It was more evident in conversation with the most experienced midwives who viewed it as a learning opportunity. It was seen as essential to provide an opportunity for junior staff to discuss any difficult events. This provided them with the opportunity to revisit and reflect on issues to ensure they were adequately addressed and combined with the provision of appropriate support and guidance. In some instances this was more formalised as a case study:

> *We used to analyse certain cases and look at the management and it wasn't*
> *scrutinizing the management, it was looking at different ways we could have*
> *managed the woman, and found that was very helpful (Gabbi).*

Summary

The initial significant point of interest arises from the insight gained with regard to how midwives see themselves. This insight provides us with the essence of what the midwives interviewed perceive as intrinsic to them functioning as a midwife. While they responded as might be expected and as past research has indicated, they also spoke in terms that suggested as a collective they were hardy.

The notion of control is complex, but in terms of their personal qualities the midwives indicated that they had an internal locus of control (Rotter, 1966). They understood that there were many things beyond their control, but indicated that they expected to behave in a manner commensurate with their training and expertise. There was also a general acceptance of the challenge that their role would change, of a requirement for them to accept greater responsibility as they gained experience and they

also saw novel events not always as a threat but ultimately as an opportunity to learn. With these characteristics, there was also a commitment to their role and to being the best midwife they could be.

To be the best midwife they could be, they used their skills at introspection, or were able to undertake a 'deep stocktaking' that gave them an awareness of their inner person, facilitating changes in themselves and personal growth that assisted in maintaining meaningfulness in their role as a midwife.

Of particular importance to the stress they experienced was the notion of their sense of control. This was based on a personal assessment of their abilities, stemming from a perception of what their skill set (training, experience and expertise) provided in terms of them being able to manage any given situation. Therefore their stress was underpinned by the sense that their personal performance expectations had been challenged.

In conjunction with this is the individual midwife's perception of stress, or her appraisal of it. There is the suggestion that the midwives interviewed presented collectively as being 'hardy', and so appraised many situations as manageable, enjoying the challenge presented. Thereby a case can be made for such situations to be considered ones of eustress, however for some there was a consistent and persistent underlying distress, which may be linked to a possible lack of confidence in their personal skill set.

While it is understandable to conclude that issues around workload, striking a balance between providing satisfactory care and completing tasks, conflict of any nature, and displays of aggression from other staff, the woman in their care or the support people would challenge a person's sense of control, it is worth considering the impact of the support resources available. This is an area beyond the control of the midwives as much of it relates to staffing levels and the skill mix of the staff for any given shift. Its impact on a midwife's sense of control, no matter their level of expertise is significant however. For those with the greater responsibility, their ability to maintain oversight was compromised, thus challenging their sense of control. The less experienced staff recognised there was a lack of oversight and due to the perception of a lack of support their sense of control was also challenged.

To maintain a sense of wellbeing and to regain their sense of control, the most consistent form of support with regard to achieving this was derived from other midwives. While many spoke of the support of family, in social support terms this fell within the realms of *attachment* and *nurturance*. A sense of security and place was provided, along with a sense of purpose and being needed. This is in contrast to the *reliable alliance, social integration* and *reassurance of worth* derived from their relationships with trusted midwife colleagues (Weiss, 1974). These were the relationships that provided the more significant emotional support while assisting in the formulation of a line of action and demonstrating or restoring a belief in their competence.

The insights supplied by this scientific phenomenological qualitative assessment of birthing suite midwives stress suggests that while many constituents have been identified as playing a role in creating or being additive to the stress incurred by this particular group, it is the constituents directly impacting on their sense of control that initiates the stress experienced. The notion of sense of control will be further explored in phase two of the study.

Chapter 6

PHASE TWO: RATIONALE AND HYPOTHESES

Rationale

The underlying principle for carrying out most quantitative research is to identify those factors that may influence an outcome through measurement and analysis of the relevant variables. On that basis the rationale for phase two of this study was to examine the domains discussed in the literature review. Through quantifying the degree of subjective stress experienced by the midwives in relation to a series of events identified as stressors during the qualitative phase, comparisons could be made between their measures of subjective stress (their levels of stress as recorded by them in the diary), burnout and compassion fatigue, and the influence of social support and coping style could be assessed.

To achieve a clearer understanding of the influence of those domains under scrutiny, a series of hypotheses were formulated. The specific areas of interest to assess included the impact of the various categories of subjective stress on the midwives professional quality of life, particularly in terms of the burnout they experienced, the association of any given coping style with the development of burnout, any association between levels of social support and burnout, and the impact of providing bereavement care.

Hypotheses

The first hypothesis related to the aggregate stress that occurred for midwives working in birthing suite when considered in terms of the type of hospital within which they were employed. Intuitively it may be suggested that a tertiary referral point, where the more difficult cases are managed, will have an environment where there is both a greater frequency of stressful situations and situations that are more stressful. The following hypotheses were therefore formulated with regard to stress and included a series of hypotheses that considered the various categories of stress listed in the Diary of Stressful Events.

1.1 It was hypothesised that midwives employed at a Level 3 hospital would experience significantly greater aggregate stress when working in birthing suite than midwives employed at a Level 2 hospital.

1.2 It was hypothesised that the Diary of Stressful Events category of workload would be positively correlated to measures of burnout as recorded on the ProQOL

1.3 It was further hypothesised that the diary category of conflict would be positively correlated to measures of burnout as recorded on the ProQOL

1.4 It was also hypothesised that the category of lack of support would be positively correlated to measures of burnout as recorded on the ProQOL

1.5 A further hypothesis suggested that providing bereavement care would be positively correlated to measures of burnout as recorded on the ProQOL

1.6 In addition, because the Perceived Stress Scale (PSS) is designed to assess global stress, it was hypothesised that the mean aggregate subjective stress recorded in the midwives' Diary of Stressful Events and their measure of monthly global stress would not be correlated.

In considering burnout as measured by the Maslach Burnout Inventory (MBI) there were four hypotheses:

2.1 The first was that lack of supervisor support would predict the exhaustion dimension of the MBI.

2.2 The next hypothesis suggested that the workload stress category would also predict the exhaustion dimension of the MBI.

2.3 The third hypothesis was that a lack of colleague support would predict inefficacy on the MBI.

2.4 The final hypothesis related to the cynicism dimension of the MBI, were it was predicted that a negative correlation would exist between the cynicism dimension and the compassion satisfaction component of the ProQOL.

The next set of hypothesis related to the notion of coping, which may intuitively be suggested that in the birthing suite environment where the population of midwives is predominantly female, there would be a reliance emotion oriented coping.

3.1 It was therefore hypothesised that there would be significantly more emotion oriented and avoidant oriented coping in comparison to task oriented coping.

3.2 It was also hypothesised that emotion oriented coping would predict elevated levels of the exhaustion dimension of the MBI.

3.3 Additionally, it was hypothesised that emotion oriented coping would predict elevated levels of the cynicism dimension of the MBI.

3.4 The final hypothesis in this series suggested that emotion coping would predict lower levels of the inefficacy dimension of the MBI.

The next in the set of hypotheses relating to the specific domains under investigation, focus on the domain of social support.

4.1 It was hypothesised that there would be a negative correlation between the exhaustion dimension of burnout as recorded on the MBI at time one and levels of social support.

4.2 It was also hypothesised that there would be a negative correlation between the cynicism dimension of burnout as recorded on the MBI at time one and levels of social support.

4.3 It was further hypothesised that midwives who reported lower levels of social support would report experiencing significantly more subjective stress.

The final set of hypothesis considered the category of bereavement care.

5.1 It was hypothesised that where a midwife provided bereavement care there would be a positive correlation between the mean monthly subjective stress experienced in this category and the measure of compassion fatigue.

5.2 It was further hypothesised that for those midwives who provided bereavement care, the midwives high on social support would report significantly lower mean monthly subjective stress for bereavement care than those midwives low on social support.

Chapter 7

PHASE TWO: METHOD

The purpose of the second phase of the study was to develop a model of stress and burnout that considered the effect of social support and coping style. As an adjunct to this, the impact of providing bereavement care was incorporated into the model with the notion of vicarious traumatisation to be investigated to make a determination if this condition was experienced by birthing suite midwives during the course of their work.

Participants

As previously stated, the participants were drawn from two Melbourne metropolitan obstetrical units. Both units had consultant obstetricians working within them, overseeing the training of junior doctors in the practice of obstetrics as well as attending to their 'private clients'. The midwives in both units had autonomy over the management of women deemed to be uncomplicated or following a normal course of birthing. If there was any deviation from normal as set out in specific hospital protocols, then oversight for the care of those women became the responsibility of the obstetric staff.

Following appropriate ethics approval from the involved institutions, arrangements were made in consultation with the Unit Managers (UM) for the researcher to provide a series of 15 minute PowerPoint presentations to the birthing suite midwives. The presentation provided details of the aims of the research and an outline of the methodology to be adopted. This was then followed by a question and answer period before providing the attendees with an information leaflet (Appendix D), plain language statement (Appendix E), consent form (Appendix F) and a prepaid envelope addressed to the researcher's principal supervisor. Those midwives willing to participate in the research completed the consent form and returned it in the prepaid envelope. To ensure privacy and confidentiality the principal supervisor (or in her absence the co-supervisor) were the only people with access to the names of the respondents who had agreed to participate. Conversely, in phase one, the principal supervisor and the co-supervisor did not have access to the names of the participants, therefore it is not known if the midwives who participated in phase one also participated in phase two.

The age range of the midwives was 24 to 64 years with a mean age of 42.65 years and a median of 43 years. All midwives were female. Seventeen were married, four partnered, and ten divorced, separated, widowed or single, while eighteen recorded that they had children. Of the ten who were not married or partnered, nine reported that they were not in a steady relationship.

Their total experience as a midwife (time worked since completion of training) ranged from three months to 31 years with a mean of 13 years and a median of 13.5 years. This is similar to their current

work experience (present continuous employment as a registered midwife), which ranged from three months to 27.3 years, with a mean of 11.3 years and a median of 9.5 years.

In order of seniority, there were six Nurse Unit Managers or Associate Unit Managers (NUM/AUM), nine Clinical Nurse Specialists (CNS), 12 Registered Midwives and 4 Graduate Midwives who participated. Twelve of the midwives (38.7%) were employed full-time, and 19 (61.3%) were employed part-time. The number of occasions that they worked in birthing suite across their twenty-four week data collection period ranged from nine days to 105 days, with a mean of 43.9 days and median of 41 days.

Some of the key characteristics of the sample can be compared to the figures for the state of Victoria as reported in the 2003 Nursing and Midwifery Labour Force Survey produced by the Australian Institute of Health and Welfare (A.I.H.W.). The report states that there were 4, 556 Registered Midwives, of whom 0.9% were male. Their average age was 44.1 years and they worked an average of 28.3 hours per week. This would be the equivalent of approximately 85 days for the period of data collection, which may be similar to the study sample because the mean reported for the sample reflects only those days worked in birthing suite and excludes any time spent in other areas of the hospitals. Similar to the study sample the majority of midwives, 69.1%, were employed on a part-time basis (A.I.H.W., 2005).

Materials

A battery of scales was selected to explore the domains of interest. With regard to the stress experienced by midwives, an area where little research has been carried out, there were no relevant scales available. Therefore the diary central to this phase was initially informed by current available literature with regard to stressors that affect nurses and midwives. However, because of the paucity of information particular to midwives working in birthing suite, it was the content of the interviews carried out in Phase One that provided the knowledge of the items to include in the *Diary of Stressful Events*. Therefore the data collected from the completed diaries is central to the association between Phase One and Phase Two of the study.

In keeping with Betz (1996) who specified that the development of an appropriate scale can be drafted from information gathered during a qualitative interview, a list of items was drafted from the ten interviews carried out in the first phase. While undertaking the initial reading of each interview to gain a global sense of its content, any event that had been mentioned as stressful was recorded. The recurrent topics for discussion that arose and had also been mentioned in the nursing and midwifery literature related to emergency events, conflict with others, lack of support, workload, and case management (McVicar, 2003; Tyler & Ellison, 1994) , while Mackin and Sinclair (1998, 1999) and Mander (2000, 2005, 2006, 2009) had identified stillbirth and or termination of pregnancy as sources of stress.

114

The resultant list of events drafted during the initial reading of the interviews was then arranged into the descriptive categories identified by previous research as listed above. The list of events in each category was refined to ensure there was no repetition of any event and this resulted in the twenty five items included in the diary. The diary was then pretested on five midwives with birthing suite experience who reported that no other events needed to be included, the instructions on how to use the form were clear and concise and that it would not be a burden on the midwives to complete.

The *Diary of Stressful Events* (Appendix G) is a 25-item record of events that commonly occur in birthing suite that were noted to have caused stress and was designed to be completed at the conclusion of each shift. The 25 items were arranged in alphabetical order, and grouped under descriptive headings. These groupings were also arranged in alphabetical order. This was done in order to lend no particular weight to any item. There was a tick box beside each item to be ticked to indicate if the event had occurred on that shift. Each item was accompanied by a seven point Likert scale that ranged from 0 *(Not stressful),* indicating that such an event had occurred, but without a sense of stress, through to 6 *(Very stressful),* indicating a sense of being overwhelmed. This scale was completed for each event that was ticked. The primary purpose of the scale was to ascertain, which events occurred most frequently and the subjective stress rating attributed to each event.

The validity of the construct of the scale could not be established because of the small number of participants in relation to variables. For the ratio of participants to variables Kline (1994) suggests a minimum ratio of 2:1, indicating that a minimum of 50 participants would have been required to obtain some meaningful results. Further to this Kline also suggests the minimum ratio of participants to extracted factors should be at a ratio of 20:1, indicating the possibility of requiring 100 participants. An additional issue was that the variables were not normally distributed and would have required transformation (Tabachnick & Fidell, 2001), adding to the complexity of interpreting the data.

There were two scales administered in conjunction with the *Stress Diary.* The first of these was the *Perceived Stress Scale (PSS 10).* It is a 10-item self-report scale considered appropriate for use in community samples with an educational level above primary school level. It contains items that were designed to elicit how unpredictable, uncontrollable and overloaded the individual perceived their life to be (Cohen & Williamson, 1988). The respondent is required to reflect on the frequency of particular feelings and thoughts over the previous 4 weeks, which they then record on a 5 point scale ranging from 0 (*Never)* to 4 *(Very often).* The PSS 10 (Appendix I) yields a score from 0 – 40, with a higher score indicating higher perceived stress. During the development of this version of the PSS, Cohen and Williamson reported an alpha coefficient of .78 and suggested it to be as strong as the original 14-item version. Roberti, Harrington and Storch (2006) supported previous findings (Cohen, Kamarck, & Mermelstein, 1983) confirming its internal consistency (alpha = .89) and concurrent validity as they

endeavoured to determine the convergent and divergent validity of the instrument. A PDF version of the scale is available from http://www.mindgarden.com/docs/PerceivedStressScale.pdf.

The second scale was the *Professional Quality of Life-R III (ProQOL-R III)* (Appendix J)*,* which is an updated version of the Compassion Fatigue Self Test (CFST), which was recognised as having psychometric problems. The CFST is a commonly used scale to assess the negative and positive affects of caring for others and has been translated into for use in 17 languages other than English. It consists of three subscales, 'compassion satisfaction', 'burnout', and 'compassion fatigue/secondary trauma'. Each subscale has 10 items, seven of which have been retained from the original CFST and three new items to strengthen that scale. The alpha reliabilities for the scales are 'compassion satisfaction' alpha = .87, 'burnout' alpha = .72, and 'compassion fatigue' alpha = .80 (Stamm, 2005).

Higher scores on 'compassion satisfaction' indicate a sense of being an effective caregiver, having positive feelings about your colleagues and being able to contribute in the work setting. This can be contrasted with 'burnout' where higher scores on this scale indicate a propensity for burnout and can be reflective of feelings of hopelessness, ineffectiveness, a very high workload, or a non-supportive work environment. The final subscale, 'compassion fatigue' is about the trauma experienced as a result of secondary exposure to another's stressful event or story and a higher score is usually as a result of an association with a particular event.

These subscales do not yield a composite score with some complex relationships being noted between them. For example, while it is unlikely that a high score on burnout will be associated with a high score on satisfaction, it is possible that there can be a high degree of trauma along with high satisfaction. While the author recommends using the scores in their continuous form, high and low scores are given and a conservative quartile method is recommended when employing cut scores.

The remaining scales were the *Social Provisions Scale, Maslach Burnout Inventory (Human Services Survey)*, and the *Coping Inventory for Stressful Situations*, which were accompanied by a demographic questionnaire.

The *Social Provisions Scale* (Appendix K) is a scale designed to assess the provisions received from social relationships with other people. It has been used on diverse populations that include nurses (Abualrub, et al., 2009), university students (Cutrona, et al., 1990), and door-to-door booksellers (Beehr & Glazer, 2005).To this end it is made up of twenty four questions, with four questions devoted to each of the six provisions identified by Weiss, which are 'attachment', 'social integration', 'reassurance of worth', 'reliable alliance', 'guidance', and 'opportunity for nurturance'. For each of the provisions, two questions describe the absence of such support and two describe the presence of such support. A four point scale is used for the respondents to indicate the extent to which each statement applies to their

social network, with responses ranging from 1 *(strongly disagree)* to 4 *(strongly agree),* indicating that following reversal of the negatively worded items high scores indicate a greater degree of perceived social support. Following the reversal of scores it is appropriate to sum all scores and obtain a global assessment of social support. The internal consistency for all provisions range from above .60 in a study of 300 school teachers to above .70 in a study of approximately 100 elderly subjects (Cutrona & Russell, 1987b).

The *Maslach Burnout Inventory Human Services Survey* (MBI) is a very commonly used 22-item self-report questionnaire that measures the three dimensions of the burnout syndrome. For the exhaustion dimension (emotional exhaustion) there are nine questions, the cynicism dimension (depersonalisation) has five, and the inefficacy dimension (personal accomplishment) has eight questions. Each question is answered using a seven point scale that assesses the frequency of occurrence ranging from *0 – 'never'* to *6 – 'every day'*. Examples of typical questions for each dimension are "Working with people all day is really a strain for me" (exhaustion), "I worry that this job is hardening me emotionally" (cynicism), and "I deal very effectively with the problems of my recipients" (inefficacy). The reported reliability coefficients for the three dimensions are .90 for exhaustion, .79 for cynicism, and .71 for inefficacy (Maslach, Jackson, & Leiter, 1996).

The *Coping Inventory for Stressful Situations* is a multidimensional inventory that assesses the three basic coping styles of 'task', 'emotion', and 'avoidance'. It has been used on college students, correctional populations, psychiatric populations and various population groups (Endler & Parker, 1999). It is made up of forty eight items with sixteen items for each coping style. The avoidance scale has two subscales that assess 'distraction' and 'social diversion'. Respondents are required to indicate on a five point Likert scale (1 = *not at all* to 5 = *very much*) how frequently they utilize various activities when encountering a stressful or difficult situation. Examples of typical questions for each style are "Focus on the problem and see how I can solve it" (task), "Feel anxious about not being able to cope" (emotion), and "Think about the good times I've had" (avoidance). Examples for the two avoidance subscales are "Window shop" (distraction), and "Try to be with other people" (social diversion). The internal consistency for these scales in a sample of women are reported as ranging from .72 to .89 (Endler & Parker, 1999).

Procedure

Because some of the participants may have been known to the researcher and considering the need to protect their privacy and confidentiality, the principal academic supervisor was responsible for maintaining the database containing the names and addresses of each participant. Therefore, after reading the plain language statement (Appendix E) and returning a completed consent form (Appendix F) to the principal supervisor, she initiated the enrolment procedure by allocating a unique code to that

participant, which was recorded in a database with their name and address. Only the principal supervisor, or as required, the associate supervisor had access to this database. The researcher identified each participant by their unique code, and every form posted to the participants was identified by this code only. This ensured the privacy and confidentiality of each participant was maintained.

Upon enrolment, the participant was forwarded the initial battery of scales containing the SPS, MBI, CISS, and a demographic questionnaire. The initial *Diary of Stressful Events* was also included in this bundle, along with a covering letter. The letter gave a brief description of the anticipated time required to complete the battery of scales, information on how to complete the scales accurately, the date to commence recording data in the 'Stress Diary', the procedure for returning both the scales and the dairy, and details regarding the ongoing delivery and collection of subsequent stress diaries and scales. The completed scales and diaries were placed in a secure box located in the staff room of each birthing suite. The scales and diaries were collected by the researcher at the end of each four week period.

During the third week of each four week cycle, the next *Diary of Stressful Events*, PSS and ProQOL were prepared by coding with the unique identifier. These were then placed in an envelope, also identified by the unique code, along with a cover letter detailing the diary number, the date for it to be commenced, the number of the scales for completion, and the procedure for returning the scales and the diary. The envelopes were given to the principal supervisor for addressing and posting. This procedure was repeated for six four week cycles. During the sixth four week cycle, instead of the *Diary of Stressful Events*, a second MBI was included with the PSS and ProQOL along with a cover letter thanking them for their participation and indicating that participation would cease with completion of the included scales.

The mail out program for the various scales and the diary therefore, was as follows:
ENROLMENT: Demographic Questionnaire, Social Provisions Scale, Coping Inventory for Stressful Situations, Maslach Burnout Inventory (1), Diary of Stressful Events (1)

WEEK 3:   Dairy of Stressful Events (2), Perceived Stress Scale (1), ProQOL (1)

WEEK 7:   Dairy of Stressful Events (3), Perceived Stress Scale (2), ProQOL (2)

WEEK 11:   Dairy of Stressful Events (4), Perceived Stress Scale (3), ProQOL (3)

WEEK 15:   Dairy of Stressful Events (5), Perceived Stress Scale (4), ProQOL (4)

WEEK 19:   Dairy of Stressful Events (6), Perceived Stress Scale (5), ProQOL (5)

WEEK 23:   Maslach Burnout Inventory (2), Perceived Stress Scale (1), ProQOL (1)

Analysis

The initial analysis of the "Stress Diary" data was managed in an Excel database. This facilitated not only the recording and preliminary analysis of the contents of the completed dairies, but also the ongoing tracking of the completion and return of diaries for each participant. At the completion of data collection the data recorded within the Excel database was collated and transferred into an SPSS database for further analysis. The data obtained from the various scales that had been administered was entered directly into an SPSS database for scoring and analysis.

To explicate the data contained within the *Diary of Stressful Events* the initial analysis was descriptive. Following this the data was assessed for normality and to determine if there were any outliers prior to carrying out a series of two-way correlations. Because the assumptions of Pearson's *r* were not fulfilled with regard to the distribution being normal (both skewness and kurtosis were identified), and with outliers detected, it was considered appropriate to use a non-parametric procedure. With the sample size being relatively small and as the results contained a number of ties it was decided to use the Kendall's tau-b procedure, which is considered to provide better estimations than Spearman's rho in such circumstances (Clarke-Carter, 2009).

The correlations were initially carried out at the 'meta' level to determine if there were any relationships between the various categories with regard to the frequency of events. When a significant correlation was found, it was explored at a more 'micro' level, which entailed completing a two-way correlation between the items within the correlated categories.

The next stage of analysis then considered the findings of the *Diary of Stressful Events* in conjunction with the results of the MBI. The first step in this stage was to establish if there were any correlations between the frequency of events within the various categories and the three dimensions of the MBI assessed at the completion of the data collection period. Where a correlation was established at the categorical level, once again an examination at the item level was carried out to establish which categorical item was correlated to the particular MBI dimension.

Having gained an overview of the data in relation to the frequency of events, the next stage of analysis moved to assessing the diary data in terms of the subjective stress ratings recorded by the midwives. The same logic and sequencing of analysis was employed when examining this data. Therefore, correlations were established at the 'meta', then 'micro' level, to assess if any underlying patterns were revealed that may further indicate the circumstance in which the midwives were reporting their stress. To complete the analysis by correlation the three dimensions of the MBI were considered in relation to the levels of subjective stress reported by the midwives.

This process provided the opportunity for the effect of frequency of events and the subjective stress rating of events to then be considered in parallel, facilitating some judgements to be made with regard to how these factors impacted on the reported burnout of the midwives, in conjunction with the other parameters assessed of coping and social support.

To test the hypotheses, a combination of t-tests, regression and some further correlations were planned. It was, therefore, necessary to assess the normality of the data obtained from the completion of the scales administered at the commencement of data collection and also for the MBI administered to complete the data collection period. This was done and it was determined that the data did not violate the assumptions of normality, permitting the analysis to proceed as planned, but in the knowledge that an equivalent non-parametric procedure would be used where the planned analysis involved data obtained from the Diary of Stressful Events.

Chapter 8

PHASE TWO: RESULTS

While the first part of this section describes the sample and its characteristics, the first objective is to provide a comprehensive reporting of the descriptive statistics compiled from an examination of the 'diary data'. The diary provides both an indication of the frequency with which the listed events occurred, and the stress rating attributed to each of these events as they occurred. The events were conceptually bracketed together under the descriptive headings of *Bereavement Care, Case Management Issues, Conflict, Emergency Care, Support (lack of)* and *Workload.*

The focus will then move to reporting the results for the hypotheses that had been postulated. Therefore, the reporting will be centred on the notions of stress, burnout, coping, social support and bereavement care and some of the interactions they shared. This will then lead into the final section of the chapter which will supply coverage of the supplementary analysis that arose from the primary analysis of the hypotheses.

Participation

As a result of the recruitment process, thirty seven midwives initiated the enrolment procedure. Of these, one did not return the initial questionnaire, two formally withdrew, and three completed the initial questionnaire and early diaries before discontinuing participation through failing to return any further diaries. Therefore, a sample of thirty one midwives remained. Of the remaining sample, fourteen midwives returned all of the dairies and accompanying stress scales. For the nine whose data set was incomplete, five failed to return either just one completed dairy, or one completed set of stress scales, and another took Maternity Leave. For the remaining three midwives, one did not return a two month series of diaries midway through her data collection period, and the other two were Graduate Midwives who were possibly not rotated to birthing suite for extended periods of time. These three midwives all completed the second Maslach Burnout Scale (MBI).

Diary Data

In examining the dairy data, there are two perspectives to be considered. One perspective considers levels of burnout in terms of the frequency of occurrence of the stressful events recorded, permitting an analysis of the effect of the frequency of stressful events on burnout levels. A second perspective considers levels of burnout in terms of the degree of stress experienced and gives consideration to how stressful an event is perceived to be and the notion of accumulated subjective stress. As previously discussed however, the reliability and validity of the Diary could not be ascertained, and therefore the results achieved can at best only be considered indicative.

The first perspective to consider relates to the data in terms of the frequency with which events within each category occurred. The twenty-five events had been bracketed together into six conceptual groups as listed above. An initial examination of the data considered the relationship of burnout levels to frequency of events at the 'meta' or category level. Where correlations were found for the frequency of categories, these were explored at the 'micro' level to determine which events within the categories were correlated.

The second step considered the accumulated subjective stress in terms of the groupings or categories used in the diaries. This was followed by considering the accumulated stress per category of events in terms of its association with the scales of the Maslach Burnout Inventory (MBI). Where any significant correlations were found, the category was then explored more deeply by establishing what events within the category may have correlated with burnout scores.

Overview

Frequencies:

At the completion of each shift worked, the midwife recorded any stressful events that occurred and made an assessment of the subjective stress experienced for each event that shift. The period of data collection spanned 30/08/2004 to 5/02/2006, and during this period the midwives reported on a total of 1360 shifts worked in birthing suite. Across the shifts worked in birthing suite, 3358 events occurred that were rated for their subjective stress. Another 89 events occurred that were not considered to have caused any subjective stress and were accordingly rated as '0'.

A preliminary review of the categories revealed that of those events that created some subjective stress, the events categorised as *Workload* occurred with the greatest frequency. In order of frequency of events per category they were *Workload* 1369 events, *Emergency Care* 644 events, *Case Management* 597 events, *Conflict* 406 events, *Lack of Support* 183 events and *Bereavement Care* 159 events.

As may have been anticipated the three most commonly occurring stressful events were all located within the *Workload* category. In order of frequency they were 'In-charge duties/providing supervision' (477 occurrences), 'Staff/patient ratio (397 occurrences), and 'Staff skill-mix' (350 occurrences). A summary of all event frequencies can be found in Appendix L.

Sample means:

An initial overview of the data was gained by calculating the sample means for the number of shifts worked in birthing suite, the number of events assessed and the subjective stress experienced for the complete period of data collection. This was achieved by initially calculating the number of occurrences for each event and the total stress experienced for each event per participant for the 24 weeks of data collection. These results were then summed and divided by the number of participants to arrive at the

mean (Table 1). All of the midwives included in this sample completed a minimum of one diary (the maximum being six).

Table 1

Mean Shifts Worked in Birthing suite, Events Rated and Subjective Stress Experienced per Twenty-four Week Data Collection Period

	M	*Mdn*	*S D*	*Min*	*Max*
Shifts Worked	43.87	41	23.18	9	105
Events Assessed	105.87	71	98.08	17	426
Subjective Accumulated Stress	334.32	192	422.65	61	2214

n = 31

From this data, it can be seen that for the thirty-one midwives who returned at least one completed diary, of the possible six for any four week period of data collection, on average they worked 7.31 days per four week period in birthing suite. For each four week period worked in birthing suite they reported on average 18.05 stressful work events with an accumulated rating of 55.72 per midwife, indicating that each reported event on the 'stress scale' of 0 to 6 averaged 3.09.

Categorical frequencies
Continuing with the overview approach, a review of the data according to the categories of Bereavement care, Case management issues, Conflict, Emergency Care, Lack of support, and Workload as listed in the diary was carried out. The first task in gaining an overview of the category data was to determine the mean frequency of events within each category per midwife across the twenty four week period of data collection. The results are shown below in Table 2, and it can be seen that while workload events predominated as the most frequently reported events, emergency events were experienced by all midwives.

Table 2

Frequency Means per Category per Midwife for the Period of Data Collection

Category	Event occurrences per midwife				
	M	*Mdn*	*S D*	*Min*	*Max*
Bereavement Care	5.00	1	8.80	0	31
Case Management	19.23	15	21.77	0	109
Conflict	13.19	6	13.91	0	46
Emergency Care	19.84	15	17.40	2	75
Lack of Support	5.90	5	5.27	0	18
Workload	42.97	28	49.79	0	210

n = 31

Categorical correlations:

The next step was to determine what correlations existed between the categories when considered in terms of the frequency with which categorical events occurred per day worked. Therefore, the frequencies of occurrence for all events were summed for each category to provide the sum of events per category per participant. This figure was then divided by the number of days worked in birthing suite per participant to give a mean daily categorical frequency per participant. The results were then examined employing the Kendall's tau-*b* procedure and the correlations coefficients are shown in Table 3 below. An examination of these results revealed some generally moderate correlations in the frequency of events per shift worked. It is of interest to note that the category of lack of support shared the greatest number of correlations to other categories, with correlations to case management, conflict and workload.

Table 3

Event Category Correlations for Frequency per Shift Worked

	Bereavement Care	Case Management	Conflict	Emergency Care	Lack of Support
Case Management	-.01				
Conflict	.24	.40**			
Emergency Care	.35**	-.09	-.03		
Lack of Support	.19	.47**	.39**	.11	
Workload	.18	.19	.16	.11	.45**

n = 31, *p* < .05, two tailed, **p* < .01, two tailed

The second step in the process of analysis with regard to these frequencies was to determine the correlations between the individual events of those categories where a correlation had occurred. Therefore, the frequencies per participant per shift worked for bereavement care events were correlated with the frequencies per participant per shift worked for emergency care events.

With regard to bereavement care, the frequency of caring for a woman with a fetal death was found to be correlated with just the one emergency care event of shoulder dystocia, τ (31) = .46, p < .01, while for the frequency of midtrimester termination care, this was found to be correlated to the emergency care event of immediate Caesarean section, τ (31) = .38, p < .01.

The next in the series of event frequency correlations explored was for the category of case management with the categories of conflict and lack of support. The events for the category of case management were listed as compromised standards of care (compromised care), determining appropriate care (appropriate care – coming to a determination as to the course of action to be followed in the circumstances) and unclear treatment plan (treatment plan – where the course of action to be followed has not been clearly stated). The event of compromised care was found to not share a correlation to any of the conflict events, while the frequency of determining appropriate care events shared moderate correlations to both conflict with medical staff and conflict with midwife colleague events. Similarly, unclear treatment plan events shared the same although slightly weaker correlations as determining appropriate care events. The results are shown in Table 4 below.

Table 4

Correlations for Frequency per Shift of Case Management Events and Conflict Events

	Events of conflict with				
	Ancillary staff	Medical staff	Colleagues	Patients	Partners/ Support people
Compromised standards of care	.24	.17	.18	.17	.20
Determining appropriate care	.10	.35**	.33**	.19	.09
Unclear treatment plan	-.12	.32*	.27*	.18	.04

n = 31, *p < .05, two tailed, **p < .01, two tailed

In considering the frequency correlation of case management category events and lack of support category events, generally more moderate correlations were found to exist between the frequencies of all case management events and midwife colleague lack of support events per shift, with a weaker correlation found for supervisor / unit manager lack of support. Therefore, the correlation for midwife colleague lack of support with compromised standards of care, τ (31) = .32, p < .05, was weaker, while determining appropriate care, τ (31) = .42, p < .01, and unclear treatment plan, τ (31) = .40, p < .01, were more moderate. The only correlation found for the supervisor / unit managers lack of support event was a weaker one with that of unclear treatment plan, τ (31) = .27, p = .05.

The frequencies of events within the conflict category were then correlated with the frequencies of those events within the lack of support category. When the frequency of conflict and lack of support events were examined, it was found that a more moderate correlation existed between the events of lack of support from midwife colleagues and conflict with patients, τ (31) = .40, p < .01, while a weaker correlation was found between the events of lack of support from midwife colleagues and conflict with medical staff, τ (31) = .30, p < .05. There was only one correlation of frequency for the event lack of support from /NUM, which was a weaker one with the event of conflict with midwife colleagues, τ (31) = .27, p < .05.

The final event frequencies to be correlated were for the categories of lack of support and workload. Here, the stronger correlations were found to be between events of supervisor / unit manager lack of support and the workload events of being in-charge/providing supervision, τ (31) = .41, p < .01, and staff skill mix, τ (31) = .34, p < .01. While for the event of midwife colleague lack of support, there

was a moderate correlation with the event staff skill mix, $\tau (31) = .40$, $p < .01$, and a weaker correlation with staff patient ratio, $\tau (31) = .30$, $p < .05$.

Correlations between frequency of events and dimensions of burnout:

A further step in the overview of the data found in the diaries was to establish if there were any correlations between the frequency in the occurrence of events and the MBI scores. This was considered relevant from the perspective that the frequency with which events were experienced may have impacted on the experience of burnout.

Again the first step was to ascertain if there were any correlations at the 'meta' level. In this instance the category frequencies employed were those derived from the sum of events that occurred within each category per participant. This was considered to be the most appropriate assessment because of the notion that it may be the accumulation of events that precipitates the development of the various dimensions of burnout as measured by the MBI. Therefore, these accrued frequencies were correlated with the MBI scores collected after submission of the final diary. The results shown in Table 5 show moderate correlations on both the 'Emotion' and the 'Cynicism' dimensions for the frequency of bereavement care.

Table 5

Correlation of 'Category' Frequencies with the MBI Post Data Collection Scores

	Emotion	Cynicism	Inefficacy
Cynicism	.37**		
Inefficacy	.08	-.06	
Bereavement Care	.30*	.37*	.04
Case Management	.14	.18	-.19
Conflict	.01	.12	-.13
Emergency	.17	.21	-.24
Lack of Support	.25	.23	-.13
Workload	.24	.21	-.12

*n = 28, *p < .05, two tailed, **p < .01, two tailed*

For completeness, a correlation for the accrued bereavement care event frequencies with the scores on both the emotion and cynicism dimensions was carried out. This revealed weak to moderate correlations on the exhaustion dimension with the frequency of both fetal death in utero (FDIU) care, τ (28) = .30, $p < .05$, and mid-trimester termination (MTT) care, τ (28) = .29, $p < .05$. For the cynicism dimension, weak to moderate correlations were also found with the frequency of FDIU care, τ (28) = .32, $p < .05$, and MTT care, τ (28) = .40, $p < .01$.

Categorical stress

Once again the first step was to gain an overview of the data by determining the sample mean subjective stress rating for each category for the period of data collection. The initial calculations were done within an Excel spreadsheet where the sum of the subjective stress for each category per participant was arrived at. This data was then entered into an SPSS database where a descriptive analysis was carried out. The results of this initial analysis are displayed in Table 10 below, and reveal that workload issues scored the highest mean subjective stress rating for the overall data collection period.

Table 6

Mean Categorical Stress Ratings per Midwife for Period of Data Collection

	M	Mdn	SD	Min	Max
Bereavement Care	16.23	5	39.70	0	217
Case Management	62.10	34	103.12	0	572
Conflict	38.65	26	46.70	0	215
Emergency Care	62.16	46	56.90	7	276
Lack of Support	18.71	11	21.82	0	96
Workload	136.48	70	201.58	0	1023

n = 31

An estimate of the mean subjective stress rating for any four week period can be arrived at by dividing by six. It was determined that this was the most appropriate mean to use as it is representative of the accrued stress the midwives were experiencing. This relates directly to their perceptions of stress as gauged by the Perceived Stress Scale (PSS) along with their compassion fatigue, compassion satisfaction and burnout as assessed by the ProQOL. These were the two scales completed at the conclusion of each four week cycle.

128

When the calculation was done, it indicates that workload issues has a rating of 22.75, which is more than twice that of the nearest two categories of case management issues with a rating of 10.35 and providing emergency care a rating of 10.36. The other ratings were for conflict at 6.44, lack of support at 3.12 and bereavement care at 2.71.

Categorical correlations:

The next task was to determine if there were any correlations between subjective stress ratings for the six event categories. To do this it was necessary to calculate a mean monthly subjective stress rating per midwife for each event category, which was achieved by summing each midwife's stress rating for all events within each category and dividing that figure by the number of diaries returned (months spent in birthing suite). In keeping with the notion of accrued stress, the mean monthly figure was once again deemed as the most appropriate to employ.

Table 7 below displays the correlations found employing Kendall's tau-*b*. Many inter-correlations can be seen, particularly with workload, which is correlated with all of the other categories, as is lack of support. The exception to this is the category of emergency care which has a moderate correlation to bereavement care and slightly weaker correlations to lack of support and workload, but it is not correlated with either case management or conflict. It can also be noted that bereavement care is not correlated with case management.

Table 7

Event Category Correlations for Subjective Stress per Month

	Bereavement Care	Case Management	Conflict	Emergency Care	Lack of Support
Case Management	.18				
Conflict	.40**	.52**			
Emergency Care	.42**	.18	.17		
Lack of Support	.40**	.57**	.55**	.29*	
Workload	.30**	.36**	.34**	.31*	.54**

n = 31, *p* < .05, two tailed, **p* < .01, two tailed

In an endeavour to gain greater insight into how the stress was being experienced for those categories where correlations were found to exist, the subjective stress ratings within each category were examined employing the Kendall's tau-*b* method. Therefore, the events within bereavement care were correlated with the events within conflict, emergency care, lack of support and workload. Then the events within

129

case management were correlated with those of conflict, lack of support and workload, which preceded an examination of the conflict events with those of lack of support and workload. The penultimate groupings were emergency events with workload events, while the final groupings were lack of support events with workload events. The mean used to determine these correlations was calculated for each midwife by summing the total stress experienced per event and dividing by the frequency of each event.

The events for the bereavement care category were the first to be examined where some moderate correlations were found indicating a link between experiencing stress when caring for a woman with a FDIU and both stress arising from conflict with patients, τ (13) = .45, p < .05, and conflict with partners / support people, τ (14) = .56, p < .01, while the stress of providing care for a midtrimester termination was correlated to experiencing stress through conflict with patients, τ (10) = .51, p < .05. When the stress of emergency care events was examined it was found that the stress of caring for a woman with a FDIU was associated with experiencing stress in relation to fetal distress, τ (16) = .57, p < .01, and immediate Caesarean section, τ (17) = .47, p <.01. With regard to the stress associated with experiencing lack of support from both colleagues and supervisor / unit manager, no individual correlations were found for either of the bereavement care events, while for workload stress it was the events of caring for complex cases, τ (16) = .44, p < .05, and staff/patient ratio, τ (17) = .40, p < .05, that were found to be correlated to FDIU stress. There were no correlations with midtrimester termination stress.

The next in this series of correlations examined the stress experienced in relation to issues of case management. With the exception of stress arising from conflict with ancillary staff where no correlations were detected, moderate to strong correlations were found for all other conflict events, which are displayed in Table 8 below.

Table 8

Correlations of Subjective Stress for Case Management and Conflict Events

		Ancillary staff	Medical staff	Midwife colleagues	Patients	Partners / support people
				Conflict with:		
Compromised standards of care		.24	.55**	.43*	.58**	.43**
	n	9	18	20	18	20
Determining appropriate care		.24	.63**	.58**	.51**	.66**
	n	10	20	22	18	20
Unclear treatment plan		.20	.52**	.60**	.47**	.60**
	n	10	22	25	20	22

*p < .05, two tailed, **p < .01, two tailed

An inspection of the results for case management stress and lack of support found at the minimum moderate correlations on all events with the exception of supervisor / unit manager lack of support with compromised standards of care where no correlation was seen. Therefore, stress arising from lack of support from colleagues was correlated to compromised standards of care, $\tau(20) = .40$, $p < .05$, determining appropriate care, $\tau(20) = .43$, $p < .01$, and unclear treatment plan, $\tau(22) = .45$, $p < .01$. The correlation for supervisor / unit manager lack of support with determining appropriate care was moderate, $\tau(18) = .49$, $p < .01$, while for unclear treatment plan there was a strong correlation, $\tau(19) = .62$, $p < .01$.

The final series of correlations for case management events was with workload events where a set of moderate to strong correlations were found between all events. The results are displayed below in Table 9.

Table 9

Correlations of Subjective Stress for Case Management and Workload Events

		Complex cases	In-Charge duties	Staff skill mix	Staff/Patient ratio
Compromised standards of care		.49**	.44*	.47**	.52**
	n	21	18	21	23
Determining appropriate care		.69**	.44**	.51**	.60**
	n	23	19	23	25
Unclear treatment plan		.62**	.56**	.63**	.62**
	n	24	21	25	27

*p < .05, two tailed, **p < .01, two tailed

The next category of events for consideration was that of conflict. When the stress experienced here was considered in conjunction with the stress of lack of support events, it was found that conflict with ancillary staff was not correlated to any of the stress experienced with lack of support, however a series of moderate to strong correlations were found between all of the other events. Therefore, the correlations in terms of the stress reported due to lack of colleague support and conflict events were with medical staff, τ (19) = .63, $p < .01$, midwife colleagues, τ (21) = .66, $p < .01$, patients, τ (19) = .53, $p < .01$, and partners/support people, τ (20) = .46, $p < .01$. For stress arising from supervisor / unit manager lack of support the correlations with conflict events were medical staff, τ (20) = .50, $p < .01$, midwife colleagues, τ (17) = .58, $p < .01$, patients, τ (14) = .42, $p < .05$, and partners/support people, τ (17) = .65, $p < .01$.

An examination of conflict events with the workload events, once again the stress of those events concerning conflict with ancillary staff was not correlated to the stress of workload events. Moderate correlations were found for the events of conflict with medical staff and caring for complex cases, τ (20) = .50, $p < .01$, I/C duties, τ (18) = .48, $p < .01$, staff skill mix, τ (20) = .55, $p < .01$, and staff/patient ratio, τ (22) = .41, $p < .01$. Stress from conflict with midwife colleague events displayed moderate correlations with caring for complex cases, τ (22) = .38, $p < .01$, I/C duties, τ (19) = .49, $p < .01$, and staff/patient ratio, τ (25) = .43, $p < .01$, while there was a strong correlation for staff skill mix, τ (23) = .63, $p < .01$. Generally moderate correlations were also found for stress arising from conflict with patients and complex cases, τ (19) = .36, $p < .05$, I/C duties, τ (15) = .42, $p < .05$, staff skill mix, τ (19) = .57, $p < .01$, and staff/patient ratio, τ (21) = .48, $p < .01$. The final conflict event to be considered was the stress arising from conflict with partners or support people. While a moderate correlation exists between the stress of this event and caring for complex cases, τ (21) = .45, $p < .01$, the remaining

correlations are strong for I/C duties, τ (19) = .60, $p < .01$, staff skill mix, τ (21) = .75, $p < .01$, and staff/patient ratio, τ (23) = .71, $p < .01$.

An interesting pattern of results were found for the stress of emergency events and lack of support events. No correlations were found for the emergency events of 'Code Blue', cord prolapse, and shoulder dystocia with either of the lack of support events (colleague & supervisor / unit manager). With regard to lack of support from colleagues, a strong correlation was found for bleeding, τ (14) = .60, $p < .01$, with weaker correlations for fetal distress, τ (21) = .35, $p < .01$, 'flat baby', τ (21) = .39, $p < .05$, and Caesarean section, τ (22) = .39, $p < .05$. While similar correlations were found for supervisor / unit manager lack of support including a moderate correlation to 'flat baby', τ (19) = .48, $p < .01$, and Caesarean section, τ (19) = .47, $p < .01$, and a strong correlation to fetal distress, τ (18) = .62, $p < .01$, there was no correlation to bleeding.

Except for the stress arising from caring for a woman with a fetal death in labour or cord prolapse, the stress of all emergency events were found to have a correlation with the stress of at least two of the workload events, with the correlations being generally moderate to strong. The emergency events that were correlated to all workload events, were fetal distress with caring for complex cases, τ (23) = .64, $p < .01$, I/C duties, τ (21) = .63, $p < .01$, staff skill mix, τ (24) = .47, $p < .01$, and staff/patient ratio, τ (26) = .58, $p < .01$. The next emergency event was 'flat baby', which displayed correlations with caring for complex cases, τ (26) = .46, $p < .01$, I/C duties, τ (21) = .44, $p < .01$, staff skill mix, τ (25) = .42, $p < .01$, and staff/patient ratio, τ (28) = .60, $p < .01$. The final emergency event to share correlations with all workload events was Caesarean section with caring for complex cases, τ (26) = .42, $p < .01$, I/C duties, τ (22) = .40, $p < .05$, staff skill mix, τ (25) = .32, $p < .05$, and staff/patient ratio, τ (28) = .47, $p < .01$. While there was no correlation between bleeding and staff skill mix, the stress of this event displayed an association with caring for complex cases, τ (18) = .59, $p < .01$, I/C duties, τ (14) = .63, $p < .01$, and staff/patient ratio, τ (19) = .46, $p < .01$. Code blue was correlated to caring for complex cases, τ (12) = .65, $p < .01$, and staff/patient ratio, τ (12) = .67, $p < .01$, while shoulder dystocia was correlated to caring for complex cases, τ (16) = .61, $p < .01$, and I/C duties, τ (24) = .52, $p < .05$.

The final correlations to be considered in this examination of the stress associated with events encountered by midwives in their daily work were those events occurring in the categories of lack of support and workload. Moderate to strong correlations were found between all events. The correlations for colleague lack of support were as follows, caring for complex cases, τ (21) = .41, $p < .05$, I/C duties, τ (18) = .47, $p < .01$, staff skill mix, τ (22) = .58, $p < .01$, and staff/patient ratio, τ (23) = .45, $p < .01$, while for supervisor / unit manager lack of support the correlations were caring for complex cases, τ (19) = .47, $p < .01$, I/C duties, τ (17) = .61, $p < .01$, staff skill mix, τ (19) = .65, $p < .01$, and staff/patient ratio, τ (20) = .58, $p < .01$.

Correlations between subjective stress and dimensions of burnout:

The mean category subjective stress scores were then correlated with the three dimension scores of 'Emotion', 'Cynicism' and 'Inefficacy' derived from the Maslach Burnout Inventory completed for the second time after the final period of data collection. Once again the Kendall's Tau-*b* method was employed and the results are displayed in Table 10. It is noted that a correlation between the two MBI components of 'emotion' and 'cynicism' was found, while the 'inefficacy' component was not correlated with either of the other components, and more interestingly with any of the event categories. Further to this the category of Conflict revealed no correlation with any component of the MBI.

Table 10

Maslach Burnout Inventory and Mean Event Category Subjective Stress Rating Correlations

	Emotion	Cynicism	Inefficacy
Cynicism	.37**		
Inefficacy	.08	-.06	
Bereavement Care	.37**	.36**	.00
Case Management	.32**	.23	-.14
Conflict	.17	.16	-.05
Emergency	.37**	.16	-.09
Lack of Support	.39**	.29*	-.08
Workload	.34*	.12*	.04

n = 28, *p* < .05, two tailed, **p* < .01, two tailed

To gain further insight into the above significant correlations, where a categorical correlation was found, the mean subjective stress rating for the events in that category as calculated previously for each midwife (total stress experienced per event summed and divided by the frequency of each event per midwife) was correlated with the corresponding MBI scale score. The Kendall's Tau-*b* method continued to be employed to achieve this.

The first to be correlated were the subjective stress for the events of bereavement care, case management, emergency care, lack of support and workload with 'Emotion', and these results are displayed in Table 11. In this instance, all of the case management and workload subjective stress ratings were moderately correlated with 'Emotion', as were the more commonly occurring emergency events of fetal distress, 'flat baby' and Caesarean section along with supervisor / unit manager lack of

support. It can also be noted that while FDIU was not correlated, there was a relatively strong correlation for the stress associated with caring for a woman having a mid-trimester termination.

The next dimension of the MBI to be considered was 'Cynicism', which was correlated with bereavement care, lack of support and workload events. It is of interest to note that as individual events none of them approached a significant correlation with the cynicism dimension.

Table 11

Correlation Matrix for Bereavement Care, Case Management, Emergency Care, Lack of Support, and Workload Events with 'Exhaustion'

Category	Event	Exhaustion	n
Bereavement Care	Fetal death in utero	.31	17
	Midtrimester termination	.51*	14
Case Management	Compromised Standards of Care	.33*	21
	Determining Appropriate Care	.43**	24
	Unclear Treatment Plan	.40**	25
Emergency Care	Bleeding	.09	19
	Code Blue	.42	13
	Cord Prolapse	.53	4
	Fetal distress	.46**	24
	'Flat baby'	.56**	26
	Caesarean Section	.35*	27
	Shoulder Dystocia	.39	15
Lack of Support	Peers	.24	21
	Supervisor / unit manager	.43*	19
Workload	Complex Cases	.48**	26
	In Charge Duties / Supervision	.37*	21
	Skill Mix	.33*	25
	Staff/Patient Ratio	.47**	27

$n = 28$, *$p < .05$, two tailed, **$p < .01$, two tailed

This completed the overview analysis of the data collected from in the midwives' Diary of Stressful Events, which had been completed at the conclusion of each shift worked.

Hypothesis Testing

The hypotheses were considered in relation to each area of interest, beginning with the area of stress.

Stress

Prior to testing the first hypothesis it was necessary to calculate an appropriate mean for the aggregate stress experienced by each midwife. Therefore, the mean aggregate stress for each midwife was calculated by summing the total amount of stress they experienced and dividing by the number of months they worked in birthing suite during the data collection period, thereby providing a mean monthly aggregate of stress per midwife. This procedure was repeated to determine the mean monthly aggregate stress for each category of the Dairy of Stressful Events and also to determine the mean for each measure (compassion satisfaction, compassion fatigue and burnout) on the ProQOL. A series of six hypotheses were then tested.

1.1 It was hypothesised that those midwives working in birthing suite at a level three hospital would experience higher levels of subjective stress when compared to midwives working in birthing suite at a level two hospital.

When the mean monthly aggregate stress ratings for the midwives of each hospital were compared, it was found that staff at the Level 3 hospital (n=22, M=15.68, SD=6.49) recorded more stress than staff at the Level 2 hospital (n=8, M=10.17, SD 3.35). The mean difference between hospitals was 5.51 and the 95% confidence interval for the estimated population when equal variances are not assumed is between 1.51 and 8.91. The effect size was calculated using the square root of the pooled variance technique (Brace, Kemp, & Snelgar, 2009) with a large effect size being demonstrated (d = 5.86). Therefore the initial hypothesis that there would be a significant difference in the subjective stress experienced by the birthing suite midwives at a Level 3 hospital when compared with those from a Level 2 hospital was supported, t (24.17) = 3.03, p <.01, equal variances not assumed.

The next four hypotheses considered individual categories of subjective stress, as reported in the stress diaries, in relation to the burnout assessed each month by completion of the ProQOL. Because it was known that the data obtained from the diaries violated the assumptions of normality, and the hypotheses suggested there would be a relationship between the categorical stress and burnout levels, it was considered appropriate to continue using the non-parametric procedure of Kendall's tau - *b*. Also, because all of the hypotheses in this series predicted a positive correlation, a one-tailed procedure was employed.

1.2 It was hypothesised that the category of workload stress would be positively correlated to burnout as measured by the ProQOL.

137

As predicted a significant moderate correlation was found, $\tau\,(31) = .42, p < .01$, indicating that as the stress experienced from the combination of caring for complex cases, having in-charge duties, and experiencing issues to do with skill mix and staff / patient ratios increased so did the experience of burnout.

1.3 It was hypothesised that the category of conflict stress would be positively correlated to burnout as measured by the ProQOL.

This hypothesis was not supported, $\tau\,(31) = .16, p = .11$, indicating that conflict stress was not associated with burnout.

1.4 It was hypothesised that the category of lack of support stress would be positively correlated to burnout as measured by the ProQOL.

This hypothesis was supported, $\tau\,(31) = .34, p < .01$, indicating that there is a weak relationship between experiencing stress as a result of not feeling supported by supervisor / unit manager's and midwife colleagues and the experience of burnout.

1.5 The hypothesis suggested that the stress of providing bereavement care would be positively correlated to burnout as measured by the ProQOL.

This was also supported with a weak correlation, $\tau\,(31) = .22, p < .05$, indicating that as the midwives experienced stress associated with providing care to those with a fetal death in utero or a mid-trimester termination there was an associated increase in the likelihood that they would experience higher levels of burnout.

1.6 It was hypothesised that the global stress experienced by the midwives, as measured by the PSS, would not be correlated to the mean monthly subjective stress as assessed above.

This was not supported as a small correlation was revealed, $\tau\,(31) = .30, p < .05$, indicating that the stress the midwives experienced in their everyday life displayed some relationship to the stress they were experiencing with their work in birthing suite.

Burnout

Four hypotheses were formulated with regard to burnout, with three of these relating directly to each dimension of the MBI scale. While the initial hypotheses in this domain indicated that certain categories of stress would predict a particular dimension of burnout, because the data derived from the Diary of Stressful Events violated the assumptions of normality required for a regression analysis, this procedure could not be employed. Therefore, the data was transformed into categorical data to enable tests of association to be carried out using the Chi Square method. For each of the analyses, while the

rule of thumb that all expected counts were greater than one was met, the number of cells with an expected count of less than five was greater than 20% (Field, 2005). While it was recognised that the accuracy of the data would have been influenced by this, it was considered that the exploratory nature of the research made it worthwhile to proceed using the Fisher's exact test and to consider all associated findings as indicating where future follow-up may be indicated.

The median split method was employed to derive high and low groupings for the relevant categories of stress derived from the Diary of Stressful Events. For the scores on both the emotion and inefficacy dimension of the MBI to be transformed into the categories of 'low', 'average', and 'high', the categorizations provided in the MBI Manual (Maslach, et al., 1996) were consulted, where it was decided that the ranges for the 'Overall Sample' would be used. The scores recorded for the MBI at the completion of the data collection period were used to complete these analyses.

2.1 It was hypothesised that an association would exist between the exhaustion dimension of burnout and the degree of stress experienced as a result of lack of supervisor / unit manager support.

The analysis indicated that five cells had an expected count less than four therefore an exact significance test was selected for Pearson's chi-square. The findings did not support the hypothesis that a relationship existed between the exhaustion dimension and the degree of stress experienced as a result of supervisor / unit manager lack of support, χ^2 (2, $n = 28$) = 5.31, $p = .07$. While significance was not attained, it could be suggested a trend was found that warrants further exploration to more conclusively establish whether a relationship exists.

2.2 It was also hypothesised that an association would exist between the exhaustion dimension of burnout and the degree of stress experienced as a result of workload stress.

Once again the analysis indicated that two cells had a count less than five, therefore Fisher's exact test was once again employed. The hypothesis was supported with a significant relationship found between the exhaustion dimension and the amount of workload stress experienced, χ^2 (2, $n = 28$) = 11.50, $p < .01$. It is worth noting that Cramer's V = .64, indicating a strong association where 41% of the variance for the exhaustion dimension score was accounted for by the association with workload stress.

An inspection of the contingency table revealed that for those midwives who fell into the high category of the exhaustion dimension, 77% reported high levels of stress associated with workload while just 13% reported low levels of workload stress. Conversely, 60% of those midwives who reported low levels of workload stress fell into the low category of the exhaustion dimension, while just 15% in this category reported high levels of workload stress.

2.3 It was hypothesised that there would be an association between the inefficacy dimension of burnout and stress arising from lack of colleague support.

As with the previous analyses, Fishers exact test was employed due to there being two cells that had a count less than five. A significant association was not found, χ^2 (2, $N = 28$) = 2.62, $p = .30$, therefore the hypothesis was not supported.

2.4 It was hypothesised that there would be a negative correlation between the cynicism dimension of burnout and the compassion satisfaction component of the ProQOL.

This hypothesis was supported with a moderate correlation being found, τ (31) = -.39, $p < .05$, 2-tailed, indicating that as midwives experience a diminished sense of providing comfort to those in their care, they become less idealistic and more indifferent to these people, while possibly also distancing themselves from their colleagues.

Coping

Four hypotheses were formulated with regard to coping. The first related to which style of coping would predominate, while the subsequent ones related to style of coping in relation to the various burnout dimensions.

3.1 It was hypothesised that the predominantly female population of midwives would display significantly more emotion oriented and avoidant oriented coping when compared with task oriented coping.

Table 12 shows the mean, median and SD for the three scales and two subscales of the Coping Inventory for Stressful Situations (CISS), where it can be seen that while the mean for Avoidance is greater than Task, that Emotion has the lowest mean of all the scales and subscales, indicating that the hypothesis that midwives would display significantly more emotion oriented coping when compared to task oriented coping is not supported.

Table 12

Mean, Median and S.D. for the CISS Scales and Subscales

	M	Mdn	S D
Task	48.28	46.00	9.29
Emotion	47.93	46.00	9.32
Avoidance	53.69	55.00	10.01
Avoidance - distraction	52.54	52.00	11.39
Avoidance – social diversion	50.97	55.00	13.00

n = 29

A paired t-test comparing Task and Avoidance scores was undertaken to test the hypothesis that the midwives would display significantly more avoidance coping than task oriented coping. A significant difference was found, (t (28) = -2.27, p <.05), indicating that the hypothesis was supported. Therefore, while the midwives did use avoidance oriented coping as predicted, they did not predominantly rely upon emotion oriented coping and relied upon this at a similar level to task oriented coping.

As an adjunct to these findings another t-test was carried out to determine if there was a significant difference between the styles of avoidance coping employed, that is did the midwives prefer distraction or social diversion. While the mean for distraction (52.54) was greater than the mean for social diversion (50.97), no significant difference was found, t (28) = .60, p = .55.

The subsequent hypotheses tested the notion that there was an association between coping styles and the three dimensions of burnout as measured by the MBI done at the commencement of data collection. A series of stepwise regressions were undertaken, where the predictor variables of 'task coping', 'emotion coping', and 'avoidance coping' were entered into the model to determine if this was supported.

3.2 The hypothesis suggested that emotion coping would predict higher scores on the exhaustion dimension of burnout.

This was supported with a significant model emerging, F (1, 27) = 10.80, p < .01. The predictor variables of task and avoidance coping were excluded from the model, leaving emotion coping as the only predictor, with it explaining 25.9% of the variance (Adjusted R^2 = .259).

3.3 It was hypothesised that emotion coping would predict increased cynicism.

This hypothesis was not supported with none of the variables being entered into the equation.

3.4 It was hypothesised that emotion coping would predict a diminished sense of efficacy.

This hypothesis was also not supported with none of the variables being entered into the equation.

Social Support

With regard to social support, three hypotheses were formulated. The first two considered the relationship between global social support as measured by the Social Provisions Scale and the burnout dimensions of exhaustion and cynicism. The data from these scales did not violate the rules of normality therefore a Pearson's correlation was carried out.

4.1 It was hypothesised that a negative correlation would exist between the level of global social support and the exhaustion dimension of the MBI.

While there was a negative trend there was not a significant correlation, $r (31) = -.13, p = .24$, therefore the hypothesis was not supported.

4.2 Similarly, it was hypothesised that a negative correlation would exist between the level of social support experienced and the measure of cynicism on the MBI.

This hypothesis was supported, with a moderate negative correlation being found, $r (31) = -.44, p < .01$, suggesting that there is a relationship whereby those reporting higher levels of social support also report lower levels of cynicism. This indicates that as the midwives sense of the 'global' support they received grew, they were more likely to have a positive outlook and one where they didn't distance themselves from colleagues, were less irritable, and were less apathetic about the work they were doing.

The third hypothesis considered the effect of lack of support in relation to the mean subjective stress experienced by the midwives. The mean subjective stress had been calculated as previously described. A median split was then carried out on the global social support score derived from the Social Provisions Scale to create groups designated as high and low social support before proceeding with the t-test.

4.3 It was hypothesised that those midwives who experienced low levels of social support would report significantly more total work stress.

This hypothesis was not supported, $t (29) = .59, p = .56$.

Bereavement Care

As previously described, for each midwife the sum of stress per category of stressors was summed and divided by the number of months spent in birthing suite by that midwife to arrive at the mean stress per category per midwife. The same procedure was followed to arrive at the mean compassion satisfaction,

burnout and compassion fatigue scores per midwife as derived from completing the ProQOL at the conclusion of each four week period. The Kendall's tau – b procedure was then employed to assess if any relationships existed between bereavement care and compassion fatigue, while a t-test was carried out to determine if there was a difference in the experience of bereavement care stress according to the level of reported social support.

5.1 It was hypothesised that the stress associated with providing bereavement care would be positively correlated to measures of compassion fatigue.

This hypothesis was supported with a moderate correlation found, τ (21) = .51, p < .01, indicating that as midwives reported increased levels of subjective stress related to the provision of bereavement care there was an associated increase in reports of compassion fatigue.

5.2 It was hypothesised that there would be a significant difference in the amount of bereavement care stress reported between those midwives who were classified as either low or high on global social support.

This hypothesis was not supported, t (19) = -1.241, p = .23.

Supplementary Analyses

With the completion of the analyses in relation to the hypotheses, consideration was then given to those areas that warranted further investigation or where the results had raised further questions. Such an area included making an assessment of the two scores recorded for the MBI.

The MBI was initially completed as part of the battery of scales forwarded to participants at the commencement of the data collection period. As the final Diary of Stressful Events neared completion, the MBI was included with the final ProQOL and Perceived Stress Scale (PSS) and forwarded with a letter indicating this was the final piece of data collection.

By having the MBI completed twice at approximately a twenty four week interval, it was planned to make an assessment of the change in burnout scores recorded by the midwives, although previous findings suggested the subscales of the MBI remained stable over a span of three months to one year, with correlations in the .50 to .82 range (Maslach, et al., 1996). Interestingly for this sample, there were correlations within that range on the exhaustion dimension, r (28) = .75, p < .01, and the inefficacy dimension, r (28) = .57, p < .01, but there was not one on the cynicism dimension, r (28) = .31, p = .11. This indicates that while the changes in the scores of the exhaustion and inefficacy dimensions were uniform, the changes in the scores of the cynicism dimension were perhaps more reactive and presented a more inconsistent pattern of change.

The means and standard deviations for 'time one', 'time two' and the demographic norms for females (Maslach, et al., 1996) are displayed below in Table 13. While some change in the means are apparent, these were not significant for either exhaustion, t (27) = .744, p= .46, or cynicism, t (27) = -.09, p= .93, and it can be noted that they were very similar to the demographic norms.

With regard to the change in the inefficacy mean, it can be seen that there has been a decrease in the mean and that it falls below the demographic mean. This change was found to be statistically significant, t (27) = 3.95, p <.01, indicating that there was a significant diminution in how adequate the midwives were feeling in their roles and that they would have had an increasing sense of feeling overwhelmed. A single sample t-test was then carried out which confirmed that the 'time two' inefficacy score was significantly different to the demographic norm, t (27) = 3.95, p <.01).

Table 13

Means and S.D. for the MBI dimensions at 'Time One', 'Time Two', and Demographic Norms

	M	S D
Exhaustion – 'time one'	22.75	10.85
Exhaustion – 'time two'	21.68	10.60
Demographic norm	20.99	10.66
Cynicism – 'time one'	6.14	5.94
Cynicism – 'time two'	6.25	4.39
Demographic norm	7.02	6.34
Inefficacy – 'time one'	36.89	6.78
Inefficacy – 'time two'	31.96	7.36
Demographic norm	36.50	6.56

n = 28

Because a significant difference in the subjective stress levels experienced for the 'level two' and the 'level three' hospital was known to exist, it was decided to assess the change in the inefficacy dimension according to hospital grouping. While the result for the level two hospital was not significant, t (7) =

1.02, $p = .35$, a significant change was found on the measure of the inefficacy dimension at the level three hospital, $t (21) = 4.14, p < .01$). This suggests that those midwives were experiencing a deeper state of burnout.

Chapter 9

PHASE TWO: DISCUSSION

It is the aim of this discussion section to provide an initial synopsis of the quantitative findings before moving to a more in depth discussion of those findings considered noteworthy. The first section will therefore be restricted to focussing on providing some explanations for the associations found between the various events included in the *Diary of Stressful Events*. These associations will be considered in terms of both the frequency of occurrence and the subjective stress levels experienced. The next section will then focus on those areas identified as important to this research and thus the results of the hypotheses will be discussed. This will also incorporate the findings of the supplementary analyses arising as a result of questions that occurred in light of the current findings.

The first step is to once again make an initial assessment at the 'meta' level. Therefore, after initially considering the gross categorical data obtained from the diary of stressful events, the opening discussion will move to considering the results for both the frequency and subjective stress data, also initially at the categorical level. This will provide an overview of the findings and lead into a more detailed discussion of the diary of stressful events data at the event level. The discussion of these findings in terms of the available literature will be completed in the final chapter, where the findings of the two phases of research will be merged into one coherent account of the study.

While it is important to understand what events occur most frequently and which are the source of the most stress, it is also important to understand the shared relationships. Therefore, to provide this context for the correlations the overall means for each category for both frequency of events and subjective stress ratings have been reviewed.

When considering the frequency of events at the categorical level, it was found that the workload category provided on average the greatest number of events per midwife with emergency care and issues of case management coming a distant second and third. These were then followed by conflict, lack of support, and bereavement care.

It is perhaps not surprising to find that over the twenty four week period of data collection the mean subjective stress ratings per midwife per category provide a similar order of results to that of frequency. Therefore, once again the workload category was on average the greatest source of stress, with emergency care and case management falling into a distant second and third position. The order remained the same for conflict, lack of support, and bereavement care.

When an assessment is made of the mean stress experienced per event by category, it is of interest to note that the order changes. The category of bereavement care provided on average the most stress per

event. The remainder were, in order, case management, workload, lack of support, emergency care, and conflict.

Therefore, when considering how to alleviate the stress incurred as a result of workload events, it is just as salient to consider the frequency of particular events within this category along with the degree of stress incurred. This suggests the possibility of significantly reducing the stress incurred in the workload category by studying the frequency with which certain events occur and employing strategies to reduce their frequency. However, when considering the stress arising from providing bereavement care, to simply reduce the frequency is probably not as practicable, but it is possible that appropriate supports could be put in place to assist in minimising the stress experienced. A discussion of these will be included in the recommendations.

Synopsis of categorical stress findings at the event level
Associations between event frequencies
The initial overview of the data in relation to the frequency with which events occurred for each category revealed a series of predominantly moderate correlations. The observation that each category shares a correlation with at least one other category is possibly a reflection of working within a dynamic environment that can require an individual midwife to interact with a diversity of people while managing a variety of different tasks. It could also be interpreted to indicate that the various facets of a midwife's work as indicated by the events within each category do not occur in isolation. That is to say for example, the recorded frequency of events related to case management and conflict can logically be a result of interdependence.

Of some interest is the observation that the only correlation for the frequency of bereavement care category events is with emergency care category events, which would initially appear to be contrary to the notion of interdependence. A possible explanation for this frequency is that when a midwife is responsible for providing bereavement care, because the expectations and requirements of care vary from those of other women, the midwife may more often be able to leave those in her care to assist when an emergency event is occurring. Another explanation is that often the bereavement care is provided by the more senior midwives who are also more able to be of assistance when there is an emergency care event.

However, with regard to the two categories of case management and conflict which share a moderate correlation, there would be a more clear interdependence between them. Such examples of this would be when a midwife would have felt obliged to advocate for a clearer management plan or she perceived that standards of care were compromised, thereby increasing the likelihood of her experiencing some conflict with medical staff and perhaps colleagues. Conversely, in the case of the bereavement care

category, there is a clearer management plan and appropriate care has usually been determined. Therefore the angst of an unclear treatment plan is removed and the midwife is less likely to have been required to enter into such discussions with either medical staff or colleagues.

It is also worthwhile noting that the category of lack of support shares the greatest number of correlations with other categories with regard to the frequency of events. This suggests that midwives are feeling unsupported by either their colleagues or supervisors / unit managers as they contend with compromised standards of care, determine appropriate care and work with unclear treatment plans, while perhaps being in conflict with these same people and the medical staff, the women and their support people. This may then be compounded by a lack of support with regard to the various workload issues of caring for complex cases, being in charge, having an inappropriate staff skill mix or staff women ratio. While this is not necessarily a reflection of the stress they are experiencing, it demonstrates the complexity of issues that midwives in birthing suite are managing routinely.

Associations between event stress

Similar to the assessment of categorical frequency correlations, an assessment of categorical subjective stress correlations was also completed. The first thing to note is that with regard to the perceived stress experienced by the midwives, there is a stronger display of associations. This is demonstrated by the greater number of correlations, and the strength of the correlations when compared with the frequency correlations. It also suggests that the frequency with which events occur is not directly related to the subjective stress reported.

A comparison of the categorical frequency and subjective stress correlations reveals that those categories not sharing a correlation for subjective stress experienced per month (case management with bereavement care, and emergency care with case management and conflict) display negative trends when the categorical frequency correlations are considered. This lends further support to the notion regarding protocols and procedures. Therefore, when considered in terms of the bereavement care and case management categories it can be postulated that where a clear management plan is in place, allowing the midwife to provide care in a coherent manner with minimal interruption, unconcerned about an unclear treatment plan and little concern regarding compromised standards of care, one source of stress is diminished.

As noted, the correlations for the subjective stress experienced per category show many inter-correlations. It can be observed that the workload and lack of support categories share correlations with all other categories. What this suggests is that those midwives who were experiencing increased stress due to workload events were susceptible to experiencing increased stress in a diversity of situations.

148

Similarly, for those midwives who experienced greater stress when they felt unsupported, they were also more likely to experience stress across a spectrum of situations.

While the workload category correlations were predominantly weaker, the lack of support category correlations was predominantly strong. This suggests perhaps an undercurrent of stress arose when midwives were required to manage complex cases, work in charge and/or provide supervision, experienced concern regarding an imbalance of experienced to inexperienced staff or due to the ratio of women to staff. Of interest is the fact that where a sense of lack of support from both midwife colleagues and from supervisors / unit managers existed, there was a clearer likelihood of these midwives reporting more subjective stress in relation to the workload category of events as reflected in the strong correlation demonstrated between the two categories.

While a correlation was not found for the frequency of bereavement care category events with conflict category events, a moderate correlation was found for the subjective stress experienced. Therefore, although the events in these categories did not occur together with great frequency, the stress associated with bereavement care events and conflict increased together quite strongly. Similarly, for the category of bereavement care with the lack of support and workload categories; while there was no correlation for frequency of events in these categories, the subjective stress associated with each share weak to moderate correlations. This suggests that for events in these categories, there is an inherently stressful element that is not dependent in any way on the frequency with which they occur. Further examples of this occur for the workload category of events with case management, conflict and emergency care categories, and the lack of support and emergency care categories. Examination of these categories at the event level will provide greater insight into the nature of the correlations, and provide the prospect to explain some of the underlying or inherent stress that may exist.

Shared associations between frequency and subjective stress

While an examination of the correlation matrices for the subjective stress categories reveals many correlations, of particular interest is where the categories share a correlation of $\tau =.50$ or greater at $p < .01$ two-tailed. At this level, it indicates that at a minimum, twenty five percent of the variance for the two variables was explained. Of particular interest is where the categories were found to share strong correlations for both the frequency of occurrence and the subjective stress rating assigned to each, although it must be noted that the frequency correlations were not as strong. Where more moderate to strong correlations existed, this would indicate that while the events within these categories were frequently occurring in parallel with each other, they were also sharing a commonality in the degree to which the midwives experienced them as stressful.

Although the frequency correlations did not attain the prescribed level of $\tau = .50$, it is worthwhile noting that the category of lack of support displayed substantial correlations to case management, conflict and workload. Hence, when the frequency of case management issues increased in conjunction with an increase in a lack of support from unit managers and supervisors or colleagues, there was a parallel increase in the levels of subjective stress being experienced for these two categories. Similarly, as the frequency of conflict issues and workload issues increased in parallel with lack of support, so too did the reported levels of subjective stress. Therefore, where there was an increase in frequency of case management, conflict and workload issues that was accompanied by a lack of support from colleagues or unit managers and supervisors, there was also increasing levels of stress across these same categories. When this is considered in terms of the amount of variance explained for each correlation, there is an important contribution being made by them with regard to the subjective stress experienced.

This indicates that in seeking to modify the experience of stress for events in one of these categories, consideration would need to be given to modifying the frequency with which such events occur in conjunction with considering the shared characteristics that contribute to the stress experienced. An understanding of these shared characteristics will be gained when the events within each category are examined.

While case management and conflict were correlated to lack of support, they also shared moderate to strong correlations with each other for both frequency and subjective stress. Once again, as events within these categories increased in frequency, there was a parallel increase in the amount of subjective stress being reported. As previously discussed, interdependence for the frequency of events in these two categories is readily explained, but it is important to note that a correlation also exists for the subjective stress experienced.

In concluding this synopsis of the categorical data, it is significant to note that where a category of events displayed a frequency correlation, they also displayed the strongest subjective stress correlations. From this it can be theorised that where there is an increased frequency, the stress experienced is exacerbated.

Associations between frequency of stress events and burnout
Continuing with the notion that frequency of stress event occurrences had an accumulative impact on the midwives the categorical frequencies employed previously were correlated to the MBI scores collected following submission of the final diary. Interestingly, the only category to have a correlation on any dimension of the MBI was for bereavement care, indicating that the more frequently a midwife cared for a woman with either a fetal death in utero (FDIU) or midtrimester termination (MTT), the more likely she was to display increased signs of burnout. While these bereavement care correlations

were generally moderate, the importance of these findings relates to the manner in which burnout develops.

Diestel and Schmidt (2010) demonstrated 'exhaustion' as the first thing to occur as burnout develops. Therefore, an increase in the scores of the exhaustion dimension indicates that burnout is developing. In addition, they also found that with regard to cynicism, there is little likelihood of any reverse causality with 'exhaustion'. This indicates that cynicism is the second stage in the development of burnout. Therefore, the correlations described in the previous chapter suggest there is a link between the frequency with which bereavement care is delivered and the development of burnout.

To further understand these 'meta' correlations, the frequency of the two bereavement care events were correlated to the exhaustion and cynicism dimensions of the MBI. When FDIU is considered, consistently moderate correlations were found with both the exhaustion dimension, $\tau\,(28) = .30, p < .05$, and the cynicism dimension, $\tau\,(28) = .32, p < .05$. These can be compared to MTT where a different picture developed. While there was a weaker correlation with the exhaustion dimension, $\tau\,(28) = .29, p < .05$, a considerably more moderate correlation was demonstrated with the cynicism dimension, $\tau\,(28) = .40, p < .01$. These results indicate an inextricable link between the frequencies with which either bereavement care event is provided and the development of burnout. Of particular interest is the moderate correlation of MTT with the cynicism dimension.

The cynicism dimension relates to 'depersonalisation' and was described as a coping strategy used to reduce feelings of burnout (Maslach & Leiter, 2004; Maslach, Schaufeli, & Leiter, 2001). Diestel and Schmidt (2010) suggest this concept can be linked to the theory of 'conservation of resources', as described by Hobfoll (1989). Hobfoll's theory implies that the cynicism demonstrated is in part a behavioural manifestation of burnout, as well as a loss of control strategy that is employed to limit the diminution of personal resources. It is considered a dysfunctional coping strategy because the cynicism ultimately hinders access to social support. This leads to isolation of the individual and possibly initiates what Hobfoll referred to as the 'loss spiral' where dysfunctional coping incurs repeated loss of resources.

Therefore, the more moderate correlation which suggests increased frequency of caring for women having a MTT is associated with increasing cynicism has important ramifications for the midwives who provide this care. It indicates that it may be prudent to monitor the frequency with which each midwife is required to be responsible for providing such care, and endeavours made to limit this to a level that ensures this does not become a source of burnout.

A review of noteworthy individual events

A series of mainly weaker to more moderate correlations were revealed when the frequency of individual events within those categories that displayed a correlation where explored. While these may not provide the firm basis on which to base a series of recommendations, they are in keeping with the notion of interdependence highlighted earlier in the discussion and do point the way forward from this essentially exploratory study and examination of the data.

An explanation and clarification of event frequency associations

Within the grouping of moderate to stronger frequency correlations, there were some that were more difficult than others to explain. An example of this was the correlation in frequency of caring for women with a fetal death and shoulder dystocia. While an initial thought would be to suggest that the emergency care situation of shoulder dystocia has the potential for fetal demise, which would ultimately result in the need to provide bereavement care, it is more probable that those providing bereavement care were more able to attend and provide assistance when an emergency care event such as shoulder dystocia arose. When a midwife was responsible for the care of a woman with either a fetal death in utero (FDIU), or a midtrimester termination (MTT), the need for her to remain at the bedside is not as great as when there is a baby to monitor. Therefore, those midwives were possibly better placed to assist in a variety of situations, thereby providing an explanation for this unforeseen correlation of frequency of shoulder dystocia with FDIU. A similar explanation can be suggested for the correlation of frequency of MTT with immediate Caesarean section where once again the midwives providing MTT care were more able to provide assistance for emergency care events.

The notion that an unclear treatment plan is an issue for midwives is supported by the frequency correlations that were found for this event with conflict events. The event of unclear treatment plan displayed correlations to conflict with both medical staff and midwife colleagues. Although these were weaker correlations, they suggest that the midwives placed some importance on having a clearly delineated treatment plan to follow. The benefits of this would have been to provide them with a sense of direction and certainty in managing cases, particularly where they were more difficult or complicated. It would also have allowed them to maintain their credibility by facilitating the answering of questions from the woman, her partner and support people with greater certainty and clarity.

Another overarching factor in creating a sense of there not being a clear treatment plan with regard to the two hospitals involved in the study is their status as training hospitals. Therefore, while a junior doctor may have instituted one clear treatment plan it may have been countermanded by a more senior doctor. To add to this uncertainty, the consultant obstetrician may have then considered it appropriate to

152

'tweak' this plan, or there may have been a handover to another consultant obstetrician who had a different philosophy of practice and so amended the current treatment plan. This would give rise to a situation that has been described in the burnout literature as 'role conflict' (Maslach, et al., 1996; Maslach & Leiter, 2004; Maslach, et al., 2001). In such circumstances there are multiple authorities who hold incongruent values and present conflicting demands. This prevents the worker from exercising any effective control, in this case the midwife who has to contend with a series of conflicting demands, and it becomes emotionally exhausting to work in such circumstances.

Another area of conflict for the midwives that revealed some slightly stronger correlations was for the case management event of determining appropriate care and conflict with medical staff along with conflict with their midwifery colleagues. This may be interpreted as an indicator that the midwives frequently had a very clear idea as to what they considered to be appropriate care, causing them to feel the need to voice their opinion in that process, whether that be to the medical staff or to those in charge of the ward. The midwives also see their role as one of advocacy for those in their care, indicating such a correlation may be a reflection of them performing this role.

When considering case management events and lack of support events it is noteworthy that the strongest correlations of frequency were found with lack of colleague support. The strongest correlation was for determining appropriate care, and in attempting to determine the most appropriate care, the midwives would have predominantly sought the advice and support of their colleagues. It is also possible that the doctors would have suggested what they considered the more appropriate care to be, but it was at odds with the views of the midwife who then sought the support of her colleagues. However in either situation, while it was possible the support required was not supplied, those from whom the support was being sought may not have been able to provide it in the manner expected or required, leaving the midwife with a sense of inadequate support. It has been found that factors such as whether the support was offered spontaneously, the relationship of the recipient to the provider and the consistency of the support with what was required are significant in determining the perceived supportiveness of the behaviour (Cutrona, et al., 1990).

The other lack of colleague support and case management event correlations occurred with unclear treatment plan and compromised standards of care. With regard to the treatment plan not being clearly delineated, the midwives possibly felt less sure of what they were doing which created an underlying sense of not having control of the situation, creating the need for more support from their colleagues. Once again however, the colleague either may not have been able to provide a solution to the problem or to provide support as expected or required. Also, both of these correlations may be a reflection of the frequency of the anxiety, frustration and uncertainty the midwives were experiencing in relation to these

case management events. It is also possible that they were not able to be resolved through consultation with their colleagues as they were more within the domain of the medical staff to resolve.

A further indicator of the frequency of an unclear treatment plan being an issue for the midwives is that it is the only case management event to have a correlation, although weaker, with lack of supervisor / unit manager support. As was suggested for lack of colleague support, this is most likely a reflection of the anxiety, frustration and uncertainty the midwives were experiencing which was underpinned by their sense of control being challenged. However, a degree of interdependence would also be an explanation to consider when explaining the associations found for these events. As issues of case management arose there was also a correlation in frequency of workload and lack of support issues.

The association between the frequency of conflict events and the two lack of support events included the events of conflict with women, conflict with medical staff and conflict with midwife colleagues. When considering the lack of support from colleagues, the moderate correlation that occurred in relation to conflict with women was the strongest correlation. This may be an indication that midwives seek and expect the support of their colleagues in preference to any other group when they experience such difficulties. The perception that there is a lack of support may result from colleagues being unable to resolve the issues surrounding the conflict, not concurring with the aggrieved midwife's point of view, not paying sufficient attention to the issues or not having the time to.

A weaker correlation occurred for lack of support from colleagues and conflict with medical staff, and the explanation would be similar to that described in the previous paragraph. What is pertinent with regard to these findings is the indication that as such conflict events occur, the midwives were feeling unsupported, particularly with regard to their most immediate source of support and support that is deemed of some significance with regard to inhibiting burnout (Maslach & Leiter, 2004; Maslach, et al., 2001).

The next most immediate source of support was with the supervisors / unit managers, and here the only correlation found for lack of support from this group was for conflict with midwife colleagues. Although this was a weaker correlation, the explanation for it would concur with those offered when discussing lack of support from midwife colleagues. Of greater significance is the indication that midwives perceive their two most immediate sources of support as inadequate when these situations arise. This can be considered in the context that for this group of midwives the most frequently occurring conflict events were with medical staff and midwife colleagues.

This notion is brought into sharper focus when the correlations for the frequency of lack of support and workload events are considered. As previously reported the only events to not share a correlation for these two categories were those of lack of supervisor / unit manager support and staff/patient ratio. However, with regard to In-charge duties/providing supervision, it shared a strong correlation to

supervisor / unit manager lack of support, and a more moderate correlation to midwife colleague lack of support. Therefore, when midwives have the added responsibility of working in charge of the birthing suite and or providing supervision, and are experiencing more conflict situations, they recorded that they were inadequately supported.

An explanation and clarification of event stress associations

In moving from considering the frequency correlations to considering the subjective stress correlations, a different perspective had to be adopted. The frequency correlations for the categories suggested groupings of events that were occurring in parallel and when explored at the event level a more detailed picture of the various associations was gained. For example, this brought into focus the notion of an association between having an unclear treatment plan and a variety of other events whose frequency increased in accord with this event. From this can be drawn the thought that if there were an endeavour to provide clearer treatment plans, there would be a possibility that conflict with medical staff and or colleagues could be reduced.

While the notion of interdependence remains a factor when considering the subjective stress correlations, it is of a different nature. These correlations are not necessarily a reflection of various stressful events occurring in parallel, but rather they are a reflection of constellations of event types that will generate stress in a particular individual. That is to say, the subjective stress that was experienced for the various events did not necessarily occur in unison. What has been demonstrated is a preponderance of events that generated increasing subjective stress for a sample of midwives.

As has been previously discussed, the subjective stress associated with bereavement care events did not display a correlation with the subjective stress of case management events, which may in part be explained by the clear protocols and procedures that were in place for such situations. However, it is of interest to note that bereavement care subjective stress was predominantly moderately correlated to all other categories.

The first correlations for the bereavement care category involved the event of FDIU, which was found to be correlated to the conflict category events of conflict with women and conflict with partners/support people. While the conflict with women was more moderate, the subjective stress correlation for conflict with partners/support people was quite strong. What cannot be gauged from the results is the level to which the conflict with either group is taken. If there was interdependence for these events, it is quite possible that stronger words may have been spoken between the midwife and the partners/support people. It is also possible that the conflict the midwife experienced in that situation was internalised as they determined not to cause any further distress to the women in their care. Another aspect could be that those midwives who experienced stress when they were responsible for

155

providing such care were also more susceptible to experiencing stress through conflict with women and partners/support people when they provided care in other situations.

Therefore, while the midwives were experiencing some conflict in relation to the women that may have related to their care and management or their individual wishes for the situation they found themselves in, the stress in relation to conflict with partners/support people was stronger. With regard to the partners/support people, the midwife's role as advocate may have underpinned the conflict. As people experiencing various levels of duress, the partners/support people may have attempted to ensure that the 'right thing' was done, may have made requests that were difficult to fulfil, may have made requests contrary to the women's wishes, or requests that may have been contrary to what the midwife knew or considered to be best practice. Consequently, when a midwife with such a character found herself in conflict with partners/support people over these issues, she may have also been more stressed when in the alternate situation of being called upon to care for a woman who had experienced a FDIU.

With regard to the bereavement care category event of providing care for a MTT, the only conflict event correlation was for conflict with the woman. This was a slightly stronger correlation for women's conflict when compared with that for FDIU. If there was interdependence between these events, then it could be speculated that the midwives may have experienced varying levels of conflict with the choices taken by the woman, including such things as the reasons for termination, the process the woman wished to follow, how the women reacted following the birth and the manner in which they grieved. In proffering this explanation, the work of Cignacco (2002) who described the moral dilemmas experienced by midwives when caring for a woman having a termination is brought to mind. Once again, this conflict may not have been voiced to the woman, but more internalised or spoken of with colleagues.

Conversely, the conflict experienced by a midwife may have arisen from a firm set of values that she adhered to in her overall practice. Therefore, in adhering to these values, conflict may have occurred with an array of women, and the reason for experiencing higher levels of stress in caring for a woman having a MTT may have been associated with feelings of sadness at the impending loss of life or despair for the woman and the situation she was in.

It is interesting to note that the emergency care category events that correlated with bereavement care events were fetal distress and immediate Caesarean section. While these subjective stress correlations involve different events when compared to the frequency correlations for these categories, the notion that when midwives are providing bereavement care they are more able to provide assistance at such emergency events may still have been a factor. However, the bereavement care event involved was that of FDIU, which displayed a correlation with fetal distress and immediate Caesarean section.

156

It may be suggested that a midwife who was caring for, or who had previously cared for a woman with a FDIU, had a heightened sense of awareness of the perils of pregnancy and birth. This would have made her more susceptible to experiencing stress when confronted with the situation of fetal distress, or immediate Caesarean section. With regard to FDIU, because many midwives have had the unhappy experience of providing such care, they were more anguished by fetal distress. This offers an explanation for the particularly strong correlation between FDIU and fetal distress. Also, where the events were concurrent, stress may have arisen from having attended the emergency situation which was subsequently managed successfully, but then experiencing some stress at having to return to an irretrievable situation.

While a moderate correlation was found at the categorical level for the subjective stress of bereavement care events and lack of support events, when these were examined at the event level, no individual correlations were found. While this could suggest that the categorical correlation was spurious, it may also be a function of the limited numbers for each event when studied individually. What can be drawn from the finding is that it warrants further examination in an endeavour to establish if there is an association between the stress of providing bereavement care and a sense of stress due to lack of support from colleagues or supervisors / unit managers.

Moving to the subjective stress correlations for bereavement care events with workload events, moderate correlations were demonstrated for FDIU with complex cases and staff/patient ratio, while there were none found for MTT.

For some midwives, the subjective stress experienced when caring for a complex case or a woman experiencing a FDIU may have had some commonality. In both situations there could have been a sense of uncertainty with regard to how the situation would progress leading to a sense of lack of control. Where there was a complex case, there would be increased concern for the well-being of both the mother and the baby. For some this may have initiated higher than usual levels of stress. While the stress may be inherently different, for that midwife, its level may have equated to the levels of stress she had experienced when caring for a woman experiencing a FDIU.

An important element of care for many midwives is to provide care that attends to all the needs, wants and requests of the woman or the couple in the most sensitive and caring way possible. This is potentially magnified in the instance of a FDIU. Therefore, when the staff / patient ratio was compromised such that the midwife was stressed, one of the factors in generating that stress could have been the fact that the care she was able to provide had been compromised in terms of the amount of time she had been able to spend with the woman when she wanted it. While the level of support required

during labour may not be as high, there are times when the woman requires the comfort of the midwife's presence.

With regard to the frequency of event correlations, it was discerned that having an unclear treatment plan shared an association with several other events, suggesting issues of case management may play a role in the development of midwives stress. With regard to the subjective stress experienced, case management was found to share strong correlations to conflict and lack of support, while there was a weaker correlation to workload.

It is timely to consider the consequences and implications of the subjective stress reported in relation to the events contained within the case management and workload categories. The case management category consisted of three events. The first of these was compromised standards of care, and the significance of this to the study centres on one of the findings of Vinje and Mittelmark (2007) who conducted a qualitative study of community nurses. They concluded that the 'moral distress' arising from the frustration of nurses not being able to provide the quality of care they consider consistent with nursing values makes them susceptible to burnout.

The remaining two events of determining appropriate care and unclear treatment plan fall within the realm of control, as do the workload category events of I/C duties, staff skill mix and staff / patient ratio. Maslach, et al. (2001) make the point that where individuals do not have the resources or the authority to pursue their work as they would desire there is an associated relationship with the inefficacy dimension of burnout. With the regard to the workload events, there is also an associated overload, which if prevalent has been found to be associated more frequently with the exhaustion dimension of burnout.

Correlating the subjective stress arising from case management events with the subjective stress of conflict events revealed a series of moderate to strong associations for all events except conflict with ancillary staff where there were none. With regard to the notion of conflict, if this becomes chronic or unresolved it can lead to a diminution in social support which is then associated with increased burnout. This is manifested as exhaustion if associated with supervisors and inefficacy when associated with co-workers (Maslach & Leiter, 2004; Maslach, et al., 2001).

Therefore, the case management event of compromised standards of care shared moderate to strong correlations with conflict with women, conflict with medical staff, conflict with partners/support people, and conflict with midwife colleagues. It is interesting to note the strongest correlation was for stress arising from conflict with women. This suggests that those midwives who were particularly stressed when they perceived standards of care to be compromised also became particularly stressed when she was in conflict with a woman. This is plausible from the perspective that the midwife who saw her role

as one of advocacy for the woman and who endeavoured to maintain high standards of care and registered stress when that was not attained, would also have been particularly distressed if she had experienced conflict of any form with the patient. This would have been counter to everything she was striving to achieve and to how she perceived her role. For example, if the conflict the midwife experienced was in the form of having some difficulty in complying with the woman's wishes, this would have created a dissonance within the midwife.

With regard to compromised standards of care and conflict with medical staff, there may have been a clear interdependence, as it is very likely that the stress being reported occurred concurrently. Additionally, those midwives who became distressed when standards of care had been compromised may also have been more likely to voice their opinion to the medical staff on a range of issues. This could have created an opportunity for conflict in the form of a dialogue where the midwife made suggestions counter to those offered by the medical staff. The midwife would have found this particularly distressing if her opinion had been discounted, she felt unable to express it or when the doctor's opinion was contrary to what she perceived as being more appropriate.

The correlation found between compromised standards of care and conflict with partners / support people was more moderate. Once again the association for the increasing stress experienced by the midwife between these two events may have been the result of a particular incident or set of circumstances. While the incident or set of circumstances triggered the notion that standards of care had been compromised, the partners / support people may have also had the same awareness and their concern for the woman was manifested in such a way that it had brought them into conflict with the midwife. Another explanation could be that a midwife who became stressed when standards of care were compromised was also more likely to advocate strongly for the woman in her care. In maintaining this position, the same midwife may have also been more likely to come into conflict with various partners / support people if she considered they were acting in a manner that was unsupportive for any woman in her care, or that were counter to the wishes of the woman.

Similarly for conflict with midwife colleagues, the midwife may have been in conflict with her colleagues because she considered that standards of care had been compromised and they did not. Or alternately, the midwife who experienced greater stress due to the notion of compromised standards of care was also more likely to experience increased levels of stress if she considered she was in conflict with any of her midwife colleagues.

The next case management event to be considered in conjunction with conflict events is determining appropriate care. This event shared strong correlations to conflict with partners / support people, conflict with medical staff, conflict with midwife colleagues, and conflict with women.

As with previous events, the associations may result from a direct relationship between the events or be a product of personality traits. This leads to an explanation whereby it is probable that a midwife who developed increasing stress when she considered an appropriate care plan had not been determined may have had a sense of a lack of direction or control, initiating a more deep-seated disquiet. Such a sense of disquiet may predispose her to conflict with an array of people. Moreover, as with the midwife who experienced distress when standards of care were compromised, this midwife may also have felt the need to advocate for the woman. This would have had the potential to bring her into direct conflict with the various groups of people.

Beginning with the strongest correlation, the stress experienced with regard to conflict with partners / support people may be a product of the fact that a midwife with a deep-seated sense of disquiet potentially had the greatest contact with the partners / support people. Then in endeavouring to determine an appropriate plan to overcome her disquiet, the midwife would have interacted most frequently with the medical staff and then her midwife colleagues. The conflict experienced with the woman may be more directly related to the midwife not being able to accommodate her requests. The midwife would have then been in the position of having to determine appropriate care through negotiation with the woman.

A similar set of moderate to strong correlations were also found with regard to the case management event of unclear treatment plan. Once again there were strong correlations with the two events of conflict with midwife colleagues and conflict with partner / support people, while there were more moderate correlations for conflict with medical staff and conflict with women.

The picture that has developed with regard to determining appropriate care may also be relevant when seeking to explain the correlations of conflict events with the event of unclear treatment plan. This is another situation where the midwife's perception may have been of a lack of direction and/or a lack of control. The manifestation of this, which had been precipitated by a sense of disquiet and uncertainty, occurred as conflict.

Continuing with the case management category of events and the category event of midwife colleague lack of support, a series of moderate correlations were found. While these were more moderate correlations, the strongest was for unclear treatment plan and determining appropriate care. As previously suggested, the factor underpinning the stress experienced for these two events very likely relates to the midwives sense of control being challenged. For many midwives, when they do not have a clear sense of direction or do not feel there is an appropriate plan of care in place, they may experience disequilibrium that is manifested as increasing levels of subjective stress. In other circumstances these

midwives may have also sought the support of their midwife colleagues and experienced higher levels of stress when it was not available or did not suit their requirements.

Midwife colleague lack of support also shared a moderate correlation with compromised standards of care. It is probable that a midwife whose perception was of compromised standards of care such that she experienced increasing stress would have sought support from her midwife colleagues across a range of issues. If this support did not meet her requirements, a higher level of stress would have been generated. As has been previously stated, the notion of social support in the form of supervisor or colleague support has particular significance in relation to the formation of burnout (Maslach, et al., 1996; Maslach & Leiter, 2004; Maslach, et al., 2001). Therefore the accumulative effect of this lack of support across a variety of events may be significant.

It is noteworthy that when the subjective stress arising from supervisor / unit manager lack of support is considered in relation to case management events, there is not a correlation to compromised standards of care, while there was a quite strong correlation to unclear treatment plan and a more moderate relationship with determining appropriate care. This could be interpreted as reflecting the distress a midwife experienced if her sense of control was challenged. As previously discussed, both of these events placed the midwife in a position of uncertainty as to how the course of events may unfold, or that the midwife perceived the plan as problematic. For the midwife who was distressed in this manner, it is probable that she would have attempted to reduce her distress by seeking the support of many others. However, because the circumstances that created an unclear treatment plan or made it difficult to determine the appropriate care were not readily resolved, or were within the domain of the medical staff to resolve, the support received would probably have seemed inadequate.

The final series of subjective stress correlations for the case management category of events incorporated the workload category of events. The workload events included caring for complex cases (e.g. severe pre-eclampsia), being in-charge and/or providing supervision, where there were issues to do with staff skill mix, and issues of staff women ratio.

Perhaps because these events are prevalent for many midwives, there were moderate to strong correlations between all of the events. Therefore as an example, when considering the correlation of workload events with the case management event of compromised standards, the initial explanation would be that when standards of care were compromised, it is logical that this may have been associated with providing care to a complex case where it may have taken time to initiate care. Also, when a midwife was in-charge she would have been involved in ensuring that the standard of care given to all women was maintained and would have experienced more subjective stress if it had been brought to her attention that the standard of care was inadequate. Further to this, both staff skill mix and staff women

ratio could have directly fed into the standard of care provided. This is to say that when there had been an imbalance of inexperienced staff to experienced staff, or the number of staff available precluded the women from receiving the level of attention expected, the stress experienced would have increased along with the perception that the standard of care being provided had been compromised.

Where the interest lies with this series of correlations, is with those that were the strongest. Once again the two events of determining appropriate care and unclear treatment plan were involved. A particularly strong relationship was found between the events of determining appropriate care and complex cases, τ (23) = .69, $p < .01$. This indicates that forty seven percent of the variance for the subjective stress in one of these events is explained by the other event. A reason for this could be that the stress a midwife experienced when caring for a complex case was exacerbated by events associated with determining what the appropriate care should be, which due to the complexity of the case may have taken considerable time. It may also have been that the midwife perceived there were problems associated with determining what the care should have been, causing the case to appear more complex, thereby increasing her perception of stress for this event.

The other strong correlation for complex cases was with unclear treatment plan. One explanation would be that where there was a complex case, it was possible that the treatment plan appeared unclear at various points because as further tests were carried out and a longer period of observation had passed, the treatment plan evolved and changed. Therefore, a midwife who preferred to have a clearly delineated plan or notion of what care she was to deliver, and who felt more comfortable when appropriate care was in place from the outset, would find her subjective stress levels increasing when she was required to care for a complex case.

Staff skill mix was also strongly related to unclear treatment plan. It is quite reasonable to conclude that a midwife who had concerns about the proportion of experienced staff to inexperienced staff would also have demonstrated some concern when there was not a clear treatment plan set out. The inexperienced staff member who found there was not immediacy of access to an experienced staff member for advice would have justifiably experienced increasing levels of subjective stress. For the more experienced staff member, the knowledge that the staff skill mix was placing the inexperienced staff member under added pressure which in turn increased the experienced midwife's burden while she was also concerned for the welfare of the woman, would have intensified any sense of stress she experienced. For both midwives, any stress would have been exacerbated if there was not a clear treatment plan.

With regard to the workload event of staff/patient ratio, it shared strong correlations to both unclear treatment plan and determining appropriate care. In general circumstances, the notion is readily grasped, that if the number of tasks we have to complete exceeds our capabilities higher levels of stress

162

will be induced. Therefore, when the staff/patient ratio was such that the midwives felt their sense of control challenged to the point that they were not able to provide appropriate care to the levels required, it is readily understood as a situation that would have induced high levels of stress. It is also reasonable to suggest that these same midwives would also have experienced increased levels of subjective stress when there was not a clear treatment plan or there was a delay in determining the appropriate care because as previously proposed, these situations also challenged their sense of control.

The subjective stress experienced for the conflict category of events shared a strong correlation to the lack of support category of events. When the individual events were examined, there were a series of moderate to strong correlations between all of the events except for ancillary staff which did not share a correlation to either of the lack of support events.

Lack of support from midwife colleagues shared particularly strong correlations with conflict with midwife colleagues, τ (21) = .66, p < .01, and conflict with medical staff, τ (19) = .63, p < .01. The point to be considered in relation to these findings is that a midwife who feels unsupported by her colleagues (perhaps at odds with them) is possibly more likely to find herself in conflict with those colleagues and the medical staff. This notion could also be applied where the more moderate correlations for colleague lack of support and conflict with women and conflict with partners/support people were found. Although other probable explanations would include the thought that the lack of support stemmed from unfulfilled expectations or the possibility that colleagues had taken a more moderate view of events or had in fact presented an explanation for the woman's or the partner's and support peoples' perspective.

The strongest correlation for a conflict category event with supervisor / unit manager lack of support was conflict with partners/support people, τ (17) = .65, p < .01. Therefore, as midwives experienced greater subjective stress due to lack of supervisor / unit manager support, they were also experiencing more stress as a result of conflict with partners/support people. An explanation for this could be that those midwives who felt unsupported were more likely to place themselves in positions of potential conflict as they attempted to resolve any dilemmas they had. It is also possible that midwives who attempted to resolve various issues, including those with midwife colleagues, medical staff and women that resulted in conflict and stress also anticipated that the supervisor / unit manager would provide greater levels of support than given, causing them a higher than anticipated degree of stress.

The associations found between the conflict category of events and those events in the workload category were of a generally more moderate nature, although some stronger associations were also found to exist. The first set of events to be examined relate to conflict with medical staff, which shared moderate associations with staff/patient ratio, I/C duties, and complex cases, while a stronger correlation

163

was found with staff-skill mix. As has previously been discussed, all of these events could be included as events or situations where the midwife's sense of control has been challenged, which would conceivably result in elevated levels of stress. When the midwives were challenged in this manner, the possibility of conflict would also increase. This is particularly so in relation to the medical staff as they would have had closer or more frequent contact with this group when they worked in-charge or cared for the more complex cases.

The association between the staffing issues and conflict with medical staff is a little more complex. There is a moderate correlation for the stress arising from staff/patient ratio issues, but a strong correlation with staff skill mix. A plausible explanation could be that when the staff /patient ratio was compromised, the midwives experienced higher levels of subjective stress, which precipitated some conflict, but the relationship was moderated by the fact that the midwives attempted to maintain their sense of control and were predominantly task focussed. That is to say, while there would have been many concerns, they coped by prioritising their tasks and maintaining that focus. However, in relation to staff skill mix issues, while the underlying notion of their sense of control being challenged persisted, the mechanisms were slightly different. As previously discussed, in this situation the midwives first concern probably stemmed from the consequences of a lack of oversight and general support and to overcome this they attempted to determine appropriate care plans and have clearly delineated treatment plans. This would have provided the circumstances for some conflict with the medical staff. Additionally, the medical staff may not be cognisant of either the presence of or implications of skill mix issues.

It is of interest to note that a similar pattern of moderate relationships were found for conflict with midwife colleagues and the workload events of caring for complex cases, staff/patient ratio, and I/C duties, while there was a strong correlation with staff skill mix, τ (23) = .63, p < .01. From this and the previous strong association, it can be suggested that the stress the midwives experienced as a result of having their sense of control challenged in this manner is potentially damaging as it was associated with an increased propensity for conflict with the two groups of people that they have to rely upon.

This pattern of moderate relationships is repeated for the subjective stress associated with conflict with patients and the workload events of caring for complex cases, I/C duties and staff/patient ratio, while there was a much stronger correlation for staff skill mix. This pattern of associations has now demonstrated that the subjective stress arising from issues of staff skill mix was strongly associated with stress arising from the three groups of people that a midwife would have to work most closely with on a daily basis.

The final conflict event to be considered in relation to workload events is that of conflict with partners/support people where predominantly very strong correlations were found with the workload events of I/C duties, staff/patient ratio, and staff skill mix, while there was a moderate correlation with complex cases.

A midwife working in birthing suite is required to liaise with a range of people in a variety of often fraught circumstances. Therefore, the opportunity for her to experience conflict in one of its many guises would have been greatly increased, particularly when the midwife was working in charge. Of greater importance is that once again the strongest correlations are for the workload events of staff/patient ratio and staff skill mix. It is also pertinent to note that the relationship for this conflict event and these workload events is stronger than for any of the other conflict events. This may be reflective of a culmination of the subjective stress a midwife was experiencing in any of these situations. To reiterate, the events of working in charge, and issues of staff/patient ratio and staff skill mix are all ones where the midwife may have perceived a challenge to her sense of control. While she would have endeavoured to work collaboratively with the medical staff, midwives and women, it may have been perceived as an inconvenience to have to spend 'valuable' time with the partners/support people. In turn she may have perceived their requests as less important, curtailed her conversations with them or interacted in another similar manner such that a sense of conflict was created.

As supported by the frequency data where it was found that every midwife experienced an emergency event, it may be considered inevitable that the array of emergency events experienced by birthing suite midwives would have contributed greatly to their subjective stress and therefore shared strong associations with many of the other events. Perhaps paradoxically then, unlike the categories of case management, conflict and lack of support, this category does not share an association with all other categories. Therefore, while the association for events within this category and those of bereavement care have been discussed previously, their remains only the associations with the workload and lack of support events to discuss.

In keeping with the notion that the midwives were troubled by their sense of control being challenged, it is pertinent to consider the association providing emergency care events had with workload events. It is of interest to note that fetal distress, 'flat baby', and immediate Caesarean section shared correlations with all four of the workload events. Of these, fetal distress shared predominately strong correlations, while 'flat baby' and immediate Caesarean section shared generally more moderate correlations.

There are several conclusions that can be drawn from these associations, the first being that a strong possibility of interdependence existed. That is to say that whenever any of these three emergency care events occurred in the presence of any of the workload events, there was the potential for one to

exacerbate the other in association with the midwives sense of control being challenged. As an example, if the staff patient ratio was compromised to the point that the midwives were experiencing some subjective stress and then there was an instance of fetal distress, as their perceived ability to manage the situation in the prevailing conditions was challenged the levels of stress reported for both events would be exacerbated.

Similarly, for a midwife who was caring for a complex case that was then involved in an immediate Caesarean section, the subjective stress she was experiencing would be magnified by the stress associated with the need for such a procedure, particularly as it may have been preceded by fetal distress. Such a scenario of events would be underpinned by an increasing threat to her sense of control.

While still underlined by the notion of a threat to their sense of control, it is also possible that those midwives who reported higher levels of subjective stress for any of the emergency care events were also more likely to report higher levels of stress when there was a perception of lack of support. This was the most likely scenario when staff patient ratios or the staff skill mix was compromised. Similarly, such midwives may have also had a preference not to work in charge or felt unsure of their ability when asked to care for a complex case.

To complete the discussion of emergency care events, their association with the lack of support events will be considered, beginning with lack of support from midwife colleagues. While generally weaker correlations were found for the majority of events, a strong correlation was found with bleeding. With regard to the predominantly weaker correlations, this may suggest that for those midwives who experienced some stress for the various emergency care events, they also had the perception that more support could have been provided by their colleagues. What is not revealed here is the nature of the support that was expected. While their colleagues may have been attendant for the actual event, the lack of support may have stemmed from them not being available for some immediate informal debriefing or a lack of acknowledgement of that midwife's experience or concerns regarding the event.

In relation to the event of bleeding, it is more probable that it relates to a post partum haemorrhage (PPH) as this would have been the more common event, although it may also relate to an ante partum haemorrhage (APH). In the instance of a PPH, where there is a clear set of guidelines as to the procedure to be followed, it may be that the support from colleagues was perfunctory in that they attended to the immediate needs and requirements, but then when the bleeding was controlled immediately returned to their own roles. This may have left the midwife with a sense of abandonment leading her to feel unsupported by her colleagues.

While a similar set of correlations were found for emergency care events and lack of supervisor / unit manager support, a strong correlation was found with fetal distress. The more immediate explanation

166

for this would be that the midwife responsible for the care of a woman in labour would have constantly monitored fetal wellbeing and any deviation from normal would have been noted, but may also have become a point of focus. When the deviation from normal was reported to the unit manager (or person in charge), it may have been assessed in a more dispassionate and broader context and a different assessment of its significance may have been given. This may not have completely alleviated the attending midwife's concerns, leading her to feel unsupported.

The final event associations to consider are those within the categories of lack of support and workload. In returning to the discussion of workload events, the concept that the midwives sense of control is pivotal to the subjective stress she experienced is once again paramount.

With regard to a lack of support from midwife colleagues, this was found to be moderately correlated to all of the workload events with the exception of the staff skill mix event where a strong correlation was found. As has been previously discussed, when there is a significantly negative balance of experienced staff to inexperienced staff, the perception that events could become overwhelming is heightened. If this were so, the perception that the midwife's sense of control was under greater threat may have become coupled with the need for greater support from colleagues, thereby creating the impression that there was in fact a lack of support. There is also the more obvious explanation that one was the function of the other, suggesting that there was a lack of support because there was not sufficiently experienced midwifery staff to provide the required or expected support.

While supervisor / unit manager lack of support also shares an association with all of the workload events, the pattern is slightly different in that I/C duties, staff skill mix and staff/patient ratio all share strong correlations with this event. This appears to suggest that with regard to some very specific areas of workload, while there is some impact from an associated lack of support from midwife colleagues, the association with lack of support from supervisors / unit managers suggests it may have been having a greater impact.

In considering each of these events separately, it is advisable to note that the issue of staff skill mix is once again highlighted as an event associated with midwives experiencing increased levels of subjective stress. The stronger association found with lack of supervisor / unit manager support may stem from the fact that there was an expectation from the midwives that these were the people responsible for resolving such issues and if this was not achieved it was then manifested as a lack of support.

Similarly for the issue of staff/patient ratio and its correlation to lack of supervisor / unit manager support. Once again the supervisor or unit manager would have been viewed as the person with the authority and responsibility to ensure that staffing was adequate or alternately that the client load was

167

controlled in some manner. Therefore, when the ratios were at a level that caused the midwife's sense of control to be challenged, a perception of not being adequately supported developed.

While these may be considered the more obvious or logical conclusions to be drawn from the findings, there also exists the possibility that the midwives felt unsupported by the supervisor / unit manager for a variety of other reasons which created a heightened sense of awareness to the two staffing events considered, leading to an increase in the subjective stress reported for them.

The event of working in-charge also shared a strong association to lack of supervisor / unit manager support. In considering the relationship between these two events it can be suggested that two divergent midwife groupings may be involved. On the one hand there would have been midwives who were often in-charge and the lack of support they experienced may have resulted from a different set of interactions when compared to those midwives who rarely worked in-charge.

For the midwife who more commonly worked in-charge her sense of lack of support from the supervisor / unit manager may have stemmed from a set of recurring or unresolved issues. For example, as has been previously described, working in-charge was found to have moderate to strong relationships with the three case management events and the majority of the conflict events. Therefore, while there is the possibility that a portion of the stress experienced was underpinned by a challenge to her sense of control, it is also possible that there was an accumulative effect of these other factors which may have been communicated to the supervisor / unit manager, but in the opinion of the midwife not acted upon or acknowledged to her satisfaction.

On the other hand, when considering the midwife with less in-charge experience, the notion that her stress was based on her sense of control being challenged becomes a more probable explanation. It is reasonable to suggest that a midwife in this situation would have a greater expectation or need for guidance and support when in-charge and therefore be more susceptible to reporting a lack of support.

For each of these associations, it is also possible that the midwives' notion of what was within the control of the supervisor / unit manager and therefore the level of support that could be provided did not concur with the reality. Such correlations may in part therefore be a reflection of the frustration and anxiety the midwives were experiencing as a result of these recurring events.

As has been previously discussed in relation to caring for complex cases, when the more moderate association between of lack of supervisor / unit manager support and caring for complex cases is considered, the notion of the midwife's stress being underpinned by her sense of control being challenged remains pertinent. It is therefore reasonable to suggest that this caused a heightened sense of

vulnerability resulting in a greater expectation as to the level of support required, providing the circumstances for the level of support to be reported as inadequate.

This completes this section of the discussion which has been devoted to the relationships between both event frequencies and event subjective stress ratings. The main point to be highlighted with regard to the frequency correlations is that while these events have been demonstrated to share individual correlations which can be interpreted as having specific ramifications, there is a possible nexus between several of the case management, conflict, lack of support and workload events. As an example of this, it is possible that further investigation would reveal that when the frequency of having an unclear treatment plan or determining appropriate care is associated with conflict events, there would also be a corresponding increase in the association between these two case management events and the frequency of lack of support. If this were the case, it is possible that decreasing the frequency with which one event occurred may result in a diminution in frequency of several other events.

Associations between ratings of event stress and burnout

Just as it was considered probable that the frequency with which events occurred was likely to display a relationship with the dimensions of burnout, it was also thought probable that the degree of subjective stress experienced would also display a similar relationship. As with previous analyses, the first step was to explore at the categorical level where several relationships were found. These occurred between the exhaustion and cynicism dimensions of the Maslach Burnout Inventory and, with the exception of the conflict category, all event categories of the Diary of Stressful Events. The initial conclusion to be drawn from this is that the subjective stress experienced in relation to bereavement care, case management, emergency care, lack of support and workload share a relationship with the early stages of development of burnout in birthing suite midwives.

The first stage of burnout is considered to have occurred when critical levels have been reached on the exhaustion dimension (Diestel & Schmidt, 2010; Maslach, et al., 1996). It is therefore of interest to note that the subjective stress that occurred in relation to the categories of bereavement care, case management, emergency care, lack of support, and workload all shared moderate correlations with the dimension designated as representing the first stage of burnout.

In considering the exhaustion dimension of the MBI, it is salient to compare the frequency and the subjective stress correlations. It was the increasing frequency of providing care to an FDIU that was moderately associated with an increase in scores on the exhaustion dimension, τ (28) .30, $p < .05$, while there was not a corresponding association with regard to the subjective stress experienced, τ (17) .31, p = .08 . Although these results are not vastly different, they suggest that the accumulative effect of

providing care to those experiencing an FDIU is possibly the more significant factor in the formation of burnout and not the subjective stress experienced by the midwives.

This can be compared to the midwives experience of caring for women having a MTT. While there was a weak association between the frequency of caring for these women and the exhaustion dimension of burnout, τ (28) .29, $p < .05$, the association between the exhaustion dimension and the subjective stress experienced was strong, τ (14) .51, $p < .01$. Therefore, while the frequency of providing care in this situation was a factor, it was the levels of subjective stress experienced by the midwives that displayed the stronger association with the development of burnout.

This suggests that with regard to how the midwives experienced these two events, there were different factors and or relationships at play in relation to the formation of the stress suffered. While there was an apparent accumulative effect of providing care to women whose baby had died in utero, the more salient factor for MTTs was the levels of stress engendered through this process. As both situations would be expected to generate stress, it could be postulated that the nature of that stress was quite different in either situation. For example, in instances of a FDIU the stress was in the form of a shared grief (Hunter, 2001; Mander, 2001, 2005, 2009; Moulder, 1998). The more frequently this care was provided, the greater was its accumulative effect.

This could be contrasted with the situation of a MTT where although there may be grief, the notion of ethics is more evident. As Cignacco (2002) suggests, midwives can experience ethical confusion (expectation to assist at live births but being required to end a new life) and ethical dilemmas (being forced to choose one of two unpalatable options) while being required to maintain a professional attitude as they perform their professional duty. Therefore, while the frequency of providing this care had a role, the stress generated from resolving these various conflicts possibly shared the greater association with the formation of burnout.

With regard to the remaining correlations that were found it is worth noting that all of the case management and workload events shared a correlation to the exhaustion dimension of the MBI. With regard to the case management events, there were moderate correlations for determining appropriate care and unclear treatment plan, with a weakly moderate correlation to compromised standards of care. From such results it could be concluded that with regard to the formation of burnout, there is a stronger association with situations where the midwives sense of control may have been challenged rather than to issues of the quality of care provided. However, a qualitative study into the moral distress caused by a lack of resources impacting on the course of action able to be taken by community nurses supported the notion that it burnout is exacerbated in such circumstances (Vinje & Mittelmark, 2007). While the event of compromised standards of care may not have always resulted from a lack of resources, it would

have played a role when considered in terms of the workload events of staff skill mix and staff/patient ratio, with which it shared moderate to strong correlations.

The theme of the midwife's sense of control being challenged as an important factor in the formation of burnout is further supported by the relationships revealed between the exhaustion dimension and the workload events. In all of these situations an argument can be mounted that a degree of the stress experienced had its genesis in the fact that the midwife was at various times working in a situation where there was not a clearly delineated plan (complex cases), or there was a sense that the situation may have very readily become 'unbalanced' (staff/patient ratio or skill mix), or both these situations were a factor (I/C duties/supervision).

While it is possible that a different interaction of events would have occurred to create the moderate to strong relationships between the exhaustion dimension of the MBI and the emergency care events of 'flat baby' and fetal distress, once again it can be argued that it is the midwives sense of control being challenged that underpins the stress they experience in these situations. In both these situations the midwife may have had to await the arrival of more senior staff or medical assistance, during which time any inadequacy she was feeling would have been magnified and her anxiety would have increased. The path to be followed was not always clear and not uncommonly some deliberation would have ensued as the best management was determined. During this time the midwife's anxiety would have remained high. With rectification of the situation, the midwife would have most likely then reviewed the incident, her role and her practice. While in many instances she may have been reassured by her colleagues, a lingering sense of needing or wanting to improve may have persisted.

The other emergency care event to display a weaker correlation with the exhaustion dimension was that of Immediate Caesarean Section. While this situation had similar properties to those of fetal distress and 'flat baby' with regard to the need to wait for assistance while experiencing increasing anxiety, once the decision has been made to proceed to Immediate Caesarean Section a clearly delineated and well drilled procedure is followed that generally attracts as much assistance as is required. While the event may have been unsettling, its resolution would have seemed prompt, precise and as expected.

It may be instructive to consider that it is the event of lack of support from supervisors / unit manager that also shares a correlation with the exhaustion dimension. In their review and critical analysis of twenty-five years of burnout research Maslach, Schaufeli and Leiter (2001) concluded that in the study of job resources, or their absence, there is a strong body of evidence linking lack of social support to burnout. They further state that it is the lack of support from supervisors that is especially important, this more so even than a lack of support from co-workers.

The relationship of all these events to the exhaustion dimension is significant when it is considered in terms of the exhaustion as not just the experience of being overextended and having diminished emotional and physical resources. The more essential factor is that it prompts a set of reactions presumably aimed at coping, but ones that cause the midwife to distance herself emotionally and cognitively from her work (Maslach, et al., 2001). This is the path to depersonalisation or cynicism whereby the midwife's capacity to be involved with and fully responsive to the needs of those in her care are diminished.

The picture for the cynicism dimension, which has been confirmed as following the exhaustion dimension (Diestel & Schmidt, 2010), is slightly different with a moderate correlation to bereavement care, and weaker correlations to lack of support and workload. Therefore, while increased subjective stress for all categories (except conflict) were associated with increased measures of emotional exhaustion, just the category of bereavement care shared a substantial relationship to the depersonalisation that is characteristic when there are increased measures on the cynicism dimension.

While lack of support and workload were demonstrated as having a relationship with the cynicism dimension, these were at such a low level as to be considered unlikely to have any real impact. This was verified when the events within each category were correlated to the cynicism dimension and no significant relationships were found. It was perhaps more surprising to find that neither of the bereavement care events shared a correlation to the cynicism dimension as there was a moderate correlation at the categorical level. An explanation for this may relate to the smaller number of bereavement events, particularly FDIU, that occurred and therefore it was only when the numbers were combined at the categorical level that an association could be seen. This is in contrast to the exhaustion dimension where a very informative picture was revealed when the individual events within the categories found to be associated with it were examined in more detail.

Specific findings

The following section of discussion will consider the findings arising from the series of hypotheses that were formulated in relation to the areas of stress, burnout, coping, social support, and bereavement care. This section will then be finalised with an evaluation of the additional analyses undertaken to answer those questions arising during the study or as a result of specific findings.

Stress

While the initial choice of hospitals to be involved in the study had been made on the basis that a more representative cross-section of midwives would be included, it was also seen as an opportunity to consider another factor regarding stress formation. While McVicar (2003) described six main themes

with regard to sources of workplace stress, he noted that the ranking of these would vary according to individual perception and the area of practice.

Just as the area of practice may influence perceptions, it was considered that because of the core differences between a Level 3 hospital and a Level 2 hospital it was possible that the perception of the subjective stress experienced in each may be significantly different. Therefore, the initial hypothesis tested examined the difference in subjective stress ratings for the midwives employed at the two hospitals included in the study. The hypothesis that the midwives at the Level 3 hospital would report significantly more stress than those at the Level 2 hospital was supported.

The significance of this finding is that the perception of the subjective stress experienced by the midwives in the birthing suite of the Level 3 hospital was greater than that experienced by the midwives at the Level 2 hospital. The hypothesis was based on the knowledge that a Level 3 hospital is a referral point for cases with a high degree of complexity that may engender more stress for the staff. While the increased stress was postulated as arising from the complexity of the cases managed and the increased workload associated with it, other factors not directly associated with complex cases may have been influential in the formation of this perception. From the results of the correlational analysis, some other factors to consider would include staffing issues to do with staff/patient ratios, staff skill mix, staffing stability or turnover rates, the amount of bereavement care provided and also any complicating socio-demographic features of the women.

An area of work stress that has been well researched is that of workload. With regard to nursing workload is a recurring theme as a cause of work stress (Healy & McKay, 2000; Lambert & Lambert, 2001; McVicar, 2003; Tyler & Cushway, 1995; Wheeler & Riding, 1994), and is also supported as a source of stress for midwives (Mackin & Sinclair, 1998, 1999). Within the body of work pertaining to burnout, workload has been identified as an important risk factor for this (Demerouti, et al., 2000; Duquette, et al., 1994; Maslach & Leiter, 2004). In keeping with the prior research, the hypothesis that workload would be significantly correlated to burnout was supported.

In this study workload was represented by the events of caring for complex cases, I/C duties / providing supervision, staff skill mix, and staff patient ratio, which reflect the same domains when compared to the questions used to ascertain job demands in the Demerouti et al. (2000) study. Their findings supported a model suggesting that job demands are most strongly related to exhaustion. While the burnout scale (ProQOL) employed to determine stress levels at the conclusion of each data collection period was not designed to differentiate the burnout into different domains, the correlation is suggestive that a similar situation would exist for the midwives included in this study. When discussing burnout as

173

measured by the ProQOL, Stamm (2005) makes the point that higher scores on this scale indicate an increased risk for burnout, with one of the factors for this occurring being a very high workload.

The significance of this form of stress is highlighted by Maslach et al. (2001) and Maslach and Leiter (2004). They describe how over time the worker's resources can be depleted by the excessive demands made of them, and if the workload stress is chronic it will ultimately result in them being unable to recover. The outcome is both a physical and an emotional exhaustion which impinges on their ability to perform their role to the desired level.

In considering the role of conflict as a stressor that may be associated with the development of burnout, the findings of McVicar's (2003) literature review cited both inter and intraprofessional conflict as a significant source of stress for nurses, with interprofessional conflict determined to be more of a problem. The hypothesis that stress arising from conflict would be associated with burnout was not supported however.

The lack of any association between stress arising from conflict and burnout is despite the category of conflict events sharing an association with all other event categories except for the category of emergency events. Also, the events in the workload category demonstrated moderate to strong correlations to conflict with medical staff and generally moderate correlations to midwife colleagues while conflict with patients and partner/support people shared similar associations. Further to this, the case management category of events also shared strong correlations with conflict with medical staff, midwife colleagues, patients and partners/support people.

It is possible that because the stress arising from conflict with the various groups was combined to form a 'common' score, there is an aspect that has been lost. It is possible that the experience of conflict with the woman's or the partners/support people is not associated with burnout, as the midwives may view such conflict in a different light to the conflict they experience with medical staff and midwife colleagues.

The appraisal of a situation is integral to whether it is determined as stressful and the coping mechanism to be employed to counter it as necessary (Lazarus, 1966, 1999; Lazarus & Folkman, 1984, 1991). In terms of what is commonly known as the transactional model of stress, the midwives may appraise the conflict they experience with women or the women's partners and support people as an issue that results from the anxiety and stress these people are experiencing. In this light, it is not assessed as a threat to their self-esteem or professional standing and thus the threat is minimised. While this is a form of emotion-focussed coping, the form of coping employed when it is considered unlikely that the threat can be altered; if it was considered possible to change the situation a more problem focussed form of coping may be employed (Lazarus & Folkman, 1984). In either circumstance, if the reappraisal of the situation

found them satisfied and comfortable with the effect of the coping strategy employed it would have been less likely to deplete their resources.

In their appraisal of the conflict with the medical staff or their midwife colleagues, the threat may be assessed as damaging to their professional standing and their self esteem. Also, irrespective of the form of coping strategy employed, it may also be seen as a threat that is recurring or ever present. If this is so, each reappraisal is less likely to provide the satisfaction required to prevent a depletion of their resources. Such a situation is more likely to give rise to the emotional exhaustion that characterises the initial stage of burnout. Therefore, if an assessment of the associations shared between individual conflict events and burnout had been undertaken, a different result may have been seen.

The realm of social support is diverse, but the focus for this component of the study centred on the support from midwife colleagues and supervisor / unit manager support. Early studies investigating the relationship between social support and burnout in nurses (Constable & Russell, 1986) suggested that lack of supervisor support was a predictor of emotional exhaustion, whereas McIntosh (1991) concluded that supervisory support moderated stress effects while Abualrub et al. (2009) included co-workers as moderators in the stress-job satisfaction relationship. In keeping with these previous results, the notion that stress associated with a lack of support from either supervisors or midwife colleagues would be associated with burnout (as measured by the ProQOL) was supported.

Constable and Russell (1986), who had used a regression analysis, were able to differentiate between four sources of social support , two of which related to supervisor support and co-workers. The current study has not made that differentiation, but the correlation between lack of support and burnout levels is indicative that midwives in birthing suite may also be more likely to experience burnout as a result of a lack of supervisor support.

The more important facts to consider in relation to the properties of social support are the perception of its adequacy and the effect of the combinations of the various properties (McIntosh, 1991). In this vein, it was the amount of supervisor support that was found to be the critical component, whereas for co-worker support it was the adequacy of the support. Therefore, the current finding may be indicative of two different components of social support being represented. This is perhaps demonstrated by the thought that supervisors should have a role in creating a healthy work environment by not only playing an instrumental role, but through conflict resolution and emotional support (Demerouti, et al., 2000).

Nurses who perceive high levels of support from both their co-workers and supervisors also report high levels of job satisfaction (Abualrub, et al., 2009). An important area with regard to the formation of burnout is support in the form reward (Maslach & Leiter, 2004), which can be monetary, social or

intrinsic. Where there is a high level of support resulting in high levels of job satisfaction the development of burnout becomes less likely.

Bereavement care is an area that is universally recognised as being stressful, but until the work of Mander (2000, 2001, 2005, 2006, 2009) there had been little consideration given to the impact of caring for a woman experiencing a perinatal bereavement. This is an area of work that epitomises the focus of the early writings regarding burnout in that it involves people working in health care who are responsible for providing "aid and service to people in need, and which can therefore be characterized by emotional and interpersonal stressors" (Maslach, et al., 2001, p. 399). Although only a weak correlation was revealed, the hypothesis that stress occurring from providing bereavement care would be associated with burnout was supported.

Once again there were two events (FDIU and MTT) included in the measurement of bereavement care, therefore it is possible that each had a different effect. In conjunction with this there is the fact that the burnout score was an aggregated score derived from the ProQOL. These two facts may have served to 'flatten' any associations between the provision of bereavement care and the level of burnout experienced.

As described by the midwives interviewed in Phase One, the experience of providing care in each is quite different and the results demonstrated that on average the experience of caring for a woman with a fetal death in utero is considered more stressful than caring for a woman with a midtrimester termination. Also, because the ProQOL was averaged across the number of months spent in birthing suite, the variations associated with either providing bereavement care or not providing care would have been lost. Therefore, while there was the predicted association, it may not be completely indicative of the association that exists.

The last of the hypotheses considering burnout and stress in relation to the measures gathered at the completion of each data collection period suggested that the global stress measured by the PSS would not a share a correlation to the mean monthly subjective stress experienced as a result of working in the birthing suite. This hypothesis was not supported, suggesting that the stress experienced as a result of life in general is linked to the subjective stress experienced as a result of work. However, caution must be used in drawing such a conclusion. Once again the scores for the PSS were averaged for each midwife, as were the subjective stress scores, and as has been discussed previously, this had the effect of eliminating the monthly variation in scores. This problem could have been overcome with a much larger sample size that would have facilitated a time series analysis to be undertaken.

Burnout

While an association between burnout and lack of support has been established in relation to the monthly measures gathered, the work of Constable and Russell (1986) specified that it was a lack of supervisor support which predicted the exhaustion dimension of burnout, the significance of this being that it is the initiating stage of burnout (Diestel & Schmidt, 2010; Maslach, 1982; Shirom, 2010). Although the hypothesis that there would be a relationship between the degree of stress experienced and the exhaustion dimension of the MBI was not supported, a trend was revealed that warrants further investigation to establish conclusively if the exhaustion dimension of burnout is not predicted by lack of supervisor / unit manager support.

Ideally, as Constable and Russell (1986) did, a regression analysis would be performed to establish if lack of supervisor / unit manager support predicted the exhaustion dimension of burnout. In the current study, the non-parametric nature of the data precluded this procedure from being employed. Further to this, having formed the appropriate groupings to facilitate a Chi-square test of independence, the small sample size led to more than 20% of the cells having an expected count of less than five, further eroding the robustness of these results.

The next area of stress to be considered was that of workload stress, which had also been found to predict or be associated with the exhaustion dimension of burnout (Demerouti, et al., 2000; Duquette, et al., 1994; Maslach & Leiter, 2004). The hypothesis that there would be an association between workload stress and the exhaustion dimension was supported. A strong association was identified, indicating that the stress experienced as a result of caring for complex cases, working in-charge / providing supervision, contending with issues of staff skill mix or contending with issues surrounding staff women ratios have an important association with the formation of burnout.

In developing a model of burnout and life satisfaction in nurses, Demerouti, et al. (2000) made the link from high job demands leading to exhaustion in conjunction with a lack of job resources leading to disengagement. Although their model of burnout differs from that on which the MBI is based, the effect of high job demands is highlighted as a significant contributor to the burnout process.

A constant theme throughout the midwife interviews in phase one was the frequency and importance placed on being able to 'debrief' with colleagues. In the view of Maslach, et al. (2001), people thrive when there is a shared sense of community with those with whom they work. Further to this, the support of colleagues is related to the worker's sense of efficacy. It was therefore postulated that there would be an association between efficacy and lack of colleague support, but this was not supported.

In considering why there was not an association, a point to consider is the possibility that the lack of support being measured related to instrumental support rather than emotional (community) support. The

events that colleague lack of support shared a correlation with included the emergency events of 'bleeding', fetal distress, 'flat baby', and immediate Caesarean section and the four workload events. It can be argued that all of these events have a strong instrumental component with regard to the nature of the support that was initially required and for which the midwife may have recorded the resulting stress. Continuing with this theme, it is interesting to note that there was not a correlation between lack of colleague support and the bereavement care events. This can be interpreted as indicating that the midwives received the 'instrumental' support they required and felt supported emotionally also.

Such a situation would have resulted in generally lower levels of subjective stress being recorded for the lack of colleague support event. This is possibly further supported by the fact that the mean subjective stress experienced for lack of colleague support was 2.76, while for lack of supervisor support it was 3.32.

To assess the midwives on a month to month basis with regard to any vicarious trauma they may have been experiencing, they had been asked to complete the ProQOL. One of the three discrete scales of the ProQOL assessed their compassion satisfaction, or their satisfaction in relation to their assessment of being an effective caregiver (Stamm, 2005). It was hypothesised that this scale would be negatively correlated to the cynicism dimension of the MBI, and this was supported with a moderate correlation found.

Some caution must be taken with regard to this result. The ProQOL is designed to reflect the individual's experience over the previous thirty (30) days, and is reactive to changes in the individual. The robustness of the data used for this procedure can be questioned however because the compassion satisfaction score used was an average score per midwife per month spent in birthing suite across the six month data collection period. This was then correlated to the cynicism score recorded at the completion of the data collection period. Although there may be some query regarding data, there is also some value in the result. It not only goes to confirming the validity of the scale, but in terms of assessing midwives for signs of burnout, this result indicates that the ProQOL may be considered as a tool to use.

Coping

Current conceptualisations of coping predominantly focus on it as a response to an external stressor (Endler & Parker, 1999), and that traditional personality types are unlikely to be useful as stable predictors of coping (Folkman & Lazarus, 1980), while two or three main coping strategies have been described (Rafnsson, et al., 2006). Of these coping strategies, Endler and Parker (1990) found that women scored higher on emotion, avoidance, distraction and social diversion than men, who predominantly used task oriented coping. Somewhat counter to the work of Folkman and Lazarus is the knowledge that past research has found a positive correlation between neuroticism and emotional

coping while extraversion was found to have a positive correlation to task coping (Cosway, et al., 2000; Endler & Parker, 1990; Rafnsson, et al., 2006).

The midwives in the current study were predicted to display significantly more emotion and avoidant oriented coping than task oriented coping. With regard to emotion oriented coping, this was not supported. In fact, on average this style was the least used coping style but used at a very similar rate to task oriented coping. This result may be a product of the midwives area of work, which was their focus when completing the CISS.

Many of the situations that arise in a birthing suite would have required a task oriented approach as it is an area where many of the stressful situations encountered would have required direct action to resolve the event. This is depicted by the response - *focus on the problem and see how I can solve it*. But there may have also been a need to attend to any ensuing emotion that surrounded the event, as suggested by the response - *become very upset* or *wish I could change what had happened*. This reflects the notion that there are particular types of situations that require different coping behaviours to achieve an effective outcome, or there may be overriding demands requiring the individual to use a less preferred strategy (Endler & Parker, 1990, 1994).

The implications of these findings in terms of previous research are interesting. It would appear that in relation to their work, this sample of midwives had a balance between task and emotion focussed coping. Therefore, in terms of the NEO-FFI they probably had a balance between Conscientiousness in association with their task oriented approach, but may have also experienced certain levels of Anxiety / Insomnia and some somatic symptoms in association with their emotion oriented approach (Cosway, et al., 2000). That emotion oriented coping did not predominate as predicted is healthy for the midwives from the perspective that past research suggests there is a strong relationship between this form of coping and depression (Endler & Parker, 1999) and other forms of psychological distress (Endler, et al., 2003).

The prediction that midwives would employ more avoidance coping was supported, although they did not significantly prefer either distraction or social diversion. This aspect is perhaps explained by the results of Rafnsson et.al (2006), who employed the Eysenck Personality Questionnaire-Revised Short Scale when determining the factor structure of the CISS in an Icelandic population. The general findings were consistent with previous research in relation to task and emotion oriented coping, where task oriented coping is related to extraversion and emotion oriented is related to neuroticism. However, an interesting result occurred in relation to avoidance.

Extraversion was related to social diversion and unrelated to distraction, while conversely neuroticism was unrelated to social diversion and related to distraction. In the current study there was a balance

between task and emotion oriented coping. In light of the findings of Rafnsson et.al (2006) it therefore seems a logical progression that these two forms of avoidant coping would also occur at similar rates.

Social diversion involves the seeking out of other people to avoid a stressful situation, while distraction is where the individual engages in a substitute task to avoid the stressful situation. Both of these forms of coping have been found to not have an association with any psychopathology (Endler, et al., 2003). That these strategies have not been associated with any psychopathology suggests that at the psychological level they are adaptive.

In relation to the midwives who were interviewed for phase one of the study, the strategy of distraction was typically used as a way to focus on another activity such as swimming, jogging or reading and a means of clearing the mind. In terms of the transactional model of stress this would facilitate a reappraisal of the event to perhaps cast it in a more positive or clearer light.

With regard to social diversion, this relates to social support (Endler & Parker, 1999) and was used by the midwives interviewed in phase one as a means of reassurance as well as diversion. Therefore, while some informal discussion may have occurred in relation to a stressful event (more so when it was a particularly distressing event), it was predominantly an opportunity to enjoy some social interaction that facilitated distancing from the event. Study of the effects of social support and coping suggest that in high stress situations where the level of social support does not 'overload' the recipient, a stress-buffering effect occurs (Button, 2008).

An important point to consider in relation to each form of avoidance coping, both of which have elements of denial, is that no strategy should be labelled good or bad until considered in context of the person and the situation. These forms of coping may facilitate managing emotions, maintaining self-esteem, and acceptance. All functions of coping as important as problem-solving and mastery (Lazarus & Folkman, 1991).

Narumoto et al. (2008) used three separate stepwise regression analyses to determine if factors relating to personality, coping, general health, age, education, working hours and years of working as predictor variables to ascertain those factors that predicted the three dimensions of burnout. In the current study, the limited size of the sample restricted the number of predictor variables that could safely be entered into the equation (Patton, 1990). Therefore, three separate stepwise regression analyses were carried out where it was thought that emotion oriented coping would predict each of the three dimensions of burnout.

The first regression analysis produced a significant model with emotion oriented coping remaining as the only predictor of the emotion dimension of burnout, therefore the hypothesis was supported. When

the next two regression analyses were completed, none of the variables had been entered into the equation, therefore these hypotheses were not supported.

This suggests that those midwives who have a reliance on emotion focussed coping are more likely to experience exhaustion as measured by the MBI. This would indicate that they are at greater risk of developing this first stage of burnout, which is further exacerbated if they are also high on neuroticism or anxious (Narumoto, et al., 2008).

Narumoto et al. (2008) also found that there were no predictors for the inefficacy dimension and while there was no relationship between coping and burnout, neuroticism and age were predictors of cynicism with higher age predicting lower cynicism. A worthy point made by Narumoto et al. was that such a result may arise because as the worker develops cynicism they are more likely to leave that area of work.

Social Support

In keeping with the popularly accepted notion that social support is a multidimensional construct and that Weiss's (1974) theoretical conceptualisation best described these dimensions, the Social Provisions Scale (SPS) which has been found to correspond to these six dimensions (Cutrona & Russell, 1990), was used to measure social support. This provided a score for each of the six dimensions and a global score. It had been hypothesised that there would be negative correlations between the global score for social support and the exhaustion and cynicism dimensions of the MBI.

While the result did not achieve significance, there was a negative trend between the measure of exhaustion and the global social support score. This result is in keeping with previous findings where high levels of work related social support was found to be related to lower levels of burnout on all dimensions of the MBI (Koniarek & Dudek, 1996) and Mallet et al. (1991) who reported a significant but low negative correlation between burnout and social support. Caution must be advised in comparing these results however as the MBI used in the Mallet et al. study had been modified, while social support was assessed using just three items taken from the twenty seven item 'Social Support Questionnaire'.

The findings of McIntosh (1991) may provide greater insight into the current finding. In assessing the relationship of workload to exhaustion (as measured by the MBI) in the context of property, type and source of social support, it was found that there was an optimal level of support. Above or below this level, the effects of the support were lost, increasing the propensity for exhaustion. It is possible that the current measure of social support reflects this. Therefore, while a portion of midwives reported the optimal level of social support, which is reflected in the trend of a negative association, there were sufficient who were above or below the optimal level to nullify the outcome.

Further to this, in the current study the global social support score is an aggregation of six factors, some of which correlate with the parameters used by McIntosh (1991), and others which do not. For example, 'opportunity for nurturance' is not a received form of support but relates to the perception of being needed by others. This has been found to have a positive association with stress (Varvel, et al., 2007), and therefore it is possible that this factor countered the positive effect of the other factors, leading to the more equivocal result.

These current findings in relation to social support and its association with burnout can be seen as reflective of the divergent results found in past research, which in part may be attributed to the varying choices of operalisation and measures used to assess social support. Despite this, there has been a consistent indication from previous findings that social support in the form of supervisor support is negatively associated with the exhaustion dimension of burnout (Constable & Russell, 1986; Eastburg, et al., 1994; McIntosh, 1991; Varvel, et al., 2007). An explanation for this is that while cynicism and inefficacy are possibly more dependent on the social setting, exhaustion is generated by introspective somatic and mental sensations (Koniarek & Dudek, 1996), which the findings of Eastburg et al. (1994) suggest can be overcome by positive feedback from supervisors. While in terms of matching what supervisors provide with the dimensions measured in the Social Provisions Scale, the findings of Varvel et al. (2007) in relation to fire-fighters suggest that reliable alliance, reassurance of worth and social integration may be the key dimensions provided by supervisors.

In relation to cynicism, the hypothesis was supported, indicating that those midwives having a sense of global social support displayed lower levels of cynicism. This is consistent with the notion of cynicism as an attempt to distance oneself from the recipients of their care and attention (Maslach, et al., 2001), but where there is a high degree of global support, as opposed to co-worker support, there is a lower level of depersonalization (Koniarek & Dudek, 1996). In relation to the social support received from co-workers, Eastburg, et al. (1994) found that as supervisor support and peer cohesion increased, the measure of all levels of burnout were lower. A conclusion to be drawn from the current finding is that the midwives in this study found the adequacy of the global support sufficient (McIntosh, 1991).

In a sample of hospital nurses, a positive relationship was found between levels of stress and lack of social support (Tyler & Cushway, 1995), and the positive effect of such factors as being married or in a relationship (Tyler & Ellison, 1994), while a study designed to assess the effects of workload variability and social support on performance and stress found that in some situations the perception of the level of stress experienced was diminished in the presence of social support (Hauck, et al., 2008). In keeping with these findings it was proposed that those midwives reporting low levels of social support would report significantly more total work stress, but this hypothesis was not supported.

A possible explanation for this finding once again relates to the operalisation of social support. Tyler and Cushway (1995) asked a series of demographic questions that included partnership status, number of children and availability of social support, which is not unlike the method used by Tyler and Ellison (Tyler & Ellison, 1994). These are quite different in their assessment of social support when compared to the assessment made by using the Social Provisions Scale. Further to this, Tyler and Cushway wrote in terms of the support nurses felt they had 'within the organisation', a distinction that was not made in the formulation of the hypothesis under scrutiny.

In considering the outcome, it is possible that the more important factor was the effectiveness of their coping and the role of their colleagues and supervisors in that process. It is possible that on several factors they may have registered scores low enough to place them in the low category when the median split was calculated on the global social support score. However, in keeping with the findings of Varvel et al. (2007), the midwives may have experienced reliable alliance, reassurance of worth and social integration at levels and in combination such that the stress they were experiencing was either buffered or ameliorated. This facilitated their coping in a manner whereby they did not report significantly more work stress. It is plausible that the midwives felt assured that there were others they could rely upon in times of stress (reliable alliance), who recognised their competence (reassurance of worth), or who provided a sense that they belonged to a group (social integration), factors that align with the provisions preferred by the midwives interviewed for phase one of the study .

Bereavement Care

Caring for those who die has been recognised as a nursing stressor for some years (Tyler & Cushway, 1992; Tyler & Ellison, 1994), but with regard to midwifery, the stress experienced by a midwife when caring for a bereaved couple has only recently been the subject of research. In fact the paucity of research has led some to extrapolate from the findings of research involving other health care providers (Mander, 2009).

The notion of compassion fatigue has predominantly been researched from the perspective of those who work with the traumatised and began with Vietnam War veterans, and significantly it has been distinguished from burnout, PTSD, and countertransference(Figley, 2002). It has been argued that a high level of reciprocity and mutuality characterises the midwife woman relationship, which is the equivalent of a high degree of empathetic identification, a precursor of compassion fatigue (Leinweber & Rowe, 2010). Additionally, when a midwife cares for those who have suffered a perinatal bereavement there is the need for empathetic care. To this end they engage in helping behaviours and caring acts with the aim of minimising the suffering of those in their care. Although they may reach some sense of achievement and self-efficacy through providing this empathetic care, their skills and the time available to them make it unlikely that they will effect or witness sufficient reduction in the trauma

experienced by the bereaved, and consequently become susceptible to experiencing secondary traumatic stress (Papadatou, 2009).

In light of this information and the fact that two studies of antenatal midwives suggested that there can be a cumulative emotional effect when midwives are repeatedly required to care for those who have stories of child abuse, domestic violence, substance abuse and other social issues (McKosker-Howard, et al., 2005; Mollart, et al., 2009), it was hypothesised that the stress midwives recorded in relation to bereavement care would be positively related to their measure of compassion fatigue. This was supported, with a moderate correlation found.

This finding has to be viewed with some caution however. The ProQOL, from which the measure for compassion fatigue was derived, was completed at the end of each data collection period. As previously stated, it is designed to reflect on the previous month and is reactive to events in that time frame. Ideally a time series analysis would have been done, but there were insufficient participants for this to occur. Therefore, because this was not possible, a mean compassion fatigue score was calculated for each midwife and correlated with their mean score for bereavement care stress.

The significance of the finding is that it indicates further research needs to be carried out to determine if this is a condition that birthing suite midwives are experiencing. It is important to note that burnout is considered a risk factor for compassion fatigue (Figley, 1995), and therefore an earlier result indicating a weak correlation between bereavement care stress and burnout (as measured by the ProQOL) may have greater significance than first specified.

Stamm (2005), in describing the 'complex relationships' between the discrete scales of the ProQOL, makes the point that although some may score high on the compassion fatigue scale, if they retain their altruistic desire they may also score high on the compassion satisfaction scale. However, it would be atypical to find someone with a high score on burnout and compassion satisfaction. She further states that the combination of burnout and compassion fatigue puts the person at greater risk of negative outcomes including depression and poor professional judgment.

These findings are of concern for both the midwives and for the hospital that employs them. In relation to the midwives, there must be concern for their well being. From the perspective of the hospital, some of their staff could become a liability with regard to the provision of high quality care. In the longer term there may also be an issue regarding staff retention as they lose their 'altruistic desire' and become burnt out while suffering from compassion fatigue. This would expose them to becoming depressed, possibly experiencing symptoms of post-traumatic stress disorder, and ultimately moving to another area of employment.

It has been recognised that the support of colleagues is an important facet of providing perinatal bereavement care (Cowan & Wainwright, 2001; Foster, 1996; Gardner, 1999; Moulder, 1998; Rashotte, Fothergill-Bourbonnais, & Chamberlain, 1997). In this vein, and similar to the notion that the experience of work stress would be associated with lower levels of social support, it was thought that those midwives who experienced lower levels of social support would also experience greater subjective stress in relation to providing bereavement care. However, although there was an indication that those categorised as high on social support displayed lower measures of bereavement care stress, a t-test confirmed this was not a statistically significant difference, and the hypothesis was not supported.

The non significant finding is possibly related to the sample size and the use of a median split procedure. In comparing only those people who had provided bereavement care, then removing one case that was an extreme outlier, the sample size was reduced to twenty. If a quartile split or similar had been performed and the middle group discarded, this would have resulted in an even smaller sample, therefore a median split was performed. This still has the problem of loss of power, making it more difficult to find any effect that may exist (Aiken & West, 1991).

Further Outcomes

With the understanding that the subscales of the MBI were said to be stable over a period of time from three months to one year, it was planned that by undertaking a longitudinal study over a twenty-four week period any changes in the levels of burnout experienced by the midwives would be captured. When this was explored the first finding of note was that the cynicism dimension scores for this sample of midwives had not been stable, with no correlation found between the Time 1 and Time 2 measures. In relation to doing multiple regression or structural model analysis, it has been reported where a high correlation does exist on the cynicism dimension, little variance remains to relate to other predictors when attempting to determine the relationship between Time 1 exhaustion and Time 2 cynicism (Maslach, et al., 1996). Therefore, with a larger sample there may have been the opportunity examine that relationship more closely.

In this study, it can be said that the exhaustion dimension remained very stable with there not only being a moderate correlation of the scores across time, but also the change in the mean score was not significant. There is some difficulty in interpreting the three subscale scores however, as there are no norms for Australian nurses or midwives available. While the results were compared to demographic norms for women in general, it is of interest to note the means on the exhaustion dimension for nurses in Poland and the Netherlands were 20.00 and 16.20 respectively (Maslach, et al., 1996), indicating that this sample of Australian midwives scored slightly higher than either of those.

While the change in the mean cynicism dimension score across the period of data collection was not significant, it is of interest to note that a correlation was not found between the Time 1 and Time 2 scores. This indicates that although there was a slight increase in the overall mean, there was not a uniformity of scores from Time 1 to Time 2. Therefore, although the midwives were more uniform in their experience of exhaustion, their experience of cynicism was potentially more reactive to the various events that occurred, which aligns with the notion that it is a coping strategy (Maslach & Leiter, 2004; Maslach, et al., 2001).

As Maslach et al. (1996) suggest, events that occur between the first and second administration of the inventory may have contradictory effects, or there may be reciprocal relationships. Examples of this would be cynicism leading to diminished efficacy, or high cynicism causing a greater increase in exhaustion over time (Diestel & Schmidt, 2010). This is in keeping with the thought that cynicism is a dysfunctional or maladaptive coping strategy that ultimately reduces access to social support leading to greater isolation and diminished resources.

The findings in relation to the inefficacy dimension are more concerning when considering the psychological well being of the midwives, particularly those working at the 'level three' hospital. While there was a significant increase on the inefficacy dimension for the whole sample, when the sample was grouped according to hospital worked at, a significant increase was only found for the 'level three' hospital.

An explanation for this result can be drawn from the findings of Diestel and Schmidt (2010). They assert that exhaustion has a lagged effect on inefficacy. Therefore, those midwives who were more chronically exhausted could have been displaying this effect. There is also the possibility that those who were higher on cynicism at Time 1, and also higher on efficacy, found that their efficacy was attenuated by Time 2. The midwives may have behaved cynically such that their access to resources was hindered, which in turn made it more difficult to achieve or maintain a sense of efficacy.

The relationship between exhaustion and cynicism seems to be clear, with the notion that exhaustion is the first stage of burnout and the distancing associated with cynicism seen as the first reaction to exhaustion (Maslach & Leiter, 2004). This linear association is also seen as reciprocal whereby those that are cynical have a perception of higher job demands that feeds back into their sense of exhaustion. Alternately, as explained above, cynicism leads to a diminution of social support. This acts as a stressor, causing exhaustion to develop more rapidly than if more adaptive coping strategies were used (Diestel & Schmidt, 2010).

Inefficacy has more complex relationships with the other dimensions, but in the simplest terms, a midwife who is chronically exhausted and develops degrees of cynicism is placed in a situation where

her sense of efficacy is more likely to be impaired. If she is chronically exhausted, she is unlikely to gain a sense of accomplishment or efficacy. Similarly, if she is feeling or maintaining a sense of detachment from those in her care, she once again is unlikely to derive any sense of accomplishment or efficacy from her efforts (Maslach & Leiter, 2004).

Therefore the implications of the findings for both the midwives and the organisation for which they work are important. It can be suggested that a portion of the midwives included in the study were suffering a significant degree of burnout. This has ramifications in relation to the nature and the manner of the care they were providing. It would ultimately also have an effect on the rates of staff retention and turnover.

Although the data was not considered in terms of the experience and age of the midwives, this would be a pertinent line of inquiry. If the rates of burnout were higher in the younger midwives, this is a concern from the perspective of maintaining a workforce for the future. If the rates of burnout were higher in the more experienced midwives, this is a concern from the perspective for the potential loss of expertise.

Summary

In considering the findings of this quantitative phase of the study, several key observations can be made. The first of these relate to the associations found when the frequency with which events occurred was examined. The number of correlations found when the categorical frequency of events for bereavement care, case management, conflict, emergency care, lack of support and workload provided an insight into the dynamic nature of birthing suite work and the interdependence of events within each category. Of particular interest was the finding that the lack of support category shared the greatest number of correlations with other categories, indicating that as the frequency of events within the categories of bereavement care, case management, conflict and so on increased the midwives were more likely to report that they felt unsupported by either their midwife colleagues or the unit managers and supervisors.

When the associations between categories were examined in terms of the levels of subjective stress reported, it was of interest to note that the pattern of associations varied from that of the frequency of events. This minimises the likelihood that the frequency with which events occurred had a direct bearing on the subjective stress reported for all event categories. However, there was an indication that the amount of subjective stress experienced was influenced by whether the midwives had clear protocols and procedures to guide them and to follow or not. The pattern of correlations also made it apparent that the two categories of lack of support and workload had a role that warranted further investigation with regard to the subjective stress experienced by the midwives.

While there was an indication that the frequency of events did not go hand in hand with the amount of subjective stress experienced for all categories, there were some parallel findings of interest. When events within the category of lack of support increased in frequency there was an associated increase in the frequency of events in case management, conflict and workload. This pattern was repeated with regard to the amount of subjective stress reported, leading to the conclusion that modifying the frequency with which some of the events occur may lead to a diminution in the amount of subjective stress experienced.

When the frequency results were examined at the level of the individual events within those categories that shared a correlation, the notion of interdependence between various events was more clearly supported. Greater clarity was also provided with regard to those events germane to the midwives experience of stress.

It became clearer that the more frequently the midwives attempted to provide appropriate care with certainty, there was an associated increase in frequency of conflict with both their colleagues and the medical staff and was accompanied by an increase in the frequency of them not being supported by their colleagues. This lack of support was also associated with conflict events, where it appeared that the more a midwife experienced conflict with medical staff, women or their support people, the anticipated support from colleagues was inadequate or did not occur, as demonstrated by an increase in the frequency with which they reported 'lack of support'. Further to this, reported frequencies of lack of support were also related to workload events. It was concluded that those midwives working in charge and/or providing supervision, who were also experiencing more conflict situations, were also more likely to record that they were inadequately supported. To reiterate, the outcome of this examination of the frequencies at both the categorical and event level demonstrates the interconnectedness of events that a birthing suite midwife experiences in her work day.

The predominant conclusion to be drawn from the event subjective stress relationships is the notion that much of the stress the midwives experienced was underpinned by the perception of a potential challenge to the control they had over a situation. Where the midwives were able to proceed with a sense of purpose, direction and surety the levels of stress they experienced were limited when compared to situations where there was a level of uncertainty.

This is demonstrated by two disparate categories of events, emergency care and bereavement care. In both of these categories the care that is expected is clearly delineated in the form of protocols and procedures that everyone has knowledge of and adheres to. Therefore, although there are particular stresses associated with providing care in either of these situations, these are not underpinned by a sense of uncertainty. The significance of this is to be found in the fact that for events where there was

uncertainty, they were linked to an increase in conflict and the need for or perception that more support was required.

The accumulative effect of such a set of circumstances would most probably have an impact on the levels of burnout experienced. In various studies of burnout where the focus has been on the qualitative demands of the job, both role conflict (resolving conflicting job demands) and the notion of role ambiguity (lack of adequate information to complete the job well) have been demonstrated to share moderate to high correlations with burnout (Maslach, et al., 2001).

A parallel can be drawn between role ambiguity and the challenge to their sense of control the midwives experienced. For some events such as determining appropriate care and unclear treatment plan it was a lack of the necessary information to proceed with certainty and complete the job well that appears to be the genesis of their stress.

The concept of burnout has been central to this study. It was significant therefore to find that both the frequency with which events occurred and the subjective stress that was reported had some involvement with either the formation of burnout or the degree of burnout experienced. For example, an important finding related to the frequency of providing bereavement care. The results suggest that the more frequently this care was provided, the more likely it became to see an increase in scores on one of the dimensions of the Maslach Burnout Inventory (MBI).

When the two events within the bereavement care category were examined, it was found that as the midwives increased the frequency of care to a woman with a fetal death in utero (FDIU), there was an associated increase on the exhaustion dimension of the MBI. Further to this, when the frequency of providing care for the event of midtrimester termination (MTT) was examined, a stronger association was found, but with the cynicism dimension. This is considered to reflect dysfunctional coping that in turn can lead to a greater loss of resources.

In contrast, when the categorical subjective stress ratings were considered the association of ratings of subjective stress by category with the dimensions of burnout revealed that while stress arising from conflict was not a factor in the formation of burnout, all the other categories shared moderate correlations to the exhaustion dimension of burnout.

An examination of the subjective stress data at the event level lead to the conclusion that burnout formation, as indicated by higher scores on the exhaustion dimension of the MBI, was more strongly linked to those situations where the midwives sense of control was challenged rather than to issues of the quality of care that could be provided, and this would have been exacerbated by a sense of a lack of support.

Significantly, the only subjective stress rating to share an association with the cynicism dimension was for the category of bereavement care. However, when the two bereavement care events were examined no associations were found. This may have been due to the small numbers in the samples, but indicates that further investigation is warranted.

The overarching conclusions that can be drawn from the results obtained in relation to the hypotheses regarding work stress are aligned to previous findings. As with other fields of work, the stress experienced by midwives arising from workload issues and lack of support play a role in the development of burnout, however unlike other populations, they did not display an association with conflict.

With regard to coping, the midwives were atypical. Perhaps due to the nature of their work, they displayed more task oriented coping than is usually found for woman. In parallel with this, they did not use a preponderance of emotion focussed coping. This is important from the perspective that emotion focussed coping was found to be a predictor of the emotion dimension of the MBI. They did however employ avoidant focussed coping as predicted, which was balanced between social distraction and diversion, indicating that while they may have retreated into past times such as reading or viewing a movie, they were also just as likely to seek the company of others to avoid the aftermath of a stressful situation.

While achieving consistent operalisation and assessment of social support for research purposes appears problematic, there was an indication that midwives with 'appropriate' levels of global support were protected from developing burnout. This conclusion is drawn from the associations found between the emotion and cynicism dimensions of the MBI and the global support measure. There was a trend indicating a negative association between emotion and global social support levels, while there was a significant negative correlation between cynicism and global social support levels. While these findings are not conclusive, there is an indication that further research is warranted.

Previous findings demonstrated that bereavement care was associated with burnout, and it has been found that burnout is a risk factor for compassion fatigue (Figley, 1995). Therefore, it is significant that a positive association was found between the stress incurred when providing bereavement care and levels of compassion fatigue. As an avenue of research that has not been pursued in detail, this finding indicates that it also warrants further investigation.

This thought is brought into sharper focus when it is considered in terms of the supplementary analyses that were carried out. It was known that the midwives working in the 'level three' hospital were reporting significantly more subjective stress than those working in the 'level two' hospital. When the change in burnout scores as measured by the MBI were studied, it was noted that there was a significant

190

diminution of efficacy for the midwives at the 'level three' hospital across the twenty four week period of data collection. 'This would suggest that the midwives at the 'level three' hospital are at a greater risk of developing not only burnout, but also compassion fatigue.

Chapter 10

CONCLUSIONS OF QUALITATIVE AND QUANTITATIVE FINDINGS

Prologue

The aim of this section is to provide an overview of the significant findings. In completing this overview, connections will be made between the various elements that have been the focus of the quantitative phase of the study as well as between the findings of the two phases of the study. This will provide the basis for a discussion of the recommendations that can be made as a result of these findings before proceeding to a consideration of the limitations of the study.

The major conclusion drawn from the analysis of the qualitative data was centred on the midwife's sense of control, because it was this that underpinned the stress she experienced. It was determined that a midwife made a personal assessment of her abilities in accordance with her perception of her skill set. This skill set was a derivative of her training, experience and expertise and generated a sense of what her personal performance expectations were. When her sense of control was challenged, her personal performance expectations were challenged and she experienced stress.

When the subjective stress for the various events included in the quantitative analysis was examined it became apparent that the notion of the midwife's sense of control was often central to the stress that was experienced. The events that featured in this manner related to issues of workload (staff/patient ratio, staff skill mix, and working in charge / providing supervision) and case management (determining appropriate care and unclear treatment plan). While it is readily apparent that a sense of being overburdened by the number of cases to manage, an imbalance of experienced to inexperienced staff and a requirement to maintain oversight of all events as they unfold would challenge the midwife's sense of control, the case management issues are perhaps less obvious. When the midwife was not provided with the information that would allow her to proceed with surety and confidence her sense of control was challenged, and thus her ability to meet her personal performance expectations were compromised.

It can be argued that this initial assessment regarding the midwives' sense of control being challenged is the beginning point of the transactional process described previously (Lazarus, 1966, 1999; Lazarus & Folkman, 1984, 1991). The initial assessment may be that the staff/patient ratio challenged their capacity to provide all care adequately and commensurate with their ability. If the reappraisal phase included the information that there were no more staff available to assist, the stress remained or increased. At that point other factors and events would have gained greater traction. For example, the notion that standards of care had been compromised may have been additive to the stress, a sentiment of lack of support became more likely, and the likelihood of conflict was increased.

The insight and understanding achieved as to what underpins the stress experienced by midwives provides the information required to develop strategies and to put in place the necessary and appropriate scaffolding to support midwives in their work environment, and an indication of the direction in which measures can be taken to limit the stress they experience.

Another theme that was dominant in both phases of the study was support. In drawing a conclusion from the qualitative phase, it was clear that while many midwives spoke of the support of family, which has been characterised as *attachment* and *nurturance,* in keeping with Weiss's theoretical concept of social support (Weiss, 1974), the support more central to managing the stress experienced at work was derived from trusted colleagues. In Weiss's typology, the relevant features of this support would relate to *reliable alliance, social integration* and *reassurance of worth,* a notion supported by Varvel et al. (2007).

Reliable alliance is associated with instrumental support, or the knowledge that real assistance is available as required (Weiss, 1974). This is the nature of the support initially required when an emergency care event occurred. While the notion of reliable alliance may have persisted, the reality of it would have been diminished in certain situations. When individual resources were stretched, as in instances of staff/patient ratios being compromised or where there was an imbalance of staff skill mix, the support offered may have been more perfunctory. Therefore, the instrumental support or assistance would have been provided on a needs basis, but there would not have been ongoing support. For example, in the instance of an immediate Caesarean section, there would have been sufficient support to manage the event in a timely manner. However, once the event was resolved (the woman had been transferred to the operating theatre) further assistance would not have been available, precluding any opportunity for *succouring debriefing.*

This is a form of debriefing midwives value because of its immediacy and the ability to restore their equilibrium. It assists in dissipating many of the emotional aspects of the stressful situation they have just experienced. This probable inconsistency in the support assists us in understanding the lack of support that was reported in relation to the workload category of events and is related to the findings of (Cutrona, et al., 1990) who reported on the interaction effect of various factors. Therefore, although the instrumental component of the support required was provided, the overall support was not consistent with what was required. The social integration and reassurance of worth components were adjuncts not provided in this scenario.

Social integration relates to the notion of the individual feeling included as part of a group that shares similar values and concerns, provides comfort and security, and endows the person with a sense of identity (Cutrona & Russell, 1987a). Varvel, et al. (2007) suggest that in relation to fire-fighters,

supervisors that involve themselves in the daily routine of work provide social integration support, which has been associated with improved coping. This is significant from the perspective that lack of support from supervisors / unit managers was associated with many of the stressful events experienced by the midwives. It can be argued that if the comfort and security a supervisor / unit manager provided through greater involvement in the daily routine had been greater, then the stress experienced by the midwives would have been mitigated.

While it has not been possible to quantify the exact significance of each support factor, reassurance of worth intuitively appears as one of some importance. The view that the skills of the worker should be acknowledged and their efforts praised is not novel and is aligned with the thoughts of social learning theory which proposes that in the absence of major stress those with high reassurance of worth would have enhanced self-efficacy and self-esteem, allowing them to function more effectively. Where there is stress, the effects would not be as detrimental with the prospect of more effective coping (Cutrona & Russell, 1987a).

There is support for the idea which suggests that reassurance of worth is negatively associated with perceived stress (Cutrona & Russell, 1987a; Varvel, et al., 2007), while Constable and Russell (1986) found that lack of supervisor support was a significant predictor of emotional exhaustion on the MBI, indicating that coping is not as effective. This can now be considered in conjunction with the further finding of Varvel et al. that while peer support played a role, supervisor support was most strongly negatively linked with stress. When all of these factors are considered, the significance of lack of support as a factor that mediated the midwives experience of stress from the perspective of their ability to cope and the development of burnout is brought into sharper focus.

Added to the complexity of the interactions described above is the notion of any moral distress the midwives may have been experiencing. As revealed in the qualitative analysis, where the midwives felt the standards of care were compromised, the staffing was inadequate or they felt overloaded, they would have experienced a moral distress, as was found with nurses (Corley, 2002). The psychological disequilibrium resulting from this moral distress is many fold, but significantly there can be a loss of self worth. Hence, the impact of lack of support in the circumstances described above is magnified.

It is of value to consider the categories of subjective stress ratings where the associations were small or did not exist. In this group of events are those of the emergency care category, which did not share correlations with all other categories. Importantly, two of those categories were case management and conflict, while there were only small associations found with the remaining lack of support and workload categories.

In analysing the qualitative data it was determined that for some events the concept of eustress was the more appropriate description of the stress being experienced. This was seen as a positive stress exemplified by a rush of adrenaline and a sense of achievement, and was most frequently associated with emergency situations. As has been previously described, these situations have clearly delineated procedures and protocols to be followed and usually, instrumental support is more readily available. Therefore, the idea that when the treatment plan or management is clear, the stress experienced can be positive and not experienced as distress is supported by the findings of the quantitative phase of the study.

An explanation for the small correlation between the emergency care category of events and those of lack of support and workload can also be offered. As has been previously discussed, there is usually sufficient instrumental support offered with these events. Therefore, the lack of support that was reported may be more a reflection of a lack of reassurance of worth experienced once the event has passed. Similarly for workload, the instrumental support provided at the time of the event ameliorated the impact of issues to do with staff skill mix or staff patient ratio.

The finding associated with regard to the levels of stress reported at the two hospitals involved in the study has implications for the retention of staff in the longer term. If the level three hospital midwives continue to experience higher levels of subjective stress, they will be placed at greater risk of developing burnout. The areas of particular concern for this sample of midwives include the events within the categories of workload, lack of support and providing bereavement care. These three categories were found to share an association with burnout as measured by the ProQOL.

Further to this, a regression analysis found that the workload category of events was a predictor of the exhaustion dimension of the MBI, and while there was not statistically significant support for a positive association between lack of support and the exhaustion dimension, there was a trend suggesting further exploration is warranted.

While exhaustion as measured by the MBI is considered to be the initiating stage of burnout, cynicism can be viewed as more problematic. It has been determined as the second stage of burnout and is considered to be a deterioration in the individual's well-being (Diestel & Schmidt, 2010). In this sample of midwives it was found to share a negative association with compassion satisfaction as measured by the ProQOL. While this is an unsurprising association, it confirms the negative aspect of this dimension of burnout.

In the current study, a consistent development or increase in cynicism was not detected. This was seen as lending weight to the suggestion that it is a reflection of coping. The concern with this is the nature

195

of the coping as typically it would see the midwife distancing herself emotionally and cognitively from her work (Maslach, et al., 2001). This ultimately has an effect at both the personal and professional level. Personally, she is more likely to disengage from the social supports available to her and begin the path to inefficacy, the final stage of burnout (Diestel & Schmidt, 2010; Maslach, et al., 1996). Professionally, she is more likely to not engage with and be responsive to the needs of the women, resulting in their care being diminished. It is relevant to note that this notion of disengagement from social supports is supported in the current study by the negative association found between cynicism and global social support.

The little researched area of bereavement care as provided by midwives found a significant and concerning association with an area unexplored in relation to midwives, compassion fatigue. The area of compassion fatigue or vicarious traumatisation is one that has been recognised in counsellors who work with the traumatised since the 1970's (Figley, 1995). It is understandable that with the lack of research relating to the involvement of midwives in the provision of bereavement care (Mander, 2009), the notion of compassion fatigue has not been considered. The finding of a moderate correlation between the subjective stress reported in relation to the provision of bereavement care and the levels of vicarious traumatisation indicates that further consideration needs to be given to this area. There is probably an inextricable link between the midwives' experience of burnout and developing compassion fatigue as a result of providing bereavement care.

Perhaps the most concerning finding from the study was that in relation to the midwives who were found to have experienced a significantly greater sense of inefficacy over the twenty four week period of data collection. This suggests that these midwives were chronically exhausted, had become cynical to the point where they had withdrawn from their usual supports and their coping strategies had become ineffective (Diestel & Schmidt, 2010; Maslach & Leiter, 2004).

With regard to the midwives coping orientation, it was interesting to note that as a group of women they did not rely upon emotion oriented coping as previous research would predict. It is uncertain if this is a true reflection of their coping orientation, or a reflection of the demands of their work and the necessity to use a less preferred strategy (Endler & Parker, 1990, 1994).

With regard to avoidance oriented coping, this was found to be preferred by the midwives with them relying equally upon distraction and social diversion. Distraction was spoken of by the midwives interviewed in phase one of the study as a 'release valve'. The activities pursued included jogging or running, swimming, watching a movie or reading a book. These activities were seen as an opportunity to displace the stress or put it from their mind. Shifting their focus was also seen as an opportunity to see the issues in a new light. This would correspond to the reappraisal stage in the transactional model

of stress (Lazarus, 1966, 1999; Lazarus & Folkman, 1984, 1991), and on that basis would be considered an adaptive process.

The social diversion aspect of coping would entail them being involved with other people, which places it in the realm of social support and the concept that it would provide the element of social integration. When this is considered in terms of the midwives interviewed for phase one of the study, the social diversion they spoke of involved spending time socialising with colleagues, and was considered to provide an opportunity for receiving reassurance while also being a diversion. It can be suggested that the midwives gained a sense of identity, comfort, security and pleasure as described by Cutrona and Russell (1987a). Therefore, despite an element of denial being attached to this form of coping, there is also an implication that this is an adaptive form of coping for many of the midwives, and has the potential to buffer stress effects (Button, 2008).

The considerations in relation to the use of avoidance coping have greater significance when considered in light of the findings in relation to emotion oriented coping. While it was not found to be the preferred coping orientation, it was found to be a significant predictor of the emotion dimension of burnout. The implication of this is that the midwives who predominantly used emotion oriented coping were predisposed toward developing the first stage of burnout.

Although Endler and Parker (1999) have conceptualised coping as a stylistic variable where the pattern of reactions may change according to the situation, it could be suggested that for the midwives working in birthing suite there is a strong possibility that their coping style would remain stable relative to the area. If this is true, there reliance upon emotion oriented coping could become problematic from the perspective that their exhaustion could become chronic and place them at greater risk of developing cynicism as a response to this (Maslach & Leiter, 2004). Further to this, Diestel and Schmidt (2010) also suggest that exhaustion has a negative lagged effect on efficacy. Therefore, in time there will be a negative effect on the midwives efficacy and the more persistent their exhaustion, the greater the impact will be.

Recommendations
The recommendations to be made in relation to the findings fall into discrete groupings. The first group of recommendations was generated by the insight gained from the knowledge of the frequency with which certain events occurred, the degree of subjective stress reported, and any shared relationships between the frequency of an event and the associated subjective stress. The next grouping of recommendations are of a wide-ranging nature as they were initiated by the understanding gained from both the qualitative and the quantitative findings and the influence of the various domains that have been a focus of this study. These lead into those of a more specific nature with the focus being on

197

specific events, while the final recommendations pertain to those areas where further research would be considered beneficial.

Suggested interventions

There was an initial observation that the workload category of events had on average the greatest frequency of events per midwife, and three events within this category featured as the most frequently reported events. Therefore, while it may be difficult to limit the most frequently occurring event of *in-charge duties / providing supervision*, the next two events of *staff / patient ratio* and *staff skill mix* are areas where there could be a focus to limit the frequency with which they occur and thereby reduce the number of stressful events the midwives experience. Perhaps unsurprisingly, the events of staff skill mix and staff / patient ratio were also noted to have a recurring presence when the intercorrelations for the events within the other categories were reviewed. That is to say, these two events were associated with many other events. This lends weight to the notion that if the frequency of these events is reduced, then other events may also not occur as frequently, further reducing the number of stressful events experienced.

When the average stress per event per category was assessed it was found that the two bereavement care events of caring for a woman experiencing a fetal death in utero (FDIU) or midtrimester termination (MTT) were found to cause on average the greatest stress per event, indicating that factors other than frequency were responsible for generating the subjective stress experienced. Therefore, a more considered and detailed approach is required. This issue will be addressed later in conjunction with the domains of coping, social support, compassion fatigue and the mechanism of this stress.

When the categories were considered from the perspective of which had the strongest associations for both frequency and subjective stress, *lack of support* was the category identified. When there was an increased number of lack of support events, this was associated with an increased frequency of *case management, conflict* and *workload* events. When the subjective stress reported was examined, the same pattern of associations was found. While there can be no attribution of causality, there appears to be an undercurrent of, or sense of lack of support that is associated with increased stress. Therefore this is an area that needs to be addressed and efforts made to ensure that the midwives have a sense of support. Once again, by reducing the frequency of this as a stress inducing event, there is not only a reduction of stress associated within this category, but also the probability that the stress associated with issues of case management, conflict and workload will also be reduced. The way to achieve this reduction in frequency will be discussed in conjunction with subsequent and more wide-ranging recommendations.

The major conclusion drawn from the qualitative phase of the study was that it was a challenge to the midwives sense of control that underpinned the stress experienced. When the quantitative findings were analysed, the events that gave rise to the greatest stress in terms of both frequency and the subjective stress reported also related to the midwives sense of control.

The notion of control has been found to be a significant factor in the empowerment of midwives (Matthews, et al., 2006). From the qualitative phase, the midwives' sense of control was described as pertaining to their feelings of adequacy, competence and confidence, and the ability to manage. Such control is considered multifactorial and derived from the four components of predictability, task control, self-control and general control and relates to what it is the individual has control over and its significance to the them (Troup & Dewe, 2002).

Having knowledge of events, or predictability, was demonstrated as beneficial to the midwives when considered in terms of those events where there were clearly delineated procedures and protocols to be followed. This can be contrasted to those events where the midwives did not have a clear knowledge of events or they were unable to predict what care was going to be given. While it is understood that it is not always possible to clearly delineate a management plan, consideration should be given to developing strategies to eliminate some of the uncertainty that currently exists.

In terms of task control, or the ability to complete duties, this is an issue that relates to a number of the areas deemed as stressful by the midwives. The more obvious is in relation to workload and more particularly the events of staff / patient ratio and skill mix. Both these events place the midwives in a situation where they are more likely to be unable to complete their work in a manner that they deem as satisfactory. There would also be an association with the case management events of determining appropriate care and unclear treatment plan. When a clear plan of management or action is not in place, the midwife's experience would be one of not having provided satisfactory care, an element described in relation to the *genesis* constituent of stress. This finding further underscores the importance of addressing the workload issues in conjunction with providing clearer management or treatment plans.

While self-control or the ability to remain calm may have some association with personality factors, an individual's sense of calm may be lost when their perception is that events are overwhelming. Therefore, it can be argued that if an individual is feeling supported they are less likely to feel overwhelmed and more likely to remain calm. The support received can be considered as either instrumental or emotional. An example of instrumental support is that received from colleagues to assist in managing an emergency care event. This can be contrasted with the emotional support the midwives seek in the form of *succouring debriefing* following the emergency care event. Thus the issue of appropriate support is another area that should be addressed.

For professional decisions to be made responsibly, or for a midwife to have general control, the previous components of predictability, task control and self-control would need to be satisfied. Therefore, to provide the optimum circumstances for birthing suite midwives to work while experiencing minimum stress, it is recommended that strategies to minimise uncertainty of care and to bolster the support received from colleagues and supervisors / unit managers be devised, while the issues of skill mix and staff / patient ratios also be addressed.

It has been established that bereavement care as undertaken by midwives is under researched and therefore little understood. Therefore, the current study is able to provide some important insights into this area, because when all of the findings in relation to the provision of bereavement care are brought together it becomes apparent that it has a role in the development of burnout in birthing suite midwives.

The two events included in bereavement care were fetal death in utero (FDIU) and midtrimester termination (MTT). Taking from the findings of phase one of the study, it was apparent that while they have some shared characteristics, they also have some individual characteristics which must be taken into account. An important shared characteristic however was with regard to the frequency of either event. They were found to be linked to the exhaustion dimension of burnout. This indicates that the frequency with which staff were required to provide care for both events needs to be monitored and an endeavour made to have an even allocation across all midwives.

Further to this and taking from the work of Mander (2006) who concluded that the three primary reasons for midwifery staff experiencing difficulty in coping with perinatal death are the untimely nature of the death, the sense that it is a failure to perform the role of a midwife as expected, and it is an area that midwives are neither trained in nor have knowledge in, it is suggested that midwives need to be trained in this area. This training should be included in their undergraduate training to furnish them with the required knowledge to enable them to provide this care upon registration. This notion is further supported by the findings of Sprang, et al. (2007) who concluded that those mental health workers with specialised training in trauma work displayed higher levels of compassion satisfaction.

When considering the two events, there are inherent differences that need to be considered. While the frequency of providing care to a FDIU was associated with exhaustion, the more troubling finding was that MTT was more strongly associated with cynicism. This is suggestive of the midwives developing dysfunctional coping strategies that may in the longer term find them disassociating from the social support available to them.

In addressing this problem, it needs to be considered from several aspects. An overarching consideration should relate to the support that is offered. While the support of midwife colleagues is valued, it is the support of supervisors that is most closely linked with preventing the development of

exhaustion, the first stage of burnout (Constable & Russell, 1986; Eastburg, et al., 1994; McIntosh, 1991; Varvel, et al., 2007). Therefore, the unit managers / supervisors need to be made aware of the importance of their support and offered training in how to provide the appropriate support in a confident manner. The nature of the support would not be exclusive to the situation of bereavement care, but more general. As Varvel et al. determined the key dimensions of reliable alliance, reassurance of worth and social integration can be provided by the supervisors, and it is this that may limit the development of exhaustion.

In terms of social support, the support offered by colleagues is thought to relate more strongly to social integration or the sense that they belong to a group. While the predominant coping strategy employed generally by the midwives was found to be avoidance, this could be used to advantage to facilitate their sense of social integration and maintain it as a more adaptive approach. A list of social functions and group activities would be devised that caters to the diversity of interests articulated by the midwives in phase one. For example, regular jogging or swimming sessions could be arranged, visits to exhibitions, movie previews as well as dinners and coffee mornings. The organisation of these events could be the domain of the clinical nurse specialists and considered part of their development as a leader.

In discussing the difficulties encountered in relation to bereavement care and more particularly MTT care, a point raised by the midwives interviewed for phase one can be linked to their sense of control. In terms of the literature, it would be expressed as predictability (Troup & Dewe, 2002). It was intimated that there was no control over the numbers and they just arrived. While it is not feasible for the midwives to control the number of terminations undertaken, there could be some predictability introduced where possible through the allocation of care to a particular midwife one to two days prior to admission. This would provide advantages at several levels. It would assist in ensuring an even distribution of this type of bereavement care across all midwives and it would also provide the midwife with an opportunity to become familiar with the facts of the case before meeting the woman or couple. It should also provide her with the opportunity to discuss the case with the attending doctors and to gain an understanding of the treatment plan and to clarify any concerns she may have.

A final recommendation arises from phase one of the study. While it was not a focus of the quantitative phase of the study, an issue that became evident during the qualitative analysis pertained to the abuse that some midwives experienced. In terms of the retention of midwives, this is an area that has the potential to be problematic. On that basis, it is an area that should be monitored to ensure more proactive management if any escalation should be detected.

Further research

This has been an exploratory study, and therefore throughout the analysis and discussion of both phases many issues have been raised. With this in mind a judgement has been made in determining those areas where it is considered more immediate research is required. Therefore, in keeping with the notion that it is imperative to retain midwives, more research needs to be aimed at gaining an insight into the effect of age and work experience in relation to how midwives experience work stress and how this is related to any burnout they experience. Further to this a greater understanding also needs to be gained with regard to the impact of a lack of support (particularly in relation to supervisors and unit managers) has on the development of burnout and the practices that may be instituted to limit this.

The area of bereavement care from the perspective of the midwife is one that has been identified as having limited research and the results of this study suggest there is a need to address this. There is an indication from both phases of this study that there is an inherent difference between caring for a woman experiencing a fetal death in utero and a midtrimester termination. It is therefore apparent that an understanding needs to be gained as to what these differences are. This would then enable individual measures to be taken that could buffer or ameliorate the effects of burnout that may arise as a result of providing care in either of these situations.

Also within the area of bereavement care is the finding that midwives were experiencing compassion fatigue, a condition that is predisposed to when burnout is also being experienced (Stamm, 2005). Future research in this area should be aimed at demonstrating more clearly the degree of compassion fatigue being experienced and the impact this is having on the health and wellbeing of midwives. This could be combined with determining if there is an association with any burnout the midwives may be experiencing.

Limitations
The major limitation of this study was the restricted sample size for phase two. Due to the small sample size, some of the planned analyses could not be performed and the validity and reliability of the Diary of Stressful Events could not be ascertained. It would be the aim of any future studies to obtain a sample size that would facilitate the assessment of the validity and reliability of the diary.

With regard to the diaries returned, there were only three midwives who completed a full set of diaries for each month. This was due to the midwives taking Annual Leave, Sick Leave, or both (eleven), while there were another nine who were employed on the basis of rotating between the birthing suite and other areas such as antenatal and postnatal wards. Of the three who completed the full set of six diaries, only two also returned a full set of six completed stress scales, which further limited the quality and capacity of the quantitative data.

The Diary of Stressful Events was designed in a manner to facilitate easy completion of it at the conclusion of each shift worked. To achieve this, there are several instances where two events were 'collapsed' to make one event. The examples of this are APH / PPH (antepartum or postpartum haemorrhage), Supervisor / unit manager, and I/C duties / providing supervision. In all examples, this has lead to some difficulty in interpretation of the results. For example, there is a qualitative difference between an APH and a PPH because there is the threat of fetal demise with an APH, adding a level of complexity to the management of the situation and the emotions that may be experienced. Therefore, if there were to be future research, refinement of the diary would be required.

A series of regression analyses had been planned to determine those variables that predicted stress and burnout in midwives, however this was not achievable and the selection of variables to be assessed was severely restricted. Further to this, the data obtained from the Diary of Stressful Events was found to violate the assumptions of normality which in turn required the use of less powerful nonparametric procedures.

The study involved two hospitals, one of which was a level three hospital in a metropolitan location and the second a level two hospital in an outer suburban location. While they may be representative of hospitals of these levels and locations, they are not representative of all hospitals were midwifery is practised. A more representative sample would include hospitals in regional and rural settings and also where terminations are not performed.

Conclusion

The area of stress and burnout as it affects birthing suite midwives is one that is relatively poorly understood, but the current study has offered some insight and illuminated several areas that need to be addressed. Therefore, the overarching aim to extend our knowledge of the stressors that affect birthing suite midwives has been achieved.

The aim to achieve a more holistic understanding of midwives' stress and burnout was adversely affected by the difficulty faced in recruiting a sufficiently sized sample. A larger sample would have enabled the use of appropriate parametric statistical procedures to more conclusively determine the predictors of stress and burnout in birthing suite midwives. There would also have been the possibility of developing a model of burnout for this group of midwives.

Despite the failure to achieve a more holistic understanding or to develop a model of burnout, a number of areas have been identified as problematic, particularly in relation to the provision of bereavement care and the nature of the support that is required. In addition, the correlational analysis has provided a body of information that demonstrates the complexity of interactions between the various events contributing to the stress experienced by the midwives. These interactions have been demonstrated at

both a frequency level and in terms of the subjective stress experienced. This information could be used to either inform further research, or to guide the development of strategies to limit the stress and burnout being experienced.

Importantly, the major understanding derived from the study that the midwives' stress is underpinned by their sense of control being challenged will provide the basis from which future actions to improve the work environment can be planned and implemented.

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213

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Appendices

Appendix A: Qualitative interview guide

The purpose of this interview is twofold. Initially I want to gain an insight into your understanding of what stress is and what it means to you. Then I want develop a broad knowledge of the delivery suite environment. I will discuss with you the inherent stressors that exist there, and also talk about some of the things that help you adapt to that environment.

To begin with, I would like you to tell me what you personally recognise or would describe as stress. Is it seen as a cause or an antecedent of an effect (stimulant), or is it an effect (response), or is it a combination.

Some of the stress seems to arise from the nature of the work you have to do, and some of it seems to arise from conditions within your workplace. For a moment I would like you to focus on those things within the workplace that are professionally stressful for you.   (During the discussion elicit age, years of experience, grade, frequency of work, method of training.)

Conditions	Personal	Communication	Organisation	Staff
Workload / overload	Lack of control	With colleagues	Role ambiguity	Conflict with doctors
Paper work	Grade / status	Dealing with bureaucracy	Degree of autonomy	Conflict with colleagues
Research work	Career commitment		Continuity of care	Supervisors support
Shift work / night duty			Equipment failure	

I would now like you to move your attention to the patients. Describe for me those characteristics about them that have caused you any anxiety or misgivings: interactions with patients, reason for admission, patient requests / birth plans, dealing with death, interactions with families / support people.

I am now interested in hearing how you cope with the stress that you experience when working in delivery suite. When you are at work, what do you do that enables you to cope with the stress you experience? debrief with colleagues, adjust workload, blame others, suppress feelings, do active problem solving, seek reassurance or diversion. And what do you do when you have finished work, or are away from work and something is weighing on your mind? Absenteeism, arranges leave, seek self-improvement / attend courses, do physical exercise or sport, read a book, socialise, smoke, use alcohol, consider changing jobs.

As individuals, we all have different personalities that go toward determining how we cope with various situations that may arise throughout our lives. It is sometimes said that it takes a certain type to be a nurse, or that nurses are born not made. I am interested in knowing what sort of person you would describe yourself as. What do you consider to be the most important characteristics to have to be a midwife? Explore concepts of commitment, control and challenge

We all have friends, colleagues and family who we turn to for support at different times. I now want to discuss with you the people you turn to for support. You might like to begin by describing who you turn to. Do you prefer to talk to friends, colleagues or family? (Elicit if participant is married, has children, lives alone)

In relation to the support, describe what is it that you are seeking or hoping to gain? Is it someone to talk to, get advice from, or get physical support from? What is your perception of the support available to you, does it feel adequate? Discuss perception of how beneficial the various forms of support are

Appendix B: Plain Language Statement (Phase one)

VICTORIA UNIVERSITY

DEPARTMENT OF PSYCHOLOGY

Invitation to Participate in a Research Study

Understanding stress and burnout in birthing suite midwives: The implications of organisational environment, coping, hardiness, and social support.

I am a practicing midwife and PhD candidate at Victoria University, supervised by Dr. Bernadette Hood, and Ms. Anne Graham, Department of Psychology, Victoria University, St Albans Campus.

I am inviting you to participate in a study aimed at gaining an insight into the factors considered to be the most important in contributing to stress and burnout in those midwives who work in delivery suite. Included in this will be an assessment of what effect providing perinatal bereavement care has on midwives. As midwives who work in this area, you will be aware of its uniqueness. Because of this uniqueness, and a lack of research, there is limited knowledge of what the birthing suite midwives' experience is, and what the most significant stressors leading to burnout are.

In this the first stage of the study, I wish to interview a cross-section of midwives to inform me of the 'work' factors that are considered most stressful. This will assist in the development of a questionnaire that will be used to assess stress in delivery suite midwives.

It is envisaged that each interview will last approximately one hour. Each interview will be tape recorded and transcribed. Both the recording and the transcription will be kept confidential. Participation is entirely voluntary, and anonymity of the interviewee will be maintained at all times. If you choose to participate and during the course of the interview issues are raised that you find too distressing, you have the right to cease the interview, and you may withdraw from the study at anytime.

The second stage of the study will entail ongoing data collection. This will involve birthing suite midwives being asked to complete a series of questionnaires. It is therefore possible that you may be approached again in relation to this study.

If you should require any further information regarding this study, you may contact:

Dr. Bernadette Hood	Ms Anne Graham	Ms. Lyn Walpole
Victoria University	Victoria University	Royal Women's Hospital
Ph. 9365 2334	Ph. 9365 2159	Ph. 9489 7458

Appendix C: Consent Form (Phase one)
Victoria University of Technology

Consent Form for Participants Involved in Research

INFORMATION TO PARTICIPANTS:

We would like to invite you to be a part of a study aimed at gaining an insight into the factors considered to be the most important in contributing to stress and burnout in those midwives who work in birthing suites. Please read the appended *Plain Language Statement* for a more detailed explanation of the study

CERTIFICATION BY PARTICIPANT

I, _____

Of _____

  _____

certify that I am at least 17 years old and that I am voluntarily giving my consent to participate in the experiment entitled:

Understanding stress and burnout in birthing suite midwives: The implications of organisational environment, coping, hardiness, and social support.

being conducted at Victoria University of Technology by:

      Dr. Bernadette Hood
      Ms. Anne Graham
      Ms. Lyn Walpole

I certify that the objectives of the experiment, together with any risks to me associated with the procedures listed below to be carried out in the experiment, have been fully explained to me by:

      Lyn Walpole

and that I freely consent to participation involving the use of these procedures.

Procedures:
      AUDIOTAPED INTERVIEW

I certify that I have had the opportunity to have any questions answered, and that I understand that I can withdraw from this study at any time and that this withdrawal will not jeopardise me in any way.

I have been informed that the information I provide will be kept confidential, and that access to the audiotape and transcript of the interview will be restricted to the researchers listed above.

Signed: **... }**

Witness other than the experimenter (as appropriate) **}**   **Date: ....**

..}

Any queries about your participation in this project may be directed to the researcher (Dr Bernadette Hood: ph. 9365 2334). If you have any queries or complaints about the way you have been treated, you may contact the Secretary, University Human Research Ethics Committee, Victoria University of Technology, PO Box 14428 MCMC, Melbourne, 8001 (telephone no: 03-9688 4710).

Appendix D: Phase two enrolment procedure (Phase two)

Midwives Stress

♦ A DETAILED DESCRIPTION FOR PARTICIPANTS

♦ Carefully read the 'Plain Language Statement' and 'Consent Form'.

♦ To enrol in the study, complete the 'Consent Form' and place in reply paid envelope to return to Dr. Hood.

♦ A detailed questionnaire will be delivered to your home address.

♦ Complete the questionnaire, which will take approximately forty minutes and place in the designated box in your birthing suite.

♦ Also, on the first shift worked in the new month begin the accompanying 'diary'.

♦ Complete a page of the 'diary' for each shift worked (1-2minutes), recording the date and time of the shift at the top of the page.

♦ At the end of each month you will be sent another dairy, and two short questionnaires to complete.

♦ Complete the questionnaires (approx 10 minutes) and place in the box in your birthing suite along with the diary completed for the previous month.

♦ Continue to complete a 'dairy' for each month for the next six months

♦ When you have completed six diaries, you will be sent a slightly longer questionnaire as well as the two short questionnaires. These will take approximately ten minutes to complete and should also be placed in the box when completed.

♦ This will signal the end of your involvement in the study.

♦ The results of the study will be published and will be made available to you.

♦ Thankyou for your participation.

VICTORIA UNIVERSITY
SCHOOL OF PSYCHOLOGY
Invitation to Participate in a Research Study
Understanding stress and burnout in birthing suite midwives

I am a practicing midwife and PhD candidate at Victoria University, supervised by Dr. Bernadette Hood, and Ms. Anne Graham, School of Psychology, Victoria University, St Albans Campus.

I am inviting you to participate in a study aimed at gaining an insight into the common factors associated with contributing to stress and burnout in birthing suite midwives, while also considering some of the factors that influence the way individuals manage stress and develop burnout. As midwives who work in the area, you will be aware of its uniqueness. Because of this uniqueness, and a lack of research, there is limited knowledge of what the birthing suite midwives' experience of stress and burnout truly is.

My aim is to study a cross-section of birthing suite midwives, each for a period of six months. Because of the personal nature of the questions being asked, it's understood that your confidentiality must be protected. Initially you will be required to give consent to participate. To maintain your confidentiality, you have been supplied with a reply paid envelope to return the consent form to Dr. Hood. She will be the only person with access to the names of the participants. She will assign a unique code to each participant. It is this code that will appear on all of the questionnaires. Dr. Hood will also be the only person with access to the list of codes, and will be responsible for forwarding new questionnaires to your home address.

Once enrolled in the study, you will be forwarded an initial questionnaire to complete. This will ask for some personal details and information relating to the factors that influence the way an individual may manage stress and develop burnout. This initial questionnaire is central to the study and quite detailed and may take up to 45 minutes to complete.

Following this, over a six month period you will be asked to keep a checklist 'diary' of stressful events for each shift worked. This should take just a few minutes to do. At the end of each month another short questionnaire will be forwarded to you, asking you questions about how you have felt in the previous month. It will take up to just five minutes to complete.

At the completion of your participation in the study, there will be another ten minute questionnaire forwarded to you for completion. This will provide further information on the effect of working in the birthing suite. You will not be required to have any further involvement in the study after this point.

It is realised that for some people, having to reflect upon work events may trigger a 're-living' of these events. This may lead to some psychological discomfort or distress. If this should happen, you have the right to seek whatever assistance you may feel is necessary. There is a 'Peer Support' program available within the hospital, or the services of a Registered Psychologist on staff. Do not hesitate to see these people if you feel the need. Further to this, it is your right to withdraw from the study at anytime without any prejudice.

If you should require any further information regarding the study, you may contact:

Dr. Bernadette Hood	Ms. Anne Graham	Ms. Lyn Walpole
Victoria University	Victoria University	Royal Women's Hospital
Ph. 9365 2334	Ph. 9365 2159	Ph. 0417 500 409

Any concerns resulting from your participation in this project may be directed to the principal researcher (Dr Bernadette Hood ph. 9365 2334). If you have any queries or complaints about the way you have been treated, you may contact the Secretary, University Human Research Ethics Committee, Victoria University of Technology, PO Box 14428 MCMC, Melbourne, 8001 (telephone no: 03-9688 4710).

Victoria University
Consent Form for Participants Involved in Research

INFORMATION TO PARTICIPANTS:
We would like to invite you, as a midwife of The Angliss Hospital, to be a part of a study aimed at gaining an insight into the factors considered to be the most important in contributing to stress and burnout in those midwives who work in the birth suite. Please read the appended *Plain Language Statement* for a more detailed explanation of the study

CERTIFICATION BY PARTICIPANT

I**,**
of

certify that I am at least 18 years old and that I am voluntarily giving my consent to participate in the experiment entitled:
Understanding stress and burnout in birthing suite midwives: The implications of organisational environment, coping, hardiness, and social support.

being conducted at Victoria University of Technology by:
Dr. Bernadette Hood
Ms. Anne Graham
Ms. Lyn Walpole

I certify that the objectives of the study, together with any risks to me associated with the procedures listed below to be carried out in the study, have been fully explained to me by:

Lyn Walpole

and that I freely consent to participation involving the use of these procedures.

Procedures:
- Completion of initial set of questionnaires upon enrolment
- Participating in ongoing data collection over a six month period
- Completion of a final questionnaire at the end of the six month data collection period

I certify that I have had the opportunity to have any questions answered and that I understand that I can withdraw from this study at any time and that this withdrawal will not jeopardise me in any way.

I have been informed that the information I provide will be kept confidential.

Signed: **.. }**

Witness other than the experimenter (as appropriate) **}**   **Date: ....**

...}

Any queries about your participation in this project may be directed to the researcher (Dr Bernadette Hood: ph. 9365 22334). If you have any queries or complaints about the way you have been treated, you may contact Suzanne Walsh, Secretary, Human Research Ethics Committee, Angliss Hospital, telephone no: 03-9764 6117.

Appendix G: Diary of Stressful Events

DATE: /   /   **AM   PM   ND**

Not   Very
Stressful   stressful

Bereavement care
☐ FDIU/FDIL | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
☐ MTS | 0 | 1 | 2 | 3 | 4 | 5 | 6 |

Case management issues
☐ Compromised standards of care | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
☐ Determining appropriate care | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
☐ Unclear treatment plan | 0 | 1 | 2 | 3 | 4 | 5 | 6 |

Conflict with:
☐ Ancillary staff | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
☐ Medical staff | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
☐ Midwife colleagues | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
☐ Patients | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
☐ Partners / Support people | 0 | 1 | 2 | 3 | 4 | 5 | 6 |

Emergencies
☐ APH/PPH | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
☐ Code Blue | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
☐ Cord prolapse | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
☐ FDIL | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
☐ Fetal distress | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
☐ "Flat baby" | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
☐ Immediate C/section | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
☐ Shoulder dystocia | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
☐ Other ……………………….… | 0 | 1 | 2 | 3 | 4 | 5 | 6 |

Support (lack of from)
☐ Midwife colleagues/peers | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
☐ Supervisors/NUM | 0 | 1 | 2 | 3 | 4 | 5 | 6 |

Workload
☐ Complex cases (Severe PE etc) | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
☐ I/C duties or providing supervision | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
☐ Staff skill mix | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
☐ Staff patient ratio | 0 | 1 | 2 | 3 | 4 | 5 | 6 |

Appendix H: Meaning Units

Original transcript	*Meaning Units*	*Transformations*	*Category and constituent*
I don't know, it's very hard. When people say they're off on stress leave I sort of use to say 'what a load of poppy', you know, because ….. to me it seemed like a cop-out. Although reflecting back I probably would have thought that I was under a lot of stress, but because my coping mechanisms where really high, I didn't realise it. And I suppose my life ethics have always been get on with it, do it, you know as much as you can.	I don't know, it's very hard. When people say they're off on stress leave I sort of use to say 'what a load of poppy', you know, because to me it seemed like a cop-out.	Stress was considered to be an invalid reason for having leave	**STRESS - management**
	Although reflecting back I probably would have thought that I was under a lot of stress, but because my coping mechanisms where really high, I didn't realise it.	Efficient coping mechanisms adequately offset unidentified excessive stress levels	**STRESS - reaction**
	And I suppose my life ethics have always been get on with it, do it, you know, as much as you can.	Response to a situation is guided by inherent attitudes and principles	**STRESS - reaction**

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Perceived Stress Scale

The questions in this scale ask you about your feelings and thoughts **during the last month**. In each case, you will be asked to indicate by circling *how often* you felt or thought a certain way.

0 = Never   1 = Almost Never   2 = Sometimes   3 = Fairly Often   4 = Very Often

1. In the last month, how often have you been upset
    because of something that happened unexpectedly? 0   1   2   3   4

2. In the last month, how often have you felt that you were unable
    to control the important things in your life? 0   1   2   3   4

3. In the last month, how often have you felt nervous and "stressed"? 0   1   2   3   4

4. In the last month, how often have you felt confident about your ability
    to handle your personal problems? 0   1   2   3   4

5. In the last month, how often have you felt that things
    were going your way? 0   1   2   3   4

6. In the last month, how often have you found that you could not cope
    with all the things that you had to do? 0   1   2   3   4

7. In the last month, how often have you been able
    to control irritations in your life? 0   1   2   3   4

8. In the last month, how often have you felt that you were on top of things? 0   1   2   3   4

9. In the last month, how often have you been angered
    because of things that were outside of your control? 0   1   2   3   4

10. In the last month, how often have you felt difficulties
    were piling up so high that you could not overcome them? 0   1   2   3   4

Please feel free to use the *Perceived Stress Scale* for your research.

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Appendix J: ProQOL - R III
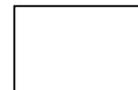
PROFESSIONAL QUALITY OF LIFE

Compassion Satisfaction and Fatigue Subscales – Revision III

Helping others puts you in direct contact with other people's lives. As you probably have experienced, your compassion for those you help has both positive and negative aspects. We would like to ask you questions about your experiences, both positive and negative, as a helper. Consider each of the following questions about you and your current situation. Write in the number that honestly reflects how frequently you experienced these characteristics *in the last 30 days*.: 0=Never   1=Rarely   2=A Few Times   3=Somewhat Often   4=Often   5=Very Often

_____1. I am happy.

_____2. I am preoccupied with more than one person I help.

_____3. I get satisfaction from being able to help people.

_____4. I feel connected to others.

_____5. I jump or am startled by unexpected sounds.

_____6. I feel invigorated after working with those I help.

_____7. I find it difficult to separate my personal life from my life as a helper.

_____8. I am losing sleep over a person I help's traumatic experiences.

_____9. I think that I might have been "infected" by the traumatic stress of those I help.

_____10. I feel trapped by my work as a helper.

_____11. Because of my helping, I have feel "on edge" about various things.

_____12. I like my work as a helper.

_____13. I feel depressed as a result of my work as a helper.

_____14. I feel as though I am experiencing the trauma of someone I have helped.

_____15. I have beliefs that sustain me.

_____16. I am pleased with how I am able to keep up with helping techniques and protocols.

_____17. I am the person I always wanted to be.

_____18. My work makes me feel satisfied.

_____19. Because of my work as a helper, I feel exhausted.

_____20. I have happy thoughts and feelings about those I help and how I could help them.

_____21. I feel overwhelmed by the amount of work or the size of my caseload I have to deal with.

_____22. I believe I can make a difference through my work.

_____23. I avoid certain activities or situations because they remind me of frightening experiences of the people I help.

_____24. I plan to be a helper for a long time.

_____25. As a result of my helping, I have intrusive, frightening thoughts.

_____26. I feel "bogged down" by the system.

_____27. I have thoughts that I am a "success" as a helper.

_____28. I can't recall important parts of my work with trauma victims.

_____29. I am an unduly sensitive person.

_____30. I am happy that I chose to do this work.

Appendix K: Social Provisions Scale

Please indicate how much each statement describes your situation by circling the best response.

For example, if you feel a statement is VERY TRUE you would circle "Strongly Agree". If you feel a statement CLEARLY does not describe your relationships, you would answer "Strongly Disagree".

	Strongly Disagree 1	Disagree 2	Agree 3	Strongly Agree 4
1. There are people I know will help me if I really need it.	1	2	3	4
2. I do not have close relationships with other people.	1	2	3	4
3. There is no one I can turn to in times of stress.	1	2	3	4
4. There are people who call on me to help them.	1	2	3	4
5. There are people who like the same social activities I do.	1	2	3	4
6. Other people do not think I am good at what I do.	1	2	3	4
7. I feel responsible for taking care of someone else.	1	2	3	4
8. I am with a group of people who think the same way I do about things	1	2	3	4
9. I do not think that other people respect what I do.	1	2	3	4
10. If something went wrong, no one would help me.	1	2	3	4
11. I have close relationships that make me feel good.	1	2	3	4
12. I have someone to talk to about decisions in my life.	1	2	3	4
13. There are people who value my skills and abilities.	1	2	3	4
14. There is no one who has the same interests and concerns as me	1	2	3	4
15. There is no one who needs me to take care of them.	1	2	3	4
16. I have a trustworthy person to turn to if I have problems.	1	2	3	4
17. I feel a strong emotional tie with at least one other person.	1	2	3	4
18. There is no one I can count on for help if I really need it.	1	2	3	4
19. There is no one I feel comfortable talking about problems with	1	2	3	4
20. There are people who admire my talents and abilities.	1	2	3	4
21. I do not have a feeling of closeness with anyone.	1	2	3	4
22. There is no one who likes to do the things I do.	1	2	3	4
23. There are people I can count on in an emergency.	1	2	3	4
24. No one needs me to take care of them.	1	2	3	4

Appendix L: Frequency of events by category

Bereavement Care		Case Management		Conflict with		Emergency Care		Lack of Support from		Workload	
Fetal death in utero	48	Compromised standards of care	156	Ancillary staff	15	APH / PPH (Bleeding)	85	Midwife colleagues	105	Caring for complex cases	145
Midtrimester termination	111	Determining appropriate care	261	Medical staff	150	Code blue	28	Supervisors / Unit managers	78	In-charge duties / providing supervision	477
		Unclear treatment plan	180	Midwife colleagues	120	Cord prolapse	5			Skill mix	350
				Patients	46	Fetal distress	153			Staff / patient ratio	397
				Partners / support people	75	'Flat baby'	102				
						Immediate Caesarean section	165				
						Shoulder dystocia	42				
						Other	64				