Disempowered midwives and traumatised women: exploring the parallel processes of care provider interaction that contribute to women developing Post Traumatic Stress Disorder (PTSD) post childbirth

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Abstract

Background: Around 4% of women develop Post Traumatic Stress Disorder Post Childbirth (PTSD-PC). During childbirth a woman's perception of her care provider's interpersonal verbal and nonverbal relationship behaviours, termed 'Quality of Provider Interaction' are significantly associated with the development of PTSD-PC.
Aims: To understand how women who develop PTSD-PC and midwives, experience their interactions during care provision. In particular, how they feel during their interactions and what this means to them.
Methods: The qualitative method of Interpretative Phenomenological Analysis that incorporates a reflective approach, was used to gain deep understanding of the lived experience of care provider interaction. Six women who met full diagnostic criteria for PTSD-PC and six midwives who provided intrapartum care, participated in individual face-to-face interviews.
Results: Two key findings were identified: 1) Failing to recognise and meet the human needs of both women and midwives, results in poor quality interactions from midwives and poor perception of care provider interaction by women; 2) The study groups of women and midwives both identified the quality of their relationship as central to positive interactions.
Recommendations for practice: (1) Raise the status of psychological wellbeing for childbearing women and make it of equal importance to physical wellbeing, with clear focus upon care provider interaction; (2) Create a midwife centred system that enables midwives to provide optimal care provider interaction and improve relationship-based care; and (3) Challenge underlying toxic cultures that currently persist in the maternity services system, which undermine the work of midwives and consequently the experience of women.
Conclusion: Failure to recognise and meet the human and relationship needs of both childbearing women and midwives contributes to poor care provider interactions offered by midwives and negative perceptions of care provider interactions by women. In response, NHS maternity services need to highlight the importance of the quality of care provider interaction alongside perinatal psychological wellbeing. This requires improved working environments for midwives, so they can optimise their quality of interaction with childbearing women. This will in turn impact upon the incidence and levels of trauma and PTSD-PC experienced by women.

Key words: PTSD, Childbirth, Midwives, Care Provider Interaction, Maternity care

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Introduction

Perinatal mental illness in women requires maternity services attention (NICE, 2014, Brockington et al., 2017, WHO, 2017). Post Traumatic Stress Disorder Post Childbirth (PTSD-PC) requires attention, since 4% of childbearing women develop full PTSD-PC (Yildiz et al., 2017) and 10%-18% develop severe Post Traumatic Stress symptoms (Ayers, 2004, Beck et al., 2011). Furthermore, Alcorn et al. (2010) reported that potentially up to 45.5% of women experience childbirth as a traumatic event that fulfils the Diagnostic and Statistical Manual of Mental Disorders IV Criterion A for PTSD (APA, 1994) (Box 1).

Box 1. DSM-IV diagnostic Criterion A for PTSD (APA, 1994)

The person has been exposed to a traumatic event in which both of the following were present:

A1: The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.

A2: The person's response involved intense fear, helplessness or horror.

Note: At the time of this study no published research was identified that explored the % of women who meet Criterion A in relation to the subsequent and most recent version (V) of the Diagnostic and Statistical Manual of Mental Disorders released in 2013 (APA, 2013).

PTSD-PC negatively affects women's interactions with their infants (Ayers et al., 2006, Davies et al., 2008, Parfitt and Ayers, 2009), decisions regarding breastfeeding (Beck et al., 2011), child development (Barlow et al., 2013) and partner relationships (Nicholls and Ayers, 2007). PTSD-PC can create severe fear of childbirth (tokophobia) that negatively influences decisions regarding future pregnancies and childbirth choices (Gottvall and Waldenström, 2002, Otley, 2011) and bears economic cost (Bauer et al., 2014). Patterson et al. (2019) identified that women's subjective experiences of childbirth significantly contribute to the development of PTSD-PC (Garthus-Niegel et al., 2013), while interpersonal factors are the strongest predictors for developing PTSD-PC (Harris and Ayers, 2012). Within interpersonal factors, the measure 'Quality of Provider Interaction' (QPI) represents

women's perceptions of care provider interpersonal verbal and nonverbal relationship behaviours, which are assessed on a scale from 'disaffirmation' (woman treated as an object & denial of personhood) to 'affirmation' (recognition & support of personhood) (Sorenson, 2003). QPI has been shown to significantly correlate with the development of PTSD-PC (Sorensen and Tschetter, 2010). In contrast, positively perceived care provider interactions may reduce risk of developing PTSD-PC (McKenzie-McHarg et al., 2014). Within PTSD-PC literature, two quantitative studies have explored care provider interaction from the woman's perspective, while only one qualitative study has explored midwives' perspectives of PTSD-PC with limited focus on care provider interaction (Patterson et al., 2019).

Within UK maternity services there exist ongoing issues such as: short staffing, bullying, undermining, and midwives leaving the profession early, often within a few years of qualifying (RCOG/RCM, 2015, RCM, 2016b, Hawkins-Drew, 2017). It is anticipated that these issues may affect midwives' interactions with women.

The research now presented was conducted in keeping with calls for further research to be conducted in relation to care provider interaction (Slade, 2006, McKenzie-McHarg et al., 2015, Simpson and Catling, 2015). Within this paper the term 'CPI' refers to overall perception of *Care Provider Interaction*, rather than the specific 'QPI' scale devised by Sorenson (2003). The study was performed in Scotland where midwives are the main providers of care during normal birth (NMC, 2015). Therefore, the exploration of CPI was focussed specifically on women and midwives, with a view to creating recommendations for Scottish and UK maternity services that may serve to reduce trauma related to CPI and subsequent PTSD-PC. The following aims and research questions were developed.

Aims

(1) To understand how women who have developed PTSD-PC experienced their interaction with midwives during the labour, birth, and the early postnatal period.

(2) To understand how midwives experience interacting with women whilst providing care during labour, birth, and the early postnatal period.

Research questions

(1) How do childbearing women who develop PTSD-PC and midwives experience their interactions during labour, birth, and the early postnatal period?

(2) How do women and midwives feel during their interaction and what does it mean for them?

Note, it was considered neither practical nor ethical to approach the specific midwives who had cared for the study women. Nevertheless, the study midwives described their experiences cognisant that women can find their care provider interactions to be traumatic.

Methods

Qualitative methodology was used in balance to existing quantitative studies and to gain deep understanding of the lived experience of CPI. A phenomenological strategy was considered appropriate for expanding understanding of lived human experience through gathering women's and midwives' descriptions and interpretations of their interactions during childbirth (Dahlberg et al., 2008). The qualitative method of Interpretative Phenomenological Analysis (IPA) was employed. IPA is theoretically underpinned by phenomenology, hermeneutics, and idiography. Phenomenology *uncovers* meaning and hermeneutics *interprets* meaning (van der Zalm and Bergum, 2000, Pringle et al., 2011). The idiographic aspect incorporates a sense of detail, depth of analysis, and the understanding of individual experience from the perspective of people uniquely situated in a specific context, which in this case is the interaction between women and midwives (Smith et al., 2009). IPA involves a double hermeneutic process in that the informant interprets and makes sense of their experience, whilst the researcher interprets and makes sense of the informant's sense-making through the lens of their own preconceptions (preconceived theories and understanding) (Smith et al., 2009). This involved the reflexive action of acknowledging preconceptions but not allowing them to dominate what is referred to as 'bridling' (Dowling, 2007).

Sample size

This study required a small sample because an in-depth approach was taken to yield high *information power* (Malterud et al., 2016). For IPA it is recommended that 3-6 homogenous informants enable an idiographic in-depth focus (Smith et al., 2009, Hefferon and Gil-Rodriguez, 2011). This study sample comprised two groups from within Scotland: six women and six midwives. Hence, the insight gained from idiographic examination of informants' experiences within each group was extended by exploring relational and intersubjective

perspectives between groups (Larkin et al., 2018). Although the study midwives were not the midwives who had cared for the women, exploring the experiences of CPI from both women and midwives strengthened the representativeness of the findings.

Informants

Informants consisted of (n=6) childbearing women who had developed PTSD-PC and (n=6) midwives who provide care during labour, birth, and the early postnatal period.
Both primiparous and parous women were eligible, as recommended by Iles and Pote (2015). *Table 1* presents inclusion/exclusion criteria used.

TABLE 1

Women were recruited between 9th October 2016 and 31st December 2016 via non-NHS postnatal groups based in Lothian Region Scotland. Advertisements included the term *distressing,* simply because this word is associated with PTSD-PC (Soet et al., 2003, Stevens et al., 2012). Midwives were recruited through an online survey distributed via non-NHS social media between the 14th November 2016 to 16th January 2017. The survey asked midwives about their understanding of PTSD-PC and their thoughts about potential factors that contribute to PTSD-PC for women.

Ethics

Full consent was received prior to data collection and processing. Anonymity and confidentiality were preserved. Ethics approval was granted by Edinburgh Napier University committee (FHLSS/1676) and NHS clinical governance.

Data-collection

Women applicants were screened for PTSD-PC using the City Birth Trauma Scale (City BiTS) (Ayers et al., 2018), with those meeting the diagnostic criteria invited to participate in an interview. Informants chose the time and place of interview, which included their home, café or university office. Individual face-to-face interviews were conducted and initiated using open-ended questions (Box 2).

Box 2. Interview opening questions

Opening question for women: Please tell me about your experience of being with and cared for by midwives during your labour, birth, and first few hours after birth? I am particularly interested in how you felt and what things meant to you. **Opening question for midwives:** From the background that some women who develop PTSD-PC tell us they found their interactions with midwives to be negative, please tell me about your experience of interacting with women while providing intrapartum and early postnatal care. I am particularly interested in how you feel when you are with women and what it means for you?

A loosely structured interview schedule and occasional note taking as an aide memoir, enabled the researcher to appropriately probe meaning and experience (Smith et al., 2009). While some informants expressed some distress during their interview, all were eager to tell their story and found the process cathartic. All informants were given the option to take breaks or discontinue the interview at any time. All informants received written debrief / support information post-completion. Interviews were audio-recorded.

Data-analysis

Interview audio-recordings were transcribed verbatim and analysed case-by-case following a step-by-step process (Box 3).

Box 3. The 8 steps of IPA analysis process (adapted from (Smith et al., 2009)).

1: Reading and re-reading 2: Initial noting 3: Developing emergent themes 4: Searching for connection across emergent themes 5: Moving to the next case 6: Looking for patterns across cases 7: Writing up the analysis 8: Identifying convergent or divergent themes across both groups

The principal investigator (first author) performed data processing and analysis by hand. Transcripts were read and re-read, which enabled the data-immersion intrinsic to the in-depth quality of IPA. Initial noting detailed descriptive (what was said), linguistic (how things were said), conceptual (the meaning to the informant) and interrogative (exploring what lay

beneath what was said) aspects of the transcript. From this, emergent themes were generated. Identifying connections between emergent themes to produce sub and master themes was an iterative process. During course the principle investigator used a reflective journal to examine the influence of preconceptions on data interpretation and bridle these as required (Finlay, 2014). In line with recognised quality assurance requirements for qualitative research (Mays and Pope, 2000, Yardley, 2000), the authenticity of findings was supported by direct data extracts, with coding reviewed by an IPA expert (Dickson, 2016) and the second author who is both a researcher and midwife. Informant checking was considered unnecessary, since IPA requires the researcher to interpret the informant's interpretation, which means that findings move beyond the informant's description (Biggerstaff and Thompson, 2008). Pseudonyms have been used throughout to preserve anonymity and confidentiality.

Findings

Informants

Of the 30 eligible women applicants, 24 consented to participate in the screening stage and 8 met full diagnostic criteria for PTSD-PC. Six consented to be interviewed. All 6 women were white, married and living with their husband, aged from 29 to 45, with an average age 35. All were primiparous and between 6 months and 4 years post birth at the time of interview. Regarding pre-existing factors that may influence the childbirth experience, 5 of the women had not experienced (or did not disclose) any prior interpersonal trauma. One woman described herself as a survivor of adult rape. 57 midwives completed the survey and 6 of the 38 who expressed a willingness to be interviewed met the interview inclusion criteria. All 6 midwives were white, aged from 30 to 55, average 41, with 6-30 years, average 14 years, midwifery experience. Five were mothers. Demographically, each group was reasonably homogeneous as appropriate for IPA, and somewhat aligned with the other group.

Themes from each group

The in-depth nature of the IPA process yielded more results than can be effectively presented in one paper. Therefore, this paper presents the overall key findings. An overview of the identified underlying IPA master and sub themes is presented for each group with a

selection of extracts as appropriate (Smith et al., 2009). During reporting, informants are referred to as '*The Women'* and '*The Midwives'.* For '*The Women',* key trauma *hotspots* (Harris and Ayers, 2012) incorporated negative aspects of CPI, yet they all simultaneously expressed positive interactions, which shows that they were not predisposed only to negative interaction. '*The Women'* highly valued when midwives spoke *with* them rather than *at* them. They appreciated when midwives used positive affirming verbal tones, actively listened, explained things, and provided reassurance that wasn't empty. Alongside this, when midwives engaged body language such as physically being beside them and making eye contact, '*The Women'* felt acknowledged, listened to, and safe in the hands of competent staff. When '*The Women'* perceived positive interactions they used words such as: *fantastic, amazing, as hoped for,* and *deep joy.* However, as Catriona expressed: '*it was like a game of fortunately, unfortunately…fortunately the good midwife was there, unfortunately the bad midwife...'.* This left Julie '*dreaming of the other midwife coming back*'. Therefore, while acknowledging the importance of positive behaviours and their impact on *'The Women',* this paper focusses upon informants' negative perceptions to highlight potential issues that need addressed and inform recommendations for improved midwifery practice. In balance to existing PTSD-PC research that has focussed on women's experiences, the voices of *'The Midwives'* are presented first.

'The Midwives' experiences

Figure 1 and *Table 2* present the identified themes and key extracts from *'The Midwives'* data.

FIGURE 1

TABLE 2

'The Midwives' reported finding joy and gain of job satisfaction when they are able to build relationships with women, make a difference to women's experiences, and keep women and babies safe. To achieve this '*The Midwives'* require time to tune into individual needs, yet they find their workload frequently leaves them unable to be *with women*. As a consequence, angst occurs when competition arises between meeting women's desires and demands from management, compounded by the need to adhere to systemic procedures

and keep women safe. Such pressures leave '*The Midwives'* lacking control over care provision, which includes CPI. '*The Midwives'* also expressed a need to be trusted, respected and seen as humans and not machines, all of which requires them to be provided with appropriate time and resources. *'The Midwives'* further highlighted their need for colleagues and women to appropriately fulfil their roles.

'The Women's' experiences

Figure 2 and *Table 3* present the identified themes and key extracts from *'The Women's'* data.

FIGURE 2

TABLE 3

'The Women' expressed vulnerability whilst childbearing and strongly desired to feel safe in the hands of midwives, to develop positive relationships with them, and be kept informed throughout the childbirth process. *'The Women'* needed to trust their midwives' intention, integrity, honesty, competency, availability, and to believe they have their interests at heart. When this happened '*The Women'* perceived positive CPI. Shattered world views resulted when midwives' behaviours were unexpectedly negative and inconsistent, which has been named sanctuary trauma (Silver, 1986, Bloom, 2018). Poor, negative, mistimed and absent communication or support contributed to '*The Women'* feeling abandoned. In turn, this for some deepened into fear, horror, and helplessness through perceived threat or danger from midwives' behaviours. Some of the '*The Women'* perceived that their power was undermined by midwives' negative attitudes, power struggles, and perceived physical violation.

Bringing together 'The women's and 'The Midwives' sides of story

Two key converging themes emerged (Box 4).

Box 4. Key themes converging across both groups

- **Being human**: women and midwives need to feel safe and be acknowledged as human.
- **Relationship**: women and midwives strongly desire positive and affirming relationships and see them as central to positive CPI.

Being human

Both '*The Women'* and '*The Midwives'* expressed explicitly or implicitly that they are first and foremost human, with shared fundamental human needs for safety, respect, power, and support. Yet, the nature of these needs diverged. For '*The Women',* being safe required a continuous and trustworthy presence and input from their midwives. In contrast, for '*The Midwives'* being safe consists of a desire to keep women and their midwifery registration safe, which can at times conflict with demands from both the women and the system. Also*,* the preparation and knowledge that each side carry is not always fully respected through being recognised, understood, or accounted for by the other. Importantly, the fundamental human need to maintain some power and personal control is usually informed by the need for safety, which at times could arouse emotional and physical conflict. Hence, the source of support differs given that '*The Women'* require support from midwives, whilst '*The Midwives'* require support from colleagues and the system. Consequently, both sides experienced their own specific emotions when these needs were unmet (*Figure 3* & *Table 4*).

FIGURE 3

TABLE 4

Relationship is core

The clearest convergence occurred in the master themes *Being with me* and *Building relationships*, with both '*The Women*' and '*The Midwives'* desiring to experience positive and affirming relationships. The depth of distress experienced when relationships are dysfunctional, absent, or lost, illuminates the strength of this shared desire to connect and journey through the process together. Consistent with the interpersonal factor of CPI being

a strong predictor of PTSD-PC, dysfunctional, absent, or lost relationships featured as strong hotspots of trauma for '*The Women',* particularly in relation to the behaviour and attitudes of midwives towards them (*Figure 4*). When positive relationships did occur, all of the informants expressed joy and satisfaction.

FIGURE 4

Dysfunctional, absent, or lost relationships reflect lack of power for both '*The Women'* and '*The Midwives'.* Whilst lack of power is potentially most damaging for '*The Women'*, *'The Midwives'* also experience distress when they lack power to fulfil their role in a way they see fit. As shown in Table 5, this often arises when '*The Midwives'* are physically required elsewhere, which creates the issue of 'separation', or are psychologically distracted due to multiple demands giving rise to the issue of 'ticking boxes'. Together these issues have consequences regarding the effectiveness of communication.

TABLE 5

Discussion

As appropriate for IPA the samples of women and midwives in this study are homogeneous, which is beneficial for comparing and contrasting their perspectives. Yet, this could mean the findings are not representative of the wider populations of women and midwives. However, the study findings are consistent with wider research regarding CPI (Patterson et al., 2019), and echo those from a recent study exploring the woman/midwife interaction at the start of labour (Shallow et al., 2018). The key converging themes highlight that when the human needs of women and midwives remain unrecognised or unmet, or when positive affirming relationships are not enabled nor supported, the consequence can be poor provision of CPI by midwives and a poor perception of CPI by women. That these themes emerged strongly from the perspectives of both groups, alongside the significant role of CPI in the subsequent development of PTSD-PC, both these issues require attention.

Being human

The primacy of being human exists for all women and their care providers and results in shared vulnerabilities that are clearly expressed in the wider literature:

> *'I dunno, there is something wrong in a system that doesn't allow you to feel like a human being'* Julie (woman informant)
>
> *'I suffer from a condition called being human.'* (Pezaro, 2018)
>
> *'The woman giving birth is a human being, not a machine and not just a container for making babies.'* (Wagner, 2001) p.S25
>
> *'Humanity is important in any culture and within the NHS it feels like humanity should be core.'* (West, 2013b, West, 2013a) p.3

The informants' human needs for safety, respect, power, and support reflect wider understanding that the woman/midwife interaction encompasses personal histories, the current situation, other people, and the situated context (Paradice, 2002). In particular, women's needs for safety extend beyond physical wellbeing to encompass mental wellbeing (Edwards, 2010). Women's childbirth trauma is often attributed to *unrealistic* expectations (Kirkham, 2017), consistent with having a world view shattered, which is a core element within PTSD (Janoff-Bulman, 1992). In this study '*The Women's'* master theme *'Shattered expectations'* related to midwives' behaviours more than the childbirth process.

'*The Midwives'* desire psychological safety and security, and to build relationships with women. '*The Midwives'* highlight the need to be a person who matters and not just a machine, which is acknowledged within the wider NHS '*We cannot run an organisation without paying attention to the humanity of the staff. We cannot keep piling more and more onto the people'* (West, 2016). The needs of midwives are further highlighted by the Royal College of Midwives Caring for You Campaign survey (RCM, 2016a) and their recent report (Hunter et al., 2018). In this study '*The Midwives*' master theme *'Others need to do their bit'* reflects their human susceptibility to the behaviour of colleagues and women, as well as the systemic culture.

Relationship

The formation of a unique and potentially rewarding relationship is recognised within the woman/midwife interaction (Lundgren, 2004, Thomas, 2006). The informants' shared desires for positive affirming relationships and the depth of distress when relationships were experienced as dysfunctional, absent, or lost is consistent with wider midwifery

literature that highlights the centrality of meaningful, trusting women/midwife relationships (Kirkham, 2010, Crowther et al., 2018, Edwards, 2018) that are crucial to positive experiences (Sandall et al., 2016, Homer et al., 2017).

Within the woman/midwife interaction acknowledgement of the humanity of the other forms a connection from which a reciprocal partnership can exist (Hunter, 2006), and from which relationship might grow. Yet, reciprocity is not a guaranteed component of the woman/midwife interaction given that both sides do not introduce equal influence (Hunter, 2006). When the weight of power is maintained on the professional side it can drive '*a wedge between the mother midwife relationship*' (O'Boyle, 2014) p.217. The power differential embodied within the woman/midwife interaction between midwives and their regulatory bodies (Wagner, 2007, O'Boyle, 2014) was reflected in the informants' narratives. Women are in a state of vulnerability and require care, while midwives *need* women to fulfil their professional directive to perform their role appropriately and safely.

The ideal/reality gap

The demands and constraints from the oft-conflicting cultural discourses of childbirth and maternity services influence how human needs are met and influence the quality of women/midwife relationships. The master themes of *Shattered Expectations* and *Reality of being a midwife* reflect an ideal/reality gap consistent with wider childbirth literature (Edwards et al., 2018, Shallow et al., 2018). Systemic pressures result in efficiency, and prioritising of physical over psychological health. Subsequently obstetric practices are prioritised over the relationship and women's emotional needs (Edwards, 2009, Health Service England, 2012). This was further emphasised through the shared experience of abandonment through separation.

Conflicting ideology

The conflicting ideology between approaching midwifery as a *Vigil of Care* or *Care as Gift* (Fox, 1999, Walsh, 2011) encompasses tensions between the biological, technical aspects of the midwives' professional role versus the kind, compassionate, and comforting aspects of being *with woman* (see Box 5) (Barker, 2011, Kirkham, 2018).

Box 5. Tensions between *Vigil of Care* and *Care as Gift* approach

- The responsibility to maintain a *Vigil of Care* for safety
- The lack of systemic or collegial support to do more than simply maintain a *Vigil of Care*
- A deep wish to engage with *Care as Gift*

'The Midwives' experiences of being *Torn in Two* in the context of workplace pressures, childbirth events, colleagues' actions, and lack of systemic support reflect wider literature. For example, *'Midwives struggle to cope in a system which does not share their professional values, and which exploits their commitment to those values.'* (Kirkham, 2015) p.107. Yet, providing collegial support as desired by '*The Midwives'* and required by the NMC (NMC, 2015) may be impossible alongside tasks to maintain safety. Consequently, midwifery care becomes more *Vigil* than *Gift* (Bolton, 2000), leading to disappointment and distress for many midwives (Kirkham, 2010, Davies and Coldridge, 2018).

'*The Women'* expressed distress when *Care as Gift* was lacking, and only a detached, seemingly fragmented *Vigil of Care* was offered. The surveillance of maternal and fetal wellbeing by midwives reflects a *Vigil of Care* approach (Walsh, 2011). This surveillance implies midwives' authoritative knowledge and power over women, undermines relationships (Kirkham, 2010), and often creates pressure on midwives to maintain this power (O'Boyle, 2014). Simultaneously, women can become caught up in a conveyor belt system and rendered passive to institutional power (Kirkham, 2010).

Cognitive dissonance

The ideal/reality gap and conflicting ideologies can lead to cognitive and emotional dissonance for midwives (Festinger, 1957, Aronson, 2011, Delgado et al., 2017), with a subsequent shift in their ideal vision (see *Figure 5*).

Figure 5 here

A midwifery culture of service, self-sacrifice, and emotional labour is highlighted by Pezaro et al. (2016), where midwives provide *Care as Gift* at great cost to themselves within a healthcare system that already demands an '*impossible, constant level of maximum effort'* (Kirkham, 2015 p.105, Kirkham, 2018) using minimal resources and especially time (Mander

and BPG, 2018). This lack of time is reflected in '*The Midwives'* sub theme *'The pressures we face'* and contributes to midwives' fear of compromised safety due to things being missed and being unable to form relationships with women (Mander and BPG, 2018). Cognitive and emotional dissonance for midwives can result in stress and guilt for midwives who subsequently can become worn down and experience burnout (Kirkham, 2015, Riley and Weiss, 2016, Delgado et al., 2017, Favrod et al., 2018). In response and as a coping strategy midwives may withdraw from women (Lythe, 1988, Shallow, 2018). This is referred to as '*switching off*' or '*going into robot'* (Hochschild, 2012) p.129, and is widely documented in midwifery literature (Berg et al., 1996, Edwards, 2009). Consequently, midwives may appear hardened towards women (Hunter and Deery, 2009), reflected in '*The Women*'s' feelings of *being a bother* (Table 3: *'Supporting me'* and *'How not what'*).

Emotional labour

Midwives '*switching off*' reflects emotional labour, which is a powerful and intense aspect of women/midwife interaction (Kirkham, 2010, Healy et al., 2016). Personal background, institutional demands, dissonance generated by conflicting ideologies, and the shared desire for relationship all contribute towards emotional labour for midwives (Hunter, 2004, Hunter, 2005). These complex circumstances challenge one's ability to remain reasonable. A reasonable response is engendered through having one's informational needs met, alongside the opportunity to act effectively and appropriately. In contrast, an unreasonable response undermines trust (Kaplan and Kaplan, 2003).

Toxic culture in midwifery

The informants' experiences highlighted interpersonal behaviours and attitudes that are potentially detrimental to women and midwives. Negative interactions with colleagues featured in all '*The Midwives'* narratives, especially in the sub themes '*Others need do their bit'* and '*Support me'.* This impacted on their functioning both practically and emotionally, and CPI. A *toxic* and *broken* system contributes to bullying (Hughes, 2017, Kirkham, 2017), which continues to be a serious issue within the maternity services (RCM, 2016b). While calls exist for bullying and undermining to be addressed (RCOG/RCM, 2015), negative behaviour by some midwives and midwifery managers, has persisted unchallenged for many years (Hughes, 2017).

Moving forward from these findings

It is clear that there is a need to optimise CPI so that trauma and subsequent PTSD-PC from this iatrogenic source is reduced. These findings suggest that it is therefore essential to acknowledge and meet the human needs of both women and midwives, and to enable and protect the development of meaningful and trusting relationships between women and midwives. The gap between the ideal quality of relationships desired by both groups and the reality that currently exists due to workplace pressures and prioritising of physical wellbeing, need acknowledged. This gap creates tensions, stress, and emotional labour for midwives; power imbalance between women, midwives, and management; and the potential for a toxic culture of undermining and bullying. These aspects together are a matter for meaningful consideration and response from the NHS maternity services.

Recommendations for practice

For women, PTSD-PC consequent to poorly perceived CPI is effectively iatrogenic harm. In addition, psychological harm can alter physiological childbirth, increasing the need for obstetric intervention and its incumbent risk of further harm (Buckley, 2009, Uvnas-Moberg, 2011, Mobbs et al., 2018). In this context, optimal CPI is not just a nice extra (Wagner, 2001, Renfrew, 2016), making it essential to improve CPI for all childbearing women. As such, this requires trauma focussed care (Moore, 2018, Yusko, 2018), which incorporates protection of both midwives and women, and their unique, valuable relationships. Importantly, it is unrealistic and unjust to expect midwives to provide optimal CPI when they are suffering, and their own needs are unmet. This was highlighted across the wider UK NHS following the Mid-Staffordshire Foundation Trust Inquiry (Francis, 2013, West, 2013b, West, 2013a):

> '*If we want to treat women with compassion, respect, and dignity we need to treat the staff like this too.'* (West, 2016, RCM, 2018).

The existing system-wide loss of midwives (RCM, 2016b, Hawkins-Drew, 2017) and concerns regarding a prevailing toxic culture have contributed to an emphasis on the development of resilience in midwives (Hunter and Warren, 2014, Killingley, 2016). However, responsibility for change lies within the system and can at first point be addressed through recognising

major organisational issues that undermine midwives, lead to stress and burnout, and contribute to bullying (RCOG/RCM, 2015, Hughes, 2017).

Therefore, this study makes several recommendations (*Table 6*).

TABLE 6

In summary it is important to:

1. *Raise the status of psychological wellbeing*
   For childbearing women and make it of equal importance to physical wellbeing, with clear focus upon CPI.
2. *Create a midwife centred system*
   To enable midwives to provide optimal CPI and improve relationship-based care in keeping with government strategies (NHS England, 2016, Scottish Government, 2017)
3. *Challenge underlying toxic cultures*
   That currently persist in the maternity services system, which undermine the work of midwives and consequently the experience of women.

Study limitations and strengths

There are several limitations that relate to this study. The first, involves the study being retrospective, and as such relying on memories that may have become re-constructed. Although, childbirth memories remain strong and coherent (Takehara et al., 2014) and while factors other than CPI may have contributed to PTSD-PC, all of '*The Women'* highlighted CPI related trauma hotspots. While homogeneity is desired for IPA, this limits our understanding of the experiences of CPI, particularly from a wider range of women. Furthermore, self-selection for participation may have created bias (Denscombe, 2014). Within midwives' demanding roles they also experience trauma and PTSD (Warren and Hunter, 2014, Pezaro et al., 2016, Edwards et al., 2016, Favrod et al., 2018) and this may have influenced participation. Accompanying this point, awareness that a negative perception of CPI contributes to the development of PTSD-PC, may have initiated the Hawthorne Effect (Verwellmind, 2018) in *'The Midwives'*. Nonetheless, there are many strengths of this study.

For example, the qualitative methodology provided a strong platform for researching lived experience of all the informants. In-depth IPA, and specifically the double hermeneutic and reflexive processes involved enabled a rich understanding of informants' experiences. Also, exploring convergent perspectives of both sides of the story highlighted key areas for attention of the maternity services.

Conclusion

This study enabled a multi-perspective exploration of the lived experience of midwives interacting with childbearing women during labour, birth, and the early postnatal period in relation to CPI and its influence upon developing PTSD. This IPA study has identified that failure to recognise and meet the human needs of both midwives and childbearing women can result in poor CPI offered by midwives and a negative perception of CPI by childbearing women. Accompanying this point, both the participating women and midwives identified that the quality of their relationships together are central for creating a positive perception of CPI. In response, steps require to be taken by NHS maternity services to highlight the importance of CPI and perinatal psychological wellbeing and also to improve the working environment of midwives, so they can optimise their ability to provide high levels of CPI to childbearing women. This will in turn impact upon the incidence and levels of trauma and PTSD experienced by postnatal women.

Conflict of interest

None declared.

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Not applicable

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Highlights

1) Optimal women/midwife interactions need human needs to be acknowledged and met.
2) Women and midwives highly value developing positive, affirming relationships.
3) Women's psychological wellbeing needs acknowledged alongside physical wellbeing.
4) Optimal care provider interactions are essential not optional extras.
5) Maternity services must meet midwives needs and remove toxic workplace cultures.

Table 1. Inclusion/exclusion criteria for recruitment of informants.

Women informants

Inclusion	Exclusion	Rationale
Gave birth at least one month ago.	No upper limit	In keeping with the DSM-IV Criterion E and DSM-V Criterion F regarding duration of PTS symptoms being at least one month. (APA, 1994, APA, 2013)
Gave birth to a healthy baby who is still well.	Admission of the baby to neonatal unit for more than routine checks.	Exclude women whose subjective childbirth experience was influenced by the death or serious morbidity of their baby.
Had reached at least 37 weeks of gestation in pregnancy.	birth of a premature baby, i.e. prior to 37 weeks of pregnancy gestation.	Exclude women whose subjective childbirth experience was influenced by having a premature baby.
Described their childbirth experience as distressing or traumatic.		Recruit women who may have met Criterion A of the DSM-IV or DSM-V for PTSD.
	At recruitment were receiving medication for mental health conditions that existed prior to this childbirth experience.	Reduce the confounding effect of pre-existing mental ill health.
	Diagnosed with Postpartum Psychosis following this childbirth experience.	Reduce confounding effects of co-existing serious postnatal mental ill health. Postnatal depression was not excluded as it is highly co-morbid with PTSD.
Aged 18 or over.		Women younger than 18 are a particular maternity group and require a specific research focus.
Able to read and speak English fluently.		To facilitate ease of understanding regarding the research questions and the interview responses.

Midwife informants

Inclusion	Exclusion	Rationale
Registered at time of recruitment and actively practising for at least 6 of the previous 12 months.		Gain information from currently practising midwives who were able to reflect on a current maternity care environment and experience.
Provide intrapartum and early postnatal care for women.		Women informants primarily recounted their traumatic experience to occur during labour, birth or the early postnatal period. It was important to hear from midwives who could provide their *side of the story* during this time period.

Table 2. Summary of each theme from 'The Midwives' with supporting data extracts.

Master theme: Being with women, what it is all about

Building relationship	Actively building and maintaining relationships. Getting to know women and tailoring care. Time and continuity are essential.	*"You've not had that chance to get to know them."* Kerry *"…more opportunity to be that woman's advocate if you know her and you've known her all along*." Alice "*you're not gonna…you know…get to know her as well, If you're in and out, in and out*." Susan *"Maybe not so much intrapartum, but in the immediate postnatal period **(…)** I think women deserve, you know, time to talk about the experience that they've just had em…time to help with breastfeeding."* Brenda
Let's talk	Talking with and listening to women is strongly valued.	*"…just talk to women about their lives about their health about how they felt about what their wishes were."* Brenda *"I feel like listening to what the woman's saying is the **very first** thing that you need to do (…) listening to them is the **least** they can expect from us."* Alice
Seeing women as individuals	While acknowledging individuality, sometimes building relationships can be challenging.	*"Always putting the woman and the child at the centre of the care."* Kerry *"Support the women in whatever they want."* Alice *"It's a vulnerable time for women (…) being sore and being tired and being upset*." Mandy *"We are all very different, and we cannot get on with, you know, with everybody (…) sometimes quite difficult to bond with."* Rosie
Being responsible	A strong sense of responsibility regarding the woman's experience, keeping women and babies safe.	*"It's a massive thing…to be a midwife, and to be with women when their having their babies, because it's massive for women isn't it? it affects their whole life."* Alice *"To think…that we…in any…shape or form can influence that…it's…it's…it's a huge **thing** and…I'm not sure many midwives…quite understand that."* Susan *"We're here to make sure they stay safe (…) to make sure this woman and this baby stay safe, all the way through the process **whatever**."* Mandy

Table 2 continued. Summary of each theme from 'The Midwives' with supporting data extracts.

Master theme: What we have to work within

Torn in two	Frustrated and distress at being torn between meeting women's needs, workplace policies, and colleagues' expectations.	*"You're caught between a rock and a hard place (…) trying to be; you know go between the two kind of parallel universes (laughs) and sort of try and make a bridge."* Brenda *"We become like the middle person."* Susan *"conflicts between everybody"* Rosie *"battling all the time against the system."* Alice. *'This is why I don't like very strict birth plan."* Mandy
The pressures we face	Impact of the daily workload.	*"We are too busy to do, you know, stuff to help them*." Mandy *"It's impossible utterly impossible (…) It's not doable you are missing things left right and centre."* Brenda *"It's not that you're not hearing, you're…too busy to take it on board… thinking about everything else."* Susan
	Lack of time with women. Being separated after birth. Abandoning women.	*"For a service that's supposed to be on its knees we do a lot of unnecessary stuff."* Alice "*If only I'd had the time (…) she might have had a normal delivery."* Susan *"Running between women, you've just not got the time that you would like with everyone*." Kerry *"bounced from one room once the placenta's out … shoved into another room (…) completely abandoned that woman."* Brenda *"It's kinda like 'next' and off you go"* Rosie *"It's very frustrating if you've looked after a woman, delivered her baby and you have no time afterwards with them at all (…) I think that that's the one I find the worst."* Kerry
	The negative culture that undermines their ability to be with women in the way they desire.	"A *really, really, brutal place to work."* Rosie *"quite small in comparison* (to the) *huge culture of lots of very negative things"* Brenda *"when you're just constantly getting beat down and beat down"* Susan *"People can be changed or their behaviour can be changed…by the environment, I think that's really sad."* Brenda
We cannot control	*The Midwives* express their humanity and vulnerability. Being unable to control everything.	"*I can be guilty of that (…) you don't always do it perfectly (…) you can't help it, you're only human."* Rosie *"We cannot control everything (…) this is not their fault, this is not our fault, this is just the way it is."* Mandy *"You can't 100% say if I did this that wouldn't have happened*." Susan *"…not engaging with them very well, it's like a personal…protection… because I can't, I know I can't."* Brenda *'To be completely honest sometimes I just switch off a little bit and take a wee step back because I can't' Alice*

Table 2 continued. Summary of each theme from 'The Midwives' with supporting data extracts.

Master theme: Enable me as a midwife

Others need to do their bit	To be able to trust colleagues to care for women well, to safely hand over and not need to repair damage caused by others.	*"…communicate, be open with me as I can be open with her and their expectations."* Susan *"Women are bullied a bit and especially when it comes to medicalisation, and the birth the whole birth journey, I do feel like they…they're a bit…they're coerced at best and bullied at worst."* Alice *"Sigh…it sounds really bad, but you feel that they're not going to get the care that they would have got with you."* Kerry *"Badly managed and very…she was very badly treated (…) It's so frustrating I was so **angry** when I went home after that particular incident. I was so **angry."*** Brenda *"Very tricky to rebuild that relationship." Rosie*
Support me	To feel part of a team, to get breaks. For colleagues to be available for reflection and decision making, and in advocating for women.	*"Everybody works together as a team, it feels…a lot better for everybody, for you as the midwife in that room, for the woman and the partner*." Rosie *"You don't always get your breaks…you don't get that time to kinda get your head sorted and get back into it again."* Kerry *"A lot of the time the outcomes are…devastating for people and we don't have any support."* Rosie *"I think if we all just supported each other, and looked out for each other, and worked as a team, you know, half the nonsense would go, and we would actually have more time."* Susan
Trust and respect me.	To be trusted by women and colleagues for their skills and efforts in caring for and being with women.	*"I'm glad you're with me because I will stand up for you*." Alice *"Some of us are better than others at picking these things up, and I suppose it's a lot to do with your own sort of level of emotional intelligence and how…you, how you perceive others."* Susan *"Because we would think this is the best care at that point*." Mandy *"I think they (medical staff) should respect the women more maybe and respect the midwives more."* Alice *"She didn't want any interference (…) she wouldn't let us do anything*." Kerry *"I've been met with quite a lot of undermining behaviour (…) I've been met with with eh…quite negative response and…em…almost a…a questioning of me and who I am and how I am as a midwife and my experience and…em…quite a kind of eh…undermining em…response."* Brenda

Table 3. Summary of each theme from 'The Women' with supporting data extracts.

Master theme: Shattered expectations

Haunted by disbelief	Disbelief with regard to CPI. Shock at contrasting behaviour: refusing care, making unrealistic demands, being reprimanded, acting without consent, especially when violating expressed wishes.	*"What was left was glaringly the bad interactions I had (…) haunted by the frustration of Moira's behaviour…you know for…for over a year afterwards."* Catriona *"I was dreaming of the other midwife coming back."* Julie *"I no idea that a member of hospital staff would just do it without asking me."* Marie *"They said: "Oh you never wake a sleeping baby' and they actually walked away."* Lesley
Keeping me safe	Realistic awareness and preparation for childbirth. Also, expected to be cared for by trained professionals, to be in the safe hands of trustworthy and competent midwives.	"I *wasn't afraid of giving birth (…) I knew it was going to be messy and I knew it was going to be painful."* Valerie *"It was very painful, but I was **fine** I didn't panic with the pain."* Julie *"Somewhere in me I think…'It's alright, it's alright, any minute I'll be enveloped in this warm welcoming…kind of' you know 'These lovely people will take care of me and all will be safe and nice'."* Catriona *"...a place where you expect to be safe."*. Marie
Trusting you	Often unable to trust midwives or other care providers. Shattered expectations about being cared for appropriately and competently.	*"…especially when it was on the front of your birth plan that…you're a…a survivor and that something like that going to be deeply traumatic to you…em…and they did it anyway."* Marie *'I couldn't let myself trust that the next person would be nice to me*." Geraldine *"**Oh God** (sighs) I can't rely on them to look out for my wellbeing."* Catriona
Threatening me	Sometimes felt directly threatened by midwives, resulting in perceptions of danger for both self and baby.	*"It really felt like I was being manhandled." Valerie* *"She definitely made me feel quite…very unsafe…and very…vulnerable and very, I needed to protect myself and Euan from **her** that's how I felt. I thought 'God she's going to hurt me or something'."* Julie *"She told me, that if I didn't move myself I was going to hurt my baby."* Geraldine *"I just couldn't believe it was happening. I was in a hospital and I was telling people to stop, and they wouldn't stop."* Marie

Table 3 continued. Summary of each theme from 'The Women' with supporting data extracts.

Master theme: Being with me

Building relationship with me	Strong desire to feel a connection or relationship with their midwives and for midwives to tune in and recognise their needs. Sometimes this happened.	"*I just needed someone to like…pick me up and say: 'It's all going to be ok and I'm' you know 'I know what's happening I'll guide you through it'."* Catriona *"I felt facilitated by her she was like right okay this is what's going with you and she connected in with me."* Catriona *"They looked at me directly and they listened to the words, but they also read my body language (…) I felt safe in their care."* Valerie
	More frequently felt a lack of, or indeed negative relationship with their midwife.	*"So perfunctory it almost felt like I'd gone into labour in the supermarket queue and it was the checkout women…they probably would have been warmer to be honest. They were just cold."* Catriona *"She was writing down in a book the whole time that I was in labour, em so I didn't have an interaction with her."* Marie *"She didn't really check on me very much, and she didn't talk to me, and she didn't seem to engage with me very much. Um she was just sitting in a corner typing."* Valerie
See me, I need you	Midwives appeared to neither see, nor even attempt to acknowledge their physical or emotional needs.	*"I wanted to hold him, but nobody would come and give him to me."* Marie *"I was so badly cut and damaged, and infection was setting in that nobody knew, and prolapsed bits, and nobody was really paying any attention to that."* Geraldine *"Nobody ever looked at my birth plan."* Julie
Supporting me	*Support needs were often not met, leaving them feeling like they were being demanding*	*"Stop asking for help because she doesn't want to help me*." Geraldine *"When I did ask for help, I was met with this dismissive stop making a fuss attitude*." Catriona *"I didn't really feel like I was supported by the midwives (…) don't really feel like they were there for me at all."* Lesley
Talking and listening to me	Communication needs sometimes remained unmet, leaving them feeling isolated and abandoned.	*"It felt like nobody was listening a lot of the time (..) and just nobody would give me any answers."* Marie *"Nobody came, nobody informed us, nobody asked us what we wanted, or what we needed or anything (…) quite forgotten. (…) That was the worst thing about the entire experience."* Valerie

Table 3 continued. Summary of each theme from 'The Women' with supporting data extracts.

Master theme: Whose Power?

Finding and losing power	Embarked on childbirth feeling powerful and capable, but many negative experiences, left women feeling worn down with an ultimate loss of power.	"*A strong woman and being empowered in birth and I thought yeah, yeah, I can do this*." Geraldine *"Just absolutely helpless and absolutely powerless."* Valerie *"Completely out of control, completely…lack of…any…sense that I was in charge of the process, any more."* Geraldine. *"I'm clearly not in a position to make this decision or certainly not in a position to read the form on my back with tears streaming down my face when they're wheeling me into surgery."* Lesley
	Feeling vulnerable and powerless, in an alien environment is often intrinsic to the childbirth. Women attempted to claim back power, through struggles described below, with some success.	*"So extremely tired"* Valerie. *"I couldn't sit down…without crying, because…I was so badly cut and damaged."* Geraldine *"I'm the one that's incapacitated and can't lift him up could you just give me him*." Valerie *"I'm just leaving, I came here in a taxi and I will leave in a taxi."* Marie *"I am going home I am not doing this anymore."* Valerie
Struggling for power	Vivid trauma 'hotspots' of struggles to gain or maintain power. Struggles related to options, or sometimes violation.	*"No! I don't, I know I don't need to lie back, I'm having a baby I want to squat*." Marie *"She kept shovelling the gas in my mouth (…) she was saying to take that gas, and I said 'No, I don't want it'."* Julie *"Oh God, how could you do that to me, like it feels like a violation of, like that's just so horrible, my most vulnerable*." Catriona *"Invaded and manhandled."* Valerie *"It made me remember my rape in a way that I hadn't remembered it for years all these people holding me not letting me go."* Marie
How not what	Undermined by perceived negative attitudes, seeing this as a power tool. Felt chastised, as though annoying and causing anger in midwives.	*"I felt poo pooed whenever I asked for something (…) so scared to ask for anything*." Lesley *"...kind of hummed and hawed and huffed."* Valerie "*…tutting and huffing."* Catriona *"…just always kind of reinforced, the…the, the "'You're being a bother'."* Geraldine

Table 4. Exploring the convergent human needs across the divergent pathways in both groups

Human need	***Shared aspects***	***Divergent aspects***
Keeping safe	Protecting oneself. Women felt unsafe when: physical / psychological needs were unrecognised; they felt abandoned; or actively threatened. Midwives felt torn in two and sometimes protected their psychological wellbeing and job by withdrawing from women.	Midwives want to keep women safe. Yet, women felt unsafe, threatened, or violated. Midwives' actions may not convey understanding of what women require to feel safe. Midwives are torn if they feel women's desires potentially jeopardise physical safety, and that physical safety sometimes requires sacrificing psychological safety.
Being respected	As competent, autonomous adults. Acknowledgment of each unique individual, their personal wisdom, and values. Women desire respect for being realistic and prepared. Midwives desire respect from everyone for being skilled and knowledgeable.	Midwives challenged if they felt women were unrealistic about birth, particularly with very fixed birth plans. This inflexibility contributes to trauma when things do not go to plan. *Women* felt realistic about birth and their expectations to be cared for and kept safe, but shocked when midwives' behaviours left them feeling vulnerable.
Having power	All experience unpredictable nature of childbirth. Interpersonal powerlessness occurred for *Women (with midwives)* and for *Midwives* (with colleagues, management, systemic demands, or workplace culture). Trust help *Women* relinquish control, and *Midwives* to manage care.	Women sometimes want to hand over control and entrust themselves to midwives. Concerns related to not being informed / involved in the process, not that birth was not the way they expected. Midwives feel little control due to extrinsic workplace pressures, or women's fixed birth plans that they feel powerless to influence.
Receiving support	Safety, respect, and control are dependent on the support of others. *Women* seek support from midwives and other care providers. *Midwives* require support from colleagues and management.	Women desire personal, practical support in terms of physical, emotional, and informational needs during a uniquely vulnerable life experience. Midwives are expected to provide support to women, while their needs become secondary or unacknowledged. This contrast is potentially problematic as explored in the discussion.

Table 5: Data extracts highlighting key issues due to dysfunctional, absent, or lost relationships

Issue		Representative data extracts
Separation	Strong distress expressed by both groups at the separation from each other directly after birth, described by everyone as the *worst*. This reflects strong feelings about abandoning (midwives) or being abandoned (women). Abandonment distress was further highlighted during public engagement workshops regarding the study findings (Patterson, 2018)	"*You feel you've completely abandoned that woman."* **Brenda (midwife)** *"That's the one I find the worst…"* **Kerry (midwife)** *"I felt like they were done with me um yeah the baby was born the baby was fine and I didn't really matter (…) right we've done her she's okay, next one*." **Valerie (woman)** *"Left me, sat in my own mess for over an hour."* **Geraldine (woman)**
Ticking boxes	All highlight the shared impact of a surfeit of extraneous tasks. Consequent pressures on midwives' abilities to be with women, and perceptions by women, distracted from and damaged relationships.	*"The woman was totally focussed on her paperwork and her forms and files."* **Catriona (woman)** *"Ticking the boxes and signing the boxes that need to be signed and that's, that's all you can really do you can't, you can't develop relationships with those women at all."* **Brenda (midwife)**
Impact on communication	Convergent themes *Talking and Listening to me* and *Let's talk* highlight the value of communication. Dysfunctional, lost, or absent relationships due to the above issues of 'separation' or 'ticking boxes' affect communication that is required to facilitate relationship, information exchange, and optimal recognition and response to women's needs.	*"So, nobody came. Nobody explained, and I think for me that was crucial to not blame myself."* **Julie (woman)** *"Some people did listen…em…some people didn't and there wasn't any like messing about around it."* **Marie (woman)** *"You start stopping engaging with anybody and you just go in and do your work, and tick your boxes, fill out your paperwork and get home*." **Rosie (midwife)** *"It's not that you're not hearing, it's just that you're…too busy to take it on board really cos you're thinking about everything else."* **Susan (Midwife)**

Table 6: Recommendations for practice

Policy development.	• Acknowledge the iatrogenic harm caused by poor CPI. Consider referring to Post Traumatic Stress as an Injury (PTSI) (PTSiNJURY, 2018), rather than disorder (PTSD). This shifts the focus beyond the individual to the system. • Prioritise reducing iatrogenic harm due to poor CPI for all women regardless of perceived risk. • Create a midwife centred system to optimise the care quality, particularly CPI. • Develop and implement a culture of zero tolerance for negative interpersonal behaviour by midwives towards women, colleagues, and other maternity care staff.
Pre-registration Education and continuous professional development	• The key importance of women's psychological wellbeing throughout the childbirth process. • The core influence of CPI and that this is more than a nice extra. • Prioritise the development and assessment of interpersonal skills for all staff.
Leadership and management	• Prioritise and protect the women/midwife relationship by supporting midwives to be with women throughout labour, birth, and early hours after birth. • During obstetric interventions or emergencies prioritise midwives to *be with* women. • Revision of midwifery tasks to remove unnecessary *Ticking of Boxes.* • Meet the physical and psychological needs of midwives and wider maternity care staff by prioritising time for support, restoration, and optimising workplace environment. • Support and safeguard study leave for successful implementation of CPD (McInnes and Mc Intosh, 2012).
Future research	• Develop, implement, and evaluate an interpersonal skills toolkit for midwives. • Urgently examine factors that prevent midwives having time with women, especially in the immediate postnatal period. • Explore midwives' wider needs, including from prior or work-related trauma, or mental health illness. • Identify and implement organisational steps to meet midwives' wider needs. • Design, implement, and evaluate a program to introduce midwife centred features into maternity services.

Figure 1. Master and sub themes from '*The Midwives*" experiences of interacting with women during labour, birth, and the early postnatal period.

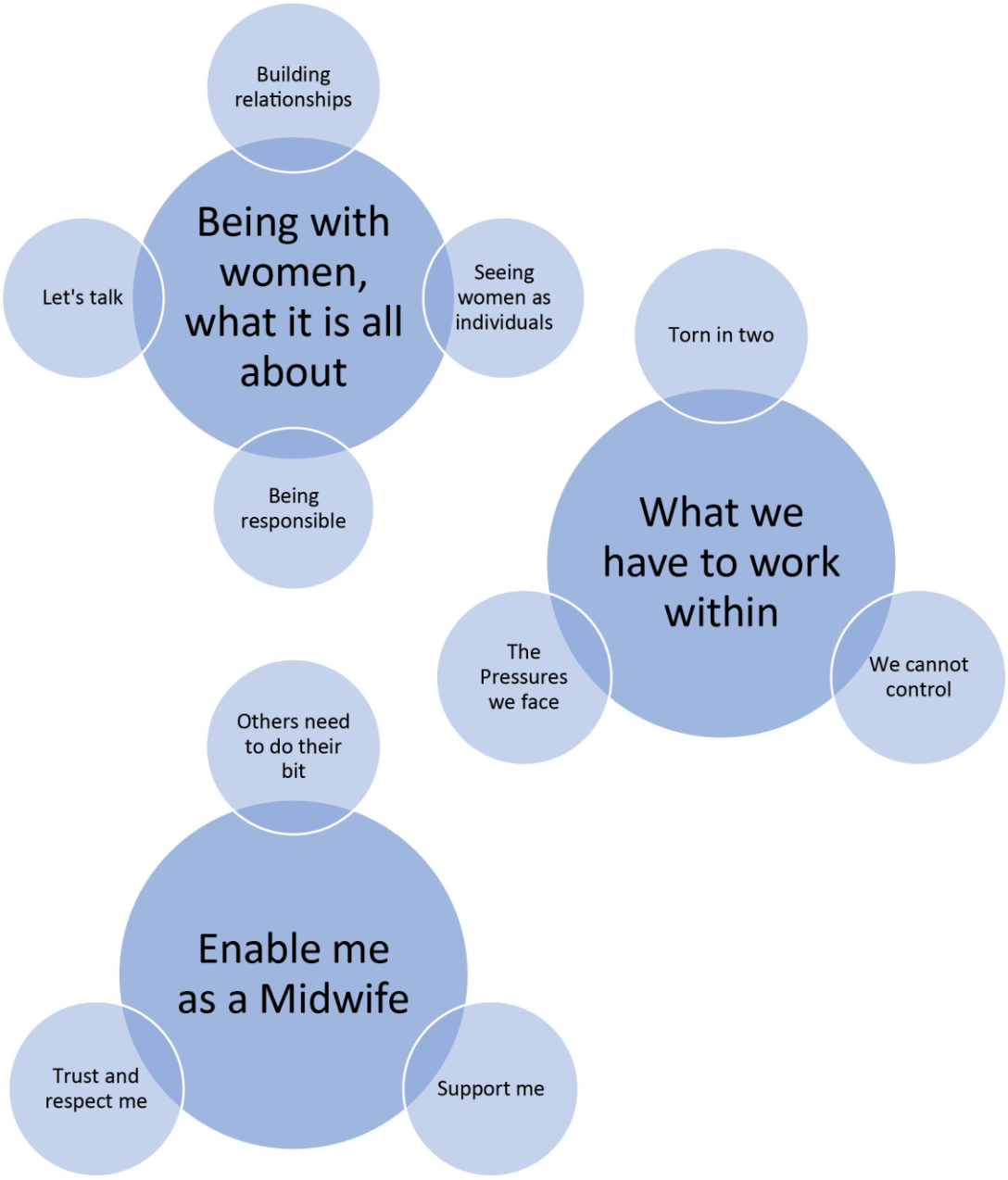


Figure 2. Master and sub themes from '*The Women's*' experiences of interacting with midwives during labour, birth, and the early postnatal period.

Figure 3. The convergent human needs of *The Women* and *The Midwives,* the associated sub themes, and the expressed human emotions and concerns.

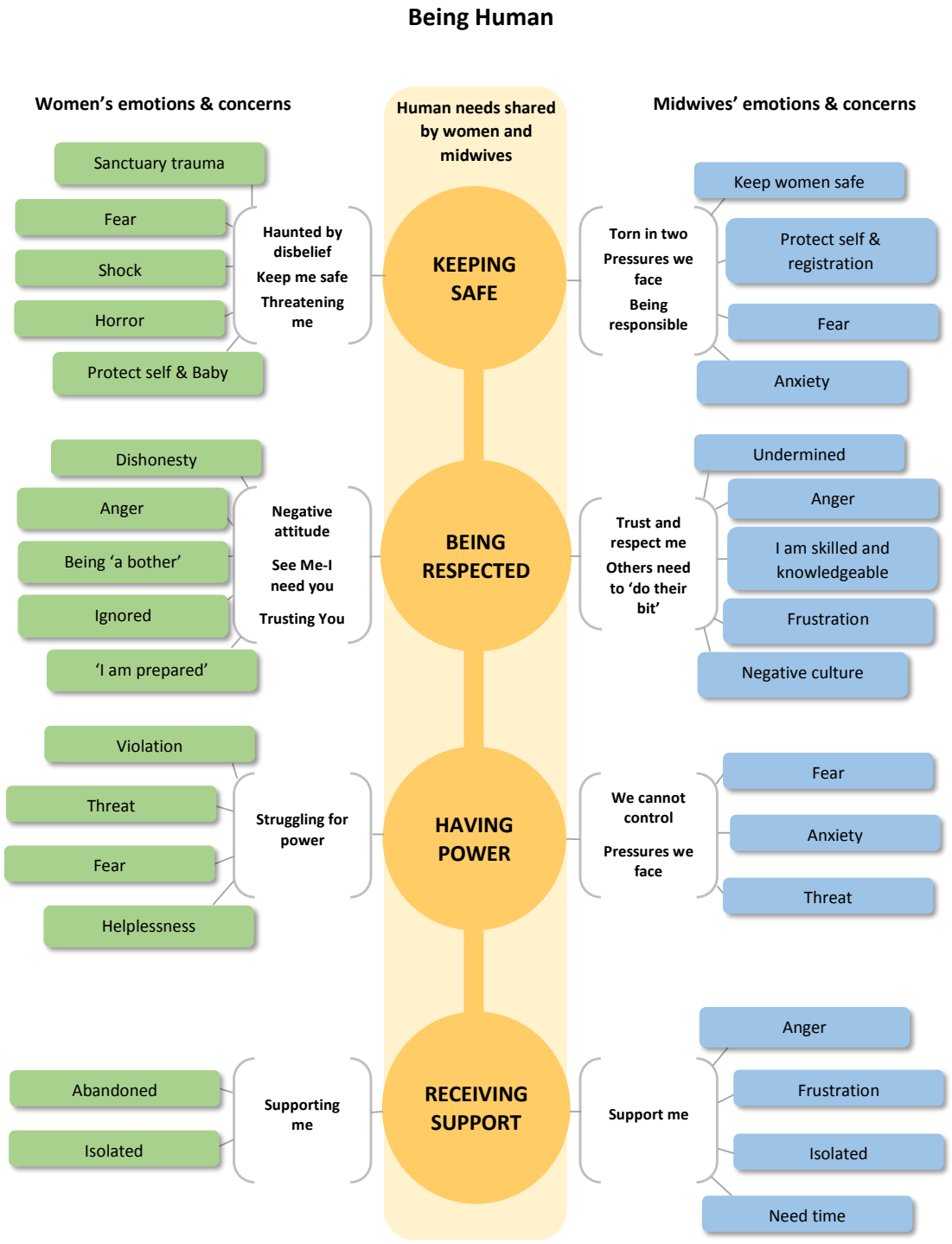


Figure 4. How relationship was experienced by each group

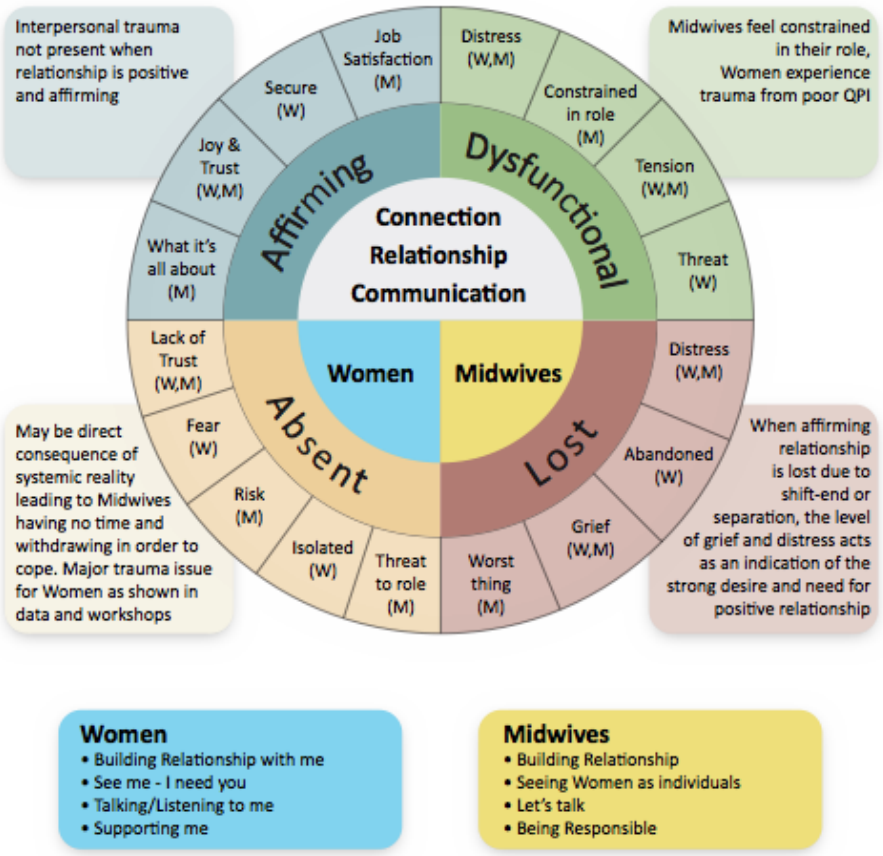
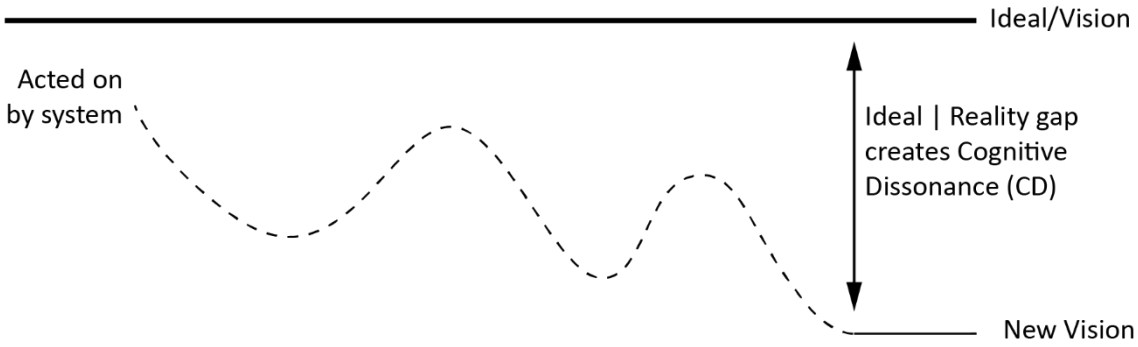


Figure 5. Suggested model of Cognitive Dissonance



To alleviate the unease caused by CD, changed behaviours and changed beliefs are adopted and the subsequent New Vision is a lower expression

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