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# *"We are in this together" – Polish midwives' reflections on perinatal care for Ukrainian women after the outbreak of war*

BACKGROUND
February 24, 2022, the beginning of Russia's invasion of Ukraine, was also the beginning of an exceptional situation and a challenge for the Polish health care system, the health care workers and Polish citizens. This study aims to conduct a qualitative analysis of midwives' experiences of maternity care for Ukrainian women after the outbreak of war.

PARTICIPANTS AND PROCEDURE
Eight midwives with experience working with both Ukrainian patients and Ukrainian war refugees (who came to Poland after February 24, 2022) participated in a semi-structured interview. The interview data were transcribed and thematically analysed to identify the observations, challenges and medical personnel needs.

RESULTS
The most frequently observed reactions in Ukrainian patients included crying, increased anxiety and irritability, fear, withdrawal, and constant information seeking about the current situation. Breastfeeding problems understood as a consequence of chronic stress were also observed and assisted by the midwives. All respondents pointed out the language barrier and their involvement, showing empathy and attentiveness to the patients' situation. No hospital introduced additional support for midwives. A high level of emotional burden on midwives was observed.

CONCLUSIONS
The midwives were eager to help Ukrainian patients – they emphasized the more frequent need to make themselves available for them. However, the emotional involvement of the midwives is accompanied by the risk of traumatization and burnout, which are associated with exposure to the difficult experiences of patients. Implementation of training in trauma-informed care and supervision could support midwives in their work and prevent the consequences of long-term stress. Systemic solutions concerning translators' presence and hospital documents' translation are also essential.

KEY WORDS
pregnancy; trauma; maternity care; war in Ukraine; refugee women

ORGANIZATION – Institute of Psychology, Faculty of Social Sciences, University of Gdansk, Gdansk, Poland

AUTHORS' CONTRIBUTIONS – A: Study design · B: Data collection · C: Statistical analysis · D: Data interpretation · E: Manuscript preparation · F: Literature search · G: Funds collection

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## BACKGROUND

Since February 24, 2022, the beginning of Russia's invasion of Ukraine, more than 10.1 million refugees from Ukraine have crossed the Polish-Ukrainian border (Straż Graniczna, 2023). During the first two months after the outbreak of war, most of the refugees were women and children, some pregnant. The exact number of pregnant war refugee women is difficult to determine. According to the United Nations Population Fund (2022), an estimated 265,000 Ukrainian women were pregnant when the war broke out, and 80,000 women were estimated to give birth in the following three months. In 2022, 4,500 Ukrainian infants were born in Poland after February 24 (National Health Fund data for 2022). Although for most European citizens, the date of the outbreak of war is 24.02.2022, the war in Ukraine started in 2014. Ukrainians were coming to Poland also before February 24, 2022. The first wave of refugees came to Poland before the end of April 2022 (over 3 million), and the intensification of war-related fear also among Polish people (63.0% of Poles were afraid of war with Russia and it was their main concern; CBOS, 2022) was an exceptional situation and a challenge both for the Polish health care system, the health care workers and Polish citizens.

Experience of war is a risk factor for adverse, negative outcomes in pregnancy and after childbirth (Arnetz et al., 2013; Fatušić et al., 2005). It can result in premature birth and low birth weight, which is also observed in a population exposed to armed conflict (Davis & Sandman, 2010; Fatušić et al., 2005; Keasley et al., 2017). However, the rate of preterm births, stillbirths and miscarriages depends on direct exposure to conflict. For example, the adverse outcomes are often related to exposure to chemicals, radiation, exhaust fumes, contaminated water, or food during wartime (Arnetz et al., 2013; Signorello et al., 2010). Maternal mental health is also at additional risk. The perinatal period (from pregnancy to 1 year after childbirth) is a vulnerable time for the onset and recurrence of mental disorders, with perinatal depression, anxiety disorders, and posttraumatic stress disorder (PTSD) as the leading diagnoses. According to pre-COVID-19 pandemic data, it was estimated that 1 in 5 women would develop a perinatal mental disorder (Andersen et al., 2012; Fawcett et al., 2019; Hahn-Holbrook et al., 2018; Shorey et al., 2018). Also, the stress that a pregnant woman is exposed to, related to adaptation difficulties, stresses of daily life and other stressors, can reverse the cognitive assessment of the situation faced by the pregnant woman and complicate the adaptation process. For example, the tendency to perceive adverse events as uncontrollable is associated with an increased risk of perinatal depression (Ilska & Przybyła-Basista, 2014; Koss et al., 2014). The experience of war or forced refuge is undoubtedly associated with the experience of severe stress, anxiety and destabilisation, which can result in various negative consequences. Primarily, a risk factor in the group of pregnant and postpartum women from Ukraine is the experience of forced migration itself. A meta-analysis of 40 studies ($N$ = 10,123) found that one-third of refugee women from low- and middle-income countries suffered perinatal depression (Fellmeth et al., 2018). A systematic review found a higher incidence of postnatal depression in migrant women, with rates 1.5-2 times higher than those of the general population (Falah-Hassani et al., 2015). According to clinicians working with the refugee population, a group of pregnant women and new mothers is an especially vulnerable group of the migrant population "in a precarious situation in a foreign country, when the sense of inner homelessness can quickly develop (which triggers the sense of homelessness), the capacity for empathy and intuitive parenting can be weakened" (Utari-Witt & Walter, 2021, p. 58). Studies conducted in war-affected Syria indicate a high percentage of women scoring higher on the postpartum depression scale (28.2%; Roumieh et al., 2019).

Supporting and protecting the mental health of refugee mothers also protects infant mental health. Genetics and environment influence brain development during gestation, so high neuroplasticity makes the brain particularly susceptible to environmental exposure to 'nonoptimal' levels of maternal distress (Monk et al., 2013). Stress during pregnancy has been related to poorer infant regulation (Fuller et al., 2018; Huizink et al., 2002), more negative affect (Davis et al., 2004; Graham et al., 2019), and corollary neural disruptions in early life (Demir-Lira et al., 2016).

According to Punamäki et al. (2018), pregnant and postpartum women living in the Gaza territory during the times of the Gaza War experienced not only the deterioration of mental health – increased PTSD symptoms, depression, anxiety, dissociative states, pregnancy complications – but also their children were more likely to be born prematurely. The infant's psychomotor and language development was delayed. Maternal mental health during pregnancy and postpartum mediated the negative impact of war trauma on the child's psychomotor and language development at 12 months. These authors' previous study also showed that the mother's ability to establish a strong bond with her unborn child, despite the stress experienced, is associated with more optimal sensorimotor and language development (Punamäki et al., 2017).

The abovementioned reports apply to non-Western societies. Therefore, when analysing these data, it is essential to keep in mind that they may not explicitly translate into characteristics of Ukrainian and also that things might be different in European cultures. However, given the lack of research on the

importance of the war for the functioning of individuals in Western societies, it is worth paying attention to these studies to understand the possible outcomes better.

Working with people who experience the war trauma poses the question of what a normal reaction to grief, terror, and violence is. The international classifications of disorders – International Classification of Disease (ICD-11; WHO, 2018) and the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; APA, 2013) – can help us to think about the difference between acute stress reaction (ASR), acute stress disorder and PTSD and possible ways of treatment. As described in ICD-11, an ASR is a "normal reaction, given the severity of the stressor, of an extremely threatening or horrifying nature", "a natural disruption in functioning in the midst of extreme stress that should not be medicalised". These reactions can range from autonomic to cognitive signs of anxiety, such as disorientation, non-responsiveness, or hyperalertness. The individual may be in a stupor or engage in overactivity. Regardless, these reactions are expected to subside within a few days after the event or following removal from the threatening situation. Acute stress disorder described in DSM-5 is characterised by intrusion symptoms, negative mood, dissociation, avoidance, and arousal, with symptoms defined as beginning after exposure to a traumatic stressor and lasting for at least three days and not longer than a month. PTSD may be diagnosed for individuals reporting similar symptoms from four clusters (intrusion symptoms, avoidance, negative alterations in cognition and mood, and alterations in arousal and reactivity) lasting more than a month and leading to distress or functional impairment. The person may reexperience the traumatic event in a distressing way during nightmares, flashbacks, and intrusive recollections of the event. They can also avoid situations that are similar to the trauma and present a numbing of general affective responsiveness. Symptoms of increased arousal, such as sleep disturbance, irritability and difficulty concentrating, are also part of the stress reactions (Ryding et al., 1997). The war in Ukraine is a lasting stressor. The relatives of refugees are endangered, and their houses and cities are destroyed – the exposure, even if not direct, is chronic. It is also possible that a pregnant woman who has not been directly exposed to an armed conflict, and was living in Poland before February 2022, may be more traumatised than a mother hiding from shelling (Chrzan-Dętkoś et al., 2022). The fear concerning relatives who stayed in Ukraine/joined the army, fear regarding the future of the country of origin, and watching the news of one's country being destroyed could also be understood as criterion A of PTSD: reaction to the threat for relatives (Chrzan-Dętkoś et al., 2022). This shows that the experience of stress and its consequences can be very complex and require special attention from the environment, including medical personnel.

After the outbreak of war, the authors, as coordinators of the postpartum depression prevention programme, collaborating with 37 primary care health centres, had many inquiries from midwives focusing on what a normal grief reaction is and what a red flag signaling a potential problem is. The questions from midwives described the following typical situations: *a new mother does not touch her newborn baby, and she is watching her mobile phone and talking in Ukrainian on the phone; the new mother is crying while watching TV and talking on the phone – however, she seems to care for her baby. Are these acute stress reactions or acute stress disorders? Shall we only accompany and support the mothers or refer them?*



These examples show that the role of midwives in health care is crucial: midwives are often the first health care professionals with whom women have contact. Midwives face challenges of giving emotional support, accompanying and co-sharing their pain, identifying the most vulnerable women, and assisting in more complicated pregnancy and childbirth outcomes. Poland, compared to other European countries, is a culturally homogeneous country. The war in Ukraine challenges midwives to care for women from different cultural backgrounds. However, we do not know what would be the most challenging cultural differences – if such exist – between Polish and Ukrainian patients. These two cultures are perceived as close, sharing similar language, religion and values. However, getting to know midwives' perspectives and daily observations is essential. Some data show that women from different cultural backgrounds may differ in describing their problems or accessing help. For example, migrant women from non-western cultures may describe somatic rather than psychological symptoms (Jadhav, 2000; Templeton et al., 2003) or may have symptoms of postpartum depression, but the concept may not exist within their language or culture (Jain & Levy, 2013). Although all women rated childbirth pain as very high, the women from the Middle East (women whose mothers were born in Asia or North Africa) compared with women from a Western background (women whose mothers were born in Europe, the United States, or one of the other English-speaking countries) gave higher ratings of pain. They showed more pain behaviour (Weisenberg & Caspi, 1989) – such information may be helpful for midwives.

## PARTICIPANTS AND PROCEDURE

The primary objective of this study was to conduct a qualitative analysis of midwives' experiences of maternity care for females from Ukraine after the outbreak of war in the context of any cultural dif-

ferences and possible degrees of war traumatisation. Additionally, the study aimed to identify the main challenges of working with potentially vulnerable Ukrainians after the outbreak of war and the need for support for patients and midwives. The present study is part of a larger international project concerning the perinatal mental health of refugee women and represents the result of exploratory activities. In our study, we sought to answer the following questions:

1. Do midwives perceive Ukrainian patients as traumatised/affected by warfare?
2. Do midwives perceive themselves as traumatised/affected by warfare?
3. Do midwives perceive cultural differences between Ukrainian and Polish patients?
4. What do midwives find most challenging in their work with female patients from Ukraine after the outbreak of war?
5. What would midwives need help with/what support would they expect?
6. What do midwives consider the most important in their work with the Ukrainian women after the outbreak of war?

## PARTICIPANTS

Eight midwives from northern Poland-based hospitals with maternity ante- and postnatal wards participated in the study. On average, midwives have worked for 25.60 years (*SD* = 10.13, min = 5, max = 33). The average working hours per week is 50.75 hours (*SD* = 8.12, min = 38, max = 60), which gives essential information about overtime work. All midwives were working in the public health sector. Two of them additionally work in the private health sector. Three midwives work as lactation consultants, and two work as nurses. The midwives work in obstetrics, gynaecology, neonatology wards, lactation clinics, and primary health care. All midwives have experience in working with patients coming from Ukraine (mean 33 patients, *SD* = 36.13, min = 6, max = 100); 5 of them worked with war refugee patients who came to Poland after February 24, 2022 (mean two patients, *SD* = 1.98, min = 0, max = 6). We decided to analyse the responses of all midwives – including those who only had experience working with Ukrainian women who arrived in Poland before February 24, 2022 ($n$ = 3) – because we also wanted to take into account the situation of those women who may experience the consequences of the outbreak of war indirectly. We based this assumption on ICD-11 and DSM-5 criterion A of PTSD – Indirect exposure: Witnessing the trauma. Learning that a relative or close friend was exposed to a trauma is still criterion A in ICD-11 and DSM-5. In addition, it was noted that midwives also perceive working with these patients as demanding.

## PROCEDURE

In our study, we used a semi-structured interview. Selection for the study group was purposive and was made through social media and the researchers' networks. The necessary requirement for inclusion in the group was to have experience in working with Ukrainian patients after the outbreak of war and to be employed in the perinatal or postnatal care sector. The data were collected from northern Poland-based hospitals with maternity ante- and postnatal wards. The data were collected from April to mid-May 2022. The interviews were conducted by telephone by psychology students at the Institute of Psychology, University of Gdansk. Each interview lasted about 20 minutes and was conducted individually with each midwife. The interviews were audio recorded with the consent of the participants and then transcribed.

Ten midwives were willing to participate in the study. Two were rejected due to a lack of experience working with Ukrainian patients. The questions that were part of the interview addressed the importance of the wartime context in maternity care. They were created best to address the authors' research questions. Questions focused on the professional experience of a midwife, experience working with Ukrainian patients after the outbreak of war, challenges of caring for patients who have experienced war, and possible cultural differences and differences in caring for Ukrainian patients. The interview also addressed issues related to the possible need for additional support, subjective assessments of patients' burden of war (on the Likert scale) and subjective assessments of midwives' burden of war (on the Likert scale), and perceived consequences of the experience of war for both pregnant women and health care professionals themselves. All midwives were asked to refer to experiences from their work only from the period after February 24 – their answers were explicitly about the period between February 24 and May. All the patients the midwives referred to were pregnant or a few weeks postpartum. They gave us informed consent concerning participation in the study.

It should be noted that the present study was conducted during the 'honeymoon period'. According to the theory of disaster curve (Prot-Klinger, 2021), the first month or months after the crisis is the 'honeymoon period' with increased mobilization of the society, which was very committed to helping people.

Due to the small study group and the study's exploratory nature, it was decided to use mainly a qualitative method of data analysis.

# RESULTS

A detailed analysis of the collected material was conducted. Quantitative data on the degree of traumati-

sation were counted using statistical analysis methods in the SPSS program. After being transcribed in advance, the qualitative data were analysed thematically in detail by two expert judges. First of all, judges got acquainted with all the collected material. In the beginning, the focus was on analysing points of commonality in the responses of individual midwives. Next, the observed differences were analysed to assess the degree of divergence. In the next step, the focus was on assessing the relevance of the midwives' statements to the subject matter analysed to obtain answers to the research questions posed. The results are presented below.

## THE BURDEN OF TRAUMATIC STRESS ON MOTHERS AND MIDWIVES

The midwives rated the degree of traumatic stress in refugee women (those who came to Poland after February 24, 2022) at an average of 4.67 (*SD* = 1.63, min = 3, max = 7; 1-7 Likert scale); the degree of traumatisation in Ukrainian patients who have lived in Poland longer (came before February 24, 2022) at an average of 3.09 (*SD* = 3.09, min = 1, max = 7). Their burden of the war situation at work was rated with a mean of 4.71 (*SD* = 2.69, min = 1, max = 7). The midwives identify stress behaviours in their patients as crying (*n* = 3), increased anxiety (*n* = 2), irritability (*n* = 1), fear (*n* = 3), withdrawal (*n* = 4), preoccupation with the war situation (*n* = 2) and problematic contact (*n* = 5). One midwife also noted stress reaction symptoms in her patient – increased arousal and reactivity to sound stimuli.

ID 8. *Well, certainly nervousness, crying, irritability and such uncertainty. That is the most common question, 'what is next?' However, that is something none of us knows. So we are together in the situation of not knowing basic things concerning our safety.*

ID 8. *They feel threatened and unsafe because of the situation they are in. They are outside of their place of residence, outside of their country. They often have limited verbal contact.*

In the context of Ukrainian women who have lived in Poland longer, there was a range of responses from women. The midwives noted increased anxiety, fear, and intense preoccupation with reports about the war (*n* = 5), relatively good coping, and no signs of increased anxiety (*n* = 3). It could be observed that women who came to Poland earlier cope with the stress of war to varying degrees – some find their way through the situation better, others worse.

ID 1. *When I come for home visits, it is common to have the TV on where the news from Ukraine is watched. The main behaviours seen in patients are related to anxiety and feelings of danger.*

ID 3. *They are happy to be here and do not intend to return. They say it is good here. They do not despair. They have made a life here. They are happy.*

Midwives acknowledged the need for greater involvement in working with Ukrainian patients and their psychological burden of the war situation (*n* = 8). In addition, the personal emotional burden and anxiety associated with the war were also emphasised (*n* = 6).

ID 2. *I feel more burdened, even though I do not have much contact with people who have fled the war. That is because it also affects me – this war and what I see in my work.*



## CULTURAL DIFFERENCES

The midwives did not notice any significant cultural differences. However, two midwives observed that their patients tended to overdress their babies more than their Polish counterparts. A general aversion to vaccinations was also mentioned by respondents (*n* = 2).

Ukrainian patients perceived the standard of perinatal care as higher in Poland (*n* = 5). However, the answers regarding relationships and attitudes towards healthcare professionals needed to be clarified. Half of them perceived Ukrainian patients as more trusting and relying on the knowledge of doctors and midwives. However, the remaining four midwives perceived Ukrainian patients as more withdrawn.

ID 3. *Yes, they trust us more. They contact me more often. This is because they do not have anyone to turn to here. They do not have close relatives here, so they turn to us with different problems.*

ID 5. *There are not big cultural differences between our countries. Our religions are quite similar. They understand the cultural difference. We try to understand their culture and their religion. However, it does not matter to them. They want to feel safe.*

ID 2. *She (refugee woman) slept a lot, and also the girls (other midwives) said that she is just reluctant to make contact.*

ID 4. *These are patients who are withdrawn. They cannot open up yet.*

ID 8. *Maybe temporarily they are so much more withdrawn, because… the situation, the losses they have, the language barrier, they are so much more withdrawn.*

## CHALLENGES IN WORKING WITH FEMALE PATIENTS FROM UKRAINE

All midwives perceived the work with Ukrainian women as an emotional challenge, overloading them more than caring for Polish women. The most significant difficulty mentioned by midwives was the language barrier (*n* = 7) and lack of systemic solutions (*n* = 4). The midwives used various tools, including online translators (*n* = 4), the use of basic vocabulary (*n* = 3), and non-verbal communication (*n* = 4).

Also, available people acted as translators (ward employees, friends, and people from the patient's environment) ($n$ = 5). They used other languages, mainly English or the basics of Russian ($n$ = 6). Two midwives received information from their employer about the possibility of interpreting assistance.

ID 4. *It is more challenging because of the language barrier. I know a little bit of the Russian language, so this is the way I try to communicate. I also have a colleague from Ukraine, and after she and the patient give consent, I call her, and she relays to the patient what I have to say, and vice versa.*

Additionally, working with people affected by war trauma was challenging, and as a result, it could be a source of burnout or recall of one's own traumatic experiences. Midwives were aware of the consequences of war-related stress, and they associated the anxiety and irritability of their patients with their experiences. For example, one midwife was aware of the greater risk of preterm births and lower birth weight among war refugees. In addition, two midwives observed lactation difficulties. However, no midwife was informed by their employer about the possible consequences of war-related stress. In addition, none of the midwives received information from the employer on dealing with people with war experience and what behaviours and signals to watch out for.

ID 2. *The most challenging for me is that I want to do a good job and calm them down and that I want to restore a sense of security. So it is my biggest challenge.*

ID 3. *I want them to feel at home here, and I want them to feel safe. I want them to know that they can reach out to me. My personal phone number is available to them. They understand me, I also understand the Ukrainian language, and I use a translator if there is a communication problem.*

ID 7. *Severe stress can cause lactation problems, which I was dealing with in the last days.*

### NEED FOR SUPPORT

Four midwives confirmed the need for additional support in their workplace. The recurring element was language and support in translation. The need to provide psychological support for healthcare workers was also identified ($n$ = 2). Finally, the need for systemic support, including introducing general procedures and regulations concerning the management of maternity care for Ukrainian women and top-down and available guidelines for hospitals, was mentioned by all participants.

ID 1. *We need doctors, staff in general. Staff with the Ukrainian language.*

ID 2. *What we would need most are regulations and the financial issue – we're trying to help, and we're able to do it, but we need some support. It's just not regulated by any laws.*

ID 8. *I think there is also this factor in us that we're also afraid, that we're also experiencing, so that also affects us, the quality of those relationships because it is hard to distance ourselves in a situation like that, so we would like to be able to get psychological support.*

### VITAL ELEMENTS OF WORKING WITH PEOPLE WHO HAVE EXPERIENCED WAR AND THOSE WITH WHOM WE DO NOT SHARE A LANGUAGE

All midwives emphasised that empathy and openness to the difficulties a woman may be experiencing are vital factors that help them while working with Ukrainians after the outbreak of war. In addition, midwives wanted to give the women a sense of security, establishing a relationship based on trust and understanding. Again, informational and organisational support was also highlighted as extremely important in the case of Ukrainian patients ($n$ = 4).

ID 3. *That kind of sensitivity and openness for these women. You can't stigmatise them – they need normalcy, and they need to be treated that way – normal.*

ID 6. *Being open about the difficulties that this woman is going through, the reactions may be difficult to predict because of the experiences that she has had.*

ID 5. *I think taking care of her like any mother, so she feels safe. Well, and arranging appointments, often after birth the baby needs vaccinations or to see an orthopaedist, then we help them arrange that because it's a big challenge.*

ID 1. *Support. Just being with them because they need it.*

However, in the broader context of working with people who communicate in another language, nonverbal communication seemed crucial from the midwives' perspective. All midwives emphasised the importance of supportive gestures, showing understanding, and having an open attitude towards the patient. Therefore, verbal communication may be of secondary importance.

ID 8. *Understanding and such a helping, warm hand. A smile, because sometimes that's enough. The kind of simple phrases that we have is enough.*

ID 2. *Empathy – to me, that word is enough. If I understand the patient's needs, it is sufficient because it gives her that.*

ID 4. *Sensitivity, empathy, communication through translators, dictionaries, normal treatment, holding hands, giving encouragement.*

## DISCUSSION

This small study on the midwives' experiences aimed to examine their reflections and challenges in working with Ukrainian patients after the outbreak of war through in-depth interviews. We asked how mid-

wives assessed the patients and themselves regarding the traumatic stress overload, cultural differences, and their need for help and assistance at work.

Midwives feel burdened with the war. They show empathy, support and increased commitment but feel left alone, unprepared by the system or the employer to care for a new group of patients. Of course, the war was so sudden and unexpected that there was no time for preparation. However, our earlier study (Chrzan-Dętkoś & Walczak-Kozłowska, 2021b;) showed that in general, the preparation of medical staff for the management of patients with mental health issues, including earlier trauma, is relatively low. Despite the significant positive changes in perinatal care in Poland, initiated in 1994 with the "Rodzić po ludzku" campaign, there are still many women who experience feelings of incomprehension, harm and violence from medical personnel during childbirth, which shows the frequent lack of adequate preparation to build a relationship with the patient based on trust and empathy (Adamska-Sala et al., 2018). However, it is worth emphasising that interested midwives could take part in a series of webinars focused on possible cultural differences and work with traumatised patients, which were prepared by specialists and shared on social media for free. Midwives and other health care professionals can benefit from recommendations developed from the literature review for working with women in the perinatal period who have experienced the war (for more see Chrzan-Dętkoś et al., 2022). The vital protective elements were identified, which may alleviate the negative impact of war and refugee status experiences.

Nevertheless, participating midwives reported ease of establishing contact with Ukraine patients after the outbreak of war, the willingness to build relationships and provide support. All the surveyed midwives emphasised that they were willing to offer their patients themselves by showing empathy, holding their hands, trying to recognise the patients' needs and understanding the language. The midwives felt that they could support their patients, whether the Ukrainian women chose to disclose their situation or not. It is probably a protective factor for mental health of Ukrainian patients after the outbreak of war (Bielska & Czerkawski, 2016), but it can be an additional burden for midwives, for whom work even under standard conditions is often a stressor (Jankowiak et al., 2011). The additional burden of the patient's complex emotions, midwives' anxiety about the war and the common anxiety observed in Poland concerning the war with Russia (63.0% of Poles; CBOS, 2022), and the pressure to help the patient in the best way possible can consequently lead to a state of compassion fatigue or vicarious traumatisation. The latter is a phenomenon that occurs in contact with trauma survivors, whose severe stress or crisis exceeds the coping strategies of the healthcare provider and indirectly leads to various mental abnormalities (Gawrych, 2022). This phenomenon was observed among medical workers during the COVID-19 pandemic (Gawrych, 2022). In the subjective opinion of midwives, the average result of the emotional burden of war was slightly higher in them than in patients. An explanation for this phenomenon may be the heavy emotional burden on midwives, which can cause burnout, as well as evoking traumatic and harrowing memories of the war, which are often still vivid in Polish people. In addition, the situation when midwives who care for the patient try to contain their difficult emotions without any extra support from the employers can be demanding and difficult. Only one of our respondents had basic information about the consequences of war trauma and stress during pregnancy for the course of childbirth and puerperium. This shows that midwives may feel unprepared to respond to the needs of war-experienced patients while feeling a strong need to make their responses as helpful as possible to patients.



Participating midwives declared that they show compassion and acknowledge a history of trauma and current fear. 'Acknowledging' or 'validating' someone's painful experiences can be healing as a vital intervention element and may help foster positive relationships. Embracing and storing a patient's negative emotions and trying to mentalise them and show that they can be overcome can be an essential factor in building relationships in maternity care (Bronowski, 2017). As the survey shows, women describe expectations of midwives in terms of building a trusting relationship with them (Berg et al., 1996). Communicating empathetically is an integral part of supporting a woman during pregnancy and childbirth (Baranowska & Doroszewska, 2018; Chrzan-Dętkoś & Walczak-Kozłowska, 2021a). In the context of the traumatic and stressful experience, empathy and trust may be even more critical. As research conducted during the COVID-19 pandemic (also a highly stressful situation for pregnant women) shows, the experience of a crisis can be associated with an increased need for extra caution and mental health support for postpartum women (Chrzan-Dętkoś et al., 2021a). Our respondents seem to try to do it in their work by being more accessible, showing empathy and understanding, and non-verbal communication. However, combined with emotional involvement and the emphasised lack of employer support, the high score of traumatic stress, indicating our respondents' risk of compassion fatigue, vicarious trauma and burnout, is not surprising. Research shows that dissatisfaction with work is related to exposure to chronic stress and anxiety situations (Leinweber et al., 2017). Based on the interviews, we can hypothesise that contact with traumatised patients is emotionally demanding. Participating midwives, like many others in Poland, work in a few places, often exceeding the required 40 hours

of workweek time, and may burden their resources. Midwives' role is to contain the intense feelings of their patients: they help them organise ambivalent feelings of love and anxiety, stress and guilt for being safe while their relatives are still in danger. They risk being vicariously traumatised by approaching war-experienced patients with greater openness and empathy. In addition, the experience of World War II and the devastation associated with it is still vivid in Poland. The war across the eastern border could reactivate intergenerational fears. According to international studies, in crises, front-line healthcare staff who are directly involved with trauma-affected patients are especially vulnerable to stress and mental health problems (Holmes et al., 2020).

The study shows the necessity to introduce actions aimed at preventing vicarious traumatisation and compassion fatigue, which already affect the representatives of this profession. Our respondents tried to create a safe environment in maternity wards and primary care health centres by establishing trust-based relationships with patients, showing compassion, and providing more attention and understanding. This can prevent the adverse effects of the trauma for Ukraine patients after the outbreak of war or reduce its negative impact on the well-being of mothers and thus protect infants while significantly burdening midwives. The knowledge about trauma-informed care in the perinatal period must be higher among the participating midwives. This is not surprising, as this topic is not discussed during studies, and employers do not conduct such training (Chrzan-Dętkoś & Walczak-Kozłowska, 2021b). To minimise the negative psychological impact of the war, it is necessary to develop appropriate prevention strategies, as well as training and support programmes. It is extremely important to identify risk factors that may help detect groups at increased risk and develop adequate interventions. Also, the help with translation should be organised by the employer, not individual workers. A typical example of cultural awareness and sensitivity (caring) is, for example, offering print and electronic materials in the languages spoken by people accessing care and offering translation services. Visual cues within the hospital with information in the Ukrainian language could be a vital sign of support.

Moreover, it is necessary to introduce well-organised, systematic procedures and guidelines that will improve maternity care and work with Ukrainian patients. Another factor facilitating work with Ukrainian patients is their high assessment of maternity care, which they perceive as better organised than in Ukraine. Additionally, midwives see Ukrainian women as representatives of a similar culture, sharing similar values, making their work easier. Therefore, the differences observed by midwives are due to the different organisation of the medical system rather than cultural differences. However, our study shows that the issue of vaccinations may be a future problem. The WHO data show that, for example, only 42.0% of children received measles vaccination in 2016, with an improvement in 2019 to 85.0%. However, it is still below the expected rate of 95.0% (WHO, 2022).

### LIMITATIONS

The small sample size is the first limitation of the study. We cannot draw general conclusions, and the results we have presented should be considered as material providing further hypotheses. We have to emphasise also that hospitals and primary care health centres in Poland may differ in organising their care for war refugee women and other Ukrainian patients, and our data may only be representative of some midwives' experiences in Poland.

According to sociological analyses concerning the so-called disaster curve (Prot-Klinger, 2021), our study was conducted during the 'honeymoon period' – increased mobilisation of the Polish society, which was very committed to helping people fleeing war. According to Prot-Klinger (2022), in the case of war in Ukraine, this phase is longer than expected. Nevertheless, according to the dynamics of the 'disaster curve', the next phase is the disappointment phase, with a feeling of overload, abandonment, depression, and reactivation of past traumas. Therefore, it would be worthwhile to conduct further analysis, taking into account the changes above and comparing midwives' reflections over time. Probably now, or at the end of 2022, the results could be different. We have much more experience. Due to the disaster wave, mixed emotions are more visible now.

## CONCLUSIONS

In this short study, which is part of a larger project concerning the perinatal mental health of Ukrainian women after the outbreak of war, we would like to draw attention to the situation of medical personnel who report the need for additional psychological support for themselves while caring for Ukrainian patients. The experience of giving birth in forced exile may have negative consequences for the mother and child, and the war stress may even increase. However, the role of the midwife-mother relationship may mitigate the burden (Chrzan-Dętkoś et al., 2021b). This shows the enormous importance of prevention and the preparation of staff to work with women with refugee status or those who have trauma experience and who are in a double risk group: both due to the war-related experiences and a greater risk of perinatal complications re-influencing the mental state (Collins et al., 2011; Fellmeth et al., 2017). The

more the medical staff feels prepared and supported in new challenges, the easier it will be to care for patients who have experienced many losses and stress.

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### Disclosure

The authors declare no conflict of interest.

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