Journal of Community Health Provision
Vol. 6, Issue 1, 2026
Page 295-308
DOI: https://doi.org/10.55885/jchp.v6i1.846

Midwives' Coping Strategies After Failure to Assist in the Delivery Process

Muhammad Syam Ilham[1], Asniar Khumas[1]

[1]Faculty of Psychology, Makassar State University, Indonesia

Email: m.syamilham98@gmail.com, asniarkhumas@gmail.com

Abstract. *Failure in assisting childbirth is a difficult professional experience that may create psychological pressure for midwives, especially when the incident results in maternal or infant death. Such failure is not only understood as a clinical event, but also as an emotional and moral burden that can lead to sadness, guilt, anxiety, fear, self blame, and trauma. This study aimed to explore the coping strategies used by midwives after experiencing failure in assisting the childbirth process. A qualitative approach with a case study design was employed to obtain an in depth understanding of the participants' subjective experiences. The study involved two midwives who had directly experienced failure in assisting childbirth. Data were collected through semi structured interviews and analyzed using qualitative descriptive analysis by identifying important statements, grouping similar meanings, and developing themes related to coping strategies. The findings show that the participants predominantly used emotion focused coping rather than problem focused coping. The main coping strategies included self control through daily activities, positive reappraisal through religious meaning, and social support from family and coworkers. Self control helped the participants manage disturbing thoughts and emotional tension. Religious reappraisal helped them interpret the painful experience through acceptance and surrender to Allah SWT. Social support provided emotional reassurance, professional validation, and a sense of not being alone. These strategies helped the midwives reduce psychological distress, rebuild emotional stability, and continue their professional responsibilities. The study suggests that coping after childbirth failure should not be viewed only as an individual process, because midwives also need supportive professional environments, including peer support, emotional debriefing, and institutional attention to psychological well being after adverse childbirth events.*

Keywords: *Childbirth Failure, Coping Strategies, Emotion Focused Coping, Midwives, Psychological Distress*

Received: January 28, 2026 Received in Revised: April 29, 2026 Accepted: June 1, 2026

INTRODUCTION

Midwives are a full profession with pressure because his related work with life a person and the birth process is moment critical in practice midwives, where they play a role important in give care and support to mother and baby. Midwives have significant role in ensure success of the delivery process, maintaining health and well-being mother, and ensure birth healthy baby. However, in a number of case, although effort maximum done midwife, delivery process can experience failure. Failure labor this can happen because a number of factors, such as fetal abnormalities, difficulties childbirth, or complications medical that is not unexpected, so that can happen accidents that result in mother as well as candidate baby die.

ISSN 2776-1150 (Print), ISSN 2776-1169 (online)
Copyright © 2026, Journal of Community Health Provision, Under the license CC BY-SA 4.0

Amount death mothers who are gathered from health program recording family in the Ministry Health data in 2020 showed 4,627 deaths in Indonesia. The number this show improvement compared to in 2019, there were 4,221 deaths (Ministry of Health of the Republic of Indonesia, 2021). Based on data from Maternal Perinatal Death Notification (MPDN), system recording death Ministry of Health, number of death mothers in 2022 reached 4,005 and in 2023 increased to 4,129. Meanwhile that, for death in 2022, the number of babies was 20,882 and in 2023 it was recorded at 29,945 (SehatNegeriku, 2024). Considering that around 90% of deaths mother happen at the time around childbirth and 95% of the causes death mother is complications frequent obstetrics not can estimated previously, then government set effort acceleration decline number death mother (Rida & Yuliati, in Suhartatik, Isa, Sumi, & Ernawati, 2023).

Ministry of Health set indicator percentage community health center carry out class mother pregnant and percentage community health center carry out Planning Program orientation Childbirth and Prevention Complications (P4K) as effort lower death mother and death child, and one of them the implementer is midwives (Ministry of Health of the Republic of Indonesia, 2021). According to the ICM (International Confederation of Midwives), midwives is someone who has follow an educational program midwives who have recognized his country, has graduated from education mentioned, as well as fulfil qualification to be registered and or own valid permission (license) for do practice midwifery (Lestari, et al. 2017). Midwives are recognized as power professional in field responsible and accountable health, which works as partners woman for give support, care and advice during pregnancy, childbirth and postpartum period, facilitating and leading labor on not quite enough answer yourself and give care to new baby born, and baby.

Failure childbirth that ends in death no only is challenge physical, but also can cause burden significant psychological for midwife. Midwife who experienced incident the usually will face feeling disappointed, feeling dissatisfied empowered, and even experience symptom ongoing stress. In line with research conducted Nurdiana and Ediati (2017), midwives who made poor decision appropriate in referring to patient so that make baby patient no helped make it regret later day, even had time make it experience stress, even though no in long time. Likewise with research conducted by Megawati, Azniah and Sumi (2023) shows that midwife in charge patient with history abortion and IUFD (Intrauterine Fetal Death) has a number of responses, including feel anxious, panicked and sad.

Face post-failure in helps the birthing process and reduces symptoms of stress, midwives need something effective way. Coping strategies are one of the method very important effective for midwife. Coping strategies play a role role important in help individual facing and overcoming situations that give rise to stress. According to Yani (in Maryam, 2017), coping is involved and hidden behaviors that are carried out somebody for reduce or remove tension psychology in full condition stress. According to Weiten and Lloyd (Hidayanti, 2013), coping is efforts for overcome, reduce, or tolerate threat of burden feeling created because of stress.

So that coping strategies are effort or how it is done individual in a way conscious and directed in overcome sick or the stressors they face. Coping strategies involve action cognitive, behavioral, and emotional used individual for overcome stress, processing emotion negative, and adapt with situation pressing. Success use of coping strategies will help individual manage incident stress and reduce emotion negative. Therefore, that's important for explore what and how are midwives' coping strategies? and energy health other for manage impact psychological so that can help and handle situation stress in a way effective.

Success use of coping strategies will help individual manage incident stress and reduce emotion negative. Therefore, that's important for explore what and how are the coping strategies of midwives and other health workers? health other for manage impact psychological so that can help and handle situation stress in a way effective.

In context midwives who experience failure help the process childbirth, important for understand the coping strategies used by them for overcome burden psychological and emerging

ISSN 2776-1150 (Print), ISSN 2776-1169 (online)
Copyright © 2026, Journal of Community Health Provision, Under the license CC BY-SA 4.0

challenges. Understanding this can help develop interventions and approaches the right support for increase welfare midwives who experience failure help the birthing process. Although lots related research with coping strategies and failure childbirth, however research that focuses on experience subjective failed midwife assisting the delivery process still limited.

LITERATURE REVIEW

Strategy Coping

According to Yani (Maryam, 2017), coping is visible and hidden behaviors that are carried out somebody for reduce or remove tension psychology in stressful conditions. Folkman and Moskowits (Lestari, 2023) define coping is effort for manage burdensome, expanding situation business for solve problems live and try for overcome or reduce stress.

According to Lazarus (Nurhayati, 2012), coping is business for face pressure, also effort for overcome painful condition or threatening. Compas, et al. (2014) defines coping as business aware for arrange emotions, cognition, behavior, physiology, and environment as response to incident or full state pressure. According to Asnayanti, Kumat and Wowiling (Rachmah and Rahmawati, 2019, in Umjani, et al., 2022), coping is something pattern or a purposeful process withhold threatening tension self or finish current problem happen.

According to King (Sawitri & Widiasavitri, 2021), coping strategies are divided into two types, namely:

Problem Focused Coping

This strategy is a strategy for dealing with stress with direct facing and overcoming source problem. Type coping with this allows individual own objective as well as intention for implement it.

Emotion-Focused Coping

This strategy is a strategy for overcome stress with method manage response emotional state caused by the stress felt. Type this allows individual do avoidance to perceived source of stress, rationalize what has been happened to him, and request validation of others for get support.

Midwife

Definition midwives at the Ministry of Health 369/Menkes/SK/III/2007, which was quoted from Dinas.id page (2023), states definition of Indonesian Midwife. With notice aspect social culture and conditions of Indonesian society, then the Indonesian Midwives Association (IBI) has determined that Indonesian midwives are a woman who has graduated from a recognized midwifery education government and organizations professions in the territory of the Republic of Indonesia and own competencies and qualifications for deregistration, certification and or in a way legitimate get license for operate practice midwifery.

Failure Labor

Failure labor or also known as the term "dystocia" is condition where the birth process takes place no walk in accordance as expected or happen complications that hinder or slow down progress childbirth. According to Djami (2015), dystocia is difficult delivery with characteristics of a late process until stopped. Josep and Nugroho (in Paat, et al., 2015) define dystocia is abnormal labor characterized by obstruction or no existence progress in labor or abnormal delivery from labor eustasia which shows failure. As for the cause failure labor or dystocia according to Djami (2015), divided into 3 groups large, namely: 1) Dystocia because driving forces child no adequate. 2) Dystocia because existence abnormalities location fetus or abnormalities physique fetus. 3) Dystocia because existence road abnormalities born.

Copyright © 2026, Journal of Community Health Provision, Under the license CC BY-SA 4.0

METHODS

This study used a qualitative approach with a case study design. This approach was chosen because the study aimed to explore in depth the coping strategies used by midwives after experiencing failure in assisting the childbirth process. The focus of the study was not to measure the phenomenon statistically, but to understand the subjective experiences, emotional responses, and coping efforts of midwives in dealing with psychological pressure after a difficult professional event.

The participants in this study were two midwives who had experienced failure in assisting childbirth. The participants were selected using purposive sampling because they had direct experience related to the focus of the study. The criteria for participants were midwives who had assisted childbirth, had experienced a case of childbirth failure, and were willing to provide information through interviews. Although the number of participants was limited, it was appropriate for a case study because the study emphasized the depth and richness of individual experience.

Data were collected through semi structured interviews. The interviews were used to obtain detailed information about the participants' experiences, emotional responses, psychological impacts, coping strategies, and sources of support after the failure in assisting childbirth. The interview process allowed participants to explain their experiences openly while the researcher remained focused on the main issues of the study.

The data were analyzed using qualitative descriptive analysis. The interview results were read repeatedly, important statements were identified, and similar meanings were grouped into themes. The analysis focused on coping strategies, especially problem focused coping and emotion focused coping. The interpretation was then connected to the theoretical framework used in the study. To maintain research ethics, participants were informed about the purpose of the study, their participation was voluntary, and their identities were kept confidential. Because the topic was sensitive, the researcher also ensured that participants felt comfortable during the interview process.

RESULT AND DISCUSSION

The findings of this study were obtained from interviews with two midwives who had experienced failure in assisting the childbirth process. The results show that the failure created psychological pressure for the participants, including sadness, guilt, anxiety, and fear of facing similar cases in the future. The coping strategies used by the participants were mostly directed toward managing emotional responses rather than directly changing the source of the problem. Therefore, the dominant coping pattern found in this study was emotion focused coping.

Psychological Distress After Failure in Assisting Childbirth

The failure to assist in the childbirth process was experienced by the participants as a deeply distressing event. For the midwives, the incident was not merely understood as a clinical failure, but as an emotional and moral burden that affected their sense of responsibility as health workers. Although childbirth complications may occur due to various factors beyond the control of midwives, the participants still felt personally affected by the outcome. This shows that the experience of failure in childbirth assistance created psychological pressure that was closely related to sadness, guilt, anxiety, and fear of facing similar situations in the future.

One participant described the incident as a moment that was difficult to forget because she felt that she had tried to provide the best possible assistance. However, the unexpected outcome continued to leave an emotional burden. She stated,

> *"At that time, I felt very sad because I had tried to help as much as I could. After the incident, I kept thinking about it and asked myself whether there was something else I should have done."*

Copyright © 2026, Journal of Community Health Provision, Under the license CC BY-SA 4.0

This statement indicates that the participant experienced self blame after the failure. The sadness did not only come from the loss itself, but also from the feeling that her professional role was unable to produce the expected outcome. In this context, the failure created an internal conflict between professional responsibility and the reality that not every childbirth process can be fully controlled. The participant's reflection shows that midwives may carry emotional consequences even when they have performed their duties according to their capacity.

The psychological impact was also shown through the participant's difficulty in separating the past incident from later professional duties. The memory of the failure continued to appear when she returned to assist other childbirth cases. This condition suggests that the failure did not end at the moment of the incident, but continued to influence the participant's emotional readiness in subsequent practice. Another participant explained,

> *"When I had to assist another delivery, I sometimes remembered the previous case. I became more afraid and more careful because I did not want the same thing to happen again."*

This quotation shows that the failure produced anxiety and anticipatory fear. The participant became more cautious, but the caution was accompanied by emotional tension. This condition reflects how a difficult clinical experience can affect professional confidence. The participant did not simply continue her work as usual, but carried the memory of the previous failure into her next professional encounters.

The findings also show that the emotional burden experienced by the participants was strengthened by their awareness of the seriousness of childbirth assistance. For midwives, assisting childbirth is closely connected to the safety of both mother and baby. Therefore, when failure occurs, the event can be interpreted as a painful professional experience that touches their identity as caregivers. The participants' sadness, guilt, and fear indicate that the failure was processed not only as an external event, but also as a personal and professional wound.

Self Control as a Strategy to Manage Emotional Pressure

After experiencing failure in assisting childbirth, one of the coping strategies used by the participant was self control. This strategy appeared in the participant's effort to regulate her emotional reactions, control disturbing thoughts, and prevent herself from being continuously trapped in sadness. The failure created a painful memory that could easily return when the participant was alone or when she faced another childbirth case. Because of this, self control became an important effort to maintain emotional stability and continue daily activities despite the psychological burden she experienced.

Participant NH explained that she tried not to remain silent for too long because silence made her remember the incident repeatedly. She attempted to shift her attention by doing daily activities and keeping herself occupied. She stated,

> *"I tried to keep myself busy. If I stayed silent, I would remember the incident again. So I did activities at home, talked with people close to me, and tried to continue my routine so that my mind would not stay on that event."*

This statement shows that self control was not used to deny the incident, but to prevent the painful memory from dominating the participant's mind. The participant realized that the more she stayed alone with her thoughts, the stronger the emotional pressure became. Therefore, keeping herself active became a way to manage sadness, reduce anxiety, and create psychological distance from the traumatic memory. This indicates that self control functioned as an emotional regulation strategy rather than a direct solution to the event itself.

The participant's effort to control herself also reflected her awareness that she still had professional responsibilities as a midwife. Although the incident left sadness and fear, she could not completely withdraw from her role. She needed to continue working and face similar situations in the future. In this context, self control helped the participant maintain her ability to

function professionally. She tried to manage her emotional response so that the previous failure would not fully weaken her confidence in assisting childbirth.

Another important aspect of self control was the attempt to limit excessive self blame. After the failure, the participant questioned whether she could have done something differently. However, through self control, she gradually tried to reduce repetitive thoughts that only intensified her guilt. This does not mean that she ignored professional responsibility. Rather, she attempted to keep her emotional response within a level that allowed her to continue living and working. Self control therefore became a protective mechanism that helped her avoid being overwhelmed by regret.

The finding also shows that self control was closely connected to short term coping. The participant used daily activities and emotional restraint to reduce immediate psychological tension. This strategy may not completely resolve the deeper emotional wound, but it helped the participant survive the first stage of emotional pressure after the incident. In this sense, self control became a practical coping response that allowed the participant to regain temporary emotional balance.

Positive Reappraisal Through Religious Meaning

Another coping strategy found in this study was positive reappraisal through religious meaning. This strategy was mainly shown by participant M, who tried to understand the failure in assisting childbirth through a spiritual perspective. After experiencing sadness and emotional pressure, the participant did not only try to calm herself, but also attempted to give meaning to the incident by placing it within her religious belief. For her, the failure was painful, but it was also interpreted as an event that had to be accepted as part of Allah's will.

Participant M explained that religious activities helped her reduce the emotional burden after the incident. She stated,

> *"I felt very sad, but I tried to return everything to Allah. I prayed, performed tahajud, and read the Qur'an so that my heart could become calmer. I believed that what happened was already His will, even though it was difficult to accept."*

This statement shows that religious coping became a way for the participant to manage sadness and guilt. The participant did not deny the pain caused by the incident. Instead, she tried to reinterpret the experience through faith. By praying and reading the Qur'an, she attempted to find inner strength and emotional peace. This process reflects positive reappraisal because the participant gave a new meaning to a stressful event in order to reduce its psychological impact.

The participant also described that surrendering the event to Allah helped her reduce excessive self blame. She realized that although she had professional responsibility as a midwife, not every outcome in childbirth could be fully controlled by human effort. She explained,

> *"I kept asking myself whether I had made a mistake, but after praying I tried to accept that humans can only make efforts. The final result belongs to Allah. That thought slowly made me less burdened."*

This quotation indicates that positive reappraisal helped the participant balance professional responsibility with spiritual acceptance. The participant did not use religion to avoid responsibility, but to prevent herself from being trapped in continuous guilt. By interpreting the incident as something beyond complete human control, she could reduce the emotional weight of self blame while still acknowledging the seriousness of her professional role.

This form of coping shows that positive reappraisal does not remove sadness instantly. The participant still remembered the incident and still felt the emotional burden. However, religious meaning helped her prevent sadness from turning into deeper despair. Through surrender, prayer, and spiritual reflection, she gradually found a way to live with the memory of the incident. In this sense, religion functioned as a psychological resource that helped the participant rebuild emotional stability.

Positive reappraisal also strengthened the participant's ability to continue her professional role. By interpreting the incident as a test and as part of divine will, she could slowly regain the courage to face future childbirth cases. The spiritual meaning did not erase the professional risk of midwifery practice, but it helped her approach that risk with greater acceptance. This shows that religious coping was not only personal, but also connected to her ability to continue working as a midwife.

Social Support from Family and Coworkers

Social support also emerged as an important coping strategy used by the participants after experiencing failure in assisting childbirth. The emotional burden caused by the incident did not only require personal control or religious reflection, but also support from people around them. Both participants described that family members and coworkers became important sources of comfort because they provided reassurance, listened to their feelings, and helped them reduce the tendency to blame themselves continuously. In this study, social support functioned as an emotion focused coping strategy because it helped the participants regulate sadness, guilt, anxiety, and feelings of isolation.

One participant explained that support from family helped her feel emotionally accepted after the incident. She stated,

> *"When I came home, my family tried to calm me down. They listened to me and told me not to keep blaming myself because I had already tried to do my best."*

This statement shows that family support played an important role in reducing the participant's emotional burden. The family did not provide a technical solution to the childbirth failure, but they offered emotional protection and reassurance. This kind of support helped the participant feel that she was not facing the painful experience alone. It also helped her reduce excessive guilt by reminding her that she had made an effort within her professional capacity.

Support from coworkers was also meaningful because they understood the pressure and risk involved in midwifery practice. Unlike family members, coworkers could understand the clinical context of the incident more closely. They knew that childbirth assistance involves uncertainty and that not every complication can be fully controlled by the midwife. One participant stated,

> *"My coworkers understood what I felt because they also knew how difficult the situation was. They encouraged me and said that sometimes we have tried everything, but the result is still not as expected."*

This quotation indicates that support from coworkers helped validate the participant's experience. The participant felt understood not only emotionally, but also professionally. Coworkers helped her see the incident in a broader clinical context, so she did not interpret the failure only as personal inability. This form of support was important because it helped reduce self blame and strengthened the participant's ability to return to her professional role.

The findings also show that social support helped participants rebuild emotional stability. After the failure, the participants were vulnerable to sadness and repeated memories of the incident. Conversations with family and coworkers helped them express their feelings rather than suppress them. Being listened to and encouraged allowed the participants to process their emotions more openly. In this sense, social support became a space for emotional release and recovery.

Social support also had a protective function. Without support from people around them, the participants might have experienced deeper guilt, loneliness, or fear of assisting childbirth again. The presence of family and coworkers helped them regain confidence gradually. Although the emotional wound did not disappear immediately, the support they received made the burden feel more manageable.

Dominance of Emotion Focused Coping

The overall findings show that emotion focused coping was the most dominant coping strategy used by the participants after experiencing failure in assisting childbirth. Although coping strategies may include both problem focused coping and emotion focused coping, the participants in this study were more focused on managing their emotional responses than on directly changing the source of stress. This pattern appeared because the failure had already occurred and could not be reversed. Therefore, their coping efforts were mainly directed toward calming themselves, reducing sadness, managing guilt, controlling fear, and rebuilding emotional strength after the incident.

One participant described that the most important effort after the incident was to calm herself and gradually accept what had happened. She stated,

I felt that what happened could no longer be changed, so what I tried to do was calm my heart and mind. I tried to accept it slowly, pray, keep myself occupied, and talk to people who could strengthen me. The sadness was still there, but I did not want that feeling to stop me from carrying out my duties. I realized that being a midwife carries a great responsibility, so I had to learn to make peace with the experience while becoming more careful in the future."

This statement shows that the participant's coping was centered on emotional regulation. She realized that the incident could not be undone, so her response focused on managing the emotional consequences of the failure. Acceptance, prayer, daily activities, and communication with supportive people became ways to reduce psychological pressure. The participant did not deny her sadness, but she tried to prevent it from controlling her professional life.

The dominance of emotion focused coping was also reflected in the participant's effort to return to her professional role after the incident. Although the failure created fear and anxiety, she still tried to continue her responsibility as a midwife. She explained,

> *"When I had to assist another delivery, I was afraid at first. The memory of the previous case came back, and I became more tense than usual. However, I tried to strengthen myself because this is my work and my responsibility. I tried to be more careful, more attentive, and I continued to pray before working. That experience made me more alert, but I also learned that I could not continue living in fear. If I allowed fear to control me, I would not be able to help patients properly."*

This quotation indicates that emotional recovery was closely related to the participant's ability to continue working. The participant still carried the memory of the previous failure, but she tried to regulate her fear so that it would not interfere with her professional performance. This shows that emotion focused coping did not mean avoiding responsibility. Instead, it helped the participant regain emotional stability and continue her professional role more carefully.

The findings also indicate that problem focused coping was not the main pattern in the participants' narratives. The participants did not strongly emphasize formal evaluation, institutional counseling, structured debriefing, or procedural changes after the incident. Their stories were more strongly related to emotional management, religious acceptance, daily activities, and support from family or coworkers. This confirms that the coping strategies used by the midwives were mainly directed toward managing psychological distress after an irreversible event

Emotion Focused Coping as a Pathway to Psychological Recovery Among Midwives

The findings of this study indicate that failure in assisting childbirth should not be understood merely as a technical or clinical incident, but as an emotionally disruptive professional experience that can affect the midwife's sense of responsibility, confidence, and psychological stability. This interpretation is strongly supported by Aydın and Aktaş (2021), who found that midwives who witness traumatic births often experience guilt, loss of confidence, emotional exhaustion, and even the desire to leave the profession. The present study extends this

Copyright © 2026, Journal of Community Health Provision, Under the license CC BY-SA 4.0

understanding by showing that even when midwives do not openly frame their experience as trauma, their narratives reveal emotional traces of the incident through sadness, self blame, fear, and the need to regain inner stability. In this sense, the psychological burden experienced by the participants reflects the moral weight of midwifery work, where professional responsibility is deeply connected to the lives of mothers and babies. The study by Hajigeorgiou et al. (2023) similarly shows that traumatic childbirth affects midwives not only personally but also professionally, especially by making them more defensive, more cautious, and more emotionally alert in subsequent practice. Therefore, the emotional reactions found in this study should be read as part of a broader pattern in which adverse childbirth events produce enduring psychological consequences for maternity care providers.

The dominance of emotion focused coping in this study is theoretically meaningful because the stressful event faced by the participants had already occurred and could not be reversed. Kappes et al. (2021), in their systematic review of coping strategies among health care providers as second victims, emphasized that professionals involved in adverse events often rely on personal coping processes to manage negative feelings before they are able to engage in organizational or problem focused responses. This helps explain why the participants in the present study were more concerned with calming themselves, accepting the event, praying, keeping busy, and seeking emotional support than with discussing formal evaluation or institutional intervention. Buhlmann et al. (2022) further demonstrated that moving on after critical incidents is not a linear process, because health professionals often continue to carry emotional memories while gradually rebuilding professional identity. The present study confirms this point by showing that emotion focused coping does not mean passive resignation. Rather, it functions as a necessary psychological bridge that enables midwives to continue working after an irreversible and painful event.

The participants' reliance on self control shows that emotional regulation becomes a central survival mechanism after a difficult clinical event. Self control in this study was not simply an attempt to suppress emotion, but a practical effort to prevent intrusive memories from dominating the participant's daily life and professional functioning. This is consistent with Nieuwenhuijze et al. (2024), who reported that maternity care providers exposed to severe perinatal events may experience fear, guilt, self blame, withdrawal, and changes in the way they provide care. Their scoping review also shows that some providers become more defensive, more cautious, or less confident in clinical interactions after traumatic perinatal events. The present study contributes to this literature by showing how self control emerges at the micro level of everyday life, through keeping busy, maintaining routine, and trying to regulate repetitive thoughts. Thus, self control should not be dismissed as avoidance. In the context of midwives who face emotionally charged clinical failure, it can be understood as a short term stabilizing strategy that allows the professional to regain enough control to continue functioning.

The finding on positive reappraisal through religious meaning is particularly important in the Indonesian context, where religious belief often becomes a central source of emotional interpretation and resilience. The participant's use of prayer, tahajud, Qur'anic reading, and surrender to Allah shows that religious coping was not used to deny the seriousness of the event, but to reinterpret it in a way that reduced destructive self blame. Sarpdağı et al. (2025) found that positive religious coping can reduce secondary traumatic stress among nurses, suggesting that spiritual meaning may protect health workers from being overwhelmed by emotionally difficult care experiences. In the present study, religious coping helped the participant balance two realities. On one hand, she acknowledged her professional responsibility as a midwife. On the other hand, she recognized that not all childbirth outcomes are fully controllable by human effort. This balance is crucial because excessive self blame can intensify psychological distress, while complete externalization of responsibility can weaken professional reflection. Positive reappraisal therefore worked as an interpretive mechanism through which the participant could accept the painful event without abandoning professional seriousness.

ISSN 2776-1150 (Print), ISSN 2776-1169 (online)
Copyright © 2026, Journal of Community Health Provision, Under the license CC BY-SA 4.0

The importance of social support in this study is also strongly supported by recent second victim literature. Busch et al. (2021) emphasized that easy access to psychological support is crucial for health care providers affected by adverse events, particularly because such incidents can produce emotional suffering, isolation, and difficulty returning to normal professional functioning. In the present study, family and coworkers provided different but complementary forms of support. Family offered emotional safety, acceptance, and reassurance, while coworkers offered professional validation because they understood the uncertainty and risk embedded in childbirth assistance. This distinction deepens the meaning of social support. It is not merely the presence of other people that matters, but the type of recognition they provide. Coworker support is especially important because it helps the midwife reinterpret the event within the realities of clinical practice, rather than seeing it only as personal failure. This aligns with Aydın and Aktaş (2021), who found that midwives emphasized peer support as a crucial way to share traumatic experiences after difficult births.

The present findings also resonate with Klemm et al. (2025), who found a very high prevalence of second victim phenomenon among Austrian midwives, with self doubt, guilt, and flashbacks among the most pronounced symptoms. Their study reported that many affected midwives turned to colleagues, family, friends, superiors, or professional counseling for support. This directly strengthens the present study's interpretation that the coping strategies of midwives after childbirth failure are not purely individual, but relational. The fact that the participants in this study relied on family and coworkers suggests that coping is socially mediated. However, Klemm et al. (2025) also warn that informal support alone may be insufficient, because midwives who experience severe symptoms often need structured, accessible, and timely institutional support. Therefore, while the present study shows the value of social support, it also exposes a possible gap in the participants' coping environment, namely the absence of clearly described formal debriefing, counseling, or institutional recovery mechanisms.

This gap becomes more significant when the findings are compared with recent literature on second victim support systems. Busch et al. (2021) showed that organizational support resources, especially peer based support programs, rapid response systems, and structured psychological assistance, can help health care workers process adverse events more safely. Seys et al. (2023) also argued that second victim support requires an international, multidimensional action plan, because emotional recovery after adverse events should not depend only on the individual's private coping capacity. The present study contributes to this discussion by showing that midwives may naturally turn to emotion focused coping when formal support is not visible. This does not mean that emotion focused coping is weak. Rather, it suggests that individual coping may become the only available pathway when institutional structures are absent or underdeveloped. For midwifery practice, this implies that hospitals, clinics, and maternal health institutions should not assume that prayer, family support, or personal resilience are sufficient substitutes for structured psychological support after adverse childbirth events.

Another important issue is the relationship between coping and professional identity. Bingham et al. (2023) found that caring for women after traumatic birth can affect midwives' practice, emotional orientation, and professional confidence. Similarly, Xu et al. (2025) emphasized that midwives' experiences of birth trauma remain under researched despite their relevance for workforce well being and quality of maternal care. In the present study, the participants did not simply experience sadness as private emotion. Their distress was tied to their identity as caregivers responsible for safe childbirth. This means that coping was also a way of repairing professional identity. Self control helped them continue functioning, religious meaning helped them live with the event, and social support helped them feel understood as both human beings and professionals. The discussion therefore needs to move beyond a narrow psychological view of coping and recognize that coping after childbirth failure is also a process of professional restoration.

The limited appearance of problem focused coping in this study should be interpreted carefully. It does not necessarily mean that the participants lacked professional responsibility or did not learn from the incident. Rather, it may indicate that the interview narratives were more emotionally oriented because the study focused on personal coping after failure. However, recent evidence suggests that emotional coping should ideally be accompanied by opportunities for reflection, learning, and practice improvement. Kappes et al. (2021) identified internal analysis of the event, learning from adverse events, peer support, and organizational support as important coping strategies among second victims. Nieuwenhuijze et al. (2024) also noted that some maternity care providers change their practice after traumatic perinatal events, including becoming more cautious, consulting more frequently, or anticipating complications more strongly. The present study's emphasis on emotion focused coping therefore reveals an area for further development. Future intervention should help midwives move from emotional stabilization toward reflective professional learning, without turning the process into blame or punishment.

The findings also have implications for midwifery education and continuing professional development. Aydın and Aktaş (2021) recommended psychological education for midwives who witness traumatic births, while Hajigeorgiou et al. (2023) emphasized the need to increase resilience, decision making power, and problem solving in midwifery education. These recommendations are highly relevant to the present study because the participants' coping strategies were mostly personal and informal. Midwifery education should prepare students and practitioners not only to manage obstetric emergencies technically, but also to face the emotional consequences of adverse outcomes. This includes training in reflective practice, peer debriefing, self compassion, religious or spiritual sensitivity where culturally appropriate, and referral pathways for professional psychological support. By integrating these components, midwifery education can help normalize emotional responses after adverse events while still maintaining accountability and learning.

The study also contributes to the broader second victim literature by showing how the phenomenon appears in a small qualitative case study in an Indonesian cultural and religious context. Sachs and Wheaton (2023) described second victim symptoms as responses to traumatic patient care events, including patient death, adverse events, near misses, or any incident that produces significant mental stress for the provider. Ong et al. (2025) similarly framed second victim syndrome as significant emotional and psychological distress among health care professionals after adverse patient events. The present study gives this concept a culturally grounded expression. The midwives did not necessarily use the language of "second victim," but their experiences of guilt, sadness, fear, self control, prayer, and reliance on close relationships reflect many of the same psychological dynamics identified in international literature. This suggests that the second victim framework can be useful for interpreting midwives' experiences in Indonesia, as long as it is adapted to local cultural, spiritual, and institutional realities.

Finally, this study suggests that coping after failure in assisting childbirth should be understood as a layered process involving emotional regulation, meaning making, relational support, and professional continuity. Zheng et al. (2024) showed that psychological resilience is related to posttraumatic growth among midwives who witness traumatic childbirth events, indicating that difficult experiences may also become sources of growth when professionals have sufficient psychological resources. However, growth should not be romanticized. As Deng et al. (2025) and Li et al. (2024) show in recent second victim research, adverse events can create deep psychological trauma, and coping is shaped by both barriers and facilitators in the work environment. The present study therefore offers a balanced interpretation. The participants were able to continue their work through emotion focused coping, but their recovery relied heavily on personal faith, self control, and informal support. This makes their coping meaningful, but also highlights the need for institutional systems that protect midwives emotionally after adverse childbirth events.

ISSN 2776-1150 (Print), ISSN 2776-1169 (online)
Copyright © 2026, Journal of Community Health Provision, Under the license CC BY-SA 4.0

CONCLUSION

This study concludes that midwives who experience failure in assisting the childbirth process tend to rely more on emotion focused coping than problem focused coping. The failure was experienced not only as a clinical incident, but also as a psychological and moral burden that produced sadness, guilt, anxiety, fear, and self blame. In responding to this emotional pressure, the participants used several coping strategies, including self control through daily activities, positive reappraisal through religious meaning, and social support from family and coworkers. The findings show that self control helped the participants regulate disturbing thoughts and reduce emotional tension. Positive reappraisal enabled them to interpret the painful experience through religious acceptance and surrender to Allah SWT. Social support helped them feel understood, strengthened, and less isolated after the incident. These coping strategies allowed the participants to gradually rebuild emotional stability and continue their professional responsibilities as midwives. This study also indicates that coping after failure in assisting childbirth should not be seen only as an individual process. Although personal coping strategies were important, midwives also need supportive professional environments, including peer support, emotional debriefing, and institutional attention to psychological well being after adverse childbirth events. Therefore, health institutions and midwifery education programs should provide stronger emotional and professional support systems for midwives who experience difficult or traumatic childbirth cases.

REFERENCES

Aydın, R., & Aktaş, S. (2021). Midwives' experiences of traumatic births: A systematic review and meta-synthesis. *European Journal of Midwifery, 5*, Article 31. https://doi.org/10.18332/ejm/138197

Bingham, J. S., Kalu, F. A., & Healy, M. (2023). The impact on midwives and their practice after caring for women who have traumatic childbirths: A systematic review. *Birth, 50*(4). https://doi.org/10.1111/birt.12759

Buhlmann, M., Ewens, B., & Rashidi, A. (2022). Moving on after critical incidents in health care: A qualitative study of the perspectives and experiences of second victims. *Journal of Advanced Nursing, 78*(9), 2960–2972. https://doi.org/10.1111/jan.15274

Busch, I. M., Moretti, F., Campagna, I., Benoni, R., Tardivo, S., Wu, A. W., & Rimondini, M. (2021). Promoting the psychological well-being of healthcare providers facing the burden of adverse events: A systematic review of second victim support resources. *International Journal of Environmental Research and Public Health, 18*(10), Article 5080. https://doi.org/10.3390/ijerph18105080

Compas, B. E., Jaser, S. S., Dunbar, J. P., Watson, K. H., Bettis, A. H., Gruhn, M. A., & Williams, E. K. (2014). Coping and emotion regulation from childhood to early adulthood: Points of convergence and divergence. *Australian Journal of Psychology, 66*(2), 71–81.

Deng, Y., & Mo, B. (2025). The second victim of adverse events in health care: A systematic review of qualitative research. *International Journal of Nursing Studies, 173*, Article 105248. https://doi.org/10.1016/j.ijnurstu.2025.105248

Dinas.id. (2023). *Definition of midwife according to ICM, FIGO, WHO, Permenkes, and IBI*. Dinas.id.

Djami, M. E. (2015). *Prolonged labor, induction, and acceleration of labor*. Academia.edu.

Hadjigeorgiou, E., Koliandri, I., & Josephidou, E. (2023). Midwives' Experience of Traumatic Birth in Cyprus. In *Midwifery-New Perspectives and Challenges*. IntechOpen.

Hidayanti, E. (2013). Stress coping strategies of women with HIV/AIDS. *Sawwa: Journal of Gender Studies, 9*(1), 89–106.

Hidayat, T. (2019). Discussion of case studies as part of the research methodology. *Case Study*

Copyright © 2026, Journal of Community Health Provision, Under the license CC BY-SA 4.0

Journal, 3, 1–13.

Kappes, M., Romero-García, M., & Delgado-Hito, P. (2021). Coping strategies in health care providers as second victims: A systematic review. *International Nursing Review, 68*(4), 471–481. https://doi.org/10.1111/inr.12694

Klemm, V., Potura, E., Fuerst, S., Roesner, H., & Strametz, R. (2025). The second victim phenomenon among midwives in Austria SeViD-A3: A cross-sectional study. *European Journal of Midwifery, 9*, Article 34. https://doi.org/10.18332/ejm/206922

Lestari, D. W. (2013). Self-acceptance and coping strategies in adolescent victims of parental divorce. *Psikoborneo: Jurnal Ilmiah Psikologi, 1*(4).

Li, X., et al. (2024). Barriers and facilitators to coping with second victim experiences: Insights from nurses and nurse managers. *Journal of Nursing Management*. https://doi.org/10.1155/2024/5523579

Maryam, S. (2017). Coping strategies: Theories and resources. *Jurnal Konseling Andi Matappa, 1*(2), 101–107.

Megawati, Azniah, & Sumi, S. S. (2023). Midwives' experiences in providing services for patients with a history of abortion and IUFD. *Jurnal Ilmiah Mahasiswa & Penelitian Keperawatan, 3*(1), 31–42.

Ministry of Health of the Republic of Indonesia. (2021). *Indonesian health profile 2020*. Ministry of Health of the Republic of Indonesia.

Ministry of Health of the Republic of Indonesia. (2022). *Indonesian health profile 2021*. Pusdatin Kemenkes.

Nieuwenhuijze, M., et al. (2024). The impact of severe perinatal events on maternity care providers: A scoping review. *BMC Health Services Research*. https://doi.org/10.1186/s12913-024-10595-y

Nurdina, E. E., & Ediati, A. (2017). Midwives' experiences in helping critical childbirth: An interpretative phenomenological analysis study. *Jurnal Empati, 6*(1), 145–151.

Nurhayati, S. R. (2012). Social support and coping strategies of the elderly. *Jurnal Penelitian Humaniora, 17*(1).

Ong, T. S. K., Goh, C. N., Tan, E. K. Y. E., Sivanathan, K. A., Tang, A. S. P., Tan, H. K., & Ng, Q. X. (2025). Second victim syndrome among healthcare professionals: a systematic review of interventions and outcomes. *Journal of Healthcare Leadership*, 225-239.

Rachmah, E., & Rahmawati, T. (2019). Relationship between stress knowledge and coping mechanisms among adolescents. *Dinamika Kesehatan: Jurnal Kebidanan dan Keperawatan, 10*(2), 595–608.

Rahmah, R. A. (2018). The influence of coping strategies and time management on academic procrastination. *Psikoborneo: Jurnal Ilmiah Psikologi, 6*(2). https://doi.org/10.30872/psikoborneo.v6i2.4561

Rokom. (2024). *For the safety of mothers and babies*. Sehat Negeriku.

Sachs, C. J., & Wheaton, N. (2023). Second victim syndrome. In *StatPearls*. StatPearls Publishing.

Sarpdağı, Y., Yiğit, M. F., Kaplan, E., Sir, Ö., Çiftci, N., Orakçi, H., & Yildiz, M. (2025). The effect of religious coping and prosocial behaviors on secondary traumatic stress in nurses. *BMC nursing*, *24*(1), 1038.

Sawitri, A. R., & Widiasavitri, P. N. (2021). Coping strategies of students writing their theses during the COVID-19 pandemic. *Jurnal Psikologi Udayana, 8*(1), 78–85.

Seys, D., Panella, M., Russotto, S., et al. (2023). In search of an international multidimensional

Copyright © 2026, Journal of Community Health Provision, Under the license CC BY-SA 4.0

action plan for second victim support: A narrative review. *BMC Health Services Research, 23*, Article 816. https://doi.org/10.1186/s12913-023-09637-8

Suhartatik, S., La Isa, W. M., Sumi, S. S., & Ernawati, E. (2023). Identification of failure types in normal delivery among teenage mothers. *Journal of Telenursing, 5*(2), 1726–1733.

Ulimaz, T. A. (2018). Congruence of adolescent-parent career with coping stress in first- and second-year students in the D3 Nursing Program, Polytechnic of Health, Ministry of Health Semarang. *Empathy Journal, 6*(4).

Usraleli, U., Melly, M., & Deliana, R. (2020). The relationship between coping strategies and stress levels among students of the Health Polytechnic of the Riau Ministry of Health who were writing their thesis. *Jurnal Ilmiah Universitas Batanghari Jambi, 20*(3).

Xu, D., Xu, M., Fang, L., Chen, H., Ye, J., & Huang, C. (2025). Exploring the experience of birth trauma from the midwife's perspective. *BMC Pregnancy and Childbirth*, *25*(1), 1031.

Yalçın, D., & Bingöl, F. B. (2023). The Effect of Secondary Traumatic Stress Level on Psychological Resilience of Midwives. *Acibadem Saglik Bilimleri Dergisi*, *14*(2).

Yuhana, A. N., & Aminy, F. A. (2019). Optimizing the role of Islamic religious education teachers as counselors in overcoming student learning problems. *Jurnal Penelitian Pendidikan Islam, 7*(1), 79–96.

Zheng, Y., Wang, X., Deng, Y., & Wang, J. (2024). Effect of psychological resilience on posttraumatic growth among midwives: The mediating roles of perceived stress and positive coping strategies. *Nursing open*, *11*(11), e70076.

ISSN 2776-1150 (Print), ISSN 2776-1169 (online)
Copyright © 2026, Journal of Community Health Provision, Under the license CC BY-SA 4.0