Vicarious birth trauma and post-traumatic stress disorder: Preparing and protecting student midwives

The focus of the theoretical aspect of the first year of the pre-registration midwifery programme is on low risk and physiological birth; however, the clinical area is dynamic and unpredictable in nature, and so, in reality, student midwives may be witness to traumatic events from day 1 of their clinical practice. Given that anyone who witnesses a traumatic birth can also experience symptoms of vicarious birth trauma or post-traumatic stress disorder (PTSD), it is important to consider what measures are put in place before, during, and after clinical placements to prepare and support students to cope with the emotional stressors of the job. This is particularly necessary when one considers the severity of the condition and its impact on the individual. As Griffin and Tyrell (2013:319) describe:

> ***'A traumatised creature lives in a private hell, terrorised by an invisible mental wound, helplessly in thrall to a powerful emotional memory of a life-threatening event'.***

Previous articles in this series have developed a 'Survival Guide' to support student midwives on their first labour ward placement (Power, 2015), and the need for student midwives to develop resilience during their training to be better equipped to cope with the complexities and stressors of clinical practice once they qualify (Power, 2016). This article will review the evidence in relation to vicarious birth trauma and PTSD, and will suggest a personal 'Survival Guide' for students, as well as proposing areas of consideration for midwifery education providers.

For around 80% of those involved in a traumatic experience, after a period of approximately 4 weeks, as the brain sets to work engaging the natural processing mechanisms, the trauma will no longer be the focus of their lives. Unfortunately, for the remaining 20% of suffers, psychological intervention and treatment will be needed to help the brain to process the traumatic event (Griffin and Tyrrell, 2008).

© 2017 MA Healthcare Ltd

Abstract

Post-traumatic stress disorder was first recognised in war veterans who had experienced extreme violence during military combat; however, it is now understood to be caused by a wide range of traumatic experiences, including serious accidents, abuse, natural disasters or terrorist attacks—any event in which a person fears for their life. Traumatic childbirth is also a potential cause, not only for the mother, but also for those who may witness the birth, such as midwives, student midwives, obstetricians and birth partners. This condition is termed vicarious birth trauma.

This article will examine the definition of both vicarious birth trauma and post-traumatic stress disorder, and consider the evidence in relation to how these conditions affect midwives and student midwives. It will offer suggestions for personal and organisational management and support strategies, based on research findings and expert advice.

Keywords

Post-traumatic stress disorder | PTSD | Vicarious birth trauma | Student midwives | Resilience

Normal processing of trauma

When a birthing mother finds herself in a traumatic situation, in particular, if she feels trapped and unable to escape, her stress levels will rise rapidly and remain very high. The amygdala, which senses the threat, will trigger the 'alarm system', setting the fight/flight/freeze response into action. The hippocampus, which sits adjacent to the amygdala and normally works in partnership with it, is affected by the very high levels of arousal and increased

Alison Power
Senior Lecturer in Midwifery, University of Northampton

Jenny Mullan
Trauma specialist and founder of Birth Trauma Resolution Therapy

Alison.Power@northampton.ac.uk

Box 1. Post-traumatic stress disorder: Causes and symptoms

Post-traumatic stress disorder (PTSD) can start after any traumatic event, defined as an event where a person sees that they are in danger, their life is threatened, or if they see other people dying or being injured.

The symptoms of PTSD can start immediately or after a delay of weeks or months, but usually within 6 months of the traumatic event.

Symptoms include:

- Flashbacks and nightmares (mentally reliving the event)
- Avoidance and numbing (keeping busy and avoiding anything or anyone that acts as a reminder)
- Being 'on guard' (staying alert all the time; inability to relax, feeling anxious, inability to sleep)
- Physical symptoms (muscle aches and pains; diarrhoea; irregular heartbeats; headaches; feelings of panic and fear; depression)
- Drinking too much alcohol or using drugs (including painkillers)

Source: Royal College of Psychologists, 2017

production of cortisol and cannot perform its normal function (Griffin and Tyrrell, 2008).

When arousal is low, the hippocampus can add context to the situation, allowing the narrative to be stored as a normal memory in the neocortex. However, when a mother experiences a traumatic birth and arousal remains high, the trauma memory is stored in the amygdala as a terrifying, emotionally intense state. The crude trauma memory or mental pattern, without any story or narrative to add context to the situation, will pattern-match to anything vaguely similar to the original traumatic event (Griffin and Tyrrell, 2008). For example, a woman who has endured a traumatic birth and was attended by a redheaded midwife may start experiencing feelings of panic and anxiety when she meets a redheaded woman while shopping in the supermarket. The amygdala has unwittingly matched the redheaded woman in the supermarket to the redheaded midwife, thus triggering feelings of panic and terror, warning the mother that she is in danger. Unfortunately for the mother, she has no conscious awareness of this process, and the feelings of panic appear to come out of nowhere and with no rational explanation for them. The inexplicable terror that she experiences in the supermarket can create feelings of hypervigilance, leaving the mother alert, tense, tearful and scared to experience new situations.

Fortunately, for most mothers, when stress levels begin to fall enough for the hippocampus to belatedly create a context, the trauma memory can be filed away as a normal memory in the neocortex. This does not mean that the mother will forget the traumatic situation, but rather that the emotional charge will have dissipated, allowing the mother to tell the story of her birth without the strong associated feelings of panic and terror. This will enable her to make more positive plans for a future pregnancy and birth with the increased understanding and awareness that the next birth could be very different. As a result, the woman will be able to take back control and make positive decisions about future births, giving her a more fulfilling experience.

Inability to process trauma

Unfortunately, for around 20% of mothers, because they are living in a state of hypervigilance with the accompanying intense feelings of terror and panic, arousal never decreases enough for the context to be added belatedly, and such cases will require fast and effective therapeutic intervention.

It is not only mothers who are left dealing with unhelpful pattern-matching, however, and there is growing evidence, both in the UK and Australia, of the impact of vicarious birth trauma or PTSD on midwives and student midwives, particularly as PTSD can be cumulative, with symptoms occurring after a period of years of witnessing traumatic events.

What is the evidence?

Sheen et al (2015) conducted a national postal survey of midwives in the UK to investigate their experiences of traumatic perinatal events. The survey had 421 responses, with 33% (*n*=139) of midwives self-reporting symptoms commensurate with PTSD. This study was followed up in 2016, with Sheen et al interviewing 35 midwives who had experienced a traumatic perinatal event. Midwives were assigned groups according to their distress level (low or high) as identified in the Diagnostic and Statistical Manual of Mental Disorders (version IV) Criterion A for PTSD (American Psychiatric Association, 2000). Participants in both groups were found to have similar symptom levels of emotional upset, self-blame and feelings of vulnerability. While participants valued the support of their peers, they felt that support from senior colleagues was lacking, leading the authors to recommend the development of more effective ways of promoting support facilities at a personal and organisational level for midwives who have experienced a traumatic birth.

Rice and Warland (2013) conducted a qualitative study to explore 10 Australian midwives' experiences of witnessing traumatic births to determine if, like other caring professionals, such as nurses, social workers and emergency department personnel, midwives are at risk of negative psychological sequalae. Key themes from this study were that midwives felt a sense of responsibility, questioning what they could, or should, have done differently to have avoided it; they felt pressured into adopting a medical model of care rather than practising according to their midwifery philosophy of being 'with woman' and, most importantly, they felt a great responsibility for the welfare of the women and babies

© 2017 MA Healthcare Ltd

involved in the traumatic birth. Recommendations from this study included the need to further explore appropriate support mechanisms for midwives who experience vicarious birth traumatisation.

Leinweber et al (2017) aimed to explore Australian midwives' reactions to birth trauma and the prevalence of PTSD and found that almost 20% of Australian midwives met the criteria for probable PTSD. Recommendations from this study included the need to acknowledge PTSD as an occupational hazard for midwives.

In relation to student midwives' experiences of birth trauma, Davies and Coldridge (2015) explored student midwives' perceptions of witnessing a traumatic birth and how they were supported post-event. Findings concurred with those of Rice and Warland (2013), discussed above, suggesting too that participants felt vulnerable in the clinical environment, where the realities of practice did not reflect their pre-conceived ideology of the midwife practising 'with woman'. Implications for practice identified by Davies and Coldridge (2015) included the need to recognise that the definition of 'traumatic' lies with the individual, and that a more supportive culture that offered debriefing opportunities could help students make sense of their experiences and develop resilience for future practice. A follow-up study explored 'the psychological tensions and anxieties that students face from a psychotherapeutic perspective', with findings suggesting 'a focus on the psychological complexities in the midwifery role could assist in giving voice to and normalising the inevitable anxieties and difficulties inherent in the role' (Coldridge and Davies, 2017:4).

Research into vicarious birth trauma and PTSD suggests that midwives and student midwives can develop PTSD as a result of witnessing traumatic births—either from a single incident or over a number of years. As such, universities have a responsibility to act on research findings and to offer appropriate support and guidance.

Preparing and protecting students

Knowledge

Studies have shown that pre-registration midwifery education should therefore provide student midwives with education and information on birth trauma, including vicarious birth trauma. Curricula should also advise on how student midwives can take steps to prevent PTSD, and how get treatment for the associated symptoms. Support can be accessed from mentors via debriefing sessions at their Trust sites; through the University from personal academic tutors and counselling services; via their GP; or through specialist charities such as Mind or the Mental Health Foundation (*Box 2*).

© 2017 MA Healthcare Ltd

Box 2. UK mental health charities

Anxiety UK
www.anxietyuk.org.uk/anxiety-type/ptsd/

Mental Health Foundation
www.mentalhealth.org.uk/a-to-z/p/post-traumatic-stress-disorder-ptsd

Mind
www.mind.org.uk/information-support/types-of-mental-health-problems/post-traumatic-stress-disorder-ptsd/causes-of-ptsd/#.WeSBjGhSy1s

Rethink Mental Illness
www.rethink.org/search?s=PTSD

SANE
www.sane.org.uk/uploads/PTSD.pdf

Young Minds
www.youngminds.org.uk/find-help/conditions/ptsd/

Talk

Student midwives should be given the opportunity to discuss stressful birth experiences in a safe, supportive and non-judgemental environment, where their perception of their experience is validated—this could be with their mentor or personal academic tutor, or in a peer support group. This may help to lower arousal, supporting the natural trauma processing system in the brain. It also provides the opportunity for identifying when students require further help, support or therapeutic intervention. The importance of debriefing and reflection was highlighted in a study into resilience in midwifery (Hunter and Warren, 2013), which was conducted among trained midwives. The authors suggested that their findings could have implications for pre-registration midwifery education, and recommended implementing sessions to discuss both the realities of practice and strategies to enhance emotional awareness of self and others. Reflection was also identified as key to developing resilience, in order to consider the emotional implications of clinical practice as well as its practicalities.

There is some evidence in the literature to suggest that debriefing (including critical incident debriefing) is contraindicated for trauma and PTSD and can strengthen the trauma template (Griffin and Tyrell, 2013). Anecdotal evidence, however, suggests that if debriefing is offered to students to provide them with an opportunity to talk about their experience with a sympathetic and non-judgmental mentor or tutor, and that if this tutor listens to, and validates, their perception of the traumatic event, this can lower levels of arousal. This, coupled with further information, including clinical knowledge, could help students to make sense of their experience while further lowering arousal and developing resilience.

Key points

- The theoretical focus on 'normality' in year 1 of the pre-registration midwifery programme does not always reflect the realities of practice
- The definition and perception of trauma lies with the individual and those who witness a traumatic birth are at risk of developing vicarious birth trauma with its associated physical and emotional symptoms
- In order to manage the emotional demands of their chosen career, student midwives should be supported and encouraged to develop resilience throughout their training
- Universities have a duty to ensure student midwives are well prepared for the unpredictable nature of clinical practice; are well supported during and after clinical placements and have robust support systems in place for students who may require more specialist therapeutic interventions or support

Balanced life

It is important that student midwives ensure that their own lives are in balance. This includes taking care that they are emotionally and physically well. The Human Givens Institute have developed the Emotional Need Audit (Human Givens Institute, 2016), which allows an individual to assess their emotional health and wellbeing and make corrections as needed. When emotionally well, our ability to deal with stressful situations is enhanced. It is also important to get regular exercise, which helps to increase endorphins and reduce cortisol in the body, lower arousal, and support the brain's natural trauma processing system.

Therapeutic interventions and support

It is important that student midwives who present with the symptoms of trauma or PTSD have access to appropriate therapeutic interventions. Such interventions may include trauma-focused Cognitive Behavioural Therapy (CBT), eye movement desensitisation and reprocessing (EMDR) and Human Givens rewind technique (Griffin and Tyrrell, 2013).

Conclusion

In the unpredictability of the clinical environment, student midwives are exposed to the risk of developing vicarious birth trauma and/or PTSD as a result of witnessing traumatic births. Student midwives in their first year of practice are particularly vulnerable, as the theoretical element of their programme of study focuses on physiological birth, whereas the realities of practice can mean they are exposed to events they perceive to be traumatic from day one. It is therefore important that students are adequately prepared before going into practice, in terms of the difficulties that they may witness and where to go for help. Students should be supported and encouraged to develop resilience to occupational stressors and should endeavour to improve their self-awareness to be proactive in seeking support if they feel they have been affected by a traumatic event in the workplace. Education providers also have a responsibility to support and protect their students, and should take on board research recommendations to have robust support mechanisms in place, both in the clinical area and in the university setting. Providing debriefing sessions, along with the opportunity to reflect on their experiences individually and in groups, will help students to become increasingly resilient and to cope with the complex emotional demands of their chosen profession. BJM

American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders (IV-TR). Washington DC: American Psychiatric Association; 2000

Coldridge L, Davies S. Am I too emotional for this job? An exploration of student midwives experiences of coping with traumatic events in the labour ward. Midwifery. 2017; 45: 1–6. https://doi.org/10.1016/j.midw.2016.11.008

Davies S, Coldridge L. No Man's Land: an exploration of the traumatic experiences of student midwives in practice. Midwifery. 2015; 31(9): 858–64. https://doi.org/10.1016/j.midw.2015.05.001

Griffin J, Tyrrell I. How to Master Anxiety (1st edn). Chalvington: HG Publishing; 2008

Griffin J, Tyrrell I. Human Givens: The New Approach to Emotional Health and Clear Thinking (2nd edn). Chalvington: HG Publishing; 2013

Human Givens Institute. Emotional Needs Audit. 2016. https://www.hgi.org.uk/resources/emotional-needs-audit-ena (accessed 27 October 2017)

Hunter B, Warren L. Investigating Resilience in Midwifery: Final report. Cardiff: Cardiff University; 2013

Leinweber J, Creedy DK, Rowe H, Gamble J. Responses to birth trauma and prevalence of posttraumatic stress among Australian midwives. Women Birth. 2017; 30(1): 40–5. https://doi.org/10.1016/j.wombi.2016.06.006

Power A. Welcome to practice: A guide for the first labour ward placement. British Journal of Midwifery. 2015; 23(12): 902–3. https://doi.org/10.12968/bjom.2015.23.12.902

Power A. Midwifery in the 21st century: are students prepared for the challenge? British Journal of Midwifery. 2016; 24(1): 66–8. https://doi.org/10.12968/bjom.2016.24.1.66

Rice H, Warland J. Bearing witness: midwives experiences of witnessing traumatic birth. Midwifery. 2013; 29(9): 1056–63. https://doi.org/10.1016/j.midw.2012.12.003

Royal College of Psychologists Post-traumatic Stress Disorder: key facts. 2017. http://www.rcpsych.ac.uk/healthadvice/problemsdisorders/ptsdkeyfacts.aspx (accessed 16 October 2017)

Sheen K, Spiby H, Slade P. Exposure to traumatic perinatal experiences and posttraumatic stress symptoms in midwives: prevalence and association with burnout. Int J Nurs Stud. 2015; 52(2): 578–87. https://doi.org/10.1016/j.ijnurstu.2014.11.006

Sheen K, Spiby H, Slade P. The experience and impact of traumatic perinatal event experiences in midwives: A qualitative investigation. Int J Nurs Stud. 2016; 53: 61–72. https://doi.org/10.1016/j.ijnurstu.2015.10.003

© 2017 MA Healthcare Ltd