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Vicarious Birth Trauma/PTSD: preparing and protecting student midwives

Abstract

Post-traumatic Stress Disorder (PTSD) was first recognised in war veterans who had experienced extreme violence, including military combat; however it is now understood that it can be caused by a wide range of traumatic experiences such as a serious accident; being abused/raped; being kidnapped; surviving a natural disaster or terrorist attack - in fact any event in which a person fears for their life (Mind, 2017). Traumatic childbirth is also a potential cause of PTSD, not only for the mother but also for those who may witness the birth such as midwives; student midwives; obstetricians and birth partners - a condition termed vicarious birth trauma/PTSD.

This article will look at the definition of PTSD and consider the evidence in relation to vicarious birth trauma/Post-traumatic Stress Disorder (PTSD) and midwives/student midwives. It will go on to offer suggestions for personal and organisational management and support strategies, based on research findings and the expert advice of Jenny Mullan (Founder of the certified birth trauma/PTSD resolution practitioner training programme).

Key words: Post-traumatic Stress Disorder; PTSD; vicarious birth trauma; student midwives; resilience

Introduction

The focus of the theoretical aspect of the pre-registration midwifery programme is low risk/normality in year one; however, the clinical area is dynamic and unpredictable in nature and so in reality student midwives may be witness to traumatic events from day one of their clinical practice. In view of the fact that anyone who witnesses a traumatic birth can also experience symptoms of vicarious birth trauma/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, particularly when one considers the severity of the condition and its impact on the individual as described by Griffin and Tyrell (2013:319) '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), with another focussing on the importance of 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 current evidence in relation to vicarious birth trauma/PTSD and will go on to suggest a personal 'Survival Guide' for students and areas for consideration for education providers.

Post-traumatic Stress Disorder Causes and Symptoms

PTSD can start after any traumatic event that is an event where you see that you are in danger, your life is threatened, or where you 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 (reliving the event in your mind again and again)
- Avoidance and numbing (keeping busy and avoiding anything or anyone that reminds you of it)
- Being 'on guard' (staying alert all the time; inability to relax, feeling anxious, inability to sleep)
- Physical symptoms (eg muscle aches and pains; diarrhoea; irregular heartbeats; headaches; feelings of panic and fear; depression)
- drinking too much alcohol or using drugs (including painkillers)

(Royal College of Psychologists, 2017)

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 take centre stage in their lives. Unfortunately, for around 20% of sufferers, psychological intervention/treatment is needed to help the brain to process the traumatic event (Griffin and Tyrrell, 2008).

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 very rapidly and remain very high. The amygdala which feels under 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 production of cortisol and cannot perform its normal function (Griffin and Tyrrell, 2008).

When arousal is low the hippocampus can add the context to the situation allowing the story/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 feeling state. The crude trauma memory or mental pattern, without any story/ 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 red headed midwife may start experiencing feelings of panic and anxiety when she meets with a red headed woman whilst shopping in the supermarket. The amygdala has unwittingly matched the red headed 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 on hyper alert, tense and tearful and scared to go out into 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; rather 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. It will allow her to take back control and make positive decisions about future births allowing for 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 comes down low 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 and there is growing evidence both in the United Kingdom (UK) and Australia of the impact of vicarious birth trauma/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?

In 2015 Sheen *et al.* conducted a national postal survey of midwives in the United Kingdom (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. Participants in both groups were found to have similar symptoms in terms of levels of emotional upset; self-blame and feelings of vulnerability. Whilst participants valued the support of their peers they felt support from senior colleagues was lacking, leading to the recommendation for the development of more effective ways of promoting support facilities at a personal and organisational level for midwives who have experienced a traumatic birth.

Elsewhere, Rice and Warland (2013) conducted a qualitative study to explore 10 Australian midwives' experiences of witnessing traumatic births to determine if, like other caring professions such as nurses, social workers and emergency department personnel, midwives are at risk of negative psychological sequelae. 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 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 PTS as an occupational stress for midwives.

In relation to student midwives' experiences of birth trauma, Coldridge and Davies explored student midwives' perceptions of witnessing a traumatic birth and how they were supported post event (2015). Findings concurred with those of Rice and Warland (2013), suggesting 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 included the need to recognise that the definition of 'traumatic' lies with the individual and a more supportive culture offering debriefing could help students make sense of their experiences and develop resilience for future practice. A follow up study (Coldridge and Davies, 2017:4) 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'.

The existing body of research evidence into vicarious birth trauma/PTSD suggests that midwives and student midwives can develop PTSD as a result of witnessing traumatic births – whether this be a single incident or over a number of years and as such universities have a responsibility towards their students to act upon research findings to offer appropriate support and guidance.

Vicarious Birth Trauma/PTSD: preparing and protecting student midwives

Knowledge

Pre-registration midwifery education should provide student midwives with education and information on birth trauma, including vicarious birth trauma and how to take steps to prevent or 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 specialist charities such as Mind or the Mental Health Foundation.

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 and/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 further help, support or therapeutic intervention is required. The importance of debriefing and reflection was highlighted in Hunter and Warren's study into resilience in midwifery (2013) which suggested that their findings in relation to trained midwives could have implications for pre-registration midwifery education and therefore recommended the implementation of sessions to discuss 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.

Whilst there is literature to suggest debriefing, including critical incident debriefing, is contraindicated to trauma and PTSD and can strengthen the trauma template (Griffin J and Tyrell 2013), anecdotal evidence 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 who listens to and validates their perception of the traumatic event, this can lower arousal. This coupled with further information including clinical knowledge could help students make sense of their experience whilst further lowering arousal and developing resilience.

Balanced Life

It is important that student midwives ensure that their own lives are in balance. This includes ensuring that they are emotionally and physically well. The Human Givens Institute have developed the Emotional Needs Audit (available here: <https://www.hgi.org.uk/resources/emotional-needs-audit-en>) 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 intervention/support

It is vitally important that student midwives who present with the symptoms of trauma or PTSD have access to appropriate therapeutic intervention. Such intervention may include trauma focussed Cognitive Behavioural Therapy (CBT), Eye Movement Desensitization 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/PTSD as a result of witnessing traumatic deliveries. Student midwives in their first year of practice are particularly vulnerable as the theoretical element of their programme of study focusses on normality, whereas the realities of practice can mean they are exposed to events they perceive to be traumatic from day one in practice. It is therefore important that students are adequately prepared prior to going into practice in terms of the realities of practice and where to go for support. Students should be supported and encouraged to develop resilience to occupational stressors and develop 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 to provide debriefing sessions along with the opportunity to reflect on their experiences individually and in groups to become increasingly resilient in order to cope with the complex emotional demands of their chosen profession.

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Mental Health Charities UK

Anxiety UK

<https://www.anxietyuk.org.uk/anxiety-type/ptsd/>

Mental Health Foundation

<https://www.mentalhealth.org.uk/a-to-z/p/post-traumatic-stress-disorder-ptsd>

Mind

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

Rethink Mental Illness

<https://www.rethink.org/search?s=PTSD>

SANE

<http://www.sane.org.uk/uploads/PTSD.pdf>

Young Minds

<https://youngminds.org.uk/find-help/conditions/ptsd/>

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