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“Am I too emotional for this job?” An exploration of student midwives’ experiences of coping with traumatic events in the labour ward

Abstract

Background

Midwifery is emotionally challenging work, and learning to be a midwife brings its own particular challenges. For the student midwife, clinical placement in a hospital labour ward is especially demanding. In the context of organisational tensions and pressures the experience of supporting women through the unpredictable intensity of the labour process can be a significant source of stress for student midwives. Although increasing attention is now being paid to midwives’ traumatic experiences and wellbeing few researchers have examined the traumatic experiences of student midwives. Such research is necessary to support the women in their care as well as to protect and retain future midwives.

Aim

This paper develops themes from a research study by Davies and Coldridge (2015) which explored student midwives’ sense of what was traumatic for them during their undergraduate midwifery education and how they were supported with such events. It examines the psychological tensions and anxieties that students face from a psychotherapeutic perspective

Design

A qualitative descriptive study using semi-structured interviews.

Participants

11 student midwives from one university in the North West of England were recruited by poster campaign.

Findings

The study found five themes related to what was traumatic for the students. The first theme *Wearing the Blues* referred to their enculturation within the profession and experiences within practice environments. A second theme *No Man’s Land* explored students’ role in the existential space between the woman and the qualified midwives. Three further themes described the experiences of engaging with emergency or unforeseen events in practice and how they coped with them (“*Get the Red Box!*”, *The Aftermath* and *Learning to Cope*). This paper re-examines aspects of the themes from a psychotherapeutic perspective.

Key conclusions

Researchers have suggested that midwives' empathic relationships with women may leave them particularly vulnerable to secondary traumatic stress. For student midwives in the study the close relationships they formed with women, coupled with their diminished control as learners may have amplified their personal vulnerability. The profession as a whole is seen by them as struggling to help them to safely and creatively articulate the emotional freight of the role.

Implications for practice

For midwifery educators, 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. Further research could explore whether assisting students to have a psychological language with which to reflect upon this emotionally challenging work may promote safety, resilience and self-care.

Key words

Student midwives, traumatic stress, resilience, containment, safety, midwifery culture, hospital midwifery

Highlights

Mentors and educators need to provide students with the psychological space to explore their anxieties in relation to supporting women in labour

Using containment models from psychotherapeutic literature may help discussion and normalisation of students' anxieties

Students' abilities to facilitate containment in mothers were also shaped by their experiences of being psychologically held and contained by mentors and colleagues.

Further research should explore how students can be aided to learn the psychological skills to protect themselves against trauma

Introduction

Midwifery work is emotionally challenging. It involves being witness to, and sharing in moments of joy as a baby is welcomed into the world, and it involves being emotionally present for parents as they undergo loss and/or trauma. In addition the midwife carries professional responsibility for the physical and psychological safety of the mother and her baby (NMC 2015).

It is increasingly recognised that midwives are at risk of experiencing work-related psychological distress (Beck and Gable, 2012; Beck et al., 2015;

Mollart et al., 2009; Mollart et al., 2013 ; Sheen et al., 2014; Sheen et al., 2015; Sheen et al., 2016a; Sheen et al., 2016b; Pezaro et al., 2015; Leinweber and Rowe, 2010; Rice and Warland, 2013; Mander, 2016).

Midwives who are exposed to traumatic events when working in unsupportive, hierarchical cultures often ‘soldier on’ in silence and standards of maternity care are jeopardised (Pezaro et al 2016). In addition Sheen et al (2015) conducted a survey of UK midwives which found that a third of those who had experienced a traumatic perinatal event, where the mother and/or baby are thought to be at risk of serious injury or death, reported clinically significant symptoms of post-traumatic stress disorder.

Those learning to become midwives may be more vulnerable to secondary traumatic stress due to their student status and their intensely empathic relationships with women (Davies and Coldridge, 2015:863). For students, clinical placement in a hospital labour ward is especially demanding because the process of labour is unpredictable, and a labour which appears to be unfolding normally can rapidly become complicated (Brunstad et al 2016).

In this paper we apply two models of psychological containment from psychoanalytical thinking to the role of the student midwife in the hospital labour ward. The findings from our study (Davies and Coldridge 2015) which depicted traumatic elements for students in the context of NHS labour wards are considered from these perspectives. We examine how student midwives articulated their relationship with labouring women and the complexities of this in practice.

Psychoanalytical thinking has been applied to midwifery practice at times over the last fifteen years (Taylor, 2010; Hall, 2011; O'Higgins, 2011). Midwives have been presented as able to take on aspects of the maternal containment function (Winnicott, 1978; Bion, 1962). Containing functions in this paper refer to psychological processes and the environment of care rather than to any concepts related to physical restraint. For Winnicott (1978), the concept of “holding” involves a physical spatial relationship between child and mother that translates into a psychological experience of being held; this holding enables an infant sense of self to cohere from within the envelope of non-intrusive maternal care.

For Bion (1962) containing is an unconscious process where a mother who is open to receiving the unrefined projections of an infant’s feeling states e.g. feelings of anger and fear, can transform them into feelings that can be mentalised and understood by the growing infant. This is enabled by a process of expansive, non-defensive receptivity to unconscious feelings in the infant (Bion, 1962).

From a psychoanalytical perspective the facilitating psyche of the midwife can assist in the building of the mother's capacity to process her anxieties in the birth process. Midwives achieve this in a number of ways; they set aside their own needs when supporting women (Hall, 2011; O'Higgins, 2011), they provide environmental safety and create a trusting relationship (Carolan, 2011). They are also seen as able to think on a labouring woman's behalf (O'Higgins, 2011). On a physical level they provide soothing, holding and appropriate touch (Hall, 2011). A containing role for maternal anxieties is further established when midwives acquire practice experience and learn to tolerate in themselves feelings of inability to help and loss of control (Hinshelwood and Skogstad, 2000).

The environment of care for learners

In the UK and internationally experienced midwives have pointed up the tensions in balancing the needs of women and the needs of the institutions in which they work (Scamell, 2011; Stapleton et al., 2002; Levy, 1999; Nolan, 1999). A recent review of the literature has highlighted dysfunctional, unsupportive cultures which add to midwives' experience of psychological distress (Sheen et al, 2014). In our study, based in hospital units, tensions were amplified for students who were learning to understand and tolerate the limits to their new helping roles. Echoing Walsh (2006: 1331) who described the environment as an 'assembly line', students suggested that psychological support was seen as a dispensible extra:

...it's just like a conveyor belt getting people in and getting people out, just doing the basic care rather than giving doing that extra care that they might need ...they might have a nice healthy baby but they might have wanted more... like the emotional side or the psychological support that might have meant more to them than just a good outcome.
(M3)

In their role students were trying to make sense of the way women were treated, and some perceived a disjuncture between promoting choice and safety for women.

I felt a bit like she was being coerced and I felt a bit uncomfortable about that but I was also listening to a midwife who has been doing the job for ages and thinking well I need to know as a student what is safe for women. So it's a really hard balance to find as a student. Of what's best for women and what's safe for women... (M6)

From the perspective of a novice, this student describes what she sees as a conflict between 'what's best and what's safe', suggesting that she is in the role

of 'being with' the mother, supporting her with autonomous decision-making, while also trying to manage the tensions of risk management (Scamell, 2011). The role of learner is a complex one influenced by professional and individual attitudes (Hunter, 2001). Students flipped between the role of participant observers who shared with mothers the impact of what other professionals did to them to the assumption of a practitioner role that demanded that they step back and evaluate women's needs and act upon them. In several instances, students who were mothers themselves experienced the birth processes in highly personal ways derived from their own birth stories; some talked about wanting to give care to women that had not been available to them:

I didn't know what to say, I had no idea what to say, but I remember I had lost a baby previously and had no sympathy or empathy at all... and really felt that this was my opportunity, well, not at the time did I think "oh I've got an opportunity" but I think in hindsight... what I was doing was taking the opportunity to give that care to somebody. (M10)

The degree of personal engagement in the birth processes of others described here points up the potential for emotional investment that can unconsciously inform practice. As noted by Sheen (2016b) personal salience has been identified as a factor in midwives' traumatic experiences.

A lack of professional containment

Students' abilities to promote and facilitate containment in mothers were also shaped by the quality of their experiences of being held and contained by mentors and colleagues. Busy hospital units often overshadowed their needs as learners. They expressed feelings of being lost, invisible and often powerless. They perceived wide inconsistencies in attitudes by registered midwives related to how labour should be managed (or supported to unfold). As Nolan (1999) and Stapleton et al. (2002) noted some midwives can feel threatened by women's desires for unmedicalised labour and want to control the experience for women. This attitude was described by many in the study and was disillusioning for students. It was a stark contrast to their learning about the importance of women's agency in making their own decisions about labour and birth.

...actually giving women the proper information, as to the full procedure, and being constantly interrupted by a mentor that's just trying to say "We actually want to get that over, cos we don't want to frighten women and if you keep saying what you're going to say she's going to get up off the bed and pack her bags and go home" and you're thinking well... and you're trying to say, you shouldn't even be here according to your own dates so maybe you could have a discussion with your own community midwife about it, but being told by your

mentor “Well she’s here get on with it just do the deed, just do the job”. It’s incredibly hard... yes, so feeling quite tainted by that I think. (M8)

In further illustration of points made by Barkley (2011) and Kennard (2004), students often felt that they did not belong and did not feel accepted or valued for their role by other staff. They considered that there was little appreciation by professional colleagues of their need to talk through what made them anxious in the labour rooms. Following unforeseen events in labour, when issues had been resolved, students were not seen as requiring emotional support. In many instances there were no obvious outlets for them due to the absence of consistent contact with mentors.

Students perceived their advocacy role for women was limited. Freedom to think for oneself appeared to be stifled in students, mirroring the restrictions placed on women in labour. In this sense they struggled to gain opportunities to ascertain and test out the limits of what was possible with women. Many described feeling intimidated into complicity.

I think it is so easy “Just to do it”, in the working conditions because so many midwives have been told just do it, because they have been told to speed up the labour and just you know to get things to move quickly and me being a junior student and I didn’t know, I just thought this is what you did. But now I am near the end of my training I look back I’ve reflected back on that and developed my own care... and I think I am worried about being able to stand up for myself when I am actually qualified - that will be a challenge. (M3)

As these excerpts show in many instances students felt closer and more in tune with women and their aspirations regarding their births than with the professionals who were dealing with them. This chimed with students’ sense of being controlled in the hospitals.

The freedom to think new or independent thoughts is seen as emerging from “active imagination” (Cwik, 2011; Jung, 1967) and an appropriate experience of being contained (Winnicott 1978). To be containing of others requires non-defensive, openness to experience. Difficulties in thinking about good midwifery practice and maintaining it is recognised as problematic in NHS environments (Scamell 2011). The impact of care is culturally denied in what Rizq describes as a “perversion of care” (Rizq, 2012). Discussing UK NHS mental health services Rizq argues that governance driven protocolised care serves to mask unbearable feelings of helplessness in the face of service limitations when trying to help those in psychological distress (Rizq 2012:9).

For midwifery students in the study a lack of encouragement to think about a range of options for women could be seen as diminishing their “active

imagination”. When the service container in midwifery is shaped by defensive orthodoxy students may struggle to develop the capacities for independent creative thinking (Weston and Stoyles, 2007). A student, who reported having a particularly difficult experience in one hospital, said:

I was completely at odds with how they ran their affairs there, it broke my midwifery spirit, to me it was just a big processing plant I could not learn anything because the mentors I was with ...could not answer me. When you asked why they did such a thing they'd say “that's what we do and that's what we have always done”. I couldn't learn. I didn't learn anything in that year till my last placement because I almost felt the midwives were like robots, they did things by rote. (M2)

A consequence of limiting student autonomy may be to create alienation from an empowering vision of midwifery shared by many student midwives. (Carolan, 2011). As in the quotation above, there is a potential loss of the ‘midwifery spirit’ which can act as a spur to managing anxieties in practice.

A space to talk

There was evidence in the study of a lack of recognition of students' need to talk over distressing events.

You don't see any of your peers, you don't see other students really while you are there all day apart from everyone has a break together. But in that room there's all the midwives, all the HCAs and all the students and you kind of get to this behaviour where if you see a student you know them you will say “Hi are you all right?” “Yeh, yeh” “Is it going well?” “Yeh, yeh, it's going well” “Yeh” and then if anyone even starts to say things are bad you just cut the conversation off, you can't have that sort of discussion.(M1)

Another student (M8) talked about having a “safe” space in hospitals to sit and talk with other students, a space to reflect in and process their anxieties and painful experiences. The culture in midwifery of soldiering on in silence (Kirkham, 1999; Pezaro et al., 2016) was reinforced by a fear that speaking out about distress would render the student vulnerable to being labelled as inadequate or difficult.

I wanted to talk! I wanted to talk but talking about that wasn't encouraged on placement... I felt that if I wanted to talk I would've been seen as weak and inefficient cos “these things happen”...but these things have never happened to me, you know. (M10)

Silence may have also represented a profession uneasy with thinking the unthinkable, that midwives may ‘fail’ and that not all births are normal births (Mander, 2007, 2009; Robins, 2012).

Students described some midwives as mechanical, cold or emotionally shut down and struggled to understand how they could carry on in their role. Some saw this demeanour as a response to trauma, as an attempt to erect buffers against the pain and distress generated by intimacy with women.

Keep it inside, move on to the next lady cos you can’t have what happened impact on somebody else but... if you do that and you keep everything inside and hold it all for yourself and try and deal with it all yourself, it’s not a healthy way of being cos if you cannot unravel that... then it is just going to stay there. Because it is going to be like a ball of mess that you cannot undo. (M6)

In our study, when students experienced care, understanding and containership from colleagues they were more able to continue to face unexpected events in practice (Davies and Coldridge 2015). They highlighted the important role of colleagues’ capacities to validate and normalise their emotional responses. They were deeply appreciative of those individuals who held them unjudgmentally or who tutored them into an understanding of the difficulties they encountered in labour.

My mentor was very relaxed about it, obviously having more experience than myself she probably understood that there was nothing we could do... so that probably helped me in turn because if she was to panic then that would have increased my level of panic. (M4)

In the study appreciation of students’ emotional and professional needs appeared to lead to a shift in their resilience and ability to cope. However, chiming with the findings of Pezaro et al (2016), others described a profession that lacked a strong supportive culture :

(doctors) they stick together like glue; they you know form a wall. And they won’t say anything but if anything happens with midwives everyone finger points and it’s kind of like “Oh well it’s her; it’s nothing to do with me I wash my hands of that”. You know and everyone kinds of steps back and points the finger rather than saying “Oh well I don’t know about that”...we’ll ask somebody’s opinion on that” rather than supporting each other- it doesn’t happen. (M5)

Interpersonal and intrapsychic work- identification and empathy “with woman”

Being “with woman” in labour is about learning to be present alongside elemental emotions. Students in the study often articulated an ideal vision of

midwifery that emphasised a commitment to be a companion in a caring contract as part of a transformative journey:

I would strive not to be that institutionalised midwife, you know, if there was an option that wasn't so difficult, where you could be the midwife, where you're on your hands and knees and that woman looks in your eyes and she can see how much you care! And if something awful happens they know that you've felt that, cos your heart's out there with them! That's the kind of midwife I want to be. (M10)

They talked about the emotional impact of working with mothers and were concerned to find out what they could bear in practice. In this way they were consciously exploring their emotional boundaries and capacities. The capacity to empathise with and support women was depicted as a source of joy but it was also viewed as painful and distressing. In comparison with experienced colleagues students tried to hold women's fears and anxieties in labour when they themselves did not know what was going to happen and what outcomes would be.

I think seeing people in situations that I can't do anything for them almost that ...that's when you can't control things or if the people you are working with may not do things to help and where you feel powerless that's very difficult. (M1)

The physical circumstances of their training added to their stresses. They were regularly left without breaks or interludes where they could withdraw from events to gather themselves or reflect. They often elected to be with women in labour after their shifts were over. Being physically present and psychologically receptive for long periods promoted attachment and empathic availability to women but also may have created unconscious identifications with them that were hard to manage. In this sense a capacity to separate psychologically from the mothers in their care was often lessened. Several students described the women in their care as the people they could trust in the hospital or, in some instances, as friends. These images often contrasted with negative views of qualified midwives who were cast as dismissive or conspiring against the woman.

On an interpersonal level students' experiences of invisibility and unimportance in the physical environment of large, impersonal wards appeared to parallel their perceptions that women received "robotic", "cog in the machine" care. They endeavoured to offer trusting relationships to women in contexts where they could not easily trust or feel trusted.

Psychological splitting is an unconscious defensive response to managing anxieties (Menzies-Lyth, 1959). In times of stress black-and-white thinking

appears to relieve anxiety. Students' frequent negative perceptions of midwives and idealized, positive views of women could be seen as a form of psychological splitting into "bad" midwives and "good" women and students.

It's supposed to be a caring profession but a lot of people I come across are the least caring people you could meet. (M5)

...with the women it's easier, they are the people I feel I can trust to be honest. (M1)

Although it is clear that students witnessed a lack of compassion by some midwives, this process of compartmentalisation could also be understood as a manifestation of their internal anxieties associated with birthing experiences. By separating good from bad they may have been attempting to preserve their sense of positive agency for women in the face of overwhelming anxieties about what could happen to them. This potential for splitting is likely to have been intensified by an anxious relationship to their environment.

Comforting and soothing

An intense empathetic relationship to women was evident in students' acute sensitivity to cues from the mothers and partners. In several instances when labour had been difficult the woman's or her partner's face were alluded to as haunting students afterwards. It was as if these faces represented the shock and disappointment of the experiences for the student also.

Physical contact between students and mothers was presented as an instinctive means of anchoring women when unexpected elements occurred in labour. It appeared also to afford comfort to the student who, in times of emergency, did not know what other role to occupy. At a psychological level it may have assisted them to manage their own anxieties related to powerlessness. However physical closeness to women was not easy to switch off in the face of traumatic birth events. When things went in wrong in labour there was a deep poignancy to students' desires to be present for the woman to protect them:

I just wanted to run out the room, I just thought, my heart was beating, and I just thought, I'm either going to pass out or I just got like a sense of anxiety and thought, oh I need go, I need...but then I thought, this isn't me, this isn't my baby, I've just got to support her and I just remember seeing them trying to resuscitate this baby and almost like standing in front of the mum because I didn't want that to be her image of her baby, watching them do that.(M11)

Students were distressed and saddened by a lack or loss of physical contact with women when things had gone wrong in labour. Many felt they could not burden women with their feelings afterwards. This led to feelings of isolation:

It wasn't that I didn't want to deal with it, to speak with them, it was I didn't want to put my emotions on them because I was so upset and I just thought they have got enough to deal with. If I go on there I know that I will just cry (laughs) cos I would not be able to control myself. And I thought I don't want to put my kind of upset and feelings on them. They have got enough to deal with so I kind of just left it alone.(M5)

Knowing what to do, knowing what to say

In the vital, emotionally fierce atmosphere of labour the range and depth of unconscious thoughts and feelings about birth for all parties can be alarming and a student midwife can face a struggle to find an appropriate psychological space for herself and for a mother. To be containing a midwife needs to be open to these projected elements and to tolerate them within herself. This may mean being able to contemplate the horror of things going wrong for a mother and baby. The use of verbal reassurance to motivate and reassure fearful mothers was presented as an important soothing function by students but was also a source of guilt when they felt that they had misled or betrayed women when outcomes were poor. It may be that the unconscious identification with and acts of comforting mothers in these frightening moments lessened students' capacities to think about alternative less positive outcomes for mothers. In this sense students' own needs to see themselves as protectors of women and to protect the unborn may have contributed to the closing down of a psychological space where it would have been possible to embrace other less positive outcomes for both student and mother.

In psychotherapeutic training contexts overidentification with patients leading to rescuing behaviour by a therapist is discouraged but equally underidentification by, for example, emotional shutdown and withdrawal is equally damaging to establishing optimal therapeutic skills (Kottler and Swartz, 2004). In an analogous way student midwives were aiming to find an appropriate stance that enabled them to hold women in mind without flight into restricted ways of thinking, feeling and behaviour in environments where there were few models for this creativity.

Implications for educators

Empathetic relationships with women may be a factor in the development of traumatic stress for midwives (Leinweber and Rowe 2010). The organisational context of care has also been found to play a part; professionals who experience traumatic stress have reported a high degree of work-related stress such as

feeling over-extended, fearing adverse consequences to care, and unpleasant team interactions (Czaja, Moss and Mealer, 2012). This adds to Sandall's (1998) finding that lack of occupational autonomy was the most important factor in emotional distress amongst midwives. Students in this study were working long hours in situations where they had little control over events. Feeling powerless allied to the close relationships with women may have amplified a sense of personal vulnerability.

The cultural and psychological expectations placed upon student midwives are significant actors in any birth drama. Students may need to be able to contextualise and understand the competing narratives within the role. In addition focus on psychological processes could assist in normalising the inevitable anxieties that face them in practice. Reflecting on their work this way may further promote self-care and resilience.

Providing students with a psychological understanding of the pushes and pulls in their roles may support them to confront a range of complex and sometimes painful feelings. For example it may be important to hold onto an existential awareness of the fact that not all labours end with an optimal outcome and that the emotional expectations associated with normal birth are not always fulfilled (Mander, 2007, 2009). Student midwives need to retain an openness to and honour the possibility of loss in order that they are able to emotionally contain mothers in these situations. In real terms this may mean holding back from reassurance of mothers (to meet one's own needs for a happy outcome) and to appreciate the psychological unknowability of the moment. The converse of this, an unconscious denial of the possibility of damage or loss, may lead a student or midwife to fail to register signs of distress or problematic labour.

Teaching psychological understanding as part of reflective practice involves a commitment to compassionate self-monitoring that recognises the impact of how we feel on the work we do. As Anderson (2000:101) noted the role of the midwife in labour is help women feel 'safe enough to let go'; to provide a sense of security that enables women to safely enter the disconnected state and thus facilitate the birth process. Similarly educators require a feeling language to contain the vulnerable student during the transition to midwife.

Conclusion

Being "with woman" in labour is about learning to be present alongside elemental emotions. The psychological tasks for student midwives involve learning about how to tolerate not being in control in a control-oriented environment. Not being in control is tolerable if there are bounded spaces where students are held and valued in their role as learners. Mentors and educators need to creatively think about student midwives' anxieties in practice and to make sense of them with students in a way that enables both to manage

them appropriately. These spaces cannot be held open in a prohibitive environment where creativity in terms of having an enquiring mind and openness to options is quashed by negativity of colleagues (Hunter, 2005; Barkley, 2011). In many instances students appear to be left to make sense of safe containership and its failures on their own. This can lead to students feeling unsupported, traumatised and uncertain as to their ability to become part of the profession.

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