Trauma experienced by student midwives

Davies, SE and Coldridge, E

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Chapter

Introduction

Research has recently focussed on the extent to which midwives suffer traumatic stress as a result of the work they do (Leinweber et al 2017; Pezaro et al. 2016; Beck et al. 2015; Sheen et al. 2015; Rice and Warland). Witnessing traumatic events in childbirth, and working in a negative organisational culture (where there are staff shortages, conflicting ideologies, and lack of support for staff) have both been implicated in findings of a high level of emotional distress amongst midwives. Midwives are also more likely to report work-related distress than other healthcare professionals (Griffiths, 2016). The highly empathetic relationship between midwives and women is seen as an important element in midwives' work- related trauma (Rice and Warland 2012). In a large UK-based survey of midwives who had experienced traumatic birth events a third of the sample reported clinically relevant posttraumatic stress symptoms (Sheen et al 2015); while an online survey of Australian midwives found that 33% of the respondents met criteria for posttraumatic stress disorder (PTSD) and that those midwives were four times more likely than others to expess an an intention to leave midwifery (Leinweber et al 2017).

Student experiences during their course shape their professional attitudes (Jameton, 1984), and traumatic experiences may have enduring adverse effects including attrition, so it is important to explore how student midwives might be affected by trauma and how best to support them. With this in mind we conducted the first study of the traumatic experiences of student midwives (Davies and Coldridge, 2015; Coldridge and Davies, 2017). We interviewed 11 student midwives in the 2nd and 3rd years of their undergraduate course, in one university in the North West of England, and the method used was interpretive phenomenological analysis (IPA) in order to allow for open exploration of the topic (Smith and Osborn 2008). After conducting thematic analysis, we concluded that the student midwife inhabits a uniquely vulnerable position in what one described as the 'no man's land' of hospital practice. Five main themes emerged from the analysis. *Wearing your Blues*

depicted the 'bleak' landscape of practice and students' enculturation into the profession. *No Man's Land* was concerned with the traumatic tensions in the student role, exploring their role in the existential space between the woman and the qualified midwives. Three further themes described the experience of being in emergency or unforeseen events in practice and how they coped with them (*"Get the Red Box!", The Aftermath* and *Learning to Cope*).

To avoid prejudging what students found traumatic we did not set criteria for trauma. For several students, what they found distressing was not necessarily a specific traumatic event but the environment in which they were working, and their own feelings of powerlessness within it, while others recounted emergency situations which were made more traumatic through taking place in this difficult environment. This chapter will explore some aspects of the themes in the light of the current crisis in the UK maternity services (relate to book title)

Wearing your blues

The phrase 'wearing your blues' captures students' concept of the midwifery role in two ways. The blue uniform symbolises the responsibilities carried by the midwife, while the 'blues' also depicts their sense of disappointment with the realities of the role. This sense of disappointment or 'shattered fairy tale' has been identified in research exploring the role of newly qualified midwives (NQMs) too, where the 'idealised fiction' of midwifery disappeared as they qualified and began to practice (Kitson Reynolds, Cluett and Le-May, 2014:664).

Similarly, Carolan noted in a longitudinal study (Australian) that student midwives begin their education with a powerful motivation to support childbearing women and well-defined ideas about what constitutes a 'good midwife'(Carolan, 2011). She found that as students progressed through the course their views became 'more aligned' with those of qualified midwives, but nonetheless concluded even at the end of the course that the students' 'intense passion and enthusiasm for midwifery practice may make them vulnerable to disappointment with the profession' (Carolan,

2013:115). She refers to this enthusiasm as 'somewhat extreme' (p120) inferring that students need to adapt their unrealistic expectations to avoid disillusionment, and in order to minimise attrition from the workforce.

However, students' passionately held ideals are consonant with the rhetoric about maternity care that has informed UK government policy since 1993 – from the 'choice, continuity and control' of Changing Childbirth (DH 1993) to the most recent maternity service reviews in England: '*Personalised care, centred on the woman, her baby and her family, based around their needs and their decisions, where they have genuine choice, informed by unbiased information*'(NHS England p7).

The 2017 Scottish government (2017) maternity services review similarly focuses on the central importance of the mother-midwife relationship, recommending that services be reconfigured to ensure continuity of midwifery carer. Indeed the notion of holistic, partnership working with women is further reiterated in the curricula of Higher Education institutions through the Nursing and Midwifery Council midwifery competencies (NMC 2009) and by midwifery professional bodies both national and international (RCM 2016; ICM 2011). This vision contrasts starkly with the protocolised care that students in our study witnessed and experienced in obstetric units. Students talked of striving to be the 'ideal' midwife in an environment where that was difficult if not impossible:

' *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! (M5)*

Struggling with the contradictions between the 'with woman' ideal and the constraints of the hospital system is not peculiar to the situation of students but has been noted in NQMs and team based hospital midwives (Hunter 2004),as well as implicated as a major factor in midwives' decisions to leave the profession (Curtis et al., 2006). As Kirkham (2017) observes: '*…. NHS midwives are torn*

apart. Their leaders speak the rhetoric of midwifery while clinical midwives work within the reality of a service aiming for maximum efficiency'. The drive to achieve ever-greater 'efficiencies' (such as centralisation of obstetric units, minimum staffing levels and midwives being moved at short notice by managers) is part and parcel of the marketisation and commodification of the NHS set in train in the UK by the Conservatives in 1979 and further developed and entrenched by successive governments (Mander and Murphy-Lawless 2012) . As Reiger and Lane (2013) point out: '*Provision of personalised, continuous care focused on 'well women' is now central to midwifery identity and work ideals, but it remains difficult in hospital contexts shaped by increased demand and by neoliberal policies*'. Echoing Walsh (2006: 1331) who described the environment as an 'assembly line', students suggested that psychological support was seen as a dispensable 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 to, 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)

The tension between their deeply held ideals and the realities of working in a busy obstetric unit was experienced by the students as deeply distressing:

Everything's standard practice where the woman almost becomes invisible and I think those sorts of behaviours are so deeply entrenched it becomes quite distressing if not traumatic… I'm not sure about the word traumatic, I think, but certainly deeply distressing to see women treated in that way I think and sort of processed through a system… (M8)

Another perspective on the commodification of care, and the damage it does to both patients and carers is offered by Risq (2012). From a psychotherapeutic perspective she argues that the privileging of attention to targets and protocols acts to reduce feelings of empathy, diminishing the caring role and indeed resulting in what she terms 'a perversion of care'. (Risq 2012:9). Further, the focus on risk governance and protocols serves to disavow, or mask, the anxiety of recognising the limits to our capacity to care in such environments (Risq 2012:9).

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Students found it distressing when women's needs were not listened to and they did not receive the care students knew to be appropriate. This breaking from the ideal had profound consequences not just for the women but also for students and qualified midwives :

'it broke my midwifery spirit. To me it was just a big processing plant' (M2)

and

'I have known people, people who were of great experience who were nearly broken or on the way to breaking, I don't think they intend to break people or break spirits it is just that it is an occupational hazard in working there… It's not like the discipline of the armed forces where they actually try to break the person to then… start creating them. I don't think it's that sort of breaking it's a breaking from their passion, from their autonomy. I don't think there's autonomy either. You have to keep in line and go with their policy whether or not you agreed with it … (M2)

So becoming part of the profession involved a breaking of one's spirit and a breaking from the idealised picture of midwifery as an autonomous profession where midwives have the agency to respond authentically to women's needs.

No man's land

The student midwife is in a liminal state between being a lay person and a qualified midwife and, as we have outlined, is caught between competing ideologies which midwives themselves find difficult to manage. Can she be 'with woman', or must she be 'with institution' (Hunter 2004)? Midwife, or 'medwife' (Cebulak 2012)? At the same time as managing these tensions, students have the task of learning to be psychologically present for women alongside the elemental emotions evoked by birth. The midwife's role involves becoming a psychological container of powerful feelings for a mother and providing a safe space for her to process her anxieties (Taylor 2010). For student midwives, when relationships worked well, which they did when students experienced continuity and support from clinical mentors, both the student and the mother experienced support and containment.

Students talked passionately about empathising with women and there was often an intense mirroring relationship between women and students.

Although there were instances of appropriate containment for mothers and students as discussed above, this powerful empathy felt by student midwives for the women was generally difficult to regulate in a busy obstetric unit and increased students' vulnerability:

They (the women) are the people I feel I can trust to be honest - (laughs) but you don't want to get too close because ultimately somebody might come in and do something that will really hurt them and I've got to emotionally back away from that then. So you are kind of in a bit of a no man's land with that, it's strange really (M1)

When women suffered unnecessarily, participants felt that they had betrayed them and were wounded by this:

I just thought if she spoke English none of that, it probably could have happened to her but she wouldn't have been treated the way that she was treated and I…I…felt really bad that it happened and I do (tearfully) blame myself for not stopping it really …(M1)

This is 'moral distress'; defined by Jameton in 1984 as negative feelings that arise when one knows the ethically appropriate response but is unable to carry it out due to institutional constraints. There is a difference between distress and moral distress – for example a student could be emotionally distressed from witnessing a traumatic birth, but feel morally distressed if the trauma was caused by or exacerbated by health professionals (for example through disrespectful treatment), and the student felt unable to advocate for the women. Often this might be a woman with whom the student strongly identified, as in one of her own continuity caseload (NMC 2009). In these situations students described feeling voiceless and complicit in betrayal of women. Some students described their fear of speaking out for themselves and what they believed to be right:

It does mean that you are powerless even though you know and you have been told, read, that evidence is, that you should treat certain conditions with certain behaviours this way, or women labour better standing up, these sorts of things. Even if you say that, even if you can convince a midwife to do that sort of thing she can pull the rug straight out from underneath you… can be easily dismissed. (M1)

and it's quite hard to witness that on a daily basis and not feel you can do very much. (M8)

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 .(M6)

Students in this study were working long hours, often without breaks, in situations where they had little control over events. Feeling powerless, allied to the close relationships they formed with women may have amplified their vulnerability.

Emergency and unforeseen situations

The intense empathy students felt for women rendered them particularly vulnerable in emergency situations. In the quote below, the student included herself in the familial 'we':

And they were both crying, and I said "Can I hug you?" And she said "Oh please, yeah please, will you hug me?" and I gave the dad a hug and I was just like "I don't know what happened, but I'm just so sorry". And they (the parents) said, "Well we've not got a name for a little xxx" and I was like, "Right ok, so we've got to have a name, can't leave without a name…" (M10)

The students who had faced clinical emergencies they had found traumatic described long periods of doubt and worry about their role in events

I was … wanting answers to why it happened you know, because she had no risk factors for it, so I didn't quite understand why it happened and I think it changed my practice a bit because I was wary; everyone I had I was wary, is something going to go wrong? and it kind of made me withdraw from what I love doing. It took quite a while to get back to normal and just accept that. (M3)

Witnessing trauma affected students' confidence to perform their day-to-day duties. For some there was a fear of revisiting places or activities that recalled the event.

Still terrified of being in a labour room on my own really. I know like when we talk about one- to- one midwifery my initial reaction is absolutely not. …I do think this has impacted on how I felt because before that I was...they could stand at the door you know leave us alone it's normal… and from that it was actually, I quite like that emergency buzzer there. (M9)

When they encountered traumatic events, there was little time or safe space in the institution in which to reflect and learn from them. Formal support for the student's emotional wellbeing in practice was rarely depicted as adequate. Similarly to the midwives discussed in Sally Pezaro and colleagues' (2016) exploration of midwives' traumatic experiences, midwives appeared to carry on and soak up difficult events without access to others. A culture of silence was the norm and this

heightened participants' self blame and sense of being emotionally inadequate. The sense of self blame was exacerbated in a blame culture:

it was all about, blame…(…) it turned from being traumatic to this real resounding emotion of fear – it was tangible – you know, who's done it, whose fault is it, who's to blame, … who's to blame? And that, that also put me off midwifery a lot, cos where I felt like it's a caring profession we'd rally round, it was then more finger-pointing…(M5)

Students are likely to be vulnerable as they go through the journey of socialisation into a profession dealing with life and death (Werner and Korsch 1976). The student midwives in our study were rendered particularly vulnerable because of the passionate empathy they felt with the women in their care, reinforced professionally but played out within an institutional framework that largely denied the possibility of authentic caring relationships. They felt hurt when women were hurt, and they also spoke of blaming themselves when things went wrong, feeling that they should have been able to protect the women.

Conclusions

The attempt to provide relational care in an organisation geared towards a business-style mode of management results in a psychic burden for practitioners. Student midwives have particular vulnerabilities due to the intense empathy they feel for women, coupled with their relative powerlessness as learners in a hierarchical sysyem. Traumatic events they recounted took place within a litigious and blaming culture, where there were staff shortages and a lack of spaces for midwives and students to make sense of traumatic events together. To begin to address this damaging complexity, midwifery educators need both a psychological language as well as political understandings with which to promote discussion of the tensions that will inevitably arise for student midwives. Ultimately institutional ethics must be prioritised, and compassionate cultures nurtured to potect practitioners and patients alike. This will require abandonment of the business model as fundamentally incompatible with healthcare. Recognition and valuing of the midwifery role is imperative if the next generation of midwives is to possess the strength and self-awareness to to be authentically present for childbearing women.

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