Traumatisation in staff

Traumatised maternity staff

- Indirect trauma exposure in a professional context
- Secondary traumatic stress (intrusions, avoidance, arousal)
- 85% were exposed to traumatic birth
- More medical errors, less empathy, intention to leave the workplace, more absenteism

Schroder, Jorgensen, Lamont & Hvidt, 2016; De Boer et al., 2012

Courtesy of Maternity Unit, CHUV

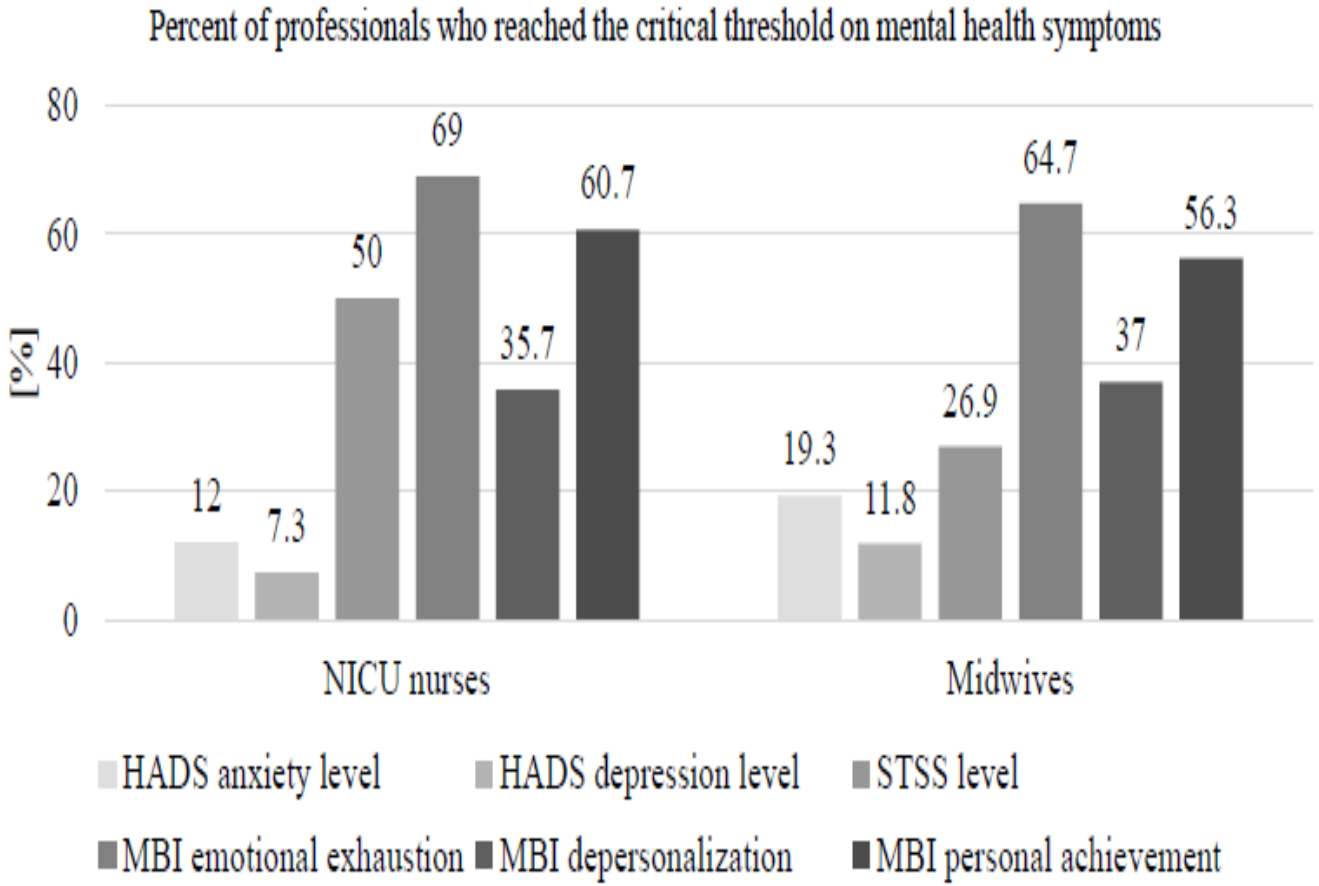
Courtesy of Neonatology Service, CHUV

- regularly manage traumatic births and traumatic perinatal loss events
- principal fears are related to death, medical emergency and being the cause of a negative birth experience
- high empathy is associated with a higher risk of PTSD

- intensive care staff regarded as particularly vulnerable compared to other healthcare professionals
- frequent acute stressors, such as dealing with dying and with death and responding to critical situations
- Often little time to recover between traumatic events

Mackin & Sinclair, 1998; Knezevic et al., 2011; Blaaka & Eri, 2008; Hunter, 2004; Kalicinska, Chylinska, & Wilczek-Rozyczka, 2012; Mollart, Skinner, Newing, & Foureur, 2013; Sheen, Spiby, & Slade, 2015; Sheen, Slade, & Spiby, 2013; Dahlen & Caplice, 2014

- high levels of secondary traumatic stress, burnout and anxiety symptoms
- NICU nurses had more secondary traumatic stress but less anxiety symptoms than midwives
- no sign group differences concerning burnout
- 46% of work-related stressors are traumatic



Favrod et al., 2018

	Traumatic situations		Non-traumatic situations	
	NICU nurses	Midwives	NICU nurses	Midwives
Working environment	Resuscitation in the delivery room of a newborn at term (in connection with poor management of childbirth)	A long and significant deceleration of the fetus' heartbeat during the ultrasound without the possibility of calling for help or stopping the current examination because no nearby alarm	Unable to support (help) patients and especially the parents for lack of time	Lack of staff for emergencies
Nursing/ midwifery care	Emergency intubation - very difficult	Neonatal resuscitation	Fear of having to take care of a case that is too difficult, not to be in control of the situation, not to observe important signs that should make me worry about the state of health of the patient	Shoulder dystocia
Dealing with death and dying	Death of a term baby due to asphyxia	Maternal death	_	_
Case management	Resuscitation of a child of 6 months, deceased (child shaken by the father)	Death threats made by the husband of a patient giving birth	A parent who becomes aggressive	Having to manage a complex patient living in social and psychological precariousness
Others	Massive digestive haemorrhage when working with adults	_	Clinical teaching (teaching and evaluation at the same time)	Waiting to manage a situation that was announced without being able to act (receiving a telephone call and waiting that the patient arrives)

Favrod et al., 2018

Adverse outcomes

Midwives and obstetricians:

- Worry about the patient and about being blamed
- Worry about reaction from peers
- Worry about an official complaint
- Feeling guilty
- Existential considerations

Schroder, Jorgensen, Lamont & Hvidt, 2016

events in which the infant or the mother suffered presumed permanent, severe and possibly fatal injuries related to the birth

The following statements are about your experiences after the traumatic childbirth. How do you agree?	*n*, All
1. I have become a better midwife or doctor due to my experiences from the traumatic birth	Agree: 51.5%
2. The event gave rise to personal development opportunities of an emotional and/or spiritual character	Agree: 33.9%
3. In the beginning I felt guilty that things turned out the way they did	Agree: 33.8%
4. I will always feel some sort of guilt when thinking about the event	Disagree: 34.0%
5. Comments or behavior from one or several colleagues caused more guilty feelings and/or lower self-esteem	Strongly disagree: 57.3%
6. The traumatic event has made me think more about the meaning of life	Agree: 36.8%

Schroder, Jorgensen, Lamont & Hvidt, 2016

Support for the individual

- Strategies to manage anxiety linked with maternal death
- Psychoeducation about early reactions
- “Debriefing” in a blame-free environment
- Regular screening for psychopathological symptoms and access to professional help if necessary
- Address feelings of guilt and shame and provide opportunities for posttraumatic growth

Staff support at the organisational level

- Give staff time to recover in-between frequently occurring traumatic events
- Trained peer support/buddy system at work, e.g., adapted version of Trauma Risk Management (*TRiM*)
- Increase organizational resilience, e.g., adapted version of *SPEAR*: peer support for organisational resilience (not trauma-focused)

Jones, Burdett, Green & Greenberg, 2017*;* Jones et al., 2018

Trained peer supporters

- Healthcare professionals prefer colleagues or supervisors to provide support but barriers

What should trained peer supporters do?

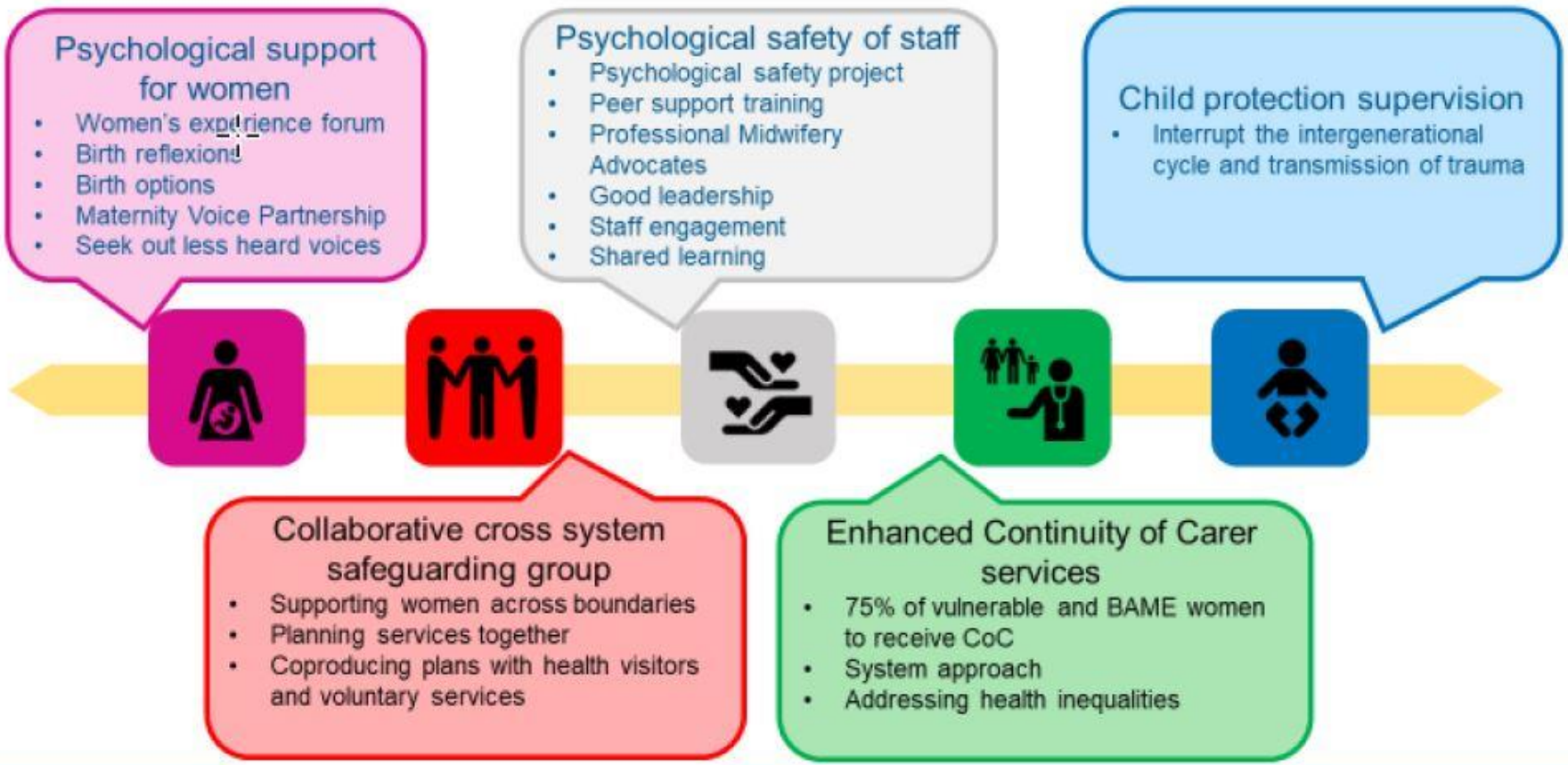
- Provide an empathetic, listening ear
- Provide low level psychological intervention (psychoeducation, normalising)
- Identify colleagues at risk
- Facilitate pathways to professional help

Hu et al., 2012; Creamer et al., 2012

Example of trauma-informed care

Caring well for women and staff in Maternity Services, Gloria Rowland, Director of Midwifery

Supporting implementation of trauma-informed care in the perinatal period



Caring well for women and staff in Maternity Services, Gloria Rowland, Director of Midwifery

Enablers

ELLMS EAST LONDON LOCAL MATERNITY SYSTEM

East London Health & Care Partnership

COLLABORATION

- Working together with health visitors, voluntary organisations and service users to improve the services

COMMUNICATION

- Facilitate Women's Experience Forum
- Facilitate service improvements work streams

TRAINING

- Ensure that standardised training is available across the system by outsourcing

AUDIT AND EVALUATION

- Ongoing quality assurance to ensure equitable services are available across the system

ENGAGEMENT AND COPRODUCTION

- Engaging with services and service users to coproduce services that are fit for purpose

FUNDING

- Finance system wide training for peer support

Conclusion

- Women and partners with history of trauma have specific risks and needs and care needs to be adapted to this
- Guding principles:

1) Compassion and recognition
2) Communication and collaboration
3) Consistency and continuity
4) Recognising diversity and facilitating recovery

- Traumatised maternity staff also need support and this needs to be integrated into organisational approach
- Trauma-informed care may interrupt the intergenerational transmission of trauma

Key sources

Seng, J. (2015). *Trauma informed care in the perinatal period*. Dunedin Academic Press Ltd.

Law, C., Wolfenden, L., Sperlich, M. & Taylor, J. (2021). *Trauma-informed care in the perinatal period.* Commissioned by NHS England and NHS Improvement.

Illustrations:

Artwork by Amanda Greavette

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https://womenshealthtoday.blog/2017/08/24/why-trauma-informed-care-needs-to-be-our-standard/

https://www.kingsfund.org.uk/publications/creating-space-compassion-empathy-learning

https://medium.com/@auldyn.matthews/from-empathy-to-compassion-an-evolution-in-ux-3a56d4b31be9

https://metro.co.uk/2020/03/24/black-women-neglected-12406357/

https://www.theguardian.com/commentisfree/2016/mar/21/secret-life-midwife-factory-maternity-ward

Thank you for your attention

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