INTRODUCTION

Approximately one in two hundred births in the UK result in stillbirth and approximately one in four hundred babies die within the first four weeks of life (Office for National Statistics, 2015). Those mothers who experience perinatal loss (as a result of childbirth) have considerable emotional and psychological needs (Mills, 2015). Bereaved parents' interactions with health professionals often have a profound effect on their capacity to cope with their loss, and this may have consequences if patient care is poorly managed (Downe et al., 2013). While many student midwives may have some experience of dealing with death during pregnancy or childbirth (Mitchell, 2005), midwifery education and textbooks have been shown to fall short of providing essential ‘practical’ information regarding perinatal loss and the management of bereavement for families (Cameron et al., 2008). As a result, midwifery students may not have the necessary skills to guide parents through this difficult time and may themselves be vulnerable to grief (Cameron et al., 2008).

The role of the midwife is to provide open and honest communication to parents while offering guidance and support following a perinatal loss (Roehrs et al., 2008). This can cause considerable stress and anxiety for midwives who report that caring for families experiencing a perinatal loss is makes them feel vulnerable (Wallbank and Robertson, 2013). Caring for women with perinatal loss often takes a significant toll on the psychological well-being of midwives, including student midwives (Leyland, 2013).

Despite guidance being available for midwives on the management of families who have experienced loss (Avelin et al., 2013), there is a limited research which explores the experiences of student midwives when caring for parents with a perinatal loss (Gerow et al., 2010). This is problematic, as understanding the experiences of student midwives and their perception of how difficult situations are dealt with, can

predict levels of confidence and behaviour as future practitioners. (Mitchell, 2005). Professional experience and experiential learning may be a protective factor for health professionals in coping with grief and loss (Wright and Hogan, 2008). However, student midwives are less likely to have this level of clinical experience, or to have developed advanced coping strategies in dealing with perinatal loss, therefore may be more affected by loss than those practitioners with more clinical experience (Fenwick et al., 2007).

BACKGROUND

Understandably, when a baby dies most of the focus of care is on the grieving parents. However, those who are involved in the care of the mother and child may also feel grief and distress (Brunelli, 2005). The feelings of staff involved in the care of bereaved parents are often ignored or inadequately dealt with resulting in long-lasting ramifications, especially for those who are in training or who have no previous experience on this aspect of maternity care (Puia *et al.*, 2013).

Midwives aim to form close personal relationships with women during pregnancy, birth and postpartum and as a result play a significant role in providing emotional support to mothers and families following perinatal loss (Wallbank and Robertson, 2013). However, some midwives may attempt to protect themselves emotionally from the burden of perinatal loss through maladaptive coping styles such as self-blame, disengagement, and denial (Wallbank and Robertson, 2013). Studies have shown that student midwives may be left to deal with negative feelings themselves, and may be given very little if any opportunity to work through and acknowledge the grief they may be experiencing (Wallbank and Robertson, 2013, Lee and Dupree, 2008).

A phenomenological study using diaries and interview data indicate student midwives were not confident in their ability to communicate properly with grieving parents (Begley, 2003). For example, students reported being so overcome with emotion that

they were unable to support parents. Often students believed that they needed support as much as the affected family (Begley, 2003). Student midwives' experience of caring for bereaved families resulted in feelings of distress, guilt and anxiety regarding their competence to offer appropriate care (Begley, 2003). In a study by Begley (2003) student midwives experience of bereavement care was strongly related to training and to the support they received from senior staff in the clinical area. However, the study also indicates that many students received only minimal training in caring for parents following bereavement, with a very limited focus on personal coping (Begley, 2003).

This current study aims to explore the experiences of student midwives in the care of women with a perinatal loss, the support they receive when caring for women and the impact this experience might have on them as midwives of the future. There is limited research exploring student midwives' experiences in dealing with bereavement and the availability of training and support to help develop the skills needed to be most effective.

THE STUDY

Design: The aim of this study is to explore student midwives experience of caring for women with perinatal loss. A qualitative approach was adopted as this allows an exploration of the personal meanings and experiences of midwifery students in the care of parents following a perinatal loss (Neuman, 2005).

Method:

Two focus groups were conducted, composed of ten final year student midwives who were completing a BSc (Hons) Midwifery programme in a UK Higher Education Institute. Focus groups were an appropriate method of data collection as they allowed student midwives to interact in a group setting while facilitating a more detailed discussion of topics (Kidd and Parshall, 2000). Focus groups aim to mimic

the social context in which the topic under investigation occurs, therefore can be more representative of the environment in which students experience training and education[1 1] (Kidd and Parshall, 2000). Focus groups provide a different type of data to other types of data collection used in qualitative research, for example, one to one interviews in that they allow an interaction and synergy between focus group members.

Focus Group Discussions

Convenience sampling was used to recruit final year midwifery students. A total of ten student midwives participated in two focus groups. Students recruited to the study were those completing both pre-registered and direct entry midwifery programmes (see Table 1). The study was introduced to students via a short presentation along with written information. Final year students were recruited to the study as these students often have considerable exposure to clinical practice and also recent learning of current theory related to midwifery practice. Those students who expressed an interest in the study were asked to select, a preferred date and time to attend the focus group from one of two options.

As the focus of the study was to explore student midwives experiences of bereavement care, a requirement for the study was that participants had some experience of caring for a women with perinatal loss the This included stillbirth, neonatal loss, termination of pregnancy or miscarriage. Discussion of students during the focus group was generated using a series of semi-structured questions. Each focus group took place in a private room in the University campus and lasted approximately fifty to fifty-five minutes. A light lunch was provided for students during the group discussion.Ground rules for the focus group were established prior to the discussion and students were advised of the support they could access if they

1. [1] While the authors are aware of the debate concerning student midwives in receipt of training or education and the implications of this, for the purpose of this article these terms are interchangeable.

required support or counselling. Focus group discussions were audio-recorded and transcribed to enable a robust analysis of the data. In order to maintain confidentiality any information that might reveal the identity of those students who participated was removed from the transcripts.

Ethics

The study was approved by the University Ethics Sub-Committee at the host institution. Written informed consent was obtained from each student prior to the focus group.

Analysis:

Data analysis was performed using a process of thematic analysis Initial phase of the analysis involved a reading of the complete transcripts followed by identification of key words and phrases (codes), as they relate to the aims and objectives of the research. Once this process was completed for both transcripts, the codes were organised into overriding themes. These themes were then compared with the original transcripts to ensure accuracy and that data distortion had not occurred (Clarke and Braun, 2013).

The findings from analysis of the data were reviewed and checked by the second author (PJ) for consistency. Throughout the study, various strategies were employed to ensure the credibility and trustworthiness of the study was maintained. This included memo keeping and keeping a reflective diary throughout the study. To avoid bias that might influence findings, quality checks were conducted by the second author and this included comparison of findings from analysis of the focus group data from both researchers (Creswell, 2009).

RESULTS

.Four themes were identified from an analysis of the focus group data. These were (1) Preparation for perinatal loss; (2) 'just dealing with it'; (3) Contradiction and challenges with the role of the midwife, (4) emotional impact and coping strategies.

Preparation for perinatal loss

Many students reported being unprepared in caring for grieving parents and students appeared unconfident in how they should care for parents with perinatal loss.

"You're not prepared for it...you don't want to say 'oh, hello, how are you?' How do you think they are? You know, you can't say that. It's really difficult...because you don't know what to say when you walk in there, you know?" **(Jay, FG2)**

Another student reported;

"I don't think you are ever prepared for something like that [bereavement]" **(Abby, FG2)**

Participants acknowledged that it might be difficult to prepare adequately for a perinatal loss because the experience was different for every woman and required individualised care. Although students reported having lectures and group seminars as part of their midwifery training, they often identified a lack of clinical experience in caring for women, and this contributed to their lack of confidence. Student midwives believed that more "hands on" experience in caring for women would enable them to provide more effective care. This was exemplified in the following quote*:*

"Interviewer: What would help you kind of overcome the situation?

Andrea: Experience [clinical experience].

Interviewer: Experience, yes. What kind of experience?

Andrea: To deal with this situation more often. More experience [clinical experience] in dealing with this situation." **(Andrea, FG1)**

Despite recognising the benefits of clinical experience in caring for women with bereavement, students were often discouraged by mentors from participating in the care of bereaved women care. Student midwives reported being told to focus instead on caring for women with uncomplicated pregnancies.

One student reported;

"It's difficult to get the experience because we often are kept out of the room by the preceptor when a mother has had a stillbirth or neonatal death…" **(Abby, FG2)**

Students, therefore, believed the practical clinical experience was a key to enhancing their ability to cope with bereavement care. Practical experience was believed to be more important in improving student midwives confidence than formal didactic learning. The best way to learn about bereavement care and the appropriate manner with which to respond to women was, as with many clinical situations, through direct observation and participation in that experience.

"Just dealing with it."

Providing support to women and families following a perinatal loss, while distressing for students, was considered by many to be part of the transition to becoming a midwife. Being able to cope with, and respond to, stressful and challenging situations was believed by these students to be part of the role of midwife. Several students believed that being able to cope with traumatic situations, including bereavement was character building.

One student reported

"I think that sometimes [a difficult situation] comes with the job that you are in, [for example] situations which make you [feel] uncomfortable…and you just [have to] deal with it." **(Abby, FG2)**

And another

"I think if you make it to the end of your third year, and you have had an experience like we have had, then you're built to be a midwife." **(Jay, FG2)**

There was a strong belief that dealing with challenging situations such as bereavement and loss were part of a midwives professional identity and role. It was sometimes believed that dealing with challenging situations, such as bereavement, strengthened a student's ability to cope with what was often a difficult and demanding role. Being able to cope with stressful situations was seen by some students as a "rite of passage" in becoming a midwife.

Contradiction and challenges with the role of the midwife

Role contradiction and helplessness

Students experienced difficulties in making the adjustment from caring for a woman with a healthy pregnancy and live baby, to caring for a bereaved woman. Students described this as a contradiction in the role that was difficult to reconcile. Students commented that instead of "being busy" carrying out their normal role of helping mothers bond and care for their newborn baby or unborn child during pregnancy; perinatal loss changed that role to a one of inactivity. Students reported that they preferred to keep busy and felt awkward in the mother's room unless they were actively engaged in some activity. When caring for a woman with a perinatal loss the need for activity was reduced because of the absence of the baby or unborn child.

"I think we are used to moving around, and you are now sitting there and not doing anything." **(Graca, FG1)**

When students cared for bereaved women and families, they remained uncertain about their role and unsure about how to behave. Part of the difficulty was the role conflict they experienced in dealing with death and loss when their usual role was

concerned with assisting birth and new life. The main difficulty appeared to be adjusting to the needs of the mother who has lost her baby and being able to adapt and provide the significant level of support they will need.

Communication

Participants described themselves as being preoccupied with routine care, for example completing paperwork or taking routine vital signs when caring for a bereaved woman because they were unclear and unsure how to communicate with bereaved parents and families. Students were concerned they might say "the wrong thing" (**Andrea, FG1)** and this was believed would have negative impact on the experience of the bereaved women and her family.

One student commented;

"Yeah, because it's the first time I didn't really know [what to say]…you just don't really know what to say...you say something, and it sticks to them, and you think…oh, they're going to remember you said that." **(Karima, FG1)**

Another student reported:

"We sort of throw it [conversation with bereaved family] onto the bereavement midwife." **(Jay, FG2)**

Students' perceived inability to effectively communicate with bereaved parents resulted in considerable self-doubt and created a barrier to developing an effective and trusting relationship.

Emotional impact and coping strategies

Students did not identify perinatal loss as always traumatising, and some types of loss were considered more difficult to deal with than others. For example, caring for a woman who was in the second or third trimester of her pregnancy and had suffered

an intrauterine death was more difficult for a student than caring for a woman whose pregnancy was in the first trimester of her pregnancy.

"…it was quite hard to kind of separate the fact that she was visibly pregnant and that her baby has passed away. It was quite hard to see that." **(Karima, FG1)**

A second student explained how she felt when asked to care for a woman in labour with an intrauterine death.

"….when I was told I was going to be in with that labouring lady with an IUD it scared the life out of me because I've only ever dealt with babies being born alive. I just started to feel a bit scared and panicky when I knew I was going to be going in and delivering a dead baby, I got really anxious and panicky. So when they said she didn't want as student, I kind of felt a bit relieved. I though oh God, thank God…." **(Jay, FG2)**

Student midwives acknowledged that that bereavement care was difficult and that they were affected in providing care to women after perinatal loss.

Making sense of bereavement

Students believed feeling sad or upset after the death of a baby to be a natural reaction regardless of the level of experience or preparation they might have.

"I don't know, but it's just…it's normal to think when a baby dies that it's sad to see the mother holding the baby..." **(Andrea, FG1)**

Caring for women and families was believed less stressful when students had known the women and their families for only a short period, and strong attachments had not been made. This resulted in a lower emotional burden and stress for the student midwife. However, student midwives expected to feel sad as a normal reaction was a significant coping mechanism.

Self-reflection and reflection on practice

The ability to reflect on clinical practice is an important part of experiential learning. Self-reflection leading to self-awareness was a strategy used by most student midwives when coping with bereavement and loss. Students in both focus groups believed self-reflection, either with a mentor, friend or alone, were beneficial for experiential learning and increasing self-awareness.

One student commented

"We have an opportunity to talk about it when we come back from clinical placement, and we talked about it in class." **(Karima, FG1)**

And another student reported

"Yeah, just debrief with someone that's the best way. They don't have to say anything, just be quiet." **(Asma, FG2)**

In conclusion, self-reflection was a coping strategy recognised and used by some student midwives as a coping strategy in the care of bereaved women.

Maintaining life and work balance

Separation of events at work from private life was another coping strategy employed by student midwives when caring for bereaved families.

One student said;

"I leave my work at work, and then I tend to carry on with my normal life to separate my personal from my work life. These things happen so you try to move on." **(Graca, FG1)**

Being pragmatic about both their limitations and their abilities in caring for bereaved families was an important coping strategy for student midwives. Achieving a good work-life balance was intrinsic to that process.

DISCUSSION

The aim of this study was to identify the experiences of final year student midwives in the care of women with perinatal loss. Findings indicate students often felt unprepared and uninvolved in the care of bereaved families in comparison with other aspects of their training. Although being able to deal with difficult situations, including perinatal loss was believed to be an important “rite of passage” in the transition to becoming a midwife, students were often excluded from caring for such women. Students believed that learning how to care for women with a perinatal loss was best achieved through placement with a bereavement midwife.

One of the difficulties encountered by students in caring for bereaved parents was role contradiction. Students sometimes struggled with the different skills needed in caring for a bereaved woman as opposed to caring for a woman with a healthy pregnancy and baby. Students believed they would be affected by a bereaved women’s’ experience, however, believed maintaining a good work-life balance and reflecting on practice either alone or with another person were helpful in coping with what was inevitably a stressful experience.

Maintaining psychological well-being

Previous studies indicate that health professionals often develop coping strategies to manage emotionally challenging situations at work, particularly when coping with death and bereavement (Gold et al., 2008; Erlandsson et al., 2013). Achieving balance between compassionate and empathetic care while maintaining clear professional boundaries is believed to be an important aspect of professional practice (Wuthnow, 2012). In the current study, student midwives recognised they would

experience grief and sadness when caring for women; however, the majority of students adopted a pragmatic approach in bereavement care through maintaining a good work-life balance and through reflecting on practice either alone or with colleagues.

Communication with bereaved parents

Communication is an important aspect of care and communication skills are designated as one of the essential skills clusters that student are required to achieve in their midwifery training. The NMC Standards for pre-registration midwifery education state that students must demonstrate appropriate interpersonal skills to support women and their families. Communication also includes providing care that is warm, sensitive and compassionate as well as listening to women and helping them identify their feelings and anxieties (NMC 2012).

Inability to communicate with grieving parents was a major difficulty identified by students. Student midwives believed they did not benefit from being shielded by mentors and others from caring for bereaved women and families. Student midwives believed this hindered development of their communication skills and left them unprepared to achieve the essential skills competencies required for NMC registration (NMC, 2012). The findings from this study would indicate a serious discrepancy in the training of student midwives in standards of effective midwifery practice and would suggest more emphasis is needed on developing the communication skills of student midwives particularly concerning issues of bereavement.

Impact on future role as a midwife

Being able to cope with difficult and stressful situations was recognised as an important part of being a midwife (Allchin, 2006). Some students believed that coping

with issues around bereavement was a “rite of passage” and a test of their suitability for their future role as a midwife. There is a concern that those students who find it difficult to cope with traumatic situations will have difficulties completing the programme, and may leave them with dissatisfaction and unresolved issues if not addressed efficiently (Fenwick 2007). Additionally, those student midwives who have not receive adequate training and support in dealing with perinatal loss may experience, psychological trauma resulting in mental health difficulties (Begley, 2003). Effective training in the care of women with bereavement and management of this particular aspect of midwifery care would, therefore, seem crucial in maintaining the health and welfare of midwives of the future.

There was a feeling amongst student midwives that either they had developed coping strategies as part of their practical training, or had a natural aptitude to cope with difficult situations. It may be more important to focus on providing support to students at an early stage of their clinical training rather than adopting a process of “whittling”, due to natural selection (Ness et al., 2010). This is an important point as a reaction to an experience of perinatal loss is highly dependent on the situation itself, as well as the intrinsic coping mechanisms of the student (Allchin, 2006), and coping strategies can be learned.

Salutogenic model in maternity care

There is growing interest in the use of salutogenic theory in maternity care (Perez-Botella et al. 2015; Sinclair and Stockdale, 2011). Salutogenic theory suggests the role of professionals involved in health promotion is to provide options that enable people to make sound choices about their health while increasing awareness of determinants of health and enabling choices to be expended. Through a process of problem-solving, identification of both internal and external resources for resistance and of a collective sense of coherence (comprehensibility, manageability and

meaningfulness) salutogenic theory promotes and enhances positive states in an individual's health (Lindstrom and Erikson, 2006).

Students in the current study were often anxious concerning their lack of knowledge and lack of interpersonal and communication skills in bereavement care. Many of these deficiencies in practice might feasibly be addressed by adopting a broad framework of the salutogenic theory of care whereby students are able to focus on health promotion, well-being and empowerment of bereaved women rather than seeking iatrogenic or other models of care (Perez-Botella et al., 2015).

Limitations

This was a small, self-funded project conducted over a limited period of time when many student cohorts were on annual leave or in clinical practice. Since recruitment was dependent solely on access to students during their university placement, agreement from students to participate in the study was often difficult. Additionally, students were sometimes reluctant to participate in focus groups due to pressures of academic work. It is important to speculate that the reticence of students might be because they did not fit the criteria for participant selection, that is, they had no prior experience of perinatal bereavement. Conversely, those who did put themselves forward and were comfortable taking part might have developed effective coping strategies in dealing with these experiences. These caveats may have affected the generalizability of the findings to the wider population of student midwives.. However, the ten student midwives who did participate in the focus groups generated vibrant and interesting discussions which provided rich and insightful data therefore the initial problems with recruitment were not seen as problematic.

There was a broad range of loss contexts used in the inclusion criteria for respondents. These included miscarriage and termination of pregnancy. While the authors were aware that these inclusions might attract some speculation, it was felt

that all women regardless of gestation or reason are enormously affected by perinatal loss and consequently this must impact on students' experience of caring for all women who have had this experience.

Conclusion

Focus groups were conducted to explore final year student midwives experiences of caring for bereaved women and families. Four themes were identified from the data, these were, preparation for perinatal loss, ‘just dealing with it’, contradiction and challenges with the role of the midwife and emotional impact and coping strategies. Student midwives felt inadequately prepared to deal with perinatal loss and requested more “hands on” clinical experience in caring for bereaved women and families. Students expressed difficulties in communicating with bereaved families which was further exacerbated by their perceived lack of contact with such families. Although students adopted strategies which allowed them to cope with bereavement care, the support that students were able to access and the strategies they adopted required further exploring. Finally, the beliefs of some students towards their ability to cope well with a stressful situation as being indicative of their suitability to practice might also require some further exploration. A larger study involving more diverse groups of students from a range of backgrounds is recommended with the possible inclusion of views from midwifery educators and clinical mentors in the analysis.

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