

Nursing students' experiences of caring for women with stillbirths at public hospitals in Gauteng Province, South Africa

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Abstract

Nursing students are expected to support women after a stillbirth, while they themselves experience difficulties to deal with the emotional impact of a stillbirth. The objective of this article is to explore and describe nursing students' experiences of caring for women with stillbirths at public hospitals in South Africa. A qualitative approach was used to conduct a descriptive, explorative and contextual study. The population consisted of all nursing students registered for the Diploma in Nursing allocated to the obstetric sections of five public hospitals in Gauteng Province, South Africa. Purposive sampling was used to select 30 nursing students who had taken care of women who experienced stillbirths. Five focus groups and reflective journals were used to collect data. Data was analysed according to Tesch's method by the researcher and an independent coder. Psychologically nursing students experienced emotional trauma and overwhelming feelings of guilt, helplessness, and anxiety. They struggled with emotional conflict related to the expression of compassion and were faced with certain dilemmas in caring for women after stillbirths. Recommendations were formulated to make provision for availability of bereavement and emotional support of nursing students when exposed to stillbirths.

Keywords: Nursing student, stillbirth, bereavement, obstetric nursing care.

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Introduction

Childbirth is a process concerned with new life, hope, joy and expectation. Stillbirth results in grief and emotional trauma and affects not only the parents, but also significant others and caregivers (Cacciatore & Bushfield, 2007; McCool, Guidera, Stenson & Dauphinee, 2009). A stillbirth is defined as a fetal death at the gestational age of at least 28 weeks or 1000 g birth weight. This definition is recommended by the World Health Organisation (2004) for purposes of international comparison.

Globally at least 2.6 million stillbirths occur each year (Lawn, Blencowe, Pattinson, Cousens, Kumar, Ibiebele, Gardosi, Day & Stanton, 2011; WHO, 2014). The incidence of stillbirths vary greatly, for example, in high-income countries, the rate per 1000 births is below 5 (Lawn, Kinney, Lee, Chopra, Donnay, Paul, Bhutta, Bateman & Darmstadt, 2009), while the average number

of stillbirths in South Africa is 23 per 1000 live births, a growing healthcare concern (Stevens, 2007).

Stillbirth is an emotionally devastating experience and parents may experience long-lasting grief as they struggle to find meaning in the event (Cacciatore & Bushfield, 2007). Bereavement should be sympathetically acknowledged by healthcare professionals and women should be provided the opportunity to express their emotions (Pullen, Golden & Cacciatore, 2012). Caring for a woman after stillbirth is one of the most challenging practice situations. Women react in complex and different ways to the loss which might be just as painful to the healthcare professional (McCool, Guidera, Stenson & Dauphinee, 2009; Kelley & Trinidad, 2012; Friedman & Bloom, 2012). Nurses experience a stillbirth as a traumatic event (Puia, Lewis & Beck 2013), some may go through a period of grieving (Jones, 2012; Jonas-Simpson, Pilkington, MacDonald & McMahon, 2013), or experience clinically significant levels of distress, especially when they practice negative coping styles and lack personal support (Wallbank & Robertson, 2013). Similarly, a South African study (Modiba, 2008) found that healthcare professionals experienced difficulty to cope with the emotions associated with stillbirths and needed to develop adaptive coping strategies and explore their experiences of loss.

The South African Nursing Council (SANC) Regulation R425 (1985) requires that nursing students pursuing the four-year diploma course for registration as a general nurse and midwife should be allocated to an obstetric unit for 1000 hours to gain clinical learning experience in midwifery (Gauteng Nursing Colleges, 2002). During this period it is likely that nursing students will witness the trauma of a stillbirth and will be required to remain with the bereaved woman to render support. From involvement in midwifery as a practitioner and clinical facilitator, the first author has observed that nursing students are not emotionally prepared to deal with the trauma of a stillbirth. Their insecurity may manifest itself as anxiety which may have an effect on their clinical performance (Moscaritolo, 2009).

Nursing students' struggles to cope with stillbirth has not been sufficiently addressed in the practice setting and in research. An Australian study (McKenna & Rolls, 2011) explored undergraduate midwifery students' experiences of stillbirth. The students felt ill-prepared when they encountered a stillbirth and the authors concluded that midwifery students require specific preparation and support strategies to deal with such an event. Even midwives feel at times unprepared to support bereaved parents after a stillbirth, especially when they had limited professional and personal bereavement experiences (Chan, Lou, Zang, Chung, Lai, Cao & Lu, 2007).

Stillbirths, as well as the parents' loss and emotional responses, pose unique challenges to nursing students. Nursing students have to cope with their own emotions and provide support to parents, an experience that can have an effect on their academic progress and clinical abilities. The purpose of this research was to explore the experiences of nursing students of caring for women with stillbirths at public hospitals in Gauteng Province, South Africa.

Methodology

A qualitative design was used as it allowed the researcher to explore and describe nursing students' experiences on stillbirths in-depth (Polit & Beck, 2012).

Participants

The participants comprised nursing students registered for the Diploma in General Nursing and Midwifery at a specific nursing college. These students are allocated to obstetric sections of five public hospitals in Gauteng Province for midwifery practice from their 2nd year, so all students from the 2nd year and higher were invited to participate in the study.

Population and sample

The nursing students described under the previous heading comprised the target population for the study. Students who had taken care of women after stillbirth deliveries and were willing to participate in the study were purposively selected.

Sampling procedure

Purposive sampling was used to select 30 students who were exposed to stillbirth deliveries during clinical practice. Data saturation was reached after four focus groups when themes started to repeat themselves. The researcher did one more focus group to ensure data saturation,

Data collection

Prior to conducting focus groups, students were requested to document their experiences of taking care of women with stillbirth deliveries in a reflective journal for a period of six months (Munhall, 2012). A focus group was conducted at each of the five selected public hospitals. A central question was asked: "*How did you feel when you took care of a woman after a stillbirth delivery?*" Probing questions and communication skills such as reflection and paraphrasing were used to allow participants to explore and describe their experiences in-depth. The focus groups lasted 45-60 minutes and consisted of five participants. Focus group proceedings were audio recorded and field notes taken during each group (Polit & Beck, 2012).

Trustworthiness

Trustworthiness strategies were applied; namely credibility, transferability, dependability and confirmability (Polit & Beck, 2012). Prolonged engagement was ensured as group members were given adequate time to reflect on their experiences until no new information emerged. The data were densely described and the researcher discussed the findings with participants (member checking) to ensure accuracy. Triangulation of data collection methods occurred through the use of focus groups and reflective journals. Data analysis was done by the researcher and an independent coder and the findings were supported by participants' direct excerpts.

Ethical considerations

The research proposal was approved by the Research Ethics Committee, Faculty of Health Sciences, University of Pretoria (S123/2011), the Department of Health and Social Development, the management of the nursing college and the public hospitals. Written informed consent was obtained from each participant and the ethical principles of beneficence, justice, confidentiality and respect for human dignity were adhered to (Polit & Beck, 2012).

Data analysis

Tesch's (Creswell, 2009) method of qualitative data analysis was used. The researcher and an independent coder analysed the transcribed focus groups and the data from the reflective journals. The identified themes were developed into categories and the independent coder and researcher agreed on the themes and categories during a consensus discussion.

Results

The demographic profile of participants is summarised in Table 1.

Table 1: Demographic profile of participants (n=30)

Variables	Frequency	Percentage
Gender		
Male	5	17
Female	25	93
Ethnic group		
Black	19	63
Coloured	6	20
Indian	2	7
Whites	3	10
Level of training		
2 nd Year	9	30
3 rd Year	13	43
4 th Year	8	27
Age (years)		
19-24	21	70
25-30	9	30

Two main themes emerged from the data analysis namely, the psychological impact on students and challenges experienced by students (Table 2).

Table 2: Nursing students' experiences of caring for women with stillbirths

Themes	Sub-themes
Psychological impact on nursing students	Emotional trauma Overwhelming feelings of guilt, helplessness and anxiety
Challenges experienced by nursing students	Emotional conflict related to expression of compassion Dilemmas in caring for women after stillbirth deliveries: <ul style="list-style-type: none"> • Provision of comfort to the partner, • Placement of the woman in the post-partum ward • Cultural issues

The psychological impact on nursing students

The following sub-themes emerged from this theme: emotional trauma and overwhelming feelings of guilt, helplessness and anxiety.

Emotional trauma

Participants indicated that they were emotionally affected by the experiences of women who had stillbirths as illustrated in the following excerpt: *“As students we are human and therefore affected by other people’s emotional pain.”* Some participants described the confrontation with the stillbirth as a traumatic event: *“I have always delivered live infants and was severely traumatised by looking at the lifeless body of the stillborn infant.”* Another participant described the emotional effects as a burden worsened by disturbing memories of the bereaved mother: *“For days on end I carried a heavy emotional feeling. Each time I established the reason for the sadness I would visualise the face of the mother who delivered a stillborn infant.”*

Overwhelming feelings of guilt, helplessness and anxiety

Participants were sometimes called to conduct a delivery without being informed that the fetus was not alive. They felt overwhelmed, not knowing how to cope with the situation: *“I felt distressed and overwhelmed that I could not provide the mother and the family with a definite answer when they wished to know what went wrong.”* One participant felt so overwhelmed that she left the delivery room: *“Delivering a stillborn infant without being informed is completely overwhelming. I actually ran away. The professional nurse who was supervising the delivery completed the procedure.”* Participants found it especially overwhelming to deal with the emotional tense atmosphere surrounding the bereaved woman: *“The atmosphere around the bereaved mother was so uncomfortable because I made an attempt to comfort her, but because she was not showing any emotion, neither was she crying, it made me feel that I might not have said the right words”.*

Participants blamed themselves because they felt they could have prevented a stillbirth: *"I blamed myself for not doing enough, and yet I had no idea what I could have done to prevent this."* Some participants avoided interaction with the women. However, this compounded their feelings of guilt in that they were not affording the women the emotional care they deserved: *"I silently performed the post natal checking on the mother but when I got home I felt so bad about the silence and wished I could have said something."*

Participants were filled with anxiety with the thought of facing the bereaved woman: *"I consulted a religious mentor from my church because the thought of facing the mother made me very anxious."* The anxiety affected their functioning, leading to insomnia, for example: *"I had nightmares, couldn't sleep and moved out of the nurses' residence in order to be with family and have company at night."* Continuous reference to lawsuits by professional nurses in the obstetric units contributed to anxiety: *"Professional nurses threatened us with disciplinary action by the South African Nursing Council if a baby is stillborn."*

Challenges experienced by nursing students

Emotional conflict related to expression of compassion and dilemmas in caring for women after stillbirths are sub-themes that emerged from this theme.

Emotional conflict related to expression of compassion

Participants were tempted to acknowledge the bereaved women's emotional pain in a non-verbal way through physical closeness: *"I wanted to sit next to the bereaved mother, comfort her and be there for her like we do at home when a person is bereaved."* However, participants experienced difficulty to express their emotions and show compassion in a professional way. For example, one participant felt an urge to hug the woman, but thought that touching might not be regarded as professional: *"Expressing sympathy without touching did not make sense to me. I tried very hard to resist the temptation of hugging the woman".* Being a male nurse made it even more difficult: *"I wished to hold the woman's hand, but I was not sure if it is professionally acceptable as I am a male."*

Some participants felt compassion and empathy with the bereaved woman, but struggled to apply emotional regulation resulting in them doubting their professional skills: *"I am a very compassionate and emotional person. I always question my skill in comforting a bereaved person because I find myself crying. Will I make a good nurse?"* What they were taught so far, did not seem to help: *"We were taught about emotional intelligence in psychiatry but I could not apply it to the situation."* Looking up to the professional nurses as role models did not help either as one participant concluded: *"Looking at the senior personnel's reaction towards the bereaved mothers I came to a conclusion that compassion in midwifery has died."*

Dilemmas in caring for women after stillbirth deliveries

Nursing students mentioned three dilemmas in caring for women after stillbirth deliveries namely, the provision of comfort to the bereaved woman's partner, the placement of the woman in the post-partum ward and cultural issues.

Participants stated that there seemed to be no consideration for partners of women who had a stillbirth, especially if they were not married. The example set by professional nurses in terms of supporting the woman's partner disillusioned nursing students: *"Grieving partners were given minimal attention as if they were being dismissed."* Especially male nursing students felt isolated: *"There is no emotional place for men in the entire scenario of stillbirth deliveries."*

In some hospitals women who had a stillbirth delivery were nursed in the same room as mothers with live infants, whilst in other hospitals they were nursed in side wards. Both arrangements posed a dilemma for participants because they could not determine which arrangement was ideal: *"Mothers with stillborn infants were nursed in isolation, away from attention"*; *"It seemed unfair for mothers with live babies to be nursed in the same room as mothers who delivered stillborn infants"*.

Participants perceived their young age and gender (in the case of male nursing students) as barriers in the provision of support to women with stillbirths: *"In my culture issues of bereavement are handled by elderly women, therefore the presence of young girls and males were a turn-off for mothers who delivered stillborn infants."* The bereaved women sometimes disregarded nursing students' attempts to provide compassion: *"Some mothers expressed that we are too young to engage in matters of bereavement."* Nursing students themselves experienced discomfort to disregard a cultural taboo: *"I felt very uncomfortable dealing with death because at home young males are nowhere near death-related activities; even when a male is bereaved, elderly women are at the forefront of activities regarding bereavement"*.

Discussion

The findings reflect the psychological impact nursing students experience when they are required to care for women with stillbirths. They experienced recollections of the stillbirth, the "lifeless infant", the "mother's face", in an intrusive way, accompanied by disturbing feelings. These recollections resemble the intrusive symptoms of post traumatic stress, namely, unwanted images of the trauma that may include sensory experiences and may be accompanied by the emotions experienced at the time of the traumatic experience (Taylor, 2006). In a study on perinatal loss by Puia, Lewis and Beck (2013), nurses reported never forgetting a traumatic stillbirth. The memories and impressions left by stillbirths

may increase nurses' susceptibility to secondary traumatic stress. McCool, Guidera, Stenson and Dauphinee (2009) used the term 'critical incident stress' to conceptualise midwives' emotional responses (anxiety and a sense of guilt) to perinatal loss. Critical incident stress can contribute to impairment of daily functioning. The overwhelming emotions experienced by nursing students are supported by Fenwick, Jennings, Downie, Butt and Okanaga (2007) who indicated that providing care to a bereaved mother after a stillbirth has a potential to be an all-consuming, emotional and exhausting event as midwives struggle to deal with their own confusion, shock and distress. Feelings of guilt as experienced by nursing students are evident in many studies exploring the responses of healthcare professional to stillbirth (Gold, Kuznia & Hayward, 2008; Modiba, 2008; McCool, Guidera, Stenson & Dauphinee, 2009; Jones, 2012). Puia, Lewis and Beck (2013) found that nurses questioned themselves about the stillbirth and experienced self-doubt. Healthcare professionals' are expected to save lives and prevent adverse outcomes, and a perceived failure to do so may result in guilt feelings. Healthcare professionals experiencing anxiety after stillbirths are in many cases related to concerns about possible litigation (Gold, Kuznia & Hayward, 2008; McCool, Guidera, Stenson & Dauphinee, 2009). These concerns are a real threat; stillbirths are the number two reason for lawsuits against obstetricians in the United States (Gold, Kuznia & Hayward, 2008). The National Health Service Litigation Authority (2009) received claims in respect of 2.2% of stillbirths occurring in England during 2007. In South Africa, inappropriate management of fetal distress during labour resulting in hypoxic ischaemic encephalopathy, followed by cerebral palsy, is one of the major reasons for successful obstetric litigation (Odendaal, Howarth & Pattinson, 2011).

Compassion is an emotional response that arises in witnessing another's suffering (Goetz, Keltner & Simon-Thomas, 2010) and results in an "inclination to relieve the suffering" (Gelhaus 2012:399). Nursing students verbalised their confusion on how to express their compassion in an acceptable and professional way. They also struggled to maintain emotional regulation, a prerequisite to empathy that requires the ability to control one's own emotions to prevent emotional overwhelm and burnout (Moriguchi et al., 2007; Gerdes, Segal & Lietz, 2010). Empathy, the ability to take another person's perspective and vicariously share the emotion (Smith, 2006), can indeed become a "double-edged sword" for a midwife when she identifies with the woman and experiences the loss of stillbirth as her own loss and pain (Jones, 2012). Bereaved parents regard empathy as a valuable skill and expressed the need for healthcare professionals to recognise their grief after a stillbirth and engage with them in a compassionate way (Kelly & Trinidad, 2012; Pullen, Golden & Cacciatore, 2012). Contrary to the above, uncaring and dismissive responses may have long-lasting effects on a bereaved parent (Morrison, 2006; Cacciatore & Bushfield, 2007). After a stillbirth parents appreciated empathy displayed by healthcare

professionals, for example, sitting quietly with or holding the person's hand (Kelly & Trinidad, 2012). Evidently, this is exactly what nursing students felt like doing, but some of them doubted the professional appropriateness of such an action. Nursing students were concerned by the lack of support of the father after the stillbirth. Kelley and Trinidad (2012) also commented on this phenomenon by indicating that society sometimes does not expect the partner to grieve the loss of the stillbirth. Mothers and fathers grieve in different ways and healthcare professionals should understand these differences in order to intervene effectively (Avelin, Radestadt, Saflund, Wredling & Erlandsson, 2012).

Wallbank and Robertson (2008) found that caring for both the bereaved and the non-bereaved mothers required diversion of attention, answering to diverse patient needs. Such ambiguity and role conflict may result in inadequate provision of care. As women with stillbirths found the cheerful and happy atmosphere in the obstetric unit painful, Kelly and Trinidad (2012) recommend designated private areas with dedicated staff for stillbirth care. In the absence of such units, these women can be given a separate room (Conry & Prinsloo, 2008), or be placed in the surgical ward. However, such placement creates another dilemma as it might be seen as disregarding these women their parenthood (Modiba, 2008). Culture denotes acquired knowledge that is used to interpret experiences and generate social behaviour in specific contexts. In the context of stillbirth culture determines how grief is defined and expressed and who gets involved. In order to provide appropriate care, nurses need to be sensitive to the role personal values and culture play in the interaction and respect of beliefs and customs of others, even when they do not fully understand or appreciate these beliefs or customs (Hsu, Tseng, Banks & Kuo, 2007).

Conclusion

The findings provided crucial insights into nursing students' experiences that could potentially affect their academic progress and the quality of care provided to women after stillbirths. It is vital that education programs make provision for support and counselling of nursing students exposed to stillbirths. Care for a bereaved woman cannot be learnt without talking about, sharing and integrating the emotional experiences and reflect on possible ways of coping. A limitation of the study is the small sample size that will only be applicable in the specific context, therefore the authors identified the need for a larger scale quantitative research to determine the extent to which nursing students are affected by stillbirth deliveries and to determine the needs of students with regard to emotional and academic support to empower them to care for women with stillbirths.

Recommendations

It is recommended that nursing students be empowered with communication and counselling skills so that they feel safe to express compassion towards bereaved parents. Students should be exposed to psychiatric nursing methods such as crisis intervention and trauma debriefing before allocation to obstetric units. The skills training should include cultural competencies with regards to grieving and bereavement. Clinical facilitators and lecturers should be briefed on the students' experiences of stillbirth deliveries in order for them to guide and support nursing students sensitively. Nursing students experiencing overwhelming emotions such as guilt and anxiety should be identified through subtle questioning and be referred for counselling with the focus on coping strategies. All hospitals should have policies and guidelines in place to support midwives and nursing students through supervision and debriefing. Clinical discussions on stillbirths should rather be supportive than punitive.

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