

Description

Exploring Midwives' Experience of Bereavement Care

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Supporting parents as they experience the devastating loss of their baby, be it before, during, or shortly after birth presents a particular challenge to the midwife. The midwife must skilfully and compassionately meet the often considerable physical, emotional and psychological needs of women suffering loss (Mills, 2015), carry out correctly the subsequent paperwork and finally must be able to navigate their own feelings and reactions to the loss. This article offers a brief exploration of the impact of bereavement care on the midwife, why this is important and what can be done to support midwives through the experience thus ensuring bereaved parents receive the excellent care they need.
While strides have been made to reduce the incidence of stillbirth in the UK, progress is slow and according to 2016 data, approximately 1 in 225 births end in a stillbirth (Office for National Statistics, 2017). Similarly, on a global scale, the rate of worldwide stillbirth has remained unchanged between 2011 and 2015 with an estimated 2.6 million third trimester pregnancy losses annually (De Bernis et al, 2016), with the World Health Organisation (WHO) stating that stillbirth remains a 'neglected issue' requiring an integrated, respectful and supportive approach (WHO, 2016).

One chance to get it right

In all settings, the long-term impact on the parents is profound and so the demands on the caring staff **must be** rightly set to a high standard of individualised and compassionate care. Clear, honest and sensitive communication is key; ideally health professionals would be trained in, and have a good understanding of the many facets of bereavement care (Stillbirth & Neonatal Death Charity, (SANDS 2017).



Though a multidisciplinary approach to perinatal bereavement is absolutely vital, the midwife will often carry out the majority of care for bereaved parents. '*One chance to get it right*' (Downe et al 2013) speaks of taking care at every point of contact and taking responsibility for the care provided in the knowledge that the impact is far reaching. If care is not optimum and caregivers fail to meet the needs of bereaved parents, then the long term consequences to those parents may be exacerbated in a situation which is already known to negatively impact on the parents mental health, home life, future family life and even employment (Downe et al 2013).



It is crucial therefore that the midwives undertaking bereavement care are not only prepared for the complexities of such care, but that they receive the support required in order to bear the emotional and psychological cost of truly being with bereaved parents and 'with woman', as is the heart of midwifery care. It is however this very essence which may leave the midwife vulnerable to experiencing feelings of deep and personal loss, further complicated by midwives perhaps questioning whether, in the face of the parents tragic loss, they are entitled to have any personal needs at all (Jones and Smythe 2015).

There is currently limited research into the impact on midwives caring for women experiencing a perinatal loss, however the evidence which exists points to maternity staff suffering physical, emotional and psychological symptoms and distress at significant clinical levels as a result of providing bereavement care (Wallbank and Robertson 2008). While it is impossible to generalise the extent to which midwives will experience trauma, by identifying and acknowledging, and therefore validating the potential impact it is possible that midwives may be able to process and work through their



The initial and varied responses of midwives often demonstrates the delicate balance required as they simultaneously provide care at the same time as processing the immediate shock of discovering that the baby has died. Physical symptoms such as nausea, feelings of numbness and cold sweats may present and the midwife may consciously keep those feelings in check for the sake of the family, going on to cry alone or with colleagues (Puia et al 2013). It is reassuring to note that parents appreciate signs from the staff caring for them that they are sad and upset too (Downe et al 2013) and while professionalism will ultimately be maintained, the demonstration of empathy and acknowledgement of a precious life lost may be comforting to the parents. Other midwives may need to have time alone as soon as physically possible in order to attempt to process the overwhelming emotions experienced and as a form of self-protection (Fenwick et al 2007).

In the days and weeks following, it is common for midwives to experience further physical symptoms including but not limited to, headaches, muscle tension, problems getting to sleep as well as psychological effects such as recurrent dreams, depression, “consuming thoughts” and feelings of self-doubt and guilt (Puia et al 2013, p326) all of which may start to have an effect on the midwifes professional and home life. There is a risk that midwives will feel isolated in the feelings they are experiencing due to a perceived expectation that they should ‘cope’ for the sake of the women and perhaps a belief that showing those feelings will be perceived by others as weakness in their practice.

With a workforce which is already struggling under the pressures of insufficient staffing whilst caring for a pregnant population with ever increasing medical and obstetric needs, the evidence is compelling for the necessity of compassionate support for all midwives and maternity staff.

However in the case of midwives carrying out bereavement care it may be the difference between the ability to continue in the profession as a woman centred and resilient practitioner, face burn out and leave the profession or continue to work but provide care which does not meet the needs of bereaved parents because they have developed negative coping strategies to protect themselves from further damage.

In countries where bereavement care does not yet receive the recognition it deserves and requires, the midwife’s grief may be yet further complicated by the marginalisation and stigma suffered by many bereaved women, an associated blame culture toward health workers and though by no means a broad generalisation, some cultural norms such as fatalism and complacency (De Bernis et al, 2016).

Self-care is vital

As midwives there is a professional responsibility to ensure ‘fitness for practise’ (NMC 2015) and it is wise to interpret this in a holistic way, applying it equally to our emotional and psychological wellbeing, applying kindness and self-compassion as necessary tools of resilience and self-care. This statement is not without its challenges however as in the busy clinical caring environment there is often no time to ‘stop’ and it may be that doing so is felt as a selfish or even “narcissistic” thing to do (Knapp 2017), but for the sake of the continuing good mental health of the midwife, as well as

providing excellent care for women it is essential. Acknowledgement of the emotional impact as well as endeavouring to create a good work to life balance needs to be seen as a vital necessity rather than a cliché to be paid lip service to.

Self-care and support

- Acknowledge your own feelings of loss and/or trauma
- Informal debriefing with colleague friends
- Access support systems already in place such as formal clinical debriefs
- Self-referring for professional support
- Creative reflection such as writing or poetry

(Developed from Downe et al 2013, Jones & Smythe 2015, Wallbank & Robertson 2013)

Structured support and acknowledgement

The responsibility does not stop with the midwife however and at an organisational level there is an overarching



ssed already, will have a positive impact on ort is put in place for all staff involved and Providing a space where they can debrief thoroughly in a way that does not apportion blame and acknowledges the complexities of the experience in terms of emotional and psychological impacts will enable midwives to begin to process and reflect on that experience in a healthy way. It may also be appropriate to offer professional formal support through a course of counselling or psychotherapy. Furthermore the ongoing nature of processing difficult experiences could be met by facilitating regular drop-ins or support groups.

This is a complex area of practice with many elements requiring research and exploration however what is clear is that recognising and acting on the need for support for those carrying out bereavement care is vital for midwives' mental health and wellbeing and the subsequent impact on all parents in their care.

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