TITLE PAGE

TRANSFORMING STUDENT MIDWIVES' LIVED EXPERIENCE OF CARING FOR BEREAVED PARENTS EXPERIENCING PERINATAL LOSS USING HIGH -FIDELITY SIMULATION: AN INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS.

ANNE LEYLAND

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GLOSSARY OF TERMS

Simulation- a term used to describe an attempt to recreate a real-life experience, event, or task

Fidelity- a term used to describe how closely a simulation replicates a real-life event.

High-fidelity- a simulation that involves very realistic human patient simulators that can breathe, blink, or respond physiologically to drugs and other events

Low-fidelity- the use of basic equipment, for example a part-task trainer to practice skills such as cannulation

Psychological fidelity- the extent to which a learner believes the simulated scenario resembles that of a realistic clinical event

Standardised patient- use of real people or actors who are trained to enact different roles, illnesses, or experiences to enhance the authenticity and realism within a scenario

Debriefing- a term used to describe a form of guided reflection following a simulation in which learners are enabled to formulate an action plan for future situations in practice

Pre-briefing- a term used to describe the preparatory activities prior to a simulation which includes an overview of the learning objectives, the orientation to the simulation suite and equipment, and the clarification of a learner's role and expectations.

Loss- defined as the severing of an attachment to someone or something

Perinatal loss- the death of a baby beyond 24 weeks gestation or of an infant within the first seven days of life**.**

End of life care simulation- using simulation as a learning opportunity to enable students to provide end of life care to families experiencing perinatal loss.

Palliative end of life- a caregiving approach aimed at optimising the quality of life for people faced with serious, life threatening diseases and illnesses.

ABSTRACT

The unexpected death of a baby to stillbirth is a tragic and traumatic event both for parents and caregivers. The period after stillbirth has profound emotional and psychological consequences for parents which can persist for 1000 days and beyond (Manifesto, 2014). Whilst nothing can alleviate the pain of a stillbirth, the quality of care that bereaved parents receive is crucial to their psychological well-being in the aftermath of the loss.

Student midwives frequently encounter bereaved parents as part of their experience in clinical practice. Yet many students report feeling unprepared and anxious when caring for them during this difficult time. Consequently, midwifery students often lack the necessary skills in communicating with bereaved parents and providing emotional support which can impact on the quality of care that parents receive.

This study presents an interpretative phenomenological study which aims to explore student midwives' experiences of bereavement simulation. The use of simulation to teach student midwives about bereavement care is relatively unexplored in the literature. It warrants considerable attention given the concerns highlighted in a series of reports in recent years regarding bereaved parents' experiences of maternity care following perinatal loss (Kirkup, 2015; Ockenden, 2020, 2022).

This study utilized a purposive sample of nine first- and second-year undergraduate midwifery students and used in-depth semi-structured interviews to explore the meaning of the experiential phenomena of bereavement simulation. Mezirow's Transformative Learning Theory was also applied as a framework to analyse the data.

Three key super-ordinate themes emerged from the data analysis. Firstly, '*a rollercoaster of emotions'* captured the complexity of feelings and emotions that students experienced as they encountered the bereaved parents for the first time. Secondly, '*trying to console and making things easier'* depicted the deep sense of powerlessness and the professional dilemmas experienced as the students struggled to emotionally console and communicate the helpful words to the grieving

parents. Thirdly, '*a unique learning experience*' conceptualised the students' transformational journey as they critically reflected on significant aspects of their learning and identified the professional and personal insights that would enable them to provide effective care.

The findings of the study highlight the important role of simulation as a defined model of bereavement education that equips students with the necessary knowledge, skills, and values to provide safe and compassionate care to bereaved parents during this traumatic time.

Chapter 1: Introduction

This thesis presents an interpretative phenomenological study which aims to explore student midwives' experiences of bereavement simulation. It focuses on how student midwives understand, make meaning, and respond to bereaved parents who experience perinatal loss within the context of a simulated scenario. The use of simulation to teach student midwives about bereavement care is relatively unexplored in the literature. However, it warrants attention given the concerns highlighted in a series of recent reports regarding bereaved parents' experiences of maternity care following perinatal loss (Kirkup, 2015; Ockenden, 2020, 2022).

Another major issue of concern is that undergraduate bereavement education for student midwives is somewhat inadequate and sparse (Doherty, Cullen, et al., 2018). In addition, students are often shielded from such situations in practice and therefore have limited clinical involvement in caring for bereaved parents (Alghamdi & Jarrett, 2016; Brunt, 2020). The result is that students are ill-prepared and feel anxious and fearful when they encounter bereaved parents for the first time (McKenna & Rolls, 2011). These negative emotions can be a major barrier to providing high quality care (Bakhbakhi, Burden, Storey, & Siassakos, 2017). This thesis critically examines the important role of simulation in preparing students to care for bereaved parents. As indicated earlier, there is a paucity of literature regarding the use of simulation to teach bereavement care within undergraduate midwifery curricula.

The methodological approach chosen for this study is Interpretative Phenomenological Analysis (IPA) as outlined in Chapter 3. This approach involves a detailed exploration of the student midwives' experience of bereavement simulation. It is concerned with their perceptions and views of the simulated experience and the meaning they ascribed to it (Smith, Flowers, & Larkin, 2009, 2022). IPA places considerable emphasis on the idiographic, detailed examination of experience based on the views and feelings of a group of people within a particular context (Smith et al., 2009, 2022). Therefore, this study utilizes a small purposive sample of nine student midwives using in-depth semi-structured interviews to explore the meaning of the experiential phenomena of bereavement simulation. In addition to using IPA

as the methodological approach, this doctoral thesis will also explore the students' transformative learning journey by using Mezirow's transformative learning theory as a framework to analyse the data.

The remainder of this chapter will provide the context and background for the research study as outlined in section 1.1. It will explore the emotional impact of perinatal loss from the perspective of bereaved parents, midwives, healthcare professionals and student midwives. Given the inconsistent approaches to bereavement education within healthcare education, the chapter concludes with the rationale for developing and implementing bereavement simulation as a defined model of teaching and learning within undergraduate midwifery curricula.

1.1 Background and Contextual Overview

Globally an estimated 2.6 million stillbirths and 2.7 million neonatal deaths occur every year (Aggarwal & Moatti, 2021). Stillbirth is legally defined as a baby delivered after 24 weeks with no signs of life regardless of when the death occurred (MBRRACE-UK & Draper, 2018). A neonatal death is the death of a baby born alive within the first seven (early) to 28 (late) days of life. According to the most recent Perinatal Mortality Surveillance Report, in 2019 an average of 2399 babies in the UK were stillborn, while 1199 babies died in the neonatal period (Draper et al., 2020). Despite a significant decline in the rate of stillbirths from 5.1 per 1,000 total births in 2010 to 3.8 per 1,000 total births in 2020, in 2021, the UK stillbirth rate increased to 4.2 per 1000 births compared to 3.8 in 2020 (Office For National Statistics, 2020). Whilst the exact cause of this increase is not yet clear, it is possibly associated with the Covid-19 pandemic and the direct pressures on the National Health Service (NHS) maternity and neonatal services (Stowe et al., 2021).

UK stillbirth rates are considerably higher than some European countries such as Finland (2.0 per 1000 births), Germany (2.7 per 1000 births) and Ireland (2.8 per 1000 births), although this is not necessarily related to factors such as poverty, maternal age, birth or ethnicity (Brierley-Jones et al., 2018). Nevertheless, mortality rates in the main tend to be higher for babies of Black and Black British ethnicity and this closely correlates with areas of high social deprivation (MBRRACE-UK & Draper,

2018) and the associated social inequalities experienced by women accessing or avoiding maternity services and care (Matthews et al., 2022)

Stillbirth rates are a major public health concern and a critical indicator of the quality of maternity care provided during pregnancy and childbirth (Hug et al., 2022). The United Nations Global Strategy for Women's, Adolescents and Children's Health (Kuruvilla et al., 2016) and Every Newborn Action Plan (WHO, 2014) instigated an end to preventable stillbirths. Furthermore, given the significant psychological, social, and economic impact of stillbirth on women, their families and society in general, a reduction in stillbirth rates is imperative (Heazell et al., 2016).

In an effort to reduce and prevent stillbirth in the UK, the Saving Babies' Lives (SBL) Care Bundle was launched in 2016 and subsequently re-launched in 2019 to improve the quality of care in pregnancy (NHS, 2016, 2019). These improvements in care aim to halve the number of stillbirths by 2030 through the better detection, monitoring, and management of babies at risk of premature birth and stillbirth. In 2021, Widdows, Roberts, Camacho, and Heazell (2021) conducted a retrospective cohort study of 463,630 births in 19 NHS Trusts in England to evaluate the impact of implementing the SBL Care Bundle and reported a significant decline in the rates of stillbirth. The authors concluded that an early adoption of the SBL care bundle within these trusts improved the identification, management, and care of women with significant risk factors, including medical co-morbidities and smoking which are commonly associated with stillbirth and adverse outcomes.

1.1.1 The Impact of Perinatal Loss on Parents

There is no doubt that the unexpected death of a baby to stillbirth is a tragic and traumatic event, both for parents and caregivers. Perinatal bereavement is a complex, multifaceted phenomenon characterised by a complexity of grief responses (Fenstermacher & Hupcey, 2013), which can incur profound - but often overlooked - psychological and social costs to women, families, healthcare professionals, the government and wider society (Heazell et al., 2016). Many bereaved parents experience some form of negative psychological sequelae including intense grief, depression, anxiety, and post-traumatic stress following a stillbirth (Avelin, Rådestad,

Säflund, Wredling, & Erlandsson, 2013; Cacciatore, 2013; Hutti et al., 2017). In the UK-based Listening to Parents study (Redshaw, Rowe, & Henderson, 2014), 68% of mothers and 44% of fathers reported four or more depressive symptoms at 10 days after a stillbirth. Psychological symptoms often persisted into subsequent pregnancies ranging from relief and worry, to panic attacks, anxiety and depression, and a fear of childbirth (Mills, Ricklesford, et al., 2014).

For many parents, experiencing a stillbirth has a major impact on their self-esteem, identity, and confidence to be parents. This can leave them feeling stigmatised, socially rejected, and isolated (Brierley-Jones, Crawley, Lomax, & Ayers, 2014). The burden of having a stillborn baby can lead to long term emotional, psychological, and financial problems (Bakhbakhi et al., 2017; Brierley-Jones et al., 2014; de Bernis et al., 2016) and cause major disruption to relationship dynamics with spouses and families (Kirui & Lister, 2021). A systematic review by Burden et al. (2016) reported suicide ideation and post-traumatic stress disorder (PTSD) as the most frequently reported symptoms for parents experiencing stillbirth. Unresolved PTSD can have major implications for women's decisions about future pregnancies and may result in choosing to have fewer children, or a longer interval between children (Meaney, Everard, Gallagher, & O'Donoghue, 2017). Psychiatric symptoms combined with pathological grief can also predispose a woman to chronic conditions such as diabetes and heart disease, which combined with obesity can contribute to premature mortality and have implications for future pregnancies, resulting in adverse outcomes for mother and baby (Huberty, Matthews, Leiferman, Hermer, & Cacciatore, 2017). Fear of future childbirth can also result in high cortisol levels in the unborn child, predisposing a woman to premature birth and a small gestational age baby (Zhu, Tao, Hao, Sun, & Jiang, 2010). Unresolved PTSD can negatively affect a mother's attachment and bonding with her baby often resulting in poor social-emotional outcomes for the child in the long term (Üstündağ–Budak, Larkin, Harris, & Blissett, 2015).

Perinatal loss is also associated with negative psychological sequelae for men. A review of the literature exploring men's experiences of perinatal loss concluded that the lack of validation of their grief by healthcare professionals and family contributed

to feelings of emotional vulnerability; this subsequently altered their expectations of being a parent for fear of another difficult outcome (Nguyen, Temple-Smith, & Bilardi, 2019). The review highlighted the necessity of further research to a gain deeper insight into the grief and loss of fathers experiencing perinatal loss, regardless of gestation. Similarly a scoping review by Jones, Robb, Murphy, and Davies (2019) exploring fathers' grief and loss following stillbirth and neonatal death identified a lack of social recognition and loss of identity as a grieving father were major contributors to disenfranchised grief (Bonnette & Broom, 2012; Ellis et al., 2016). An additional source of stress was that men felt compelled to take on the role of supportive partner, which left them feeling marginalised in their grief. This subsequently impacted on their psychological health and well-being, and adjustment to their loss (Bonnette & Broom, 2012). Findings from this review highlighted the important role of healthcare professionals in providing empathic care and tailoring support to fathers according to their needs.

Within the context of bereavement care, a confidential enquiry of 133 term stillbirths in the UK found considerable variations in care including poor communication between bereaved parents and health professionals, which impacted negatively on parents' long term memories of their loss (Draper, Kurinczuk, & Kenyon, 2015). For some parents, their loss and grief was often unacknowledged or the care was '*insensitively or clumsily delivered'* by healthcare professionals (Boynton, 2016, p. 525) and lacked both kindness and compassion (Ockenden, 2020, 2022).

A more recent study exploring bereavement experiences of Pakistani, Bangladeshi, and white British women in the UK also reported poor communication and the lack of emotional and practical support as contributing factors to their distress (Garcia, Ali, Griffiths, & Randhawa, 2020). A key recommendation from this study included the need to provide culturally competent bereavement care that encompasses the religious and cultural diversity of bereaved women and their families experiencing perinatal loss.

In some situations, it was reported that midwives often distanced themselves from parents, focusing on tasks as a way of coping, which further compounded their

emotional trauma (Cacciatore, 2013; Ellis et al., 2016; Siassakos et al., 2017). A recent survey conducted by The Stillbirth and Neonatal Death Society (SANDS) into parents' experience of the hospital review of their care following perinatal loss also confirmed 'stark' variations in the quality of care some parents received. Whilst most parents reported a positive experience overall, others raised issues regarding poor and insensitive communication, and a lack of clarity and compassion in relation to the baby's death (SANDS, 2021). Similarly, findings from an Economic and Social Research Council (ESRC) funded study investigated the level of care bereaved parents received in the UK following pregnancy loss. They also revealed inconsistencies in the standard of communication, particularly with regard to information, support and choices about their care (Littlemore, McGuinness, Fuller, Kuberska, & Turner, 2020). Findings from these studies recommended a combination of evidence-based training in advanced communication and bereavement care skills. This is vital to ensure healthcare professionals are responsive to both parents' and their own emotional, psychological, and physical needs and that neither professionals or parents are feeling traumatised for life (SANDS, 2021; Siassakos et al., 2017).

1.1.2 The Impact of Perinatal Loss on Healthcare Professionals

A consistent theme in the literature is that healthcare professionals and students across many disciplines find death and dying situations difficult to cope with (Jors et al., 2016; Kirkpatrick, Cantrell, & Smeltzer, 2017; McNamara, Meaney, & O' Donoghue, 2018; Robson & Williams, 2017). An integrative review of 19 national and international end of life care studies found nursing students viewed death and dying situations as a major source of stress (Kirkpatrick et al., 2017).

In midwifery, the fundamental role of the midwife is to be 'with-woman' (Carolan & Hodnett, 2007). For midwives 'being-with' a woman is an emotional journey travelled together based on mutual trust and support (Bradfield, Hauck, Duggan, & Kelly, 2020). When midwives witness or become involved in a traumatic birth such as stillbirth, it can result in profound psychological symptoms including guilt, anger, blame, anxiety, and sadness (Nuzum, Meaney, & O'Donoghue, 2014; Shorey & Wong, 2021). These symptoms are often intensified particularly if the loss is

unexpected and the midwife has formed a close bond with the woman and her family prior to the baby's death (Fernández-Basanta, Coronado, Bondas, & Movilla-Fernández, 2020).

A national survey of 2800 UK midwives found that 421 midwives experienced approximately seven perinatal traumatic events throughout their careers. Following these episodes, 33% midwives experienced feelings of helplessness, fear and horror symptomatic of PTSD (Sheen, Spiby, & Slade, 2015). Similarly in an Australian study, Leinweber, Creedy, Rowe, and Gamble (2017) assessed the reactions and prevalence of PTSD amongst midwives after witnessing traumatic events in practice, which included the death of a baby. The findings revealed that midwives experience a myriad of emotions ranging from guilt, fear and powerlessness and were significantly more likely to recall feelings of horror and symptoms indicative of PTSD.

McDaniel and Morris (2020) also reported that healthcare professionals involved in traumatic events in practice - either directly or indirectly - are susceptible to a condition known as the *Second Victim Phenomenon*. The *Second Victim Phenomenon* is a term used to describe a set of psychological symptoms like other mental health conditions such as PTSD. It is often accompanied by compassion fatigue, burnout and secondary traumatic stress due to the emotional burden of caring for others at times of profound trauma (Winters, 2018).

There is evidence that these psychological effects are often intensified through fear of litigation and disciplinary action. This is further exacerbated through a lack of support from their colleagues, workplace violence in the form of shaming and blaming (McCool, Guidera, Stenson, & Dauphinee, 2009; Robertson & Thomson, 2016) and more recently a hostile social media culture highlighting systemic failures in maternity care, as outlined in the Kirkup and Ockenden reports (Kirkup, 2015; Ockenden, 2020, 2022). For some midwives, experiencing a traumatic event in practice is so profound it can result in defensive practice, the provision of depersonalised care, or in leaving the profession altogether (Leinweber et al., 2017; Sheen et al., 2015; Wahlberg, Hogberg, & Emmelin, 2019). In order to protect themselves emotionally and maintain a professional demeanour, midwives often

suppress their emotions (Lin, Liu, & Chiang, 2021) or resort to maladaptive coping styles, such as low morale, self-blame, disengagement and denial, making them more vulnerable to psychological stress (Wallbank & Robertson, 2013). Again, these emotions and behaviours are a concern as professional attitudes can negatively influence a midwife's morale and performance (Barsade, 2002) and consequently impact on the standard of care bereaved parents receive throughout their grief journey (Pastor Montero et al., 2011).

Similarly, a meta-ethnography exploring midwives' and nurses' emotions when caring for bereaved parents, reported that the attempt to maintain a professional demeanour generates feelings of emotional conflict (Fernández-Basanta, Coronado, Bondas, Llorente-García, & Movilla-Fernández, 2021). This lack of legitimacy and feeling disallowed to openly express emotions and process grief reactions, aligns with Doka's (2002) concept of disenfranchised grief, which refers to grief that is not validated or recognised. Healthcare professionals are often considered disenfranchised grievers as they are frequently prohibited from actively grieving which is outside the norms of professional behaviour (Kaplan, 2000). Therefore, it is critical that caregivers' feelings are validated, otherwise over time disenfranchised grief can contribute to symptoms of physical and emotional exhaustion indicative of occupational burnout (Spiby et al., 2018).

For midwifery students, the experience of caring for bereaved parents following a stillbirth can be a significant source of traumatic stress (Alghamdi & Jarrett, 2016; Coldridge & Davies, 2017; Davies & Coldridge, 2015; McKenna & Rolls, 2011). Davies and Coldridge's (2015) qualitative study exploring second and third year student midwives' (n=11) experiences of providing care to women facing traumatic perinatal events in practice concluded that the psychological effects of supporting and empathically caring for women with unforeseen events made them susceptible to secondary traumatic stress and PTSD (Davies & Coldridge, 2015).

This is further compounded by the fact that many student midwives will have limited experience of seeing a dead body or a dead baby, which can be very traumatic (McKenna & Rolls, 2011). Therefore, they feel unprepared to emotionally support

and communicate with grieving parents effectively (O'Connell, Meaney, & O'Donoghue, 2016; Shorey, Andre, & Lopez, 2017; Wallbank & Robertson, 2013). In some situations, students expressed feelings of ambiguity and a sense of uncertainty when adjusting to caring for a woman with a viable pregnancy, compared to caring for a bereaved woman experiencing perinatal loss (Nurse-Clarke, 2021). These feelings can lead to compassion fatigue, anxiety, and burnout (Beaumont, Durkin, Martin, & Carson, 2016; Mollart, Skinner, Newing, & Foureur, 2013). Beaumont et al. (2016) also found that compassion fatigue and a lack of self-compassion in student midwives negatively correlates with empathy and compassion towards others. Findings from this study recommended the importance of incorporating self-care measures, mindfulness training and reflection within undergraduate curricula to promote students' emotional wellbeing and self-kindness and thereby enable them to provide sensitive, compassionate care to grieving parents (Beaumont et al., 2016).

A recent UK longitudinal study involving student nurses also reported an association between a lack of pre-registration preparatedness for death and dying situations and an increased risk of mental health problems and heightended stress reactions (Galvin, Richards, & Smith, 2020). For newly qualified midwives, the distress from encountering perinatal loss combined with emotional unpreparedness resulted in a fear of birth (Sheehy & Baird, 2022), which subsequently undermined their confidence to support and promote normal birth (Aydın & Aktaş, 2021). This further highlights the importance of preparing and educating the current and future workforce of midwifery students for potential stressful events in practice that will positively benefit them and the parents in their care (Leinweber et al., 2017).

A fundamental aspect of midwifery care and the midwife's role is that all parents have the right to receive safe, kind, respectful care from healthcare professionals (Downe, Finlayson, Oladapo, Bonet, & Gülmezoglu, 2018; Nursing and Midwifery Council, 2018; World Health Organization, 2014). For bereaved parents, sensitive, compassionate care is crucial to support them through the grieving process and to minimise the psychological and emotional risks associated with perinatal loss (Gausia et al., 2011; Heazell et al., 2016). Compassion is defined as being sensitive to the suffering of the self and others (Gilbert, 2015), thus kind, compassionate care

can reduce the risk of developing PTSD in the future (Hughes, 2012). Women expect midwives to be competent, kind and caring, and midwives have a duty to prioritise women's physical and emotional needs, particularly those of bereaved parents (Reed, Sharman, & Inglis, 2017). Unfortunately, it is a neglected aspect of care and many parents do not receive the standard of care they should be able to expect (Ockenden, 2020, 2022; Peters, Lisy, Riitano, Jordan, & Aromataris, 2015). As a result, they are left feeling fearful, unsafe, betrayed, and powerless.

1.1.3 The Need for Effective Bereavement Education and Training

As previously suggested, the negative effect of stillbirth on parents, families and health care professionals could be addressed through effective education and training interventions which ensure better positive experiences for parents after a stillbirth (Heazell et al., 2016). In 2018, the Stillbirth and Neonatal Death Society (SANDS, 2018b) published the Bereavement Care Pathway for Pregnancy and Baby Loss to help staff cope with all types of loss, and acknowledge their own training needs and support structures. Whilst bereavement education and training is also available for all healthcare professionals involved with bereaved parents (SANDS, 2018b), this is not always feasible. In the last audit of bereavement care in the UK, there were inconsistencies in the level of staff training undertaken (Sands, 2018a). This suggests that bereavement education and training is not always considered a priority due to other competing demands, a lack of funding or staff shortages in the NHS, particularly in light of the Covid-19 pandemic (Luyben, Fleming, & Vermeulen, 2020).

A recent survey exploring health professionals' knowledge, training needs and confidence in supporting bereaved parents experiencing loss from a twin pregnancy, also confirmed a need for more specialist training to enable healthcare professionals understand the emotional complexity involving the death of a twin (Rankin, Hayes, & Embleton, 2021). Rankin et al. (2021) concluded that inexperienced midwives are less likely to have the opportunity to avail of specialist bereavement training. Consequently, they lack the confidence to emotionally support bereaved parents.

In addition to the bereavement training available for qualified midwives, Academic Education Institutions (AEI) have a responsibility to offer quality curricula and education that enables the future workforce to be well prepared, educated and equipped with the necessary knowledge, skills, attitudes and values to provide safe and better care overall (Nursing and Midwifery Council, 2018). However, a challenge exists in both nursing and midwifery education in preparing future nurses and midwives to provide effective bereavement care. The unpredictable nature of perinatal death combined with the competing demands of clinical practice may result in students never encountering bereaved parents throughout their whole programme (Sheehy & Baird, 2022). Often, they are excluded or shielded by their midwifery supervisors and assessors from this aspect of care for fear of traumatising them, (Brunt, 2020) or to protect pregnant colleagues from the pain of perinatal loss (Hutti et al., 2016). Nevertheless, students believe this to be an important rite of passage in the transition to becoming a midwife (Alghamdi & Jarrett, 2016). When students have some exposure, sometimes they are left alone to support a distressed, grieving mother, (Oates et al., 2020b) or there is limited opportunity or time to debrief, critically reflect, and adequately explore the issues to optimise their learning (Heise, Wing, & Hullinger, 2018; Randall, Garbutt, & Barnard, 2017).

Oates et al. (2020a) conducted a descriptive qualitative study exploring factors that affect student midwives' (n=20) mental wellbeing in the UK. The study concluded that the culture of midwifery practice combined with inconsistency in the provision of emotional support results in students having to '*personally manage and contain their emotions as part of their professional socialisation to becoming a midwife'* (Oates et al., 2020b, p. 5). Davies and Coldridge's study (Davies & Coldridge, 2015), which specifically highlighted the mental distress that student midwives experience when caring for women during traumatic births, further strengthens the case for incorporating educational strategies and support mechanisms to effectively prepare students for the complexities of the maternity care journey, and transform their attitudes towards the reality of death and loss in practice.

Another area of concern is that within undergraduate curricula, the teaching of bereavement care is mainly delivered in a theoretical format. A systematic review by

Carmack and Kemery (2018) explored the methods used to teach end of life care and reported considerable variations in quantity, content and approach to teaching within undergraduate nursing curricula. In some undergraduate nursing curricula, there was a distinct lack of content involving the end of life care of a dying person (Gillan, van der Riet, & Jeong, 2014). Within undergraduate medical education, a systematic review examining the content and methods of teaching palliative care education also found considerable variations in the method of teaching palliative care education globally (Fitzpatrick, Heah, Patten, & Ward, 2017). Within this review, only four studies incorporated the use of simulation to teach palliative care and none of the studies were conducted in the UK. Ravi et al. (2020) also conducted a survey of 35 UK medical schools and found that stillbirth-related teaching was only included within 57% of medical curricula, despite the inclusion of bereavement care and advanced communication skills as a core component of doctors' Generic Professional Capabilities Framework (General Medical Council, 2017).

Similarly, within undergraduate midwifery education, and despite the Nursing and Midwifery Council's (NMC) recommendation that student learning should be facilitated by a diverse range of methods including simulation (Nursing and Midwifery Council, 2019), there is still considerable emphasis on both didactic and theoretical approaches to bereavement education (Martin, Robb, & Forrest, 2016a). A survey of tertiary education examining stillbirth education for student midwives reported inconsistencies with regard to the content and method of teaching (Warland & Glover, 2019). A mixed-methods study exploring pre-registration midwifery education also reported considerable emphasis on the 'normality 'of birth. Perinatal loss was represented as an unexpected event in childbirth as opposed to a potential adverse outcome in the continuum of pregnancy and birth (Lukasse, Lilleengen, Fylkesnes, & Henriksen, 2017). These studies concluded that acquiring the knowledge and skills to deal confidently with bereavement is difficult to achieve using traditional pedagogical methods of teaching and learning. These works highlight a need to strengthen and standardize undergraduate midwifery curricula to prepare future midwives for the full scope of midwifery care including pathological events such as perinatal loss.

What is evident from the literature is that inconsistent bereavement content within undergraduate curricula, combined with a lack of clinical exposure can impact on students' contextual understandings of grief and loss (Bassah, Seymour, & Cox, 2014; Hörberg, Galvin, Ekebergh, & Ozolins, 2018). This is a major concern given that the disruption caused by Covid-19 meant that students across many disciplines had to withdraw from clinical placements, which minimised their practical experience and opportunities to engage in hands-on clinical learning (Luyben et al., 2020). To address this learning requirement, there is a need to create both experiential and transformative forms of learning that enable students to develop their skills in providing compassionate and sensitive care within complex situations such as bereavement and allows them time to reflect on the meaning of that experience (Hörberg et al., 2018).

In recent years, simulation has evolved as a powerful experiential form of learning, particularly when clinical experience is limited or inequitable across student cohorts. The integration of both theoretical and practical education through simulation on death and dying situations within undergraduate curricula has the potential to adequately prepare students for their future role and complement traditional methods of teaching and learning (Dimoula et al., 2019). Moreover, as the Covid-19 pandemic had a significant impact on the education and training of the healthcare workforce, Health Education England set out a National Vision that prioritized the role of simulation in addressing education and training needs arising from the pandemic (Health Education England, 2020). The Nursing and Midwifery Council (Nursing and Midwifery Council, 2019) and The Greater Manchester Health and Social Care Strategy also endorsed simulation as an effective approach to teaching and learning and confirmed that learning opportunities using simulation should be maximized (Health Education England, 2021-2024).

Within undergraduate midwifery education, the use of simulation is becoming an increasingly popular method to teach a broad range of skills and competencies, mainly in relation to obstetric emergencies (Daniels et al., 2010). However, few studies have focused exclusively on the experiences of simulation from a student perspective within midwifery and particularly in relation to bereavement education

(Vermeulen et al., 2017). Therefore the use of simulation across the lifespan is an area that warrants further research (Randall et al., 2017), and thus, the aim of this study is to explore student midwives' 'lived' experiences of participating in bereavement simulation.

From the research it is evident that both bereaved parents and healthcare providers can be traumatized by the unexpected loss of a baby through stillbirth. Emotional preparedness amongst student midwives is critical in enabling them to adapt personally and professionally so that bereaved parents receive high quality, safe care (Renfrew et al., 2020). Midwives and students are also the main providers of midwifery care within the UK and are privileged to care for women at this critical time in their lives (Ockenden, 2020, 2022). Therefore, to develop a pedagogical model of education that has the potential to improve the quality of bereavement care, it is essential to ascertain student midwives' feelings about this aspect of care. It is argued that through exploring students' experiences, knowledge about the complexity of providing bereavement care can be understood from a student's perspective. It is also intended that this research will enhance students' understanding about grief and loss from parents' perspectives as well as their own knowledge and experience about compassion and caring within this emotionally complex situation. Additionally, from a higher education perspective, it is hoped that this study will inform the development and delivery of a defined impact model of education within both undergraduate and postgraduate midwifery education across a variety of disciplines.

1.2 My Personal and Professional Motivations for Undertaking this Study

In this section, I will now address my personal and professional experiences that inspired and motivated me to undertake this this research by using an interpretative phenomenological approach. I have been a midwife for 30 years and a midwifery lecturer with over 15 years' experience. My initial interest in perinatal loss arose from my own personal experiences of early pregnancy loss and the quality of care that I received following the news that my pregnancy was no longer viable and that the baby had died. For many years after, I thought about the multitude of parents

receiving the same bad news daily and the emotional turmoil they would experience following this catastrophic event.

When I began my role as a midwifery lecturer, I became aware that clinical experiences of bereavement care posed considerable challenges for many students and qualified midwives. The real impetus for the study came from having meaningful discussions with student midwives about their experiences of caring for bereaved parents in clinical practice. These discussions gave me a deeper insight into the stress and anxieties that traumatic events in practice created for students. Often students were left ‘floundering’ and feeling emotionally distressed without any support from other experienced midwifery staff. Even though students knew they could seek any help or support in the form of Restorative Clinical Supervision (NHS, 2017), sometimes follow-up support or debriefing in the immediate aftermath of an incident did not occur. This left students to cope alone and rely on the limited skills they had or to seek support from their peers. These traumatic events highlight the vulnerable position such students find themselves in. A deeper concern for me was that bereaved parents would not receive the quality of care they so deserved, as highlighted in the Kirkup and Ockenden reports (Kirkup, 2015; Ockenden, 2022). These issues led me to reflect and consider more innovative ways of teaching and supporting students to provide compassionate care for bereaved parents.

In 2014, I completed a Master’s in Psychology with the Open University (OU). Throughout my years of study with the OU, I developed an interest in the psychological theories associated with grief, loss, and bereavement. I decided this was an area I would like to develop further within the midwifery curriculum. Then, in 2015, a nursing colleague invited me to observe nursing students participate in an end-of-life scenario using a high-fidelity simulated mannikin. It was at this point I realised that simulation using real people as actors could potentially be a more effective method to teach midwifery students about bereavement care. Since then, I have integrated bereavement simulation into the curriculum and the evaluations from the students have been overwhelmingly positive.

In March 2018, I was short-listed for a Royal College of Midwives Award for using simulation to teach students about bereavement care. In September 2018, I invited a service user, a bereaved father to observe a bereavement simulation. His story about being a bereaved father enabled students to gain insight into the impact of loss from a father's perspective and lessened their anxiety about talking to bereaved parents. Since then, I have had numerous requests to undertake bereavement simulation across many trusts for training purposes. Because of this, I consider this research has the potential to influence Higher Education Teaching and Learning strategies within other institutions, both in the UK and abroad.

Based on these experiences and my own personal interest in bereavement care in general, I feel it is a logical progression and of critical importance to undertake this research as it provides evidence that students value experiential forms of learning particularly around traumatic and catastrophic events like perinatal loss.

1.3 Overview of the Aims of the Study

In November 2017, ethical approval was granted from the University of Salford Research Ethics Committee to undertake the study – *To explore student midwives lived experience of participating in bereavement simulation.* (Ethical approval Appendix 1). The context and rationale for the study outlined in Chapter 1: and Chapter 2: and the selection of the research methodology outlined in Chapter 3: led to the development of the research question. The initial research question was quite broad as it was designed to capture students' lived experience and was formulated as follows:

- *What is the lived experience of bereavement simulation from the perspective of individual student midwives?*

1.4 Aims of the Study

The following aims were further developed and elaborated to address key aspects:

- To understand the meaning-making and learning processes that student midwives undergo from participating in the simulation.

- To gain insight as to how simulation facilitates a transformative change in students' perspectives about grief and loss.
- To explore student midwives' perception of simulation as a model of teaching and learning in preparing them for clinical practice.

1.5 Overview of the Structure of the Thesis

This thesis is presented in the following chapters.

Chapter 1: provides an introduction and a contextual overview relating to the rationale for the chosen study.

Chapter 2: presents a critical review of the literature in relation to the methods used to teach midwifery students bereavement care within the context of midwifery education. The findings and recommendations of the literature review conclude with recommendations and justifications for the proposed study.

Chapter 3: discusses the methodological approach and the rationale for using IPA. The theoretical and philosophical concepts that underpin IPA are also presented. An overview of the ethical considerations including the recruitment strategy, sampling technique and use of semi-structured interviews as the method of data collection are justified and discussed. This chapter also provides a detailed discussion of the data analysis procedures and the methods used to ensure quality and rigour throughout the research process.

Chapter 4: provides a comprehensive summary and discussion of the findings of the nine qualitative interviews, which are based on three super-ordinate themes and their related sub-themes. Each of the themes are presented and illustrated with verbatim quotes from the students to ensure the transparency and authenticity of their lived experience.

Chapter 5: provides a synthesis and discussion of the findings in relation to the three super-ordinate themes and wider literature.

Chapter 6: summarizes the thesis and highlights the contribution of the research concerning the use of simulation to prepare student midwives to care for bereaved parents experiencing perinatal loss. This chapter concludes with the strengths and limitations of the study and implications for midwifery education, practice, and future research.

Chapter 2: Literature Review

2.1 Introduction

The previous chapter provided an overview from a variety of perspectives of the devastating impact of perinatal loss on parents and healthcare professionals. It also outlined the important role of education and training to prepare future midwives to care for bereaved parents. The focus of this chapter is to provide a thorough, critical analysis and syntheses of the available literature on bereavement education and perinatal loss. This chapter will begin by addressing the following aspects:

1. The rationale for conducting a literature review.
2. The different methods for undertaking a literature review.
3. The steps involved in undertaking a literature review.

A review of the literature is an integral part of any research study and fundamental to understanding the accumulated body of evidence about a particular topic or issue under review (Garrard, 2020). It involves the researcher critically appraising existing literature to address any gaps that may exist which in turn can provide a rationale and context for the chosen study (Aveyard, 2014; Polit & Beck, 2022). A literature review is an ongoing, iterative process (Williamson & Whittaker, 2019). Therefore, for the purposes of this study, it was important that I constantly engaged with the literature as the study progressed to take account of new or emerging evidence and knowledge that would inform my research topic, as recommended by Williamson and Whittaker (2019).

Prior to outlining the methodological approach to conducting the review, it is important to establish that, in qualitative research, considerable debate and a lack of consensus exists about undertaking a literature review, particularly in relation to grounded theory (Dunne, 2011) and phenomenology methodologies (Finlay, 2011a). Some theorists argue that in a phenomenological study, a thorough in-depth, critical examination of the literature prior to data collection is not necessary (Fry, Scammell, & Barker, 2017). In their critique of literature reviews in phenomenological research, Fry et al. (2017) advocated a more open and flexible approach and recommended

that the researcher reads minimal relevant literature on the topic area. This aims to avoid being unduly influenced by any preconceptions or findings which can result in a duplication of research. Nonetheless, for the purposes of this study, a systematised and critical examination of published literature was deemed appropriate to gain a contextual overview of the literature relating to bereavement education in midwifery.

2.1.1 Different Methods to Undertake a Literature Review

Since the 1990's, prominent methods for a literature review have ranged from the highly rigorous 'Cochrane style' systematic review to the narrative review consisting mainly of qualitive studies (Aveyard & Bradbury-Jones, 2019). In the UK, the Cochrane Collaboration, a large international organisation, focuses mainly on systematic reviews in healthcare as they are considered the 'gold standard', for reviewing the most detailed and robust forms of evidence that exists (ten Ham-Baloyi & Jordan, 2016). As a result, systematic reviews are used to provide '*an authoritative guide'* to healthcare decisions and produce the highest quality evidence for best practice guidelines including those for the National Institute for Health and Care Excellence [NICE] (Aveyard, Payne, & Preston, 2016; Norman & Griffiths, 2014).

While systematic reviews are considered fundamental to evidence-based practice (Peters, Godfrey, et al., 2015), they are time consuming and usually conducted by a team of researchers who undertake a detailed, extensive, critical appraisal of the evidence and in some cases a re-analysis of study findings (Aveyard et al., 2016). They are also highly selective and rely mainly on high quality studies such as randomised controlled trials and quantitative studies that focus on a particular condition or interventions to determine their effectiveness (Peters, Godfrey, et al., 2015). However, this approach can be restrictive as other forms of relevant research may be excluded (Dixon-Woods et al., 2006; Norman & Griffiths, 2014).

Over the years different approaches to conducting literature reviews have emerged. These include a scoping review, meta-synthesis, integrative review and narrative review (Norman & Griffiths, 2014). For the purposes of this study, a narrative review was deemed appropriate as it is particularly useful where a scholarly overview of the

literature is required that includes both quantitative and qualitative research (Harvey & Land, 2022; Norman & Griffiths, 2014). In the past, narrative reviews were considered subjective, and biased in their methodological process (Harvey & Land, 2022). However, a narrative review can provide a comprehensive overview of the topic provided the author adheres to a systematized approach to the review process (Norman & Griffiths, 2014).,

2.1.2 The Steps Involved in Undertaking a Literature Review

A literature review comprises part of a research methodology (Siu & Comerasamy, 2013), and involves a series of steps that must be undertaken in order to retrieve the most relevant literature to address the review question (Coughlan & Cronin, 2020). For this study, the process was structured by adapting the principal steps outlined by Aveyard et al. (2016, p. 3), as listed in **Error! Reference source not found.**.

Table 1 The literature review process

1	Developing a focused review question
2	Defining inclusion and exclusion criteria
3	Developing a search strategy to locate sources of evidence
3	Data extraction from selected studies
4	Critical appraisal of studies
5	Presentation of findings from all papers
6	Analysis and synthesis of findings
7	Summary of the literature review
8	Justification and rationale for the chosen study considering what is known and remains unknown

2.1.3 The Literature Review Process

A critical part of the review process involves having a clear aim and focus. Without this, the review focus will 'drift' and uncover a '*hodgepodge*' of unrelated literature with no clear aim or focus (Coughlan & Cronin, 2020). Therefore, the aim of this literature review is to:

1. Establish the evidence base around bereavement education within the context of undergraduate midwifery education.

2. Determine what is known about student midwives' involvement in simulation within the midwifery curriculum.

3. Explore the effectiveness of current methods of teaching and learning to prepare midwifery students with the necessary knowledge, skills, and confidence to care for bereaved parents.

To address the aim and focus of the review process, it is important that the research is led by a clear and focused review question (Aveyard et al., 2016). Having the right question is essential as it acts as a guide to finding the most relevant literature that will form the basis of the review (Aveyard, 2014). A vague or poorly defined question can lead to the most relevant literature being missed or an overwhelming volume of literature that can be difficult to process and does not actually address the question (Aveyard et al., 2016). To help me to formulate an answerable review question, I initially undertook some critical reading of the literature and literature review books to gain some ideas as to how to frame my question. I then considered a method to word the question. According to Aveyard (2014) questions can be presented as either 'interrogative' or 'declarative. An interrogative question is written in the format of a question whereas the declarative question is more of a statement. Aveyard (2014) suggested that when framing a research question, an interrogative format is preferable as it helps to keep the literature review focused throughout the entire process. Therefore, for the purpose of this review, the question used to guide the search is as follows:

How effective are the current methods of teaching bereavement care in preparing student midwives to care for parents experiencing perinatal loss?

2.1.4 Developing the Search Strategy and Using Key Search Terms

Having formulated the review question, to help locate relevant literature and journal articles regarding bereavement education and perinatal loss, the next step was to identify several keywords or search terms. Keywords are the cornerstone of an effective search and help ensure that the search strategy is both comprehensive and sensitive (Bettany-Saltikov, 2012). Aveyard et al. (2016) recommends using an extensive range of search terms that do not digress from the original and using journal articles and Google searches to gain some ideas as to the most suitable key terms to use.

In addition to identifying key search terms, it is important to find other words or search terms which include synonyms (words that mean the same) to maximise the chance of finding relevant literature (Aveyard et al., 2016). Combining the search terms using Boolean operators such as ‘AND’ (to retrieve records with both words), and ‘OR’ (to retrieve records with the same word) and by using truncation (Midwife and Midwif*) also guided the search and generated as many ‘hits’ as possible. The keywords used to retrieve relevant literature are outlined in Table 2.

2.1.5 Conceptual Tools Used to Aid Development of the Search Terms

To help further refine the search, Coughlan and Cronin (2020) stipulated the use of a conceptual tool such as PICO (Population, Intervention or issue, Comparison, Outcome) to find significant key terms and synonyms and make the search process more manageable (words or phrases that mean the same). PICO is frequently used for questions related to therapeutic interventions (Siu & Comerasamy, 2013). It is particularly useful for identifying key search terms that include all four elements of a review question and therefore prompts a more specific and comprehensive search of the literature (Aveyard et al., 2016, p. 69). Other acronyms useful for locating qualitative research included: SPICE (Setting, Perspective, Intervention, Comparison, Evaluation); SPIDER (Sample, Phenomena of interest, Design,

Evaluation) and PEO (Population, Exposure, Outcome). Examples of search terms are listed in table 2 below

Table 2 Example of search terms

Column terms combined with *OR*	*Population / and problem* *AND*	*Intervention/ exposure/* *AND*	*Comparison* *AND*	*Outcomes* *AND*
OR	*Student*	*Simulation*	*Teaching*	*Experiences*
OR	*Midwife*	*Simulat**	*Education*	*Confidence*
OR	*Midwi**	*High-fidelity*	*Bereavement education*	*Knowledge*
OR	*Midwifery*	*Standardised patient*	*Bereavement care*	*Skills*
OR	*Pre-registration*	*Role play*	*End of life care*	*Attitudes*
OR	*Pre-licensure*		*Stillbirth*	*Learning*
OR	*Undergraduate*		*Foetal demise*	
OR	*Pre-qualif**		*Perinatal loss*	
OR	*Degree*		*Perinatal death*	
OR	*Baccalaureate*		*Neonatal death*	
			Perinatal palliative care	
			Perinatal bereavement	

2.2 Selection of Databases

Having identified the search terms and synonyms, the next stage involved planning the database search. To maximise access to relevant literature including unpublished or ‘grey literature’ (policies, theses, conference papers), Aveyard et al. (2016) advised searching as many databases as possible that have an extensive

range of literature relevant to nursing, midwifery and allied health. The databases I chose to search included: CINAH, Medline (combined, Medline also includes Web of Science) and PubMed, PsychINFO, Joanna Briggs Institute, Cochrane Database of Systematic Reviews, Education Resources Information Centre (ERIC), EMBASE. In addition, I manually searched journals such as Midwifery, MIDIRS Midwifery Digest, Clinical Simulation in Nursing and grey literature. Grey literature included sources such as published abstracts, conference proceedings, along with policies and guidance from the Nursing and Midwifery Council, Health Education England, and the British Library ETHOS.

To help identify terms and search for clues for relevant literature, I also used a technique called '*back chaining*'. This involved locating an article relevant to my topic and checking its search terms and list of references (Rees, 2012). The reference list of these articles and previous systematic reviews were subsequently checked for suitable articles until the same articles relevant to my topic kept reappearing. Aveyard et al. (2016) recommended using search engines such as Google Scholar, with caution as it can generate a large volume of literature irrelevant to the search as well as limited access to academic resources. However, Google Scholar can provide additional links to cited papers which can help to locate additional sources of recent up-to date literature.

2.2.1 Inclusion and Exclusion Criteria

In addition to identifying appropriate search terms and sourcing relevant databases, to access literature directly related to the topic areas, it was important to establish strict inclusion and exclusion criteria. Inclusion and exclusion criteria help focus the review and prevent the researcher from getting side-tracked by topics that are not relevant to the research question (Aveyard, 2014). Inclusion criteria were followed, as recommended by Stern, Jordan, and McArthur (2014), which are listed in Table 3.

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Table 3 Inclusion criteria

Primary research studies including qualitative, quantitative, and mixed methods and relevant non-research papers, for example case studies if relevant to the topic area.
Focus on pre-registration midwifery education and / or undergraduate education but not necessarily limited to nurses, midwives, nursing students.
Studies that relate to bereavement education, end of life care, teaching methods, content, and simulation or any education programme that focuses on perinatal bereavement care.
Studies that focus on outcomes such as experiences, knowledge, skills, attitudes, preparation for practice.
Studies that specifically address perinatal loss, stillbirth and the perinatal period, and the neonatal period up to 7 days.
Focus on papers 2000-to current date.
Studies written in the English language.

To reduce the volume of literature further, exclusion criteria were applied, as listed in

:

Table 4 Exclusion Criteria

Research studies that do not focus on perinatal loss or death.
Studies that do not include healthcare professionals or students.
Studies that do not include bereavement or palliative / perinatal care education.
Studies that relate to early pregnancy loss such as termination or miscarriage

2.3 The Process of Selecting the Studies and Extracting the Data.

An initial search of the electronic databases produced a total of 166 papers. The process of selecting or excluding studies consisted of two stages. The first stage began by initially screening the titles of each of the studies retrieved from the search (Bettany-Saltikov, 2016). The studies which did not include bereavement education involving perinatal loss as a focus were subsequently excluded. Aveyard et al. (2016) stated that just reviewing the titles of each paper is insufficient to determine its relevance to the study. Therefore, the second phase involved sifting through the abstracts of the studies to assess whether they met the inclusion criteria. Abstracts can only provide a brief insight into the content of a paper (Jacobsen, 2016) so to gain a better understanding of a study, the full text of a paper was read in its entirety. Further studies were subsequently included or rejected if they were not applicable or relevant to the predetermined inclusion criteria (Bettany-Saltikov, 2012). After screening the abstracts and reading the full text of each article, a total of 15 studies were included. The process of selecting the studies is outlined in the Prima Flow Diagram, as shown in Figure 1.

Aveyard et al. (2016) stressed the importance of documenting all stages of the review process to ensure transparency and rigour. Therefore, the search strategies were recorded and saved periodically. I initially created a folder in each of the databases and recorded the date the searches were undertaken, the number of hits and the articles retrieved. I also used software such as Endnote and inputted the articles electronically into different groups which enabled me to keep an accurate and accessible record of the literature retrieved (Aveyard et al., 2016).

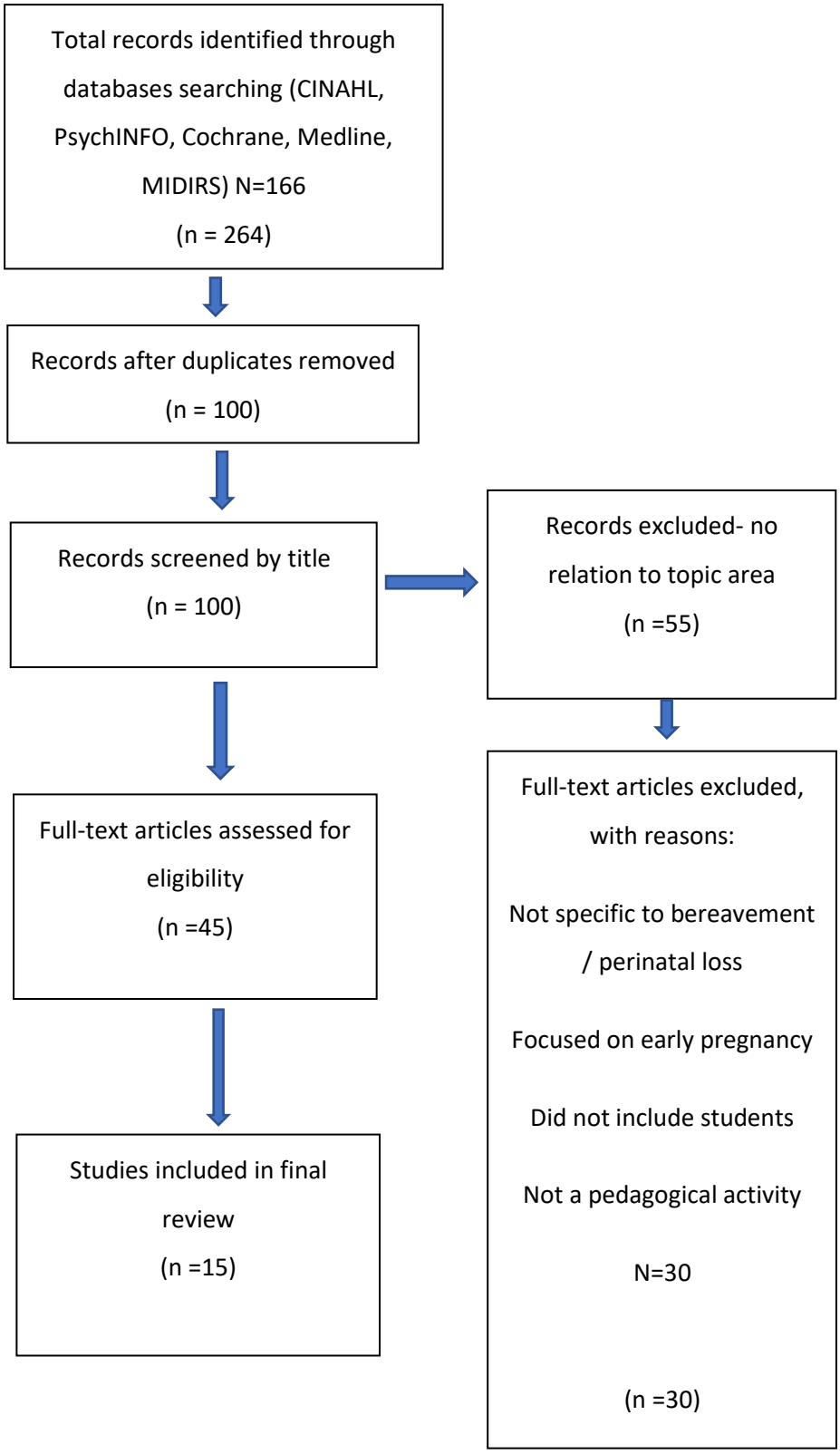

Figure 1 Prisma flow diagram

2.3.1 Data Extraction Process

Once I reviewed and selected papers against the inclusion and exclusion criteria, the next stage involved a thorough assessment of each paper (Aveyard et al., 2016). Aveyard et al. (2016) stressed the importance of having a logical data extraction process or data summary as it aids clarity and helps identity key points from a paper that determines its relevance to the review question and subsequent analysis. To begin this process, each paper was read thoroughly. A standardised table was created by extracting the following data: author, country, publication year, study design, aim of the study, participants, sample size, teaching intervention, outcomes, measurements or evaluation process, and the main findings of each study. This extraction process helped to compare the similarities and differences across the included studies and to identify the common themes (Aveyard, 2014). The characteristics of each study are presented and outlined in Table 5.

Table 5 Synthesis of core papers

Author/Year/ Location	Sample	Research Design	Methods of Data Collection	Study Aims	Teaching Methods	Key findings/Themes	Limitations
1.Foster and Donovan (2017) Australia	10 final year undergraduate nursing & midwifery students	Qualitative study	Debriefing session	To explore the impact of a simulated neonatal resuscitation on nursing / midwifery students' perceptions /preparation to provide bereavement support	Students participated in two simulated neonatal resuscitation scenarios for 30min. The simulation was videotaped and then followed by a debriefing	Main themes: feeling unprepared, communication Simulation can be effective in developing and students to reflect on their bereavement skills and neonatal death	No member checking re. themes Influence of researcher unknown
2. Cole and Foito (2019) USA	216 Nursing students	Qualitative study Pre-simulation-pre-course reading, use of vignettes	Debriefing / guided reflection Completion of a 4-question survey	To explore the impact of pediatric eol simulation on student nurses' ability to provide care	Simulated scenario involving an unresponsive baby (manikin) following ischaemic brain injury	Overall, the students felt they gained knowledge, awareness, family centered empathic care.	Use of self - reports

Author/Year/ Location	Sample	Research Design	Methods of Data Collection	Study Aims	Teaching Methods	Key findings/Themes	Limitations
3. Bailey and Bishop (2017) USA	Nursing students Sample size not stated	Case report	Post simulation reflection tool	Examining the use of a simulated fetal demise scenario on students' knowledge and communication skills in intrapartum / postpartum care	A simulated scenario involving a 28 yr. old G2 P1 with a history of reduced fetal movements	Students reported enhanced communication skills following the simulation Students valued opportunity to practice in a simulated setting prior to clinical practice	No details provided about the simulation. No evidence as to how it developed students' skills in advocacy, family dynamics
4.Doherty et al (2018) Ireland	Undergraduate midwifery students (N=41)	Quantitative A longitudinal sequential mixed-methods study	Perinatal bereavement care confidence scale Self-compassion Scale	To improve student midwives' level of confidence (knowledge and skills) in relation to bereavement care before and after participation in an educational training workshop	Education training workshop on bereavement care A short interactive quiz to measure knowledge	Significant increases in student confidence, bereavement support needs and knowledge and increased self-awareness of bereaved parents needs and their own personal needs (p <.000)	A small sample size conducted at one hospital site No adjustment made for student's age or past experiences

Author/ Year/ Location	Sample	Research Design	Methods of Data Collection	Study Aims	Teaching Methods	Key findings/Themes	Limitations
5 Barry et al. (2017) Ireland	Undergraduate post RN student midwives (N=6)	Descriptive qualitative design	Semi-structured interviews	To explore the influence of Amulet artwork and exhibition on students' perceptions of caring for parents experiencing perinatal death.	Visit to the Amulet collaborative artwork and exhibition	i) Entering the mother's world, hearing her pain; ii) the journey of grief / connecting with the parent's unique experience iii) the challenge of providing effective perinatal bereavement care; iv) maintaining a journey of compassionate practice	Small sample size 'One off' visit to an art exhibition The influence of researcher unknown
6. Colwell (2017) UK	Paediatric nursing students / midwifery (N=16)	Quantitative study	Post-session evaluation / Likert scale	To examine the use of simulation in neonatal simulation	4 discussion scenarios / 2 simulated scenarios	100% students learned a lot, 87% increased in confidence in managing the situation	Self-report knowledge scores

Author/ Year/ Location	Sample	Research Design	Methods of Data Collection	Study Aims	Teaching Methods	Key findings/Themes	Limitations
7. Patterson et al (2016) UK	Undergraduate midwifery students N=35	Descriptive qualitative study	Phase 1: Questionnaire (qualitative Phase 2: Focus group	To evaluate use of poetry (Elegy for a Stillborn Child) & establish the impact on the emotional insight of students to pregnancy loss.	Following a lecture, using poetry, students read a poem 'Elegy for a Stillborn Child' / followed by a discussion of the insights gained	Students reported increased emotional intelligence, professional insight, impact of loss on a father	No measurement of emotional intelligence Reliance on students' verbatim reports and subjective accounts
8. Sorce & Chamberlain (2019) USA	Perinatal nurses Non-randomised (N=54)	Quantitative Pre-test / post-test evaluation design	BEACONNS Measuring TOOL (Attitudes / beliefs)- Likert -type scale Multiple choice questionnaire to measure knowledge	To evaluate a bereavement educational session using didactic learning and simulation	One lecture, followed by 2 simulated perinatal loss scenarios 10 min Debrief	Participants' knowledge (p=0.000) and degree of comfort (p=0.000) with basic aspects of bereavement care showed significant improvements	Small non-randomized sample from a single setting. Difficult to determine if the levels of knowledge and comfort were due to the didactic session or the simulation 5 similar questions were used in pre / post -test which may affect results

Author/Year/Location	Sample	Research Design	Methods of Data Collection	Study Aims	Teaching Methods	Key findings/Themes	Limitations
9. Hollins-Martin et al (2014) UK	Undergraduate 2nd / 3rd year midwifery students (N=179)	Quantitative study	Pre and post completion of a workbook Understanding Bereavement Evaluation tool (UBET)	To evaluate the effectiveness of an interactive workbook to develop students' knowledge of bereavement care	Students undertook the completion of a workbook over the course of a day in a classroom Self-directed learning	Significant improvement in knowledge scores pre-intervention to post intervention (p=<0.001). Workbook an effective teaching / learning resource for students	The study was conducted over the course of a day which may impact on the reliability and validity of the results. No actual measurement of the impact on practice
10. Hollins-Martin (2016) UK	Undergraduate 2nd / 3rd year student midwives (n=179)	Qualitative study	Qualitative data obtained in the previous study (UBET)	To explore their views of potential teaching strategies that could build their confidence to deliver real bereavement care	Interactive workbook	Key themes Increasing classroom interaction, Importance of reflecting on emotions, Increased need for experience	Workbook suitable for theoretical content. Inadequate at building student confidence to manage their own emotions in a real bereavement situation. Relied on students self-reporting Researcher's influence unclear

Author/Year/ Location	Sample	Research Design	Methods of Data Collection	Study Aims	Teaching Methods	Key findings/Themes	Limitations
11. Gardiner et al. (2016) Australia, New Zealand, UK	Healthcare professionals (N=758)	Quantitative	Pre / post workshop questionnaires	To assess change in participants' knowledge, confidence, satisfaction following attendance at IMPROVE workshop	30 IMPROVE workshops consisting of a short lecture / 6 learning stations	Evaluations showed a significant improvement between pre- and post-programme knowledge and confidence in all six stations and overall, and a high degree of satisfaction in all settings.	No background information regarding participant's type of speciality Data collated immediately after the workshops No measurement of effect on clinical practice
12. Ratislavová and. Štípková, (2019) Czech Republic	Healthcare professionals including doctors, nurses, and midwives (N=200)	Quantitative pre/ post-test questionnaire	The evaluation questionnaire comprised of questions focusing on the perceived level of knowledge of respondents before and after the completion of the educational programme	To evaluate the effectiveness of prenatal loss blended educational programme	10-week programme consisting of 10 e-learning lectures and 2 practical seminars.	A statistically significant effect on the overall score in individual groups of respondents, as well as the whole set ($p<0.001$), with post-intervention scores higher than pre-intervention scores in relation to the knowledge and understanding of perinatal bereavement care.	Data only collected immediately after the educational programme. A brief evaluation tool was used, and one was not validated.

Author/ Year/ Location	Sample	Research Design	Methods of Data Collection	Study Aims	Teaching Methods	Key findings/Themes	Limitations
13. Price (2019) UK	Midwifery students (N=39) Nursing students (N=34	Mixed methods study	Quantitative / qualitative two-part questionnaire	To evaluate students' awareness of perinatal / neonatal palliative care	Attendance at a perinatal / neonatal workshop	Significant differences between pre/ post-test scores in students' knowledge, confidence, understanding of perinatal end of life care (P=0.000) Qualitative data: 3 key themes (I) Understanding of professional role in supporting grieving parents. (2) MDT input in bereavement care (3) increased confidence in support services / information for parents	Some students only attended part of the day, difficult to draw comparisons Some students had prior knowledge and experience which may impact on confidence levels

Author/Year/Location	Sample	Research Design	Methods of Data Collection	Study Aims	Teaching Methods	Key findings/Themes	Limitations
14. Mitchell (2005) UK	Student midwives (N=45)	Qualitative	Verbal feedback / written comments	To evaluate student midwives' experiences and perceptions of a one-day session on caring for bereaved parents	Video, lecture, discussion, interview with leader of SANDS group	Dealing with death / bereaved families. Students reported anxieties and fears	No validated evaluation instrument used to measure responses Relied on self-reports from students Session was only undertaken on one day

2.3.2 Critical Appraisal of the Studies

The next stage of the review process involved a critical appraisal of each of the selected studies. Critical appraisal is one of the most important features of the literature review process (Aveyard, 2014). It involves making an assessment of the strengths and limitations of a study to determine its relevance to the research question (Aveyard, 2014). Although there are a number of tools available including Critical Appraisal Skills (CASP, 2010) published by the Joanna Briggs Institute (Aveyard et al., 2016), there is no one 'Gold Standard' (Aveyard et al., 2016). For the purposes of this literature review, The Caldwell Framework was considered suitable (Caldwell, Henshaw, & Taylor, 2011) as it combines both quantitative and qualitative critical appraisal questions within one format. It can also be applied to any kind of research design and can be used to assess the quality of non-research papers thereby making it appropriate for this review (Bettany-Saltikov, 2012). A copy of the framework is included in Appendix 5.

2.3.3 Characteristics of the Included Studies

After addressing the review question on exploring the effectiveness of the current methods of bereavement education in preparing student midwives to care for parents experiencing perinatal loss, this review found only a total of 15 papers which specifically met the inclusion criteria. The papers were published between 2002 and 2019 and six of the studies were from the UK. Four studies were conducted in the USA, two in Ireland, one each in the Czech Republic and Australia, and one international research paper (Australia, New Zealand and the UK).

Study design: There were seven quantitative studies in total (Colwell, 2017; DiMarco, Renker, Medas, Bertosa, & Goranitis, 2002; Doherty, Cullen, et al., 2018; Gardiner et al., 2016; Hollins Martin, Forrest, Wylie, & Martin, 2014; Sorce & Chamberlain, 2019). A total of six qualitative studies were included (Barry et al., 2017; Doherty, Cullen, et al., 2018; Forster & Donovan, 2016; Martin et al., 2016a; Mitchell, 2005; Patterson, Begley, & Nolan, 2016) One mixed method study was also included (Price, Mendizabal-Espinosa, Podsiadly, Marshall-Lucette, & Marshall, 2019) and one case study (Bailey & Bishop, 2017).

Sampling: The study participants consisted mainly of undergraduate nursing and midwifery students. Four of the studies included other healthcare professionals such as doctors, perinatal nurses, and qualified midwives (DiMarco et al., 2002; Gardiner et al., 2016; Ratislavová & Štípková, 2019). Across the studies the sample sizes varied from six (Barry et al., 2017) to 758 (Gardiner et al., 2016). There was, however, a lack of consistency between the studies regarding gender identity, ethnicity, and age range. In most of the studies the participants tended to be female.

Within the studies there was little detail regarding the sampling strategies used. However, convenience and purposive sampling tended to be the most common methods of recruitment. An advantage of convenience sampling is that it is relatively quick and selects the most available, convenient people for participation (Rees, 2012). However, it is considered the weakest form of sampling and the people who self-selected may not be representative of the wider population (Polit & Beck, 2022). Also, the combination of small sample sizes and the inconsistency in the methods used to recruit the participants could potentially limit the quality of the evidence produced. Therefore, I was aware that the findings needed to be viewed with caution.

Teaching methods: In each of the studies, a range of teaching strategies was used to teach bereavement. However, lectures, case studies, attendance at workshops and conferences tended to be the most common methods of teaching. Only six studies used simulation and simulated scenarios (Bailey & Bishop, 2017; Cole & Foito, 2019; Colwell, 2017; Forster & Donovan, 2016; O'Shea et al., 2015; Sorce & Chamberlain, 2019).

Moreover, only two of the simulated studies used midwifery lecturers as standardized patients to enact the role of a grieving mother (Colwell, 2017; Forster & Donovan, 2016); Hollins Martin et al. (2014) used an interactive workbook. Three studies incorporated more creative approaches to help students gain emotional insights into the grief experienced by bereaved parents. For example, Patterson et al. (2016) used a poem written by Seamus Heaney (a well-known Irish Poet), entitled ‘Elegy for a Stillborn Child’. Barry et al. (2017) incorporated student midwives visiting

an art exhibition on palliative care. With regard to follow up psychological support for students, only two studies specifically referred to on-going support in the form of counselling (Mitchell, 2005) and mindfulness training (Doherty, Coughlan, et al., 2018).

Methods used to evaluate the teaching: The methods used to collect the data and evaluate the teaching methods varied. Barry et al. (2017) used semi-structured interviews. Mitchell (2005) mainly relied on verbal and written feedback which may have limited the quality of the evidence. Only two studies used debriefing and guided reflection as a data collection method (Cole & Foito, 2019) (Forster & Donovan, 2016). Neither of these studies stated if a structured approach was used to facilitate the debrief. A small number of studies used psychometrically robust instruments which were designed to measure the participants' knowledge base concerning the psychosocial and emotional aspects of bereavement care (DiMarco et al., 2002; Doherty, Cullen, et al., 2018; Hollins Martin et al., 2014; Sorce & Chamberlain, 2019). The remainder of the studies utilized pre / post-workshop questionnaires and Likert scales designed by the authors themselves without any evidence of testing for reliability and validity.

2.4 Discussion of the Findings

This section will provide a critical discussion and synthesis of the key findings and themes that emerged from the literature. According to Aveyard et al. (2016), the findings and discussion can be presented as two separate sections. However, for the purpose of this review, I chose to combine them to provide a narrative that connected the results to the review question and wider contemporary literature.

The review identified several studies that concentrated on outcomes in relation to students' perceived knowledge, confidence, and emotional competence to care for bereaved parents using a variety of teaching methods. Therefore, I have grouped the key findings into two broad headings: healthcare professionals' knowledge, professional competence in their role and responsibility in providing perinatal bereavement care, and the evaluation of the teaching methods used to teach perinatal loss bereavement care.

2.4.1 Healthcare Professionals' Knowledge and Professional Competence in their Roles and Responsibilities in Providing Perinatal Bereavement Care.

To gain an understanding of healthcare professionals' knowledge, professional competence in their role, and responsibility in providing perinatal bereavement care, Cartwright and Read (2005) conducted a series of five workshops over two days with a sample of 21 newly qualified and 'return to practice' health visitors. Phase one of the workshops consisted of interactive teaching and learning strategies, including case studies designed to explore participants' experiences and responses to perinatal loss within their role as health visitors. Phase two involved a formal evaluation of the phase one workshops. Two methods were used to collect the data: a 20-item questionnaire to measure the baseline knowledge, and their development which compared the responses pre and post workshop.

To capture the participants' thoughts and feelings, one-hour focus groups were subsequently conducted using six open questions to ascertain their view and opinions. Findings from the study revealed a significant increase in participants' knowledge from the pre and post questionnaire about the psychological impact of perinatal loss on parents. It also increased their knowledge of the importance of multi-disciplinary input in providing quality care to bereaved parents. The focus group analysis also highlighted their perceived lack of competence and a profound sense of vulnerability in this aspect of care. The opportunity to explore and discuss grief and loss from a personal and professional perspective in a safe nurturing environment was considered critical to their learning and on-going professional development.

However, this was a small study conducted in one university using one pre and post group evaluation with no control group, so it was difficult to establish the true cause and effect of the workshop intervention (Harvey & Land, 2022). Also, the study mainly focused on health visitors recruited by a lecturer known to them which could potentially incur an element of bias thereby limiting the generalizability of the findings to other healthcare professionals (Polit & Beck, 2022). However, the study contextualized the emotional difficulty that healthcare professionals experience

around this aspect of care, which is applicable to midwives and students. The findings also acknowledged the importance of developing bereavement education to strengthen healthcare professionals' knowledge and competence in providing for perinatal death and bereavement care.

In a comparable study, Mitchell (2005) evaluated a sample of midwifery students (N=45) enrolled on 18-month and three year programs following their attendance at a one-day workshop. The workshop focused on the theoretical aspects of grief and loss which was followed by the observation of a video detailing a family's experience of stillbirth and the midwifery care they received. The second part of the workshop involved user representation from the Stillbirth and Neonatal Death Society (SANDS) who discussed the important role of SANDS as a charity in supporting bereaved parents. The evaluation of the workshop consisted of students writing reflective accounts and providing verbal feedback about their learning experiences. The verbal content was recorded by the facilitator. Both the written and verbal reflections were subsequently analyzed and subjected to thematic analysis (Braun & Clarke, 2013). The students experienced a 'dichotomy' of emotions ranging from fear and anxiety to feelings of positivity and professional confidence and empathy in caring for bereaved parents. In terms of teaching methods and preparation for practice, it was reported that after attending the workshop, some students felt able to apply aspects of the workshop to a real-life clinical situation involving a woman whose baby had died. However, there was limited evidence to indicate that a one-day workshop would be enough to effectively prepare students to care for bereaved parents. The study relied mainly on self-reporting measures of confidence which can be very unreliable.

Nevertheless, having opportunities to reflect and explore their feelings within the group enabled the students to normalize their emotional reactions to grief and loss. Listening to the bereaved parents detail their experiences made it a more meaningful learning experience (Mitchell, 2005). According to Price et al. (2019), the parent voice should be part of any teaching and learning strategy on perinatal or bereavement care within nursing and midwifery curricula to enhance quality care for infants and their families. Their action research study evaluated an inter-professional workshop involving service users with a sample of final year midwifery (N=39) and

nursing students (N=34). The study found convincing evidence for the value of collaborative learning and group work discussion in improving students' knowledge and skills to support bereaved parents. Listening to the bereaved mother's experience was considered the most 'memorable' aspect of the workshop. The authors concluded that more extensive research on perinatal and bereavement care within undergraduate curricula is required.

2.4.2 Evaluation of Methods Used to Teach Bereavement Education Involving Perinatal Loss

Based on the findings from a National Maternity Support Foundation [NMFS] (2009) report highlighting inconsistencies and inadequacies in bereavement care, Hollins Martin, Forrest, Wylie, and Martin (2013) compiled an interactive workbook '*Shaping bereavement care for midwives in clinical practice*' to improve bereavement education for undergraduate and postgraduate midwives. The workbook was designed to encompass the physical, emotional, and psychosocial aspects of grief and loss. An evaluation of the workbook was undertaken using the 'Understanding Bereavement Evaluation Tool' (UBET) which was designed to measure a sample of second- and third-year student midwives' (n=179) knowledge before and after completion of the workbook. The study was conducted at three UK universities, one in the Northwest and two in Scotland. The students ranged in age from 18 to 49 years. Two classes (one comprising second and one comprising third year students) from each of the three universities were recruited from classroom sessions which would normally involve content around bereavement care. This was altered to include the completion of the workbook over the course of one day in a classroom within the university. The UBET instrument consisted of seven questions which matched the questions in the workbook. The UBET was designed to assess reliability and validity using a Likert scale to measure knowledge prior to and after completing the workbook. Previous validity tests indicated that the UBET tool was a reliable psychometric instrument showing internal consistency (Cronbach's alpha=0.78) (Hollins Martin et al., 2014).

Findings revealed that students' knowledge and understanding significantly increased from the mean pre-workbook UBET intervention score:16.04 (SD=3.81)

against the mean post-intervention score: 26.45 (SD=2.16). The third-year student midwives demonstrated higher levels of theoretical knowledge compared to year two students ((p=0.01). The author attributed this to the senior students' having longer periods in clinical practice and exposure to bereaved parents which may have enhanced their sense of self-efficacy. However, most of the students scored low in relation to a question about their level of confidence in providing care to bereaved parents. Some students found the workbook to be emotionally challenging to complete over the course of one day in the university without the opportunity to discuss and share experiences with their peers.

Hollins Martin et al. (2014) concluded that while the workbook provided some theoretical foundation on bereavement, it was inadequate in building student confidence to emotionally support bereaved parents. This may be due to the focus of the content on cognitive aspects as opposed to the affective components of grief and loss (Hollins Martin et al., 2014). In a subsequent exploratory qualitative analysis exploring students' views of teaching methods aimed at enhancing their confidence in bereavement care, Martin, Robb, and Forrest (2016b) reported that additional experiential learning using simulation would be more beneficial than simply applying theoretical knowledge to practice. However, including a convenience sample from three universities may limit the generalizability to students from other universities, which represents a key limitation to the study of Hollins Martin et al. (2014).

To complement traditional methods of bereavement education, two studies focused on using more creative approaches to encourage students to reflect on the human experience of perinatal loss. In a descriptive qualitative study, a convenience sample of midwifery students (n=35) were asked to read a poem titled 'Elegy for a Stillborn Child' to determine their emotional insight into pregnancy loss and to enhance emotional intelligence (Patterson et al., 2016). The authors described emotional intelligence as being able to acknowledge their own feelings and emotions and those of others. The study was conducted in a classroom setting in a university. Prior to the study, the students were given the poem to read, which was followed by a lecture on pregnancy and loss. Phase one of the study involved the completion of a previously validated anonymous questionnaire consisting of five questions focusing

on three key areas – emotional insight, feelings, and practice implications. Thirty-minute focus group interviews were subsequently conducted to gain students' perspectives after reading the poem. Focus groups are considered an appropriate way of gathering data around sensitive and challenging topics such as grief and loss (Harvey & Land, 2022). To ensure the process was rigorous, the interviews were audio-recorded, and notes were taken throughout the process. The data was subsequently analyzed using thematic analysis and was combined with the feedback from the questionnaires. To enhance credibility, the authors compared and verified the findings to ensure their accuracy (Harvey & Land, 2022).

Three key themes emerged from the students' greater insight, namely the impact of loss from the mother's and father's perspectives, and the lasting effects of grief and the pain that parents endure. The authors concluded that using poetry was useful in enhancing emotional intelligence in student midwives. However, the data was gathered immediately after reading the poem, so it is difficult to determine the students' level of emotional intelligence and how they might apply it to their practice in the long term. Furthermore, the students had a wide range of experiences which may have influenced the reliability and validity of the information produced (Rees, 2012). In addition, the relationship between the facilitators and the students was unclear; often if there is a hierarchical position between the interviewees or when the interviewer (in this case a midwifery lecturer) is known to the interviewees. Thus, there is a possibility that the students would provide acceptable answers to impress, or a possibly avoid criticism from, the interviewer (Rees, 2012).

Nevertheless, from an educational perspective, incorporating art-based palliative training in the form of literature, artwork and poetry can provide students with a deeper and meaningful way of learning about grief and loss (Nicol & Pocock, 2020). In comparison to lecture only sessions, creative approaches to teaching and learning can enhance the development of affective, socials and cognitive skills (Rankin & Brown, 2016). There is a growing body of literature that supports the use of more creative approaches to enable practitioners explore their thoughts and feelings around the concept of death and dying, particularly within nursing education (Nicol & Pocock, 2020). However, within the context of midwifery education this appears to

be somewhat lacking. One small qualitative descriptive was found within ‘The Amulet’, a collaborative artwork and exhibition depicting photographs of family amulets (keepsakes) and parents’ stories to explore midwifery students’ (n=6) perceptions of caring for parents experiencing infant loss (Barry et al., 2017). The study concluded that, through reflection on the art-exhibition, the students gained insight into the complexity of grief and the emotional journey that parents undergo following a perinatal death. The students valued the calm and serene nature of the artwork which facilitated open discussion and the importance of spending time with bereaved parents. However, this was a small study with limited evidence on the impact on practice.

In a more recent study, Nicol and Pocock (2020) also explored student nurses’ (n=48) experiences and beliefs about death and dying following attendance at an art-based workshop depicting expressions of death and dying. The artwork prompted emotional responses and reflective dialogue on the vital role of empathy towards the dying, and a family-centered approach around end-of-life care. Nicol and Pocock (2020) claimed that by adopting these learning approaches, students are able to build their confidence and knowledge to provide compassionate relational end-of-care that focuses on the human experience as opposed to task-orientated care. However, findings from these studies must be viewed cautiously. Art-based methods of data collection can be subjective and prone to multiple interpretations which can vary over time (Guillemin, 2004). Neither study acknowledged the impact of attending the exhibition on students’ clinical practice. Therefore, longitudinal studies identifying changes and developments in student learning over time may yield more detailed and extensive findings (Harvey & Land, 2022).

In relation to the use of simulation to teach student midwives about bereavement care, an extensive search of the literature yielded only six studies that specifically focused on bereavement simulation involving perinatal loss. This is a concern as more recent studies confirmed a lack of confidence, gaps in knowledge and skills and inadequate emotional support as contributory factors that challenge students and midwives when providing effective bereavement care (Doherty, Cullen, et al., 2018; Kalu, Coughlan, & Larkin, 2018). Furthermore, in a study exploring midwives’

and student midwives' fears around childbirth, obstetric emergencies involving the death of a baby was cited as a major cause of fear and anxiety (Dahlen & Caplice, 2014). This again further highlights the need for real life simulated scenarios to enable students to acquire the skills necessary to cope with unexpected clinical events in practice.

2.4.3 Limitations of the Review

The above section has provided a critical overview of the literature in relation to perinatal bereavement within the context of midwifery education. However, several limitations were identified. Firstly, that there was lack of homogeneity across the studies in terms of sample sizes and demographic profiles. The participants in each of the studies varied in relation to their level of experience and academic course or the context in which they attended, so it is difficult to conduct a comparative analysis. Based on the review findings, it is also difficult to determine the efficacy of the teaching methods due to a lack of consistency in teaching methods and evaluation tools. The studies only measured satisfaction levels immediately after the teaching sessions, therefore the impact on application to practice was difficult to determine. There were also variations in the methodological approach within each of the studies and a distinct lack of underpinning theoretical concepts in relation to adult learning theories and application to simulation. A conclusion from the literature review is that phenomenological studies like this thesis are relatively sparse. Also, there are no underpinning theoretical philosophical concepts that offer insight into, or address the variations in, students' lived experience of bereavement education involving simulation.

2.4.4 Summary

Having addressed a review of the literature in relation to bereavement education and perinatal loss, it is recognised that traditional pedagogical methods of teaching and learning are somewhat limited as they fail to acknowledge the important role of experience in enhancing learners' knowledge and application to practice (Manolis, Burns, Assudani, & Chinta, 2013), along with the development of critical thinking skills (Banfield, Fagan, & Janes, 2012). This highlights the need to adopt experiential forms

of learning that will effectively transform bereavement education in midwifery using a simulation-based pedagogy. Whilst much of the evidence exploring the value of simulation as a method of teaching and learning is predominantly based on studies conducted in nursing, medical and multi-professional education (Labrague, McEnroe-Petitte, Bowling, Nwafor, & Tsaras, 2019), there is still a dearth of evidence evaluating the use of simulation within the context of midwifery education (Vermeulen et al., 2020). The remainder of this chapter will discuss evidence concerning the use of simulation as a method of teaching and learning within the context of midwifery education with reference to contemporary sources of literature. The section concludes with a consideration of Mezirow's transformative learning theory and its application to simulation. The following outlines the discussion in this section:

1. Contemporary definitions of healthcare simulation and the historical origins of simulation.

2. Evidence for the effectiveness of simulation within the context of undergraduate midwifery education.

3. A review of experiential learning theories - including Mezirow' transformative learning theory - and how it applies to simulation.

2.4.5 Contemporary Definitions of Simulation

There are variations in the literature as to how simulation maybe defined. However, it is important to differentiate between the terms 'simulate' and 'simulation'. The term simulate means '*to pretend or imitate something or somebody*' (Angelini, 2021, p. 1). A 'simulator' can be classed as an object, device, situation or environment in which a number of skills or can be practiced in an almost real, simulated setting using electronic mannequins, role play, actors, and part-task trainers for training and education purposes (Gardner, 2014). Hovancsek (2007) describes simulation as an attempt to:

> '*Replicate some or nearly all aspects of a clinical situation within a safe environment, so that it becomes more readily understood and managed when it occurs for real in a clinical setting'*

Pilcher et al. (2012, p. 281) further defined simulation as '*representing an actual or potential situation whereby participants are enabled to analyse and respond to realistic events without placing patients at risk'*. More specifically the Nursing and Midwifery Council (2018 p.14) defines simulation as:

> *'Development and assessment through experiential learning with the opportunity for repetition, feedback, evaluation and reflection*".

For the purposes of this study, the definitions outlined by Pilcher (2014) and Hovancsek (2007) will be applied as both imply a holistic perspective of simulation (Miller, 2019). The Nursing and Midwifery Council's definition of simulation also encompasses the key components of feedback, evaluation, reflection, and application to practice, which underpin the principles of experiential and transformative forms of learning.

2.4.6 The Origins of Simulation in Midwifery

It is difficult to determine the exact origins of simulation. However, the use of simulation and simulators in obstetrics has been in operation for approximately 1500 years (Gardner, 2014). In the 1900s, wax or wooden models of pregnant women were used to demonstrate the mechanism of labour. In the 1700s, there was some evidence that a wicker pelvis was also used to 'simulate' normal and abnormal processes of labour. In 1756, Madame Du Coudray, a midwife to the court of King Louis XV, invented the first real life size birthing mannikin in the form of a fabric model of a pelvis using flesh coloured fabric, leather and padding (Gelbart, 1998). Madame Du Courdray's mission was to improve midwives' competence in birthing skills and to save babies' lives. She travelled all over France teaching village midwives using her birth mannikins and cloth dolls which simulated potential complications and possible outcomes that could occur in labour (Gelbart, 1998). Although Madame Du Coudray died in 1794, her skeletal and fabric models have been modified and adapted and used extensively to teach the mechanism of labour within undergraduate medical and midwifery education (Gardner, 2014).

In the 1950s, improvements in simulation technology led to the development of a computerised simulator called '*Mrs Chase'* as well as '*PLATO*' and '*Kruse dolls*'

(birthing dolls)which were used for obstetric training and education purposes (Palaganas, Epps, & Raemer, 2014, p. 111). In the 1960s, advances were made in resuscitation training when mannikins emerged with the purpose of enabling cardiopulmonary resuscitation (CPR) education. Since 1960, the Laerdal Resusci-Annie mannikin has become the most widely known form of simulation used to teach healthcare professionals and lay people resuscitation skills (Nickerson & Pollard, 2010).

Over the years, simulation technology progressed rapidly to encompass a diverse range of highly sophisticated technical and virtual reality simulation systems designed to teach a variety of technical and non-technical skills (MacLean, Kelly, Geddes, & Della, 2017). Simulation is now used extensively across a wide range of disciplines including the aviation and nuclear power industry, the armed forces, and the healthcare service. This helps train and practice high-risk skills and procedures in a simulated environment without jeopardising safety (Kneebone, Nestel, Vincent, & Darzi, 2007; O'Connell et al., 2014).

The use of simulation is now considered an integral part of healthcare education programmes and embedded within midwifery curricula as part of the Future Midwife Standard for Midwifery Education (Nursing and Midwifery Council, 2019). This is particularly important given the emphasis on patient safety and the prevention of adverse outcomes from critical incidents. It highlights failures in the clinical and non-technical skills of healthcare professionals (Paige, Fairbanks, & Gaba, 2018), alongside the increased need to utilise resources effectively and reduce healthcare costs (Rashid & Gianduzzo, 2016). As indicated earlier, the reduction in traditional clinical placements and changes to undergraduate nursing and midwifery educational standards which recommend the inclusion of simulation also represent key drivers (Elliott, Murrell, Harper, Stephens, & Pellowe, 2011). Therefore, it is vital that academic institutes - particularly in light of the pandemic - provide quality midwifery education utilising innovative methods of teaching and learning that enable students to learn the diverse range of skills and competencies required for safe, good quality midwifery care (Elliott et al., 2011; Luyben et al., 2017; Renfrew et al., 2020).

2.4.7 Realism, Fidelity, and Authenticity within Simulation

The terms fidelity, authenticity and realism are often used interchangeably to describe simulation (Maran & Glavin, 2003). Therefore, it is important to clarify them to avoid confusion. According to Lapkin and Levett-Jones (2011, p. 3545), fidelity means how authentic or real life a manikin and/or a simulation experience is perceived to be. Authenticity, on the other hand, is concerned with the process of learning and the student's subjective interpretation (how genuine it feels) or response to the simulation experience which can be very individualistic (Bland, Topping, & Tobbell, 2014). O'leary et al. (2018) further conceptualised simulation in three dimensions: physical, conceptual, emotional/experiential. Physical is what the learner can see and touch, for example a manikin. Conceptual involves skills such as problem-solving, decision making, or making predictions. The emotional/experiential element is concerned with the holistic experience of the simulation and the emotions that may accompany that simulated experience. These components are critical to enabling students' emotional engagement and effective response, as if it were a real clinical situation (Ignacio et al., 2015).

Within simulation, levels of fidelity range from being completely artificial, such as replicating a task (e.g. venepuncture on an anatomical model or part-task trainer), through to recreating a realistic situation that replicates critical events involving sophisticated, life-like programmed human simulators with physiological responses or the use of standardised patients as actors (Munshi, Lababidi, & Alyousef, 2015). Simulation scenarios involving standardised patients (SPs) or real people can create a real sense of psychological fidelity. The more realistic and authentic the simulation, the more advantageous it is in preparing students for adverse events that may occur in practice (Bogossian et al., 2014). If a simulation lacks authenticity or realism or fails to replicate a real clinical situation, students may struggle to makes links between theory and practice which may impact on their learning (Fox-Young et al., 2012). A major advantage of using SPs is that a broad range of technical and non-technical skills including human factors can be integrated to improve proficiency in recognising patient deterioration and complex behaviours, such as teamwork,

communication, leadership, and situational awareness, which can be applied clinically (Bogossian et al., 2014).

Within the studies initially reviewed, it was evident that the students valued the use of SPs compared to other types of fidelity when developing their skills in therapeutic communication and empathic awareness (Colwell, 2017; Forster & Donovan, 2016). More recent studies also confirm that adding realism to simulation can enhance learner engagement, and the use of SP's is beneficial in developing emotional competence particularly in relation to end of life care skills (Tamaki et al., 2019b).

In a randomised controlled trial using standardized patients, Tamaki et al. (2019a) evaluated knowledge, skill performance and self-confidence in a sample of third year nursing students (N=38). The students were either randomly allocated to a simulation scenario involving a terminally ill man with colon cancer (n=20), or a control group (n=18) who participated in standard classroom lectures and end of life case study scenarios. To determine their level of knowledge, skills performance and self-confidence, each student was scheduled to undertake the OSCE to measure their baseline skill performance (pre-test). Both groups undertook the post-tests a week after the simulation group had completed the EOL care simulation. The questionnaires and OSCE for post-test were similar in format and content to the pre-tests. The results of the two-way ANOVA test revealed significantly higher scores in knowledge in the simulation group (P<.001) compared to the control group (P<.604). The simulation group also scored higher for levels of self-confidence and their ability to provide psychological care (P=0.000), but not in the control group (P=0.727). The authors concluded that EOL care simulation including the use of standardized patients enhances knowledge and skill performance, and a broad scale of nursing competencies that can be applied to any situation.

Some limitations of the study were acknowledged. Due to time constraints, the students' competencies were only measured once and after a short follow-up time of one week. A self-reported instrument was used to measure self-confidence without establishing the reliability and validity of the measurement tool. Valid assessment tools such as the Bereavement Care Confidence Scale are considered more

effective in measuring perceived confidence and knowledge and how this level of confidence is sustained over time in practice (Kalu, Larkin, & Coughlan, 2020) .

A meta-analysis by Oh, Jeon, and Koh (2015) of 18 controlled trials (four randomized and 14 non-randomized) also reported that, if integrated appropriately, the use of SP's can enhance the realism of a scenario and positively impact on students' confidence and self-awareness particularly around interpersonal communication. However, limitations of this review include the small number of randomized controlled studies. The small sample sizes resulted in insufficient power to detect the effects of the SP educational approach on outcomes and there was limited evidence to demonstrate the application of knowledge and skills in novel situations.

In a small integrative review, Øgård-Repål, De Presno, and Fossum (2018) determined that incorporating standardized patients (SP) in complex scenarios can decrease students' pre-placement anxiety particularly in situations involving difficult conversations or encountering patients with mental health concerns. The authors concluded that simulation is useful in facilitating complex topics that are difficult to teach by traditional methods. It can encompass a wide range of techniques and interventions that can be staged and structured at a measured pace with varying levels of difficulty to accommodate individual learning needs and levels of experience; this is not always possible with other forms of teaching and learning (MacLean et al., 2017; Rashid & Gianduzzo, 2016) .

2.4.8 The Use of Simulation within the Context of Midwifery Education

Within the context of midwifery education, simulation can be particularly beneficial in simulating complex midwifery skills, for example shoulder dystocia, postpartum haemorrhage, or perineal suturing (Bogossian et al., 2012; Cooper et al., 2012). A systematic review by Cooper et al. (2012) consisting of 24 quantitative studies reported that simulated learning had a significant impact on midwifery and obstetricians' confidence and competence in managing obstetric emergencies. The benefits of simulated learning compared to didactic methods of teaching were particularly apparent around communication and teamwork. Recommendations from the review indicated simulation as an essential component of undergraduate

curricula for uncommon clinical events and for the development of non-technical skills such as communication, teamwork and decision making.

However, the review mainly focused on qualified midwives and doctors, and on obstetric emergencies while only a few studies focused on midwifery students. Whilst the authors provided a detailed search strategy of relevant literature, there was a low evidence range of quantitative papers and a lack of qualitative studies. Therefore, there is a need for further research to clarify why simulation is more effective compared to other pedagogical approaches particularly within pre-registration midwifery education using a qualitative methodology.

In a qualitative descriptive study, Vermeulen et al. (2017) explored third year student midwives' experiences of high-fidelity perinatal simulation training (HFPSt) (n=24) involving obstetric emergencies (breech, neonatal resuscitation, haemorrhage). Clinical scenarios were provided, each lasting ten minutes followed by a 30-minute debrief using Steinwachs (1992) model of debriefing: description, critical analysis, and application. A general finding from the study was that students found the simulation to be a valuable learning experience. The opportunity to work in small groups and collaborate with their peers helped them identify their own strengths and weaknesses which further motivated them to learn.

However, despite reported feelings of confidence, feelings of uncertainty, tension and confusion were also experienced. Students reported feeling unprepared and anxious before the simulation. They felt 'pressured to act' and disappointed because they felt they did not feel competent to provide the appropriate standards of care. However, through structured feedback and debriefing, the students were able to address their anxieties and concerns which boosted their self-confidence and enabled them to establish links between the simulated scenarios and practice (Vermeulen et al., 2017). The authors concluded that intense preparation and the repeated exposure of students to simulation throughout the program is key to managing poor performance and lessening student anxiety prior to practice.

Lendahls and Oscarsson (2017) also explored student midwives' experiences of simulation training involving performance and communication during normal and

complicated birth scenarios (e.g. breech, shoulder dystocia, vaginal examinations, suturing) using a high-fidelity mannequin. Semi-structured interviews were conducted with a sample of 61 midwifery students in 13 group interviews. Data was analysed using content analysis. Findings from the study indicated that simulation enabled the students to learn factual aspects alongside 'hand's on' midwifery skills such as communication and teamwork. Students reported feeling prepared and confident prior to commencing clinical practice even though they initially focused on the skill without considering communication with the woman and partner. Their confidence in communicating with parents only increased as the students became more proficient in their skills.

The authors acknowledged that further research was needed to evaluate and compare different teaching and learning interventions to appropriately develop and assess students' higher order critical thinking skills and metacognition as opposed to only factual knowledge. However, the study did not state the methods used to assess communication skills, the data was only gathered on one occasion, and the authors relied on student self-reported outcomes. A longer study could reveal the positive effects of simulation over time using more progressive forms of fidelity such as standardized patients or actors.

From an educational perspective, simulation is a very useful and convenient way to conduct formative and summative assessments on a variety of skills that encompass the affective, psychomotor and cognitive domains of learning (Kardong-Edgren, Adamson, & Fitzgerald, 2010). Particularly in nursing, there is increasing evidence that simulation can be an effective teaching strategy to promote emotional competence and address the psychological needs of learners, especially for students who have not experienced death in either personal or clinical contexts (Alghamdi et al., 2021).

To evaluate the effectiveness of end of life simulation versus lecture led classroom teaching, Venkatasalu, Kelleher, and Shao (2015) conducted a small qualitative phenomenography study with a sample of nursing students (n=187) encountering their first death on clinical placement. In a series of follow-up interviews after clinical

practice, the students acknowledged that both methods of teaching enhanced their knowledge around end of life. However, students in the simulation scenario felt emotionally prepared and able to apply their learning to similar events in practice particularly in relation to communication with bereaved families. Similarly, in a small descriptive study, Forster and Donovan (2016) explored the impact of unsuccessful neonatal resuscitation on midwifery students' perceptions of their ability to provide bereavement support to grieving parents. The sample consisted of ten undergraduate nursing and midwifery students in their final fourth year of training. The students were approached by the researchers who invited them to participate in the study.

The simulation involved the students engaging in an unsuccessful resuscitation using a pre-programmed, low fidelity neonatal mannequin. The second phase of the simulation required the students to communicate with the mother (staff member acting as the mother) regarding the unsuccessful resuscitation attempt. Both simulations were video recorded with their consent. The students were randomly placed into three different groups (two groups with three students and one group with four students), and each group was involved in each scenario. After the simulation, the students participated in a debriefing facilitated by a nursing lecturer. The students were encouraged to reflect on the scenario after watching the video-recording of their performance (Forster & Donovan, 2016). The data was subsequently analyzed, categorized, and coded in accordance with Charmaz's (2012) approach to data analysis.

Analysis of the students' reflections revealed that the students felt confident in managing the technical aspects of resuscitation. However, despite having previously attended theory-based and small-group tutorials on grief and loss, the students still felt unprepared to cope with the complexity of the situation and to communicate with the bereaved mother (Forster & Donovan, 2016). This could be explained by the lack of pre-brief prior to the simulation; pre-briefing is an essential aspect of simulation as it aims to promote psychological safety and reduce student anxiety (Roh, Ahn, Kim, & Kim, 2018). It may also indicate that the students were not emotionally prepared for a normal birthing scenario to change to an obstetric emergency (Coldridge &

Davies, 2017). Coldridge and Davies (2017) reported that students felt anxious and confused when a normal birth event suddenly became an obstetric emergency, or they were assigned roles and tasks they were unfamiliar with due to limited prior experience.

Low levels of self-efficacy in relation to communication skills were also highlighted in a case report using a simulated scenario involving the sudden death of a newborn (manikin) experiencing hypoxic-ischemic brain injury. The study involved a sample of undergraduate junior and senior nursing students (n=219) (Cole & Foito, 2019), and the simulated scenario focused on three key areas: symptom management, communication, and care and support for the family. Prior to the simulation the students were provided with pre-simulation learning activities including a series of professional vignettes, mock scenarios, and short answer questions that addressed end of life care topics including understanding death, therapeutic communication, symptom management and spirituality (Cole & Foito, 2019).

The simulation scenario involved a series of stages in which the students had to initially assess the deteriorating baby and at the same time communicate with the distraught parents regarding the well-being of the baby. The final stage of the simulation involved a family meeting in which the poor prognosis for the baby was discussed and the student had to respond to the parents' challenging questions. To help formulate a response, the students were provided with a series of communication prompts and phrases guided by a nursing lecturer

At the end of the simulation, 149 students completed a post simulation survey and guided reflection in which 61% of the sample stated they felt uncomfortable communicating with bereaved parents and afraid of saying something wrong (Cole & Foito, 2019). Similar to the findings of Donovan and Forster (2015), the students felt the simulation prompted them to evaluate more effective ways to communicate with bereaved parents and to explore their role as emotional caregivers (Cole & Foito, 2019). Both studies acknowledged the importance of debriefing to encourage students to reflect on and confront their own emotions and address negative responses. A number of other studies in the nursing literature also highlighted the

benefits of addressing learners' emotions following end of life care simulation, such as improvements in students' attitudes towards death and dying (Byrne et al., 2020), therapeutic communication skills (Gaylle, 2019) and decreasing stress and anxiety amongst learners (Code & Burkard, 2016). However, in each of the studies inconsistent approaches were used to guide the debriefing process which will be further explored in this study.

Having reviewed the evidence base in relation to simulation within the context of midwifery education, the next section will explore how students learn through simulation with specific reference to Mezirow's theory of transformative learning and relevant literature. This section will begin with an overview of Mezirow's theory and how it provides a structure for students to learn through simulation. This will be followed by a critique of Mezirow's theory

2.4.9 Mezirow's Transformative Learning Theory

Although the past 25 years or more has seen various theorists make significant contributions to adult learning, Jack Mezirow (an eminent professor and founder of transformative learning theory) developed the main paradigm for adult education (Morris & Faulk, 2012). In 2010, *The Lancet Commission Report on Health Professional Education for the 21st Century* endorsed transformative learning as an important pedagogical approach in transforming the nature of health professional education (Frenk et al., 2010).

Mezirow's theory was chosen as an analytical framework for this study because it is concerned with how emotionally charged learning activities involving death and dying promote critical reflection and can lead to transformative learning (Mezirow & Taylor, 2009). In the next section, the theoretical concepts that underpin transformative learning will be explored and the application of Mezirow's theory to the simulation will be critically discussed.

2.4.10 Theoretical Basis of Transformative Learning Theory

As a theoretical construct, Mezirow's theory of transformative learning is both unique and complex (Briese, Evanson, & Hanson, 2020), however his main concern was

how learners would derive meaning from experience. Mezirow claimed that the process of transformative learning would initiate a change in the way a person thinks and views the world they are in, which would prompt them to be much more open minded and reflective. He stated they would become *'more inclusive, open, emotionally capable of change and reflective, so that they generate beliefs or opinions that prove true or guide future actions'* (Mezirow, 2000, pp. 7-8).

A key concept of Mezirow's theory is that changes in a person's perspective or way of thinking need to be precipitated by a profound experience or a 'disorientating dilemma' which maybe 'epochal' (sudden) or gradual (Mezirow & Taylor, 2009). A disorienting dilemma maybe defined as:

> '*a dilemma that causes a significant level of disruption or disturbance in a person, and where their frame of reference is shown to be inadequate to explain what they have seen, heard or experienced' (Howie & Bagnall, 2013, p. 818).*

Mezirow considered a disorienting dilemma as key to activating the learning process and triggering the process of critical reflection. He further claimed that it could be so powerful and significant that it would have an 'unsteadying influence' on a person. It is this feeling of 'unsteadiness' or uncertainty that causes a person to reassess or alter their old beliefs and assumptions about a topic or how they view the world (Howie & Bagnall, 2013). It was suggested that these critical moments of adopting news ways of thinking and letting go of previously held knowledge or beliefs could provoke feelings of uncertainty and confusion as learners reflect on their current knowledge and understanding about a topic, in this case the death of baby which may prove difficult to comprehend or not easily assimilated (Crane & Abbott, 2021). Turner and Abrahams (2017, p. 81) used the term liminality to describe a state of '*being neither here nor there'* or being '*betwixt and between'* which implies being in two minds about something.

In a UK study, Crane and Abbott (2021) explored the relationship between learning and liminality within the context of nursing education. The findings revealed that, throughout their pre-registration education, students experienced varying degrees of

liminality and discomfort as they were required to reposition themselves and acquire new knowledge and skills that challenged them emotionally and their own self-identity which could be disorientating. Within the context of death and dying situations, liminality is also a salient concept as it implies an ambiguous state in which healthcare providers can experience a range emotional and existential issues that can trigger death anxiety (Ådland, Høyland Lavik, Gripsrud, & Ramvi, 2021).

Some theorists have also argued that the term 'disorientating dilemma' is somewhat problematic as it lacks clarity and consistency (Alhadeff-Jones, 2012) and has become '*watered down'* to include any significant event or episode (Howie & Bagnall, 2013, p. 827). Mälkki and Green (2014) similarly contested the potential difficulty experienced by a disorientating dilemma and the notion that a person alters from one set of beliefs and assumptions to contemplating a different worldview. Moreover, Taylor (2008) argued that some people may have a more natural predisposition to transformational change than others. Equally, a person's response to a disorientating dilemma can also be determined by other factors such as sociocultural influences and the context of that person. This may account for why some dilemmas lead to change and others may not. However, within the context of this study, students encountering parents who have experienced involuntarily infant loss are regarded as a catastrophic event which therefore aligns with Mezirow's concept of a 'disorientating dilemma' (Mälkki, 2012).

The principles underpinning transformative learning theory are that, from childhood, adults will have acquired certain 'frames of reference' or 'habits of mind' (Mezirow, 1994). A frame of reference can also refer to people having a particular set of beliefs, assumptions or 'taken for granted' ways of thinking which act as a filter for interpreting the meaning of an experience or how they view the world (Mezirow & Taylor, 2009). It generally refers to the uncritical ways in which a person sees the world, which are based on their preconceived ideas and assumptions. These can be shaped by an individual's culture, education, background, society, religion, morals or values (Cranton, 2016).

As suggested above, during the formative years of an adult's life, habits of mind and ways of thinking often remain unquestioned until a person encounters an alternative view that 'calls their habits of mind' into question' (Cranton, 2016). Mezirow identified different types of habits of mind that may influence a person's perspective which are all interrelated and come from a variety of sources. These include the epistemic habit, which relates to how a person acquires knowledge and how they learn, or their learning styles. Sociolinguistic habits reflect a person's social and cultural norms, while psychological habits are concerned with an individual's feelings, anxieties, fears, inhibitions. Finally, aesthetic habits relate to one's values, attitudes, standards about beauty (Cranton, 2016).

These concepts are relevant to this study as the topic of grief and loss is emotionally complex and can be 'disorientating'. I am aware that individual students will have different pre-conceived ideas and assumptions about death and dying based on their own personal and professional subjective experiences. However utilizing transformative learning theory within the context of adult education can act as a framework to develop teaching and learning strategies that challenge learners to re-examine and develop new habits of mind (Morris & Faulk, 2012). Therefore, within the context of this study, applying Mezirow's model of transformative learning will encourage students to challenge their underlying beliefs and assumptions about grief and loss and re-formulate meaning from the experience that will enable them to acquire new knowledge and skills to guide future practice (Cranton, 2016).

Mezirow's concept of transformative learning originated from a grounded theory study exploring the experiences of young American women returning to further education and work after a significant amount of time out of these situations. Based on the findings from the study, Mezirow concluded that women attending higher education experienced a personal transformation or a 'changed perspective' that caused them to re-examine and reflect on their identities as wives and as mothers (Cranton, 2016). This concept is relevant to this study as it may reflect the personal development and self-awareness of students who participate in the bereavement simulation educational experience (Illeris, 2014). This enhanced self-awareness may alter the students' perceptions about their role and identity as a midwife and how

they see themselves enacting their future role as caring healthcare practitioners. According to Illeris (2014), this change in identity through education is key to the transformative learning process.

On the basis of his research, Mezirow identified ten phases of learning for adult learners (outlined in Table 6), which result in changes to their perspective and understanding of the world (Morris & Faulk, 2012). The first column in Table 6 outlines Mezirow's ten phases of transformative learning while the second column, details how the phases may be applied practically to this study and relate to student midwives' experience of encountering bereaved parents for the first time.

It is important to establish that while Mezirow's transformative phases of learning have been depicted as following a linear pathway (Lonie & Desai, 2015), it cannot be assumed that all learners follow a 'universal route' (Buttigieg & Calleja, 2021). Transformational learning is a very complex, iterative process involving the learner moving back and forth between the various stages. For some learners not all of the steps are necessary or even undertaken to achieve transformation (Cranton, 2016).

Table 6 Application of Mezirow's phases of transformative learning to student midwives' transformative learning journey

Mezirow's 10-Phase Process of Transformative Learning	Application to Student Midwives' Experience of Participating in Bereavement Simulation
Experiencing a disorientating dilemma (significant life event, crisis, death)	The student midwives encounter bereaved parents experiencing perinatal loss within a simulated setting
Undergoing self-examination accompanied by feelings of fear, anger, shame	Students re-examine their existing beliefs and assumptions about grief and loss which results in them questioning their own beliefs, feelings, values about death
Conducting a critical assessment of their own internal assumptions and beliefs, experiencing a sense of alienation from traditional social expectations.	When they consider their new view of the topic, it conflicts with their own previous personal, professional, or cultural assumptions resulting in feelings of anger, fear, blame
Relating discontent to the similar experiences of others – awareness that problem is shared	Engaging in dialogue with their peers. Recognition that others share similar feelings and responses to this experience
Exploring options for new ways of acting	The students consider new ways of applying their knowledge, skills, behaviours that encompasses their new view as to how they would approach a similar event in practice
Building competence and self-confidence in new roles	Planning ways to increase confidence in their ability to apply new knowledge and skills to different situations
Planning a course of action	Acquiring knowledge and skills for implementing plans and strategies for action
Trying out new roles and behaviours	The student actively seeks new knowledge and skills to implement a plan to guide their future actions
Developing skills and confidence in new roles	Assessing and trying out new roles reflected upon and modified as required.
Incorporating behavioural change based on new knowledge and perspectives	Incorporating new / existing knowledge & skills with new insights and understandings to their practice

2.4.11 Critical Theorists who Influenced the Development of Mezirow's Transformative Learning Theory

Mezirow's transformative learning theory drew inspiration from other critical theorists, including Paulo Freire, Junger Habermas and Kuhn, who informed his concepts of disorientating dilemma, meaning schemes and meaning perspectives (Kitchenham, 2008).

Paulo Freire proposed a theory of transformative learning which he referred to as consciousness (Freire, 1989). His theory of critical consciousness originated from his work on literacy education amongst the poor living in poverty stricken areas of Brazil (Dirkx, 1998). Freire viewed learning as empowering and liberating. He argued that education plays a key role in developing learners to become critically conscious around beliefs and assumptions that influence their worldview. According to Freire, being critically conscious and 'having a voice' enables people to act on social injustice issues that are of concern to them. Freire's concept of critical consciousness informed Mezirow's theory on the role of critical reflection. Within the context of this study, the important role of debriefing in simulation is critical in enabling learners to gain a sense of agency and having the courage to question underlying beliefs and assumptions that influence their interpretation of an experience (Mezirow & Taylor, 2009).

The German philosopher Jurgen Habermas also had a major influence on the development of Mezirow's transformational learning theory (Habermas, 1984) . Habermas proposed two distinct domains of learning. Firstly, instrumental learning involves the learner engaging in task-orientated or problem-solving learning activities in which the emphasis is on learning new skills, tasks, or practices. Secondly, the communicative learning domain is concerned with the role of dialogue and understanding values, concepts, and other's point of views (Mezirow & Taylor, 2009). Habermas placed considerable emphasis on the importance of communicative learning and considered interaction and engaging with others as key to enabling change in a person's worldview and behavior. The theoretical concepts proposed by Habermas are relevant to this study as simulation provides opportunities for learners to engage in dialogue and reflection with others resulting in

possible changes to their beliefs, assumptions and behaviors about grief and loss (Morris & Faulk, 2012).

2.4.12 Application of Transformative Learning to Simulation

As previously indicated, transformative learning is a complex process, as it is not just about gaining but enabling learners to make meaning or make sense of an experience (Mezirow, 1991), in which critical reflection plays a vital role (Bass, Fenwick, & Sidebotham, 2017; Briese et al., 2020). However, and despite emphasis on the importance of reflection in preparing students for midwifery practice and professional competence, there appears to be an inconsistent approach to educational strategies which enable students to develop reflective capabilities leading to transformative learning within undergraduate midwifery curricula (Bass, Sidebotham, Creedy, & Sweet, 2020). Therefore, appropriately designed simulated scenarios which incorporate core elements include a disorientating dilemma, critical reflection, and rational discourse. These provide an ideal framework for transformative learning to occur (Howie & Bagnall, 2013) and help students to emotionally process stressful or traumatic childbirth events particularly involving grief and loss (Coldridge & Davies, 2017; Shorey & Wong, 2021).

In recent years there has been a plethora of research using transformative learning theory within the field of nursing education (Tsimane & Downing, 2020a), counselling (Nogueiras, Iborra, & Kunnen, 2018) and social work (Damianakis et al., 2019). However, relatively few studies have critically explored the application of Mezirow's theory using simulation to promote transformative learning in the context of healthcare education (Briese; Clapper, 2010; Oh, Kang, Song, & Lindquist, 2021; Parker & Myrick, 2010) or end of life care simulation (Gillan, Jeong, & van der Riet, 2021).

Clapper (2010) reviewed several adult learning theories and concluded that the experiential nature of simulation aligns well with transformative learning theory. Through the process of critical reflection learners are facilitated to develop new skills and alter their 'frame of reference' which is a crucial part of the transformative learning process and the goal of simulation (Clapper, 2010, p. e10).

Briese et al. (2020) also identified that the components of reflection, discourse, and analysis with others within the simulation resemble the ten stages outlined by Mezirow's theory. They asserted that presenting students with a 'clinical dilemma' initiates feelings of discomfort or uncertainty that encourages them to question their underpinning assumptions and expectations, making meaning from the experience that will subsequently inform future practice. Parker and Myrick (2010) also critically analyzed the role of human patient simulation in promoting transformative learning and concluded that appropriately designed simulated scenarios have the potential to trigger a disorientating dilemma that sets in motion the process of transformative learning.

In a recent Australian study, Gillan et al. (2021) reported on student nurses' transformative learning through the disorientating dilemmas experienced during end-of-life care simulation. Semi-structured interviews were conducted with a sample of 18 students, six to ten months after participating in a series of five unfolding scenarios, which ranged from pain assessment and management to the care of the unconscious and dying patient. Thematic analysis revealed that transformative learning occurred through three disorientating dilemmas including caring for a dying patient, witnessing death for the first time, and identifying similarities and emotional responses that students could apply to practice. Gillan et al. (2021) concluded that end of life care simulation represents a disorienting dilemma or a critical event that propels learners out of their comfort zone. Through the process of debriefing and reflection, students felt able to embrace the complexity of the dying process, revise their interpretations, and make new meaning from the experience. However, the authors acknowledged the sample size was a limiting factor, although for narrative enquiry, smaller sample sizes are more appropriate to gain rich and more meaningful data. The students also self-selected onto the study which may have biased the findings due their specific interest in palliative care.

In a randomized control trial, Oh et al. (2021) also applied Mezirow's transformative learning theory as a framework to explore the effects of debriefing on knowledge, critical thinking, clinical judgement, and problem-solving in a group of undergraduate nursing students involved in a diabetic nursing care scenario over a series of four

weeks. The students were randomly assigned either to the transformative learning debriefing protocol according to Mezirow's ten phases (n=26) or a control group (n=30) using a debriefing model which was structured around three steps: gather-analyze-summarize.

Findings from the study revealed significantly higher scores for knowledge, problem-solving, critical thinking and clinical judgement in the transformative learning group compared to the control group. Oh et al. (2021) concluded that phases eight to ten of Mezirow's transformative learning were instrumental in enabling students to seek new knowledge and skills and gain self-confidence and competence in their ability to apply this to future practice. The study acknowledged the value of collaborative problem-solving and group discussion in promoting students' reflective capabilities. Briese et al. (2020) also agreed that post simulation debriefing provides students the opportunity to 'deconstruct' or explore a simulated scenario from multiple perspectives. Through self-analysis and interaction with others, students were challenged to question and critique their prior knowledge and assumptions to help them make decisions that will guide future practice. According to Briese et al. (2020), the combination of shared group discussion, reflection and discourse within a safe secure learning environment are crucial elements of transformative learning. They are also fundamental to enabling students alter their frames of reference and habits of mind, which have the potential to affect how they approach future experiences.

2.4.13 Critique of Transformative Learning Theory

It is important to establish that despite Mezirow's valuable contribution to adult learning theory, transformative learning, is still relatively ill-defined and there remains a distinct lack of understanding of the key underpinning concepts (DeSapio, 2017). Even though Mezirow's theory has been adapted over the years to accommodate the affective, emotional, and social aspects of learning, there is still considerable emphasis on the individual and minimal attention given to the social, cultural, spiritual influences of learning, the role of community (DeSapio, 2017), or the functional role of emotions (Mälkki, 2010).

Taylor and Cranton (2012) also refuted the idea that transformative learning inevitably results in positive outcomes. Indeed Mälkki (2010, p. 48) criticised Mezirow's concept of transformative learning and the role of critical reflection as a somewhat idealised process. As previously indicated, transformative learning is a complex, fluid, recursive process (Cranton, 2016). The notion of a person acquiring new ways of thinking and letting go of previously held beliefs and assumptions can be difficult and demanding. Some learners may not have the emotional capability to deal with new situations, while the complexity of a 'disorientating dilemma' can result in regression or withdrawal from learning (Illeris, 2014).

In a critical review of the issues in transformative learning, Taylor and Cranton (2013, p. 35) highlighted methodological concerns about the lack of theorectical development of research into transformative learning. They argued that typical methodology tends to '*fall into the basic interpretivist paradigm'* and suggested the need for more in-depth theoretical analysis that incorporates more empirical and critical theorectical approaches within research (Taylor and Cranton (2013, p. 35). In response to this lack of theorectical progression, they identified other key areas that warrant further research. These included: the contextual nature of an experience, the role of empathy in fostering transformative learning, and the theoretical assumptions underpinning people's readiness or 'desire' to learn or change.

In another review of the literature on transformative learning theory, Hoggan (2016) argued that transformation lacks any distinct meaning and expressed the need for a reconceptualisation of what is meant by transformative learning. Hoggan proposed that 'perspective transformation' is a distinctive feature of Mezirow's theory, whereas transformative learning is a metatheory, an umbrella term that describes a broad range of learning outcomes which are concerned with the significant and permanent ways a person interprets, understands and experiences the world they are in.

Despite criticisms of Mezirow's theory, transformative learning is considered a suitable learning theory for this study as it focuses on how a profound educational experience, such as bereavement simulation. It can have a significant impact on how students interpret grief and loss to the extent that it alters their way of thinking

and how they may enact care in the future. For the purposes of this study, transformative learning provides a comprehensive framework to capture how learners learn and ‘transform’ how they view grief and loss, both from their own perspective and those of bereaved parents

2.5 Summary

This chapter has reviewed the available literature exploring the teaching and learning strategies used to teach bereavement care involving perinatal loss within the context of midwifery education. The review identified considerable variations amongst the teaching and learning strategies utilised and a dearth of evidence concerning the use of simulation to address student midwives’ learning needs on bereavement care involving perinatal loss. It has also confirmed a distinct lack of qualitative research exploring midwifery students’ experiences of bereavement care using simulation. A conclusion from the literature review is that studies related to simulation and transformative learning within the context of bereavement care and midwifery education are relatively sparse. Therefore, the literature review has provided valuable insights that will help to address the research question and explore student midwives’ experiences of end-of-life care simulation, including how learning can occur through application of Mezirow’s learning theory

To conclude, this chapter has situated this research study within the context of the available literature and evidence on bereavement education and the use of simulation within undergraduate midwifery education. The significant gap identified in bereavement care simulation involving perinatal loss, and the dearth of evidence exploring the existential experience of student midwives caring for bereaved parents, provides a justifiable rationale for undertaking this study. It also supports the use of Interpretative Phenomenology Analysis as a suitable methodological approach to examine and interpret student midwives ‘lived’ experience of bereavement care simulation.

Chapter 3: Research Methodology and Methods

3.1 Introduction

The purpose of this chapter is to explain and justify the research design that explores student midwives 'lived' experience of participating in bereavement simulation. This chapter will begin by outlining my ontological and epistemological position. I will then address IPA as a methodology and provide a rationale for choosing it as an approach for conducting this research. This chapter also details the methods used in the study, including the sampling strategy, recruitment process, method of data collection and analysis of the data. The ethical considerations will also be discussed in detail. The chapter concludes with a discussion of the limitations of IPA and the alternative approaches considered to address the research question.

The main research question for this study is: 'What is the lived experience of bereavement simulation from the perspective of the individual student midwife?' IPA research is concerned with gaining in-depth exploration of lived experience. The development of the research question and its aims were driven by a gap in the literature, the need for insight into how students 'lived' through the experience of bereavement simulation, and the way in which they made meaning from that experience (Braun & Clarke, 2021; Peoples, 2020). In addition, I was interested to explore how students perceived bereavement simulation prepared them for practice. Consequently, the following aims were developed:

1. To gain insight into student midwives 'lived' experience within the context of a bereavement simulation scenario.

2. To understand the meaning making and learning processes that student midwives undergo due to participating in the simulation.

3. To explore student midwives' perception of simulation as a model of teaching and learning that prepares them for clinical practice.

3.2 Choosing my Methodology

Prior to conducting this study, it was important to consider the three key elements of the research process. These included: the philosophy (epistemology and theory), method (data collection and analysis), and a methodology that suitably addressed the research question (Gaus, 2017). This study sought to explore student midwives' lived experience of participating in bereavement simulation. Due to the emphasis on 'what it is like' to experience this phenomenon, I considered interpretative phenomenology the optimal methodological choice for this study.

3.2.1 My Ontological and Epistemological Position

Choosing a methodology and ensuring it aligns with the research question is not always sufficient (Gaus, 2017). An important starting point for any researcher is to consider the philosophical stance that underpins their chosen methodology (Crotty, 1998). The philosophical assumptions underlying a method or approach and whether these respect the researcher's own views are vital to consider as a researcher's personal philosophy, assumptions or beliefs can influence and determine the chosen paradigm, research goals, methodology and data collection methods (Crotty, 1998). There is also a consensus that researchers are often shaped by their own background and experience and are 'positioned' in relation to their own research (Crotty, 1998). Having knowledge and insight into our own ontological position (the nature of reality, the nature of things) can give rise to epistemological assumptions (ways of researching, enquiring into the nature of reality). This, in turn, helps the researcher to decide on the most appropriate research methodology (Cohen, 2011). In addition, when the researcher explores their own assumptions and axiology (values and beliefs) they are better positioned to approach the topic more openly (Cohen, 2011).

Traditional approaches to research tend to be broadly categorised into two methodologies: quantitative research, which is synonymous with scientific, empirical research, and qualitative research, which tends to focus on gaining a more holistic understanding of human experience (Rees, 2012). However, these binary distinctions are considered somewhat outdated, and simplistic as they do not reflect

the complexity of the world or that of human experience (Costley & Fulton, 2018). To some extent, this binary implies qualitative research is somewhat inferior to the scientific rigour associated with quantitative studies (Rees, 2012).

There is a myriad of ways in which research can be conducted and interpreted (Costley & Fulton, 2018). Even though quantitative and qualitative research may have different underpinning philosophical and theoretical principles, both approaches can complement and be applied to the same piece of research, and equally make a valuable contribution to knowledge, enabling different understandings of the human mind (Smith & Nizza, 2022). To illustrate this, Coyne and Calarco (1995) conducted a qualitative study using focus groups to explore previously depressed women's experiences of depression. Statements from the focus group were thematically analysed and organised in to eight different categories and used as a basis to construct an 83-item survey instrument, the Self- Appraisal Questionnaire (SAQ). Coyne and Calarco concluded that the combination of focus groups and survey illuminated the broad dimensions associated with the experience of depression and its impact on women and warranted considerable attention.

In the latter part of the twentieth century, there has been a shift towards the use of qualitative research to explore and understand human experiences within the context of nursing and midwifery research (Harvey & Land, 2022). Qualitative research focuses on understanding the human experience, how people make sense of the world and experience events or phenomena (Willig, 2013). Unlike quantitative research, it refutes the idea that there is one single truth or meaning or a 'simple relationship' as to how people perceive the world (Langdridge & Hagger-Johnson, 2009). In qualitative research, the emphasis is on describing and explaining experiences rather than determining cause and effect relationships (Willig, 2013). Compared to quantitative research, it is much more fluid and flexible and lends itself to the discovery of new or serendipitous findings (Bryman, 1984).

An important characteristic of qualitative research is subjectivity. People construct their own or different interpretations of reality which are individual; as a consequence, there can be multiple 'truths' or different interpretations of that same

experience (Harvey & Land, 2022). In other words, there is no one absolute truth or reality, but rather a multitude of different realities or experiences of the same situation (Peoples, 2020). The epistemological assumption underpinning qualitative research is that knowledge or understanding is generated or 'shared' between people, and that the researcher is positioned 'inside' the research. Therefore, the researcher's own knowledge, values and beliefs need to be acknowledged throughout the research process through ongoing process of reflexivity (Harvey & Land, 2022).

Qualitative research takes place in naturally occurring settings, for example homes, hospitals or the street (Willig, 2013). In order to understand a certain topic, it must be viewed through the eyes of those who are experiencing it (Rees, 2012). This way of thinking can provide the researcher with a deeper understanding and insight as to how people might experience an event or perceive reality. Furthermore, one of the strengths of qualitative research is the emphasis on the holistic, individualistic aspects of the human experience (Polit & Beck, 2022). Qualitative research is much more fluid and flexible and tends to be used in situations where very little is known about a phenomena so that new insights are revealed about the topic under investigation (Polit & Beck, 2022).

Qualitative research is particularly relevant and meaningful to midwifery and other healthcare professionals because it is concerned with the heart and individuality of the human experience (Biggerstaff & Thompson, 2008). My view as a midwife has always been consistent with a qualitative approach as it explores a topic from a participant's perspective and values the individual holistic experience that perhaps is not always achievable through quantitative research (Harvey & Land, 2022). However, one of the criticisms of qualitative research is that it is 'anecdotal' and lacks scientific rigour (Harvey & Land, 2022). Gathering information from people can be misleading or 'fallible' and their interpretation can depend on the context in which the experiences occur (Polit & Beck, 2022). Because of the subjective nature of qualitative research, it is often misunderstood and labelled 'less scientific' (Pope et al., 2000). However, the subjective nature of qualitative research and the unique ability of the researcher to 'situate' themselves inside the participant's world can

reveal hidden insights and interpretations that perhaps may not always be attained with quantitative research. This aspect of qualitative research is acknowledged by scientific and medical journals as very valuable (Lambert, Jomeen, & McSherry, 2010).

My philosophical position in relation to epistemology (forms of knowledge) and ontology (study of being) is one of interpretivism. Based on my own learning experiences as a midwife and a lecturer, I subscribe to the view that there is are different approaches to understanding a phenomenon or acquiring knowledge (Lambert et al., 2010). I also concur with Crotty's (1996) view that people have multiple realities and construct different meanings, even in relation to the same phenomenon (Crotty, 1998). There is no definitive, objective truth or single answer. This contrasts with a positivist epistemology which is synonymous with quantitative research and based on the notion that an objective reality exists that is separate from how people experience it (Crotty, 1998). In comparison, quantitative research is generally hypothesis driven and concerned with prediction, measurement, and causality using tight controlled research designs leading to generalisations or universal laws about human nature (Polit & Beck, 2022).

For the purposes of this study, I needed to reflect deeply on the methodological choices that would be most appropriate for this study. I was also aware that there is no one ideal analytic approach that would be most suitable for the conduct of this study (Braun & Clarke, 2021). As a practising midwife with over 30 years' experience, I was exposed to the multi-faceted, subjective experiences and realities of women and their families from diverse cultural, economic, and social backgrounds. Therefore, I struggled to comprehend the idea that there is one version of reality or a definitive worldview. I was not convinced that a quantitative approach would provide me with meaningful insights relating to an emotional topic like bereavement. For this study, I felt it would leave many unanswered questions about the richness and complexity of student midwives' experiences of caring for bereaved parents.

From the onset of this study, I considered that a phenomenological approach to study the lived experience of student midwives participating in bereavement simulation would be most appropriate. My aim was to capture the complexity of the human experience within the context of bereavement simulation and to uncover new, rich descriptions as to the meaning of that experience for students (Finlay, 2009). From the variety of different phenomenological methodologies available, I chose IPA as it is an approach that is not commonly used within the context of simulation. Also, the philosophical underpinnings of IPA are congruent with the fundamental principles of midwifery in that it is person-centred, empathic and holistic (Harvey & Land, 2022). Therefore, it would offer an avenue in which to explore the subjective experience of bereavement simulation and the meanings that the students attach to that particular experience (Smith et al., 2009).

3.2.2 Interpretative Phenomenological Analysis

It is important to clarify that IPA is classified as an experiential approach that is concerned with the study of the human experience from the perspective of those living through that experience (Smith & Nizza, 2022). It is also a qualitative form of research introduced by Jonathan Smith in 1996 as an alternative to the dominant quantitative and qualitative methodologies (e.g. grounded theory, conversational and discourse analysis) commonly used in the field of psychology at the time (Cassidy, Reynolds, Naylor, & De Souza, 2011). IPA is underpinned by three key theoretical perspectives which include phenomenology, hermeneutics and idiography (Smith et al., 2009). In the next section, I will explain each of the fundamentals of phenomenology, the philosophical underpinnings related to these concepts, and their relevance to this study.

3.2.3 What is Phenomenology?

Phenomenology is both a philosophical and methodological approach that is concerned with the study of human experience (Langdridge, 2007). Researchers using phenomenological methods aim to gain insight into people's lived experience in an attempt to find out how people make sense of and derive meaning from that particular phenomenon (Harvey & Land, 2022). Phenomenology is a tradition of

philosophy that originated in Europe and is attributed to the writings of the German philosopher and mathematician Edmond Husserl (Draucker, 1999), and other influential philosophers including Heidegger, Merleau-Ponty and Sartre (Richardson, 2012). There are two distinct philosophical approaches to phenomenology: descriptive and interpretative. Descriptive phenomenology is rooted in the tradition of transcendental phenomenology and is associated with Edmund Husserl's ideology which focuses on the *lifeword (lebenswelt)* or lived experience as the basis for understanding human experience (McConnell-Henry, Chapman, & Francis, 2009). Husserl's transcendental phenomenology preceded Martin Heidegger's interpretive phenomenology.

From a philosophical perspective, Husserl's phenomenology focused on the science of phenomena, which examines the ways in which objects are experienced and present themselves to human consciousness (Smith, 2008; Smith et al., 2009). He insisted that researchers attend to things as they appear to, or are experienced by, them. In other words, by viewing a subject objectively and avoiding assumptions a researcher to see it as it is experienced. For Husserl, one of the key features of phenomenology is intentionality. Intentionality is not simply about intending to do something (like going to the gym!) (Langdridge, 2008); rather, it is the notion of always having a consciousness or awareness about something, whether that is related to one's child, another individual or a particular idea, etc. (Langdridge, 2008; Smith et al., 2009). Husserl's belief was that all experience is an experience of something and there is a relationship or a correlation between what is experienced (*noema*) and the way it is experienced (*Noesis*) (Langdridge, 2008).

Husserl's claimed that to really understand someone's lived experience, and in situations where the researcher maybe familiar with the phenomena under investigation (Harvey & Land, 2022), it is necessary for the researcher to adopt a phenomenological attitude and be objective (Willig, 2013). In order to ensure this, the researcher needs to 'bracket off' *(epoché)* or deliberately set aside their own preconceived ideas, cultural, religious, beliefs and assumptions so as not to influence the participants' accounts of their own experiences (Langdridge & Hagger-Johnson, 2009). In Husserl's view, it is this epoché, detachment or reduction that

helps a researcher accurately uncover and access the essence of a phenomenon. This level of objectivity also enhances the validity of their findings (Chan, Fung, & Chien, 2013).

Martin Heidegger (1889-1976), who was a student of Husserl, was the founder of interpretative phenomenology or hermeneutics (Heidegger, 2010). Heidegger's emphasis was more on interpretation as opposed to description; he stressed the importance of '*being-in -the-world'* (Dasein) (what it is to be) and understanding (Verstehen) (McConnell-Henry et al., 2009). Heidegger's interpretative view of phenomenology was to closely engage and dig deep beyond the surface to uncover the meaning of human experience. He placed considerable emphasis on the use of language and a person's interpretation and meaning they ascribed to a particular experience or phenomenon (Langdridge, 2007).

Central to Heidegger's philosophy was the belief that, as humans, we are already immersed within social, cultural, and historical contexts from which we cannot be isolated (Heidegger, 2010) Our pre-suppositions are part of our being (McConnell-Henry et al., 2009). Heidegger described our way of being-in-the world as '*Sorge*', which in English means a concern and care for things, and solicitude which is care for others and '*being-there'* (Walters, 1995). The concept of '*Sorge*' is relevant to midwifery and this study as it concerns the human aspect of caring which underpins the relationship and sense of connectedness that midwives have with women and their families (Miles, Chapman, Francis, & Taylor, 2013).

In Heidegger's view, the notion of bracketing is understood to have limited value. As human beings, it is difficult to be objective or have a neutral stance about things. Our lived experience of 'being in the world' is always in relation-to something and situated within the social, cultural, and historical context in which we live (Smith et al., 2009). The extent to which people can truly bracket off one's preconceptions is controversial. Because IPA acknowledges the researcher as an integral part of the research process that takes account of their beliefs and position (Peat, Rodriguez, & Smith, 2018), its practical application can be somewhat vague or confusing (Chan et al., 2013). In midwifery research, it is a challenge for any researcher to put aside any

preconceived ideas particularly if the researcher has prior knowledge and years of experience about the topic under investigation or if they are unaware of their own pre-suppositions (Rolls & Relf, 2006).

So, in conducting this study, I am fully aware that my own unconscious assumptions, foreground knowledge and experience as a midwife, lecturer and previously bereaved mother could potentially obscure participants' interpretations and impact on me researching the topic (Peat et al., 2018). In light of these concerns, I knew from the start of this research journey that to do justice to the students' accounts and stories (Peat et al., 2018), it was important for me to 'be aware' and uncover how my own knowledge, beliefs and values could impact on the research process by engaging in the art of reflexivity (Chan et al., 2013; Peat et al., 2018). Therefore, to make explicit my potential biases and judgements and assist me in this ongoing process, I used a reflexive diary and journal to document how my own assumptions about knowledge, values and beliefs influenced each stage of the research process (Ahern, 1999; Chan et al., 2013). Below is an excerpt from my reflexive journal prior to commencing the study.

I feel both anxious and excited about doing this study. Will I start to re-visit my own personal experience of perinatal loss to the extent that it may influence my relationship with the students? Will they see me in a different light? I am a lecturer but also a mother who has experienced grief and loss. Am I strong enough to manage and contain my emotions? These are questions I ask myself constantly. I am hoping that my own experience will enable me to connect with them on a human level and see it from their worldview.

In Table 7, I have listed the key differences between Transcendental and Interpretative Phenomenology, as adapted from Neubauer, Witkop, and Varpio (2019, p. 92).

Table 7 Comparisons between Transcendental Phenomenology and Interpretative Phenomenology

	Transcendental (descriptive) phenomenology	Interpretative phenomenology
Philosophical origins	Husserl	Heidegger
Ontological assumptions and beliefs	Reality and experiences are internal to the person, what appears in their consciousness	Focus is on human experience and how people 'live' through it. Emphasis is on the interpretative process
Epistemological assumptions	To understand phenomena descriptively as it appears requires the researcher / observer detaching oneself from their own physical being.	Researcher / observer is part of the process and understands phenomenon though interpretation
Researcher role in data collection	The researcher uses bracketing (epoche) to suspend any pre-existing beliefs assumptions, attitudes	The researcher's past experiences, knowledge is integral to the analytic process. The researcher's role is to reflect on their subjectivity throughout the process.
Researcher role in data analysis	Phenomena are considered from different perspectives, identification of units of meaning and formation of themes	Researcher engaged in hermeneutic circle. Iterative process of reading / attention to the whole of a text and its parts to gain a meaningful understanding of the lived experience

3.2.4 IPA and Hermeneutics

The theoretical underpinnings of IPA are attributed to three hermeneutic theorists: Heidegger, Schleiermacher, and Gadamer (Smith et al., 2009). As a theologian, Schleiermacher analysed and interpreted biblical texts. His belief was that to gain deep and meaningful interpretation requires an in-depth analysis and attention to the linguistic and psychological components of a narrative text. Through this level of interpretation, the researcher can gain a holistic and more meaningful understanding

of the phenomenon under investigation. Schleiermacher's theory resonates with IPA research in that to make meaning, people use language to describe the world they are in and their relationship to it (Smith et al., 2009). Therefore, when analysing a narrative, it is important the researcher pays close attention to the participant's use of metaphors and language which may reveal hidden meanings about the world they are in and their experiences of it (Smith et al., 2009).

Influenced by Gadamer's theory of interpretation, Heidegger further developed his hermeneutic philosophy and moved away from Husserl's concept of bracketing. Heidegger insisted that as humans we are self-interpreting beings and embedded in a world of people, language, relationships from which we cannot be disconnected (Heidegger, 2010). Therefore, for IPA researchers, it is impossible to ignore the historical, cultural personal or emotional contextual basis of their own experiences.

From a Heideggerian perspective, to approach the data sensitively and responsively, it is important for the researcher or analyst to acknowledge their own foreground knowledge or pre-suppositions in advance and engage in a cyclical process of constant analysis and interpretation with the participant's accounts until new meanings and understandings emerge (Peoples, 2020). Heidegger refers to this process as the hermeneutic circle. In this study, the hermeneutic circle involved moving back and forth between various parts of the students' accounts and exploring the individual meaning of the words within the context of the whole sentence (Heidegger, 2010). According to Smith et al. (2009), the hermeneutic circle is an iterative process which facilitates the relationship between the researcher and the participants and enables a deeper level of interpretation and coherency between the different parts or whole of a text. In IPA research, reference is also made to the concept of the double hermeneutic. A metaphor implies a participant's attempt to make sense of their world that the researcher simultaneously tries to understand (Pietkiewicz & Smith, 2014). The concept of the hermeneutic circle describes the relationships between 'the part' and 'the whole' at various levels within participants' accounts and is outlined in Table 8.

Table 8 The concept of the hermeneutic circle adapted from Smith et al. (2022, p. 23)

The part	The whole
Relates to a single word	Relates to the sentence in which the word is inserted
A single extract	This relates to the whole text
A particular text	The complete oeuvre
The interview	The research project
A single episode	The complete life or experience

In IPA, the researcher's constant engagement in the 'hermeneutic circle' allows new understandings and different perspectives to emerge between the researcher and the researched; this underpins Gadamer's concept of the 'fusion of horizons' (Smith et al., 2009). Gadamer used the phrase 'fusion of horizons' to describe the merging - or 'fusion' - of different points of view, namely the researcher's and participant's world views, in the hermeneutic process (Smith & Nizza, 2022). Therefore, applying these concepts to this thesis will lead to a deeper more meaningful understanding and interpretation of the students' lived experiences of bereavement simulation.

3.2.5 IPA and the Idiographic Focus

The third main theoretical concept underpinning IPA is idiography. Idiography focuses on how a particular experience or experiential phenomenon is understood from the perspective of a distinct group of people within a specific context (Charlick, McKellar, Fielder, & Pincombe, 2015). To achieve this, the data analysis needs to follow a thorough and systematic approach. The emphasis is on 'distinct' and 'particular', while at the same time identifying patterns and themes that are common or shared within a sample. Thus, IPA is also more concerned with examining convergence (similarities) and divergence (differences) within a sample and while

also encompassing a degree of homogeneity (they fit certain criteria) (Brocki & Wearden, 2006). The result is an in-depth description of the shared experience that accounts for these similarities and differences (Langdridge, 2007).

Due to the intensity of analysis required for each individual case, small purposively selected samples are frequently used In IPA studies along with single case study analysis (Charlick, Pincombe, McKellar, & Fielder, 2016). The benefit of small samples is that phenomenologically rich and thick descriptions of an experience can be obtained that may not be possible with larger sample sizes (Smith et al., 2009). This rich level of analyses was outlined in a study by (Charlick et al., 2015) involving a case study of a first-time mother who achieved exclusive breastfeeding for six months. To explore the themes from the case study in more depth, a subsequent study was undertaken with a sample of five mothers who exclusively breastfed for two months but ceased prior to six months. Findings from this study illuminated a deeper understanding of the individual and shared experiences of a specific but minority group of women around breastfeeding. Using a purposively selected sample enabled the researcher to make assumptions regarding a specific experience of a group of women that could not be generalised beyond that sample in that context. Findings from the study also contributed to the body of knowledge about this major life experience for breastfeeding women in general (Charlick et al., 2016).

In summary, this thesis is underpinned by the hermeneutic and interpretative concepts developed by Heidegger (1927, 1962) and Gadamer (1975). The methodological approach of IPA will be used to explore student midwives lived experience of bereavement simulation. The key theoretical principles underpinning IPA acknowledge that the students will have different views and multiples realities and insights into the simulation experience that may be influenced by their own thoughts, background, or personal experiences of grief and loss. Through adopting an IPA approach, the emphasis is on the different ways that students construct their own unique meaning from the experience and how they express and share that commonality.

3.2.6 The Limitations of IPA

Despite the growing popularity of IPA in healthcare research, IPA methodology is not without its criticisms. A common critique is the tension between the development of common themes and maintaining the idiographic focus (Wagstaff et al., 2014). Nolan (2011, p. 52) noted that the process of identifying superordinate themes, like '*drowning in a bowl of spaghetti'*, and the emphasis on the commonality of experience is inconsistent with the idiographic focus of IPA. Nolan asserts that, despite the structure of IPA, there is limited guidance to assist in the process of interpretation. However, it is difficult to agree with this as Smith et al. (2009) provide a meticulous, detailed step-by-step framework with examples that help guide the researcher at each stage of the process (Smith et al., 2009; Smith & Nizza, 2022).

One of the main criticisms of IPA is that the methodology pays little attention to the role of language (Willig, 2013). Smith et al. (2009) reject this criticism claiming that meaning-making occurs through use of metaphors, narratives, and discourse. They argue that whilst the principle aim of IPA is to understand experience, it encompasses the important role of language and culture and how that influences how one interprets the meaning of an experience.

Another challenge highlighted in the literature is the considerable length of time it takes to analyse the data (Brocki & Wearden, 2006). Analysing each individual transcript can take several weeks and up to two weeks to produce a draft of the first analysis (Smith et al., 2009). This can be daunting for novice researchers, those with time constraints or based in settings where rapid results and findings are required.

However, Tuffour (2017) also contests whether IPA can accurately capture peoples' experiences and meanings as opposed to mere opinions. Nevertheless, IPA relies on the participant being able to articulate the subtleties and nuances of their emotional and physical experience (Tuffour, 2017). For some people expressing thoughts, feelings or emotions is difficult to do as they may not be used to it, or may have suffered some form of injury or have a condition that affects their ability to communicate. Therefore, in some situations, a phenomenological research study is

unsuitable, confirming that an IPA approach is limited in certain situations (Willig, 2013).

3.2.7 Alternative Methodologies Considered

Grounded Theory: Initially, I considered Grounded Theory (GT), which was originally developed by two sociologists, Glaser & Strauss (1967;(Rees, 2012). The purpose of grounded theory is to '*explore a phenomenon and develop a theory about an aspect of human behaviour'* (Harvey & Land, 2022, p. 68). GT is concerned with human interaction and behaviour within social contexts (Holloway & Wheeler, 2010). It is used when there is little known about a topic and the theory that is developed is 'grounded' in the data (Harvey & Land, 2022). In a grounded theory study, the main emphasis is on the generation of a theory or model that explains the data collected (Rees, 2012).

Both GT and IPA adopt an inductivist approach to inquiry and acknowledge that insight can be gained about a person's internal world, but in IPA this experience is not always directly measurable (Smith et al.). In this thesis, I chose a phenomenological approach as opposed to grounded theory due to IPA's emphasis on the phenomenological experiences of participants (Smith et al., 2009). Grounded theory aims to explain social processes as opposed to the meaning and interpretation of individual experiences; thus, it does not align with either my research question or the study aims. In IPA, the role and position of the researcher is an integral part of the research process, whereas in a grounded theory study the themes are generated during analysis and the influence of the researcher is minimised (Braun & Clarke, 2013). Because of my own personal experiences of perinatal loss and having been a midwife and lecturer for many years, I felt it would be difficult to put aside my own personal beliefs and standpoint. In IPA, the researcher's beliefs are not seen as biases but are necessary for making sense of other people's experiences through the process of reflexivity (Smith et al., 2022). For these reasons I felt a phenomenological approach was more suitable for this study.

Discourse Analysis: I also considered Discourse Analysis (DA) for this study. DA is a methodology that encompasses different approaches and techniques (Frost,

2011). DA is concerned with the 'performative' use of language and the way people do things with language (persuade, excuse, explain, justify, etc) (Langdridge, 2009). Foucauldian discourse analysis (FDA), originally developed by the philosopher Michel Foucault, is concerned with the power relations that underpin the use of language.

Both DA and FDA could be used in this study to explore the students' use of language when communicating with bereaved parents. Given the sensitive nature of bereavement research and the different power relations that can occur between healthcare professionals and parents, particularly following perinatal loss, this approach could provide useful insights. However, I wanted a methodology that would encompass the true meaning of students' experiences within the context of the simulation. It was felt that discourse would provide too narrow a focus and therefore would not be suitable for this study.

Ethnography: Ethnography is concerned with studying the culture of people and their behaviour within a particular context; it is usually applied in naturally occurring settings (Frost, 2011). This methodological approach requires the researcher to enter the world of the participants, immerse themselves in their culture, observe and listen to what is being said, and to ask questions to gain first-hand information (Hammersley, 2004). The aim of this approach is to understand another way or life or culture from the participants' points of view; therefore, it involves spending time in that cultural or social context (Frost, 2011). I decided against using ethnography for various reasons. Ethnography is concerned with understanding human behaviour in the cultural or social context in which it occurs whereas the context for my study is a contrived, simulated environment which may not entirely replicate an ordinary, real-life setting. Finally, because my research was not concerned with exploring cultural behaviour or cultural aspects of care (Polit & Beck, 2022), I considered ethnography unsuitable for this study.

Thematic Analysis: Earlier on in my research journey, I also considered Thematic Analysis as an alternative approach to IPA. Thematic Analysis (TA) is a form of phenomenology or experiential qualitative research that is conducted extensively

within counselling and psychotherapy research (Braun & Clarke, 2021; McLeod, 2011). It is a method of analysing qualitative data in which the data is organised and coded into broad themes and sub-themes across cases. There are conceptual and procedural similarities between TA and IPA in that the process of searching for connections between themes and generating superordinate themes echoes that of an IPA study. However, Braun and Clarke (2021) suggest that TA is preferable where the emphasis is not just on a personal experience, on how people make sense of significant life experiences, or in cases where interviews are not the main source of data collection. For these reasons and the purposes of this study, I felt that IPA was a more powerful and creative methodological approach to address the research goals. Due to IPA's interpretative and idiographic focus on the depth and meaning of the lived experience, I regarded it more suitable in providing a richer and deeper understanding of students' midwives unique experiences of bereavement simulation.

Having provided a justification and rationale for choosing IPA as a suitable approach for this study, the next section will discuss how I considered the principles to ensure quality and validity throughout the study.

3.2.8 Assessing for Quality in the Study

The following section will address the key principles that determine the assessment of quality in qualitative research, and establish the criteria proposed to ensure that quality and validity standards were achieved (Smith et al., 2009, 2022). According to McLeod (2011), a key challenge for qualitative researchers is to establish a set of criteria that can accurately assess the quality of a piece of research. In quantitative research, specific criteria - such as reliability and validity - are well established and upheld as 'proof' that the research is scientifically robust and rigorous. Whilst validity and reliability are important considerations, qualitative research, with its concepts of reflexivity, subjectivity, and the researcher's perspective, suggests that the research needs to be judged and evaluated using the criteria deemed most appropriate (Smith, 2008).

Nevertheless, it is difficult to establish a definitive set of criteria that can be applied to all qualitative research. Smith et al. (2009) recommended Yardley's four principles as a framework for assessing quality. These include sensitivity to context, commitment and rigour, transparency and coherence, impact and importance. In the next section I will discuss and explain how I adhered to these principles whilst undertaking the study.

3.2.9 Demonstrating Sensitivity to Context

According to Yardley (2000), sensitivity to context begins at the early stages of the research process and involves the researcher's knowledge of the theoretical concepts of IPA, namely the philosophy, methodology and underpinning epistemology. Sensitivity to context also requires the researcher to consider existing literature and how it informs the rationale for the study and the research question. Evidence for this was detailed in Chapter 2. Throughout this study, I have adhered to this principle by ensuring an in-depth awareness of the data collection method and interview process. Given the sensitive nature of the study, I used empathy and compassion throughout whilst interviewing the participants. At all times I endeavoured to put them at ease. I was also sensitive to the handling of their data. I ensured that the use of verbatim accounts remained true to the participants' voices and formed part of the analytical process.

3.2.10 Demonstrating Commitment and Rigour

Yardley's principle of commitment and rigour is determined by an appropriate sampling strategy, extensive data collection, detailed data analysis, and that the researcher demonstrates an understanding of the methodological process (Yardley, 2000). In this study, the sampling strategy, sample size, method of data collection, and discussion of the findings are addressed in Chapters 3 and 4. Rigour also relates to the epistemological and theoretical concepts as well as the limitations of the methodology (these areas are discussed in Chapter 3). Commitment means ensuring that the researcher possesses the right skills and competence to ensure the completion for the study. To develop my skills in IPA methodology, I attended IPA workshops and study days at the University of Salford, University of Derby, and

University of Cardiff. In addition, I attended the University of Salford's IPA forum group on a regular basis. These fora were facilitated by a counselling lecturer with expertise in IPA research. The forum was particularly beneficial as it enabled postgraduate students to meet, discuss and present our research, and share learning, particularly in relation to data analysis. I also engaged in an online IPA community of practice website. In addition, to strengthen the analysis process, both of my supervisors reviewed two samples of transcripts at various stages of the analytic process and provided comments and feedback that they felt were interesting and important.

3.2.11 Transparency and Coherence

Transparency and coherence also relates to the disclosure of the research process (Yardley, 2000). Throughout this study, I endeavoured to provide a thorough and clear description of all the processes undertaken. These ranged from the sampling and recruitment process through to the analytic process. A transparent pathway was also provided in which a clear audit trail of the ethical approval (Appendices 1, 2 ,3 and 4) and analytical processes were detailed (as provided in the data analysis chapter).

3.2.12 Impact and Importance

Yardley's (2000) final principle of impact and importance relates to the theoretical value and practical impact of a research study which extends beyond the research setting. As stated in the introduction and background section, it is anticipated that the findings of the study will offer recommendations to support and improve bereavement care education involving perinatal loss within both undergraduate and postgraduate healthcare education. I am also committed to ensuring the future dissemination of the findings within professional and academic journals, conferences, and webinars. Having considered Yardley's criteria for good quality research, Nizza, Farr, and Smith (2021) recently introduced four key indicators to enable quality in research. These are outlined Table 9, with examples as to how they applied to this study.

Table 9 Four key indicators for assessing quality and validity

Quality Indicator	Description	Application to this study
Providing a convincing and unfolding story of the participants' experiences	There is a depth and breadth of analysis that develops the narrative cumulatively, and progressively and is illustrated through selected quotes	The researcher conducted in-depth analysis using verbatim quotes and the hermeneutic circle to provide a coherent and compelling account of the participants' narratives
Constructing a robust experiential and / existential account	The analysis is engaging and attentive to the experiential and existential meaning of the experience of the participants	Through interpretative analysis, the researcher illuminated the meaning and significance of the experience leading to deeper levels of insight
In-depth and close analytical reading and interpretation of the participants' words quotes	Analysis is detailed and provides a meaningful interpretation of the participant's experience	The researcher was attentive to the linguistic comments, repetition and use of metaphor identified through a close reading of the verbatim accounts
Attention to convergence and divergence	The analysis illustrates areas of commonality and differences in the varied accounts	The researcher illustrated the shared and unique features of experience using cross-case analysis

3.2.13 Ethical Considerations Undertaken in Conducting the Study

This section will address how ethical considerations were addressed throughout this study. Ethical considerations are a critical part of any research study. Regardless of the design, context or structure of the research, the ongoing ethical issues that exist or may emerge for those involved in the study must be considered (King, Horrocks, & Brooks, 2018). Ethical principles govern the rights, dignity, and safety of the research participants. In conducting any research study, the protection and safeguarding of participants is of paramount importance. However, despite ethical

debates about adherence to the principles of beneficence (do good), non-maleficence (do no harm), and the tensions that may exist with regard to protecting the confidentiality and anonymity of participants as co-researchers (Palaiologou, Needham, & Male, 2015), it was important to uphold the ethical principles in undertaking this study. This ensured that the student's autonomy and identity were respected and that strategies were incorporated to mitigate any risk resulting from participation in the study (King et al., 2018).

The main ethical issues that needed to be addressed before conducting any research included: gaining valid informed consent, safeguarding the confidentiality and anonymity of the participants, and protecting the participants. To ensure these principles were addressed, ethical approval was sought and granted from the ethics committee in the university where I am employed and undertaking my PhD.

3.2.14 Informed Consent

Informed consent is an important aspect of safeguarding participants when conducting any type of research (Polit & Beck, 2022). Informed consent means that participants are fully informed about the nature of the study, understand the information and have the right to choose or decline to participate in the study voluntarily (Polit & Beck, 2022). The underlying principle of informed consent is to ensure that potential participants do not in any way feel coerced, pressurised or persuaded to take part in the study and their decision to participate is voluntary (Anderson, 2011). In conducting this study, it was important that I did not make any assumptions that midwifery students understood the research process (Anderson, 2011). Therefore, it was important that balanced information was provided in a timely manner so that the implications of taking part in the study were understood (Anderson, 2011).

Prior to undertaking the study, an information sheet was distributed to two cohorts of students outlining the purpose of the research and what was involved should they choose to participate. The information sheet was designed to respect students' autonomy and freedom to make their own decisions whether to take part in the study (Polit & Beck, 2022). This was distributed six weeks in advance of the study to allow

the participants enough time, space, and opportunities to discuss and clarify any issues and to reassure me as the researcher that they understood the implications of taking part in the study. Following receipt of the information sheet, potential participants were encouraged to contact me if they had any questions or concerns about participating in the study. Once a student agreed to take part in the study, I also gave them the information sheet prior to obtaining consent.

Potential participants were also reassured that their refusal or withdrawal from participation would not result in any form of penalty or discrimination, or impact on the relationship between researcher and student - either positively or negatively (Anderson, 2011). This also involved obtaining both verbal and written informed consent and confirmation that the participants understood the purpose of the study and the associated benefits or potential risks of taking part (Polit & Beck, 2022). It is important to establish that the practice of informed consent was a continuous process throughout the study (Dewing, 2007).Therefore, once students agreed to take part, I verified their consent again prior to commencing the study and upon their arrival for the interview.

Phenomenological research has the potential to ‘draw out people’s stories’, that perhaps they are not used to telling thereby making them potentially emotionally vulnerable (Thomson, Dykes, & Downe, 2012). Due to the nature of this research, I was aware that the simulation could provoke powerful emotions and that the students could become upset talking about how they felt and their own personal experiences. As an ethical phenomenological researcher, I had a duty of care to ensure that the emotional and psychological safety of each student was protected throughout the study (Finlay, 2011b). Therefore, I was sensitive to signs of any distress or alteration in their general well-being. The participants were advised of the right to withdraw from the study at any point if participation caused any undue stress or they did not - for personal or any other reason - wish to carry on. In this event, I confirmed that follow up support and counselling would be offered and available immediately if needed.

3.2.15 Relational ethics

Given the importance of standard ethical considerations when undertaking any study (King et al., 2018) as a researcher, lecturer, personal tutor and learner, it was equally important that I reflected on my own ethical responsibilities and had a broader understanding and appreciation of the term relational ethics. Relational ethics is an integral part of any study, particularly in palliative or bereavement care research (Haraldsdottir, Lloyd, & Dewing, 2019). It implies that the researcher is true to their *'own character'* and have a deep awareness and responsibility for the consequences of their actions on others (Ellis, 2007; Palaiologou et al., 2015). Ellis (2007, p. 3) stressed the importance of '*researchers acting from their hearts and minds and acknowledging our interpersonal bonds with others'.*

As a phenomenological, axiological researcher, I acknowledged, valued, and gave voice to the students throughout the research process (Palaiologou et al., 2015). I was constantly aware of the importance of being empathically attuned and actively listening, and of '*listening in silence*' to the participants stories, giving them time to make sense of the experience (Finlay, 2011b, p. 210). My aim was to uncover the real meaning of the experience for participants; therefore, I was mindful of approaching each interview from a position of '*unknowing*' that was underpinned by a deep sense of '*curiosity'* about how it felt for them. (Finlay, 2011b, p. 208). In undertaking this research, I was also aware of the importance of the relationship and the interaction between myself as the researcher and the participants when creating the data. Finlay (2011b) emphasised the importance of '*inter-subjective reflexively* and of being attentive to the embodied lived experience for participants engaging in the study. Therefore, I was sensitive to any forms of embodied communication (verbal and non-verbal communication) throughout that would indicate any levels of stress or imply whether the participant wanted to continue with the study or not.

3.2.16 Maintaining Confidentiality and Anonymity

An important part of informed consent is the participants' right to confidentiality and anonymity (Rees, 2012). As the researcher conducting this study, I needed to ensure confidentiality by not allowing any unauthorised access to the raw data collected

(Rees, 2012). Throughout this research process and the dissemination of the study findings, I also needed to ensure anonymity by protecting the identity of those participating in the study. Therefore, I did not include any details that could potentially link the participants to the actual data (Polit & Beck, 2022).

To guarantee participant anonymity and confidentiality, codes (only known to the researcher) were used to replace names or locations. To meet the requirements of the Data Protection Acts 1998, 2003 and to protect participants' confidentiality, strict procedures were adhered to in both the handling and storage of the data. As recommended, any data is stored electronically on a password protected computer. This data should only be accessed by a specific encrypted password only known to the researcher. All consent forms, interview recordings and transcripts had specific codes and were encrypted against risk of loss. Any paper copies were stored in a locked cupboard in a room only accessible by the researcher. Any data that was stored or transported on a USB disc was also coded and encrypted against identification and loss. In the event of the future publication of findings and dissemination of the research, all ethical procedures will be adhered to, so that the anonymity and confidentiality of the participants' identity, location and involvement in the research will be preserved and guaranteed.

Throughout the study, I am constantly aware of my position as a researcher and attentive to the power imbalances that could potentially occur between both myself as the researcher and the participants being researched (Undurraga, 2012). Whilst qualitative research supports the unique contributions of both the researcher and participants and the co-production of knowledge, methodological dilemmas related to power issues can occur (Karnieli-Miller, Strier, & Pessach, 2009).

In undertaking this study, I am aware that students are valuable sources of knowledge in healthcare research. However, they are also potentially vulnerable due to my roles as a lecturer, researcher and personal tutor which can create power imbalances and impact on their autonomy (Anderson, 2011). It was therefore my responsibility to take steps to mitigate against any power imbalances as much as possible and ensure that the students did not feel disempowered or that their student

status was impacted. From the beginning of the study, I was mindful of the need to be honest and transparent with the participants about the nature and conduct of the study. I respected their contribution by sharing feelings, emotions, and experiences. Throughout the study, I verified their consent to continue with the interviews and once I completed the data analysis I endeavoured to avoid distorting the meaning of the participants' voices or words and protected their anonymity (Karnieli-Miller et al., 2009).

3.2.17 Research Methods Used to Conduct this Study

Having addressed the ethical considerations, this section will address the methods used to undertake this study and how they align with the conceptual and epistemological principles of IPA

3.2.18 Sampling Strategy

In undertaking this study, I was aware that the method of sampling needed to be consistent with IPA in terms of homogeneity (Smith et al, 2009). This means that the participants shared the same experience of the phenomenon, with no considerable variation in terms of their demographic characteristics (Langdridge, 2007). The aim of IPA research is to illuminate each individual's lived experience (Smith & Nizza, 2022). Therefore, for the purposes of this study, the strategy needed to identify a purposive sample of students for whom the experience would be deep and meaningful (Smith et al., 2022). Also, for practical purposes, it was essential that I obtained a sample that could be easily accessible, with some clinical experience, and was prepared to participate in the study (Smith et al., 2009).

For this thesis, a decision was made about homogeneity, which was based on the participants' length of clinical experience as student midwives. This was defined as having been a student midwife for nine months or more. I considered this an appropriate length of time as students would be able to reflect on their own practice-based experiences and be able to compare the simulated bereavement experience against similar experiences in the clinical setting. Because I wanted to gather information about a specific midwifery experience (perinatal loss) from a specific group of students (Langdridge, 2007), I selected a purposive sample of midwifery

students who could offer insight into the simulated bereavement scenario. To reduce recruitment challenges, I also decided to recruit from the university in which I am based as I felt confident, I would secure enough participants to participate. Consequently, the inclusion criteria for eligible participants are outlined in Table 10.

Table 10 Inclusion and exclusion criteria

Inclusion criterion	Exclusion criteria
Midwifery students with nine months or more clinical experience	Students in the final year of the midwifery programme
	Students who had already experienced or participated in bereavement simulation.
	Students from other disciplines, e.g., paediatric, neonatal or children's nursing

My rationale for these exclusion criteria is consistent with the IPA methodology whereby emphasis is not placed on achieving 'maximum variation sampling' or variation in demographics (Langdridge & Hagger-Johnson, 2009). Instead, IPA research focuses on sampling that is purposive and homogenous. In selecting the above exclusion criteria, I am aware that third year student midwives could potentially offer valuable insights and perspectives into the bereavement simulation. However, because they had already participated in bereavement simulation, I felt this might bias the results or findings of the study. However, I am aware that the impact of bereavement simulation on their practice is an area that warrants further research in the future.

3.2.19 Choosing the Sample Size

IPA research is orientated towards the use of small sample sizes as a large amount of data can still be generated from small numbers (Smith et al., 2009). Whilst there is no definitive correct sample size (Smith et al., 2009), due to the idiographic focus in

IPA, small sample sizes are preferable, as a large sample could result in the loss of subtle meanings (Brocki & Wearden, 2006). Although sample sizes can vary in some IPA studies, for professional doctorate studies, between four and ten interviews (as opposed to participants) are recommended (Smith et al., 2022). However, decisions about sample size can be based on each individual study (Brocki & Wearden, 2006). For the purposes of this study, and considering the literature, recruitment strategy, and research question, I considered that 8-10 participants would be suitable to explore the research question in depth. I also considered one-to-one interviews most appropriate to capture a deeper understanding of the students' unique and individual experience.

3.2.20 The Recruitment Strategy

An effective recruitment strategy is crucial to getting good quality data. However, I was also aware that recruiting people to take part in bereavement research can be challenging due to the sensitive and emotive nature of the topic which could potentially impact on the student's decision to take part (Crowther & Lloyd-Williams, 2012). On determining the recruitment strategy, I decided to adopt different methods to approach the potential participants. To generate interest in the study, I initially posted some brief information on the programme's Blackboard website asking first and second year students if would they be interested in participating in the study and what it involved. I then took the step of speaking to the first and second student cohorts in the classroom and re-affirmed the aims and objectives of the study. Following this, I received emails from 15 students who expressed an interest in participating and requested further information. I then directly contacted the students via telephone and discussed with them what the study was about and addressed any questions or concerns they had. Once I provided the participants with the necessary information about the study, I offered them time to consider before making a final decision to take part. I then compiled an invitation letter and a participant information sheet asking them to read the information and to consider whether they wished to take part or not. These invitation letters were distributed by the programme leader and/or a third party for confidential reasons, and not by me as the researcher. I also wrote a letter to the Head of Midwifery at the time informing her about the study.

A total of 12 students confirmed they would like to take part in the study (the final sample with pseudonyms is shown in Table 11). I then arranged to meet each student on an individual basis, discussed the content of the information sheet again, and asked them to sign the consent form (which had been presented to Salford University's Ethics Committee in July 2017). I explained that the subject area could be emotional and outlined the various supportive mechanisms (e.g. on-site counselling, tutorial support, midwifery advocates) in place if they felt upset at any point in the study.

Table 11 Final sample

Participant	**Gender**	**Age range**	**Ethnicity**	**Level of experience / personal history and / or clinical of perinatal loss**
Angie	Female	20-25	White British	End of year 2, no history / experience disclosed
Kim	Female	26-30	Mixed race	End of year 2, personal experience of family member and perinatal loss
Catherine	Female	20-25	White British	End of year 2, no personal history / experience disclosed
Emma	Female	20-25	White British	End of year 2, no history / experience disclosed
Andrea	Female	30-35	White British	End of year 1, experienced some exposure in clinical practice
Gayle	Female	28-30	White British	End of year 1, no history / experience disclosed
Orla	Female	25-28	White British	End of year 1, some clinical experience disclosed
Susan	Female	30-35	White British	End of year 2, personal experience disclosed
Ethel	Female	25-30	White British	End of year 2, no personal or clinical experience disclosed

Once I had received final confirmation of numbers, I subsequently sent out further information about the date, time, and location of the bereavement simulation event. I also included the dates, times and locations of the post-simulation interviews which were scheduled to take place within one week immediately following the simulation. In the end, due to sickness and transport issues on that morning, a total of nine students participated in the study. Having addressed the sampling and recruitment strategy, the next section will outline the simulation scenario and the pre-simulation preparation of the students.

3.2.21 Developing the Simulation Scenario

The study was conducted at the University of Salford's Simulation Suite within the 'Home-Room' which was used as the setting for the triage room. The scenario was subsequently streamed to a classroom so the other students could observe their peers, as illustrated in figure 2

Figure 2.

Figure 2 Live streaming of the simulation into the classroom

The development of an appropriate simulation scenario is a key aspect of high-fidelity simulation training. A scenario maybe defined as '*a patient case with a main storyline with specific learning outcomes for the participants and the observers'* (Alinier, 2011, p. 10). A well-designed simulated scenario requires careful planning and needs to be broken down into several different stages (Harrington & Simon, 2021). Therefore, in developing the bereavement scenario, it was important that I approached it systematically taking account of the specific aims, the intended learning outcomes, and the target learners (Willhaus, 2016). A well-executed scenario should also be at an appropriate level for the students so they can utilise some of their knowledge and skills to cope within the scenario. In designing the scenario, I took account of the educational principles underpinning Bloom's Taxonomy in relation to students' progression from novice to expert (Benishek et al., 2015).

Another important consideration was that the simulated scenario should be 'fairly realistic' so participants could '*suspend disbelief*' (Alinier, 2011). I chose a scenario based on a real-life situation and one that is sometimes encountered by students in clinical practice (see Appendix 6). The scenario is based on a couple using the pseudonyms 'Holly' and 'Ben' (using standardised actors) who present to their local maternity unit with a history of reduced fetal movements at 38 weeks' gestation. The scenario unfolds following the initial confirmation of the death of the baby and includes the breaking of the bad news through to the birth of the baby. The scenario concludes with the parents' decisions about seeing and holding their baby. The students were expected to provide care to the couple and respond to their needs as required throughout the different stages of the scenario.

As stated earlier in the literature review, creating a sense of realism and authenticity is key to enabling learners to engage and immerse themselves in the simulation. To further convey a sense of realism and authenticity, I asked colleagues to play different roles (e.g. bereaved parents, doctor, triage midwife) and I briefed them on the possible emotions to portray, including what words or cues they could use or questions to ask so students could respond naturally and behave as they would in a real life situation (Issenberg, McGaghie, Petrusa, Lee Gordon, & Scalese, 2005). I

also used additional props (memory box, use of a doll in a Moses basket) to '*help set the scene for the participants'* (Alinier, 2011, p. 15) as shown in Figure 3.

Figure 3 Example of props used

3.2.22 Pre-Simulation Preparation

Simulation experiences incorporate three key components: Pre-briefing, an unfolding scenario, and a debrief (Page-Cutrara, 2014). Pre-briefing the students and providing them with preparatory information is critical to learner engagement (Tyerman, Luctkar-Flude, Graham, Coffey, & Olsen-Lynch, 2016). The prior exposure of learners to the simulated scenario can also help decrease their anxieties and promote comfort which in turn can encourage active engagement in their learning, as well as the development of critical thinking skills and reflective practice (Gantt, 2013). Therefore, for the purposes of this simulation, the activities that supported the pre-briefing phase included orientation to the simulated setting, explanation about the different props and equipment available, clarification of the roles and expectations during the simulation, and the important role of debriefing. A sample outline of the simulation plan is shown in Appendix 7.

3.2.23 The Model of Debriefing

Debriefing following a simulated learning event is crucial to optimise student learning. Whilst reflection after a simulated learning experience may occur naturally, it is likely to be informal and therefore a more structured debrief is critical to focus the

reflective process (Fanning & Gaba, 2007). There are several models for facilitating a debrief, similar to models of reflection and reflection on-action. However, for the purposes of this study, I chose ‘The Diamond Debrief Model’ proposed by Jaye, Thomas, and Reedy (2015). It provides a series of structured questions and prompts which are designed to include each phase of the debrief from the initial description of what happened followed by more in-depth analysis and application to practice. The key components of the Diamond debrief model are outlined in Figure 4.

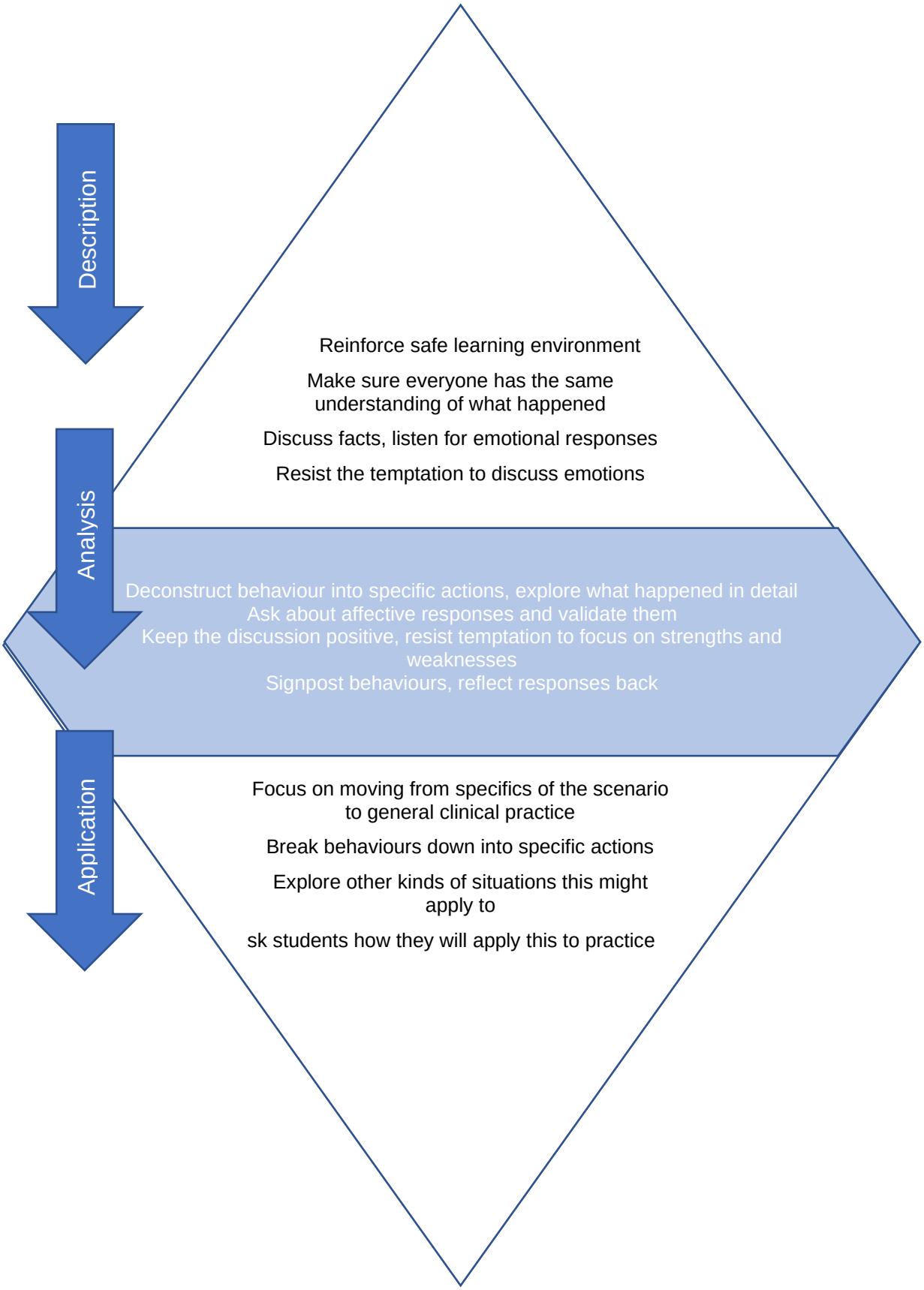

Figure 4 The diamond debrief structure for simulation,

3.2.24 The Method of Data Collection

IPA research requires a data collection method that will invite and encourage participants to provide a detailed, rich and first person account of their experiences (Frost, 2011, p. 54). Willig (2013) suggests that there are no particular 'right or wrong' methods of data collection, but a good quality study needs to obtain quality data through appropriate data collection and analysis methods that answer the research question (McConnell-Henry, DNE, & Karen Francis, 2011; Willig, 2013). My research question explicitly set out to address the lived experience of bereavement simulation. I particularly wanted the participants to tell me, in their words, their thoughts, feelings, and emotions about how it felt to be within the context of the bereavement simulation and what kind of learning would emerge as a result. I wanted to adopt an insider perspective, to see what it was like from their point of view (Willig, 2013) and give a 'voice' to their concerns including what mattered to them (Larkin, Watts, & Clifton, 2006). From a methodological perspective, IPA *'requires rich data'* (Smith et al., 2009, p. 56) which involves the intensive analysis of verbatim accounts produced by a small number of participants (Larkin et al., 2006). This required me to consider the adoption of a flexible method of data collection that positioned the participants' experiences as central. Therefore, semi-structured interviews were deemed appropriate to capture their verbatim accounts (Larkin et al., 2006).

Interviewing is a valuable method of data collection and most commonly used in qualitative research (Harvey & Land, 2022). Interviews are generally categorised according to their degree of structure (Rees, 2012).They can range from highly structured, semi-structured, or unstructured. Highly structured interviews tend to be used in quantitative research, for example survey designs or cases where a complex questionnaire needs completion and where the participants are unable to complete a questionnaire on their own (e.g., young children). Structured interviews rely on a fixed and ordered set of questions with a pre-determined set of answers with minimal variation (Langdridge & Hagger-Johnson, 2009). In this format, the interviewer adheres to a tight and precise schedule which makes it easier to quantify and analyse the data, reduce bias and produce generalisable results (Langdridge &

Hagger-Johnson, 2009). It also guarantees compatibility with statistical analysis programmes (Rees, 2012).

A disadvantage of a highly structured approach to interviewing is that it can be superficial allowing with little scope for spontaneity and potentially reducing the richness or depth of information obtained. It was therefore considered unsuitable for this study (Rees, 2012). On the other hand, unstructured interviews do not follow a pre-determined interview schedule. The interview format tends to be more exploratory and is particularly suitable to theoretical approaches such as ethnography, life-story research and/or therapy (Langdridge & Hagger-Johnson, 2009). Semi-structured interviews sit somewhere between 'these extremes' and have commonalities with both (Rees, 2012). They may be defined as:

> *'a verbal interchange where one person, the interviewer, attempts to elicit information from under the person by asking questions although the interviewer prepares a list of predetermined questions, semi structured interviews unfold in conversational manner offering participants the chance to explore issues they feel are important.*' (Longhurst, 2003, p. 143)

Unlike unstructured interviews, they contain standard, open-ended questions that cover the main topic areas and are generally asked of everyone (Willig, 2013). The questions posed to participants are used as a guide, meaning they are non-directive and adjusted in response to the participants' accounts. In this study, a form of conversation that allowed participants the opportunity to be open about their experiences was paramount (Reid, Flowers & Larkin, 2005). In addition, I sought to gain insight into how they contextualized and 'made sense' of these experiences (Larkin et al., 2006). Therefore, semi-structured, one-to-one interviews seemed appropriate to address these aims. I also considered using a focus group as they are particularly useful for generating discussion and gaining valuable insights and opinions from a variety of perspectives (King et al., 2018). When researching sensitive topics such as bereavement and loss, a focus group can encourage people to 'open up' or express their views particularly when others in the group have similar opinions or experiences (King et al., 2018). However, because my research was

concerned with the participants' individual experiences and interpretations, the use of a focus group may not generate the depth of understanding of the lived experience that could potentially be obtained from a one-to-one interview (Rees, 2012). In addition, I was also conscious that people's individual views or experiences may be inhibited or influenced by the general views and opinions of a focus group.

3.2.25 Conducting the Interviews

It is recommended that face-to face interviews are undertaken in a quiet, private and comfortable location where participants can feel at ease (Brinkman & Kvale, 2015). The date, time and venue should be left for the participants to decide for themselves (Alase, 2017). However, for convenience purposes, I chose to conduct the interviews at the University of Salford's Counselling Suite. It was a familiar and accessible location for the students and the rooms provided an ideal environment as they were tranquil, comfortable, and free from interruption (King et al., 2018).

Smith and Nizza (2022) stipulate that when conducting interviews, physical and psychological comfort - particularly for the interviewee - is paramount. If the interview is too formal or if the participant feels tense or uncomfortable, it can often result in the interview being quite '*stilted'* which can inhibit progress (King et al., 2018, p. 72). To promote a feeling of informality, I arranged two easy chairs with a small table between them at an angle that were close enough to hear the person speaking but at the same time avoided intruding on their personal space. The interviews were conducted in May 2018 over a period of one week.

When conducting interviews, it is important that participants are well protected in terms of their safety and wellbeing. Before I began the interview, I reassured the participants that confidentiality would always be adhered to, as outlined in the ethics procedure. I also explained that it was their right not to answer questions if that was their choice and that the interview could be paused or discontinued if they so wished. Because IPA research is concerned with '*significant existential issues'* (Pietkiewicz & Smith, 2014, p. 10) and bereavement research could invoke strong emotions, I was sensitive throughout to any verbal or non-verbal forms of communication that indicated emotional distress or upset. From my position as a lecturer, I was aware of

the potential power dynamics that could occur and the risk of *'exploiting' the* students to get rich and meaningful data (Wagstaff et al., 2014, p. 5). To minimise this, on-going consent was continually discussed with each participant. To gain their trust and encourage them to narrate their story without feeling judged, I aimed to establish a therapeutic relationship with them from the start (Wagstaff et al., 2014). I was also mindful of using kind, caring language throughout. I made every effort to be compassionate and empathic in both my questioning technique and acknowledgment of their responses. (Beaumont et al., 2016; Beaumont & Martin, 2016). Empathy implies having a sense of what it feels like from the perspective of another person. This aligns with Heidegger's concept of the hermeneutic circle in that, as the researcher, I was seeking to understand and interpret the students' interpretations of the meaning of the bereavement simulation.

There is a concern in the literature of the ambiguity of roles that researchers may experience when conducting sensitive research (Dickson-Swift, James, & Liamputtong, 2008). As the researcher conducting this study, I was already immersed in the setting I had chosen to explore and somewhat shaped both by experiences of caring for bereaved parents in the past and my own experience of perinatal loss. Consequently, there was a risk that the boundaries between myself as the researcher and the students within the study could become 'blurred' or merged, as highlighted by Dickson-Swift et al. (2008). I was also aware of the potential problems that could occur if professional boundaries were not handled appropriately which could mean putting myself at risk of being emotionally overwhelmed, exhausted and burnt out, or of feeling guilty about what might be disclosed to me and likewise for the students. The NMC Code stipulates that midwives need to be objective and establish clear professional boundaries (Nursing and Midwifery Council, 2018). However, given the emotive nature of the topic, I was worried that this may be difficult to maintain. The following extract is a reflective account about maintaining my professional boundary.

Reflexive notes- maintaining my professional boundary as a lecturer and a researcher

This was my first experience of being in the dual role as a lecturer and a researcher. I was aware that adopting multiple roles could potentially contribute to a power imbalance and impact on the students' perception of me. As a lecturer I was also aware of the students' anxieties in relation to this area of practice. For this reason, I did have some pre-conceptions about the emotions that the simulation may provoke, particularly for students who may have had their own personal experiences of grief and loss that I was unaware of. However, in keeping with the principles of IPA research, it was important that I set aside these assumptions otherwise I could potentially influence their narratives. I took some time to reflect on my positionality with the students and maintaining a professional boundary that would not impose on the research process, whilst at the same time acknowledging them as '*the topic experts'* (Smith & Nizza, 2022, p. 12).

I attended workshops and I read extensive literature on conducting interviews around sensitive research. As recommended by Smith and Nizza (2022), in the early stages of the study, I found it useful to write my own personal statement documenting my personal beliefs and views about the topic and imagining the type of responses that I might offer if I was being interviewed about the same topic. I found that the act of writing down and acknowledging my own preconceptions and experiences helped me to be actively aware of my position and focus on the process of fully understanding the experience from the students' perspective.

3.2.26 The Interview Procedure

Interviews are generally audio-recorded but prior to each interview, I reaffirmed the participant's consent to the recording and the use of verbatim quotes (Harvey & Land, 2022). I used a small, unobtrusive compact Sony recording device placed to the side of myself and the participant to record the conversations and I made sure I was thoroughly familiar with how it worked before I began interviewing (King et al.,

2018). The quality and working order of the digital recorder was checked prior to each interview. Spare batteries were in supply for each interview. Data was then transferred from the hand-held digital recording device to recordable compact discs immediately after the interview had concluded. In conducting any research study, Alase (2017) also advises using a combination of different methods to collect data; therefore, I opted to use the traditional 'notepad and pen' to jot down any observations and field notes as the interviews progressed. Finally, to ensure privacy a 'Do not disturb' notice was posted on the outside of the door.

When conducting the interviews, my focus was to validate the students' subjective experience, both as individuals and as participants, within the context of the bereavement simulation. Therefore, and due to the sensitive nature of the research, it was important to establish a level of trust and rapport with the participants and have reciprocal relationship with them, otherwise I would not gain good quality data (Kvale, 1996). Once the student entered the room, I adopted a friendly approach and made them feel at ease by welcoming and thanking them for agreeing to participate in the study. Even though I made it clear when recruiting them that I wished to record the interview, I was also concerned that it may cause them to feel uncomfortable (King et al., 2018). Therefore, to overcome this and help the student to get used to the recording device in the background (King et al., 2018), I switched the recorder on as I explained the interview procedure to them. I offered a refreshment and gave them time to settle into their surroundings which helped them to feel relaxed. I also provided some water and tissues in case anyone became upset during the interview (Harvey & Land, 2022).

Conducting qualitative interviews requires careful preparation as it can be a complex social situation and the interview itself should not simply be a way to gather data (Smith et al., 2022). My aim throughout each interview was to be an attentive listener and give each student time and space to talk freely about how it felt for them. I particularly wanted the interview to flow like a normal conversation. Smith et al. (2022) advised preparing an interview schedule in advance, formulating interview questions, and memorising them beforehand. I was aware that this might change once the interview got underway, but it provided me with a 'loose agenda' of the

aspects I wished to explore. The aim of the interview schedule was to act as a 'mental prompt' but at the same time give some element of structure and purpose to the process (Kvale, 1996).

The first question was designed to be open-ended, broad, and non-directive focusing on participants' lived experience of the simulation. This question attempted to ease them into talking openly and freely about their experience. For many students, this opening question seemed to work quite well and required minimal prompting. For example:

> *'Can you tell me how you felt or thought about being in the bereavement simulation scenario?*

As the interview progressed, I modified the questions in light of the students' responses to encourage the students to be more evaluative and reflective about their experience (Alase, 2017). For example, I probed further by asking:

> '*Can you tell me was there anything that was most significant for you whilst you were in there in that situation? Can you describe how it felt?*

During the interview, I was mindful of monitoring the impact of the interview on each student. I was particularly sensitive and attentive to any signs of discomfort or nonverbal cues indicating signs of upset given the sensitive nature of the topic (Smith & Nizza, 2022). Therefore, in the event of this occurring, I would make the decision to abandon the interview altogether or rephrase my question, as suggested by (Smith et al., 2009).

Each of the interviews lasted approximately 45-60 minutes. I was conscious of allowing the interview to come to a natural ending. However, after any prolonged pauses or hesitations, I took the opportunity to ask them '*if there is anything else you would like say?'* In some cases, the students elaborated on the topic further which added to the depth of the interview (Smith, 2019). Following the interview, I spent some time discussing some of the emotions that the interview may have provoked and thanked each student for their contribution. I also provided a list on-going support and/or counselling services if they felt they wished to avail of them and a

copy of the consent form. The following is a reflection on my experience of the interviews:

In comparison to other types of interviews, IPA interviews require an in-depth search for meaning on highly emotive topics like grief and loss. This type of interview is demanding (Smith et al., 2009) and much harder than I expected. The following extract is a short reflective account of adjusting to my role as an IPA researcher after conducting my first interview.

Reflexive notes: Conducting my first interview as a naïve IPA researcher

I was somewhat nervous about conducting my first interview as this was my first real attempt as an IPA interviewer. Prior to the interview, I placed a box of tissues and some water on the table. However, I decided that placing the tissues on the table was not appropriate. I felt it might give the impression that the interview would be upsetting. So, I placed them where I could access them if I needed to, but not in full view.

I felt my first interview went quite well and the student talked openly and freely about what the experience felt like for her. The student relied on the use of metaphors quite frequently which I was quite pleased about, as I felt this would add to the richness of the data. However, the interview was quite short and on reflection I realised there were areas that I could have probed further and more in-depth.

Initially, I was quite reliant on using the interview questions as a guide and extremely focused on meeting the aims and outcomes of the study. According to McCormack and Joseph (2018), if the interview is too ‘outcome focused’, tension can occur which can limit in-depth exploration and produce a descriptive, superficial account of the participant’s narrative. Having undertaken the first interview, I subsequently attended an IPA workshop in Derby to help me to perfect and develop my skills and techniques in IPA interviewing. I read journal articles on conducting IPA interviews. I also attended a series of IPA fora and shared similar concerns with other students. After this period of training and development, I felt more relaxed about conducting the subsequent interviews. My interviewing style improved, and I was able to apply different tactics that enabled me to probe deeper and gain insight into the experiential world of the students and how it felt for them.

Reflexive notes about my initial interviews

'Some of the initial interviews left me filled with self-doubt. Perhaps I was not getting the information I needed. I want to do justice to their experience but then I worry when I talk to them that they may not feel the same about the experience or if it is worthwhile.' I realise I need to develop my skills in this area '

3.2.27 Data Management and the Process of Analysis

IPA requires an *'intensive qualitative analysis of detailed personal accounts from participants'* (Smith, 2011, p. 9). It is recommended that transcription is undertaken by the researcher to ensure close familiarity with the data (Balls, 2009). Good quality transcription is essential in qualitative research and inaccurately recorded transcripts or missing context can have a detrimental impact on the data analysis process (King et al., 2018). Therefore, for the purposes of this study and to minimise any threats to the quality of the transcription and ensure an accurate, verbatim record of the data, I decided to employ the use of a professional transcription service.

Smith et al. (2009) provided a heuristic framework which outlined a detailed set of steps in an IPA analytic process. However IPA is not meant to be a prescriptive, linear process, which can indicate a limited level of analysis, a lack of creativity and little exploration of the 'unexpected paths' which could add depth to the analytical process (Reid, Flowers & Larkin, 2005). Instead, it is an inductive, iterative and fluid process which is subject to constant change and interpretation (Smith et al., 2009). However, as a novice IPA researcher embarking on an IPA study for the very first time and to mitigate the risk of being overwhelmed by the process (Smith et al., 2009), I considered it appropriate to adopt the analytic process outlined below and detailed by Smith et al. (2009). In the next section, I will provide a detailed overview of the steps taken to analyse the data. Table 12 provides an outline of the six-step analytic process.

In addition to using the IPA framework to analyse the data, I also applied Mezirow's ten phases of transformational learning theory. I was interested not only in what the

students learned but also how they interpreted and made ‘meaning of the experience’. This theory was considered appropriate as it focuses on how people make sense of an experience and their interpretations and meanings of it. Mezirow’s theory also aligns well with the principles of IPA as it focuses on the idiographic nature of the individual experience.

Table 12 Table outlining the six steps of the IPA analytical process (adapted from Smith, Flowers & Larkin, 2009)

Stage 1	*Reading and re-reading the transcript*	*Become familiar with the transcript and immersed in the participant’s world*
Stage 2	*Initial noting (or exploratory coding)*	*Note the participant’s content, linguistic interpretations and conceptual or interpretative comments*
Stage 3	*Developing emergent themes*	*Analyse the exploratory comments to identify/generate themes*
Stage 4	*Searching for connections across emerging themes*	*Explore the emergent themes to develop a superordinate theme structure that captures the most interesting and important aspects of the participant’s account*
Stage 5	*Moving to the next case*	*Repeat the process for subsequent cases*
Stage 6	*Looking for patterns across cases*	*Create a master table of the superordinate themes*

Stage one: Initial engagement with the data and making notes

The first step in IPA analysis requires the researcher to read and repeatedly read each individual interview transcript in its entirety. Smith et al. (2009) stated that reading a transcript several times gives the analyst a general ‘feel’ for the transcript and a holistic overview the participant’s account. Also, due to the idiographic focus of IPA, it is preferable to conduct an in-depth, detailed analysis of one participant’s transcript before moving onto the next case.

To further engage in a detailed analysis of one single case, I also listened to the audio-recording of the first interview (participant pseudonym 'Gayle') whilst reading the transcript. This helped me to keep focused, attentive and empathically attuned to her words (Amos, 2016). Closely listening to each participant's voice also helped me to note any nuances, particularly pauses, hesitations, and feelings, including reactions such as laughter or crying (Biggerstaff & Thompson, 2008).

According to Smith et al. (2009), this initial part of the coding process is non-prescriptive and relatively unsystematic. It is about getting one's ideas down first and being open minded as well as staying close to the participant's words without trying to jump to conclusions at this early stage. This involved writing down some generic notes directly onto the transcript, detailing my initial thoughts, observations or anything that seemed interesting or significant (Amos, 2016). I then procee13ded to note any linguistic comments, the use of language and areas such as repetition, contradiction, hesitancy, and use of metaphor. To illustrate this, I produced a table in a Word document, creating wide margins or columns to help document the descriptive, linguistic, and conceptual/interrogative comments. I left the fourth column for the general themes implied by what the participant said. The extract in Table 13 is a short, worked example of this initial stage of analysis based on a small section of the interview with Gayle (see Appendix 9 for the full worked transcript).

Stage two: Exploratory coding

This next stage of the analysis is quite detailed and time consuming as it involves a closer examination of the text and considers the use of language at a more exploratory level (Smith et al., 2009). Again, using Gayle as an example (illustrated in Table 13), I began this process by underlining possible connections, keywords, phrases, and the use of 'I' which concerned the participant's thoughts and feelings about their experiences. Smith et al. (2009, p. 83) stated that this stage is '*about taking things at face value'* and noting aspects such as experiences and emotions that are concerned with the participant's lifeworld. I was mindful at this stage that any interpretations I was making were merely preliminary and I avoided the tendency to making some definitive conclusions which could jeopardise future analysis (King et

al., 2018). I then returned to the transcript afresh and re-read it line by line and identified any linguistic comments or use of language that seemed of interest or significant. I began underlining areas where there was evidence of repetition, contradiction, speech tone or changes in tone from hesitance to articulation, laughter, or the use of pronouns. I also highlighted the participant's use of metaphor. Shinebourne and Smith (2010) stated that metaphors are powerful tools of communication and can capture a rich and vivid picture of the participant's experience or convey negative emotions that perhaps are too difficult to express directly.

It is important to establish that this level of annotation and notetaking requires the analyst to adopt a more interpretive approach to the transcript. This involved ''*shifting' my focus more towards the participants'* understanding of what really mattered to them (Smith et al., 2009, pp. 88,89). This proved challenging as it required me to 'draw on' and question aspects of my own previous experiential and professional knowledge and reflect on my own thoughts and experiences to help focus and stay grounded in the participant's account of her own experiences (Smith et al., 2009, p. 90).

At this stage of the analysis, Smith et al. (2009, pp. 90,91) stressed the importance of staying really close to the participant's words and maintaining the importance of their lived experience. The aim is to engage in an abstract, critical level of thinking to help 'push' the analysis to a more interpretative level. To enable this, I used a process of de-contextualization. This involved reading a paragraph backwards, one sentence at a time. Smith et al. (2009) stated this process helps to get closer to the actual words a participant uses and helps to avoid a superficial reading. For the researcher, this is an iterative process and requires a constant fluid engagement with the transcript to help develop a strong conceptual level of analysis and ensure that the integrity of what was said by the participant is preserved (Eatough & Smith, 2006; Smith et al., 2009).

Table 13 Extract of a coded transcript - Gayle

	Transcript Gayle	Descriptive	Linguistic	Conceptual
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17	**So, can you tell me how did you feel about the simulation**? Yeah, I found it really useful to be able to experience that kind of situation, kind of, without it being real, like I found it useful to be in that and it was, yeah it was good to see like how people might react and it made me think about how I reacted in that situation, and how I might change how I'd behave in the future. To be honest, I felt like I just kind of froze and I didn't know what to do or what to say, because obviously in that kind of situation there's not a lot you can do to make the situation, I can't fix things, but it's knowing what I can say and what I can do to try and help in that situation, and I think, I've had a kind of think about it and, yeah, it's a difficult one. On reflection I probably, I did just freeze and I didn't know what to say, and I think because you've not been in that situation before, you think about things, but then actually being in that situation is different	Repeated that she found it useful Interesting dilemma on '*without it being real'* Made her think, so it was a good self- reflective experience Talking about how she might change her behaviour Opening here about how she really feels Not knowing what to do or say It is difficult Sense of powerlessness here –'I can't fix things'- 'not a lot you can do' Is this something about her as a person or a student? Does she feel undermined in her position or capability?	Really useful Emphasis on really 'that kind of situation'- sense that it is different from any other 'to be honest'- is she trying to be truthful and open about this- an attempt to explain this is how I really feel 'but it's knowing' – real sense of a desire to know, as yet she doesn't know Repetition of 'freeze', 'froze' Emphasis on 'I', moves from 'you' to 'I' Strong use of metaphor here 'froze', depicts a sense of being stiffened / stopped in her tracks by the whole process Lots of reference to the word '*think*', '*think about things'* uses the word reflection, this situation triggered the need for her to reflect	Some change in her learning here about how she can change her behaviour Belief she can change her behaviour- '*made me think*' Realisation that this type of situation is different and challenging Starting to look to herself, more introspection, Shift in focus to '*what I can do',* She talks about being able '*try to help'*, knows she has some capability. There is a sense of an imagined future here

I found this analytical process quite intensive as it focused on the fine details of the interview. I also felt a sense of the participant beginning to emerge that was somewhat 'bigger' than the exploratory codes. My concern was that I might lose these ideas in the detailed analysis. Therefore, to remain grounded in the data, help capture areas of interest that might be significant in each individual story and get a feel for 'the gist' of the interview, I followed Shaw's recommendation of writing a 'potted' summary of the person's account. The following is an extract from a reflexive summary of the transcript of another student called Kim (Shaw, 2010).

Reflexive notes: Kim's extract

I found the interview with Kim quite emotional; she was very open and honest about her feelings. At times she talked about how being in the bereavement simulation triggered some powerful memories for her personally and particularly for her own brother and wife losing their baby at term. I felt quite privileged that she trusted me, and she felt she could talk freely about a deeply personal and private matter. What I found most interesting in Kim's account was that for her the scenario was so realistic and so profound that in the aftermath of the simulation she couldn't get the image of the mother crying out of her head and she said, '*it will always stick with me'*. This really caused me to reflect on how much more emotional support is needed for students following the aftermath of a traumatic event such as the death of a baby. Kim also talked openly about how she '*stumbled over with how to say things'* and her concern was '*about not always having a quick, direct response'.* This really made me think about a student's sense of professional insecurity and powerlessness particularly around handling difficult conversations in practice, and below is my reflection following the interview:

'There are aspects emerging here that are significant. Listening to Kim's narrative revealed a new understanding about the simulated experience. I felt I really needed to acknowledge and listen to her discomfort at a meaningful level. If I don't understand her discomfort, then I am not learning something new. I know that often learning often comes from feelings of discomfort'

Stage three: Developing the emergent themes

The next stage in the analytic process involved returning to the transcript afresh and developing the emergent themes based on the original exploratory codes and the rest of the participants' accounts. At this stage of the analysis, my aim was to ensure that the themes captured not only the participant's words but also my own interpretation (Smith et al., 2009). IPA is a constant iterative process which involves reading and re-reading the transcript and going back and forth through the data to ensure that the voice of the participant is preserved (Frost, 2011). It is at this point that the concept of the hermeneutic circle, one of the key principles of IPA, is particularly relevant. The idea of the hermeneutic circle is that the researcher understands or interprets the meaning of parts of the text in relation to the text as a whole and the participant as an individual, and vice versa. It is this whole interpretation and deeper examination that drives the interpretation (Smith et al., 2009). So, for example, as I was reading Gayle's transcript, I was mindful that the meaning of a word only became clear as I was reading it within the context of the whole sentence. At the same time, the meaning of that sentence was very dependent on the meaning of the overall interpretation (Smith et al., 2009).

As indicated above, this stage involves generating themes based on the notes and comments within the transcript. Because IPA is concerned with meaning of the experience, I was also mindful of the need to ensure that the themes captured that experiential aspect that was found in the transcript (Willig, 2013, p. 88). Smith et al. (2009) stressed the importance of producing concise, meaningful statements or phrases which capture the experiential world of the participant (Smith et al., 2009). Once I established some initial themes for Gayle, I then typed out the list of themes in the order they occurred on the transcript along with the corresponding quote from the original text in the righthand column and the page and line numbers of the quote in a central column, as illustrated. Table 14 is an example of Gayle's transcript which illustrates the themes as they occurred in the interview. At this point, the themes were not considered to be 'fixed' as I was conscious that they could possibly change and may require further re-evaluation with more in-depth analysis.

Table 14 Initial list of themes from Gayle's transcript

	Theme (Gayle)	**Page / Line Number**	**Quote**
1	Change my behaviour	P1:L6-8	*it made me think about how I reacted in that situation, and how I might change how I'd behave in the future (Gayle).*
2	Not knowing what to do or say'	P1: L9-11	*To be honest, I felt like I just kind of froze and I didn't know what to do or what to say (Gayle)*
3	Powerlessness / I can't fix things	P1: L11-14	*because obviously in that kind of situation there's not a lot you can do to make the situation, I can't fix things, but it's knowing what I can say and what I can do to try and help in that situation (Gayle),*
4	Finding the right words'	P2: L28-33	*I think just trying to find the words, the right words to say to someone when their baby's just, when they found out their baby died, what words can I say to them, and what can I do to try and help them. Yeah, I found that quite difficult (Gayle).*
5	Feeling the emotion	P2: L23-27	*I think it's hard not to feel emotional; when someone's going through that and you feel their emotions with them as well and I think doing this job, you build, you have that connection with people and it's hard not to feel the emotion (Gayle)*
6	Preparation for that situation out in practice	P2: L35-39	*I think it was really useful because now I've obviously been in that kind of situation it's got me thinking about, what could I do, what could I say, and I think it's prepared me for that kind of situation out in practice (Gayle)*
7	It felt so real	P2-3: L72-77	*It didn't feel like it was a sim- when you were in there, it didn't feel like a simulation and you couldn't sense the cameras, it just felt like you were in that situation and it felt so real, and I think because you've got, like the nerves and the adrenalin pumping Gayle)*

	Theme (Gayle)	Page / Line Number	Quote
8	Kindness, compassion	P3: L18-20	*it made me kind of think a lot about how important words are, and yeah, and just being kind and how you can just be kind to someone (Gayle).*
9	The importance of silence	P4: L86-90	*it's okay to have silence as well, you don't have to fill that silence, you can just sit there and sit with someone, and that's okay as well, and you can kind of wait for them to say something if that's how you feel. Because I think we like to fill silence (Gayle)*
10	Unknown expectations	P4: L94-102	*I don't know what I was expecting, but I wasn't expecting, I was expecting upset, but I don't think I was expecting so much anger, that kind of, I didn't kind of think that that would happen. So, I think that kind of surprised me a little bit, and that kind of, I was taken aback by it, and I think that's partly why I kind of frozen,*
11	Dad's grieving as well	P5: L116-125	*Yeah, I think it was the dad, it's important to remember that they're grieving as well and not to forget about them, because although it's, you know, the main focus is on the mum and obviously she's carrying the baby and she's going to have to go through all the giving birth and everything, but the dad's grieving as well, and I think it'd be easy to forget them, and it's nice to keep them involved and to make sure that they're part of the process as well.*

Stage four: Searching for connections across the emergent themes

Once I had established a set of themes for Gayle, I then cut up each theme into a separate piece of paper and placed them on a large white sheet of card on a table, as illustrated in Figure 5. As suggested by Smith et al. (2009), this spatial representation helped me to visually explore and 'eyeball' how each of the themes appeared connected to each other. To help cluster the themes together and develop a set of super-ordinate themes, I re-ordered them and used a process of abstraction whereby themes that seemed similar or parallel to each other were placed together and those that were dissimilar or polarised were placed at opposite ends. Smith et al. (2009) uses the analogy of a magnet to describe how some experiential statements

attract other statements and pull them in. For example, for Gayle there appeared to be a series of themes around the use of language and the difficulty in communicating with bereaved parents and each of these were highlighted in green and clustered together. The list of emergent themes was colour-coded according to the theme group they represented. These colour codes were also applied to subsequent participants to illustrate where the commonalties and divergences existed in participants' experiences.

Using the example of Gayle, the analysis identified a total of 19 themes at this stage. Some related to the sense-making of the experience and the emotional challenges of being in the bereavement simulation, a fear of the unknown and the difficulty of death and dying situations involving a baby. Others related to communication issues, using the right language, and determining appropriate responses. Further themes related to having an urge to ease the pain and making the experience better, not having the right skills and knowledge, and feeling ill-equipped to provide emotional support. Further themes referred to learning to acknowledge and validate each parent's individual responses to grief.

Stage five: Moving onto the next case

Smith & Nizza (2022) suggested that once the researcher feels a level of satisfaction with the data analysis process for the first participant and it begins to feel meaningful, then the process can be repeated for the remainder of the participants. However, at times, this proved difficult, and a considerable number of hours was taken deliberating over whether a deep level of interpretation had been reached with the first case analysis. I found that time away from the process was useful to help me reflect on the language I used to support the themes. I also wanted to keep an open mind and felt reassured by the fact that I could always return and re-evaluate the themes in light of new or emerging themes from subsequent transcripts (Smith et al., 2009).

Another issue that concerned me was that, having undertaken the analysis of the first case, it could potentially influence my subsequent analysis for the remainder of the participants. Smith (2008) stated that the analyst can 'bracket' off any previous ideas or concepts that may have emerged with the first case analysis. Alternatively,

the analyst can use the themes for the first participant to help orient the subsequent analyses. However, in keeping with the idiographic nature of IPA, I considered each case on an individual basis and I used the super-ordinate themes from Gayle's account to inform the analysis of the other transcripts (Smith, 2008). I felt that being aware of what was done before helped me to keep an open mind to new or different emerging themes in the subsequent transcripts

Stage six: Looking for patterns across cases

Once all the transcripts had been analysed, the next stage involved looking for patterns and connections across the nine participants and creating a master list of themes that reflected the experiences of the entire group. To do this, I manually printed out all the participants' superordinate themes, placed them on a large piece of chart paper and grouped them according to their colour code (as illustrated in Figure 5). Smith et al. (2009) stated that this part of the process can be particularly creative and imaginative for the analyst as reconfiguring and relabelling of the themes can advance the interpretation to a more theoretical level.

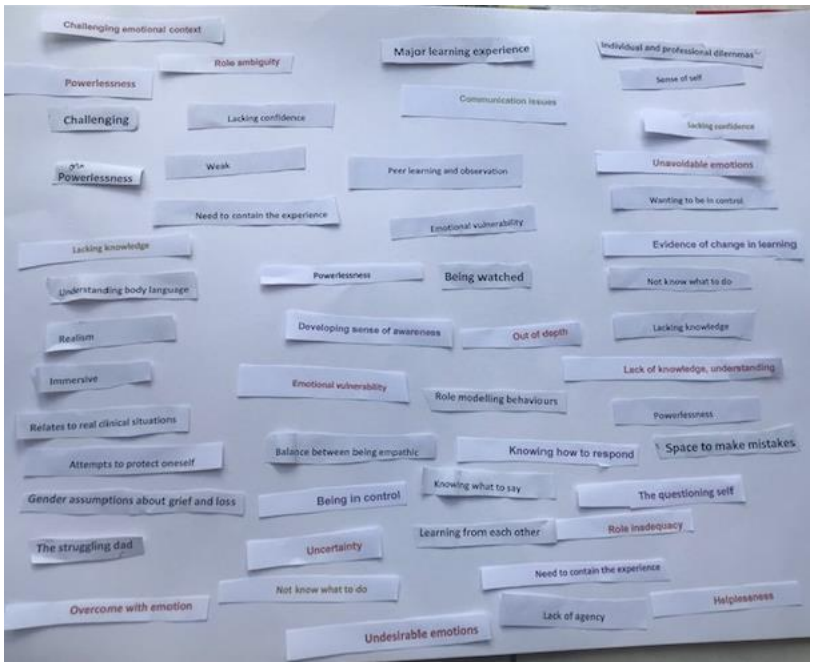

Figure 5 Sample representation of emergent themes

At this point in the process, the challenge for me was to decide which themes I needed to focus on and prioritise. Smith (2008) stressed that themes should not be

selected based on frequency of recurrence, as sometimes an important theme may be only evidenced once. Other aspects that needed to be considered were the richness of a particular account and how a particular theme helped to shed light on pertinent aspects of the participant's account (Smith, 2008). Initially, when I began collating the pattern of themes, some emergent themes became clear quite quickly. The criteria as to whether an emergent theme remained was determined by its importance and that it was represented throughout the analysis (Smith et al., 2009).

To further develop the super-ordinate and sub-ordinate themes, I used the processes of abstraction (putting themes that are similar together) and subsumption whereby one emergent theme becomes a super-ordinate theme if it encompasses a series of related themes. I subsequently narrowed down their responses to a few words that captured the true essence and meaning of their lived experience of the simulation (Smith & Nizza, 2022). For example, feelings of anxiety, worry, fear, and nervousness were grouped together under the super-ordinate title "*rollercoaster of emotions*" and the related sub-theme "*I didn't know what to expect*". I also employed other techniques including contextualisation and the way it related to the individual participant's story or how the context shaped their narrative as well as illustrate how the students' positioned and represented themselves either positively or negatively in terms of the meaning of the experience for them (Smith et al., 2009). The focus at this final stage was an in-depth iterative process, which continued to move between the text to interpretation to capture the key super-ordinate themes which encompassed most of the participants' experiences. Once I had identified a list of recurrent themes, I then spent time reading and re-reading them and reflecting on what they had to say in their entirety (Smith et al., 2009, p. 114). I then proceeded to summarise the shared experience of all the participants. Smith et al. (2009) stated this process helps to get a sense of the overall picture as well as the individual experiences. Again, this is where the hermeneutic circle was significant, prompting a constant iterative process that circled backwards and forwards between individual words and the transcript as a whole (Smith et al., 2009).

The next step in the analysis involved selecting the list of extracts that captured the range of views within the group, and developing the subordinate themes. Smith et al.

(2009) suggested using a graphic display to illustrate the connections across the group. To demonstrate transparency and an evidence trail, each quote contained under a theme is indicated with the page line number from where it occurs in the transcript. Table 15 is an example of how the super-ordinate theme '*a rollercoaster of emotions'* with its final subordinate theme is defined, including the number of participants who expressed similar feelings and emotions to illustrate the prevalence and representation of the theme across all participants.

As indicated in Table 15, the final stage in developing and identifying the super-ordinate themes involved a constant iterative process of abstraction and moving between the text to interpretation and then categorising the themes to capture the most salient aspects of the participant's overall experience.

Table 15 Example of super-ordinate theme and the accompanying quotes that relate to the theme

Theme 1: '*A rollercoaster of emotions'*	Illustrative quotes
Sub-ordinate theme '*A good but hard experience'*	'*It was* a *good but hard experience, a real emotional roller-coaster'* (Orla*:* P5: L:146-153). *'it was really good, I actually – I got a lot from it, it was quite emotive* (Susan: P1: L1-2) *'I think it just, it stirred it all, stirred it all back up again'* (Kim: P2: L58-61). *'It made me feel like uncomfortable', I just kind of froze'* (Gayle: L162-171). *'I think the hardest part of the whole simulation was the bit I had, where we were, we had, we were there for the news being broken* (Angie: P11-12: L397-411) *'It was emotional I thought, but it was good as a student to be put in that situation'* (Andrea: P1: L3-4) '*like it just makes your heart go uh a bit* (Ethel: P2: L39-41) '*it is just the sheer emotion of it all-isn't it' –(Catherine: P1: L2)*

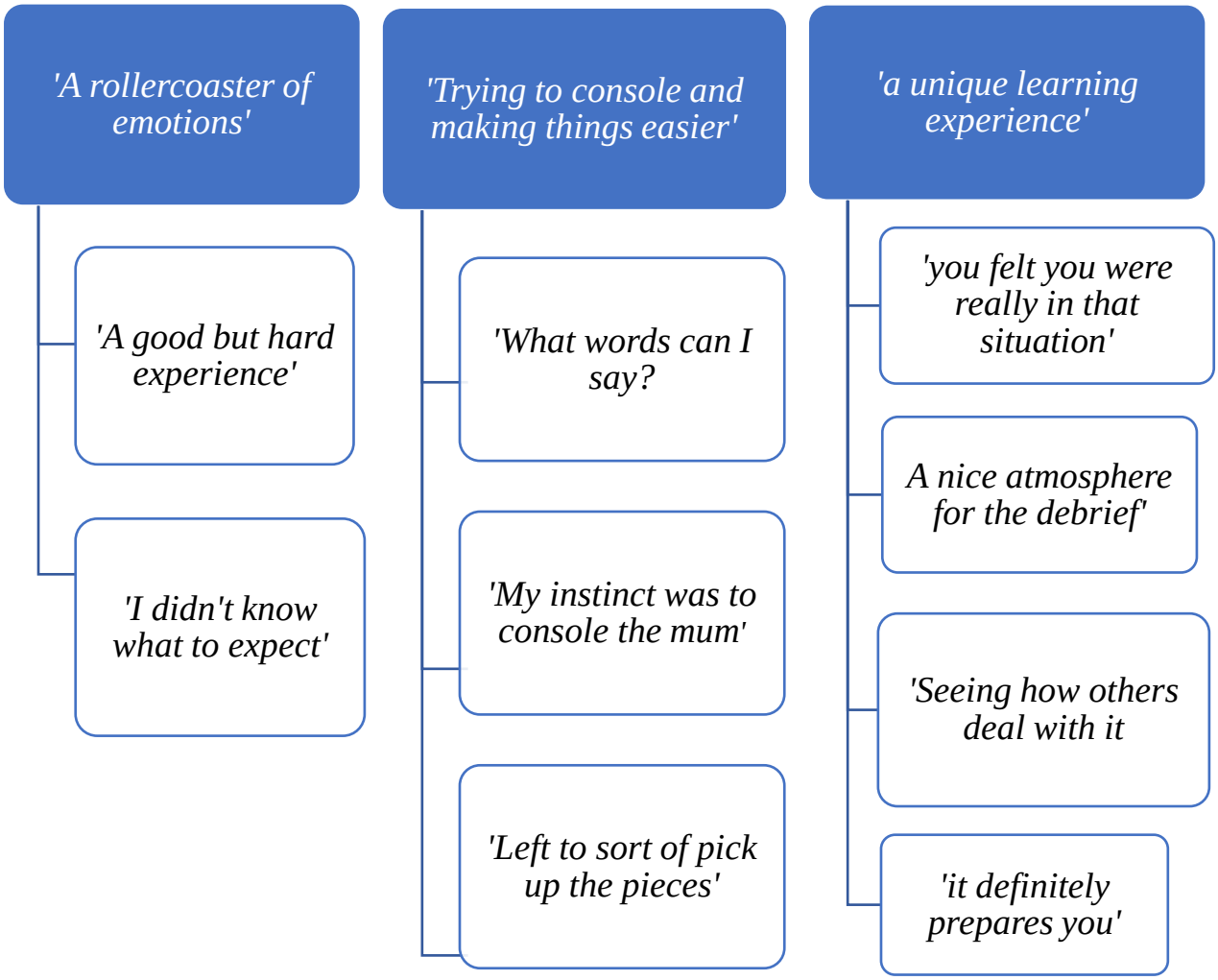

Figure 6 Final list of super-ordinate and sub-ordinate themes

3.3 Summary

In summary, this chapter has presented and discussed the rationale for using IPA as a methodological approach to explore student midwives lived experience of bereavement simulation. The philosophical concepts that underpin IPA have also been discussed as well as the ethical considerations in relation to the recruitment, sampling strategy, and methods of data collection. The chapter also detailed how the study adhered to the quality criteria outlined by Yardley (2000) as a way of assessing validity and quality in qualitative research. The researcher's influence on the research process has also been acknowledged through an exploration of my

epistemological position, my influences in relation to recruitment of the participants, and my relationship with them. The chapter concludes with a detailed discussion of the data analysis procedures and the development of the super-ordinate themes and related sub-themes following the heuristic framework outlined by Smith et al. (2009). The next chapter will present a summary and discussion of the findings based on the three main super-ordinate themes.

Chapter 4: The Findings

4.1 Introduction

The following chapter provides my interpretation of the lived experiences of the nine student midwives' involvement in bereavement simulation. The findings are taken directly from the semi-structured interviews following the analysis and audit trail outlined in Chapter 3. For the purposes of this study, I used a theme and quote approach to provide an accurate representation of the students' lived experience in the bereavement simulation. Frost (2011, p. 61) argued that a narrative account should be as persuasive as possible consisting of '*an interplay between the participant's account and interpretative activity of the researcher*.' Therefore, each super-ordinate (master theme) and sub-theme is taken in turn and presented using verbatim quotes and extracts from the students' own words which are then underpinned with my own interpretative comments. (Frost, 2011) Within each theme, I have applied the ten different phases of Mezirow's transformation theory to show evidence of the students' individual transformative learning experiences as well as the collective experience of the students overall.

IPA studies use a structured format whereby the emergent or developing themes are presented under the results section and the discussion chapter focuses on linking the themes to '*the extant literature'* (Smith, 2008, p. 77). Within this study, I chose an alternative method to include some of the links to the literature within the analysis of each theme. Then, in the discussion chapter, I will expand the analysis further and '*shift the focus towards a wider context of a dialogue with the existing literature'* as recommended by Frost (2011, p. 77).

Before presenting the findings, it is essential to revisit the interview questions which initially guided the analytical process and set out to address the following:

'*Can you tell me how did you feel about being in the bereavement simulation scenario'?*

'What do you feel were the most significant aspects in relation to your learning?'

'*How do you feel this simulated experience might prepare you for practice or when you are out in practice?*

4.2 Super-Ordinate Theme One: *'A rollercoaster of emotions'*

The participants recognised the need to interpret their bereavement simulation experience although at times they struggled to make sense of it. It proved to be somewhat more emotionally challenging and difficult than they anticipated. Therefore, the first master theme I identified was entitled '*a rollercoaster of emotions.* I identified two sub-themes which related to this master theme, which were: '*A good but hard experience'* and '*I didn't know what to expect*'

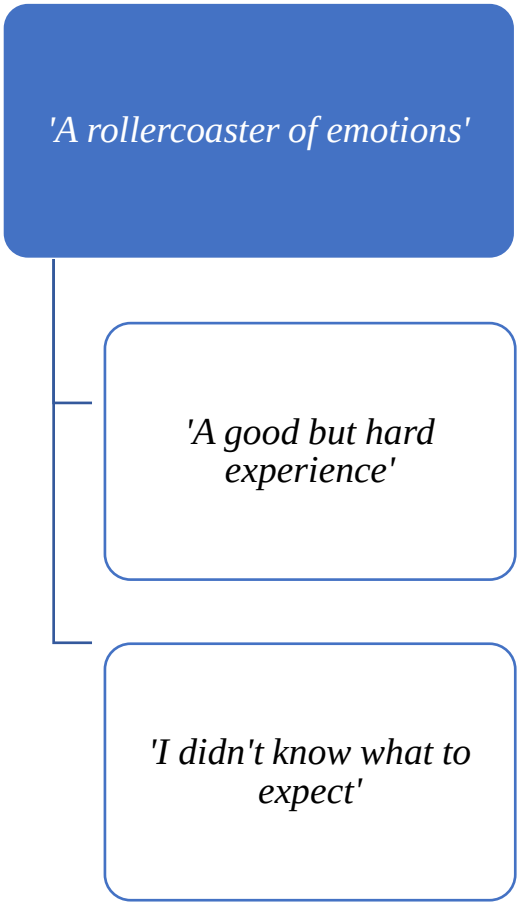

Figure 7 Super-ordinate theme one and related sub-themes

4.2.1 'A good but hard experience'

This sub-theme explored the complex array of emotions the students experienced in their efforts to support and care for the bereaved parents following the loss of their baby. Mezirow and Taylor (2009) stated that a disorientating event like grief and loss, can trigger a diverse range of emotions resulting in feelings of emotional chaos and discomfort. To describe their emotions, the students relied on the use of metaphor to illustrate how they felt about being in the simulation. Shinebourne and Smith (2010, p. 60) argued that people often use metaphors to make sense of '*previously unexpressed or unexplored experiences'* for concepts that are difficult to explain in literal terms (Miller & Fredericks, 1988). This was evident in the following quotes. For example, Orla described her experience as a '*good but hard experience'* (Orla*:* P5: L146-153). The use of the words 'good' and 'hard' in the same sentence highlighted the complexity of her feelings. Orla also referred to her emotions as a '*rollercoaster*'. The use of the metaphor '*rollercoaster of emotions'* was very powerful as it indicated the student's struggle to manage and control the intensity of their emotions (Palmer-Wackerly & Krieger, 2015).

Orla also described the effect of the experience as '*emotionally draining'* because she had '*never been in that situation before'* (Orla: P1: L6-8). Likewise, Susan said '*yeah, I went away afterwards and felt, felt quite emotionally drained'* (Susan: P3: L67-68). The language used by Orla and Susan drew on the mechanistic and containing metaphors which were concerned with '*the body as a container'* and the *'emotions are fluid within the container*' (Froggatt, 1998, p. 333). The phrase '*emotionally draining*' implied a decreasing level of emotional energy, suggesting they metaphorically felt emptied and drained of everything and their movement out of the body felt out of their control (Froggatt, 1998). Orla also stated that the most difficult aspect was that the '*the emotion and everything was acted out'.* She referred to it as *'it was just so raw, I felt it was really raw'* (Orla: P5: L146-153*).* She emphasised the word 'raw' which conveyed a sense that this experience for her felt very crude, harsh, and real.

Transformative learning involves having an enhanced awareness of one's feelings and emotions. These feelings and emotions can be present and difficult to control in

any learning experience (Dirkx, 2006). There was a sense from the interviews that the students felt quite powerless to control their emotions. This required the students to develop their own coping strategies to help control them. The following accounts illustrate the students' use of language as they struggled to contain their emotions and their physical manifestation in response to the diagnosis of the baby's death. There was a sense that the emotions and their movement out of the body were beyond their control and expressed in a negative way (Froggatt, 1998). For example, Orla talked about how '*she could feel herself kind* of *cringing internally and she could feel herself starting to overcompensate'* (Orla: P4: L127-133). Gayle described how she *'just kind of froze'* (Gayle: P1: L10). The description of being physically '*frozen*' appeared to shape Gayle's embodied experience about the coldness of death

As well as trying to contain their emotions, other students alluded to some forms of physical embodied response to the experience. The students provided some vivid descriptions of what the experience felt like, and for many the heart was '*a central element of the experience'* (Smith et al., 2009, p. 18) For example, Ethel said it felt '*like it just makes your heart go uh a bit'* (Ethel: P2: L39-41) while Susan said, '*oh my god, my heart sank'* (Susan: P5: L16-162). Orla also referred to how '*My heart was you know dropping for them*' (Orla: P6: L214-215). The expressions of dropping and sinking imply a downward containment of emotion and are often used metaphorically to describe death as something that brings a person down (Froggatt, 1998, p. 335).

The view that the body is central to one's experience of the world is further acknowledged by phenomenologists such as Merleau-Ponty and Sartre. Both disregard the Descartes dualist concept that the mind and body are separate and distinct from one another (Smith et al., 2009). In their view, as humans we have an embodied relationship with the world, and our bodies can be a way of communicating with it (Moran & Mooney, 2002). In their attempts to convey the meaning of the experience and how the experience felt for them, the students provided some very rich descriptions and metaphors '*which explicitly conveyed their lived embodied experience'* of being in the simulation. However, like other types of emotions, such as anger, these feelings and emotions are complex and to some

extent fail to capture the true complexity of the lived, embodied experience of the simulation.

Mezirow and Taylor (2009) suggested that a process of critical self-reflection often occurs in response to situations of emotional perplexity. Self-reflection and rational dialogue with others can act as a stimulant for new insights and understanding. This was evident in Susan's quote (below) when she articulated that the experience felt so emotionally overwhelming, that it lingered and evoked some personal memories as she took time to reflect and process what she had experienced. However, sharing and discussing the experience with others seemed to provide her with some comfort that others felt the same. Recognition that the problem is shared can lead to personal transformation which aligns with Mezirow's fourth phase of the perspective transformation process (Cranton, 2016). As Susan stated:

> '*yeah, I went away afterwards and felt, felt quite emotionally drained. I know having talked to some of the other girls they felt the same as well; and having things in our personal lives that kind of triggered little emotions with what other people were saying, or the reactions that we got from mum and dad, it, it kinda of hit home a little bit for me'* (Susan: P3: L67-73).

According to Mezirow and Taylor (2009) transformative learning can often occur as a result of having some insight into a previously unresolved traumatic experience, which may have previously been hidden. However, learners need to be able to reflect and process their emotions in order to learn and make meaning from the experience (Mälkki, 2012). For Kim (see excerpt below), the experience triggered a personal memory of loss and stated that the memory of the bereaved mother crying in the simulation '*will stick'* with her. Corr, Nabe, and Corr (1997) stated that encountering death can provoke different responses and there is often a desire to express emotions as an upward movement (Froggatt, 1998). For example, in Kim's case, it unearthed uncomfortable personal feelings which she tried to contain. She alluded to her emotions as an upward movement when she referred to how '*it stirred it all, stirred it all back up again'*. This suggested a reliving of unresolved memories of trauma from her past and a struggle to cope when feelings from the past resurfaced

and intermingled with the present. Kim's excerpt reveals how the unexpected loss of the baby affected her and the intensity of her anguish is evident below:

> *'I think (pause) it affected me, it did afterwards; when I reflected on it, I think it just, it brought back memories for me, I think it just, it stirred it all, stirred it all back up again .It's only afterwards when you actually think, uh, and you can't get them out of your head kind of thing, so even though I know that it was a simulation yesterday, like I've still got the mum sort of crying and being really angry in my head, so yeah, it'll stick with me for a while'* (Kim: P2: L58-61).

Likewise, for Catherine, the significance of the loss resonated with her and evoked a powerful memory of her own personal experience of a miscarriage. As illustrated in her excerpt below, Catherine talked about '*life goes on around you ….yet your whole world's ended'.* I felt the phrase '*your whole world's ended*' illustrates the enormous impact of the finality of death and how it can potentially rob a person of everything including their '*whole world'*. However, for Catherine, engaging in a process of self-reflection generated feelings of empathy and sympathy for the parents, but also an acknowledgement of the emotional anger associated with her own experience. This reflected the findings of Taylor (2000) who stated that exposure to intense emotional experiences prompts a process of critical reflection often accompanied by feelings of anger, as illustrated below.

> *'Yeah, it's sad, because it's like, life goes on around you and your whole world's just ended and, but everyone just carries on, and it is really, it's awful and I think, I'd get really angry - I'd had a miscarriage and I came out of the scan room, and coming out of the scan room was this woman with her 20-week scan and I was dead angry, and I was like, well afterwards I thought, oh that poor woman, I was really angry, like I didn't say anything to her, but I was just scowling'* (Catherine: P7: L122-128).

Mezirow and Taylor (2009) argued that often people approach an experience with a variety of preconceived ideas and assumptions (habits of mind) based on social and cultural expectations that influence how they view the world. However, in their view, perspective transformation starts when learners encounter emotionally intense

situations that do not fit with prior expectations and appear to lack meaning (Mezirow, 1990a). In this case, the students reflected on how the death of a baby was not considered the norm as it is '*so cruel'* and '*often there is no explanation*' (Andrea: P3: L86-89). This aligns with phase 2 of Mezirow's transformation journey which suggests that when learners undertake a '*critical assessment of assumptions and feelings, it provokes a sense of alienation from traditional social expectations'* and the process of learning begins (Mezirow & Taylor, 2009, p. 19).

For Susan, the unexpected loss of a baby was perceived to be in stark contrast to the death of an older person. Death takes away the expectation of a new addition to the family and for the parents the loss of an imagined future with their child. Susan said, '*it kind of like struck with me…how things can happen*'. As she spoke, she seemed to thrust her closed fist to her chest. I felt this indicated a realisation that something quite unexpected, such as perinatal loss, can happen at any point in a pregnancy and that perhaps she had not contemplated this before. In the excerpt below, Susan made a comparison between the death of a baby and that of an '*elderly person*' which to some extent to capture the uniqueness of perinatal loss where birth and death happen almost simultaneously.

> *'when it's something like the loss of a baby, I think it's quite (pause) I think it's quite, I think, not to sound awful, you know it is more emotional than sort of like a bereavement of an elderly relative…they've got all these memories and things whereas a new-born baby they haven't really experienced it and, for parents you know they find out they're pregnant and they're like, you know, first steps and what their first word's going to be, and going to school, It kind of like struck with me, as to (pause) how (pause) I don't know, the kind of like, you know things can happen.'* (Susan: P3: L83-100).

In the following quote, Andrea also acknowledged the emotions generated by the loss of a baby and seemed to struggle to articulate the significant impact of the loss. The use of the word '*gets you'* and repeated use of the word '*awful*' captured her overwhelming feelings of empathy and compassion for the bereaved parents.

> *'Yeah, yeah, it really gets you, no matter how many time times you've seen it, it's still awful and there's no explanation you can give them at that time, it's just loss it's awful'* (Andrea: P3: L86-89).

Mezirow purported that learners need opportunities that challenge them to think differently and to re-examine their underlying beliefs and assumptions. According to Zembylas (2015), significant learning can occur when a person encounters an unexpected event that 'jolts them out of their comfort zone' and opens them up to new ways of thinking. Exposure to the bereavement simulation caused some students to reflect on aspects they found difficult. In the excerpt below, Angie reflected on the '*hardest part of the simulation'* and feeling '*awkward*'; she had never been in this situation before, and it made her feel like an intruder in '*this incredibly private moment'*.

> *'I think the hardest part of the whole simulation was the bit I had, where we were, we had, we were there for the news being broken, and we'd both kind of said, I could've dealt with the before bit, I couldn't have dealt with all the after bit, it was that middle bit, it was just like, ah, a bit – I suppose because we've not, neither of us have been in a room when that's happened, so it was quite a, it was quite a genuine reaction, even though we knew it was coming, I suppose for both of us it did feel quite like, oh god, and you did, I just felt so awkward, like I was intruding on this incredibly private moment'* (Angie: P11-12: L397-411)

However, despite the intensity of the experience, there was also a sense that the students wanted to '*feel uncomfortable'* and '*be pushed out of their comfort zone'* so that they could face this challenge in a real clinical situation. Some expressed a desire to acquire new knowledge and an experience that would prepare them for future situations. This aligns with phase seven of Mezirow's perspective transformation process (Cranton, 2016) and echoes Wlodkowski and Ginsberg (2017) view that learners are more open to new forms of learning when they are on the edge of their comfort zone. In the following quotes, the students talked about

wanting to learn and putting themselves in challenging situations to help them in the future.

> '*I think it pushes you out of your comfort* zone, *I think it was really good', yeah because it made me feel like uncomfortable … that's why I wanted to do it, because I wanted to put myself in that situation and have some practice'* (Gayle: P4: L162-171).

For Gayle, the consequences of being pushed out of her comfort zone suggested a transformation in her thinking. She wanted to 'feel uncomfortable' so she could truly feel what it could be like in a real situation. Angie also talked about '*that skill I want to learn'*. In her excerpt below she alluded to '*not wanting to look panicked'* or '*raise panic in her (the woman) or her partner'.*

> *'it's that, there's that skill that I think I want to learn, and I want to be able to work on, so that if, for any reason, I am listening in and I can't get a heartbeat, I don't look panicked, but I also don't raise panic in her or her partner*' (Angie: P5: L162-167).

Angie's quote illustrates a very difficult and contradictory position in which she was concerned about looking panicked. She really wanted to learn this skill and implied it was something she really needed to '*work on'.* Her quote captures a deep-seated concern about maintaining a professional image as a competent functioning practitioner in front of the parents at the critical moment where she '*can't get a heartbeat'.*

4.2.2 'I didn't know what to expect'

The previous theme described the disorientating events and emotions the students experienced when they encountered bereaved parents for the first time. As a result of experiencing the disorientating dilemma, many of the students felt apprehensive and unprepared and did not know what to expect. This was verbalised by Catherine who described it as '*being really, like nerve-wracking going into it'* (P1: L7-8) and this was '*because you just didn't know what to expect* (P1: L8-9). Throughout their narratives, the students talked about how they knew the situation would be very sad,

however they did not anticipate other reactions to loss such as the feelings of anger or self-blame displayed by the bereaved mother. According to Mezirow and Taylor (2009), encountering events that are not compatible with preconceived ideas and experiences encourages learners to question their world view. In this case, the students did not anticipate the level of anger that can be associated with grief. They felt quite shocked and bewildered by the mother's grief reactions. In the following excerpt, Gayle described how the anger displayed by the grieving mother was incompatible with how she perceived grief should be manifested. For Gayle, the overwhelming display of angry feelings seemed to consume her to the extent that she claimed that was the reason '*why I kinda froze'*:

> *'I think it was, I don't know what I was expecting, but I wasn't expecting, I was expecting upset, but I don't think I was expecting so much anger, that kind of, I didn't kind of think that that would happen. So, I think that kind of surprised me a little bit, and that kind of, I was taken aback by it, and I think that's partly why I kind of frozen, I was like, I don't know how to diffuse, not that you can diffuse that kind of situation, but I don't know how to kind of get her to calm down' (Gayle: P3: L 74-79)*

It is clear from Gayle's account that dealing with the anger was quite problematic. For her, the experiential impact of this anger became so powerful that she relied on the use of the metaphor *'froze'* to convey the spatial restrictions imposed on her that undermined her and left her feeling powerless, passive, and motionless at that moment in time. She repeated the word '*I don't know'* which again conveys uncertainty as to how she could respond in this situation. Her narrative, however, made some reference to a broader cultural context and her worry that she felt unsure '*how she might diffuse it'* or '*calm her down'*. This suggests that the outpouring of emotion somehow needed to be restrained and controlled and implied a belief that grief should be silent and that a woman should perhaps be restrained in her emotions. Emma mentioned similar feelings:

> '*yeah when I've thought about bereavement I've thought about the sadness you know, not about the other parts of it, I didn't sort of expect the anger so much and the, the blaming herself, that sort of thing'* (Emma: P3: L61-65)

However, for Emma, there was a perception that bereavement had '*other parts'* that she seemed unaware of. Her narrative implied that grief could be compartmentalized. For her, sadness seemed to be the dominant emotion associated with grief, while other emotions, such as anger and blame, were perceived not to co-exist with other emotions.

Catherine also expressed feeling shocked at the level of anger displayed by the bereaved mother and questioned her ability to be able '*deal with it'* in a real-life situation.

> '*Yeah, it was good, and I was just, yeah, I was shocked by that second bit, the emotion that came across. The anger, the, it was kind of like anger, upset, it was, oh if that was for real, in a room, that would be really like hard, I think, to deal with, you know, just that' (*Catherine: P4: L135-140).

Here, Catherine also described the overwhelming powerful felt emotion of anger. She referred to '*the anger'* and '*in a room'* as if it had a physical presence and had nowhere to go. Her narrative conveyed a sense of instability and fear about '*anger'* and the difficulty of not knowing how to '*deal with it'*. Like Gayle and Catherine's accounts, there is a sense that anger is a negative emotion and so powerful and controlling that it needs to be suppressed *and* contained.

However, despite students feeling unprepared and lacking familiarity with this unexpected emotion, there was a sense that this outburst of anger was rational. In the following excerpt, Emma felt the parents had a legitimate right to be angry, at the injustice of losing their baby and drew comparisons with how she might react in a similar situation:

> *'they've every right to be angry because they do, don't they really? … I think I'd be same in that situation as well'* (Emma: P:3: L:92-97).

In contrast to the previous excerpts, Emma provided a context for the expression of anger as if to try and make sense of it. Her excerpt seemed to validate anger as an emotion that needs to be communicated and heard as opposed to being suppressed and contained.

Throughout this theme, the students' narratives captured the emotional intensity and the disorientating impact of perinatal loss on them as caregivers and the grieving mother. Nevertheless, encountering a situation that was totally unexpected provided some insight into grief and a comprehension that people can display a wide spectrum of emotional responses at any point. Both Andrea and Emma reflected on seeing grief being enacted:

> 'to see *how parents react when they go through stages of grief … from when she (the mother) was really angry, disbelief, I don't believe you*, *then blame … you could see that and how it played out and the way everybody dealt with it was quite good'* (Andrea: P1: L26-29).

> '*yeah I think, definitely more than I was expecting, like it was all the different bits to deal with, like the bargaining and the, thinking it was your fault, and the anger, at the end sort of accepting kind of, that her baby wasn't alive anymore'* (Emma: P7: L213-215).

In the two extracts above, both Andrea and Emma alluded to creating some sense of order and meaning out of the situation. For them, grief was illustrated as a phenomenological process that began with anger and moved through various emotional states ending with the bereaved mother '*accepting kind of, that her baby wasn't alive anymore'* (Emma: P7: L213-215). For Andrea, the enactment of grief was so powerful and visual, she felt she could see it. At the same time, she drew comfort and a sense of reassurance from knowing that the way '*everybody dealt with it was quite good' (*Andrea: P1: L26-29)

Mezirow (1990a) suggested that the process of transformative learning often involves learners becoming critically aware of their own beliefs and assumptions, but also reflecting on the cultural contexts in which they are in. Throughout this theme,

the students provided compelling descriptions as to the disorientating impact of not knowing what to expect. These feelings and anxieties were partly because this was their first experience of high-fidelity simulation involving the loss of a baby. However, as they reflected on their clinical experience, there was a sense that bereavement care was something that students '*don't do'* and a feeling that being a student '*you don't have to deal with it*'. In their narratives, the students referred to being 'sheltered' and 'protected in practice' from these traumatic situations, as Emma highlighted:

> '…*because when you're a student and they do shelter you, you think, oh I don't have to deal with that, that's fine … the death of a baby it is quite an unusual, not unusual, but especially with students, there has been a couple on placement but they've always said, like they shelter the students from it, so I've never been in'* (Emma: P13: L363-36).

Catherine also felt she had limited opportunity to engage in this aspect of care as '*your mentor's doing all the talking*' and in her excerpt below she explains how that feels for her.

> *'As a student, you're kind of, your mentor's doing all the talking and I feel as if I'm just stood there and I shouldn't be there. But I need to be there, because I need to know what to do, when you're qualified, and you would be put in those situations' (Catherine: P8: L200-203).*

Here, Catherine seemed anxious about being disassociated from the situation and alluded to a sense of uselessness about being '*just stood there'.* This feeling of disassociation made her question her sense of purpose as to whether she should or shouldn't be there. However, her excerpt reveals a deep-seated concern as she stressed the '*need to be there'* as '*she needs to know what to do'* in a similar event in practice.

4.2.3 Summary of Theme One

Overall, the students seemed quite bewildered at the level of anger displayed by the bereaved mother. This was attributed to the fact that the students had never

witnessed this in practice, and Angie (P1: L15-16*)* '*talks about going into these situations assuming everything's okay'.* These strong emotional reactions from the grieving mother were totally unexpected. This highlights the importance of students being adequately prepared to cope with challenging situations that they may encounter in the clinical setting. Having some prior exposure and being familiar with the simulated environment may help to alleviate their anxiety and apprehension in future situations. These aspects will be explored further in the discussion chapter.

4.3 Super-Ordinate Theme Two: *'Trying to console and making things easier'*

Throughout their narratives, the students expressed the desire to support the bereaved couple emotionally. Alongside this, the students expressed a sense of responsibility to '*try and console and make things easier*'. This master theme explores the related sub-themes '*what words can I say', 'my instinct was to console the mum' and 'left to sort of pick up the pieces'*

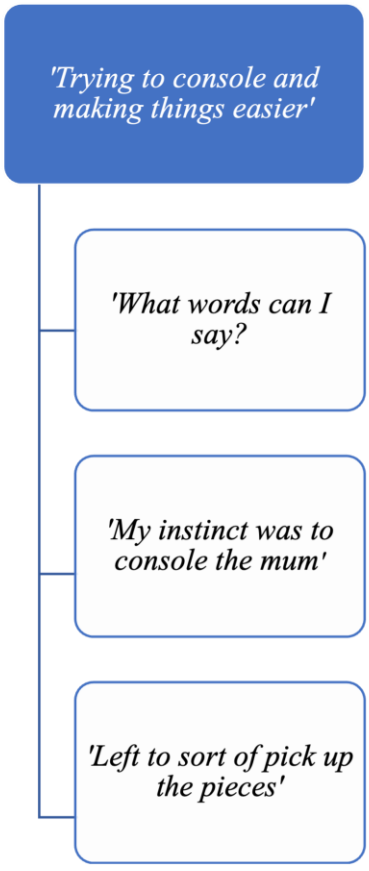

Figure 8 Super-ordinate theme two and related sub themes

4.3.1 'What words can I say'?

In this study, several of the students appeared to struggle through a minefield of complex emotions as they tried to communicate with the couple throughout the whole experience. Whilst the students communicated and provided professional emotional support as they would do in any birthing situation, their narratives revealed an underpinning tension and anxiety that their words or actions could worsen the situation. Mezirow (2000) emphasised that once learners start to engage in a process of critical reflection, they begin to question unexamined beliefs and assumptions about themselves and recognise the strengths and limitations of their own knowledge and abilities. In this case, the students acknowledged the limitations in their skills and confidence to communicate effectively and emotionally support the couple.

Kim reflected on how she 'stumbled 'over what to say. The following quote illustrates her concern at not having a quick response to the woman as she tried to reassure her that it was nothing she had done.

> '*Yeah I think, I sort of reflected on it afterwards and thought you know*, *there was a couple of things that I stumbled over with the parents, you know, just in terms of what to say, like I didn't have a quick response for when she says I think I said like, it's nothing you've done, and she's like, how do you know, like how do you know, and I didn't have a direct response for that, I really didn't'* (Kim: P3: L113-116).

In comparison, Andrea stated*:*

> *'… one of the students got right down to her level. I felt I wanted to do that just comforting her, but I just didn't have the confidence, I don't think* (Andrea: P4: L163-170).

Likewise, other students highlighted that communicating with a couple who have just lost their baby felt very difficult for many reasons. Trying to find the right words to say '*when someone has just lost their baby'* was viewed by the students as being

particularly problematic. For example, Gayle expressed her difficulty in the following quote:

> '*I think just trying to find the words, the right words to say to someone when their baby's just, when they found out their baby's dies, what words can I say to them and what can I do to try and help them*' (Gayle: P2: L28-33).

Gayle's account inferred a sense of despair that she could not find the words and emphasises '*the right words'* to say to try and console the couple. Her repetitive use of '*what words can I say to them*' and '*what can I do'* seems to imply that there was very little she could offer the couple in terms of emotional support.

Therefore, the students expressed an awareness of the need to communicate empathically with the couple, but at the same time were concerned about '*being really, really careful, mindful about the words'* that they used (Susan: P2: L11*).* In the following excerpt, Susan highlighted the difficulty in maintaining a delicate balance between being professional and caring, and mindful of the words she should use. She used the metaphor '*treading carefully'* and '*not wanting to put her foot in it*' to describe her reticence about saying anything that could impact negatively on the parents.

> '*I don't really know how to describe it, like sort of like you want to do everything to try and comfort them, but I was mindful to be really, really careful, mindful about the words that you* use; *and I didn't really want to put my foot in it, or tread on people's toes with what I was going to say and things like that'* (Susan: P2: L10-12).

Orla also acknowledged the dilemma of 'being realistic', whilst at the same time not being 'really harsh'. The following quotes illustrate the difficulty in providing not offering the couple a sense of 'false hope', and a concern that the parents could 'hold onto every word'.

> *'It is really hard, because I don't want to say the wrong thing, but equally, you know, I need to be quite realistic about it, because it is, it has happened, and*

> *you don't want it to come across like you're being really harsh. Difficult one really'.* (Orla: P3: L81-89).
>
> *'I think definitely not saying that things are okay when they are, they might not be. I think it's very easy to just quickly reassure people. I think kind of like your own reassurance that I want things to be okay for them, but I think you know that they might not be. But it's quickly realising that, you know, I can't really give false hope because, you know, parents will draw on that'* (Orla: P3: L81-89).

Therefore, once learners become exposed to a disorientating dilemma, it stimulates them to engage in a process of critical reflection. In doing so, it provides them with the knowledge and skills for '*trying out new roles and assessing them*' which subsequently guides their future actions and aligns with phase nine of Mezirow's transformational learning process (Cranton, 2016, p. 16). Throughout their narratives, students expressed their desire to act as compassionate role models and provide emotional support to the couple. To be able to relate sensitively to the couple, students felt they needed to '*constantly move and mediate in a sensitive way between closeness and detachment* (Deery & Hunter, 2010, p. 49). However, maintaining this balance of closeness and detachment requires considerable skill (Johns, 2004). For some students, this involved modifying and adapting their behaviours about respecting the couple's physical space, closeness, and privacy. According to Huffman (2017), creating this sense of '*embodied aboutness'* (making one's body about the other-to the other) is a powerful indicator of concern and compassion. This was evident in Catherine's excerpt whereby she talked about '*getting close'*, '*not trying to hug her*' while at the same time '*giving her space'*. She confirmed, *'it wasn't trying to hug her but giving her space and being close enough to know someone was there, the tone of voice, just really gentle'* (Catherine: P2-3: L68-69).

Froggatt (1995) suggested that often in intense emotional situations like death, people employ different distancing and /or spatial strategies to help contain their emotions and to enable them to function within the situation. For Angie, this involved

doing something physical as a way of '*getting a step closer''.* Being physically present seemed to provide some comfort to Angie who stated, *'I had this urge to make her a drink, and kind of, you wanted to step a bit closer to her, just so she physically knew someone was there'* (Angie: P2: L50-63). However, at the same time she felt, '*it was weird having that urge to offer her a drink'* and she appeared to question its usefulness *'like offering her a drink was going to somehow ease what was happening'* (Angie*:* P2: L50-63). This suggests a feeling of uncertainty about her role in this situation and a way of managing her anxieties relating to her sense of powerlessness.

When learners encounter uncomfortable situations, it stimulates a process of self-reflection and learning which enables them to apply their new knowledge to future challenges and aligns with phase eight of the transformative learning process (Cranton, 2016; Tsimane & Downing, 2020b). In this case, students indicated having an awareness of non-verbal forms of communication and a realisation '*that things like, not all silences need to be filled*' (Susan: P1: L18-29*)* and *'it's definitely okay to just be silent and just be there, I'd definitely take that away with me'* (Ethel: P4: L119-127).

Back, Bauer-Wu, Rushton, and Halifax (2009) maintained that compassionate silence creates a sense of caring and understanding and conveys a feeling of 'being with' the couple in a difficult moment. This was evident in the following excerpts whereby the students referred to silence as '*an opening'*, '*like the silence opens, opens it up a little bit for the parents to process, ask questions and that kind of thing'* (Ethel: P4: L119-127*).* Susan also reflected on the importance of giving the couple time and space. Her excerpt below reveals a desire to gain a deeper understanding as to how the bereaved parents are feeling and to find out '*what's going through their mind … including their feelings'.*

> *'Giving them that silence is sort of like opening the floor up to them to talk to them, and I think it shows that you, you want to know what's going through their mind and things like that and taking the time and sitting with somebody, and including all their feelings and things is quite important, instead of going, oh well, they don't want to speak, so I'm going to leave'* (Susan: P1: L18-29).

Ethel talked about how she '*felt as a student, you have to like fill a gap in that sort of situation'.* In her excerpt, she conveyed a sense of being left alone and struggling as to what to say and felt she *'had to say something'* in those uncomfortable moments. I felt Ethal gained some comfort and reassurance knowing that '*it is okay to be silent'.*

> '*Because sometimes when you are a student, especially when I was in first year, I sometimes, I'd be left in the room alone for a minute or, and you feel like you have to sort of say something … now I know*, *I've realised that it's definitely okay to just be silent, I'd definitely take that away with me'* (Ethel: P4: L119-127).

Likewise, Kim alluded to '*picking up on the body language and the vib*e *from her'* and being attuned to the bereaved mother's body language:

> *'I think I was just picking up on the body language and the vibe from her as well, like I think, I don't know if I'm remembering correctly, but she was quite closed off and pointing away sort of thing, so I kind of picked up on the fact that, you know, she didn't really want pushing too much and she obviously needed her space as well, so I think it's just picking up on that and respecting it as well'* (Kim: P2: L34-40).

As indicated earlier, Mezirow and Taylor (2009) acknowledged that once learners are exposed to intense emotional experiences, the emotions aroused can lead to a process of self-examination which is a crucial aspect of transformative learning. However, transformative learning is often experienced in the affective domain (emotional) which can result in feelings of sadness, guilt, blame and self-doubt (King, 2005). For the students in this study, there was a sense of ambivalence about the use of touch in consoling the grieving mother. This was evident in the following quotes from Kim and Gayle who expressed their lack of confidence and a sense of guilt in their efforts to try and console the bereaved mother.

> '*I'm normally quite touch-feely and I'm happy to put my hands on people and I do that quite a lot, just anyway, because I know it can be really comforting; I got as close as I could to her (laughs),* but I just couldn't bring myself *to put*

> *my hand on her shoulder, and I couldn't bring myself to say like, I really, you know, I'd like to console you but I can't* (Kim: P1: L24-32).

Gayle talked about feeling *'upset'* and said that '*it upset me a little bit, because I felt like I wasn't really supporting them, and I didn't know how to'* and '*when we came out, it was like, oh I could've done this, this and this, but then it was too late'* (Gayle: P6: L152-156). In this case, there was a sense of regret but also a level of awareness as to what Gayle could have done or done differently. This aligns with phase 5 of the transformative learning process which states that when learners encounter disorientating events, it causes them to question their responses and '*explore options for new ways of acting'* (Cranton, 2016, p. 16).

This was also evident in the quotes from Emma who expressed the need to '*make the experience easier'* and create positive memories out of a tragic situation. She goes onto say that '*I can't make it better, I can't make the baby suddenly come back, but I can make the experience easier*' *(Emma: P12: L423-432).* Emma did not presume that a positive memory could be guaranteed but stressed the importance of making '*it less of a tragic memory and a slightly nicer one, is because the care they've had is good'* (Emma: P12: L423-432). In their accounts, the students talked about encouraging the couple '*to see and hold their baby*' as a way of bringing some semblance of normality to the sorrowful situation and validating their role and identity as parents.

4.3.2 'My instinct was to console the mum'

Throughout their narratives, the students expressed the need to acknowledge and validate both parents' grief; however, there was a sense that the emphasis was always on the mother and the father was forgotten. Mezirow (2000) claimed that learners acquire uncritical views and opinions (habits of mind) about the world based on their own life experiences or cultural backgrounds that influence how they interpret an experience, in this case cultural expectations about expression of grief. Through the process of critical reflection, these assumptions can be re-examined and their validity questioned (Cranton, 2016). In this theme, Kim acknowledged how the media can influence and inform one's perceptions of grief:

> '*you always see it on TV and people just sort of throwing themselves down to the ground, but people grieve in different ways and …can be quite quiet and sombre, it doesn't mean they are any less upset by the matter* (Kim: P6: L181-189).

Other students questioned some stereotypical, cultural assumptions about '*masculine' and 'feminine' forms of emotional expression'* (Bonnette & Broom, 2012, p. 258). For some, the woman tended to be 'culturally positioned' and more 'bodily focused' (Bonnette & Broom, 2012, p. 255). Orla claimed this is '*because something physical's happening to the woman, a father can be left behind sometimes'* (Orla: P9: L321-323). Likewise, Gayle felt that '*the main focus is on the mum and obviously she's carrying the baby and she's going through all the giving birth and everything, but the dad's grieving as well, and it's easy to forget about them'* (Gayle: P5: L118-121). Catherine also acknowledged that the father is sometimes forgotten regardless of the situation, and she reiterated that '*I do think we forget about the dad and you're concentrating on the mum and even in normal labours, you forget about the dad* (Catherine: P3: L117-120). Similarly, Angie felt that '*my instinct was to kind of console her'* (P9: L295-297).

Bonnette and Broom (2011, p. 258) acknowledged that within the context of pregnancy loss, cultural norms exist that encourage the internalisation of men's emotions which lead to the belief that pregnancy loss is somewhat more significant for women and can result in male grief being overlooked. These binaries and gendered assumptions position women as passive and emotional and men as '*strong, stoic and inexpressive'.* These cultural expectations were illustrated in Susan's account who metaphorically referred to the father as '*the rock'* and '*like a robot'*. Susan's concern was that, if grief is internalised or not physically manifested then there is the likelihood for the father can be '*pushed [to] the side'.* Susan also said, '*that with dad sat there and he wasn't majorly showing all the emotion that mum* was' (Susan: P4: L112-115). Susan felt that '*dads just because he's not screaming or crying, that he doesn't feel things, because I think people just, are pushed to the side if they are not showing outward emotion'* (Susan: P6: L194-198). She challenged some stereotypical assumptions as to how men manifest their grief,

stating that '*because people are like, oh you know, have you seen him, he's like a robot'* (Susan: P6: L190-192).

According to Mezirow, engaging in critical reflection provides learners with an understanding about themselves and insight into their own personal traits and weaknesses in the learning process (Mezirow, 1990b). Even though the students acknowledged that the '*father can kind of be left behind sometimes'* (Orla: P1: L321-323), it was evident from the excerpts that they recognised the need to respond to the father's grief:

> *'I realise like I possibly could've turned to the dad and said something to him, or offered him, like a hand on the shoulder type of thing just to include him in that moment',* (Catherine: P9: L303-307).

Catherine also expressed certain expectations about the father offering support and said, *'I think probably, in my head expected him to sit closer to her and hug her'.* However, based on her observations of the couple, she concluded '*but then you sit back and think they are two separate people dealing with their emotions in different ways and this needs to be acknowledged'* (Catherine*:* P3: L105-113).

4.3.3 'Left to sort of pick up the pieces'

As previously discussed, diagnosing an intrauterine death is not an everyday experience for many student midwives and when it occurs it can provoke considerable stress and anxiety. In the following excerpts from Emma and Angie, the students' use of body language and hand gestures further emphasised the powerful physical emotions they were experiencing. Emma said '*I found it really hard when we were in at the start and we sort of, were listening with the pinard and we couldn't hear a heartbeat* (thumps her chest)' (Emma: P5: L144-145). For Angie, witnessing the breaking of bad news was described thus: the '*hardest part of the whole simulation was the bit when we were there for the news being broken'* (Angie: P11: L398-399) and as she spoke, she placed her hand across her chest.

Mezirow (1990) claimed that people have values and beliefs about the world that influence how things should be performed. When a worldview is no longer

acceptable or in conflict with what the learner perceives to be right or true, it can provoke uncomfortable feelings and trigger a process of critical reflection involving the self, others, and the sociocultural context that the learner inhabits. For the students, observing '*when doctors sometimes deliver news that you don't agree with'* (Angie: P5: L423-432) and in this case communicating contradictory information to the parents appeared to conflict with their own beliefs, values, and expectations as to how the news should be sensitively broken. Both Angie and Orla alluded to '*being there to kind of pick up the pieces'* (Angie: P5: L423-432; Orla: P9: L299-301). The metaphor 'picking up the pieces' implies trying to piece something together that is smashed or broken, in this case, the broken hearts of the bereaved parents and their shattered world.

Bordignon et al. (2019, p. 2326) stated that when students know the '*morally correct response to a situation'* but feel constrained or cannot act because of professional or hierarchical issues, it can incur feelings of moral distress. In the following excerpts, the students appeared troubled and upset as they verbalised the potential impact on the parents and the sense of confusion about the presence or absence of a heartbeat. Susan talked about '*giving her that hop*e' that the heartbeat was possibly present and how this was followed by a '*harsher fall'* with the realisation that there was no heartbeat. In the following excerpt, Susan conveyed a feeling of emotional turbulence and a sense of the parents being plummeted into a whirlpool of grief.

> '*I thought it was quite harsh…..you know, I can see the heartbeat, no wait I can see the heart but it's not beating, it was all that, it was frustrating really because it's sort of like gave her that hope and then it was even more of a harsher fall, because of the slip up with the words. I just thought oh my god, and like my heart sank, it did really have an impact'* (Susan: P5: L145-151, 159-163).

Likewise, Emma justified that '*everyone's going to make a mistake and like slip up on their words*'. However, in the following quote she indicated her concern and reflected on the potential impact of the '*slip up with the words*' on the parents.

> '*I think that was a really, would've been really hard for someone to take if they hear there's a heart but it's not beating, then I feel your emotions are already all over the place anyway, so it just confused things even more.'* (Emma: P3: L:75-80).

The perceived lack of compassion and empathy was also unsettling for Kim and caused her to reflect on and 'write' about the fact that there '*was not really any empathy'*. This aligns with Mezirow's theory that as people learn they start to establish new points of view and create negative schemas by focusing on the perceived shortcomings of others (Mezirow, 2000). The result of this is a form of transformative learning which can 'prime' students to become more aware of the personal and professional values that underpin their role as healthcare professionals (Morris & Faulk, 2012). In the following excerpt, Kim appears to be judging the doctor against her own values and beliefs about empathy and compassion.

> *'I mean the doctor like was quite abrupt wasn't she, and I mean like it was just so upsetting (pause) to hear really, what did I write – there wasn't really any empathy I think there's ways you can go about it, which feel a bit kinder'* (Kim: P4: L127-132).

Likewise, Menzies (1960) says that in times of stress, people often resort to using splitting as a defence mechanism to help them cope in a situation that feels overwhelming stressful and anxious. The students in this study alluded to this by splitting the doctor into being 'bad' (lacking empathy and appearing abrupt) whilst the student midwife was seen to be 'good' and the one who was '*picking up the pieces'*. According to Coldridge and Davies (2017, p. 5), this form of compartmentalisation is often attributed to deep seated anxieties and the student's desire to have some form of '*personal agency*' by protecting the women from the consequences of the doctor's apparent lack of compassion. The following excerpts illustrate this form of splitting. In Kim's narrative, as she began to question the moral competence of the doctor and '*not thinking outside of the box, like what's going to happen afterwards*' implies the onus was on her to support the parents.

> *'they just see it as, that's their job, so right I've done my job and then not thinking outside of the box, like what's going to happen afterwards, how're the (the parents) going to feel afterwards and things like that' (*Kim: P4: L127-132).

For Andrea, the way in which the news was broken appeared to be inexplicable and challenged her beliefs and expectations as to *'how a professional should approach the situation more compassionately*'. She also talked about being '*left then to pick up those pieces'* which again captures the discomfort the students felt. In this interview, I noted that Andrea became tearful as she talked about the doctor communicating with the parents. I paused the interview to allow her some time to stop and reflect, but she indicated to me she wanted to carry on talking. As she spoke, she shook her head briefly almost in disbelief and said:

> *'like when the doctor said, I can see a heartbeat, and I was like, oh no, but you can't, and it was just, she clung, it was like, you'd, everything's all right and then, actually no, I can't, I can see the heart but it's not beating, and it's just…Yeah, she was very abrupt and I would hope that, like a professional would approach that situation more compassionately (tearful)'* (Andrea: P3: L71-78)

Angie also used powerful language to describe how she felt in that moment and vividly compared it to '*someone else arguing'*. As she talked, I noted that she raised her hands almost in disbelief about what she was hearing. In her narrative she placed emphasis on words like '*uh', 'aahh' and 'uuhh'* which conveyed the awkwardness of the situation.

> *'I just remember thinking, oh my god, why would you say that, and then just be like, uh, and it was, it was one of those things, you know like when you overhear someone else arguing and they just say something and you're like, 'aahh, shouldn't have said that, shouldn't have said that way'. It felt like that,*

> *and that was why it so like, 'uuhh', and I think that added to the awkwardness* (Angie: P13: L450-459).

Oelhafen, Monteverde, and Cignacco (2019, p. 1380) claimed that when student midwives encounter situations, they feel they cannot control or, in this case, be an advocate for the bereaved couple who are suffering, it can lead to a profound sense of sadness and feelings of '*being silenced and powerlessness'*. This is evident in the following quote by Orla who described herself as '*just standing there'*, '*not doing anything*' and '*feeling awful*' which illustrated her sense of powerlessness:

> '*but then kind of from there, like when everyone came in it was just a little bit quiet. I found that difficult to be honest, like you are just standing there not really doing anything, I felt awful really ya ya'* (Orla: P3: L68-72).

Angie also alluded to her vulnerability in this situation and described how '*you have all this midwifery knowledge and all these skills, but there's not a skill you can have for breaking bad news*' (Angie: P11: L398-400).

Mezirow postulated that once learners begin to make sense of the disorientation dilemma, they acquire knowledge, skills, and attitudes that '*transforms their problematic frames of reference'* and a worldview that enables them to critically reflect on their misconceptions and potential biases towards a particular group (Mezirow, 1997, p. 7). In this case, even though the students found witnessing the breaking of bad news upsetting, their narratives revealed a change in their perspective and worldview about the difficulty for doctors in communicating bad news. Susan conveys a sense of empathy and understanding for the doctor as '*they're people as well'* and breaking bad news is '*such a difficult thing to do'* Susan goes on to say that:

> '*Yeah, I felt, I felt sorry for the doctor, because it is such a difficult thing to do; and when you do slip-up with your wording and things like that, it makes the*

> *impact so much more, so I did feel sorry for the doctor*'. (Susan: P5: L154-157).

Orla also appeared to have developed some insight in how difficult and challenging it is for a doctor as '*they've got to carry on in their day and make other difficult decisions*'. She used the metaphor '*put on such a hard shell*' to describe how, as professionals, they may employ protective measures to enable them to cope with their emotions:

> '*yeah it is hard like to, you know, go back, that it is what they said, it is a colleague and I do yeah, I do feel sorry for the doctors, when they've got to do it, because it's, you know, they must have to put on such a hard shell and then they're people as well*, *and then they are not really seeing the aftermath of it, they've got to carry on in their day and make other difficult decisions'* (Orla: P6: L287-293) .

4.3.4 Summary of Theme Two

Overall, this theme highlights a deep sense of powerlessness and vulnerability that the students experienced for a variety of reasons. They struggled to communicate and find the 'right words' to say to a couple who have received the devasting news that their unborn baby has died. Their narratives revealed a strong urge to try and console the bereaved mother; however. in doing so they almost 'forgot' about the needs of the grieving father. It was clear that the students' attitudes and beliefs about grief and loss widely related to cultural norms and experiences that influenced their gendered assumptions about grief and loss

This theme also revealed the emotional challenge experienced by the students after witnessing the doctor communicating contradictory news to the parents. They used powerful metaphors such as '*having to pick up the pieces'* to describe how they felt in the aftermath of the parents receiving the bad news. This theme highlights the difficulties that students experienced in trying to manage the emotional complexity of traumatic events.

4.4 Super-Ordinate Theme Three: '*A unique learning experience*'

This theme presents the final phase of the students' transformative learning journey in which the students critically reflected on their learning and how they could apply aspects of the simulation experience to their future practice. It was evident from the excerpts that the students considered the bereavement simulation to be a '*unique learning experience'* (Ethel: P1: L19*)*. Olivia also described it as a '*big learning curve'*. One of the main factors that contributed significantly to their learning was the realistic nature of the simulation, observing their peers and preparation for practice. Therefore, I have identified the following sub-themes which relate to this master theme: '*you felt you were really in the situation'*, '*a nice atmosphere for the debrief', 'seeing how other people deal with it', and 'it definitely prepares you'.*

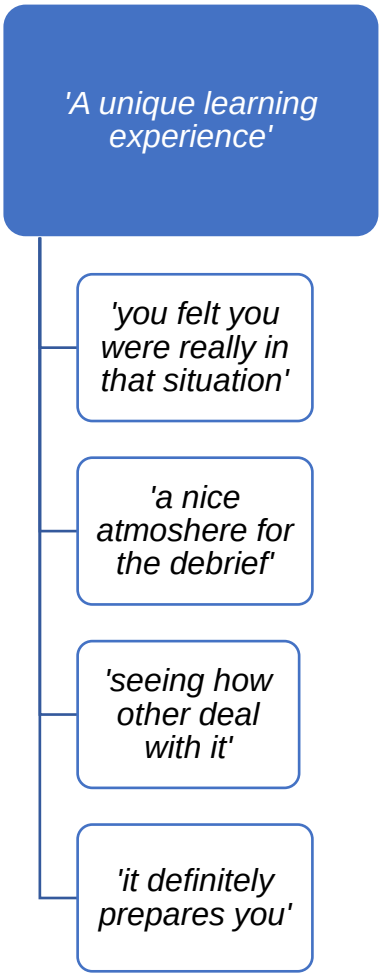

Figure 9 Super-ordinate theme three and related sub-themes

4.4.1 'You felt you were really in that situation'

One of the main factors which influenced the students' abilities to engage and partake in the simulation was the realistic nature of the scenario. In this scenario, a high level of authenticity was created using actors within a simulated maternity setting, which created the perception that the students were in a real-life situation. Bland and Tobbell (2016, p. 10) claimed that learners are more likely to 'suspend disbelief' and engage in the simulation if the situation is feels authentic and '*mirrors the professional context'.* Indeed, meaningful learning often derives from emotionally charged images that reflect one's real world (Dirkx, 2006). In this study, it was evident the students felt they could fully immerse themselves and imagine it was a real event. For Orla, '*it felt so real, I could just picture myself in practice and with that happening'* (P5: L151-152). Likewise, for Ethel the realistic nature of the experience was so powerful that it caused her to behave or respond as if she were in a real situation:

> '*when I was actually in the room…, you think, oh god, it completely changes you when you're there, you're talking to them, you're seeing them, they were such good actors, like you felt you were really in that situation'*. (Ethel: P1: L5-9)

The sense of realism and the authenticity of the scenario almost came as a surprise to the extent that they '*forgot about being watched'* and feelings of anxiety seemed to diminish once they entered the room. Bland and Tobbell (2016) suggested that often learners approach simulation with '*an initial degree of hesitation',* but then '*quickly engage in the simulation',* particularly if it reflects a real clinical situation. The following quote from Angie describes how her initial anxiety about being watched disappeared as soon as she stepped into the room. The sense of realism was so powerful and overwhelming that it caused her to shift her focus from '*what else is happening*' to focusing on the couple:

> '*I was a bit like, oh my God, we are going to be watched', then as soon as you step in, it all goes, you don't think about what else is happening anywhere*

> *else and the University, or in the rooms, or in the corridor outside; you just think about this couple that are in front of you'* (Angie: P4: L124-131*).*

For Susan, the sense of realism was so profound that it made her feel '*they were actual parents that had just lost a baby*':

> '*it didn't feel you were in the room, it didn't feel like a simulation', it felt like they were actual parents that had just lost a baby, I walked out and I was like, I cannot believe that was a simulation, you're focused and in the moment'* (Susan: P3: L75-80).

In the study, the students revealed that engaging in the simulation triggered the cognitive processes of learning and caused them to think about and reflect on what they were doing. This complies with Mezirow and Taylor's view (2009) that exposing learners to intense experiential learning activities encourages them to critically reflect on and actively engage in their learning, which in this case meant 'being with' the bereaved couple. In the following quote, Ethel described the simulation '*as a unique learning experience for me'.* She talked about '*being in there and thinking and you're in there with the parents'* which implies a sense of connection with the parents and of being active and engaged in the situation. She compared it to the classroom situation '*whereby just talking about how you would deal with it'* indicated a more passive learning approach:

> *'It was a unique learning experience for me and it's so much different to being in the classroom and just talking about how you would deal with it. And actually being in there and thinking, oh this you know, you're in there with the parents and it's completely different'* (Ethel: P1: L19-23)

Similarly, Susan talked about '*not just sat in a lecture theatre and talking through it*, *it was actually being in that situation'* (Susan: P11: L309-311). This corresponds to Bland and Toppell's (2016) view that lectures or a didactic method of teaching can 'engender' disinterest for learners making it difficult for them to make connections between theory and practice and apply what they have learned to a clinical situation. As suggested earlier, learning is much more meaningful when students engage and

immerse themselves in the simulated scenario. However, some students found it difficult to accept that the simulation was entirely real. Although Catherine acknowledged that the emotional aspect of the simulation felt real, because there was not '*an actual real dead baby'* she felt it made it difficult for her to fully engage in the simulation to the extent that it did not affect her emotionally. This suggests that, for some learners, the physical and emotional components of a simulation must be present to enable them to fully engage with the scenario and be willing to accept it as real:

> *'I think what I mean is the, the scenario and the emotion was obviously real, but it didn't, it didn't like really, really hit me emotionally because there wasn't actually a real dead baby'* (Catherine: P4: L140-143).

Despite Catherine's comment, the students generally perceived the simulation to be very realistic to the extent that they struggled to distinguish the difference between the simulation and a similar event in clinical practice. As evident in Catherine's comment, this level of realism is not always achievable. To some extent, there will always be attributes of simulation that may not be perceived as entirely real. Nevertheless, the authenticity of the scenario enabled the students to immerse themselves and experience the world of grief and loss from a healthcare perspective and those of the bereaved parents.

4.4.2 'A nice atmosphere for the debrief'

Heller, DeMaria, Katz, Heller, and Goldberg (2016b) argued that exposing students to simulated death and dying situations can impact them emotionally. Therefore, it is essential that students are guided through a debriefing process to enable them to express their emotions, diffuse any negative feelings and transform them into a positive learning experience. Thus, reflection, feedback and psychological safety are important attributes of simulation (Reierson, Haukedal, Hedeman, & Bjørk, 2017). Moreover, creating a safe comfortable environment encourages learners to engage in reflective dialogue with self and others and '*sets the stage towards transformative learning and critical questioning'* (Cranton, 2016, p. 105).

In this study, the students valued the opportunity to be able to reflect on the experience, and '*having a nice atmosphere for the debriefs'* seemed to ease their anxiety and enhance their learning, while just '*chatting about things'* felt supportive. The students talked about sharing this deeply emotional experience with their peers and how it felt supportive. Having positive and trusting relationships with others is a key factor in a transformative experience (Taylor, 2007). This was illustrated in the following excerpts by Orla and Gayle:

> '*the discussion after, the kind of in between, and everyone was really supportive and they were like, would you have said that in this situation, and I think it was that kind of analysing or the bit after'* (Orla: P6: L188-193).

> '*Yeah, it felt quite supportive, in the room together, chatting about things and just supporting one another'* (Gayle: P7: L176-187).

Morris and Faulk (2012) also emphasised that an environment of trust and a sense of non-punitive repercussion or coercion is essential to enable learners to engage in dialogue with their peers and educators. As the educator and facilitator of the simulation, I was also aware that feeling psychologically safe and secure would 'permit' the students to 'speak up' and 'identify potential mistakes and errors' (Turner & Harder, 2018). Learning in the simulation also meant they could confront and test the limits of their capabilities and there was some evidence that instances *'where you might not have said the right thing… felt reassuring that there was no blame'* (Orla: P6: L193-195). The opportunity to have a safe, secure environment in which to make mistakes contrasted sharply to the clinical setting, whereby making mistakes was not always viewed positively.

> '*When we spotted mistakes that others had done like we knew that's how it is in midwifery, like you pick up the best from people, not like you think, oh I would do that differently'* (Kim:P:3: L:72-76).

However, Kim also felt '*there was really good support for each other, it's a safe environment to do so … like you've not got it in practice'* (Kim: P3: L79-84).

Mälkki and Green (2016) claimed that when learners perceive the environment to be safe, they are more likely to feel accepted and their contribution to the discussion is well received. This was illustrated by Catherine (in the excerpt below) who talked openly and truthfully about mistakenly reassuring the bereaved mother saying that '*there is nothing to worry about*' and then stated '*and that's what she picked up on':*

> *'because if I made that mistake in practice, saying the wrong words in practice, that would be worse, whereas there, I felt all those emotions, but actually it was, it was okay; and everybody will have learned from that as well, the same as, you know, I've learnt some, what looked like good practices, people have learnt from, you know, other mistakes that have been said'* (Catherine: P7: L145-149).

Throughout Catherine's interview there was a sense of self-blame about '*saying the wrong words*' and almost a feeling of worthlessness. However, throughout the process of self-examination, rational discourse and debriefing, Catherine appeared to gain a deeper understanding and a new perspective. This again complies with Mezirow's view which suggests that undergoing self-examination and critical reflection with self and others contributes to the learner's professional development and the transformative learning process becomes emancipatory (Mezirow, 1990a; Morris & Faulk, 2012). In Catherine's excerpt, she reflects on how '*they* (her peers) *will have learned from that as well'* which perhaps indicates a belief and value about her own self-worth and a sense of openness to new meanings.

As indicated above, despite their initial anxieties about being in the simulation, it was evident that the students viewed the simulation debriefing as a valuable learning experience. The sense of '*being part of a small group*', '*being with them'* and having group familiarity was perceived as a strength and generated a sense of professional bonding that resulted from sharing the experience:

> *'Being students, they understand that we haven't got all the answers and we haven't got all the skills*, *it's quite nice that you can relate to your peers'* (Angie: P6: L216-227).

> '*Everyone, like people makes mistakes, it was just, I don't know, I just thought it was a nice, especially because it was quite a small group, it was a nice atmosphere for the debriefs'* (Emma: P3: L76-78).

4.4.3 'Seeing other people deal with it'

For many of the students, significant experiential learning was gained from observing their peers and having an opportunity to '*pick from other people's experience'.* This stimulated them to reflect upon their own learning needs and incorporate new ways of thinking and practising. This aligns with phase five of Mezirow's transformative learning theory which states that when learners become exposed to a disorientating dilemma, it can result in an exploration of new ways of thinking and acting (Cranton, 2016, p. 16). In the following excerpt, Emma talked about how '*she kept taking bits away'….as to what might be a good thing to say'* and having '*a little speech*' prepared almost like an aide memoir to help her if she was in a similar situation:

> '*watching them I thought, I kept taking bits away, thinking, oh yeah, that's a good thing to say, or that's the useful thing that I could have in like a little speech sort of, you know, if I was in that situation'* (Emma: P3: L85-87).

Gayle also commented and *'I was 'thinking, oh yeah, you might not necessarily have thought to do that yourself'* (P7: L176-187).

Another interesting aspect highlighted by the students was that, through observing their peers they gained an insight into professional role modelling behaviours which they felt they could emulate and offer a point of reference for future care and practice. Catherine articulated a specific example:

> *'it was so good seeing some of the others and how they spoke, their tones of voice and all that was so good because you can learn from that. … yeah, I think so, it's good to have watched what everybody else did, because you can learn from them … yeah. I don't think you'd learn much if you didn't watch everybody else'* (Catherine: P3: L76-78).

Susan commented that it was the friendly but professional manner that seemed to resonate with her and '*how they were, crouching down and speaking to them in a friendly, but still professional, manner'* (Susan: P8: L76-78). Their view about themselves and professional behaviour seemed to some extent to have been shaped by others. This was evident in excerpts from Orla and Andrea:

> '*I think just when we were talking together*, *some of the things that the girls said about, kind of like the knowledge they had as well, and you know, they brought different things to the table, you know, you might not have thought of, and could have been really, really, useful in that situation'* (Orla: P6: L255-258)

For Andrea, *'it was the use of language and body language'* that was significant:

> *'I think was definitely and watching how everyone else reacted, and you can take things from each person. It's like when you work with different mentors, you take a little bit of something from all of them to make who you want to be, and I think it's like that with your peers as well'* (Andrea: P9: L253-255).

Phase eight of Mezirow's transformative learning theory indicates that once learners experience a disorientating dilemma, they start to critically evaluate their new role and behaviors (Morris & Faulk, 2012). It was evident that the students' abilities to critically evaluate their new role and behaviour were enhanced through observing the knowledge, skills, and caring behaviour demonstrated by their peers. This seemed to empower them to reflect and evaluate aspects of care they had not thought about previously. Susan's excerpt below describes in detail the caring practices she observed and noted how her peers were responsive and adaptive to the holistic needs of the parents:

> '*Seeing some of the others it was, it was really nice, because they included like dad and the way that they spoke about baby, and you know, she's beautiful, she looks like you and that kind of thing, it was really, really nice to see. Yeah, how they were speaking, sort of like, we spoke after, like before and afterwards and you can see how they change, depending on the*

> *situation. You know they were, they were speaking really softly and taking into consideration both mum and dad, because mum had a really, really different reaction to how dad was, so it's switching between the two and knowing what's appropriate. Mum didn't want to see baby and they were kind of like, that's absolutely fine, we can revisit it, and not trying to put so much pressure on mum. But then offering it to dad as well, and it's not just a case of, oh if mum doesn't want to see baby then nobody else can, but making sure that, you know, mum is happy for - yeah'* (Susan: P2: L58-71).

Stone, Cooper, and Cant (2013) stated that compared to traditional methods of teaching, peer learning encourages active student engagement and critical thinking. This sub-theme clearly indicates that, through observing their peers, the students were able to critically evaluate significant aspects of care they would potentially utilize in their future practice. The value of peer learning within the context of bereavement simulation will be explored further in the discussion chapter.

4.4.4 'It definitely prepares you'

This sub-theme describes the final stage of the students' transformative learning journey. Within this theme, the students reflected on how the simulation could emotionally prepare and enable them to apply their new knowledge and skills when caring for bereaved parents in practice. Phase ten of Mezirow's transformative learning theory indicates that as learners develop confidence in their new knowledge and skills, they start to incorporate changes in their new role and behaviours based on their new perspective (Morris & Faulk, 2012). This was evident in the following excerpt by Andrea who talked about '*learning to cope with the 'emotional side of things' and how to comfort':*

> *'it definitely prepares you that way and then the emotional side of things, it does prepare you for how to react and how to comfort, yeah'* (Andrea: P4: L158-162) '

Likewise, for Ethel participating in the simulation enabled her to think '*how you can use your skills in different situations'*:

> *'how you would do, like from stage to stage, so from being told, the baby's died to then the postnatal care and how you can use your skills in each different situation, like along the journey'* (Ethel: P2: L25-30).

Andrea also talked about how the simulation could help her in situations other than bereavement. She made specific reference to '*helping you deal with conflict',* situations when parents have been '*waiting for hours'* and *'outcomes like abnormalities'*:

> *'It's knowing now what needed to be done at various stages throughout the scenario. But yeah, I think overall it does, it's helping you deal with like conflict and like patients that are angry, they could be angry for all sorts of reasons; they've been waiting for four hours, so yeah it does, and sometimes the outcome of like abnormalities and things like that, it definitely helped with equipping you for that. Yeah, like breaking bad news and stuff'* (Andrea: P4: L136-146).

A critical aspect of the transformative learning process is that when learners experience a disorientating dilemma; it can 'set in motion' a change as to how they might view the world or in this case improve their practice (Morris & Faulk, 2012). For some students, the outcome of the transformative learning process resulted in them having the belief and confidence that they '*would know what to do and what to say*' (Gayle: P6: L156-161). This was evident in *Gayle's* reflection about the simulation experience:

> *'but that's what is good about simulation, is that you had that chance to kind of, almost practice it so the then when we go out, if it does happen, or in any kind of situation where something happens, you know kind of know what to do and to say a bit better.' (Gayle: P6: L156-161).*

> *'it made me think about how I reacted in that situation and how I how I might change how I'd behave in the future'* (Gayle: P1: L6-8).

Orla also reflected on how the simulation provided her with the confidence to '*become more involved'*. In the following excerpt she articulates confidence in her

ability to provide emotional support to bereaved parents on her own and having an intuitive sense of self-awareness as to what to do. In the following excerpt, she reflects on what she used to do and what she feels she would or can do now.

> *'Like I didn't really know how to react, like I've have never been in this situation before, so then I've took a bit of a step back and I think I didn't really have the knowledge, you know, I think drawing on that experience now, I think I'd be a lot more involved. Maybe kind of sitting by them, spending more time with them, but before, if my mentor left the room, I left the room (laughs). Now I would be able to sense what they wanted, someone maybe to stay with them, I probably would stay in, and you know just offer them any more support, I think rather than leaving them and not feeling uneasy about it'* (Orla: P11: L395-408).

In the above quote, Orla recognised the importance of her presence in supporting the bereaved couple. Her narrative revealed a sense of moral agency and satisfaction in her intention to invest the time and effort to emotionally support the couple. Pask (2003) stated that when nurses and/or midwives have a positive view of themselves and a belief they can make a difference, it helps them to develop a personal and professional identity of their own; in this case, the aspiration to become a kind, caring, compassionate healthcare professional.

As suggested earlier, transformative learning can '*set in motion'* new ways of thinking and behaving that can empower nurses and/or midwives to have a more holistic understanding of their clients' needs, their professional role and how care should be provided (Morris & Faulk, 2012, p. 12). In the following excerpt, Susan illustrates her new perspective as she talked about how the '*simulation helped her to read the situation'* after she was involved with two women who had '*lost two babies'*. Her narrative reveals a sense of empowerment to do things differently or to behave in a different way. She made specific reference to '*trying not to put your own opinions forward about what the parents would like*' which indicates a new understanding of the parents' rights and choices to make memories of their deceased baby:

> *'But no, I got a lot out of it, and when I was doing a bank shift, we had two ladies that had sadly lost babies; one quite early on, and one later, and I think that simulation helped to be able to read the situations and after sort of like each individual when we all came together and discussed it, I think it helped to understand why things weren't the best, and like what you'd do in that kind of situation, and you know, don't forget to include the partner or things like that. Trying not to put your own opinions forward about what the parents would like, you know like the pictures and holding baby and that kind of thing'* (Susan: P1: L15-22).

Overall, the students identified aspects of the simulation that they felt they could utilize and apply to the care of bereaved parents. However, the students also acknowledged that despite participating in the simulation, there was a sense that nothing could ever prepare them for such an emotional event. The following extracts illustrate the students' on-going sense of anxiety and uncertainty about coping with stressful events like perinatal loss. Whilst Ethel felt *'It definitely would relieve some anxiety about being in that situation again'* (Ethel: P6: L200-203), Catherine said, '*I'd still feel worried'* but acknowledged '*but I'd feel a bit better having done the sim.'* (Catherine: P3: L84-88).

Likewise, Susan also questioned whether a bereavement simulation would ever fully prepare a person for such an emotional event: *'I don't think you can ever be fully prepared or ready for something like that'.* However, she referred to the simulation as '*a stepping stone'* and that '*it was quite a good, sort of like first stepping stone to, something like that'* (Susan: P11: L328-330).

4.4.5 Summary of Theme Three

Overall, these findings suggest that whilst the simulation may not mirror the true emotional reality of a traumatic event like perinatal death, it highlights an experiential value which can offer a useful educational opportunity to students to gain a deeper insight into their practice. It can therefore complement the more traditional methods of teaching and learning used in bereavement education within undergraduate midwifery programmes. This theme also illustrates the students' progression from

their perception of the situation as disorientating and chaotic to emerging with new insights and a different worldview about grief and loss. Despite the intensity of the experience, the students acknowledged the simulation as a '*unique learning experience'* and an important aspect of their future role. They therefore expressed a desire to continue to strive and develop their knowledge and skills in this aspect of care.

4.5 Reflection on Analysing the Themes

I found this chapter quite challenging and emotional to write and it took longer than I anticipated. Below is an excerpt from my reflexive diary based on the interview with Andrea.

'The interview with Andrea was very powerful and her use of the words 'gets you' and' there is no explanation' captures her emotive response to the situation. I ask myself if this is indicative of her own sense of role inadequacy and insecurity. I wonder also whether this relates to a broader sense of professional insecurity and that perhaps her distress relates to the lack of fulfilment of a satisfactory or professional clinical outcome for the bereaved couple'.

The remainder of this section details my feelings and anxieties about writing this chapter.

Initially, I felt compelled to produce a draft of the analysis chapter very quickly; however, as the analysis progressed, I soon began to realise that parts of my analysis were quite superficial and needed a deeper level of interpretation. Smith et al. (2009) recognised that it is not uncommon for novice IPA researchers to initially produce a descriptive account of their analysis. So, when I read over my analysis of the themes, I felt there was a considerable number of quotes but that my level of analysis needed to go deeper and be more interpretative. This prompted me to reflect on the quality of my findings as I felt a real sense of obligation to do justice to the students' words and narratives, and to truly capture and interpret their lived experience of the bereavement simulation.

To help me move beyond description and make the second draft more interpretive, I started to immerse myself in the students' own words. For considerable weeks, I sifted and manoeuvred through the verbatim quotes until finally I got to a point where I could really start to make sense of them and gained a deeper understanding of 'how this experience felt for them' and 'how they made sense of it all'. At this point I began to explore some literature in relation to the role of reflection in emotionally chaotic experiences. I found several articles relating to Mezirow's transformative learning theory, and quickly realised that this would be a suitable approach to apply to my data analysis. Having discussed this with my supervisors, I then re-read all my themes and began to apply the different phases of Mezirow's theory to the students' transformative journey of their experience of the bereavement simulation. This was a real moment of enlightenment and comfort for me as I felt that using Mezirow's theory would add a deeper layer of interpretation and enhance the quality of my findings overall.

As indicated above, writing this chapter has proved challenging. I found it very emotional and at times I was tearful listening to the students' accounts and how this experience felt for them. It also resonated with my own personal experience. However, at the end point of their transformative journey, I found it inspiring to hear that having experienced a disorientating dilemma like perinatal loss, the students were able to reflect on significant aspects of their learning that would transform and enable them to provide compassionate care to bereaved parents in the future.

Chapter 5: Discussion

5.1 Overview: Introduction

The findings outlined in the previous chapter describe the complexity and varied accounts of the students' emotions and responses to a couple experiencing perinatal loss. The interpretative nature of IPA enabled me to capture a rich, deep understanding of the emotional complexity inherent in their experience and to '*vividly bring it to life in the students own words, through the use of in-depth interviews*' (Hinsliff-Smith, Spencer, and Walsh (2014, p. 18). The findings chapter confirmed that to some extent, this aim was achieved and the application of Mezirow's transformative learning theory has contributed to a new body of knowledge around bereavement education and learning using simulation. This is particularly significant because, to date, no research has been undertaken on bereavement simulation within the context of midwifery education.

This study initially set out to explore student midwives' experiences of their involvement in bereavement simulation. It examined whether this would enable them to truly feel and learn what it is like to care for bereaved parents in a real situation, and how they would transform their thinking to help them emotionally prepare for future practice. The overall aim of the study was guided by the following question.

> *What is the lived experience of bereavement simulation from the perspective of the individual student midwives?*

In this chapter, I will contextualise the research findings and expand on this by providing a detailed exploration of the complexity of the experience described by the students under each of the super-ordinate themes and in relation to the extant literature. It is also important to note that in '*qualitative research, new literature can be introduced in the discussion chapter'* (Smith et al., 2022, p. 116). Therefore, this discussion chapter will also draw links with other relevant experiential and theoretical sources of research where appropriate.

The research questions will be addressed under each theme. I have also provided examples of quotes taken from the findings to further substantiate the evidence.

5.1.1 Super-Ordinate Theme One: 'A rollercoaster of emotions'

It was evident throughout this study, that the students experienced a myriad of emotions ranging from anxiety, apprehension, guilt, shock, sadness to feelings of sympathy and empathy for the parents. These feelings created a sense of emotional turmoil and disorientation and had '*an unsteadying influence on the students'* as they reflected on and acknowledged an experience they had not encountered before (Howie & Bagnall, 2013, p. 817). Encountering a disorientating dilemma like grief and loss has the potential to cause '*a significant level of disruption or disturbance in a person'* (Howie & Bagnall, 2013, p. 818) and the process of self-examination is often accompanied by feelings of anxiety, sadness and vulnerability (MacLeod & Egan, 2009). Similar emotional responses were also reported in other studies involving students and midwives' experiences of perinatal death and other traumatic clinical events (Rice & Warland, 2013; Schroder, Jorgensen, Lamont, & Hvidt, 2016; Sheen, Spiby, & Slade, 2016).

Additionally, the students described participation in the simulation as nerve wracking as they did not know what to expect. For many students, these anxieties and concerns were attributed to the fact that this was their first experience of real time simulation, and the death of a baby in-utero was difficult to comprehend. These feelings and anxieties were also acknowledged in several other studies involving simulation (Cantrell, Meyer, & Mosack, 2017; Nielsen & Harder, 2013; Pollock & Biles, 2016) including bereavement simulation (Donovan & Forster, 2015; Heller et al., 2016b; Knight, Dailey, & Currie, 2015) and particularly for students who had no prior experience of real time simulation (Cato, 2013).There were also concerns about being videoed or performing in front of their peers and of making mistakes. This is consistent with the study by Mill et al. (2014, p. 16) who reported that students often experience a degree of apprehension at the '*thought of being filmed'.* However, in this current study, once the students became immersed in the simulation, they seemed to forget everything else that was happening around them. This also supports the findings from Bland and Toppell's (2016, p. 10) study which showed

that when students first experience simulation, they go through a period of '*initial hesitancy'* often accompanied by feelings of apprehension and anxiety. However, as the simulation unfolds the students gradually engage and immerse themselves and actively participate, as if it were a real clinical situation.

In addition to having limited exposure to real time simulation, the students' anxieties were also compounded by the fact that they had not had any previous involvement in caring for bereaved parents in clinical practice. For many students, bereavement care was something that students '*don't do'* and there was a sense that being a student '*you don't have to deal with it'*. These findings are to be expected as it is evident that the students' abilities and attitudes towards bereavement care are, to some extent, influenced by their education and prior experience (McClatchey & King, 2015). Therefore, this lack of socialisation around death and dying, and unknown expectations impacts on the student's ability to cope and respond in an emotionally intense situation like bereavement (Brunt, 2020; MacLeod & Egan, 2009). This was highlighted in other studies when students witnessed or experienced perinatal loss or similar stressful events in practice. These can equally be an intense, emotional, and challenging experience for them (Coldridge & Davies, 2017; Halperin et al., 2011; Parry, 2011).

There are conjectures in the literature regarding the use of death and dying in simulation due to the potential for invoking intense emotions and vulnerability (Heller, DeMaria, Katz, Heller, & Goldberg, 2016a). Heightened levels of stress and anxiety can significantly impact on a student's performance and their overall learning experience (Al-Ghareeb, McKenna, & Cooper, 2019). From a phenomenological point of view, '*emotions are absolutely central to our human understanding of experience'* (Smith et al., 2009, p. 199*)*. They are key to understanding our relationships with others and about '*being in the world'* (Smith et al., 2009). Emotion theorists like Robert Solomon have argued that emotions are an essential part of an experience. He contended that '*emotions exist wholly independently but they cause us to behave in discernible ways*' (Solomon, 1993, p. 83). Indeed, emotions '*happen to you and are 'in you'* and '*they force themselves upon us'* (Solomon, 2002, p. 149).

Solomon symbolized emotions as an image of ‘fluidity ‘or fluid under pressure, emotions are marked by sinking, weighing a person down, making then feel out of place. An outcome of this model of emotion, is the ‘disabling’ of a person, causing them to be passive, lacking in agency or a sense of control. The disabling effect of these emotions was evident in some of the students’ accounts, as they resorted to metaphors such as ‘*I just kind of froze’* (Gayle: P1: L6-8)*,* to emphasise their depth of anguish. However, Al-Ghareeb et al. (2019) and Hardenberg, Rana, and Tori (2020) claimed feelings of anxiety and apprehension are not uncommon in simulation. They often occur as a natural response to unfamiliar situations, as most experiential learning involves some degree of challenge and apprehension. Indeed, emotions are considered an integral part of how we interpret and make sense of the events in our lives and are vital to the process of transformative learning and change in perspective (Dirkx, 2001).

Contemporary models of anxiety, propose anxiety as a stretch-panic-zone, suggesting that a moderate level of stress can promote learning, but too much stress (panic-zone) can ‘*push them over the edge into a temporary stage of anxiety’,* which can jeopardise their learning (Palethorpe & Wilson, 2011, p. 423). Whilst evidence suggests that adding emotional stressors in a simulation leads to improved performance in future practice (Gillan, Jeong, & van der Riet, 2014; Ignacio et al., 2015), the disempowering effect of stress needs to be acknowledged and requires moderation. The goal of simulation therefore, is to provide a safe, comfortable environment in which to learn and create opportunities for learners to critically reflect, process and normalise their emotional responses, which is a crucial aspect of the transformative learning process (Mezirow, 1990a).

In addition to creating a sense of psychological safety, the role of the facilitator in ensuring a delicate balance of psychological and emotional conditions enables students to acquire the critical skills necessary to enact the care, without putting them at emotional risk (Heller et al., 2016b; Nielsen & Harder, 2013). A concept analysis by Turner and Harder (2018) also identified three key attributes essential to promoting a safe, psychological environment. These included: adequate preparation in the form of pre-briefing, debriefing using a structured framework; an empathic and

competent facilitator with excellent communication skills, and the freedom to make mistakes without incurring any feelings of self-blame or guilt. Therefore, as the facilitator, I was aware of the importance of establishing a positive relationship with the students and 'creating a transformative space' to maximise their learning (Gillespie, 2005). I was also conscious of ensuring a safe nurturing learning environment that incorporated aspects such as pre-briefing, orientation to the learning environment and outlining learner's roles and expectations, to help decrease students' anxieties (Roh et al., 2018).

The findings of this study confirm that, despite the emotional intensity of the simulation experience, there was a sense that the students felt safe and protected to openly express their feelings and insecurities. This was further was enhanced by having the opportunity to debrief, and making a mistake was considered a potential learning opportunity, *as* '*everybody will have learned from that as well*'. This again is consistent with Ganley & Linnard-Palmer's study (Ganley & Linnard-Palmer, 2012), who state that creating an academically safe environment minimises the risk of learners feeling embarrassed by their mistakes or worried about being '*ridiculed by their peers'*. This enabled them to reflect positively on their errors and insecurities, and helped them to achieve their learning outcomes.

In a qualitative study exploring student midwives experiences of traumatic events in the labour ward, Coldridge and Davies (2017, p. 6) stressed the importance of '*creating a boundaried space*' whereby students '*can sit and talk with other students'* and are '*held and valued as learners*', which may not always happen in practice. This is key to enabling them to confront their pain, and through the process of self-reflection, gain insights and resolution from a stressful experience like stillbirth (Christie & Jones, 2014). It is also cited in traditional models of grief as significant in helping people gain resolution and making sense of tragic events like perinatal loss meaning that it is a crucial aspect of the transformative learning process (Parkes, 1998).

Thus, a prominent theme throughout the study was the students' experience of anxiety and apprehension, which were mainly attributed to not knowing what to

expect, and many of the students felt that the unexpected loss of a baby through stillbirth was one of '*experiential felt unexpectedness*' (Jones & Smythe, 2015, p. 17).

The students, along with the bereaved parents, were suddenly '*thrown into*' a situation that was unexpected and inescapable and one that they all had to share and confront. Moran and Mooney (2002) referred to Heidegger's belief that, as humans '*we are always thrust into a world*'. It is this '*thrown-ness*' that he suggests requires a person to make sense of and make meaning from 'being thrown' into an experience. In the case of this study, the context was highly emotional and poignant, which further added to any turmoil (Jones & Smythe, 2015).

The concept of '*thrown-ness*' and '*being there'* highlights the personal journey that students must negotiate and 'navigate' to provide sensitive, kind, compassionate care to a bereaved couple, whilst at the same time manage their own personal and private feelings and emotions (Jones & Smythe, 2015). The students in this study sought to contain their feelings and remain strong for the parents; however, their narratives revealed a conflict between how they should feel and what expectations they should conform to.

Hochschild (2012) described emotional labour as a way of managing and regulating one's feelings and emotions to portray an image that is appropriate for the situation. This concept is relevant to the study as the students experienced a profound sense of sadness for the parents. However, it also relived memories of their own personal losses which required them to contain and be silent in their attempts to appear professional. There are conflicting accounts in the literature as to how students or midwives should manage their emotions in front of grieving parents. In McKenna and Roll's (2011) study, the student midwives expressed a need to cry and openly show their emotions, although they were unsure if this was appropriate. In some studies, it was felt that sadness and upset were normal reactions (Alghamdi & Jarrett, 2016) and it was acceptable to openly express their grief in front of the grieving parents (Jonas-Simpson, Pilkington, MacDonald, & McMahon, 2013). For others, suppression of emotions and being emotionally distanced from the situation was

considered more professional and helped provide '*care in an automatic way'* (Fernández-Basanta et al., 2021, p. 5).

For some students, the simulation left a lingering effect, to the extent that it provoked uncomfortable memories and '*triggered little emotions*.' This was evident in Kim and Susan's excerpts, when they reflected on the aftermath of the simulation. Staying and being with the bereaved couple brought to the surface their own personal experiences of grief and loss and the re-living in private, unresolved memories of their own loss and those of close relatives. Halperin et al. (2011, p. 392) stated that stressful childbirth situations are often marked by temporal and spatial dimensions, in that they begin and end at a specific time and place (i.e., a labour room or a bereavement room), which can '*spill over'* into midwives' personal lives and challenge their sense of professional competency and identity. The intensity of these unhappy experiences can stimulate powerful overwhelming emotions and memories for healthcare professionals across many disciplines, particularly involving perinatal loss (Gandino, Bernaudo, Di Fini, Vanni, & Veglia, 2019; Minooee, Cummins, Sims, Foureur, & Travaglia, 2020). Often these emotions are quite labile and unpredictable and if grief and trauma caused by these events is not processed and supported appropriately, then healthcare professionals are at risk of developing symptoms of complicated grief (Zsák, Dömötör, & Hegedűs, 2019).

This again highlights the need for universities to recognise the trauma response and to consider how this can be addressed throughout the curriculum. Embedding effective educational strategies like simulation and additional psychological support in the form of compassionate mind training, can help mitigate against the psychological adverse effects of compassionate fatigue (Beaumont et al., 2016). A quantitative survey investigating the relationship between self-compassion, a professional quality of life, compassion for others, and wellbeing in student midwives, concluded that compassionate mind training and mindfulness within undergraduate midwifery curricula could potentially enable students to develop self-compassion, empathy for their own suffering and cope with the emotional 'cost of caring' that accompanies 'being-with' a woman experiencing perinatal loss (Rice & Warland, 2013).

5.1.2 Super-Ordinate Theme Two: 'Trying to console and making things easier'

The death of a baby is a deeply traumatic situation and completely alters the dynamics of a situation that was initially anticipated as the birth of a live healthy baby. This can impact on the nature and flow of verbal and non-verbal communication and the establishment of an effective trusting relationship between the midwife and the grieving parents. It can therefore have a detrimental effect on their psychological well-being and the adjustment to the loss (Murphy & Cacciatore, 2017; Siassakos et al., 2017).

It is imperative therefore that healthcare professionals have excellent communication skills to enable them to respond compassionately and meet the needs of the bereaved parents, as outlined in the NMC Code of Professional Standards. In this theme, the students perceived communicating with the bereaved couple particularly challenging, which somewhat conflicts with the expectations detailed in the NMC Code (Nursing and Midwifery Council, 2018). Several of the students expressed the difficulty of not knowing what to say in these difficult circumstances and talked about *'treading carefully'* and '*not wanting to put her foot in it*' (Susan: P2: L10-12). These quotes illustrate the concerns students have about knowing what to say and their worry about saying the 'wrong thing'. A qualitative study exploring student midwives' experiences of caring for women with perinatal loss found that a student's perception of their inability to communicate effectively with bereaved parents incurred feelings of self-doubt (Alghamdi & Jarrett, 2016; Brunt, 2020). Similarly, Agwu Kalu, Coughlan, and Larkin (2018) found that midwives struggled to communicate with parents due to their need to provide significant and varied emotional support and having to cope with their own emotional responses to the situation.

The findings in this study, however, indicate that despite the students' struggles to 'find the right words', they acknowledged the importance of having a presence and of responding to verbal and nonverbal forms of communication. They referred to the importance of body language, 'picking up on vibes', and the use of silence as a way of offering comfort and support.

The students in this study described ways of caring that were not only important for the grieving couple, but also a way of creating an emotional connection with them, which is the essence of compassion and fundamental to the midwifery philosophy of 'being with' the woman (Hunter, 2009; Way & Tracy, 2012) .The concept of being close and present illustrates the students' sensitivities to the importance of just '*being there'* and having a '*conscious presence'*. This creates a '*holding space'* (not necessarily a physical space), which in this case enabled the students' *to act as guardians so parents feel psychologically held and supported in their grief* (Lemay & Hastie, 2017, p. 112). Lemay and Hastie (2017) also stated by 'being there' and 'holding the space', midwives have the opportunity to transcend the clinical and practical aspects of practice and convey a compassionate and therapeutic response to the parents.

These findings are consistent with previous research, which demonstrates the benefits of using simulation to enhance students' communication skills and providing physical and psychological support to families in paediatric and perinatal bereavement care situations (Bailey & Bishop, 2017; Cole & Foito, 2019; Colwell, 2017). For the students in this study, learning through simulation enabled them to engage in the cognitive, psychomotor, affective domains of learning (Hamilton & Morris, 2012). It also stimulated a process of reflection and self-reflection, which empowered them to acquire new knowledge, values and skills, and engage in a form of professional support that goes beyond task-orientated care (Fernández-Basanta et al., 2020). This again, complies with phase 9 of Mezirow's theory, which suggests that once learners encounter a disorientating dilemma like perinatal loss, it gives them the confidence to try out new roles and behaviours and incorporate these changes into their practice, which is key to the process of transformative learning (Morris & Faulk, 2012).

As indicated above, the importance of 'being with' the woman was a significant feature for many of the students in this study. However, whilst the students expressed the need to acknowledge and validate both parents' grief, there was a sense that the emphasis was always on the bereaved mother because '*obviously*

she's carrying the baby and she's going through all the giving birth and everything, (Gayle: P5: L118-121) meaning that the father was forgotten.

A consistent theme in the literature, is that women are 'culturally positioned' as more connected to the baby (Bonnette & Broom, 2011). In some cases, the lower levels of emotion displayed by men can be interpreted as a 'form of grief suppression' (Burden et al., 2016), which conforms to society's expectations about 'being a man' and the social pressure to remain strong and stoical (Jones et al., 2019). Lang et al. (2011) reported that a significant cause of stress for men is the ambiguity around their paternal role. Furthermore, Cacciatore, Erlandsson, and Rådestad (2013) found that men experienced the death of their baby as highly traumatic, resulting in a profound sense of loss and helplessness. In an effort to contain and cope with the loss, they often remained silent about their grief and anxiety and in some cases resorted to maladaptive behaviours, such as increased alcohol consumption (Jones et al., 2019). Thus, being validated and acknowledged as a grieving parent and not merely as a 'supportive partner' is an essential component of bereavement care.

A scoping review conducted by Jones et al. (2019) revealed that bereaved fathers felt 'overlooked' by healthcare professionals and this was attributed to midwives' uncertainty as to how to approach and support them. In this study, even though the students acknowledged that '*the woman is going through it physically'* (Ethel: P7: L214), the simulated experience provided them with a deeper awareness of the need to involve the father and offer him the same level of emotional support. These findings illustrated the students' attempts to connect with the father by also being sensitive and attentive to his emotional needs as a grieving parent (Thelin, Lundgren, & Hermansson, 2014). Engaging fathers in important rituals, such as seeing and holding the baby, minimises the risk of them feeling '*emotionally side-lined in the grieving process*' (Bonnette & Broom, 2011, p. 259). It is also a powerful way of acknowledging their grief and helping them adjust to their loss (Jones et al., 2019).

These findings again highlight the benefits of simulation as an effective approach to teaching and learning non-technical skills. Moreover, they are consistent with the

Kirkpatrick, Cantrell, and Smeltzer (2019) simulation study, which found that providing students with the opportunity to engage in end of life simulated scenarios increases their knowledge, self-awareness of their own ability and overall performance of care, regardless of their previous end of life care experiences.

Throughout this theme, a significant source of anguish for the students was observing the doctor communicating contradictory information to the couple regarding the baby's viability. The students' responses and reactions indicated feelings of anger and frustration because they felt it gave the parents a sense of false hope. They were particularly sensitive to the fact that there was a lack of empathy, and they expected a healthcare professional to be more compassionate. This conflicted with their own values, beliefs and professional standards about treating people with '*kindness, respect and compassion'* as outlined by the NMC (Nursing and Midwifery Council, 2018, p. 25) and a possible cause of moral discomfort or distress (Bordignon et al., 2019; Oelhafen & Cignacco, 2020).

The term moral distress, is often used to describe feelings of anguish or distress, associated with ethical and moral issues occurring in practice (Foster, McKellar, Fleet, & Sweet, 2021). Moral distress in midwifery may be defined as '*a psychological suffering following clinical situations of moral uncertainty and /or constraint resulting in an experience of personal powerlessness.* (Foster et al., 2021, p. 2). Although research on incidences of moral distress are well explored in other health disciplines, including nursing, medicine, and pharmacy (Lamiani, Borghi, & Argentero, 2017), it is relatively unexplored in midwifery practice and often focused on one specific aspect of practice (Foster et al., 2021).

A sequential mixed-methods study exploring ethical and moral issues encountered by midwives in clinical practice found that questionable practices or situations that did not uphold the required professional standards incurred feelings of anguish and frustration. These reactions were frequently associated with moral distress and are pertinent to this study, as the students expressed feelings of anger, guilt, and powerlessness (Oelhafen et al., 2019). In the findings, they described it as '*so*

upsetting' particularly '*when the doctor delivers news you don't agree with' (*Andrea*:* P5: L:423-432*).*

These findings align with Littlemore et al's study(Littlemore et al., 2020), which investigated bereaved parents' experience of pregnancy loss in NHS trusts in England. The study found inconsistencies in the standards of communication between the bereaved and healthcare professionals and noted the impact of ineffective communication on the psychological adjustment to their loss including decisions around future pregnancies and experiences (Cullen et al., 2018; Siassakos et al., 2017).

The study highlighted the need for carers to be responsive and sensitive to their use of language and ways of communicating to the bereaved, and recognise the significance that a future life has been lost (Littlemore et al., 2020). Furthermore, when less experienced midwives observe situations involving a lack of interprofessional communication and professional competence, it can be a major cause of moral distress (Oelhafen et al. (2019). Midwives are vulnerable to moral distress, particularly in situations involving babies being removed at birth due to safeguarding issues (Marsh, Robinson, Shawe, & Gallagher, 2020), or ethical dilemmas such as late terminations, abortions and screening (Oelhafen et al., 2019). From a student midwife perspective, and within the context of stressful situations like stillbirth, the concept of moral distress seems relatively unexplored in undergraduate midwifery education (Oelhafen et al., 2019). However, similarities exist between the findings in this study and those of Borhani, Abbaszadeh, Nakhaee, and Roshanzadeh (2014), who highlighted that the impact of moral distress or discomfort can be so profound, it can result in feelings of helplessness, professional grief and sadness, and impact on an practitioner's professional position (Oh & Gastmans, 2015). In this case, the students felt they were left to '*pick up the pieces'*. Similarly, a qualitative study exploring moral distress in Australian midwives, concluded that the cumulative effects of being exposed to conflicting professional and practice values in practice, detrimentally impacted on their psychological well-being and left them powerless to advocate for families in their care (Foster, McKellar, Fleet, & Sweet, 2022).

Dirkx (2001, p. 65) argued that emotionally charged situations often give rise to a sense of self that seems '*ambivalent, contradictory and somewhat fragmented'.* However, through the process of conscious, rational, and self-reflective practices, learners can gain an understanding about 'these multiple selves' enabling them to make meaning. The students were able to 'embrace' the personal and professional dilemmas that caused them to feel personally and professionally displaced (James & Busher, 2013). This resulted in them questioning their underlying beliefs and assumptions about people, in this case other healthcare professionals' professionalisation, their values and the important role of caring (Damianakis et al., 2019, p. 2024). These findings confirm the importance of adopting a pedagogical philosophy and moral education within undergraduate curricula that encompasses care and caring practices (Noddings (2010). Therefore, transformative learning approaches combined with simulation enable students to rehearse and integrate ethical knowledge and affective attitudes and develop a sense of moral agency that will empower them to cope with similar issues they may encounter in the complex and chaotic environments of the clinical setting.

5.1.3 Super-Ordinate Theme Three: 'A unique learning experience'

The findings in this study suggest that, overall, the students found the simulation to be a positive and a beneficial learning experience. For many of the students, the experience afforded them the opportunity, to not only acquire knowledge, but also to gain an understanding about their own professional identity, their learning and how they responded to the bereaved couple, and whether that was helpful or not. Furthermore, even though the simulation challenged the students emotionally and created a sense of apprehension and uncertainty initially, through the process of self-examination, students were able to make meaning and explore a new set of expectations and perspectives about the reality of what it feels like to be in a stressful situation like perinatal loss. This further facilitated their transformative learning process (Damianakis et al., 2019).

Mezirow theorizes that, once learners experience a disorientating dilemma, it can trigger a 'deep structural shift' in their thoughts, feeling and actions (Mezirow, 1990b). However, in order for this to occur, it is crucial that students are afforded

learning opportunities like simulation that encourages them to actively engage in their learning and stimulates them to become independent, critical thinkers (Hamilton & Morris, 2012). Also, to enable students to become clinically proficient, educators need to create 'hands-on' meaningful and authentic learning experiences that reflect the complexity and ambiguity of the real clinical setting (Bland & Tobbell, 2016). To actively engage learners in simulation and apply that learning to the clinical setting, it is critical to design simulations that are real and authentic, and provoke feelings and emotions similar to that in a real-life situation (Choi et al., 2017; MacLean, Geddes, Kelly, & Della, 2019). For the students in this study, the realistic nature of the simulation proved to be of significance, as it induced a sense of presence, to the extent that they really felt they were in that situation.

These findings concur with previous studies, which suggests that physical, emotional, and contextual realism and a sense of 'being there' are critical attributes of simulation. These allow students to become fully immersed in the simulation, which ultimately helps to better improve learning outcomes than traditional methods of teaching (Dunnington, 2015; Hamilton & Morris, 2012; MacLean et al., 2019; Shin, Park, & Kim, 2015). Because of the interpersonal relationship inherent in midwifery, incorporating real actors who can display emotions and non-verbal forms of communication offers a way to ensure that students become proficient in the affective domain of learning (Kameg, Szpak, Cline, & McDermott, 2014). Other studies which suggested incorporating real people in simulation, argue that it has the potential to decrease a student's level of anxiety and increase their confidence thereby enhancing the therapeutic relationships with patients and clients. This helps to develop a broad range of competencies which resemble those encountered in a real clinical situation (Amod & Brysiewicz, 2019; Oh et al., 2015; Tamaki et al., 2019a).

However, as evident in this study, engaging students in simulation and encouraging them to act as if it was a real situation can be a challenge (Choi et al., 2017). Often, students experience some difficulty relating the simulation to a real clinical situation. This may depend on the learner's willingness to suspend their sense of disbelief and accept the realism of the situation (Choi et al., 2017). For example, one student

stated that the simulation did not affect her emotionally, as there was not a real dead baby. Although this view was not representative of the other students, it is an important aspect to consider. Whilst simulation can never fully replicate the reality of a situation, neither can it be so realistic to affect their concentration. It highlights the need to engage learners in the structure and content of the simulation and create scenarios that incorporate the physical, conceptional and emotional components, so they will engage sufficiently (Choi et al., 2017).

There are controversies in the literature as to whether simulated learning experiences impact on future clinical practice. This is mainly because few robust, empirical studies have explored the transfer of learning from university simulated experiences to the practice setting after graduation (Seaton et al., 2019). A small exploratory study that examined six graduate nurses' perceptions of how simulated learning experiences informed their practice three to six months post-graduation, indicated that patient assessment, leadership, and the promotion of patient safety, as '*lessons learnt'* from the simulated experiences (Bruce, Levett-Jones, & Courtney-Pratt, 2019, p. 22). The study concluded that barriers to the effective transfer of knowledge and skills included infrequent exposure to simulated experiences, which resulted in decreased levels of knowledge and poorer recall.

Similarly, a quasi-experimental study exploring the impact of repeated exposure to simulation on student nurses' (n=120) self-efficacy in relation to management of postpartum haemorrhage and acute pneumonia, reported a significant drop in self-efficacy levels following the first simulation (Al Gharibi, Schmidt, & Arulappan, 2021). However, over time, following repeated exposure using the same case scenario, there was a significant improvement in the students' knowledge, skills and application to practice. The authors concluded that gradual and repeated exposure to simulation using the same case scenario, is key to enhancing self-efficacy and the mastery of clinical skills. Within the context of midwifery education, repeated exposure to simulation with varying levels of complexity according to the learner's experience, is key to the effective transfer of skills to practice, particularly in relation to bereavement care.

However, it is important to establish that the specific aim of this study was not to measure the impact of simulation on clinical behaviour and transfer to practice. A significant finding was that the students perceived simulation as a '*stepping-stone'* to prepare them for similar events in practice. The students alluded to having the courage to know what to say and do in future situations. The students talked about the simulation enabling them to cope with the emotional aspects and how to provide comfort. They felt confident enough to be able to apply their skills to different situations. These findings suggest that changed attitudes and increased self-confidence seemed to influence transfer of their knowledge and competence to clinical practice. This adds to existing evidence on bereavement care simulation as an active learning approach to reducing students' anxiety and enabling courage and confidence in their ability to provide such care (Kirkpatrick et al., 2017; Venkatasalu et al., 2015).

Furthermore, despite the initial turmoil associated with perinatal death, analysis of the findings in this study illustrates how the experience of a stressful childbirth event can be a powerful stimulus for professional growth and learning. An interpretative, multiple case-study exploring midwives' experiences of caring and learning following a catastrophic event concluded that, despite the personal and professional heartache associated with these events, midwives still gain personal fulfilment and strength and a deeper insight of their personal competence and confidence to provide quality bereavement care (Laing, Fetherston, & Morrison, 2020). Findings from this study indicate the importance of experiential learning, debriefing, and critical reflection in enabling students to consider grief and loss from a wider and more complex perspective and to prepare them for the human experience of life and death in a real clinical situation. The students' perceived confidence in being able to incorporate changes into their practice and reconstruct their own identity as compassionate caregivers is indicative of transformational change and aligns with phases nine and ten of Mezirow's transformational learning framework.

As indicated earlier, the students' narratives indicated a significant change in their understanding and belief about grief and loss, and how to provide emotional support. The students attributed this to observing their peers and learning from them. This

corresponds to Bandura's social learning theory, which suggests that learners gain valuable insights and confidence through observing and role modelling the behaviours of others (Bandura, 1986). It also confirms the powerful impact of peer learning within this simulation. By witnessing positive caring attitudes and practices, such as cultural sensitivity, compassion and emotional intelligence, simulation has the potential to transform students' awareness of the importance of caring that will enable them to become competent, caring practitioners in the future; this underpins the principles of moral education (Foronda et al., 2018; McKinley & Phitayakorn, 2015; Noddings, 2010). These findings also concur with (Lave & Wenger, 1991) concept of situated learning. They stress the importance of students participating in authentic learning experiences. Learning through dialogue and engaging with others in a 'community of practice' can initiate a change in perspective and shape their understanding by challenging their existing views and opinions, and creating new knowledge through critical reflection (Brookfield, 2010; Mezirow, 1990b). Furthermore, Oates et al.'s (2020a, p. 5) descriptive qualitative study on students' well-being, concluded that students value opportunities to engage and reflect with their peers, which creates a '*a sense of a shared journey*'. This encourages feelings of belonging and connectedness (Bass et al., 2020), and according to Taylor (2007), such conditions enable transformative learning to occur.

As discussed throughout this thesis, caring for bereaved parents is a clinical reality for many students and healthcare professionals and incurs an enormous level of emotional pain for all concerned. Whilst simulation can never fully capture the true reality of grief and loss, for the students in this study, it offered a 'unique learning experience'. They described simulation as very different to sitting in a classroom and '*just talking about it',* which suggests that didactic methods of teaching alone are not particularly effective in preparing students for end-of-life care (Venkatasalu et al., 2015). The dynamic experiential nature of learning through simulation provided the students with a belief and sense of self-efficacy in their ability to embrace similar challenging situations in the future. These findings also align with (Bonanno, 2019) work on resilience and people's capability to cope despite experiencing adverse traumatic events in their lives. For the students in this study, even though the scenario posed some challenging concepts about grief and loss, their narratives

revealed a determination to improve their practice, ‘get it right’ and make a positive impact on the future lives of bereaved parents. According to Bonanno (2019), these beliefs and attitudes signify a transformational growth in resilience and facilitate a transition to capable, kind, compassionate caregiving.

As suggested earlier in the thesis, there is a concern that if students are not offered opportunities to emotionally process emotive and complex events like death, then as future midwives they may not be competent in fulfilling their role in providing compassionate care to bereaved parents. Considering the emotional nature of midwifery and the tragedies they may encounter in practice; it is imperative that future midwifery curricula is underpinned with trauma-informed care specific to perinatal loss and incorporates simulation as an adjunctive to prepare students to provide relational caregiving to grieving parents and their families.

Chapter 6: Conclusion

The discussion chapter situated the findings of the study within the context of the wider literature. Mezirow's transformative learning theory was used as an underpinning theory to illustrate how the students changed their world view about bereavement care involving perinatal loss, and how they made meaning from that experience. This chapter will now draw together the conclusions by addressing the aims of the research and outlining the implications and recommendations for undergraduate midwifery education and practice.

The initial aims of the research were:

- To understand the meaning making and learning processes that student midwives undergo from participating in the simulation.
- To gain insight as to how simulation facilitates a transformative change in students' perspectives about grief and loss.
- To explore student midwives' perceptions of simulation as a model of teaching and learning in preparing them for future clinical practice.

These aims were addressed by exploring nine student midwives' experiences of bereavement simulation using an in-depth, idiographic, interpretative phenomenological approach. Whilst this study corresponds to existing literature on the use of simulation in healthcare education, the research contributes to and extends the existing body of evidence around the use bereavement simulation, within an undergraduate midwifery curriculum. It has also provided a more in-depth understanding and insight as to how students experience the provision of emotional support to grieving parents and potentially develop coping strategies that enable them to cope with similar experiences in future practice.

Chapter 1 outlined the research problem by offering a contextual overview of the challenges that student midwives - and other healthcare professionals - experience when they encounter bereaved parents for the first time in clinical practice. In addition, the negative psychological sequelae associated with perinatal loss from a parental and professional perspective were discussed, which provided a clear

rationale for better education and training around bereavement care, particularly within undergraduate midwifery education.

The literature review in Chapter 2 further addressed the research aims by providing a critical discussion of the methods used to teach student midwives about bereavement care. The review highlighted considerable variations in the mode and delivery of bereavement education within undergraduate midwifery curricula. The literature review also identified a paucity of good quality evidence, relating to the use of simulation and perinatal loss. There was a distinct lack of literature that incorporated deeper analysis as to how student midwives made sense of complex clinical experiences, such as perinatal loss, and the effectiveness of experiential forms of learning (such as simulation) to equip them with the skills to provide compassionate care to bereaved parents. Considering the gaps identified in the literature and to gain a deeper understanding of student midwives' experience of simulation, it was necessary to choose a methodological approach that would enable deeper analysis, Therefore an IPA approach was deemed appropriate to explore the complexity of the 'lived' experience associated with grief and loss involving perinatal death (Smith et al., 2009).

Chapter 3 provided an account of the detailed, systematic engagement with the data and the generation of themes, which captured the emotional perplexity of the students' lived experience. The idiographic nature of IPA illuminated the richly detailed, nuanced accounts of the 'lived' experiences of the student midwives, empowering them to have a voice in a context that is relatively unexplored. By staying close to the students' accounts and constantly shifting back and forth through the data, in accordance with the hermeneutic circle, a credible and emotional account was formed on the meaning of the experience from a number of perspectives (Smith et al., 2009). Chapter 3 also detailed the comprehensive approach to the recruitment strategy, the interview process, and ethical considerations. Moreover, to provide transparency and credibility to the study, the researcher's role as a lecturer, personal tutor, and IPA researcher with prior experience of fetal loss was also acknowledged by using reflexivity.

Chapter 4 presented the findings and my interpretation of the lived experiences of the nine student midwives' involvement in the bereavement simulation. Each of the themes and sub-themes were presented as a transparent and plausible account, which contextualised my interpretation of the students' interpretations of the 'lived' experience of bereavement simulation. As recommended by Smith et al. (2022), the researcher attempted to provide a cross-case analysis of both the unique and shared features of the simulated experience for each of the contributing students

The first theme - '*a rollercoaster of emotions'* - highlighted the myriad of emotions the students experienced during the simulation. This theme correlated with phase one of Mezirow's transformative learning cycle, whereby the students encountered a disorientating dilemma, namely the death of a baby. This exposed students to the sudden unexpected death of a baby and the strong emotional reactions from the grieving mother. The students' narratives captured strong feelings of emotional vulnerability and apprehension about not knowing what to expect. The depth and range of emotion experienced by the students within this simulated context has not been previously identified in the literature. Moreover, the findings revealed that prior exposure and familiarity with the simulated environment (with varying degrees of complexity) can help to alleviate anxiety and apprehension for future situations.

The second theme - '*what words can I say*' - explored the students' anxieties about communicating with the bereaved parents. Their struggle to communicate with the bereaved parents and the need to 'find the right words' was clearly articulated. The students' accounts illustrated deep concerns about their adequacy in the role and confidence in their ability to provide emotional support. Their narratives revealed a strong urge to try and console the bereaved mother; however, in doing so they almost 'forgot' about the needs of the grieving father. For the students, this was aligned to some cultural and stereotypical beliefs about men and grief, which lacked acknowledgement of the level of support that grieving fathers could need. This theme also elaborated the challenges that seemed to threaten the students' sense of professional identity.

The third theme - ‘a *unique learning experience’* - highlighted how the students valued their learning experience and how this was enhanced by creating an authentic realistic situation that reflected a real clinical situation. The application of Mezirow’s framework to analyse the data and through critical reflection demonstrated a change in the students’ frame of reference (habit of mind), as they identified the changes they would incorporate into their future practice. This confirms the powerful transformational impact of simulation in emotionally preparing students to care for bereaved parents.

Chapter 5 provided a comprehensive discussion of the findings of the study in relation to existing literature. This chapter also presented a broad contextual understanding about the complexity of grief and loss from the students’ perspectives and the important role of simulation in making a significant contribution to preparing them for similar traumatic events in clinical practice.

6.1 Strengths of the study

As alluded to earlier, a key strength of this study, is that it advances the body of evidence in relation to using simulation to teach student midwives about bereavement care involving perinatal loss. Even though the NMC standard framework for Nursing and Midwifery Education (Nursing and Midwifery Council & 2018) stipulates that simulation should be integrated throughout a programme, there is no specific reference to bereavement care. To date, this is the only UK study conducted within a university in the Northwest of England that has used this model of bereavement education. Therefore, it is recommended that simulation is incorporated to complement existing methods of teaching and learning on bereavement care.

Another significant strength of the study is that it provided insight into the students’ depth of emotions and feelings about grief and loss. The application of Mezirow’s transformative learning theory enabled the students to reflect and make meaning of the experience which in turn provided them with a new perspective about death and dying. Utilizing IPA as a methodological approach provided a rich, deeper level of analysis that encompassed the linguistic, affective, and physical state of the students

and explored what that experience felt like for them overall (Charlick et al., 2016). In their narratives, the students attempted to convey the embodied experience of their emotions through metaphor. Few studies explore the subjective and embodied nature of emotions from a student midwife's perspective through the phenomenological and hermeneutic strands of IPA. Therefore, bereavement simulation provides a context in which students can express and process these emotions. This can positively help to prepare them for practice and improve the quality of care that bereaved parents will receive. Therefore, it is recommended that the midwifery curriculum utilizes the components of simulation, including debriefing and reflection, to create a sense of security so that students feel sufficiently safe and nurtured to voice their feelings and concerns.

This study also reaffirms the evidence that obstacles to high quality bereavement care include inconsistencies in the way bad news is communicated to bereaved parents (Ockenden, 2022). The bereavement scenario provided the students with a holistic overview of the continuum of care. The students were able to observe and experience the parents' journey through a series of sequential scenes with increasing complexity, from the initial diagnosis of the baby's death through to aftermath of the birth and seeing and holding the baby. The realism of the simulation enabled the students to enact their role as if it were a real-life clinical situation and to carefully plan how they would communicate effectively and responsively with the parents at critical points throughout the scenario and apply this to future practice. Throughout the simulated scenario, the students also witnessed the intensity of grief of both parents. It also provided them with a deeper insight into the cultural and stereotypical beliefs about fathers and grief. Understanding the unique experiences of grief and loss from both parents' perspective can positively impact on student midwives' practice and provide support both parents along their journey through grief. Therefore, it is recommended that using standardised patients, who are given specific themes to enact and portray the realistic emotions of grieving parents, is key to enabling students to reflect on the experience of being in that situation.

6.2 The Limitations of the Study

Having identified the strengths, it is important to discuss the limitations identified within this small-scale study. Firstly, the study was conducted in one university in the Northwest of England. The sample size consisted of nine female student midwives, who were mainly white, British, and aged between 20 and 35 years. The students' prior experiences of death and dying were not considered and how this could impact on the simulation experience. These factors could limit the transferability of the findings to other healthcare students, including male students and those from more diverse cultural and gender groups. Therefore, future research should be conducted involving students from a variety of disciplines and demographics.

Another limitation of the study related to the overlap between my role as the researcher and a midwifery lecturer. In qualitative research, this can be considered both a strength and a limitation (Harvey & Land, 2022). Firstly, I felt that in knowing the students from the start, I had already established a good rapport with them. This helped them to feel at ease and to speak openly and honestly how they felt about the simulation. However, a potential limitation was that the students may have provided socially acceptable answers, as they may have felt pressured to respond appropriately to me as the researcher. However, to overcome these potential biases, I used reflexivity throughout to illustrate transparency and rigour in the data collection and analysis process, and the presentation of the findings which acknowledges the relational and inter-subjective nature of IPA research

Finally, the students volunteered and self-selected to participate in the study, which indicates that the students already had a keen interest in learning more about bereavement care. Therefore, it is difficult to conclude that the findings truly represent the voice of all students. Furthermore, given the subjective nature of IPA as a methodology, it is possible that if the same students were to be interviewed again by a different researcher, they may offer a different narrative and have a different recollection as to how the experience of being a student in that context felt.

6.3 Recommendations for midwifery education

In this section, I will now summarise the recommendations from the study findings and the implications for midwifery education, practice, and research. At the time of writing this section, the Final Report of the Ockenden Review into the adverse outcomes experienced by families in one hospital trust in England, has been published (Knight & Stanford, 2022; Ockenden, 2022). The reports call for a radical extensive change to maternity services to ensure that women and their families receive optimal safe and quality care throughout their maternity journey. A key recommendation from the report is the important role of education in affecting behavioural change and supportive learning environments and to enable healthcare professionals to develop their skills and capabilities confidently. Therefore, as educationalists, it is important that we respond to the issues raised in the report and prepare students appropriately to ensure safe, effective care.

In relation to the findings from this study, there are inconsistencies and no standardised approach to bereavement education within undergraduate midwifery education, both nationally and globally. The result is that students feel ill-prepared and anxious when they encounter bereaved parents for the first time (McKenna & Rolls, 2011). Throughout all undergraduate midwifery programmes, it is recommended that increased exposure to simulated scenarios, with varying degrees of complexity, will ensure that students develop the full scope of midwifery knowledge and skills to provide holistic, compassionate care to bereaved parents Moreover, in line with the Nursing and Midwifery Council standards framework for nursing and midwifery education ((Nursing and Midwifery Council, 2019)(standard:6.69.7), it is recommended that students understand the additional care needs of women and their families. Therefore, introducing the concepts of grief and loss at an early stage in the curriculum and prior to students' first clinical placement, may help emotional preparedness and reduce their anxiety in such situations.

A series of reports investigating maternity services highlighted poor communication as a major source of distress for bereaved families and this has contributed to substandard care, resulting in adverse outcomes and maternal deaths for many

women (Kirkup, 2015; Knight, 2022; Ockenden, 2022). In this thesis, the students highlighted concerns about managing difficult conversations and knowing what to say at temporal moments (before and after the diagnosis) in the simulation. Therefore, it is imperative that educators facilitate the development of effective communication skills throughout the BSc midwifery programme. It is recommended, that bereavement simulation incorporates professional actors, with training in advanced communication skills, to replicate the reality of the situaton. It is also recommended that a structured model of debriefing is used and that debriefing occurs at critical points in the scenario to help students to reflect on the emotional impact of the parents receiving bad news.

In line with the recommendations of the Ockenden report, it is important that students are provided with sufficient time to reflect on and express their emotions in a physically and psychologically safe environment. Therefore, it is essential that the undergraduate midwifery programme is embedded with opportunities to engage in restorative clinical supervision with a professional midwifery advocate to enable them to personally reflect on issues that matter to them and to enhance their professional growth and sense of agency (NHS, 2017).

6.3.1 Recommendations for Midwifery Practice

The lack of exposure to perinatal grief and loss experiences in practice can be addressed by integrating bereavement education using simulation into the curriculum, to ensure emotional preparedness for practice. The Health Education England Work Experience Quality Standard Framework explicitly states that students in clinical practice should be appropriately supervised and have opportunities for reflection and debriefing (Health Education England, 2022). Therefore, clincal exposure to critical clinical incidents events should ensure that students are well supported and receive adequate supervision and debriefing to mitigate against any long term psychological and emotional trauma associated with these events. It is also recommended that students involved with caring for women experiencing adverse outcomes are allocated to either an experienced midwifery supervisor or a bereavement specialist midwife who has the required knowledge and skills to

provide emotional support, guidance and access to timely, formalised debriefing following the event.

Finally, it is recommended that students have exposure to alternative clinical bespoke placements that include paediatric bereavement care settings in order to enable students to understand and develop knowledge of the concepts of grief and loss from a variety of perspectives.

6.3.2 Recommendations for Midwifery Research

There are a limited number of studies that specifically address bereavement care simulation and perinatal loss involving student midwives. This highlights the need for further qualitative research and longitudinal studies evaluating students' experiences, such studies could determine whether this results in increased emotional preparedness for practice, and improvements in care for bereaved parents in the long term.

Further research is also needed to evaluate the extent to which bereavement simulation results in a changed or altered perspective in students' beliefs, assumptions and attitudes towards grief and loss. Moreover, there is a paucity of evidence exploring the involvement of service users from different cultural and ethnic backgrounds in bereavement simulation. In line with the NMC educational standards, it is recommended that future research explores students and service users' involvement in the co-production, design, development, and facilitation of scenarios on bereavement care. The involvement of service users as observers in bereavement simulation is an aspect that is also relatively under researched. Therefore, it is recommended that further research is undertaken involving service user involvement in debriefing students in simulation.

Finally, the NMC Standards of Proficiency (Nursing and Midwifery Council, 2019) stipulate the importance of resilience in the development of future midwives. However, there is limited research on how effectiveness of bereavement care simulation in developing this attribute. Therefore, further research is warranted to explore the effectiveness of simulation in the development of resilience in undergraduate midwifery students.

6.4 Reflection on my Doctoral Journey

The following section will provide a critical reflection on my personal and professional development throughout my doctoral journey. Undertaking this doctoral thesis has been a huge learning curve for me and throughout my time studying. I have kept a reflective diary to help me process my thoughts and feelings along the way. Reflecting on my doctoral journey, I acknowledge that this undertaking has at times, been both challenging and inspirational. Like other doctoral students, I found it hard to balance my professional commitments as a midwifery lecturer, alongside finding the time and motivation to conduct the research.

I also found the doctoral journey quite solitary, which is not uncommon for many doctoral students (Kearns & Gardiner, 2006). At times this sense of isolation negatively impacted on my personal motivation to continue with the study. At one point, early on in my research journey, and particularly during the pandemic, my motivation completely disappeared and I resorted to self-handicapping (stalling) behaviours, such as procrastination or attending to low priority tasks as a form of distraction and avoidance, which I knew could compromise the quality of my thesis and timely submission (Schwinger & Stiensmeier-Pelster, 2011). In a qualitative survey of 29 British doctoral students, Wellington and Sikes (2006) found that the demands of doctoral study, combined with difficult decisions regarding social and family responsibilities can contribute to feelings of social isolation. This can have a detrimental impact on doctoral students' psychological health and well-being. Existing research exploring doctoral students' well-being, reported high-stress levels combined with a lack of time, motivation, and the demands of family life can negatively affect students' academic motivation, self-esteem and successful completion of their studies (Sverdlik, Hall, McAlpine, & Hubbard, 2018).

In relation to my doctoral journey, I knew that striking a balance between my academic work and my personal life was critical to successful completion of this thesis. Sverdlik et al. (2018) stressed the importance of adopting learning communities in postgraduate research departments, in which doctoral students can collaborate and exchange ideas with other students and receive emotional and social support. Research by McAlpine, Jazvac-Martek, and Hopwood (2009)

concluded that engaging doctoral students in a variety of social events and activities, including research and writing workshops, can generate a sense of academic identity and belonging, which can greatly enhance their professional growth and development. Therefore, to support me in my academic learning journey and to help me to keep focused on both my personal and professional drivers to conduct this research, particularly during the Covid-19 pandemic, I attended a series of research and writing workshops and online IPA forums provided by the University of Salford and the University of Derby.

Engaging in these activities with other doctoral students enabled me to explore a variety of methodological approaches and actively encouraged me to address my epistemological position and assumptions about the nature of knowledge. Epistemological reflexivity is a key feature of qualitative research and involves the researcher examining their own beliefs about knowledge and how that may influence all stages of the research process (Engward & Goldspink, 2020). Therefore, having attended these IPA research workshops, I gained insight about the importance of the researcher being accountable for the research they undertake and the role of reflexivity in '*formalising this accountability* '(King et al., 2018, p. 181).

To support me in the process of reflexivity, I used journaling as a way of documenting my thoughts and reflections to support my analysis. I found that simply writing down these thoughts helped me to consider my position within the study and how this would influence the co-creation of knowledge and findings that would emerge from the interviews with the students. I also considered how that would influence future practice and care of bereaved parents (King et al., 2018). I frequently revisited my journal diary taking note of my original thoughts and feelings and found this process useful as it helped me envisage how my study would evolve, take shape, and steer it in the right direction.

Fulton, Kuit, Sanders, and Smith (2012, p. 134) suggested that a key objective of a professional doctorate is personal transformation, as it enables the researcher to view their profession and practice with a '*fresh lens'*. As an experienced midwife and lecturer, undertaking this PhD provided me with greater insight into student

midwives' experiences of caring for bereaved parents and their stories provided some new and interesting perspectives. Having extensively researched around this topic and after considering the findings of the Ockenden report, I now feel strongly positioned to influence many aspects of my role in relation to the education, training and support for student midwives experiencing these traumatic events in practice, with the aim of transforming the culture of care for bereaved parents in the future.

APPENDICES

Appendix 1: Ethical approval

Research, Enterprise
and Engagement
Ethical Approval Panel
Date:27/11/2017

Research Centres Support Team 2
G.03 Joule House
University of Salford
M5 4WT
T +44(0)161 295 2280
www.salford.ac.uk/

Dear Anne,

RE: ETHICS APPLICATION–HSR1617-188 – 'The experiences of student midwives participating in bereavement simulation: An Interpretive Phenomenological Study.'

Based on the information that you have provided, I am pleased to inform you that application HSR1617-188 has been approved.

If there are any changes to the project and/or its methodology, then please inform the Panel as soon as possible by contacting Health-ResearchEthics@salford.ac.uk

Yours sincerely,

Stephen Pearson
Deputy Chair of the Research Ethics Panel

Appendix 2: Bereavement simulation study invitation letter

Be part of an important bereavement research study

- *Are you currently a first- or second-year student midwife or a Post RN midwifery student?*
- *Are you interested in taking part in a study about bereavement simulation?*

If you answered YES to these questions, you might be interested in participating in my research study

The purpose of the research study is to explore student midwives' experiences of participating in bereavement simulation. I am interested in finding out about your views and opinions of bereavement simulation as a method of teaching and learning

This study will be conducted at the University of Salford Simulation Suite, once I have enough, I will clarify dates and times for you.

Thank you for taking the time to read this.

If you are interested and would like further information, please contact on the following options below to arrange an informal discussion

Anne Leyland, Email: e.a.leyland@salford.ac.uk, Phone; 0161-295-2512.

Yours sincerely

Anne Leyland

Lecturer in midwifery

Mary Seacole Building.MS 3.46

Appendix 3: Participant information sheet

Title of study: The experiences of student midwives participating in bereavement simulation: An Interpretive Phenomenological Study

Name of Researcher: Anne Leyland

Invitation paragraph

Dear Students,

You are being invited to take part in a research study. The study is about your experiences of bereavement simulation. Before you decide to do so, it is important that understand why the research is being done and what it involves. Please read this information and take your time to decide whether you wish to take part or not. The information below provides an overview of the intended study and your rights as a participant if you do decide to take part.

What is the purpose of the study?

As a PhD student, I am particularly interested in bereavement education and the use of simulation as a teaching method. Simulation is well explored in nursing literature but the its value in relation to bereavement care in midwifery is relatively under researched. My aim in this study is to explore your experiences of participating in bereavement simulation and how effective it might be as a method of teaching bereavement care.

Why have I been invited to take part?

You have been invited to take part as I value your views about participating in bereavement simulation. I have selected students on the undergraduate midwifery programme as you will be able to provide me with the information relevant to the aims of the study. The sample group will be a total of a volunteer group of 8-10 student midwives.

Do I have to take part?

Taking part in this research is entirely voluntary and it is up to you to decide. I will provide you with an overview of the study and go through the information sheet which I will give to you. You will then be asked to sign a consent form to show you agree to take part. You are free to withdraw from the study at any time; there is no need to provide a reason. In the event of withdrawal, any data provided will not be used and will subsequently be destroyed.

What will happen to me if I take part?

If you agree to take part, I will need to interview you on a one to one basis after the simulation and within the week following the simulation. I envisage the interviews may last 45-90 minutes. The research approach is Phenomenology which is about your experiences of participating in bereavement simulation

Expenses and payments / Time allocated?

Participation in the study is voluntary. **You will be allowed time to undertake this study** and I will sign your PARE documents. However, as a researcher I will not be able to compensate for travelling expenses or childcare whilst participating in the study.

What are the possible disadvantages and risks of taking part?

The research study may discuss or explore sensitive issues about infant loss, and this may cause you to become upset or emotional. I have arranged for counselling services to be readily available should you require some debriefing or if you feel you need to discuss any issues that may have arisen from the simulation. I have also arranged for personal tutor support to be available on the day the interviews are being conducted. A team of lecturers are now training to be Professional Midwifery Advocates and they are also available for additional support. The University has a Counselling and Well-being Service that is readily accessible for students.

What are the possible benefits of taking part?

There is no absolute guarantee that participating in the study will help you directly, but the information that is gained from the study will increase our knowledge and understanding about the use of simulation for teaching bereavement care. It may however assist you in learning about different

What if there is a problem?

However, if you remain dissatisfied, please contact Dr Susan McAndrew, Chair of the Health Research Ethics Panel, Room MS1.91, Mary Seacole Building, Frederick Road Campus, University of Salford, Salford, M6 6PU. Tel: 0161 295 2778. E: s.mcandrew@salford.ac.uk

Will my taking part in the study be kept confidential?

If you agree to take part, I wish to assure you that all your details will be anonymous, and all information will be stored in a secure, locked cupboard only accessible by the researcher. All audio-recordings, interview transcripts and any electronic data will be secured and only accessible by a secure password known only to the researcher.

What will happen if I don't carry on with the study?

Any information collected from you to date will be removed. Any audio-recorded interviews or any forms of identity will be automatically destroyed.

What will happen to the results of the research study?

Participants often wish to know the results of the study in which they were involved. The findings of the study will be disseminated in my thesis, conference papers and journal publications. **You will not be identified in any way either by name or location** unless I gain your consent.

Who is organising or sponsoring the research?

There is no organisation sponsoring or funding this research.

Further information and contact details:

The following is a list of support services that are available in the event of any issues arising because of taking part in the study.

Wellbeing and Counselling Services available on 0161-295 0023 / Well-being@salford.ac.uk

Here To Help: A local service in Salford. Open until 20.00hrs. 0161-883

Appendix 4: Consent form

CONSENT FORM

Title of study: The experiences of student midwives participating in bereavement simulation: An Interpretive Phenomenological Study

Name of Researcher: EAL

Please complete and sign this form after you have read and understood the study information sheet. Read the following statements and select 'Yes' or 'No' in the box on the right-hand side.

1. I confirm that I have read and understand the study information sheet, version dated *02/05/18* for the above study. I have had the opportunity to consider the information and to ask questions which have been answered satisfactorily. Yes/No

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without my rights being affected Yes/No

3. If I do decide to withdraw, I understand that the information I have given, up to the point of withdrawal, will be used in the research. The timeframe for withdrawal is 4 weeks Yes/No

4. I agree to participate by *being interviewed on a one-to-one basis.* Yes/No

5. I understand that my personal details will be kept confidential and will not be revealed to people outside the research team. *However, I am aware that if I reveal anything related to criminal activity and/or something that is harmful to self or other, the researcher will have to share that information with the appropriate authorities].* Yes/No

6. I understand that my anonymised data will be used in *the researcher's thesis/research report. I may wish to publish in peer reviewed journals and present at conferences.* Yes/No

7. I agree to take part in the study: Yes/No

_____ _____ _____

Name of participant Date Signature

Appendix 5: Critical appraisal of core papers

Author	**Was there a clear statement of the aims / rationale of the research?**	**Was the research design appropriate to address the aims of the research?**	**Was the sample /recruitment strategy appropriate to the aims of the research?**	**Was the data collected in a way that addressed the research issues?**	**Was relationship between researcher & participant been adequately considered?**	**Have ethical issues been taken into consideration?**	**Was the data analysis sufficiently rigorous?**	**Is there a clear statement of findings/ comprehensive discussion/ conclusion?**	**MMAT Score**
1.Foster and Donovan (2017);Australia	Aim is clearly stated / gap in evidence noted	Yes	Yes	Yes	Not stated	Yes- ethical approval sought	Yes- using Charmaz's approach of coding and categorising	In	75% - reflexivity/ researcher influence not stated
2.Cole, M. A& Foito, K. (2019);USA	Yes / aim - clear comprehensive overview of previous studies	yes	Yes	Yes	Not stated	Not stated – session was conducted as part of curriculum	Method of data analysis not clearly outlined – no data analysis framework applied	Yes – main findings credible / discussed.	50% - researcher's influence unclear Ethical approval not stated

3.Bailey & Bishop (2017); USA	Aim not clearly stated / prior literature showed gap in knowledge	Research design unclear	Yes	Partly	Not stated – pre-briefing clearly outlined	Not stated	Method of data analysis not clearly outlined – no data analysis framework applied	Findings briefly discussed / study addresses the gap in evidence and practice	50% - researcher's influence unclear
Author	**Was there a clear statement of the aims / rationale of the research?**	**Was the research design appropriate to address the aims of the research?**	**Was the sample / recruitment strategy appropriate to the aims of the research?**	**Was the data collected in a way that addressed the research issues?**	**Has the relationship between researcher & participant been adequately considered?**	**Have ethical issues been taken into consideration?**	**Was the data analysis sufficiently rigorous?**	**Is there a clear statement of findings / comprehensive discussion / conclusion?**	**MMAT SCORE**
4.Colwell (2017); UK	Yes- Aim clearly stated	Yes	Yes	Yes	No	Yes	No – study mainly relied on self-report measures No standard instrument used	Yes	60%
5.Barry et al (2017); Ireland	Yes - Aim is clearly stated	Yes	Yes – small sample size (n=6)	Yes – clearly outlined measuring tool	No	Yes – ethical approval obtained	Yes – using Burnard's (2006) content analysis framework	Yes	75%- Influence of researcher not stated / small sample
6.Patterson et al (2016);UK	Yes – clearly stated	Yes	Yes	Yes	Yes	Ethical approval obtained	Data analysed using content analysis	Yes	75%- Reflexivity not stated / researcher's influence not stated

7 Sorce & Chamberlain (2019) USA	Yes	Yes	Yes	Validated measuring tool reused	N/A quantitative study	Yes	Yes	Comprehensive discussion and recommendations for practice	100%

Author	**Was there a clear statement of the aims / rationale of the research?**	**Was the research design appropriate to address the aims of the research?**	**Was the sample / recruitment strategy appropriate to the aims of the research?**	**Was the data collected in a way that addressed the research issues?**	**Has the relationship between researcher & participant been adequately considered?**	**Have ethical issues been taken into consideration?**	**Was the data analysis sufficiently rigorous?**	**Is there a clear statement of findings / comprehensive discussion / conclusion**	**MMAT SCORE**
8.Hollins- Martin et al (2014) (Quan Study);UK	Yes- clearly stated, no mention of variables	Yes – use of validated questionnaire appropriate to research design	Yes- clear inclusion and exclusion criteria	Yes – clear and explained	No	Yes- clearly outlined	Yes – statistical package clearly explained / analysis clearly presented	Findings relate to aim/comprehensive discussion in relation to wider literature	100%
9.Hollins- Martin (2016); UK	Yes – Clear / rationale detailed	Yes	Yes –sample clearly defined	Yes	Reflexivity not stated / researcher's influence not stated	Ethical approval obtained	Data analysed using content analysis	Yes – discussion related to literature / conclusion / recommendations for practice stated	100%

10Gardiner et al (2016); Australia, NZ, UK	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	100%
11 Doherty et al (2018); Ireland (Quant)	Yes – aim clearly stated / rationale detailed	Yes	Yes – sample clearly defined	Yes – validated tools	No- quantitative study	Ethical approval obtained	Data clearly analysed and presented	Comprehensive discussion / conclusion / recommendations for practice	100%
Author	**Was there a clear statement of the aims / rationale of the research?**	**Was the research design appropriate to address the aims of the research?**	**Was the sample / recruitment strategy appropriate to the aims of the research**	**Was the data collected in a way that addressed the research issues?**	**Has the relationship between researcher & participant been adequately considered**	**Have ethical issues been taken into consideration?**	**Was the data analysis sufficiently rigorous?**	**Is there a clear statement of findings / comprehensive discussion / conclusion**	**MMAT SCORE**
12.Di Marco et al (2002)	Yes aim clearly stated	Yes	Yes – sample clearly defined	Yes- validated questionnaire	N/A Quantitative study	Ethical approval obtained	Yes -data analysed and presented	Comprehensive conclusion / limitations acknowledged	100%
13. Ratislavová, Kateřina Štípková, Martina (2019) Czech Republic	Yes aim clearly stated	Yes	Yes – sample clearly defined	Yes	N/A Quantitative study	Ethical approval obtained	Yes -data statistically analysed and clearly presented	Comprehensive conclusion / limitations acknowledged	100%

14. Price (2019 UK	yes	Yes-mixed methods study	Yes- final year midwifery / nursing students	Yes – pre-validated questionnaire	No	Yes	Yes -using SPSS statistical package	Yes / recommendations for practice	100%
15 Mitchell (2005)	Yes	partly	Yes	partly	No	Not stated	Relied on verbal feedback	Yes	75%

Appendix 6: Bereavement simulation scenario

Bereavement Simulation Scenario

Holly is 38 weeks pregnant with her first baby. She attends the Triage with her partner Ben as she is concerned because she has not felt the baby move for the past 24 hours. Following an initial assessment, the midwife was unable to detect a fetal heart with a pinard's stethoscope.

The simulation will encompass the on-going care that the couple will require from the initial diagnosis through to the birth and seeing and holding the baby.

Learning Objectives

Identify the midwifery skills and abilities that are required to offer effective support to the couple who have experienced a perinatal loss

Reflect on the nature of grief and grieving and understand the impact on parents and their family and friends

Demonstrate knowledge and understanding of clinical risk factors and complications surrounding late miscarriage, stillbirth, and neonatal death

Demonstrate the ability to sensitively communicate with Holly and Ben that facilitates and supports their choices

Provide the necessary guidance, information, and support that the couple may require following the diagnosis. perinatal loss.

Develop the insight and awareness necessary to seek personal support to benefit emotional well being

Initial Handover given to students

Stage 1: Initial Triage

Holly's pregnancy has been uneventful so far. She is now 38 weeks' gestation**.** She conveys she has not felt any movement in her abdomen in the last 24hrs. She is in the waiting room

This stage involves the Triage Midwife handover of the couple to the students. Student midwives are expected to conduct an initial assessment of Holly and find it difficult to locate the fetal heart.

This concern is then escalated it to the Triage Midwife.

Break for a debrief

Stage 2: Breaking of bad news

In this stage the doctor is contacted and conducts an ultrasound of the abdomen.

Confirms to the couple there is no fetal heartbeat. Students will be present for that situation.

Break for a debrief

Stage 4: This stage involves the couple's reactions and responses to the news. The couple are now left to consider the diagnosis of the baby's death. It may demonstrate different ways as to how couple may grieve. Students expected to respond to the couple's questions and concerns.

Stage 5: Now that the baby's death is confirmed the couple may want to consider their options regarding birth/induction/caesarean, etc.

In this stage the couple may request a CS/it depends on what they say. There may be questions posed about what will baby look like etc.

Debrief

Stage 6: Baby has been born. Holly and Ben consider meeting the baby, creating memories. At this stage the couple maybe reluctant to meet the baby. Use of memory box.

Stage 7: There may be a discussion of post-mortem, postnatal care, bereavement support agencies and funeral planning. Creating memories and memory box. Care and support for future pregnancies

Diamond approach to debrief is used.

Appendix 7: Bereavement simulation session plan

Venue: Mary Seacole Building / Midwifery simulation suite (Home-from-Home Room; MS 216)

Date: xxxx

Time 10-12.30

Participants: AL (researcher), Midwifery students, Actors (xxxx), Triage Midwife, Doctor (xx), Technician

Time	**Simulation day**
10-10.30	Welcome and refreshments. Attend to housekeeping issues. Orientation to the home-from-home room in the simulation suite. Explanation of standard equipment / props used Introduction to the actors- parents, triage midwife, doctor. Information provided about student support and well-being available on campus
10.45-11.00	Pre-brief to include: Overview of the scenario Identification of roles and expectations Assignment of students to rotate through various stages of the scenario.
11.30-12.30	Run the scenario Debrief following each stage of the scenario.
13.00-14.00	Lunch
14.00-15.00	Final post-simulation debriefs. Feedback from actors Questions and answers Advice re: follow-up support and counselling services available
	Close

Appendix 8: Worked example of Gayle's transcript

	Initial Analysis; annotated transcript -Gayle	Descriptive	Linguistic	Interpretative	Emergent themes
1 2 3 4 5 6 7 8 9 10 11 12 13 14	**So, can you tell me how did you feel about the simulation?** Yeah, I found it really useful to be able to experience that kind of situation, kind of, without it being real, like I found it useful to be in that and it was, yeah it was good to see like how people might react and it made me think about how I reacted in that situation, and how I might change how I'd behave in the future. **How did it feel being in there?** To be honest, I felt like I just kind of froze and I didn't know what to do or what to say, because obviously in that kind of situation there's not a lot you can do to make the situation, I can't fix things, but it's knowing what I can say and what I can do to try and help in that situation, and I think, I've had a kind of think about it and, yeah, it's a difficult one. On reflection I probably, I did just freeze and I didn't know what to say, and I think because you've not been in that situation before, you think about things, but then actually being in that situation is different	Says it didn't feel real Repeated that she found it useful Made her think, so it was a good self-reflective experience Talking about how she might change her behaviour Opening up here about how she really feels Not knowing what to do or say	Really useful Emphasis on really 'to be honest Strong use of metaphor here 'froze', depicts a sense of being stiffened by the whole process	Some change in her learning here about how she can change her behaviour Change her behaviour	Useful learning experience self-criticism Lack of knowledge Lack of confidence Communication struggles -not knowing what to do or say

15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49	**Why do you think that was?** I think it's hard not to feel emotional; when someone's going through that and you feel their emotions with them as well and I think doing this job, you build, you have that connection with people and it's hard not to feel the emotion. I think just trying to find the words, the right words to say to someone when their baby's just, when they found out their baby's died, what words can I say to them, and what can I do to try and help them. Yeah, I found that quite difficult. **Do you think that being in the simulation helped?** I think yeah, I think it was really useful because now I've obviously been in that kind of situation it's got me thinking about, what could I do, what could I say, and I think it's prepared me for that kind of situation out in practice. I think the words that you use are important and kind of, I think one person said, like, nothing to worry about, and that kind of stuck in my mind and when they said it, I could've easily have said that as well, but when they said it, I was like, oh no, they've like, they've said that and you're kind of giving false hope. I think I'd definitely be mindful of the words that I use with someone in practice, and kind of, just thinking about what you say and what you do.	Hard not to feel emotional Feel their emotion Feel connected to people Real sense of struggle here Conveys a real sense of her not being able to offer anything Got me thinking Self-reflection Words are important Observation of her peers Learning from each other's mistakes.	Use of hard repeated here Depicts the emotional challenge this 'job' presents 'just trying to find the words' Quite difficult Opposing views here, it was useful, but it was challenging. What I could do What I could say Stuck in my mind False hope	Embodied experience Feels connected to them What can I offer them- sense of her being powerless to support them? Prepared me, past tense. Evidence of change in her learning	Difficult challenging situation Self-criticism Powerlessness Preparation for practice Knowing what to say and do. Adapting the message Sensitivity to the words.

50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67	**How did you feel about how the news was broken to them?** Erm, I think (pause) I think that the doctor, the way that the doctor did it, because she, she obviously made that error when she said, I can hear, I can see the heartbeat, oh I can see the heart, but it's not beating, and that obviously would've given them some false hope, and then I think she said, I'm really sorry, your baby's died. Yeah, I don't think you can break that news in a really nice way, and I think it's better that she did say, your baby's died, because I've kind of been on study days in the past where people have said, you know, well they said, my baby's gone, and then they think, well where's my baby gone, and it's not kind of clear to them that the baby has died.	The way the doctor did it Confusing message here about the manner in which the news was broken Saying there is no right or wrong way She knows you have to be honest Being clear	False hope Pauses here Witnessing something that conflicts with what she believes to be right	Reflective learning experience here about how sensitive issues should be approached A sense of moral distress here	Lack of compassion Lack of kindness
68 69 70 71 72 73 74 75 76 77 78 79	**So, what else do you think made you feel emotional?** I think the actors were really good (laughs), they were really good and they made it feel real. It didn't feel like it was a sim- when you were in there, it didn't feel like a simulation and you couldn't sense the cameras, it just felt like you were in that situation and it felt real, and I think because you've got, like the nerves and the adrenalin pumping, and you probably would have that anyway when you're going into that situation, because it's not nice news to give to someone.	Real Felt real Realism was immersive Did not feel like a sim	Really good repetition here Strong sense of fear and anxiety here Use of metaphor' '*the nerves and the adrenaline pumping*' Laughter here – again is it nerves?	A real sense of being in it and almost an embodied experience	Realism profound Embodied experiential learning

80 81 82 83 84 85 86 87 88 89 90 91 92	**just reflecting about what was the most significant point of learning you would say?** I think it made me kind of think a lot about how important words are, and yeah, and just being kind and how you can just be kind to someone. And I think as well, when we were talking yesterday about, it's okay to have silence as well, you don't have to fill that silence, you can just sit there and sit with someone, and that's okay as well, and you can kind of wait for them to say something if that's how you feel. Because I think we like to fill silence.	Made me think Powerful self-reflection here Importance of words How you can be kind	'just being kind' Repeated here	Real transformative learning here and self-reflection about how she can be	Compassionate caring Being kind Being there Silence is okay Being present Consolation
93 94 95 96 98 99 100 101 102 103 104 105	**Is there anything else you found quite challenging?** I think it was, I don't know what I was expecting, but I wasn't expecting, I was expecting upset, but I don't think I was expecting so much anger, that kind of, I didn't kind of think that that would happen. So I think that kind of surprised me a little bit, and that kind of, I was taken aback by it, and I think that's partly why I kind of frozen, I was like, I don't know how to diffuse, not that you can diffuse that kind of situation, but I don't know how to kind of get her to calm down and, yeah, I found that quite hard.	Uncertainty here Not sure what to expect, so much anger Not knowing how to diffuse a situation	Emphasis on so much anger Use of metaphor I kinda froze Being very honest and justifies why she 'froze' Quite hard – woman needs to be silenced	Uncomfortable situation Not knowing what to do	Feeling powerless Out of control Not knowing Cannot console

106 107 108 109 110 111 112 113	**I: And do you think that that sort of, even though you froze, do you think that, how do you think that might change you with the future?** I think I'd probably try and get that, more down on her level and just trying to get her to kind of, like just use my words and try and get her to calm down that way instead of just, I don't know, kind of not saying anything.	Uncertainty here again I don't know - reinforces I don't know Get on her level Using words might help	'get on her level' Use my words	Trying to work out how she might manage and control the situation This is what I might do but she says I don't know, maybe just saying nothing might be best	Communication struggles How to respond
114 115 116 117 118 119 120 121 122 123 124 125	**So was there anything else that was significant in your learning?** Yeah, I think it was the dad, it's important to remember that they're grieving as well and not to forget about them, because although it's, you know, the main focus is on the mum and obviously she's carrying the baby and she's going to have to go through all the giving birth and everything, but the dad's grieving as well, and I think it'd be easy to forget them, and it's nice to keep them involved and to make sure that they're part of the process as well.	The dad is important Recognition of paternal grief Main focus is always on the mum The onus is on the mum, she is the one almost perceived to be carrying the burden	Not to forget Almost needed to be prompted Main focus She is having to go through it- sense of only mum involved here	Being mindful that there is Dad that needs support Care is almost perceived to be towards the mum. Dad is almost seen to be in the background	Forgotten dad The lost dad

126 127 128 129 130 131 132 133 134	**Did the simulation make you more aware of that?** Yeah, I think so, because you could tell kind of by his body language and his behaviour that he was, he was quite quiet a lot of the time and not, not saying very much, and I think you could tell that he didn't know how to act and I think as a midwife you can support both of them, and you can try and support the dad as well as the mum.	Try and support them both Body language important Can tell a lot from that	Quite quiet Almost feel the silence here	Body language Picking up cues about how they are feeling '*I could tell* Try and support the mum and the dad, almost perceived as quite difficult	Repetition here about the abandoned dad
135 136 137 138 139 140 141 142 144 145 146 147 148	**Is there anything else you want to say around communication in that situation?** I think it's like, the tone of voice that you use, changing how you speak, and obviously like, obviously when they came in and she was all like, kind of chirpy and kind of dismissive of everything that was happening and putting a bit of a front on I think, and obviously it was okay to kind of be chatty with them and just have a, kind of informal chat, but as things kind of progressed, it's changing the way that you speak, speaking more softly, speaking in a tone that is sensitive to that situation, I think	Changing how you speak Good observation here, listening to Mum Learning here about how to respond	'kind of chatty' Sense of uncertainty here about whether It is okay to be like that. Starting to think about use of language that indicates concern	Pivotal point here As things progressed the need to adapt and change tone of voice appropriate to the seriousness of the situation	Importance of communication at critical moments Adapting the message

149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171	**Did you find that the emotion aspect and that sense of being frozen, how did that make you feel?** It upset me a little bit, because I felt like I wasn't really supporting them, and I didn't, I didn't know how to, and then by the time we came out, it was like, oh I could've done this, this and this, but then it was too late. But then I think that's what's good about doing a simulation, is that you had that chance to kind of, almost practice it so that then when we go out, if that does happen, or in any kind of situation where something happens, you know kind of what to do and what to say a bit better. **So do you think it's beneficial?** I think it pushes you out of your comfort zone, but then I think it's beneficial. I think it was really good. Yeah, because it made me feel like uncomfortable, but then, that's why I wanted to do it, because I wanted to put myself in that situation and have some practice. Because otherwise the first time that you could be in that situation could be with actual bereaved parents, and I think that would be even more difficult.	Not supporting them Sense of disappointment here Again doesn't know how The simulation helps prepare for practice Made me feel uncomfortable I wanted to do it The real situation would be more difficult	Sense of regret here- I could have done this Metaphor- comfort zone Really good Made me feel uncomfortable I wanted to do it The real situation is more difficult	Reflective learning here The Some opposing views here On one hand it was good but then it made you feel uncomfortable Taking responsibility here for her learning	Simulation is beneficial but uncomfortable and challenging Helps preparation for practice Simulation is better than being in the real situation Pushes you out of comfort zone

172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195	**So was there anything else you felt was quite significant for you being in the simulation?** Well once, I was in the actual room I didn't feel like I was being watched. I didn't feel like cameras were on us and yeah, it felt quite supportive, like when we were in the room together, chatting about things and just supporting one another and talking about things, and it was, it was good to see like how other people reacted in their kind of scenarios and like, you know, being able to take things, like from what they've done and thinking, oh yeah, that's really good what they did and you might not necessarily have thought to do that yourself, and just being able to pull bits from what other people have done as well. And I think it kind of makes you feel better, like the fact that I froze and I didn't know what to do or say, it kind of feels like, I don't have to be too hard on myself about it, because it wasn't a real situation. Whereas if it was, you'd feel terrible and you'd think, I didn't support that woman, and it'd probably play on your mind a lot.	A sense of mutual support here Being able to take things like what they did Freedom to learn Best that it was not a real situation Not knowing again A real worry about not being able to support the woman Sense of safety about being able to rehearse	'it was good' – sense of relief here to be able to talk with her peers, shared journey 'Pull bits'-metaphor That's really good what they did	A real sense of learning from each other A real desire to gain an understanding as to what they are thinking Is this the only time they really get to observe each other, does this not happen clinically? Real life situation is terrible	Unique learning opportunity Observation of others Role modelling of good practice Overwhelming realism Safe haven to make mistakes Making emotional connections

196 197 198 199 200 201 202 203 204 205 206 207 208 209 210	**So overall really, what did you feel about the whole experience?** I think it was really beneficial, and I think it would be really good as first years to do more of that kind of simulation, because it does feel real when you're doing it, especially, like with the actors and things, it does feel real; and not at one, like at one point I didn't think, this isn't real, you just kind of, you get immersed in it and you're in that situation, and then afterwards you've got time to kind of reflect and think about what, you know, how things went, and what you did and what you didn't do. **Thank you I think we have probably come to a natural ending** …..	Realism again Need this in first year It feels real	Really beneficial Really good Emphasis on really Repetition here	No pretence Recognition of needing this early in the programme. Sense of ease about simulation	Profound sense of realism Safe learning environment Time to reflect and think

Appendix 9: Example of initial list of emergent themes – Kim

	Theme	Page / Line number	Quote
1	Emotional impact	P2 L64-68	*'it's only afterwards when you actually think, uh, and you can't get them out of your head kind of thing, so even though I know that it was a simulation, like I've still got the mum sort of crying and being really angry in my head, so yeah, it'll stick with me' (Kim)*
	Triggered memories	P2 L58-61	*'it affected me, it did afterwards; when I reflected on it, I think it just, it brought back memories for me, because like I said over my brother losing his baby, And it, I think it just, it stirred it all, stirred it all back up again' (Kim)*
2	Learning in a safe secure environment	P3 L79-84	*'so I think it was just, there was really good support for each other anyway, and you know like, don't worry about it, you know now, this is why, it's a safe environment to do so isn't it, like you've not done it in practice and then it's been thrown back at you, so yeah I think it's good to be able to do that.' (Kim)*
2a	Learning from each other Observing others	P 3 L72-76	*'even if we spotted mistakes that others had done, like we knew like, I think that's just how it is in midwifery anyway, like you pick up the best from people and maybe not, like you think, oh I would do that differently, and I definitely picked up on a few things like that,'*
3	Communication / determining appropriate responses	P3 L101-106	*'there was a couple of things that I stumbled over with the parents, do you know, just in terms of what to say, like I didn't really have the quick response for when she says, I think I said like, it's nothing you've done, and she's like, how do you know, like how do you know? and I didn't have a direct response for that, I really didn't' (Kim)*

3a	Not knowing	P4 L119-120	*'in terms of my part in it, and not knowing how to handle her sort of anger, and the response to give in the situation' (Kim)*
3b	'Putting your foot in it'	P3 90-92	*'but it's, it's like in any situation isn't it, you're trying to help but you put your foot in it a little bit' (Kim)*
4	Feeling unprepared	P5 L147	*'Oh god…. I suppose I was not prepared for her anger'*
4a	Fear of the unknown	P5 L154-156	*'I was just thinking, oh no, what's she going to be like for my turn, when I get in there I'm not going to be able to say anything to her' (Kim)*
4 b	Feeling nervous	P 3 L71-72	*'Yeah, like I said earlier, like we were all really nervous at the beginning' (Kim)*
5	Emotional connections	P6 L8-11	*'I'm normally quite touchy-feely, and I'm happy to put my hands on people, and I do do that quite a lot, just anyway, because I know it can be really comforting'. I got as close as I could to her (laughs), but I just couldn't bring myself to put my hand on her shoulder, and I couldn't bring myself to say like, I really, you know, I'd like to console you but I can't'*
6	Understanding grief Gendered assumptions about grief	P3 L92-97	*'but I think it's really important obviously to acknowledge the dad and make sure that they, you know, you are taking into consideration their reaction as well, because obviously mum was really vocal about her feelings, but he was quite quiet sort of thing, so we did have to probe a little bit' (Kim)*
7	Professionalism and professional behaviour	P4 L127-132	*'the doctor like was quite abrupt wasn't he, and I mean like, what did I write – there wasn't really any empathy I think there's ways you can go about it, which feel a bit kinder I think',*

	Lack of kindness and empathy		*because sometimes I think they just see it as, that's their job, so right I've done my job and then not thinking outside of the box'* (Kim)
8	The little things matter	P4 L 134-136	*'it is just all the little things, it is always about the language I found, it is always about the language and the attitude of the staff' (Kim)*
9	Importance of being professional	P4 L116-118	*'because it is too easy just to be like, it's all good, don't worry, and you know, you have to remain professional but appropriate to the situation as well'* (Kim)

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