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How the Topic 'Transition to Parenthood' Relates to the Learning and Role Expectation of Dutch Student Midwives Who-Are-Mothers

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Abstract: The aim of this qualitative exploratory study, using a constant comparison method, was to explore midwifery students who-are-mothers' perceptions on how the topic 'transition to parenthood' relates to their theoretical and clinical learning and role expectation. Student's personal maternal, and their learning experiences were utilized as a frame of reference. Twelve face-to-face semi-structured interviews were conducted with Dutch midwifery students who-are-mothers. Consent was obtained and interviews were audiotaped and fully transcribed. The interviews were analyzed by means of categorizing, coding, delineating categories and connecting them in themes. Three themes emerged from the data: 1. 'Recognizing myself' - the participants' observations of elements of transition to parenthood and the personal meaning that they assign to these. 2. 'Student experience' - how support of transition to parenthood is addressed theoretically (in-school) and how transition is addressed in the clinical area. 3. 'When I grow up' - how students intend to support women in transition to parenthood once qualified and what drives them. The results showed that the personal maternal experiences of student midwives are of merit to evaluate theoretical and practical learning strategies in midwifery education. The study is a preliminary effort for further research. These personal experiences serve as an important drive for students' intentions of future care management when graduated.

Keywords: Midwifery Education, Transition to Parenthood, Netherlands, Student Midwives

1. Introduction

1.1. The Needs of Women About Transition to Parenthood

Becoming a mother is a significant life changing event including physical, psychosocial, relational and life-altering changes and challenges [1], [2], [3], [4]. The transition process to parenthood starts to develop in early pregnancy and can last up to two years after birth [5], [6], [7]. A positive transition to parenthood contributes to emotional wellbeing of parents and their children, a satisfying couple relationship, and positive parenting experiences [8], [9], [10].

Research shows that women experience insufficient support about their transitional process [11] although they expect midwives to possess the necessary knowledge and competencies regarding transition to parenthood [12], [13]. Pregnant women have expressed the need for informative support for transition to parenthood, specifically 'expectation management': the dimension of taking care of a child and the psychosocial impact and meaning of becoming and being a parent [10], [14], [15], [16]. Women identified the midwife's combined professional and personal expertise as value-added practice [17].

The modern woman's role has changed due to demographic, economic and sociocultural changes [18], [19]. Modern women have altered ideas, values and expectations about pregnancy and birth, family-work balance, parenting, social dynamics and service quality [20], [21], [22], [23] when compared to earlier generations of women. This might imply that perceived ideas and practice of current midwives how to support women during the transition to parenthood, are not up-to-date and do not align with the needs of nowadays women [21]. The role of the midwife for supporting transition to parenthood is very likely to be subjected to change in coherence with the changing role of

the woman and that of current parenthood and parenting [20], [24].

In the Netherlands, the midwife is being assigned as a supporter of women's antenatal and postnatal experiences during the process of becoming and of being a mother. The midwife is the main provider of care during pregnancy, birth and thereafter [25] - having multiple and frequent contact moments throughout this period [26]. The midwife can therefore play an important role utilizing core competencies: the provision of information to women, including the emotional, social and practical support in transition to parenthood, i.e. manageability of parenthood [27]. The utilization of these specific transition-related competencies are incorporated in the antenatal care guidelines of the Dutch organisation of midwives [26]. Support of transition to parenthood requires midwives who are capable to ensure a positive transitional experience during pregnancy, childbirth and postpartum period [13], [27], [28]. It is, however, unclear how midwives perceive and exercise supporting women in transition to parenthood as traditionally there has been little emphasis on and preparation for this task [29]. Since practicing midwives offer clinical placements to students, they serve as role models.

To meet nowadays women's needs regarding the the midwife's support in the transition to parenthood, midwives need to be prepared for this task. It seems only logical that midwifery education plays a pivotal role in acquiring knowledge and skills for practice to internalize this task and prepare students for this coaching role.

1.2. Dutch Midwifery Eduction

The midwifery education program in the Netherlands is a vocational four-year program. Professional development of student midwives occurs through theoretical learning and exposure to relevant practice learning activities. Students spend half of their program in the clinical area, being community practices and hospital settings [28], [30]. In order for student midwives to adequately support current women in transition to parenthood, it is worth to consider how students perceive being prepared for their role in supporting women in the transition to parenthood – in theory and in practice.

Although the International Confederation of Midwives [27] encourages the topic of transition to parenthood to be implemented in education curricula, within the Dutch midwifery curricula there is little attention for the topic. As preparation for this role and responsibility requires attention [29], a sensible course of action seems to involve midwifery students' views in the discussion. Student midwives are the future midwifery care provider. Moreover, current student midwives are from the same generation as the women they care for. They can be regarded as a valuable source for exploring perceptions of concepts such as transition to parenthood [31]. Current student midwives can be regarded as the 'new generation of midwives' [32] who will shape the midwife's role in support in transition to parenthood.

Midwifery education programs are predominantly undertaken by women, with a wide range of backgrounds. Students' knowledge of becoming or being a parent will vary, specifically those students that already are parents [33], [34]. Student midwives who-are-mothers have their own experiences and expertise that will contribute to how they perceive and evaluate the educational and clinical support they receive in their development as a midwife in supporting women in transition to parenthood [24], [31], [35]. This might be a valuable source for development of the broader knowledge base of the midwifery discipline.

There appears to be very little research including student midwives who-are-mothers - specifically those with focus on the effect of these students' personal experiences, perceptions and expertise about transition to parenthood - in relation to learning to become a midwife who supports women in transition to parenthood [24]. Considering that this specific group can provide valuable ideas and recommendations [32], [33] for education and the day-to-day support of current pregnant and postnatal women, this study explores the perceptions of student midwives who-are-mothers about how the topic transition to parenthood relates to their learning and role expectation. Educational (theory and practice) experiences and their personal parental transitional expertise are regarded as their frame of reference.

2. Methods

2.1. Design

A qualitative exploratory study was performed using a within-interview and in-between interviews constant comparison method [36], [37]. The constant comparative method offered the means whereby it was expected to access, describe and analyze articulated perspectives to be integrated in an explanation and better understanding of the topic under study [37], [38].

2.2. Participants

Student midwives who-are-mothers were recruited. There were no restrictions for number of children, ethnicity, relationship or years of study. Student midwives 40 years of age or older were excluded. We aimed to explore the experiences of so called 'Millenniums' - those who are born after the year 1977 [39]. It was the aim to include participants with a similar generational background as the predominant number of women in the current midwives' caseloads, and those with mother(ing) experiences.

2.3. Procedure

Purposive sampling was applied [36], according to the preselected criteria. The three Higher Education Institutions (HEI) in the Netherlands that provide midwifery education in the west-north, south-west and southern regions were approached; to ensure geographical diversity of the participants. At the time of the study there were approximately a number of 50 students who-are-mothers ranging between 22 to 48 years of age spread among the three Dutch HEIs. All HEIs offer the same construct of midwifery education

containing a combination of theoretical education and clinical placements [30]. The three HEIs consented to recruit students. In order to secure informed consent and confidentially requirements we followed a certain procedure: (1) A lecturer of each HEI (who was not involved in the study) distributed a package of documents to the students, and explicitly stated that participation in this study was voluntarily, confidential and anonymous. The documents included information about the study and the informed consent procedure. (2) No detailed information about the students (e.g. names, birth dates) was collected to ensure anonymity of the respondents. Faculty members were not informed about the interviewee identities in order to preserve anonymity of the participating students to prevent the potential impact of participation, i.e. potential power dynamics.

Students that were willing to participate could contact the researchers by email or phone. All the students that responded were eligible and were included in the study. No participants withdrew at any point of time during the study. The participants could opt for a Skype interview or an in-person interview. It was considered that participants had to be familiar with modern communication technologies and to have access to a computer and to the internet. Skype interviewing was regarded to produce data as reliable and in-depth as produced during in-person encounters [40], [41]. Skype interviewing facilitated the wide geographical spread of the participants within the restricted timeframe and resources of the study [42].

2.4. Data Collection

Twelve interviews took place between 10 October and 10 November 2016. Nine Skype interviews and three in-person interviews were performed at a time and place convenient for the participant, being either the participant's home or the student's HEI. The participants were stressed that there were no wrong answers and were encouraged to reveal anything they wanted about the topics addressed during the interview, positively and negatively. The participants were assured of confidentiality and anonymity. The interviews were audiotaped with the participant's consent. A semi-structured topic-list, was developed to guide the interview (Table 1). The topic-list included the elements of transition to parenthood as described in the Dutch antenatal care guideline [26]. To check validity, the questions were pre-tested for comprehensibility and clarity with peer students who-are-mothers. No questions were adapted and two topics were added. The interviews lasted between 20 to 35 minutes, excluding instruction, introduction, and member checks. Two researchers (EK, GK) were present during the interview. One researcher conducted the interview and the other researcher observed and checked if all topics were addressed. At the end of each interview the answers were summarized for the participants to validate the answers given [36], [38].

Table 1. *Topic list.*

Transition to parenthood (as a topic):	1. Personal experience 2. Experiences theoretical education/ perceived knowledge and skills 3. Experiences/ observations during clinical placements applied knowledge and skills
Role of the midwife regarding support of transition to parenthood (emotional/ social/ practical/ information):	1. Personal experience 2. Experiences theoretical education/ perceived knowledge and skills 3. Experiences/ observations during clinical placements applied knowledge and skills
Importance of a positive transition to parenthood for women	1. Personal experience 2. Experiences theoretical education/ perceived knowledge and skills 3. Experiences/ observations during clinical placements applied knowledge and skills
Value of the midwife regarding transition to parenthood	
Envisage of utilization of knowledge and skills of transition to parenthood	
Recommendations for education and/ or practice	1. Personal experience 2. Experiences theoretical education 3. Experiences/ observations during clinical placements

2.5. Data Analysis

All data were anonymized. The recorded interviews were transcribed verbatim and the field notes were added to the text as an aid to interpret the transcripts [38]. All transcripts were read separately by two researchers (EK, GK) and text segments from each interview were selected on relevance to the research question, i.e. focus of inquiry. The text segments were compared within each interview and between the interviews. This was an iterative process of constant comparing and contrasting [43]. The researchers (YF, EK, GK) independently open coded (labelling), axially coded (categorized) and then selectively coded (thematically) the transcripts [36], [40]. The findings were compared and meaning was discussed until consensus was reached. All codes, categories and themes found were then arranged in a coding tree (Table 2). Themes were directly derived from the data.

Table 2. *Examples of analytical coding.*

Quote	Category	Theme
"During clinical placement I recognize what I have experienced myself, that immense responsibility, the insecurities (…) will I be a good parent, can I do it… manage it, you know… can we do this together, will we still be the same couple as before?"	Personal experience	Recognizing myself
"We don't really learn to ask the 'real' questions: How do you feel? Are you happy? Coping?"	Communication skills	Student experience

Quote	Category	Theme
"And there are those midwives who just sense what to do, who get it and who pay attention"	training (in-school) Observation of 'good' practice	Student experience
"Don't get the information out of books, real experiences are important to learn from, ask them [women] what to do, to say, what was useful, what helped, expectations, doubts, thoughts, feelings…"	Improvement of education (theory)	Student experience
"It [being a parent] has such an impact on life, on relationships, on the child (…) the midwife's support is important"	Importance of incorporating it in future practice	When I grow up
"Little things really, listening to the heartbeat, invite the partner and then observe what happens. Are there any signs of bonding? Casually inquire if the nursery is ready yet? Or postnatally: How are your nights? See how she responds"	How to incorporate in future practice	When I grow up
"As a midwife, I would tell from own experience… it was tough (…) but her [woman] experiences might be different, you know, smooth sailing (…) my information could be biased"	Use of personal experience	When I grow up

2.6. Ethical Consideration

The Rotterdam Research Ethics Committee confirmed that because of the noninvasive character of the study ethical approval was not required, and advised to conform to the ethical principles of the Central Committee on Research Involving Human Subject [44]. The study was subsequently approved by the Research Centre Innovation in Care, Rotterdam University of Applied Sciences who confirmed that the study protocol adhered to the guidelines of this research institute. Written consent was obtained from all the participants in the study. The transcripts were anonymized and stored in password-secured computer.

2.7. Rigor

The researchers were final-year Bachelor midwifery students at the time of the study and are mothers themselves. They were careful to seek clarifications about assumptions made and to keep participants' views separate from their own ideas, thoughts and experiences regarding the topic of study, to control for the influence of personal bias, and to minimize the likelihood of observant-expectancy bias [38], [43]. All used strategies were transparantely documented to enhance credibility, transferability, dependability and confirmability of the findings, including cross-referencing the research question throughout. Member checking was performed after completing the preliminary analysis of the complete data set to validate the findings [36], [38]. Participants were asked to verify the findings and to provide feedback or correction if wanted. No comments were returned. To assess the credibility of the findings, peer review and purposive sampling techniques were utilized [45]. To enhance the credibility of the findings, the final themes were discussed in a group session with midwifery lecturers and midwifery students [38]. The students (interviewers) were experienced social healthcare professionals and were supervised by the first author [46].

3. Findings

A self-selected sample of 12 student midwives who- are-mothers participated in this study. They studied at the different HEIs that offer midwifery education: West-north (n = 6), south-west (n = 3), south (n = 3). The participants had a mean age of 31.3 (SD 4.6, range 23-39) years, and had on average 2 (SD.8, range 1-3) children with a mean age of 4.8 (SD 3.6, range 0-14) (Table 3).

Table 3. *Characteristics of participants.*

Participant	Age	Number of children and age	Year of study
1	35	2 (4, 7)	1
2	30	1 (0)	3
3	30	3 (6, 3, 0)	3
4	30	2 (4, 7)	4
5	28	1 (7)	2
6	23	1 (1)	4
7	30	2 (3, 1)	2
8	39	3 (8, 6, 0)	2
9	30	1 (4)	2
10	28	2 (6, 2)	2
11	39	3 (14, 10, 8)	4
12	33	2 (7, 6)	2

Note: For anonymity reasons, the location of the participants' HEI are not disclosed

The analysis showed data saturation of the categories. Three themes emerged from the data. Relevant quotations were translated in English and checked for accuracy by a native linguist in both English and Dutch, and were added to illustrate the findings.

3.1. Recognizing Myself

During clinical placements, the participants observed aspects of transition to parenthood that strongly resonated with their own experiences. These aspects related to the feelings of responsibility towards the newborn, the partner and towards other children; the emotions of becoming a parent (again); the impact of the practical aspects; the change in the relationship and the quality of the relationship with the partner.

"During clinical placement, I recognize what I have experienced myself, that immense responsibility, the insecurities (…) will I be a good parent, can I do it… manage it, you know… can we do this together, will we still be the same couple as before?" (participant 11)

All participants recalled to have received little support regarding transition to parenthood during their own antenatal and postnatal care experiences. They all voiced feelings of being unprepared at the time for the feelings of responsibility

that belong to parenthood. They recognized this in the clinical area as, what they described, limited support in transition, because of the emphasis on the medical aspects of pregnancy during antenatal. They saw the unpreparedness in the women who they met postnatally that seemed somehow overwhelmed.

"My midwife was like the midwives during my placements… predominantly focused on physical things, medical things, checking blood pressure, fetal heart rate, palpation (…) giving information about labor. (…) Like the women during my placements I was overwhelmed, I didn't expect it [parenthood] to be like that…. I had received little information, support, help. (…) During placements, yes, it is still the same, nothing has changed really, no attention whatsoever… I see women postnatally, emotional, stressed and confused by it all, bewildered even" (participant 12)

3.2. Student Experience

All participants thought transition to parenthood was under addressed and overlooked during education, both clinically and academically. Participants recognized the following topics about transition to parenthood being discussed during in-school education: bonding and attachment theories, feeding and postpartum depression - within the scope of maternal mental health. All participants expressed they had experienced minimal guidance in how to support transition to parenthood in practice. Despite they said to receive training in communication skills, they did not experience guidance in how to respond to the transition to parenthood in management of midwifery care, e.g. how to address topics such as responsibility, relationship changes or impact of parenthood.

"Transition to parenthood is mentioned, but not translated into practical actions… insufficient… very limited… it [transition] can be difficult to women… and then, how to respond, what to do as a midwife?" (participant 6)

"We don't really learn to ask the 'real' questions: How do you feel? Are you happy? Coping?" (participant 9)

Most participants observed differences in approaches regarding the support of transition to parenthood. According to most participants, practice size, i.e. number of midwives, influenced the level of attention paid to transition. The participants also observed differences between the individual midwives in the clinical area. Some participants mentioned that (young) midwives, who-are-not-mothers lack the experience or sensitivity to address the transition to parenthood.

"The midwife's support of transition varies per practice" (participant 3)

"Smaller-sized practices with less midwives, they know the women in their practice (..) they know better what to do, how to support transition…" (participant 8)

"And there are those midwives who just sense what to do, who get it and who pay attention" (participant 11)

"Was it her age, inexperience, or both? I don't know. It just wasn't there. The role of supporter of transition to parenthood was completely lacking (…), you know, no gut feeling…" (participant 1)

"She looked as if she had just left secondary school! She might not have picked it up the woman's signs it in the way I did as a mother" (participant 9)

The participants regarded the input and exchange of women's personal experiences in theoretical education as valuable.

"Don't get the information out of books, real experiences are important to learn from, ask them [women] what to do, to say, what was useful, what helped, expectations, doubts, thoughts, feelings…" (participant 2)

3.3. When I Grow up

All participants expressed the intention to 'make a change' after they graduate - regarding support of transition to parenthood. They all agreed that supporting women in transition to parenthood is very important to them on a personal level and they all recognized that the midwife is the most suitable healthcare practitioner to do this.

"It [being a parent] has such an impact on life, on relationships, on the child (…) the midwife's support is important" (participant 7)

"The midwife has a key role (…) most suitable (…) she is there the whole process of childbirth, yeah, definitely, most suitable" (participant 5)

The participants had various ideas about how to address transition to parenthood once practicing as a qualified midwife; on an individual basis as well as in groups. They voiced the intention to facilitate peer network support. Most participants regarded group antenatal care as a useful model of care to facilitate support in transition – as they regarded peer-support as valuable. In addition, they, unanimously, want to implement the topic in a structured way during (future) care management. They identified moments during care such as ultrasound scanning, listening to fetal heart rate, talking about the preparation for the nursery as opportunities to assess transition to parenthood.

"Implement it [transition] in the care pathway, easy-peasy" (participant 4)

"Little things really, listening to the heartbeat, invite the partner and then observe what happens. Are there any signs of bonding? Casually inquire if the nursery is ready yet? Or postnatally: How are your nights? See how she responds" (participant 4)

Some participants were a bit hesitant about their role and were unsure about the influence of their own belief system and experiences as this might affect the objectivity of their information provision.

"As a midwife, I would tell from own experience… it was tough (…) but her [woman] experiences might be different, you know, smooth sailing (…) my information could be biased" (participant 2)

4. Discussion

The authors believe to have gained a more in-depth understanding of midwifery students who-are-mothers' perceptions how transition to parenthood is addressed during education. The topic has not been approached in such a manner before, in particular the level of student participation;

including student focus, collaboration, originality and even self-authorship [46]. The participants in the study regarded the transitional process, including emotional, social and practical elements as very important topics and strongly emphasized these to be addressed in midwifery practice, by their preceptors as well as in the curriculum by lecturers. Hence, importance of the topic is not unique to student midwives who-are-mothers but has also been identified by non-mothers [24]. The premise of a difference between students who-are-mothers and those who are not, provides an excellent basis for a follow up comparison study. Based on the findings, more transition-related content knowledge and guidance in communication focused on topics such as coping and resilience are required in midwifery curricula. Preceptors would benefit from use of structured practice that facilitate transition, for example practical clinical guidelines or implementation of group antenatal care. Use of narratives for internalization of transition to parenthood into the student's affective domain, can be used to support the development of reflective practice regarding the topic and reflecting on personal expertise versus or in addition to professional experience [47].

The participants in the study noticed variations between practice size (*i.e. number of midwives per practice)* that they regarded to be of influence how the topic of transition was addressed. This is consistent with findings of an earlier study about midwifery care in different sized practices in the Netherlands; showing that practices with one or two midwives were more likely to pay attention to elements of emotional and social care [48]. The participants also observed individual characteristics of midwives (*e.g. age, experience*) they thought to influence care management of transition to parenthood. Previous research including midwives who-are-not-mothers showed the impact of the interactions with mothers that indeed differed from midwives that were mothers [35]. Nonetheless, taking into account that childbearing women look for shared experiences in their midwife, it needs to be emphasized that only appropriate drawing on personal experience enhances midwifery practice [35]. This implies that although (student) midwives have children, their experiences might not always be relevant or that their responses to women are always sensitive or empathic - requiring reflection and proper communication skills. This implies that midwives, during education and thereafter, need to think how they apply personal knowledge and experiences of their transition to parenthood to practice [35]. Moreover, overrating personal maternal expertise would introduce bias against midwives without personal birth and mothering experiences [35]. Personal experiences serve as an important drive for students' intentions of future care management when graduated [24]. According to behavioral sciences, intentions precede actual behavior and have the potential to change clinical behavior [49]. Based on the findings it can be assumed that women who receive care from (student) midwives who-are-mothers are very likely to be supported in their transition to parenthood.

Midwifery education has traditionally a theory-practice approach in which theoretical knowledge and practical implementation are complementary. When disparity between theory and clinical practice occurs, we refer to a theory-practice gap [50]. When a gap exists, practitioners have to adhere to practice guidelines [50]. According to the participants there were predominantly a lack of knowledge and a lack of skills in the clinical area. Current education and practice regarding transition to parenthood therefore seem not compatible with midwifery socialization that involves the knowledge, competencies, values and beliefs of midwifery that are required for timely practice [47]. It can be suggested that a niche in midwifery education has arisen to exist – focusing on this niche is likely to enhance midwifery professionalism [50] and will most certainly adhere to the needs of current childbearing women [12], [15]. Based on the findings it can be suggested that addressing transition to parenthood in theoretical education might not be conclusive, as students are also exposed to the clinical setting. It is therefore of equal importance to work with midwifery preceptors [50] and explore the findings of this study for role modelling of professional behavior [47]. It can be recommended to involve pregnant and postpartum women in education as there is much to learn from listening to the voices of midwifery clients [51]. It is worth considering to personalize and professionalize the midwifery curriculum with regard to transition to parenthood.

The recruitment strategies of the study allowed self-selection of participants. This could have led to the inclusion of those student midwives with affinity to, or outspoken ideas about the topic. The rather homogenous nature of the sample might have contributed to the achieved theoretical saturation. Saturation could also have been caused by the purposive sampling technique, the strict use of predefined criteria and the limited total number of eligble participants. The participants in the study sample were older than the average final-year midwifery student [28], albeit that this might be a given fact. This might affect transferability to other age groups. In addition, because the study included a small number of participants and took place in the Netherlands, it is possible that students elsewhere will have different perceptions. Therefore, cautiousness with transferring the findings to other groups of students or to countries other than the Netherlands, is recommended. The majority of the participants were interviewed via Skype. Because participants had to be familiar with this medium, selection bias might have occurred. Although precautions were taken to minimize the likelihood of observant-expectancy bias, personal opinions of the researchers might have been present during the data collection process influencing the findings. In addition, gratitude bias might have occurred due to the fact that the researchers were peers.

As motherhood is not a prerequisite to become a midwife and the fact that there is currently limited education and almost non-existent access to examples of good practice, an alternative method must be sought to teach student midwives about transition to parenthood. This study is an effort to promote both a greater midwifery education and research community through involving students. It can therefore be

recommended to draw on the personal experiences of student midwives who-are-mothers, and to involve them in training and education of their peers about transition to parenthood. It is known that experiences of students who-are-mothers are quite realistic [22] and can serve as a reliable source.

5. Conclusion

The participants in the study drew heavily on their own experiences and perceptions of transition to parenthood. Those personal experiences had profound meaning to how the participants perceived the topic during academic education and clinical learning. The personal experiences of the participants profoundly influenced their perception of value of importance of addressing the topic and incorporating it in education and (future) practice - in order to provide, what they considered, *good* practice and to facilitate a positive transition to parenthood and valuable care experiences for women. Not only did this study benefit to learning – experience of the research journey -, it also shows the value of personal experiences to the broader knowledge base of the midwifery discipline and thus midwifery education.

Conflicts of Interest

The authors have no conflicts of interest to disclose.

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Note

Two final year midwifery students were involved in the study. This is an active pedagogy and emphasizes the process of Bachelor research and inquiry. Undergraduate research in this style may include ways of promoting research-teaching linkages by developing students' appreciation of research in midwifery and suggests a progressive acquisition of skills. This might support students' sense of belonging to midwifery or even a research culture.

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