Experiences of student midwives in the care of women with perinatal loss: A qualitative descriptive study

Abstract

Background: Student midwives often encounter perinatal loss, such as stillbirth and neonatal death, as part of their experience of clinical practice. Coping with these events can be challenging because loss and death are the antitheses of birth, which predominates midwifery practice. There has been limited research on how student midwives are supported when caring for women with bereavement; however, poor support may have repercussions for future practice.

Aim: The aim of this study is to explore the experiences of final-year student midwives when caring for women with perinatal loss.

Methods: Two focus groups were conducted with 10 final-year BSc (Hons) Midwifery students. The focus groups lasted approximately 1 hour and used a semi-structured interview schedule. Data were analysed using thematic analysis.

Findings: Four key themes were identified from the data: preparation for perinatal loss; 'just dealing with it'; contradiction and challenges with the role of the midwife; and emotional impact and coping strategies.

Conclusions: Final-year student midwives believed they were ill-prepared in caring for women with perinatal loss, reported difficulties in communicating with women and believed they were excluded from their care. Students valued support from the bereavement midwife and identified effective strategies which helped them cope with bereavement and loss.

Keywords: Student midwives, Perinatal loss, Bereavement, Qualitative methods, Focus groups, Experience, Training, Education

Around 1/200 births in the UK result in stillbirth and about 1/400 infants die within the first 4 weeks of life (Office for National Statistics, 2015). Those women who experience perinatal loss (as a result of childbirth) have considerable emotional and psychological needs (Mills, 2015). Bereaved parents' interactions with health professionals often have a profound effect on their capacity to cope with their loss, and this may have consequences if care is poorly managed (Downe et al, 2013). While many student midwives may have some experience of dealing with death during pregnancy or childbirth (Mitchell, 2005), midwifery education and textbooks have been shown to fall short of providing essential, practical information regarding perinatal loss and the management of bereavement for families (Cameron et al, 2008). As a result, midwifery students may not have the necessary skills to guide parents through this difficult time, and may be vulnerable to grief themselves (Cameron et al, 2008).

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

Despite guidance being available for midwives on the management of families who have experienced loss (Avelin et al, 2013), there is limited research exploring the experiences of student midwives when caring for parents with a perinatal loss (Gerow et al, 2010). This is problematic, as understanding the experiences of student midwives and their perception of how difficult situations are dealt with, can predict levels of confidence and behaviour as future practitioners (Mitchell, 2005). Professional experience and experiential learning may be a protective factor for health professionals in coping with grief and loss (Wright and Hogan, 2008). However, student midwives are less likely to have this level of clinical experience, or to have developed advanced coping strategies in dealing with perinatal loss, therefore may be

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more affected by loss than those practitioners with a greater level of clinical experience (Fenwick et al, 2007).

Background

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

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

A phenomenological study, using diaries and interview data, indicated that student midwives were not confident in their ability to communicate properly with grieving parents (Begley, 2003). For example, students reported being so overcome with emotion that they were unable to support parents. Often, students believed that they needed support as much as the affected family (Begley, 2003). Student midwives' experience of caring for bereaved families resulted in feelings of distress, guilt and anxiety regarding their competence to offer appropriate care (Begley, 2003). The student midwives' experience of bereavement care was strongly related to training and to the support they received from senior staff in the clinical area. However, the study also indicated that many students received only minimal training in caring for parents following bereavement, with a limited focus on personal coping (Begley, 2003).

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

Aim and study design

The aim of this study is to explore student midwives' experience of caring for women with perinatal loss. A qualitative approach was adopted as this allows an exploration of the personal meanings and experiences of midwifery students in the care of parents following a perinatal loss (Neuman, 2013).

Methods

Two focus groups were conducted, comprising 10 final-year student midwives who were completing a BSc (Hons) Midwifery programme in a UK higher education institution. Focus groups were an appropriate method of data collection as they allowed student midwives to interact in a group setting while facilitating a more detailed discussion of topics (Kidd and Parshall, 2000). Focus groups aim to mimic the social context in which the topic under investigation occurs, therefore can be more representative of the environment in which students experience training and education (Kidd and Parshall, 2000). Focus groups provide a different type of data to other types of data collection used in qualitative research, such as one-to-one interviews, in that they allow an interaction and synergy between focus group members.

While the authors are aware of the debate concerning whether student midwives are in receipt of training or education and the implications this has for the status of midwifery as a profession, for the purpose of this research paper the terms 'training' and 'education' are interchangeable.

Focus group discussions

Convenience sampling was used to recruit final-year midwifery students. A total of 10 student midwives participated in two focus groups. Students recruited to the study were those completing both pre-registered and direct-entry midwifery programmes (*Table 1*). The study was introduced to students via a short presentation along with written information. Final-year students were recruited to the study as these students often have recent exposure to clinical practice and theory related to midwifery practice. Those students who expressed an interest in the study were asked to select a preferred date and time to attend the focus group from one of two options. Students were given the opportunity to

Table 1. Background of student midwives who participated in the focus groups

Pseudonym	Sex	Age (years)	Nationality	Care experience	Programme of study
Graca	Female	25	European	1 SB	Pre-registered group (FG1)
Karima	Female	24	European	1 SB	
Andrea	Female	26	European	1 SB	
Jay	Male	31	European	5 SBs, 1 TAB, 1 SAB	Direct-entry group (FG2)
Abby	Female	36	European	1 SB, 1 SAB	
Mina	Female	21	Non-European	1 SB	
Fiza	Female	25	Non-European	1 SB, 1 TAB	
Asma	Female	26	Non-European	1 SAB	
Vicky	Female	23	European	1 SB, 1 SAB	
Maya	Female	32	European	2 SABs	

FG–focus group; SAB–spontaneous abortion; SB–stillbirth; TAB–therapeutic abortion

attend either focus group, however their schedule of study dictated that all pre-registered students attended focus group 1, while all direct-entry students attended focus group 2.

As the focus of the study was to explore student midwives' experiences of bereavement care, a requirement for the study was that participants have some experience of caring for a woman with perinatal loss. This included stillbirth, neonatal loss, termination of pregnancy or miscarriage. Discussion during the focus groups was generated using a series of semi-structured questions. Each focus group took place in a private room on the university campus and lasted approximately 50–55 minutes. Ground rules for the focus group were established prior to the discussion and students were advised that support was available from the research team and university counselling service, if they wanted to access either of these.

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

Ethics

The study was approved by the university ethics sub-committee at the host institution. Written informed consent was obtained from each student prior to the focus group.

Analysis

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

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

Results

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

Preparation for perinatal loss

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

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

Another student reported:

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

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

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

Andrea: [Clinical] Experience.

Interviewer: Experience, yes. What kind of experience?

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

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

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

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

'Just dealing with it'

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

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

Another said:

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

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

Contradiction and challenges with the role of the midwife

Role contradiction and helplessness

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

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

When students cared for bereaved women and families, they remained uncertain about their role and unsure about how to behave. Part of the difficulty was the role conflict they experienced in dealing with death and loss when their usual role involved assisting birth and new life. Responding to the needs of a woman who has experienced bereavement required adaptation of their normal role.

Communication

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

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

Another student reported:

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

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

Emotional impact and coping strategies

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

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

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

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

Student midwives acknowledged that bereavement care was difficult and that they were affected by perinatal loss.

Making sense of bereavement

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

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

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

Self-reflection and reflection on practice

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

'We have an opportunity to talk about it when we come back from clinical

placement, and we talked about it in class.' (Karima, FG1)

Another student reported:

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

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

Maintaining life and work balance

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

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

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

Discussion

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

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

Maintaining psychological wellbeing

Previous studies indicate that health professionals often develop coping strategies to manage emotionally challenging situations at work, particularly when coping with death and bereavement (Gold et al, 2008; Erlandsson et al, 2013). Achieving balance between compassionate and empathetic care while maintaining clear professional boundaries is believed to be an important aspect of professional practice (Wuthnow, 2012). In the current study, student midwives recognised that they would experience grief and sadness when caring for women; however, the majority of students adopted a pragmatic approach in bereavement care through maintaining a good work–life balance and reflecting on their practice.

Communication with bereaved parents

Communication is an important aspect of care, and communication skills are designated as one of the essential skills clusters that students are required to achieve in their midwifery training. The Nursing and Midwifery Council (NMC, 2010) *Standards for pre-registration midwifery education* state that students must demonstrate appropriate interpersonal skills to support women and their families. Communication also includes providing care that is warm, sensitive and compassionate, as well as listening to women and helping them identify their feelings and anxieties (NMC, 2012).

Inability to communicate with grieving parents was a major difficulty identified by students. Student midwives believed they did not benefit from being shielded by mentors from caring for bereaved women and families; they felt that this hindered development of their communication skills and left them unprepared to achieve the essential skills competencies required for NMC registration (NMC, 2012).

The findings from this study would indicate a serious discrepancy in the training of student midwives in standards of effective midwifery practice and would suggest more emphasis is needed on developing the communication skills of student midwives, particularly concerning issues around bereavement.

Impact on future role as a midwife

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

bereavement was a 'rite of passage' and a test of their suitability for their future role as a midwife. There are concerns that those students who find it difficult to cope with traumatic situations may not complete their midwifery programme and are left dissatisfied and with unresolved issues if not addressed effectively (Fenwick et al, 2007). Additionally, those student midwives who have not received adequate training and support in dealing with perinatal loss may experience psychological trauma, resulting in mental health difficulties (Begley, 2003). Effective training in the care of women with bereavement and management of this particular aspect of midwifery care would, therefore, seem crucial in maintaining the health and welfare of midwives of the future.

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

Salutogenic model in maternity care

There is growing interest in the use of salutogenic theory in maternity care (Sinclair and Stockdale, 2011; Perez-Botella et al, 2015). Salutogenic theory suggests the role of professionals involved in health promotion is to provide options that enable people to make sound choices about their health while increasing awareness of determinants of health and enabling choices to be expended. Through a process of problem-solving, identification of both internal and external resources for resistance and of a collective sense of coherence (comprehensibility, manageability and meaningfulness), salutogenic theory promotes and enhances positive states in an individual's health (Lindström and Erikson, 2006).

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

Limitations

This was a small, self-funded project conducted over a limited period of time when many final-year student midwives were on annual leave or in clinical practice. As recruitment was dependent solely on access to students during their university placement, obtaining agreement to participate in the study was often difficult. Additionally, students were sometimes reluctant to participate in focus groups owing to pressures of academic work. It is important to speculate that the reticence of students might also be because they did not fit the criteria for participant selection—that is, they had no prior experience of perinatal bereavement. Conversely, those who did put themselves forward and were comfortable taking part may have developed effective coping strategies in dealing with these experiences. These caveats may affect the transferability of the findings to the wider population of student midwives. However, the 10 student midwives who did participate in the focus groups generated vibrant and interesting discussions, which provided rich and insightful data; therefore, the initial problems with recruitment are not seen as problematic.

There was a broad range of loss contexts used in the inclusion criteria for participants. These included miscarriage and termination of pregnancy. While the authors were aware that these inclusions might be considered too broad-ranging to capture the meaningful experiences of student midwives, it was felt that all women, regardless of gestation or reason for perinatal loss, are affected by bereavement; consequently, this must have an impact on students' experience of providing care.

Conclusion

Focus groups were conducted to explore final-year student midwives' experiences of caring for bereaved women and families. Four themes were identified from the data: preparation for perinatal loss; 'just dealing with it'; contradiction and challenges with the role of the midwife; and emotional impact and coping strategies. Student midwives felt inadequately prepared to deal with perinatal loss and requested more 'hands on' clinical experience in caring for bereaved women and families. Students expressed difficulty in communicating with bereaved families, which was further exacerbated by their perceived lack of contact with such families. Although students adopted strategies that allowed them to cope with bereavement care, the support that students were able to access and the strategies they adopted

Key points

- Student midwives felt unprepared in their communication with women who had experienced perinatal loss
- Contact with bereaved families and clinical placement with the bereavement midwife were seen as key learning opportunities
- Dealing with bereavement and loss was seen as important 'rite of passage' in the transition from student to qualified midwife
- Self-reflection on clinical practice was identified as an important coping strategy in caring for bereaved families

require further exploring. Finally, the beliefs of some students regarding their ability to cope well with a stressful situation as being indicative of their suitability to practice might also require some further exploration. A larger study involving more diverse groups of students from a range of backgrounds, with the possible inclusion of views from midwifery educators and clinical mentors, is recommended. BJM

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Allchin L (2006) Caring for the dying: nursing student perspectives. *J Hosp Palliat Nurs* **8**(2): 112–17

Avelin P, Rådestad I, Säflund K, Wredling R, Erlandsson K (2013) Parental grief and relationships after the loss of a stillborn baby. *Midwifery* **29**(6): 668–73. doi: 10.1016/j.midw.2012.06.007

Begley C (2003) 'I cried... I had to...': student midwives' experiences of stillbirth, miscarriage and neonatal death. *Evidence Based Midwifery* **1**(1): 20–6

Braun V, Clarke V (2006) Using thematic analysis in psychology. *Qual Res Psychol* **3**(2): 77–101. doi: 10.1191/1478088706qp0630a

Brunelli T (2005) A concept analysis: the grieving process for nurses. *Nurs Forum* **40**(4): 123–8

Cameron J, Taylor J, Greene A (2008) Representations of rituals and care in perinatal death in British midwifery textbooks 1937-2004. *Midwifery* **24**(3): 335–43

Clarke V, Braun V (2013) Teaching thematic analysis: Overcoming challenges and developing strategies for effective learning. *The Psychologist* **26**(2): 120–3

Creswell J (2009) *Research Design: Qualitative, quantitative, and mixed methods approaches*. SAGE Publications, Los Angeles, CA

Downe S, Schmidt E, Kingdon C, Heazell AE (2013) Bereaved parents' experience of stillbirth in UK hospitals: a qualitative interview study. *BMJ Open* **3**(2): e002237. doi: 10.1136/bmjopen-2012-002237

Erlandsson K, Warland J, Cacciatore J, Rådestad I (2013) Seeing and holding a stillborn baby: mothers' feelings in relation to how their babies were presented to them after birth--findings from an online questionnaire. *Midwifery* **29**(3): 246–50. doi: 10.1016/j.midw.2012.01.007

Fenwick J, Jennings B, Downie J, Butt J, Okanaga M (2007) Providing perinatal loss care: satisfying and dissatisfying aspects for midwives. *Women Birth* **20**(4): 153–60

Gerow L, Conejo P, Alonzo A, Davis N, Rodgers S, Domian EW (2010) Creating a curtain of protection: nurses' experiences of grief following patient death. *J Nurs Scholarsh* **42**(2): 122–9

Gold KJ, Kuznia AL, Hayward RA (2008) How physicians cope with stillbirth or neonatal death: a national survey of obstetricians. *Obstet Gynecol* **112**(1): 29–34

Kidd PS, Parshall MB (2000) Getting the focus and the group: enhancing analytical rigor in focus group research. *Qual Health Res* **10**(3): 293–308

Lee KJ, Dupree CY (2008) Staff experiences with end-of-life care in the pediatric intensive care unit. *J Palliat Med* **11**(7): 986–90. doi: 10.1089/jpm.2007.0283

Leyland A (2013) The midwife's role in caring for the needs of bereaved parents following a stillbirth. *Pract Midwife* **16**(2): 20–2

Lindström B, Eriksson M (2006) Contextualizing salutogenesis and Antonovsky in public health development. *Health Promot Int* **21**(3): 238–44

Mills TA (2015) Improving support in pregnancy after stillbirth or neonatal death: IMPs study. *BMC Pregnancy Childbirth* **15**(Suppl 1): A14. doi: 10.1186/1471-2393-15-S1-A14

Mitchell M (2005) Preparing student midwives to care for bereaved parents. *Nurse Educ Pract* **5**(2): 78–83. doi: 10.1016/j.nepr.2004.03.005.

Ness V, Duffy K, McCallum J, Price L (2010) Supporting and mentoring nursing students in practice. *Nurs Stand* **25**(1): 41–6

Neuman WL (2013) *Social Research Methods: Qualitative and quantitative approaches*. 7th edn. Pearson Education, Essex

Nursing and Midwifery Council (2010) *Standards for pre-registration midwifery education*. NMC, London

Nursing and Midwifery Council (2012) *Midwives rules and standards*. NMC, London

Office for National Statistics (2015) Births in England and wales: 2015. http://tinyurl.com/jjarj85 (accessed 22 September 2016)

Perez-Botella M, Downe S, Magistretti CM, Lindstrom B, Berg M (2015) The use of salutogenesis theory in empirical studies of maternity care for healthy mothers and babies. *Sex Reprod Healthc* **6**(1): 33–9

Puia DM, Lewis L, Beck CT (2013) Experiences of obstetric nurses who are present for a perinatal loss. *J Obstet Gynecol Neonatal Nurs* **42**(3): 321–31

Roehrs C, Masterson A, Alles R, Witt C, Rutt P (2008) Caring for families coping with perinatal loss. *J Obstet Gynecol Neonatal Nurs* **37**(6): 631–9. doi: 10.1111/j.1552-6909.2008.00290.x

Sinclair M, Stockdale J (2011) Achieving optimal birth using salutogenesis in routine antenatal education. http://tinyurl.com/zrqxb7z (accessed 22 September 2016)

Wallbank S, Robertson N (2013) Predictors of staff distress in response to professionally experienced miscarriage, stillbirth and neonatal loss: a questionnaire survey. *Int J Nurs Stud* **50**(8): 1090–7

Wright PM, Hogan N (2008) Grief theories and models: applications to hospice nursing practice. *J Hosp Palliat Nurs* **10**(6): 350–6. doi: 10.1097/01.NJH.0000319194.16778.e5

Wuthnow R (2012) *Acts of compassion: Caring for others and helping ourselves*. Princeton University Press, Chicago