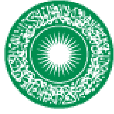

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Nurses attitudes towards perinatal bereavement care

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ORIGINAL RESEARCH

Nurses' attitudes towards perinatal bereavement care

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Abstract

Title. Nurses' attitudes towards perinatal bereavement care.

Aim. This paper is a report of a study conducted to explore the factors associated with nurses and midwives' attitudes towards perinatal bereavement care.

Background. Caring for and supporting parents whose infant has died is extremely demanding, difficult and stressful. In some situations nurses may experience personal failure, feel helpless, and need to distance themselves from bereaved parents because they feel unable to deal with the enormity of the parental feelings of loss.

Method. A correlational questionnaire study using convenience sampling was carried out in Singapore in 2007 with 185 nurses/midwives in one obstetrics and gynaecology unit.

Results. Regression models showed that nurses/midwives with religious beliefs and those with more positive attitudes to the importance of hospital policy and training for bereavement care were statistically significantly more likely to have a positive attitude towards perinatal bereavement care. Nurses emphasized their need for increased knowledge and training on how to cope with bereaved parents and requested greater support from team members and the hospital.

Conclusion. Bereavement counselling education and preceptorship supervision are recommended to reduce this stressful experience, increase the confidence and expertise of novices, and lead to increased quality of care for bereaved parents.

Keywords: attitudes, hospital policy, midwives, nurses, perinatal bereavement care, religion

Introduction

Perinatal loss is generally regarded as the most painful form of bereavement because it is unexpected, often sudden and sometimes unexplained (Chambers & Chan 2000). The general public often dismisses perinatal loss as not being true bereavement, and its traumatic potential has long been overlooked by clinicians and researchers [Stillbirth and Neonatal Death Society (SANDS) 1991]. Psychiatric morbidity such as depression, anxiety disorders, and somatic symptoms has been closely associated with such loss (Hughes *et al.* 1999; Säflund *et al.* 2004). In addition, feelings of helplessness are common, and bereaved parents need care and support through sensitive handling and careful communication (Hughes *et al.* 1999; Gaze 2000). SANDS recommends that all community health practitioners supporting bereaved

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parents should have access to basic, postbasic and in-service training to equip them to offer adequate care to such families (SANDS 1991). For many bereaved parents, the care that nursing staff provide may have a crucial effect on their response to such a death (Engler & Lasker 2000; Rowa-Dewar 2002). However, caring for and supporting parents whose infant has died is extremely demanding, difficult and stressful (Gensch & Midland 2000; Säflund *et al.* 2004), and in some situations nursing staff may experience personal failure because they feel helpless and unable to provide help (Robinson *et al.* 1999). Some nurses have commented that they need to distance themselves from bereaved parents because they feel unable to deal with the enormity of the parental feelings of loss (Paterson & Zderad 1988; Säflund *et al.* 2004). In addition, language or cultural barriers influence nurses' involvement in bereavement care (Engler *et al.* 2004).

Background

Nurses and midwives are often relied on to care for bereaved parents and families affected by these traumatic events, which are stressful for all involved (Black & Tufnell 2006), and are expected to interact with the bereaved in a supportive manner, regardless of whether they feel adequately prepared or disposed to do so (Cox & Briggs 2004). The theory of culture care diversity and universality was developed by Leininger (1997), and she emphasized that nurses should expand their thinking from a unicultural perspective to one that was multicultural, holistic, and comparative. Hence, because of the increasing need to work with families of divergent cultures, it is important for nurses to be familiar with the traditions and beliefs of others as well as what loss means to different individuals (Speck 1978; Gibson 1998). One of the culturally specific communication practices recommended for nurses when caring for bereaved family who are from Asia is speaking to the bereaved parent through a 'key person' (Engler *et al.* 2004). This person could be a respected or older person in the bereaved family. This, in turn, helps to develop positive attitudes; this can affect the quality of care provided (Gaze 2000; Birtwistle *et al.* 2002), for example by helping bereaved couples to cope with the grieving process and create healing memories.

In Asian countries, people treat death as a taboo subject (Yam *et al.* 2001; Ping *et al.* 2002), and attitudes towards bereavement are strongly influenced by the principles of Confucianism and Buddhism, which teach the importance, especially amongst men, of not crying or expressing negative emotion outside the family (Martinson 1998; Ping *et al.* 2002). The bereaved person often feels ashamed to show grief, especially outside their family (Wu & Tseng 1985). Yet the pain of losing a young child is revealed in the Chinese saying 'The white head witnesses the death of the black head with great pain' (the older generation witnesses the death of the younger generation), and for those with strong traditional beliefs, the pain is compounded by their need to be stoic and not reveal their true feelings at the loss of an infant. For bereaved couples, this very often means avoiding any discussion of the death to 'protect' relatives such as their parents or siblings (Gao *et al.* 1996). In the family, the centre of Singapore culture, the wishes of the bereaved couple must be respected. As the family interaction pattern is determined by the hierarchical family structure, nurses have to be very prudent in their approach to minimize any extreme expression of public emotion and to avoid situations that may imperil the parents' relationship. Since Singaporeans often avoid open displays of emotion or discussion of their feelings, especially with people outside the family, nurses must be able to pick up on the subtle and non-verbal ways of expressing emotion (Yam *et al.* 2001; Ping *et al.* 2002). These issues complicate bereavement care and make it difficult for affected parents to seek help. Furthermore, studies have shown that Asian people very often present emotional problems as somatic complaints (Wu & Tseng 1985). As a result of these cultural values or traits, it may not be easy for bereaved parents to express their needs nor for nurses or midwives to provide adequate help in the bereavement process.

In the past 10 years, some hospitals in Singapore have developed perinatal bereavement support groups in which staff educate, counsel and support bereaved parents. The role of these groups is to offer support and care to bereaved couples and to facilitate their recovery as they go through the grieving process. However, previous studies have revealed that hospital-based bereavement support services focus mainly on sorrow and harm reduction for bereaved families but seldom explore the needs of healthcare professionals (Chan & Chow 1998; Chan *et al.* 2005).

In 2004, the Child Bereavement Support (CBS) (Singapore) (http://www.childbereavementsupport.org.sg/; http://www.childbereavementsupport.org.sg/resources.html) was formed by a group of bereaved parents and healthcare professionals to support bereaved parents and to educate healthcare professionals (CBS; http://www.childbereavementsupport.org.sg/). Their first book, *Farewell, My Child*, published in 2005, is a collection of stories of childrens' deaths with examples of how the parents coped, and it explains how giving support to each other is therapeutic. Other related publications have addressed personal stories, shared experiences, and given advice or support for bereaved families, but few have examined nurses and midwives' needs and the supports

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necessary while providing perinatal bereavement care (CBS; http://www.childbereavementsupport.org.sg/resources.html).

Singaporean nurses/midwives work in a multi-cultural environment and are expected to understand the needs of Chinese, Malay and Indian patients, yet most of the literature is Eurocentric. To help nurses and midwives care for and support parents whose baby has died, and cope with their own feelings in this extremely demanding, difficult and stressful time, it is recommended that basic, postbasic and in-service education be provided (Gensch & Midland 2000). Special skills are needed to help bereaved parents, and after appropriate training it is logical to assume that nurses and midwives are better equipped to cope with perinatal bereavement (SANDS 1991). Typically, nurses receive little education to prepare them for dealing with the death of an infant or for assisting bereaved couples during and after this time (White *et al.* 2001; Engler *et al.* 2004). Szgalsky (1989) and Rybarik (1996) agreed that supportive and educational measures were necessary to help nurses in their work with bereaved people.

More recently, in a study in United States of America, Engler *et al.* (2004) found that nurses who had more experience and education related to bereavement were more comfortable providing this care. In addition, they found that language or cultural differences are influential factors in the level of nurses' involvement with bereaved families (Engler *et al.* 2004). In a study in Hong Kong, Yam *et al.* (2001) found that nurses felt ambivalent, helpless, and lacking knowledge and counselling skills in caring for dying infants and their bereaved families. In another study in Hong Kong, Chan *et al.* (2004) found that nurses' attitudes towards bereavement care were positively correlated with needs for training in bereavement care and support via hospital policies.

Hence, nursing models emphasize the importance of the assessment of bereaved families in a culturally sensitive manner and assist caregivers in increasing their effectiveness, overcoming cultural ignorance and coping better with their own grief responses (Leininger 1997; Keeney 2004). Much research has been conducted to investigate the needs and feelings of bereaved families and the care practices that are helpful to them, but there little information is available about the experience of, and factors affecting nurses' attitudes towards perinatal bereavement care.

The study

Aim

The aim of the study was to explore the factors associated with nurses' and midwives' attitudes towards perinatal bereavement care. We addressed two research questions: (1) What are nurses and midwives' attitudes towards perinatal bereavement care? and (2) What factors are associated with nurses and midwives' attitudes towards bereavement care?

Design

This study was a correlational study. The power analysis of the study was based on the attitudes towards perinatal bereavement care. A multiple regression model was used and 4–5 covariates were expected in the model (Chan *et al.* 2004). With an expected squared multiple correlation of 0·325, a sample size of 180 was required for the study to achieve 80% power at the 5% significance level (nQuery Advisor 2001).

Participants

Convenience sampling was chosen, and involved all nurses and midwives working in one obstetrics and gynaecology (O&G) unit in Singapore. The nurses working in the unit hold Enrolled or Registered Nurse qualifications and also a midwifery qualification.

Data collection

The data were collected in 2007 using a structured self-report questionnaire. The questionnaire, was developed by Chan *et al.* (2004), proved valid and reliable in a study with Chinese nurses in Hong Kong. The instrument has three sections. Section 1 collects demographic data (i.e. age, education level, recent ranking and religious background), experience (i.e. personal grieving, handling grieving clients and years of work in the obstetrics and gynaecology unit) and training (i.e. midwifery and bereavement care). In the original version, section 2 comprised eight attitude statements formulated to measure nurses' attitudes towards bereavement care (factor 1), but two questions were removed because of their low factor loadings (0·24), leaving a total of six questions for this study, and a high score indicates a positive and favourable attitude towards perinatal bereavement care. Section 3 was composed of two parts; the first comprised three statements used to evaluate nurses' attitudes towards the importance of hospital policy on perinatal bereavement (factor 2), with a high score indicating attitudes that are highly influenced by policy and a high demand for nurses with perinatal bereavement care training. The second part comprised four statements to evaluate nurses' attitudes towards the

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importance of formal training to deal with perinatal bereavement care (factor 3). In section 3, nurses were asked to rank each item, in each section, on 6-point Likert-type scales: (0) *Not applicable*, (1) *Very unimportant* or *completely disagree*, to (5) *Very important* or *completely agree*. Exploratory factor analysis (Table 1) was conducted to establish the construct validity of the instrument and three factors were emerged that accounted for 72·4% of the variance, with 52·3%, 11·9%, and 8·2% for factors 1, 2, and 3 respectively (KMO = 0·89, $\chi^2 = 1618{\cdot}2$, $P < 0{\cdot}001$). Cronbach's alpha values for factor 1, 2, and 3 were 0·85, 0·92 and 0·92 respectively.

Ward managers were asked to deliver information sheets, consent forms and questionnaire to all nurses and midwives in their ward to explain the aim of the study. Participants were asked to complete and return the consent forms and anonymous questionnaires within 2 weeks for collection from two boxes placed in each unit by the research team. These procedures minimized the possibility of ward managers knowing who had or had not participated in the study.

Ethical considerations

The study was approved by the appropriate ethics committee.

Data analysis

Exploratory factor analysis was used to identify the factorial construct of the instrument, and Cronbach's alpha coefficients were used to examine the internal reliability of the factor structure, while descriptive statistics were used to examine participants' background variables. A normality test revealed that the attitude scores were not normally distributed therefore nonparametric tests were used for further analysis. Although most of the data were not normally distributed, but our data set was large (n = 185) enough to presume that the data were normal. This assumption was based on the foundation of the central limit theorem that the cumulative distribution function of a variable will tends to be normal if its size was large (Spiegel 1992).

To examine which factors contributed to the attitude scores, bivariate analyses including Mann–Whitney *U* and

Table 1 Factor analysis of responses (n = 185) and comparison of responses on each item

Factor	Factor loading	Cronbach's α*	Score		
			1–2, *n* (%)	3, *n* (%)	4–5, *n* (%)
Factor 1: attitudes to perinatal bereavement care[†]					
1. I believe that the Grief Caring Programme can provide psychological support to the bereaved couple	0·60	0·85	2 (1·1)	11 (5·9)	172 (93·0)
2. I agree that the 'Good-bye Baby' Parent Support Group provides support to parents with similar experiences	0·54		3 (1·6)	18 (9·7)	164 (88·6)
3. I respect the bereaved parent's feelings and needs	0·81		0 (0·0)	3 (1·6)	181 (98·4)
4. I communicate with parents in a clear, sensitive and honest manner	0·77		1 (0·5)	13 (7·1)	169 (92·3)
5. I agree that parents should be given time to grieve	0·84		1 (0·5)	2 (1·1)	182 (98·4)
6. All those involved in the care of bereaved parents should be well-informed	0·69		3 (1·6)	8 (4·3)	173 (94·0)
Factor 2: attitudes on the importance of hospital policy to bereavement care[‡]					
7. The unit should have a clear policy for the management of bereavement	0·82	0·92	2 (1·1)	27 (14·8)	153 (84·1)
8. All staff involved should be well-informed about the policy	0·85		2 (1·1)	15 (8·2)	167 (90·8)
9. All staff involved should understand the policy	0·87		1 (0·5)	15 (8·2)	167 (91·3)
Factor 3: attitudes to training for bereavement care[‡]					
10. Joining a training programme on bereavement care	0·78	0·92	4 (2·2)	26 (14·1)	154 (83·7)
11. Participating in bereavement care	0·82		5 (2·7)	30 (16·3)	149 (81·0)
12. Sharing experiences with colleagues and working as a team	0·84		6 (3·3)	26 (14·2)	151 (82·5)
13. Seeking support when experiencing 'burnout'	0·75		5 (2·7)	17 (9·2)	162 (88·0)

*Cronbach's alpha.
[†]Strongly agree (5), agree (4), uncertain (3), disagree (2), strongly disagree (1), not applicable (0).
[‡]Very important (5), important (4), uncertain (3), unimportant (2), very unimportant (1), not applicable (0).

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Kruskal–Wills tests were used, while Spearman's correlation coefficient (r_s) was used to examine the relationships among nurses' attitudes towards bereavement care, importance of hospital policy to bereavement care, and training for bereavement care. Although most of the data were not normally distributed, our data set was large ($n = 185$) enough to presume that the data were normal. This assumption was based on the central limit theorem that the cumulative distribution function of a variable will tend to be normal if its size is large, e.g. $n > 100$. (Spiegel 1992).

A multiple regression (stepwise) model was used to identify which factors predicted attitude scores towards perinatal bereavement care, with the level of statistical significance set at $P < 0{\cdot}05$.

Results

Participant demographics

Overall, 276 questionnaires were distributed and 185 (67% response rate) were returned within 2 weeks. Table 2 shows that there were 19 senior nurses/midwives (10·3%) and 160 Enrolled/Registered Nurse/Midwives (87·0%). More than 42·0% ($n = 77$) were aged 41 years or above, 75·5% ($n = 138$) had a religious background and more than 53·0% ($n = 98$) had more than 11 years' experience in the O&G unit. Only 24·4% ($n = 44$) held a Bachelor's degree in nursing, while the remainder were diploma or certificate holders. There were 61·4% ($n = 113$) with experience in handling grieving clients, but <25% ($n = 47$) had taken a bereavement care course.

Attitudes towards perinatal bereavement care

Table 1 displays the frequencies of responses to items on attitudes towards bereavement care (statements 1–6). Most ($n = 172$, 93·0%) strongly agreed/agreed that a grief counselling programme can provide psychological support for the bereaved couple, 98·4% ($n = 182$) strongly agreed/agreed that bereaved parents should be given time to grieve, 94·0% ($n = 173$) strongly agreed/agreed that all those involved in the care of bereaved parents should be well-informed, and 92·3% ($n = 169$) that staff should communicate with bereaved parents in a clear, sensitive and honest manner. However, 11·3% ($n = 21$) disagreed/were uncertain that the 'Good-bye Baby' Parent Support Group provides support for parents with such an experience, and 5·9% ($n = 11$) disagreed/were uncertain that all involved in the care of bereaved parents should be well-informed. The results, in general, showed that the majority had indicated a positive attitude towards perinatal bereavement care.

Three items (statements 7–9) were related to hospital policy support for bereavement practices (see Table 1) and 84·1% of respondents ($n = 153$) claimed that it is very important/important that there should be a clear policy for the management of bereavement care in the obstetric unit. Over 90% claimed that it was very important/important that

Table 2 Participants demographics

Demographic	Total ($n = 185$), n (%)
Age (years)*	
18–25	24 (13·3)
26–30	28 (15·5)
31–35	14 (7·7)
36–40	38 (21·0)
41+	77 (42·5)
Ethnic group†	
Chinese	90 (49·1)
Malay	44 (24·0)
Indian	35 (19·1)
Other (e.g. European, American)	14 (7·7)
Staff grade‡	
Nursing/midwifery student	5 (2·7)
Enrolled Nurse/Registered Nurse/Midwife	160 (87·0)
Senior nurse/midwife	19 (10·3)
Educational level§	
Diploma or below	136 (75·6)
Bachelor or above	44 (24·4)
Experience in obstetrics and gynaecology‡ (years)	
<5	48 (26·1)
5–10	38 (20·7)
11+	98 (53·3)
Midwifery training†	
Yes	84 (45·9)
No	99 (54·1)
Religious beliefs†	
Yes	138 (75·5)
No	46 (25·0)
Personal grieving experiences†	
Yes	116 (63·4)
No	67 (36·6)
Taken training/courses related to bereavement care*	
Yes	47 (25·5)
No	137 (74·5)
Past experience in handling grieving parents‡	
Yes	113 (61·4)
No	71 (38·6)

*Four missing data.
†Two missing data.
‡One missing data.
§Five missing data.

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they should be well-informed (n = 167) and the policy understood by all staff (n = 167).

Four items (statements 10–13) reflected the need for formal education in grief counselling (see Table 1). More than 82% percent said that they would share experiences (n = 151) with their colleagues and seek support when feeling 'burnout' (n = 162), while 83·7% (n = 154) replied that it was very important/important to have opportunities to join a training programme on bereavement care.

Factors associated with attitudes towards perinatal bereavement care

To determine which factors might be associated with respondents' attitudes towards bereavement care, a multi-

Table 3 Univariate comparison of attitudes towards bereavement care scores by demographics

Demographic	n	Mean ± SD	Statistics	P value
Age (years)[†]				
≤25	24	26·0 ± 2·8	11·2	0·025*
26–30	28	25·9 ± 3·2		
31–35	14	28·1 ± 2·0		
36–40	38	27·5 ± 3·1		
> 41	77	26·9 ± 3·5		
Staff grade[†]				
Nursing/midwifery student	6	26·8 ± 2·5	8·8	0·008**
Enrolled Nurse/Registered Nurse/Registered Midwife	291	26·5 ± 2·4		
Senior nurse/midwife	26	28·0 ± 2·2		
Ethnic group[†]				
Chinese	90	26·5 ± 3·0	5·0	0·169
Malay	44	26·7 ± 4·2		
Indian	35	27·3 ± 2·4		
Other (e.g. European, American)	14	28·3 ± 2·1		
Education level[‡]				
Diploma or below	136	26·7 ± 2·9	2626·5	0·218
Bachelor or above	44	26·9 ± 4·2		
Experience in obstetrics and gynaecology (years)[†]				
< 5	48	26·6 ± 2·8	8·61	0·014*
5–10	38	25·9 ± 3·1		
11+	98	27·3 ± 3·4		
Midwifery training[‡]				
Yes	84	27·3 ± 2·8	3680·5	0·175
No	99	26·5 ± 3·5		
Religious beliefs[‡]				
Yes	138	27·2 ± 3·2	2271·0	0·003**
No	46	25·8 ± 3·1		
Personal grieving experiences[‡]				
Yes	116	27·2 ± 3·3	3089·0	0·019*
No	67	26·3 ± 3·0		
Taken training/courses related to bereavement care[‡]				
Yes	47	27·7 ± 2·4	2573·0	0·037*
No	137	26·6 ± 3·4		
Past experience in handling grieving parents[‡]				
Yes	113	27·3 ± 3·3	2946·5	0·002**
No	71	26·1 ± 2·9		
Attitudes on importance of hospital policy to bereavement care[§], r_s	184		0·56	< 0·001**
Attitudes to training for bereavement care[§], r_s	184		0·59	< 0·001**

[†]Kruskal–Wallis.
[‡]Mann–Whitney U-test.
[§]Spearman coefficient.
Statistically significant at $*P < 0·05$; $**P < 0·01$; NA, not available.

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variate analysis was performed. First, a bivariate analysis (see Table 3) revealed statistically significant differences between the factors of age ($P = 0{\cdot}025$), recent ranking ($P = 0{\cdot}008$), experiences in O&G ($P = 0{\cdot}014$), religious beliefs ($P = 0{\cdot}003$), personal grieving experiences ($P = 0{\cdot}019$), having taken bereavement care training/courses ($P = 0{\cdot}037$) and past experiences in handling grieving parents ($P = 0{\cdot}002$) compared with attitude scores towards bereavement care. Statistically significant positive correlations were found between attitude scores towards bereavement care and attitudes towards the importance of hospital policy ($P < 0{\cdot}001$) and training for bereavement care ($P < 0{\cdot}001$).

Second, a multiple regression (stepwise) analysis was used to identify a model to predict attitude scores towards bereavement care (see Table 4). The results showed that those having religious orientation (Beta = 1·12, $P = 0{\cdot}010$) and more positive attitudes towards the importance of hospital policy (Beta = 0·42, $P < 0{\cdot}001$) and training for bereavement care (Beta = 0·46, $P < 0{\cdot}001$) were statistically significantly more likely to have a positive attitude towards bereavement care. This model had a good fit ($F = 41{\cdot}8$, $P < 0{\cdot}001$), with an adjusted R^2 of 42·0%.

Discussion

While some important findings emerged which help inform future educational and clinical directions, some limitations should be mentioned First, the homogeneity of the sample introduces systematic bias as they were from one hospital, the majority were Chinese, and their educational level was diploma or below. Thus, generalization of the findings to the entire population of interest should be made with caution and future studies should be based on sufficient sample sizes from more hospitals. Further, based on our findings from the regression model, power analysis suggested that a sample size of approximately 366 was required to achieve 80% power and a 5% level of statistical significance. Second, we used a self-report questionnaire, which may have caused response bias (Polit & Hungler 1995). For example, under some circumstances, socially desirable responses might result in responses appearing more normal or acceptable to the researcher. Third, bereaved parents were not surveyed, and so no comparisons between nurses' and parents' perceptions can be made. Finally, we recommend that a qualitative study using individual or focus group interviews should be carried out to explore the cultural subtleties of Singapore's three main cultural groups and the meaning of perinatal bereavement care for nurses.

This study paves the way for a more systematic study of perinatal bereavement care among nurses in Singapore as caring for bereaved parents clearly has a powerful impact. Our findings confirm the need for improved communication skills and greater support from team members. This is supported by previous researchers who have likewise suggested that psychological and emotional support for nurses is necessary to enable them to support bereaved parents (Gardner 1999; Birtwistle *et al.* 2002; Chan *et al.* 2004). Supportive care practices for nurses should be established, understood, and practised by all members of the perinatal care team (Beem *et al.* 1998; Birtwistle *et al.* 2002; Black & Tufnell 2006).

In Singapore, three cultures (Chinese, Malay and Indian) involve many traditional rituals conducted during the grieving process that can facilitate the acceptance of death. In Singapore Chinese people, believe that the natural extension of a 'good death' connotes a combination of life accomplishments and death without suffering. In Chinese culture, death without suffering means death without pain or physical

Table 4 Multiple (stepwise) regression model on nurses and midwives' attitudes towards bereavement care by factors

	Singapore (n = 185)			
Factors	Beta	|t|-statistics	P value	VIF
Constant	12·60	9·72	< 0·001**	
Demographic				
• Religious belief (0, no; 1, yes)	1·12	2·60	0·010*	1·001
Attitude scores				
• Importance of hospital policy to bereavement care	0·42	3·57	< 0·001**	1·716
• Training for bereavement care	0·46	5·51	< 0·001**	1·714
Adjusted R^2		0·42		
F-statistics		41·83	< 0·001**	

Statistically significant at *$P < 0{\cdot}05$; **$P < 0{\cdot}01$.
VIF, variance inflation factor, a higher value meaning more dependent on other factors.

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What is already known about this topic

- When nurses or midwives provide bereavement care, negative attitudes may distract from the provision of good care, whilst positive attitudes can help bereaved couples to cope with the grieving process.
- Much research has been conducted to investigate the needs and feelings of bereaved families and the care practices that are helpful to them, but there is little mention of the needs and feelings of the nurses who care for them.

What this paper adds

- Nurses and midwives had a very positive attitude towards perinatal bereavement care.
- Almost all viewed their level of knowledge and understanding of grief counselling as insufficient and only 25·5% had taken courses related to bereavement care.
- The goal of quality bereavement care can only be achieved when nurses' education and training needs are addressed.

Implications for practice and/or policy

- Nursing educators should include perinatal bereavement care in nursing or midwifery curricula and provide experience in clinical practice and this should be reinforced by staff development workshops in the hospitals.
- Nurses and midwives with appropriate education and skills should carry out perinatal bereavement care as part of their regular practice and appreciate the importance of referral when appropriate.

struggle (Hsu 1983). Infant loss violates the definition of a good death because it is coloured by early ending and physical deformation. Such cultural norms, which promote the importance of family continuity in achieving wholeness and good deaths, serves to punish mothers who fail to carry out their childbearing responsibilities. To our knowledge, no research has been carried out to recognize the experiences of Singaporean nurses/midwives, many of whom do not know the meaning of such rituals despite following them blindly; this especially concerns coping strategies and interpretation of feelings towards perinatal bereavement care in different ethnic groups. Thus, research in this area could be an important step towards understanding the bereavement process and opening up cross-cultural dialogue about it. Students and junior nurses/midwives in the O&G unit need the guidance of more experienced colleagues to be able to give effective bereavement care and learn strategies to avoid negative experiences. Mentoring by preceptors would provide a more educational and less stressful experience, increase the confidence and expertise of novices, and lead to increased quality of care for bereaved families.

For Singaporean nurses and midwives, religious belief was a factor affecting their attitudes towards bereavement care and this implies that education programmes about different religions and religious practices and referral opportunities should be considered. A systematic review conducted by Rowa-Dewar (2002) has shown no overall benefit from interventions among bereaved parents, except for highly distressed mothers whose psychological symptoms and marital dysfunction were statistically significantly reduced. Applied to practice, her findings suggest that some bereaved parents will benefit from a specific bereavement support programme. Therefore, undergraduate and on-going education is necessary for staff, although in general most participants had a positive respect for bereaved parents' feelings and needs, and agreed that they should be given time to grieve. Respondents also believed that nurses working in the unit should be well- informed, with a clear policy for the management of bereavement, and given information that would help bereaved parents make plans and decisions for themselves. Some bereaved parents have felt that the care provided by nursing staff could also make them powerless (Paterson & Zderad 1988; Chambers & Chan 2000), and this phenomenon may occur when the focus is on symptoms or parts of the problem rather than on the whole person. Being treated as an object in this way can make parents keep their thoughts to themselves or lead them to feel that nursing staff were neglecting their thoughts, all of which may lead to insecurity and discouragement (Lundqvist *et al.* 2002).

Conclusion

Our findings support earlier reports that support and education are necessary to help nurses in their work with bereaved families. Bereavement counselling education and preceptorship supervision are recommended to reduce this stressful experience, increase the confidence and expertise of novices, and lead to increased quality of care for bereaved parents.

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Conflict of interest

No conflict of interest has been declared by the authors.

Author contributions

MFC was responsible for the study conception and design; performed the data analysis; and provided statistical expertise. DGA performed the data collection. MFC and DGA were responsible for the drafting of the manuscript; made critical revisions to the paper for important intellectual content.

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