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Coping with Burnout: The Emotional Burden on Healthcare Professionals in Maternity Services

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Abstract

Background. Those healthcare professionals working in the field of maternity are very much exposed to miscarriage and other trauma related with it and holds an emotional burden on them, yet this area remains underexplored. This research helps in uncovering the coping mechanisms of Gynecologists and nurses and how this affects their mental wellbeing and job with a focus on emotional burden and coping responses.

Method. For data collection, semi structured interviews were conducted including (*n*=5) gynecologists and (*n*=3) nurses. This was done through purposive sampling. Following the approach of Braun and Clark (2006,2021) thematic analysis was performed to identify the data patterns.

Results. As a result, following themes were identified: (1) Emotional Burden of working with reproductive loss, (2) Coping Strategies and personal resilience, (3) Collective support and workplace solidarity and (4) Systematic gaps and need for institutional support. Data from participants highlighted emotional pressure can be increased due to continuous exposure with miscarriage related trauma, which exceeds work related stress. Taking small breaks, engaging in recreational activities and connecting with supportive people shows great effort towards emotional regulation, however depending mainly the individual coping also reveals some of the gap formal institutional support. Emotional expression was appeared as one of the critical methods by which the participants were able to manage distress, furthermore highlighting the role of social relationships in lightening psychological strain. Personal anxieties of the participants were also reported due to ongoing exposure to reproductive loss, they showed concern of their own pregnancies which shows a mixture of professional and personal boundaries highlighting the deep effect of miscarriage exposure.

Discussion. These findings showcase the impact of social and cultural factors in Pakistani settings with respect to gynecologists and nurses working in maternity settings highlighting the emphasize on both personal coping strategies and institutional assistance.

Conclusion. This research highlights the necessity for context specific support system to enhance the wellbeing of healthcare professionals and the quality of care they deliver.

Keywords. Miscarriage care, gynae staff, burnout, emotional strain, coping strategies, qualitative research

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Introduction

The gynae staff in the maternity department assume a very special role in any healthcare system because they are constantly subjected to life-affirming and highly traumatic events. Although childbirth is usually linked to happiness and celebration, maternity care providers especially gynecologists and maternity nurses are constantly faced with pregnancy loss, miscarriage, stillbirth and other complications. Such events filled with emotions put these professionals at high risk of psychological distress and burnout when they are repeated (Beck & Gable, 2012; Leinweber et al., 2017).

Burnout is an occupational phenomenon and is multidimensional and is accompanied by emotional exhaustion, depersonalization and diminished personal accomplishment (Maslach, Schaufeli & Leiter, 2001). Burnout in healthcare professionals has been associated with such adverse effects as anxiety, depression, decreased job satisfaction, empathy impairment, and diminished quality of patient care (Shanafelt et al., 2015; West, Dyrbye & Shanafelt, 2018). The gynae staff who deal with trauma-intensive patients, including maternity and obstetric care, are especially susceptible to prolonged emotional labour and empathic connection with patients who have suffered a loss (Figley, 1995; Stamm, 2010).

There are also high psychological demands for the gynecologists and nurses, such as providing bereavement care to families experiencing a loss Ravaldi et al, (2022) or the lasting impact of being involved in critical workplace incidents (Buhlmann, Ewens & Rashidi, 2021).

Miscarriage, specifically, is a complicated clinical and emotional phenomenon that has a very significant meaning to patients and families. It has been proposed in research that healthcare delivery professionals in the event of pregnancy loss are prone to secondary traumatic stress, compassion fatigue, and moral distress when dealing with the grief of patients and having to suppress their own feelings (McCreight, 2005; Goldbort et al., 2011). Furthermore, studies also highlight that maternity healthcare providers frequently experience secondary traumatic stress and moral injury due to repeated exposure to traumatic birth events, which can significantly impact their psychological wellbeing (Kendall-Tackett, 2022). The necessity to be calm and professional even during recurrent loss may add emotional pressure and burnout in the long run (Hunter & Warren, 2014).

Although there is increasingly more awareness of burnout in the healthcare setting, there is a lack of research into emotional experiences and coping strategies of maternity professionals, specifically in the context of miscarriage care, especially in low- and middle-income nations. The literature has concentrated mostly on workload, staffing, and systemic pressures, and relatively little has been done on the emotional and psychological impact of reproductive trauma on practitioners themselves (Leinweber & Rowe, 2010). Such experiences are also culturally contextual because societal expectations, miscarriage stigma, and inadequate mental health care of institutions can contribute to the stress experienced by healthcare personnel (Koenig, 2012; Shanafelt & Noseworthy, 2017).

Strategies of coping are important in reducing burnout. The transactional model of stress and coping developed by Lazarus and Folkman (1984) emphasizes the way individuals deal with stress using both emotion-oriented and problem-oriented approaches. Social support, emotional expression, spirituality, and engagement in restorative activities have been related to adaptive coping among healthcare professionals (Folkman & Moskowitz, 2004; West et al., 2016). However, when individual efforts in coping remains limited without sufficient institutional support, its effectiveness in lowering burnout and psychological distress could notably be reduced.

With these gaps established, the present study will investigate the emotional strain, coping mechanisms, and perceived support needs for gynecological and nurses staff, particularly related to experiences of miscarriage and reproductive loss. Using a qualitative methodology, this study seeks to understand the lived experiences of gynecologists and nurses while also offering contextually relevant information that can be applied in creating trauma-informed and supportive care practices.

Objectives of the study

1. To explore the emotional experiences of gynae staff working in miscarriage and pregnancy loss settings.
2. To explore the coping strategies to manage work related emotional strain and psychological distress.
3. To identify the role of social and peer support systems, particularly among colleagues in alleviating emotional burden.
4. To explore the perceived impact of institutional support (counselling services, workload management) on reducing burnout and emotional distress.
5. To understand how repeated exposure to pregnancy loss influences healthcare professionals, their perception and anxieties including those related to their own reproductive experiences.

Research questions

1. How do gynae staff experience and interpret emotional strain while managing miscarriage and pregnancy loss cases?
2. What coping strategies do healthcare professionals employ to manage emotional distress associated with their work?
3. How do peer relationships and workplace social support contribute to coping and emotional regulation?
4. What role do institutional structures and policies play in supporting or limiting healthcare professionals' wellbeing?
5. How does professional exposure to miscarriage influence healthcare professionals' personal beliefs, fears, and psychological wellbeing?

Method

Research Design

The current research used the qualitative research design based on semi-structured interviews to investigate the emotional experiences, the burnout, and coping strategies of the the gynae staff working in maternity services. Qualitative approach was suitable because it is possible to explore subjective experiences, meanings, and emotional processes in-depth (Creswell & Poth, 2018). The data analysis was based on the thematic analysis model of Braun and Clarke (2006, 2021).

Participants

The sample was (N=8) healthcare professionals who work in maternity services, (n=5) gynecologists, and (n=3) nurses who are working in maternity services. Purposive sampling was used to recruit the participants as they were all professionals who had a first-hand experience of miscarriage care and experienced reproductive trauma.

Inclusion Criteria

- At least 5 years of experience in the field of gynecologists or maternity nurses.
- Had direct experience in giving care to women who had miscarriage or pregnancy related complications.

Data collection

The collection was done using semi-structured, in-depth interviews, which was flexible to enable us to cover personal experiences and consistent in all interviews. Data collection was guided by the principle of thematic saturation, whereby interviews were conducted until no substantially new patterns were identified in the data.

The interviews were conducted using either the Urdu or English language, depending on the language of choice of each participant, thus providing ease and sincerity in their expression. The interviews were conducted individually and scheduled according to participants' availability, including their preferred time and mode of communication. The interview time lasted between 25 to 35 minutes.

The interviews were conducted by the primary researcher, **participants were informed about the voluntary nature of participation, assured of confidentiality, and encouraged to share their experiences openly. The researcher adopted a neutral and non-judgmental approach during interviews to reduce response bias and facilitate honest disclosure.** The interviews were recorded on tape with the express consent of the interviewees and transcribed word-to-word. In order to preserve confidentiality, identifying information was eliminated and members were given role-based identifiers (e.g., G1, N2).

Ethical Considerations

The study received ethical consent of the concerned institutional ethics review committee. The participants were told the objective of the study, that they could pull out at any point and that the study was voluntary. During the research, confidentiality and anonymity were guaranteed. Since the matter is sensitive, the participants were also told that they could take a break or cancel the interview in case they felt emotionally uncomfortable.

Data Analysis

Thematic analysis was used to analyze data through the six phases proposed by Braun and Clarke (2006, 2021), following a reflexive and interpretive approach. Transcripts were read and re-read to ensure familiarity with the data, while actively engaging with emerging meanings and patterns. Initial notes and significant segments were identified, reflecting early interpretive insights. At the second stage, initial codes were generated inductively using the data, with the support of NVivo to organize the coding process. Initially coding was introduced at semantic level with focus on its latent explanation. In contrast to NVivo coding, initially the transcripts were marked manually to assure a deep insight to grip subtle interpretations. The main purpose of the coding was to unveil the patterns of mutual meanings which provided the base for possible themes. The next goal was to enhance the themes to understand and further clear to make sure internal coherence and uniqueness with intention to get the detail of impact on full story. This process of identifying and labelling themes included iterative refinement to ensure that each theme represented a consistent pattern in the data. Final themes were reviewed against the dataset to ensure the accuracy in reflecting participant's experiences.

Throughout the analysis, the researcher remained reflexive of their interpretive role and positionality, particularly within the hierarchical and cultural context of the Pakistani healthcare system, which may have influenced both data collection and interpretation. Reflexive engagement was maintained throughout the research process to ensure that participants' voices were represented authentically.

Results

Table 1

Participants Characteristics *(N=8)*

Participant	Role	Age	Experience	Average MC handled	work setting	Training in mental health
G1	Gynecologist	38	12 years	7-8 per month	Semi Government/ Maternity Clinic	No
G2	Gynecologist	46	10 years	7-8 per month	Semi Government/ Maternity Clinic	1 course
G3	Gynecologist	36	7 years	7-8 per month	Semi Government/ Maternity Clinic	1 course
G4	Gynecologist	46	20 years	2% per month	Private	No
G5	Gynecologist	38	8 years	5-6 per month (can vary)	Semi Government/ Maternity Clinic	No
N1	Nurse	33	6 years	Many	Public	No
N2	Nurse	50	18 years	8-10 per month or less	Public	No
N3	Nurse	33	6 years	5-6 per month	Public	1 course

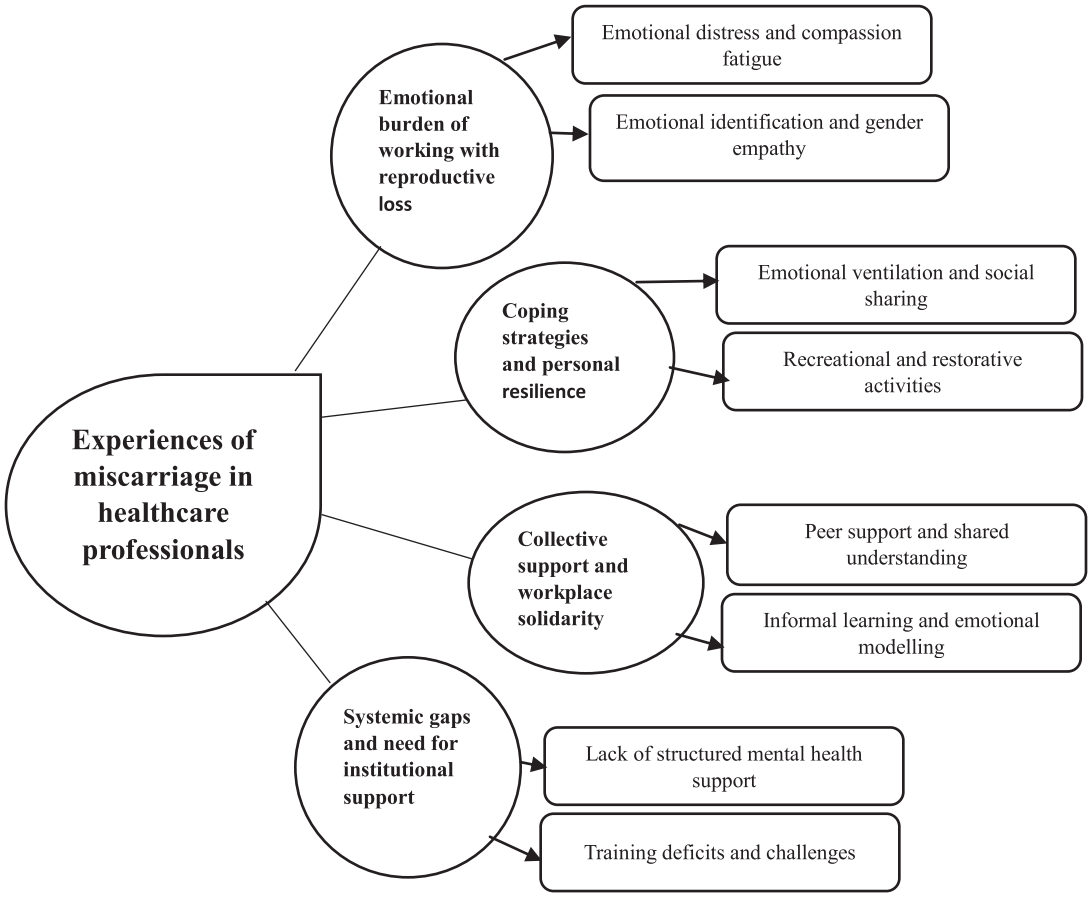

Figure 1: Thematic map illustrating the gynae staff's experiences of miscarriage related work in maternity services.

The figure depicts four interrelated themes and associated subthemes identified through reflexive thematic analysis, highlighting the emotional burden, coping strategies, collective support and systematic challenges experienced by healthcare professionals working in maternity services.

Theme 1: Emotional burden of Reproductive loss

This theme reflects the reflective emotional effect of recurrent exposure to miscarriage, trauma, and patient suffering, and how the role as a professional overlap with the emotional reaction to it.

Emotional Distress and Compassion Fatigue

Respondents said that they were sometimes deeply disturbed by their job and that they often felt emotional overload that came in tears, sadness and exhaustion. Professional training notwithstanding, recurrent experience of loss was reported to be an emotionally demanding experience: "*It is at times so disturbing that I sit down and cry and this is the truth*." (G1). Nurses also indicated emotional load especially when patients are in pain: *"I myself also feel very burdened at times. I feel deeply sad"*. These stories imply the existence of compassion fatigue, where repeated caregiving in trauma-related facilities burns out emotional strength.

Gender Empathy and emotional identification

Female medical workers, particularly nurses, emphasized a feeling of emotional attachment to the patient based on the sense of common womanhood and reproductive vulnerability: "*being women we empathize strongly*" (N2). This empathy which is gender-based, increases the emotional involvement which sometimes makes it harder to maintain professional boundaries and increases the risk of burnout.

Furthermore, it was reported by participants that their work is emotionally demanding, which shows noticeable emotional reactions. This

recommends that being into this miscarriage related trauma on daily basis contributes to increasing emotional strain, extending beyond routine occupational stress. Due to such experiences, where indirect exposure to patient's grief fallouts in psychological burden that may also reflect the foundations of secondary traumatic stress. This emphasize the need to understand the emotional exhaustion shall not only be recognized as personal reaction, but as something which is influenced by demanding nature of maternity care work.

Theme 2: Coping and Personal resiliency

This theme reflects how gynae workers manage with burnout using individual methods, emotional burnouts and changes in lifestyle.

Social sharing and emotional ventilation

The participants stressed the significance of sharing and experiencing with trusted people as one of the key coping mechanisms: *"Telling and letting out what you are feeling and letting out emotions is a huge relief."* (G3). Close friends and spouses were often recognized as the safe sources of emotions: "*I tend to share my routine and everything with my husband... I am very close to him."* (G3).

Leisure and Rehabilitation Events

Activities like reading, driving, vacations and spending time with family were reported to be an important source of dealing with emotional distress and emotional recovery: "*Vacations, I like to read books and going on drives is very good*" (G4). The need of purposeful rest was also emphasized by doctors: "*Doctors need to relax during weekends, once a month they should go somewhere*" (G1). These actions were also found to be a protective measure towards emotional exhaustion.

Coping methods such as seeking support from friends and engaging in recreational activities were reported by participants. This helps in demonstrating how individuals try to manage emotional difficulties through practical actions and support.

Theme 3: Workplace Solidarity and Collective Support

This theme highlights the role of interpersonal relationships that exists in a workplace that helps in reducing the effect of burnout.

Shared Understanding and Peer support

While interviewing the participants, the nurses especially reported that they support each other and used to express their emotions with colleagues "we sit together and discuss with each other" (N2). This feeling of being with each other and sharing the commo experiences helps in minimizing the emotional burden.

Informal Learning and Modelling of Emotions

Participants highlighted that they learned managing their emotions and communication skills through their senior's experiences. Watching them how they handle everything helped grooming their professional life which was an informal mean of learning. "*We learned watching how our seniors coped with the situation*" (G1). In this regard experiential learning is focused more as compared to institutional learning.

Peer support was found to be an important aspect, which proposes that this kind of support systems function as an important barrier against emotional strain. Role of shared professional skills in nurturing emotional validation and reducing the isolation in high-stress clinical environment were also reflected.

Theme 4: Systematic Gaps and Need for Institutional Support

This theme shows the perceptions of the participants of the systemic failures that cause burnout and emotional stress.

Absence of Organized Mental Health Care

The respondents repeatedly stressed the lack of official mental health services among the medical workers: *"Mental health is not really paid much attention here."* (N3). Doctors and nurses both supported counselling services, frequent check-ups, and emotional support systems.

Training Shortcomings and Communication Problems

Some doctors stated that they were exposed to counselling workshops and how to break bad news, how to treat the patient ant this hard time

but there were some who emphasized that there was no formal training in skills: *"there should be basic training in skills enhancement."* (G2). The participants emphasized the significance of such training as bad news breaking, patient counselling and emotional self-regulation.

Fear and Individual Vulnerability

The male professionals were affected by miscarriage as well, as they experienced personal anxieties especially when it came to female employees: "*when I became pregnant, I felt so much fear in my heart*." (N3). This is how work experiences invade personal life, making them more stressful and emotionally fragile.

All in all, the results indicate that maternity service healthcare professionals are exposed to a high rate of emotional burden and burnout as a result of repetitive exposure to reproductive trauma. Though people have their own coping styles, and they have their informal peer supports, there are no formal institutional systems to support them thus they are exposed to emotional burnouts.

Emotional stress is not just a personal concern but it has its roots within the organizations and the participants highlighted the need for support in this context. These concerns mark the importance of systematic measures in handling the burnout and helping maternity healthcare workers.

Discussion

The current study investigated the emotional load and coping strategies of healthcare workers working in the maternity department, especially those working with miscarriage and reproductive trauma regularly. In line with the available literature, the results show that burnout in gynae staff goes beyond physical workload to deep-rooted emotional labour, frequent exposure to loss, and emotional involvement with patients (Maslach, Schaufeli, & Leiter, 2001; Figley, 1995). Using a reflexive thematic analysis (Braun & Clarke, 2006,2021), four themes in relation to each other were identified, which, in totality, shed light on the psychological toll of providing care in trauma-prone maternity environments.

The emotional burden of working with reproductive loss is the first theme, which is highly similar to the literature on compassion fatigue and secondary traumatic stress in healthcare workers. The descriptions of emotional distress, tearfulness and exhaustion by the participants are similar to the findings by Figley (1995) and Stamm (2010) who reported the effect of chronic exposure to the trauma of others in draining emotional resources even in the highly trained professionals. The expression of gendered empathy is the reflection of the previous research which has suggested that the similar gendered and reproductive identity can raise the emotional response towards the miscarriage and infertility experiences of patients (Beck & Gable, 2012; Leinweber et al., 2017). Although empathic engagement will be the core of quality maternity care, the results indicate that without proper emotional protective measures, empathic engagement can make nurses more vulnerable to burnout.

Participants' accounts of emotional exhaustion and, at times, visible distress reflect the impact of sustained empathetic engagement with patients experiencing miscarriage. This corresponds with the idea of compassion fatigue, where extended caregiving in emotionally challenging environment results in a gradual emotional exhaustion (Charles Figley, 2002; Stamm, 2010). This further indicated that the emotional strain faced by gynae staff stems not only from their workload but also from continuous indirect exposure to trauma (Bride, 2007).

The second theme, coping strategies and personal resilience, shows that the healthcare professionals primarily utilize coping skills at personal level which is manifested as emotional expression, communal sharing, spiritual traditions and leisure pursuits. This result aligns with the research that have indicated that emotion-focused coping such as expressing feelings, looking for social support and process of finding meaning are the factors that can help reduce occupational stress in a healthcare setting (Folkman & Moskowitz, 2004; Lazarus & Folkman, 1984). The emphasize on prayer, faith and spirituality among the participants as a means of solace aligns with findings from research carried out in culturally and religiously contextual environment where spiritual coping has been demonstrated to facilitate and manage stress and assist the participants in adapting (Koenig, 2012).

The reliance on self-managed coping resources also reveals a systemic gap, as past research indicates that individual resilience alone cannot control high stress and burnout in high intensity clinical environment (West et al., 2016).

The third theme, focusing on collective support and solidarity in the workplace, emphasizes the importance of peer relationship in reducing emotional stress. Research indicate that collegial support is significant protective element against emotional burnout and fatigue which is also reflected in participant's descriptions that emotional support and shared comprehension helps in mitigating the stress caused by exposure to reproductive loss (Shanafelt et al., 2015; Halbesleben, 2006). The learning by observing the experienced colleagues exemplifies the hidden curriculum in medical education where skills in emotional management are not explicitly taught but acquired through indirect means (Hafferty, 1998). While the peer solidarity provides an important buffer against emotional strain, its sustainability is restricted by the lack of formal debriefing process and supervisory frameworks, particularly for less experiences staff.

Systematic gap and institutional support which is the fourth theme, underscores the structural nature of burnout within the health care settings. The concern that participants highlighted regarding the inadequate mental health provision, limited/ no access to counselling services and insufficient preparation for emotionally intensive news breaking were highlighted as the institutional shortcomings. This aligns with the work of Shanafet and Noseworthy (2017), who were explained burnout not as individual weakness but it is a consequence of organizational and workplace circumstances. Their findings further suggested that female workers during their pregnancy gets more effected by repeated professional exposure which can be even beyond their workplace. Such increased fear and exposure, being alert all the time and huge emotional sensitivity in their personal life were also highlighted in a study conducted by Mealer et al. 2012.

Strong emotional distress was reported by participants, where keeping distance from miscarriage related experiences was reported as one of the copings methods they used which further emphasizes that different people responds to repeated trauma in multiple ways. The present study findings are in line with the previous literature which suggests that coping is a multifaceted and diverse process. Transactional model of stress and coping recommends that it depends on how the person perceives challenging situations and what coping resources are available for them. Some rely on avoidance or withdrawal while some express their emotions openly.

Findings of the present study, must also be interpreted by keeping in view the cultural context of Pakistan, and with reference to our culture where this phenomenon is usually responded with silence and stigma. According to participants, especially in clinical environment, emotional suppression and the need to sustain the professional composure was reflected which prevails in our cultural norms where open expression about distress is discouraged. Relying on informal support like family and colleagues underscores the collectivistic aspect of Pakistani culture where personal connections are important in handling emotional difficulties.

These findings can also be understood through the lens of Transactional model of stress and coping which emphasizes the role of coping strategies and cognitive appraisal in managing stress. Participant's narratives showcased both emotion-focused coping methods, like expressing emotions and seeking social support, as well as problem-focused coping methods, such as taking breaks and participating in restorative activities. These responses indicate the gynecological staff evaluate miscarriage related experiences as emotionally demanding and utilize coping strategies to manage distress. Nonetheless, the results also show that when coping is primarily personal and lack organized institutional support, its effectiveness might be reduced. As this relationship between individual coping and environmental resources is also suggested in transactional model, where both personal and contextual elements influence stress results.

Trauma-informed polices, such as mental health check ins, access to professional counselling, structured debriefing and adequate rest, should be implemented within the healthcare institutions as also highlighted in the previous research (West et al., 2016; Shanafelt & Noseworthy, 2017). To support healthcare worker's wellbeing and sustaining high

quality compassionate maternity care it is very important that burnout shall be addressed at both individual and organizational level.

Limitations and suggestions

The generalizability of findings to the broader population of gynecological staff gets limited due to small sample size and purposive sampling. However, it aligns with the requirement of qualitative research methods where depth is more valued. The research reached thematic saturation, as no additional themes appeared in the concluding analysis phase, indicating that the data adequately reflected the main patterns sufficient to capture key patterns relevant to the research questions. Additionally, the sample was chosen exclusively from urban centers in Punjab, which may not accurately reflect the situation in rural or inadequately equipped healthcare settings. Self-reported information can lead to social desirability bias, particularly in cultural contexts, where there is a stigma related to mental health problems. The cross-sectional qualitative approach also does not capture the long term or evolving nature of burnout and coping overtime.

Future researches should include larger and more diverse sample across different provinces and healthcare settings in Pakistan to enhance the contextual relevance of findings. Healthcare institutions should establish formal mental health support systems for maternity staff that must include counselling services and structured peer debriefing. In addition, medical and nursing staff curriculum should be revised to incorporate training in emotional coping, trauma-informed care and effective communication. To ensure high quality maternal care and promotion of wellbeing of maternal staff it is very crucial to recognize burnout as an occupational hazard at the policy level.

Implications

This research highlights that emotional burnout among maternity healthcare staff is not only a personal issue but it is also an interpersonal and systemic concern. The findings of this study hold importance and relevance for medical practice, policy and workplace wellness of maternity staff. It also highlights the need for trauma informed workplace culture, that recognizes the psychological consequences of dealing with reproductive loss on daily basis. The gaps identified in training and communication further suggest the need to combine emotional competence, grief care and self-care strategies into medical curriculum. Multi-level approach is required that integrate coping on individual level and responsibility of institution to promote mental wellbeing of maternity staff.

Conclusion

The present study highlights the importance of emotional burden experienced by maternity healthcare staff that works in miscarriage care. Emotional exhaustion is caused by repeated exposure to pregnancy loss, while strategies such as social support and peer solidarity helps in reducing the distress. Findings suggests further that institutional support is hugely required, where individual coping cannot work alone and the need for culturally relevant support system to promote staff wellbeing and care quality was emphasized.

Declaration

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References

Beck, C. T., & Gable, R. K. (2012). Secondary traumatic stress in labor and delivery nurses: A mixed-methods study. *Journal of Obstetric, Gynecologic & Neonatal Nursing, 41*(6), 747–760. https://doi.org/10.1111/j.1552-6909.2012.01386.x

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2021). One size fits all?

What counts as quality practice in (reflexive) thematic analysis? *Qualitative Research in Psychology, 18*(3), 328–352. https://doi.org/10.1080/14780887.2020.1769238

Bride, B. E. (2007). Prevalence of secondary traumatic stress among social workers. *Social work*, *52*(1), 63-70.

Buhlmann, M., Ewens, B., & Rashidi, A. (2021). The impact of critical incidents on nurses and midwives: A systematic review. *Journal of Clinical Nursing*, *30*(9-10), 1195-1205.

Folkman, S., & Moskowitz, J. T. (2004). Coping: Pitfalls and promise. *Annu. Rev. Psychol.*, *55*(1), 745-774.

Figley, C. (1995). Compassion fatigue: coping with secondary traumatic stress disorder in those who treat the traumatized. NY: Bunner. Routledge.

Figley, C. R. (2002). Compassion fatigue: Psychotherapists' chronic lack of self-care. *Journal of clinical psychology*, *58*(11), 1433-1441.

Goldbort, J., Banerjee, M., Bernal, H., & McClellan, L. (2011). Coping strategies of perinatal bereavement care providers. *Journal of Perinatal & Neonatal Nursing, 25*(3), 231–242. https://doi.org/10.1097/JPN.0b013e3182219b87

Halbesleben, J. R. (2006). Sources of social support and burnout: a meta-analytic test of the conservation of resources model. *Journal of applied Psychology*, *91*(5), 1134.

Hunter, B., & Warren, L. (2014). Midwives' experiences of workplace resilience. *Midwifery, 30*(8), 926–934. https://doi.org/10.1016/j.midw.2014.03.010

Kathleen Kendall-Tackett**, K. A. (2022).** Psychological trauma and the maternity care provider: Secondary traumatic stress, burnout, and moral injury. *Frontiers in Global Women's Health, 3*, 835811. https://doi.org/10.3389/fgwh.2022.835811

Koenig, H. G. (2003). Religion, spirituality and health. *Medical Journal of Australia*, *178*(8), 415-415.

Koenig, H. G. (2012). Religion, spirituality, and health: *The research and clinical implications. ISRN Psychiatry*, 2012, 1–33. https://doi.org/10.5402/2012/278730

Lazarus, R. S. (1984). Stress, appraisal, and coping (Vol. 445). *Springer.*

Leinweber, J., & Rowe, H. (2010). The costs of 'being with the woman': Secondary traumatic stress in midwifery. Midwifery, 26(1), 76–87. https://doi.org/10.1016/j.midw.2008.04.003

Leinweber, J., Creedy, D. K., Rowe, H., & Gamble, J. (2017). A socioecological model of posttraumatic stress symptoms in midwives. *Midwifery, 45,* 7–15. https://doi.org/10.1016/j.midw.2016.11.005

Maslach, C., Schaufeli, W. B., & Leiter, M. P. (2001). Job burnout. *Annual Review of Psychology, 52,* 397–422. https://doi.org/10.1146/annurev.psych.52.1.397

McCreight, B. S. (2005). Perinatal grief and emotional labour: A study of nurses' experiences in gynae wards. *International Journal of Nursing Studies, 42*(4), 439–448. https://doi.org/10.1016/j.ijnurstu.2004.07.004

Mealer, M., Jones, J., Newman, J., McFann, K. K., Rothbaum, B., & Moss, M. (2012). The presence of resilience is associated with a healthier psychological profile in intensive care unit (ICU) nurses: results of a national survey. *International journal of nursing studies*, *49*(3), 292-299.

Ravaldi, C., Carelli, E., Frontini, A., Mosconi, L., Tagliavini, S., Cossu, E., ... & Vannacci, A. (2022). The BLOSSoM study: Burnout after perinatal LOSS in Midwifery. Results of a nation-wide investigation in Italy. *Women and Birth*, *35*(1), 48-58.

Shanafelt, T. D., & Noseworthy, J. H. (2017). Executive leadership and physician well-being: nine organizational strategies to promote engagement and reduce burnout. *Mayo clinic proceedings*, *92*(1),129-146). https://doi.org/10.1016/j.mayocp.2016.10.004

Shanafelt, T. D., Hasan, O., Dyrbye, L. N., et al. (2015). Changes in burnout and satisfaction with work–life balance in physicians. *Mayo Clinic Proceedings, 90*(12), 1600–1613. https://doi.org/10.1016/j.mayocp.2015.08.023

Stamm, B. (2010). The concise manual for the

professional quality of life scale.

West, C. P., Dyrbye, L. N., & Shanafelt, T. D. (2018). Physician burnout: Contributors, consequences and solutions. *The Lancet, 388*(10057), 2272–2281.https://doi.org/10.1016/S0140-6736(16)31279-X

West, C. P., Dyrbye, L. N., Erwin, P. J., & Shanafelt, T. D. (2016). Interventions to prevent and reduce physician burnout. *The Lancet, 388*(10057), 2272–2281.https://doi.org/10.1016/S0140-6736(16)31279-X