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How Nurse-Midwives Can Best Support Families Who Have Experienced Perinatal Loss

Tina Marie Egner
Bethel University

Jennifer J. Kluck
Bethel University

HOW NURSE-MIDWIVES CAN BEST SUPPORT FAMILIES WHO HAVE EXPERIENCED PERINATAL LOSS

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TINA EGNER

JENNIFER KLUCK

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Tina Egner

Jennifer Kluck

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Approvals:

Project Advisor Name: Dr. Kimberley Meyer

Project Advisor Signature: Kimberley Meyer

Department Chair Name: Dr. Jane Wrede

Department Chair Signature: Jane Wrede

Director of Graduate Nursing Program Name: Dr. Jane Wrede, APRN, CNM

Director of Graduate Nursing Program Signature: Jane Wrede

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Tina Egner and Jennifer Kluck

Abstract

Background/Purpose: Although perinatal loss remains a common occurrence and nurse-midwives are instrumental in this care, the American College of Nurse-Midwives has yet to issue a position statement or professional care guidelines for providers. The purpose of the paper is to explore the literature to answer the research question: *how can nurse-midwives best support families who have experienced a perinatal loss?* The specific focal areas will examine best practices for providers based on current evidence.

Theoretical Framework: Kristen Swanson's (1991) Theory of Caring will serve as the conceptual framework to address the research question. Swanson's middle range nursing theory of caring was conceived using perinatal contexts, including pregnancy loss. The five processes that comprise the theory of caring are central to providing compassionate care and supporting women and families who are experiencing pregnancy loss.

Methods: Twenty-one scholarly articles were reviewed with the intent to assess what women and their families experience after a perinatal loss and determine what interventions are effective so nurse-midwives can best support families.

Results/Findings: Many women who have experienced a perinatal loss may feel intense emotions that may last for several years, and cause further grief into subsequent pregnancies. These emotions are individualized and may require various interventions. Findings failed to show that certain assessment tools or particular therapies were more successful or effective than others, but instead revealed the necessity for a personalized approach to bereavement care, further research, and provider training.

Implications for Research and Practice: Further study is needed with more randomized clinical trials with larger samples and more diverse subjects over a greater period time in order to develop professional guidelines of care. Perinatal loss can be a complex issue for nurse-midwives to navigate and a "one size fits all" approach will not work with all families. When working with families who have experienced loss; acknowledgement of the loss, open dialogue, therapeutic communication (i.e. active listening, empathy, and validation), and providing detailed information and reassurance are important parts of the support nurse-midwives can provide.

Conclusion: Perinatal loss is experienced differently by individuals and they may have unique needs in order to cope appropriately; therefore, a universal approach to care management will not work for everyone. By assessing for risk factors for psychological issues after a perinatal loss, using assessment tools tailored to perinatal loss, focusing on what is important to women and their families, and providing personalized interventions, nurse-midwives can honor families' perinatal losses and walk alongside them in their journey.

Keywords: miscarriage, perinatal loss, stillbirth, spontaneous abortion, bereavement support, perinatal loss support, past pregnancy loss, perinatal loss post-traumatic stress, perinatal loss grief, perinatal anxiety, perinatal depression, perinatal loss cognitive behavioral therapy, perinatal loss coping, perinatal loss support group, miscarriage treatment, pregnancy loss, perinatal loss on family, coping with fetal demise, provider perinatal loss support, and midwife perinatal loss support

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Chapter I: Introduction

For those who experience it, perinatal loss can be one of life's most traumatic events. The umbrella term of perinatal loss is used to describe death of an embryo, fetus or newborn due to spontaneous abortion (i.e. miscarriage), ectopic pregnancy, molar pregnancy, elective abortion (e.g. pregnancy termination, selective reduction), stillbirth, or neonatal death (Cohn, 2016). In the United States, about 25% of pregnancies end in perinatal loss (Hutti et al., 2016; Johnson & Langford, 2015; MacDorman & Gregory, 2015; Sapra et al., 2016). The mortality rate for fetuses 20 weeks' gestation or greater was 5.96 per 1,000 in 2013; whereas, perinatal mortality rate (i.e. stillbirths and neonatal deaths) was 6.24 per 1,000 for the same year (MacDorman & Gregory, 2015). Thus, perinatal loss could be considered the most common complication of pregnancy (Blackmore et al., 2011; Murphy & Philpin, 2010).

Statement of Purpose

The objective of the paper is to explore the literature to answer the research question: *how can nurse-midwives best support families who have experienced a perinatal loss?* The specific focal areas will examine best practices for providers based on current evidence. Kristen Swanson's Theory of Caring (1991) was conceived using perinatal contexts, including pregnancy loss. The five processes that comprise the theory of caring are central to providing compassionate care and supporting women and families who are experiencing pregnancy loss; hence, Swanson's theory of caring will serve as the conceptual framework to address the research question.

Evidence Demonstrating Need

Perinatal loss is a common and natural phenomenon. Nurse-midwives, as holistic providers of obstetric care, are uniquely positioned to support women and families enduring

perinatal loss. In addition to being a major public health issue, perinatal loss can have a profound effect on individuals and their families. Common reactions to perinatal loss include: grief, anxiety, depression, post-traumatic stress disorder, as well as negativity in intimate and family relationships (Heazell et al., 2016). Partners may cope very differently with grief, resulting in feeling unsupported or resentful. Couples who experience intense grief after a miscarriage or stillbirth are four times more likely to end their relationship than couples who have live births (Burden et al., 2016; Koopmans, Wilson, Cacciatore, & Flenady, 2013; Ogwulu, Jackson, Heazell, & Roberts, 2015).

Perinatal loss can be a very lonely journey to navigate, since grief may not be recognized by others or family and friends may not even be aware of the pregnancy, such as in the case of a miscarriage (Gold, Boggs, Mugisha, & Palladino, 2012). In other cases, family and friends may not know how to support the couple following the loss, so they chose to not say or do anything at all. Perinatal loss represents a different type of grief for bereaved families as little to no memories have been made. This results in a loss of dreams for the future combined with imagining what could have been (Wright, Shea, & Gallagher, 2014). Additionally, research shows that when women become pregnant again following a perinatal loss, they incur greater healthcare costs as they utilize more resources, including increased provider visits and ultrasound frequency due to higher pregnancy anxiety and the need for additional reassurance as compared to those whom have never suffered a perinatal loss (DeBackere, Hill, & Kavanaugh, 2008; Séjourné, Callahan, & Chabrol, 2010).

Significance to Nurse-Midwifery

In the United States, midwives care for about one out of ten women who give birth each year (American College of Nurse-Midwives [ACNM], 2016); consequently, nurse-midwives are

at the frontline and care for women in all aspects of perinatal care, including perinatal loss. ACNM's (2012) hallmarks explicitly align with the needs of women and families who endure perinatal loss and place nurse-midwives in an ideal position to provide support during and after this sensitive period; pertinent hallmarks include:

> (1) recognition of pregnancy, birth, and menopause as normal physiologic and developmental processes, (2) promotion of family-centered care, (3) empowerment of women as partners in health care, (4) facilitation of healthy family and interpersonal relationships, (5) promotion of a public health care perspective, (6) skillful communication, guidance, and counseling, and (7) therapeutic value of human presence. (p. 2)

Although perinatal loss remains a common occurrence and nurse-midwives are instrumental in this care, the American College of Nurse-Midwives has yet to issue a position statement or professional care guidelines for providers. In their book *Guidelines for Perinatal Care*, the American Academy of Pediatrics [AAP] and the American College of Obstetricians and Gynecologists [ACOG] (2012) acknowledge perinatal loss as a time of intense emotions for families and recommend to providers "every effort should be made to determine the cause of the loss, to understand the family's grief responses, and to facilitate healthy coping and adjustment" (p. 384). Bereavement support is central to coping; however, counseling should be tailored to meet the needs of the individual families enduring the loss and account for specific cultural, moral, religious, and family considerations (AAP & ACOG, 2012).

The systemic review by Koopmans, Wilson, Cacciatore & Flenady (2013) examined the outcomes that various interventions (medical, midwifery, psychological, nursing or social support) have on individuals and families who experience perinatal loss. Koopmans et al. (2013)

found that even though pregnancy loss is common, limited randomized controlled studies have been done on this subject; therefore, they primarily looked at qualitative studies and identified that it is important that providers offer social support to families experiencing loss. Koopmans et al. (2013) concluded that based on the limited amount of randomized controlled trials and small study sizes, they could not make any recommendations for clinical guidelines for providing support for families experiencing perinatal loss. However, there were three recurring themes for providers in their research: (1) respect the patient and understand that grief looks different for each individual, (2) respect the baby that was lost, and (3) recognize resilience and the power of healing in humanity (Koopmans et al., 2013) which could be easily incorporated into all aspects of nurse-midwifery practice.

Information on the website, *UptoDate* provides similar information. Grunebaum and Chervenak (2018) reiterate the best approach to supporting families enduring perinatal loss remains unclear, since the effectiveness of different interventions has not been thoroughly evaluated (Koopmans et al., 2013). Nevertheless, provider recommendations by Grunebaum and Chervenak (2018) include providing patient-centered, holistic care through compassion and developing trusting provider-patient relationships. Crucial times in this care include: (1) at the time of diagnosis, (2) when making plans for delivery, (3) at delivery and immediately postpartum, (4) during the weeks after discharge and at the first postpartum visit, (5) at a "wrap up" meeting when all laboratory and pathology results are available, and (6) when the patient is considering another pregnancy (Grunebaum & Chervenak, 2018). When midwives give emotional support, it should be done with empathetic and honest communication that is inclusive of culture or spiritual practices and also reflects that family members grieve in different times and in different ways (Grunebaum & Chervenak, 2018). Contact should be maintained with the

parents to assess their emotional well-being, to assess if there are signs of depression, and if professional referral is needed for emotional help in anxiety, major depression, or post-traumatic stress disorder (Grunebaum & Chervenak, 2018).

Since perinatal losses are a common complication of pregnancy, all providers need to learn how to help patients who have experienced a perinatal loss. Midwives have a special ability to provide holistic continuity of care. They develop trusting and compassionate relationships with their patients. Grief from perinatal loss affects women physically, psychologically, emotionally, culturally, and spiritually. Midwives can offer care of the whole woman through pre-conception, during pregnancy, during a loss, after the loss, and through any additional pregnancies. When a woman and her family experience loss, it is a deeply profound time when a midwife's holistic and compassionate care can be most effective.

Theoretical Framework

Inspired by the work and theory of human caring developed by Jean Watson, Kristen Swanson developed a middle-range nursing theory of caring based on her observations and the results of three phenomenological studies that covered caring within a perinatal context (Swanson, 1991; Andershed & Olsson, 2009). The first study examined the caring behaviors of others that were identified as helpful by twenty women who had recently suffered a miscarriage. The result of this study was Swanson's identification of five processes of caring that would later serve as the foundation for her theory of caring (Swanson, 1991). The second study investigated care experiences of nineteen care providers (healthcare providers and parents) on a newborn intensive care unit through observation and interviews. According to Swanson (1991), one of the products of this study was the validation of the five caring processes identified in the earlier miscarriage study and refinement of their descriptions to be more specific to a caring context. In

the last study, Swanson explored the memories and experiences of the eight women who participated in a nurse-patient caring intervention four years earlier. The initial eighteen-month intervention was to empower pregnant women with high social risk to gain control of their lives and eventually provide care for their newborns (Andershed & Olsson, 2009). By studying the recollections of these eight women four years after the initial intervention, Swanson was able to validate the five processes of caring, refine one of the processes, identify sub-dimensions of each of the caring processes, and develop and propose a definition for the concept of caring (Swanson, 1991). The five caring processes recognized by Swanson are: (1) *knowing,* (2) *being with,* (3) *doing for,* (4) *enabling,* and (5) *maintaining belief* (Swanson, 1991; Swanson, 1993; Andershed & Olsson, 2009).

Swanson (1991) defines *caring* as a "nurturing way of relating to a valued other toward whom one feels a personal sense of commitment and responsibility" (p. 165). Swanson (1999) explains *knowing* as trying to make sense of an event in the life of another individual, which is composed of the sub-dimensions of avoiding assumptions, centering on the one cared-for, assessing thoroughly, seeking cues and engaging the self of both. The process of *being with* refers to being emotionally present and available for an individual; it communicates caring and is comprised of the sub-dimensions of being there, conveying ability, sharing feelings, and not-burdening (Swanson, 1991). *Doing for* is the process described by Swanson (1993) as doing for an individual what they would do for themselves if they were able. The components of *doing for* include: comforting, anticipating, performing skillfully/competently, protecting and preserving dignity (Swanson, 1991). *Enabling* is the process of facilitating an individual's journey through an unfamiliar event or time of transition; its purpose is to help the individual grow, so they are able to heal and assume self-care (Andershed & Olsson, 2009). Sub-dimensions of *enabling*

include: informing/explaining, supporting/allowing, focusing, generating alternatives/thinking it through, and validating/giving feedback (Swanson, 1991). Lastly, the process of *maintaining belief* forms the basis of caring and refers to having faith that an individual is able to persevere through an event or transition (Swanson, 1993; Andershed & Olsson, 2009). *Maintaining belief* encompasses sub-dimensions of believing in/holding in esteem, maintaining a hope-filled attitude, offering realistic optimism, and "going the distance" (Swanson, 1991). The intended outcome of the combination of the processes of caring is ultimately, an individual's well-being (Swanson, 1993). The relationship of processes of caring could be thought of like steps on a ladder, where they all need to be present to reach the top or achieve client well-being. According to Swanson (1993) "the proposed structure for the theory depicts caring as grounded in maintenance of a basic belief in persons, anchored by knowing the other's reality, conveyed through being with, and enacted through the doing for and enabling" (p. 357).

When working with women experiencing pregnancy loss, it is essential for a nurse-midwife to convey authenticity and caring. Swanson's Theory of Caring (1991) provides a theoretical framework for nurse-midwives to use in order to support women and facilitate their well-being during all aspects of their journey, especially pregnancy loss. Each of these areas as they relate to nurse-midwifery practice will be discussed further in chapter four.

Summary

In summary, perinatal loss is a common obstetric ordeal many families face. Nurse-midwifery principles which embrace life's natural processes and advocate patient- and family-centered care, align with the need bereaving families have for support; yet, the American College of Nurse-Midwives has not issued a professional position statement nor recommendations for best practice on how bereaving families should be supported. AAP and ACOG (2012) provider

guidelines for managing perinatal loss complement the recommendations of both Cochrane (Koopmans et al., 2013) and *UptoDate* (Grunebaum, & Chervenak, 2018) and the theoretical framework of Theory of Caring (Swanson, 1991). These sources may be invaluable for nurse-midwives providing bereavement care for women and their families.

Chapter II: Methods

This chapter provides an overview of methods utilized to critically review literature regarding how nurse-midwives can support those who have experienced perinatal loss. Included in these methods are search strategies used to find research studies, the criteria used for inclusion and exclusion in selection of research studies, a general summary of the selected studies, and the evaluation of the strength and quality of the articles. Studies addressed perinatal loss; the feelings associated with the loss; assessment of grief, loss, and depression; perceptions of patients' experience in their treatment during their loss; and support interventions. Patterns for the research results and conclusions were assessed and study references reviewed in order to obtain additional information for use in this review.

Search Strategies

When attempting to determine how to best support women who have experienced a perinatal loss, multiple sources must be considered to identify the maximum amount of literature available. Databases used to search for research on perinatal loss included Cumulative Index to Nursing and Allied Health Literature (CINAHL), PubMed, Google Scholar, and Cochrane Database of Systematic Review. Key words used to search these databases included: miscarriage, perinatal loss, stillbirth, spontaneous abortion, bereavement support, perinatal loss support, past pregnancy loss, perinatal loss post-traumatic stress, perinatal loss grief, perinatal anxiety, perinatal depression, perinatal loss psychotherapy, perinatal loss cognitive behavioral therapy, perinatal loss coping, perinatal loss support group, miscarriage treatment, pregnancy loss, perinatal loss on family, coping with fetal demise, provider perinatal loss support, and midwife perinatal loss support.

Criteria for Inclusion and Exclusion

Articles selected for literature review were incorporated based on inclusion of one or more of the following criteria: (1) research on perinatal loss, grief, anxiety, depression, post-traumatic stress disorder (PTSD) or postpartum depression (PPD) during or after the loss or during or after a subsequent pregnancy; and/or (2) research on interventions for women and/or families who have had a perinatal loss. Since nurse-midwives care for patients who experience all types of perinatal loss, miscarriage, abortion, fetal demise, and stillbirth were all included. Additionally, the review focused on non-pharmacological interventions and included: support groups, psychotherapy, cognitive behavioral therapy, or other coping mechanisms. All types of studies were included in the initial search. There were 175 articles identified that met the criteria for this research topic. Of the 175 articles that met the above criteria, 78 included an abstract, were free to review, and had conclusive findings.

Research studies excluded from this scholarly review included those not based on current research as well as articles published before 2013. Studies that were written in languages other than English were excluded. Studies were also excluded that did not meet the criteria for being at least of good quality according to the John Hopkins Nursing Evidence-Based Practice: Model and Guidelines Appraisal Tool (Dearholt & Dang, 2012). Further exclusion criteria included studies deemed to be not directly applicable to the topic of providing support to those experiencing perinatal loss. After including the above exclusion factors and considerable review of 78 abstracts, 21 research articles were selected for this review

Summary of Selected Studies

The scholarly articles included in this appraisal included: randomized control trials, mixed method studies, retrospective studies, qualitative comparison studies, interview studies,

prospective observational studies, and a case study. Most studies were conducted in person while others were conducted through mailed questionnaires or internet social media contact. Most of the research was conducted in the North America; however, a few studies also included areas in Europe, Australia, and South Africa.

Evaluation Criteria

The Johns Hopkins Research Evidence Appraisal Tool was used to evaluate the strength of research articles and the quality of their content; the specific tool is called the *Evidence Level and Quality Guide* listed in Appendix C (Dearholt & Dang, 2012). Each article is given an evidence level between I – IV depending on the type of study. Level I research is the highest form of evidence-based study and include experimental studies, randomized controlled trials, and systematic reviews of randomized control trials (Dearholt & Dang, 2012). Level II includes quasi-experimental studies, systematic reviews of a combination of randomized control trials and quasi-experimental studies, or systemic reviews of only quasi-experimental studies (Dearholt & Dang, 2012). Level III evidence includes non-experimental studies, systematic review of mixed method studies, qualitative studies, or systematic reviews of qualitative studies (Dearholt & Dang, 2012). Level IV consists of evidence obtained from literature reviews, quality improvement, program evaluation, financial evaluation, case reports, and opinion-based articles from experts, committees, or panels based on scientific evidence (Dearholt & Dang, 2012).

After the level of evidence was determined, articles were then evaluated to determine either “High”, “Good”, or “Low quality or major flaws” (Dearholt & Dang, 2012). This quality is assessed based on the consistency, generalization of results, sample size for study design, control group, definitiveness of conclusions, and consistent recommendations based on scientific evidence (Dearholt & Dang, 2012). If an article meets these criteria it is considered high quality

(Dearholt & Dang, 2012). If an article meets most of these criteria, then it is considered good quality (Dearholt & Dang, 2012). If an article does not meet these guidelines or meets very little criteria, it is considered either low quality or containing major flaws (Dearholt & Dang, 2012).

The scholarly studies cited in this review were individually evaluated using the Johns Hopkins Research Evidence Appraisal Tool. Of the 21 articles selected, three articles met the criteria for being level I evidence and one study met criteria for level II evidence. Due to the qualitative nature of the topic of research surrounding perinatal loss, seventeen of the articles were level III evidence.

Summary

The search for this critical literature review employed many strategies, including utilizing multiple databases and numerous search keywords. Included in this search were all types of perinatal loss and their effect on families. Excluded were articles older than 2013 or articles not specific enough to this review based on their abstract. Final articles selected included various types of research styles; however, due to the qualitative manner of the research topic, many of the studies were level III. Finally, evaluation of study quality using the John Hopkins Research Appraisal Tool determined the research included in this critical literature review good quality.

Chapter III: Literature Review and Analysis

The following chapter contains a literature appraisal and analysis regarding perinatal loss, specifically assessments and interventions that nurse-midwives can use to support families. Psychological issues associated with perinatal loss will be reviewed immediately after the loss, up to eighteen years after the loss and in a subsequent pregnancy. In addition, interventions that nurse-midwives can utilize to support families will also be examined. Lastly, a critique of strengths and weaknesses of the findings will be addressed.

Synthesis of Matrix

Using a matrix system, the data from the scholarly articles was organized and common themes were identified. Each matrix contained key information from the article including: source, purpose, sample, study design (i.e. methods and instruments), results, strengths, limitations, author recommendations, practice implications, and level of evidence assigned (i.e. article strength and quality) using Johns Hopkins Research Evidence Appraisal Tool (Dearholt & Dang, 2012). The matrix is presented with the highest quality articles listed first, followed by those of lower quality and within the groupings of quality, articles were further organized alphabetically. The matrix is composed of three level I articles, one level II article, and seventeen level III articles. The studies' objectives, designs, and relevant findings were examined and the synthesis of this data is presented in the Appendix.

Synthesis of Major Findings

For this review, 21 scholarly articles were evaluated to assess the psychological effect perinatal loss had on women and their families and the interventions evaluated to reduce their psychological symptoms. In the psychological assessment category, four articles explored the effect perinatal loss had on women or families immediately after their loss. Two articles

assessed how the loss affected women up to five months after a loss. Six articles discussed how perinatal loss affected women and their families during a subsequent pregnancy. Nine articles specifically explored interventions to help women and their families cope with their loss. Interventions included anti-anxiety/stress reduction skills, bereavement support groups, interpersonal therapy (IPT), cognitive behavioral therapy (CBT), record keeping and journaling, and training of hospital staff in bereavement support. Within each of these, an evaluation of the effectiveness of the intervention will be discussed.

Psychological issues. Perinatal loss is the loss of a pregnancy. This can include a loss at any time during the pregnancy, from first trimester miscarriages up to pregnancy term stillbirth. In the world, there are approximately two and a half million stillborn babies each year (Siassakos et al., 2018) with 6.05/1000 in the United States at 20 weeks or greater gestation and 6.24/1000 for all perinatal losses (Hutti et al., 2017). One in four pregnancies results in a miscarriage (Schreiber et al., 2016). The results of a perinatal loss can have long-term psychological effects on parents and the healthcare workers caring for bereaved parents (Nuzum, Meaney, & O'Donogue, 2018). Yet findings show one-third of care providers are not equipped to counsel patients after a loss, and fewer than half of patients felt they were allowed to be involved in their decision-making leading to a long-lasting negative experience (Siassakos et al., 2016). Some contributing factors from providers included lack of eye contact or empathy. There were also hesitations from healthcare professionals to confirm the baby's death and the desire of some women not to stay on the postnatal ward after the delivery (Gravensteen, 2013).

The psychological effect of experiencing the loss of a child is felt at various stages after the perinatal loss. Eleven studies discussed psychological concerns women and their families

feel immediately after the loss, up to eighteen years after the loss, and how the loss affects women during subsequent pregnancies.

Immediately after perinatal loss. The immediate time period after a perinatal loss is the most critical time for caregivers to make a positive impact for the families facing a loss. In order to understand the experiences families have faced when experiencing a loss and to help the families make choices following their loss, qualitative studies were conducted. Three studies reviewed the experiences of families immediately after their perinatal loss (Nuzum, Meaney, & Donogue, 2018; Schreiber et al., 2016; Siassakos et al., 2017). In these studies, there were several themes regarding emotions families felt due to the loss and how they were treated by staff.

Women often have a sense that there is something wrong with their pregnancy prior to being diagnosed with their loss (Nuzum, Meaney, & O'Donogue, 2018). Women were told to come to the hospital if there was reduced fetal movement, yet when they arrived they often felt they were not treated with any sense of emergency (Siassakos et al., 2017). In a level III qualitative study, which included 17 participants, Nuzum, Meaney, and O'Donogue (2018) found that there was a great sense of confusion that parents expressed when they found out their baby had died, especially when they felt their pregnancy had been healthy up to that point. Some described hearing the news and having an "out of body experience", while others said they felt they may have been misdiagnosed or that they didn't believe the diagnosis to be true (Nuzum, Meaney, & Donogue, 2018).

Once women were able to come to terms with their loss they felt they were ready to find closure. To do this, they were forced to make some decisions. Some patients were given multiple choices, some were counseled into a preferred choice, and some were not given a

choice. Some women felt forced into an induction when they asked to have a cesarean birth (Siassakos et al., 2017). In a level III, mixed-method design study which included 55 participants (n=55), Schreiber et al. (2016) analyzed both qualitative and quantitative data to determine who would be more likely to want medical, surgical, or expectant treatment in miscarriages. Of the participants, 55% wanted a surgical option for their miscarriage management with a significant portion ($p<0.05$) of those educated beyond high school, with higher incomes, and lower depression rates (Schreiber et al., 2016). Moreover, when 33% stated their first choice was to have medical management and 13% said they wanted expectant management, they were counseled into surgical intervention and 62% of those counseled changed their choice to surgical management (Schreiber et al., 2016). Of the women who were multigravida and received counseling only 12% changed their mind to surgical, where 50% of women who were primigravida changed their choice to surgical ($p=0.03$). All women felt it was important to have control over what choice to make and where and when it would be handled (Schreiber et al., 2016).

To better understand care given to bereaving patients after stillbirth, a level III retrospective study by Siassakos et al. (2017) interviewed participants (women n=21; partners n=14; staff n=22) in a qualitative study. Major findings about care provided by staff showed that parents felt that communication with staff was not as sensitive as they would like it to be (Siassakos et al., 2017). Staff should be better trained in bereavement, since they tend to focus only on the physical needs of the mother; whereas, the parents were still focused on the loss of the baby (Siassakos et al., 2017). After discharge, parents were left wondering what to do next, follow up care was not consistent, and patients wanted to know when they would follow up at the hospital (Siassakos et al., 2017).

Up to eighteen years after a perinatal loss. Women who have had a perinatal loss experience a wide range of emotions from a lack of emotion to intense grief and psychological issues including depression, anxiety, suicidal ideation, and PTSD, that may last for many years (Hutti et al., 2018). In two level III prospective observational studies using the perinatal grief intensity scale (PGIS), participants (n=103) with a history of perinatal loss were recruited and assessed at up to 8 weeks after their loss and again at 3 months (Hutti et al., 2018). Research showed that perinatal loss is a major public health issue for women and their families in which 25-30% of women have endured a loss, suffering significant prolonged complicated grief with high levels of anxiety, severe depression, post-traumatic stress, and four times the risk of marriages ending in divorce (Hutti et al., 2017). The PGIS scale assesses active grief, difficulty coping, and despair using a 33-item instrument (Hutti et al., 2017). Factors were found using the PGIS that helped determine the meaning that women gave to their loss and how it helps to determine their psychological response to their loss (Hutti et al., 2017). The three factors were: *Reality* as the mothers' perceived reality of her pregnancy and her baby during the time of the loss, *Congruence* as the mother's perception of support during the loss, and *Confront others* as the ability of the mother to make decisions to gain support from others she finds unsupported (Hutt et al., 2017). Although the PGIS was not meant to be a diagnostic tool for psychological conditions, it was found to be helpful for referring patients for additional psychological assessment (Hutti et al., 2018). The studies found that the use of the PGIS in the first eight weeks after the loss by providers, had a high predictability rate of psychological symptoms of severe depression (95% sensitivity, p=0.014) and severe anxiety (95%, sensitivity, p=0.029) at 3 to 5 months after the loss (Hutti et al., 2018).

Post-traumatic stress symptoms can still be assessed many years after a loss (Gravensteen et al., 2013). Gravensteen et al. (2013) found one-third of participants (n=101) continued to have symptoms 5-18 years after their stillbirth. The study used the Impact of Event Scale (IES) to quantify current PTSS and measure the degree of psychological stress after a traumatic event (Gravensteen et al., 2013). A high percentage of women reported that during the time of their stillbirth, approximately half received an uncertain explanation for the stillbirth or no explanation (Gravensteen et al., 2013). In addition, in 100% of cases where an autopsy was conducted, participants were glad they had it done, even when one-fourth of them found the discussion of autopsy uncomfortable (Gravensteen et al., 2013). Contributing factors to PTSS years later included: younger age ($p=0.001$), higher parity (>1), and induced abortion before stillbirth with a protective factor reported as having held the baby (Gravensteen et al., 2013).

Perinatal loss and subsequent pregnancy. After a perinatal loss, most subsequent pregnancies occur within 18 months after the loss (Haghparast, Faramarzi, & Hassanzadeh, 2016). Based on previous studies, psychological issues can continue for many years after a loss. Feelings of anxiety and depression can continue into the subsequent pregnancy (Haghprast et al., 2016). In a level III cross sectional study with descriptive analysis with 192 participants, Giannandrea, Cerulli, Anson, and Chaudron (2013) found 11% of women continued having symptoms during the subsequent pregnancy and 14% of those continued into the postpartum period. Women who are at greater risk of having issues during pregnancy and postpartum are those of lower socioeconomic status as they have greater numbers of abortions, miscarriages, stillbirths, and fewer resources to handle stressors including loss, poverty, violence, and lack of support (Giannandra et al., 2013).

Based on a level II case-controlled study by Haghparast et al. (2016), women participants (n=100) who had a spontaneous abortion (SAB) had significantly higher rates of depression (p=<0.001), anxiety (p=<0.001), somatization (p=0.032), obsessive-compulsiveness (p=<0.001), interpersonal sensitivity (p=0.036), psychoticism (p=0.024), hostility (p=0.037), paranoid ideation (p=0.002), and global severity index (p=<0.001) during subsequent pregnancy based on the Symptom Checklist-90-Revised (SCL-90-R), and the Pregnancy Distress Questionnaire (PDQ) than women without a history of SAB. It is thought that pregnancy distress and psychiatric symptoms are higher because SAB decreases a woman's feeling of self-worth, it gives them a feeling of loss of control, and 50% of women who have had a SAB become pregnant within a year after their loss (Haghparast et al., 2016). Women with previous miscarriage loss worry, even well into their pregnancy, that their fetus or newborn may die (Kinsey, Babtiste-Roberts, Zhu & Kjerulff, 2013).

All women who have experienced a loss are at increased risk of depression symptoms and post-traumatic stress in subsequent pregnancies, but grief intensity differs based on the type of loss and stage of subsequent pregnancy (Hutti, Armstrong, Myers, & Hall, 2015). In a level III web-based correlational descriptive study, participants (n=227) were given the PGIS, the Pregnancy Outcome Questionnaire, the Impact of Event Scale, the Center for Epidemiological Studies-Depression Scale, and the Autonomy and Relatedness Inventory to assess the psychological well-being and the quality of the relationships that partners have with women in their subsequent pregnancy after having a perinatal loss (Hutti et al., 2015). The finding supported the idea that the greater the grief felt during the time of the loss, the greater the anxiety, depression, and PTSD as well as a decrease in the quality of the relationship with their partner during the subsequent pregnancy (Hutti et al., 2015).

Although the vast majority of studies show women with prior losses experience increased psychological issues during their pregnancy and during their postpartum period, one study found no substantial difference between pregnant women with a history of miscarriage and those without a loss after giving birth to a healthy infant in terms of how they perceived their birth experience (Kinsey et al., 2013). This level III secondary analysis prospective cohort study consisted of pregnant women participants with prior miscarriage (n=453) and pregnant women (n=2401) who had no history of miscarriage and found that even though women with miscarriages reported in their interview increased levels of fear of adverse birth outcomes (p=0.33), the numbers were not significant after adjustment of confounders (i.e. confounding variables included depression in the prenatal period and any use of fertility treatment or advice) (Kinsey et al., 2013).

A study that specifically compared pregnant women after a miscarriage who had fertility treatment (n=75) with women who did not have fertility treatment (n=75), found women diagnosed with sub fertility had higher stress, anxiety and depression levels, and described more trauma from the event than those who had conceived naturally (Cheng, Chan, & Ng, 2013). Specific statistics showed increased levels in the fertility treatment group of avoidance symptoms (p=<0.001), intrusion symptoms (p=<0.001), hyperarousal (p=0.002) with continued symptoms after 12 weeks of intrusion and hyperarousal (Cheng et al., 2013).

Women are at an increased risk of depression, anxiety, and PTSD during the postpartum period after a subsequent pregnancy to a perinatal loss (Giannandrea et al., 2013). In a level III cross-sectional study, participants (n=192) completed a screening tool for depression and a semi-structured diagnostic psychiatric interview and findings showed that compared to women who had not had a previous loss, women who had were diagnosed at a higher rate of major depression

(p=0.002) and those with multiple losses were more likely to be diagnosed with major depression (p=0.047) and or PTSD (p=0.028) than women who had only one loss (Giannandrea et al., 2013). There are reports of women reporting a delay in bonding with their fetus during the pregnancy that leads to maternal-infant bonding disorders in the postpartum period, which have long-term effects on child development (Kinsey et al., 2013).

This effect on subsequent children after a loss was further assessed by Ustundag-Budak, Larkin, Harris, and Blissett (2015) in a level III qualitative semi-structured interview of women (n=6) who had a stillbirth in their first pregnancy and gave birth afterwards to a living child who at the time of the study was four months to four years old. This interpretive phenomenological analysis (IPA) found three common themes women reported feeling from the time of their loss through the care of their new child, that they titled: "Broken Canopy", "How did this happen", and "A Continuing Bond" (Ustundag-Budak et al., 2015). These groups talked about feelings of disbelief of the loss of their child, the feeling of failure from the loss, the feeling of incredulity after having a baby that was alive, the surrealness of the grief and letting go of the child lost and focusing on the joy of the new child, heightened fear of danger that affects the relationship with the new child and the mothers ability to parent, and finally the ability to move on and focus on the preset (Ustundag-Budak et al., 2015).

Interventions. Higher stress levels in subsequent pregnancies after a loss has led to increased utilization of health care, premature birth rates, low birth-weight, irritable newborns, attachment disorders, altered parenting and "impaired cognitive, behavioral, urological, and neuroendocrine development in children up to 6 years of age" (Côté-Arsenault, Schwartz, Krowchuk, & McCoy, 2014). In order to reduce stress, psychological morbidities, and poor outcomes for subsequent children, interventions for women and their families after a perinatal

loss are needed. Successful interventions that can be utilized with patients and their families after a loss are utilizing anti-anxiety and stress reduction skills, using bereavement support groups, treatment with interpersonal therapy (IPT) and cognitive behavioral therapy (CBT), use of record keeping and journaling, training of staff in bereavement support, and encouraging parents to hold their stillborn. Ten studies discussed interventions to help women after a perinatal loss.

Anti-anxiety/stress reduction skills. In the Côté-Arsenault et al. (2014) study, advanced practice nurses (APN) experienced with pregnancies after having a perinatal loss, conducted home visits for the intervention group to discuss emotions, milestones and social developments in pregnancy that included discussion of all living and lost children, and the current pregnancy. This level I, mixed method randomized trial with a control group taught women skills to reduce anxiety and cope with their feelings (Côté-Arsenault et al., 2014). Control groups and intervention groups (n=24) both received pregnancy information booklets. The intervention group received additional interventions used to reduce anxiety and stress in the form of education in skills of relaxation, problem solving, recording fetal movements, and "I" message training with return demonstration of skills, documentation of skill practices in diaries, and follow-up home visits as needed (Côté-Arsenault et al., 2014). Satisfaction rates with the program intervention group were high ($p=0.0057$) and an increase in gestational age showed a significantly higher mean satisfaction level ($p=0.0019$); however, there were no significant differences between the intervention group and control group at 22-24 weeks' gestation ($p=0.2723$) and at 32-34 weeks' gestation ($p=0.6028$), although those in the control group were disappointed they were not in the intervention group (Côté-Arsenault et al., 2014).

Bereavement support group. Many women and families feel isolated and alone after a perinatal loss. Bereavement support groups help families to cope with their loss. In a level III qualitative study, peer support persons (n=13) supported bereaved mothers (n=11) who had suffered a perinatal loss (Diamond & Roose, 2016). Themes were found from questionnaires given to both the peer support person and the bereaving mother (Diamond & Roose, 2016). Contact with families varied from the first contact in one day to up to two weeks and some were able to make contact for several months while others never did (Diamond & Roose, 2016). Positive characteristics of intervention were being able to talk to someone who had experienced a similar loss, being able to give back, normalizing feelings, feeling less alone in grief, allowed parents to honor their lost child (Diamond & Roose, 2016).

In a level I randomized control trial, women (n=40) who had experienced a miscarriage were randomly assigned to the treatment group which received bereavement support, or the control group which received the standard of care (Johnson & Langford, 2015). The intervention group received (1) a follow up telephone call; (2) hospital identification of loss on the door of their room and in their chart that acknowledged the loss; (3) spiritual services of their choice (i.e. prayer, baptism, or a special ceremony); (4) a packet of seeds to be planted at the home of the bereaved parents to honor and remember their child; (5) a plush bear was given along with other child mementos; (6) participation in a naming ceremony; and (7) a sympathy card; (8) follow-up instructions on when to return to the hospital; and (9) a 15 minute phone call one week later to reinforce instructions, give validation of the loss, and provide encouragement for seeking support (Johnson & Langford, 2015). There were significant statistical differences in the overall model between the two groups with a MANOVA result of ($p<0.001$) and the treatment group displayed

50% less despair (p=<0.001) than the control group, but the overall difference between the two groups in coping were not significant (Johnson & Langford, 2015).

Interpersonal therapy (IPT). Women who have been through a perinatal loss often feel isolated as friends and family struggle to know how to support the loss. Depression symptoms are common for women who have experienced a perinatal loss. Interpersonal therapy (IPT) has been used for women who have a history of major depressive disorder (MDD). In a study by Johnson et al. (2016), IPT was used by psychiatric nurse practitioners for women who had experienced a perinatal loss and had been diagnosed with MDD. The purpose of using IPT was to use multi-interventions, such as "education, therapeutic support, communication, and interpersonal incident analysis" to improve the social support for the person struggling with grief, a transition of role due to loss, and interpersonal conflict (Johnson et al., 2016, p. 847). This study was a level I randomized control study with participants (n=50) who had been diagnosed with MDD after a loss within two weeks to 18 months (Johnson et al., 2016). Results showed that the greater number of sessions attended for treatment, the greater the MDD recovery (p=0.001) and each additional session that was attended accrued a 20% increase in recovery (Johnson et al., 2016). The control group used "Coping with Depression (CWD)" which is a cognitive behavioral therapy that did not focus on perinatal loss or social support (Johnson et al., 2016). In comparison, the intervention group resulted in substantially more efficacy than the control group (p<0.001) in bringing down symptoms of MDD for women with a perinatal loss (Johnson et al., 2016).

Cognitive behavioral therapy (CBT). Psychotherapies, such as cognitive behavioral therapy (CBT), have been an effective tool for reducing depression and anxiety (Nakano, Akechi, Furukawa, & Sugiura-Ogasawara, 2013). In one level III open-label study without a control

group, participants (n=14) who had previously had recurrent miscarriages (RM) were given CBT therapy. It has been reported that two-thirds of women who have suffered from RM experience sustained mental stressors including depression, anxiety, anger, and grief (Nakano et al., 2013). All participants in this study were diagnosed with moderate to severe major depression based on the DSM-VI-TR (Nakano et al., 2013). There were 16 sessions of CBT given and results showed depression scores decreased after treatment from an average of 13.6 to 5.2, which was a statistically significant reduction in symptoms (p=0.001) (Nakano et al., 2013).

Record keeping and journaling. Women who have had recurrent miscarriages (RM) are often given waiting periods, in which they wonder if their pregnancy will continue or if they will have another miscarriage; further, they have no control over outcomes which gives them anxiety and fear and makes coping difficult (Ockhuijsen et al., 2015). In a level III, mixed method study that utilized both qualitative and quantitative data, pregnant women (n=13) with a history of RM were given a Positive Reappraisal Coping Intervention (PRCI) and Daily Record Keeping (DRK) to use for three weeks (Ockhuijsen et al., 2015). PRCI and DRK are meaning-based coping strategies designed to change the meaning of the situation and give the emotionally distressed person a more positive way to look at a situation (Ockhuijsen et al., 2015). The PRCI is a card that lists positive reappraisal statements and explanations on how to use the statements to cope (Ockhuijsen et al., 2015). The PRCI was used with the DRK to record feelings and reactions during the intervention period (Ockhuijsen et al., 2015). There were mixed reviews in this study; some women who had high negative emotions felt they had a positive experience using the PRCI and DRK, while others that initially had high positive emotions felt the PRCI and DRK had no effect (Ockuijsen et al., 2015).

In a level III qualitative data analysis, women who experienced a perinatal loss (n=19) were educated that anxiety is common for women who have had a loss, offered home visits every 4-6 weeks while pregnant, and given a diary to write down events in order to reduce their anxiety (Moore & Côté-Arsenault, 2017). Most women found the intervention helpful; patterns revealed shifting emotions of anxiety and hope, and physical symptoms which were consistent during the evolving process of pregnancy (Moore & Côté-Arsenault, 2017). Interestingly, there was no difference between the control group and the intervention group in terms of the level of anxiety but those in the intervention group, based on evaluations, stated that they found journaling "helpful and enjoyable" (Moore & Côté-Arsenault, 2017).

Holding stillborn baby. It was only a few decades ago when women were not allowed to see and hold their stillborn baby but more recently, it has become common for women and families to hold, dress, and spend time bonding with their stillborn baby (Gravensteen et al., 2013). In a retrospective study of women (n=379) who had experienced a stillbirth, the hospital experience was assessed to determine if contact with the stillborn child decreased PTSS (Gravensteen et al., 2013). The majority (94%) of women in the study wanted to see their baby, 82% wanted to hold their baby, and most of the women felt they were able to see and hold their baby as much as they had wanted. The majority of women who chose not to see their stillborn baby, admitted at follow up they regretted it (Gravensteen et al., 2013). Findings show holding the baby was protective of PTSS (Gravensteen et al., 2013).

The partner's mental health was evaluated, after holding their stillborn, in a level III correlational descriptive cross-sectional study. Partners (n=227) of women who had experienced a stillbirth were assessed for depression and anxiety based on the reporting of the mother of the stillborn (Hennegan, Henderson, & Redshaw, 2018). Of the partners in the group, 92% saw the

baby and 82% held the baby (Hennegan et al., 2018). There was a significant correlation between negative mental health symptoms of depression and PTSS at three months after holding the stillborn baby (Hennegan et al., 2018).

Critique of Strengths and Weaknesses

In this review, several strengths were identified. Multiple research styles provided both quantitative and qualitative information in the forms of randomized controlled, retrospective, and mixed review studies, all of which were determined good quality research. The studies were all within the last five years. Experiences of women and their partners who had faced a variety of types of losses and the staff involved in their care were discussed. Utilizing this information helped give a well-rounded assessment of what experiences families and staff go through when faced with a perinatal loss, the choices involved once a loss is discovered, and how staff can best serve those who have been through a loss. This helps caregivers determine what interventions are the most effective in supporting families through their loss, years after their loss, and during subsequent pregnancies. All studies provided information on emotions participants felt after a perinatal loss, as well as interventions or follow up recommendations for perinatal loss support. The research was consistent with other research making the findings reliable. The high amount of qualitative research gave detailed, specific information that assesses women's emotions and needs during a loss and how women feel they are best care for and supported when undergoing interventions. The research was taken from many countries, but findings showed similarities in the assessments and response to the interventions. This supports universal similarities in perinatal loss experiences in multiple cultures in the world.

The largest weakness in this review of research was the small number of participants in most of the studies. In qualitative studies, very specific, detailed information was obtained from

each participant; as a result, the researchers did not have the ability to have randomized control or to compare variables of large amounts of people. The research may be too specified to extrapolate the findings to the generalized population. The studies did not discuss key information needed to create programs to incorporate into practice, such as cost and access to care. A few articles gave specific recommendations as to what providers can do to improve care for patients after a perinatal loss, but most give recommendations requesting further research to be done, which does not help improve the standard of care for patients now.

Summary

Twenty-one scholarly research articles were critically reviewed for the purpose of assessing the impact of perinatal losses on families and determining what treatments are effective in order to best support these families. These studies determined women who have experienced a perinatal loss want to have their experience acknowledged but often find it difficult to find others with whom to discuss the loss. This makes it more difficult for the mother to feel that her feelings and experiences are valid, which isolates her and forces her to hide and deny her feelings (Üstündağ – Budak et al., 2015). Perinatal loss is associated with an increased likelihood of several mental disorders (Haghparast et al., 2016). Mothers who saw and held their stillborn baby reported higher satisfaction in their care and lower risk of post-traumatic stress (Gravensteen et al., 2013). Some studies reported success in treatment for patients who have issues with depression after having a perinatal loss, especially those with multiple losses, using CBT (Nakano et al., 2013), anti-anxiety techniques, bereavement support groups, interpersonal therapy, journaling or record keeping. It is important for nurse-midwives to keep in mind even when treatment is successful and women have recovered from their loss, studies show women who have had a successful birth after a loss, still have much higher than average levels of

depression and anxiety during the postpartum phase than those who did not have a previous loss; therefore, these individuals need closer monitoring (Giannandrea et al., 2013). Staff should have training in how to best manage care for women during and after a perinatal loss to ensure care is consistent and trauma from the event is minimized.

Chapter IV: Discussion, Implications, and Conclusions

The objective of this review was to explore the literature and determine how nurse-midwives can best support families who have experienced a perinatal loss. Using the Johns Hopkins Research Evidence Appraisal Tool (Dearholt & Dang, 2012), twenty-one scholarly journal articles were selected and critiqued. Following this appraisal, implications for nurse-midwifery practice, trends and gaps in the literature, as well as suggestions for future research were identified and will be discussed in this chapter. This chapter concludes with the application of Swanson's Theory of Caring in respect to the interventions that were found to be successful in supporting families who have experienced perinatal loss.

Literature Synthesis

To answer the question, *how can nurse-midwives best support families who have experienced a perinatal loss?* a literature review was conducted. The focus of the literature review was to examine best practices for nurse-midwives based on current evidence. The umbrella term of perinatal loss was selected due to the vast types of loss nurse-midwives may encounter in their practice. Analysis of the literature revealed themes including: (1) chronologic (i.e. immediately after the loss, years after the loss, and subsequent pregnancies); (2) psychological issues (e.g. depression, anxiety, grief, etc.); (3) assessment tools specific to perinatal loss (e.g. Pregnancy Distress Questionnaire); and (4) targeted interventions (i.e. bereavement support groups, IPT, CBT, record keeping, journaling, holding stillborn). The analysis failed to show that certain assessment tools or particular therapies were more successful or effective than others, but instead revealed the necessity for a personalized approach to bereavement care, further research, and provider training.

The literature showed that it is important for nurse-midwives to assess risk factors in patients experiencing perinatal loss. Aspects of a patient's life such as poverty, violence, lower socioeconomic status and lack of social support can increase risk for impaired coping and mental health issues (Giannandra et al., 2013). Women who have experienced loss are also at increased risk in subsequent pregnancies and during postpartum periods (Giannandra et al., 2013), as are those who have had issues with infertility (Cheng, Chan, & Ng, 2013).

Utilizing specific, validated screening tools geared toward perinatal loss can help nurse-midwives identify women who are at risk or may be experiencing psychological issues and trouble coping with the loss. The PGIS, a 33-item screening tool, has been shown to be effective in assessment of grief, difficulty coping and despair following perinatal loss (Hutti et al., 2018). The IES, a 15-item tool measuring stress related to a traumatic event, was also found to be effective and can help nurse-midwives assess for PTSS even many years after the perinatal loss has occurred (Gravensteen et al., 2013). The PDQ is a 15-item scale that nurse-midwives can use to measure pregnancy-specific anxiety in a subsequent pregnancy (Hutti et al., 2015).

Women and families experiencing perinatal loss need compassionate, sensitive care that considers their needs. Patients desire providers who have been trained in bereavement care to focus on empathy and eye contact (Gravensteen et al., 2013) as well as on their emotional needs, whereas, many providers have concentrated only physical needs (Siassakos et al, 2016). At the time of discovery of the loss, parents need timely notification and an explanation of death which may involve an autopsy if applicable (Siassakos et al., 2016).

There are several ways that nurse-midwives can empower women and families who have experienced perinatal loss. After a loss it is common for women and their families to feel like they have lost control, by providing them with choices nurse-midwives can empower them to

have some control. In earlier losses, nurse-midwives can provide information to help patients choose expectant, medication or surgical options (Schreiber et al. 2016); whereas, in later losses and depending upon gestational age, patients may be able to choose options such as induction of labor or Cesarean delivery.

Depending on patient and family needs, preferences, and resources there are many treatment options that nurse-midwives can utilize for support. Strategies such as providing information and teaching relaxation skills, problem solving skills, fetal movement counting and recording can help to relieve patient and family anxiety and reduce stress (Côté-Arsenault et al., 2014). Recommending more frequent visits antenatally in subsequent pregnancies can also reduce these symptoms (Côté-Arsenault et al., 2014). Nurse-midwives can provide referrals for therapy (Johnson et al., 2016; Nakano et al., 2013) and recommend bereavement support groups (Diamond & Roose, 2016) to further support families. Setting up a protocol that would include acknowledging the family's loss, providing spiritual services, offering meaningful mementos, and assuring good follow-up can ensure immediate support and overall satisfaction (Johnson & Langford, 2015). Finally, in the cases of later losses nurse-midwives can encourage mothers to hold their stillborn (Gravensteen et al., 2013).

Nurse-midwives can provide or advise to obtain journals to track progress and document feelings and reactions (Ockhuijsen et al., 2015). Another cost-effective, self-administered intervention nurse-midwives can offer is the PRCI card that helps patients cope using positive statements (Ockhuijsen et al., 2015).

Current Trends and Gaps in the Literature

With perinatal loss occurring in one out of every four pregnancies in the United States (Hutti et al., 2016; Johnson & Langford, 2015; MacDorman & Gregory, 2015; Sapra et al.,

2016), it is surprising the lack of research conducted regarding which interventions are most effective in treating grief, in helping families manage conflict, and in minimizing the risks of mental health issues. Another important consideration concerns who is getting help after a loss. Statistics show that minorities are disproportionately affected by perinatal loss, yet those who seek help following a loss are typically Caucasian, older, and with greater financial means and education (March of Dimes, 2019). Why is it that those who have a greater need receive less? Nurse-midwives, who provide a more economically sound solution than their physician counterparts, could help bridge this gap. Additionally, most of the discussion and research regarding perinatal loss focuses on women; however, men too can experience loss profoundly. What about a couple's other children and their experience with the loss? Further focus on perinatal loss should incorporate men and families.

Another discrepancy is lack of provider and staff training concerning perinatal loss. As cited by Ellis et al. (2016) in their research, "The first Lancet series on stillbirth in 2011 described stillbirth as one of the most shamefully neglected areas of public health" clearly requiring improvements of standardized care from staff and caregivers (p. 1). In a systematic review of qualitative, quantitative, and mixed method studies (n=52) research was done to determine the experiences of healthcare providers and parents who had experienced a loss (Ellis et al., 2016). Findings and themes were identified that determined dissatisfaction with how the diagnosis was given to parents who did not feel like they are able to make their own decisions, or not given enough time to make decisions (Ellis et al., 2016). The staff attitudes (i.e. caring and empathy) had a large influence on how parents were able to cope, make memories, and make decisions, with inadequate staff training negatively impacting care of bereaved parents (Ellis et al., 2016).

Without any position statement or professional guidelines issued from the American College of Nurse-Midwives, many midwives may lack confidence and feel uncertain about providing perinatal loss care to their patients. Midwifery school curriculum and continuing education which incorporates material on perinatal loss and focuses on increasing knowledge, holistic care, therapeutic communication skills, individual support, cultural needs through didactic learning, simulations, and real-life mentoring experiences would increase provider confidence and enhance bereaved families' experiences.

Implications for Nurse-Midwifery Practice

The critical review of the literature revealed important implications for nurse-midwifery practice. First, perinatal loss is a very individual experience which may have a profound effect on women and their families. Early perinatal loss may not minimize the impact; in fact, research shows that those who experience perinatal loss at an early gestation may experience loss and levels of grief similar to those who experience it at later gestations or of a neonate (Johnson & Langford, 2015). In addition, although this review specifically focused on the physical perinatal loss of a pregnancy or baby, there are other situations that nurse-midwives will encounter in practice and may find interventions useful. Examples of other applicable patient situations might include an unexpected diagnosis such as infertility or discovering the baby has an unanticipated condition such as a trisomy, birth mark, or limb malformations. Further, the trauma of perinatal loss from a previous pregnancy may continue to cause anxiety and stress in a subsequent pregnancy, which could result in continued mental health issues and or adverse maternal and fetal outcomes. Perinatal loss can be a complex issue for nurse-midwives to navigate and a "one size fits all" approach will not work with all families.

Because of increased health risks and potential for complications, nurse-midwives should collect comprehensive obstetric and mental health histories of all women of reproductive age (Giannandrea et al., 2013) and routinely screen all women who have experienced a perinatal loss for depression, anxiety, PTSS, and relationship issues (Hutti et al., 2015). Looking beyond the basic screening tools such as the Patient Health Questionnaires 2 & 9 (PHQ-2 & PHQ-9), Generalized Anxiety Disorder-7 (GAD-7) and Edinburgh Postnatal Depression Scale (EDPS) can further help nurse-midwives better comprehend the needs of individuals. Reliable, validated tools that nurse-midwives can use to screen women for mental health issues include:

- *Impact of Event Scale (IES),* a 15-item tool measuring subjective stress related to a previous traumatic event (Gravensteen, et al., 2013; Hutti et al, 2015)
- *Pregnancy Outcome Questionnaire (POQ),* a 15-item scale measuring pregnancy-specific anxiety (Hutti et al., 2015)
- *Center of Epidemiologic Studies – Depression Scale (CES – D),* a 20-item scale measuring depressive symptoms during the past week (Hutti et al., 2015; Hutti et al., 2018)
- *Autonomy and Relatedness Inventory (ARI),* a 30-item tool measuring the quality of intimate relationships (Hutti et al., 2015)
- *Perinatal Grief Intensity Scale (PGIS),* a 14-item questionnaire measuring grief intensity after neonatal loss (Hutti et al., 2015; Hutti et al., 2018)
- *Beck Anxiety Inventory (BAI),* a 21-item questionnaire assessing severity of anxiety (Hutti et al., 2018)
- *Perinatal Grief Scale (PGS),* a 33-item scale identifying highly intense or disturbed grief reactions to perinatal loss (Hutti et al., 2017)

- *State-Trait Anxiety Inventory (STAI),* a 40-item inventory measuring anxiety related to an event and personal anxiety level (Nakano et al., 2013)

When working with families who have experienced loss; acknowledgement of the loss, open dialogue, therapeutic communication (i.e. active listening, empathy, and validation), and providing detailed information and reassurance are important parts of the support nurse-midwives can provide. Specific ways nurse-midwives can support those who have experienced a prenatal loss include: (1) identifying and assessing them by listening to stories of their past pregnancies; (2) addressing and monitoring their anxiety levels during visits, even if they don't appear anxious; (3) providing anticipatory guidance about commonality of anxiety and dealing with it; (4) assessing prenatal attachment and help them balance self-protection with forming a bond; (5) validating their feelings and reminding them that they are not alone; (6) informing support person(s) of common trends in pregnancy following a perinatal loss; (7) teaching anxiety reducing skills; (8) utilizing the caring process; (9) providing continuity of care with consistent providers; and (10) suggesting interventions that may help them cope such as journaling, reading books or journals on this topic, attending therapy (e.g. IPT, CBT, psychotherapy), joining peer support groups, caring-based nurse home visits, doing self-care activities, and seeing or holding the stillborn (Côté-Arsenault et al., 2014; Moore & Côté-Arsenault, 2017; Hennegan et al., 2018).

Recommendations for Future Research

While the literature reviewed was able to make many solid recommendations for nurse-midwives to employ in clinical practice, several areas for further investigation were identified. First, further study is needed with diverse subjects, including men and partners, and individuals from different backgrounds including race, ethnicity, socioeconomic status, and educational level

to ensure generalizability to different populations. Due to the qualitative nature of the subject, there were only a limited number of RCTs available to review; additionally, most of the studies included relatively small sample sizes and recommended future studies including larger, more diverse samples over a greater period of time. Conducting more RCTs, which are considered the "gold standard" for intervention studies, would generate the highest level of credible evidence (Polit & Beck, 2018, p. 143) about the best ways to support families experiencing perinatal loss. Further, conducting additional qualitative studies with diverse subjects would add greater evidence regarding emotions experienced with various interventions.

Several of the studies recommended further research to confirm their findings due to small, non-diverse sample size. Ockhuijsen et al. (2015) found using a Positive Coping Intervention and Daily Record Keeping Chart with women who have a history of miscarriage (n=13) both cost- and time-effective and recommended further study to confirm the effect of utilizing these interventions on this population. Other studies suggested further research in order to elaborate on the specific intervention they were studying. Moore and Côté-Arsenault (2017) examined women's self-documented experiences of subsequent pregnancy after perinatal loss and found journaling helpful in coping with anxiety and fear. Moore and Côté-Arsenault (2017) recommended further study could investigate journaling using a more structured approach. In a secondary analysis of the data from the First Baby Study, Kinsey et al. (2013) discovered that their findings contradicted those of previous studies (i.e. previous researchers have reported increased fear in women who have experienced perinatal loss) thus, concluded further research is needed to examine how women with a previous perinatal loss experience a subsequent birth.

An interesting avenue that has surfaced in the last few decades is that of online support. As costs of technology decline and online accessibility continues to grow, further research

should assess the benefit of online support versus other types of support interventions for those experiencing grief after a perinatal loss (Hutti et al., 2018).

Another area of opportunity that was identified included simplification of and culturally relevant screening tools for providers. Nurse-midwives need screening tools that are specific to situations, fast to employ, and simple to interpret, so they can optimize their time with their patients and develop a personalized plan for their care. Hutti et al. (2015) recommended further investigation of the PGIS so that cutoff scores can be determined which could help healthcare providers predict patients' intense grief and identify those who need further follow-up.

Application and Integration of Theoretical Framework

Kristen Swanson's Theory of Caring, which was developed using perinatal contexts, including perinatal loss, can be utilized by nurse-midwives to support families that have experienced perinatal loss. Swanson's theory recognizes five caring processes: (1) *knowing,* (2) *being with,* (3) *doing for,* (4) *enabling,* and (5) *maintaining belief* (Swanson, 1991; Swanson, 1993; Andershed & Olsson, 2009). Nurse-midwives can integrate these processes into their practice when caring for women and families experiencing perinatal loss.

Knowing or making sense of an event in the life of another individual encompasses centering on the one cared-for by thoroughly assessing, avoiding assumptions, seeking cues, and engaging the self of both (Swanson, 1991). The very definition of midwife, "with woman" (ACNM, 2016, p. 285), represents the premise of *knowing*. Midwives focus care on the whole woman and partner with her and her family in their care. A midwife must meet the patient wherever she is at and this is especially true in the unfortunate event of a perinatal loss. Understanding that each woman and family will cope with loss in their own way and supporting them to do so with individualized recommendations are important components of the midwifery

care model. Using therapeutic communication and careful assessment are key in ensuring an individual patient's needs are understood and concerns addressed.

Being with or being emotionally present and available includes being there, conveying ability, sharing feelings, and not burdening (Swanson, 1991). Being emotionally present for a patient and her family confers patient-centered, holistic care through compassion and developing trusting provider-patient relationships (Grunebaum & Chervenak 2018). Techniques of therapeutic communication (i.e. active listening, showing empathy and validating loss) were recurrent themes in the literature and embodies the caring process of *being with*.

Doing for or doing for an individual what they would do for themselves if they were able involves comforting, anticipating, performing skillfully and competently, and protecting and preserving dignity (Swanson, 1991). In many cases perinatal loss can be an isolating experience; family and friends may not even be aware of the pregnancy or unsure of how to offer support, so they may say or do nothing (Gold et al., 2012). By guiding and supporting women and their families through the experience of perinatal loss, midwives can help bridge this gap.

Enabling or facilitating an individual's journey through an unfamiliar event includes, informing, explaining, supporting, generating alternatives, and validating (Swanson, 1991; Andershed & Olsson, 2009). Midwifery philosophy of care honors the normalcy of lifecycle events, including loss and death (ACNM, n.d.). Coming alongside women and their families and helping them navigate their own personal journey during an experience of perinatal loss is woven into the midwifery philosophy of care. According to ACNM (n.d.), the best model of health care for a woman and her family:

- Promotes a continuous and compassionate partnership
- Acknowledges a person's life experience and knowledge

- Includes individualized methods of care and healing guided by the best evidence available
- Involves therapeutic use of human presence and skillful communication

(para. 3)

Maintaining belief or having faith in the individual that they are able to persevere through an event involves believing in, holding in esteem, maintaining a hope-filled attitude, and providing realistic optimism (Swanson, 1991). This faith in the individual that Swanson (1991) refers to is apparent in the recurrent themes Koopmans et al. (2013) found in their systemic review: (1) respect the patient and understand that grief looks different for each individual, (2) respect the baby that was lost, and (3) recognize resilience and the power of healing in humanity. Incorporating these themes or principles into midwifery care can help women and their families feel empowered as they move through the grief processes associated with loss; moreover, it may also facilitate the healing part of the process.

Conclusion

The pertinent findings revealed in this critical review included: validity of the range of emotions women may feel immediately following a perinatal loss; the mental issues they may continue to suffer years following the loss; and the increased stress, anxiety, and depression they may experience in subsequent pregnancies. Twenty-one scholarly articles were analyzed for this review using criteria set forth in the Johns Hopkins Research Appraisal Tool (Dearholt & Dang, 2012); of these three studies included RCTs, of which only one of these studies showed statistically significant results regarding decreased intensity of despair ($p<.001$) when a structured bereavement intervention was employed immediately following miscarriage in an emergency room (Johnson et al., 2015). The other study that showed statistically significant

results was a case-control study that compared psychiatric symptoms and pregnancy distress in subsequent pregnancy in women who had a history of previous miscarriage (n=100) and those who did not (n=100) and revealed statistically significant results in areas of depression ($p<.001$), anxiety ($p<.001$), somatization ($p<.032$), obsessive-compulsion ($p<.001$), interpersonal sensitivity ($p<.036$), psychoticism ($p<.024$), paranoid ($p<.002$), and hostility ($p<.037$) (Haghparast et al., 2016). These studies illustrate the adverse psychological issues women may suffer as a result of perinatal loss.

The other seventeen studies included in this review were valuable due to their qualitative nature and the personal perspective they offered. Overall, all other interventions showed increased patient satisfaction and were generally recommended by their authors as feasible therapies in perinatal loss treatment. The studies reviewed numerous therapies including: in-person support groups, online support groups, peer support groups, CBT, IPT, psychotherapy, recordkeeping, journaling, nursing home visits, and teaching anti-anxiety/stress reduction skills. An important takeaway from this work is the variety of interventions available. What works for one individual, may not work for another and vice versa. It is important for providers to have a fundamental understanding of how these therapies work, so they can work with families to find appropriate interventions for them.

At the heart of providing care for those who experience perinatal loss is the notion of caring. Kristen Swanson's (1991) Theory of Caring provides a cohesive framework for nurse-midwives to provide support to families who have experienced perinatal loss. In summary, perinatal loss is a prevalent issue, yet it remains under-researched and many providers may lack confidence and feel uncertain providing this care due to lack of clear guidelines and education. Perinatal loss is experienced differently by individuals and they may have unique needs in order

to cope appropriately; therefore, a universal approach to care management will not work for everyone. Nurse-midwives, whose philosophy is to provide compassionate and evidence-based care, are uniquely aligned to honor families' losses and walk alongside them in their journey.

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Appendix

Literature review matrix

Source: Côté-Arsenault, D., Schwartz, K., Krowchuk, H., & McCoy, T. P. (2014). Evidence-based intervention with women pregnant after perinatal loss. *MCN, The American Journal of Maternal/Child Nursing, 39*(3), 177–186. doi:10.1097/nmc.0000000000000024			
Purpose/Sample	**Design (Method/Instruments)**	**Results**	**Strengths/Limitations**
Purpose: *Primary aim:* To examine the practicality and acceptability of a caring-based nurse home visit for women pregnant after a previous perinatal loss. *Secondary aim:* To provide a safe environment that normalizes pregnancy after a previous loss, reduce anxiety and depression via stress reduction skills and nurture prenatal attachment. **Sample/Setting:** Pregnant women who were healthy, at least 21 years old, able to read, speak and write English, receiving prenatal care with a history of at least one perinatal loss (miscarriage, stillbirth or	Mixed methods study. Phase I determined the components of the intervention in Phase II via feedback and suggestions of participants (n=8) in Phase I. Phase II, a two-group randomized trial that utilized the revised intervention components from Phase I where the control group (n=11) received pregnancy information booklets on the same schedule as the intervention group (n=13), which received six home visits. Home visits for the intervention group consisted of an experienced obstetric advanced practice nurse getting to know each woman and where she was emotionally with the current pregnancy, providing anxiety-reducing coping skills, promoting use of a pregnancy diary, offering information on	When controlling for baseline outcome and covariate, Phase II showed no differences between the intervention and control groups regarding ranks for depression scores, quality of prenatal attachment and satisfaction with social support. Though, the intervention group had a significantly higher predicted mean of satisfaction (p=0.0019) with increased weeks of gestational age. Components of the home visit were ranked by the intervention group on a scale of 0 to 4, where the home visit ranked as most liked and helpful (mean=3.8), followed by relaxation (3.57), pregnancy diary (3.0), problem-solving (3.0), I messages (2.5)	**Strengths:** • Phase II sample size was adequate to detect group differences (i.e. demographics, obstetrical history and meaning of past losses). • Study was guided by Swanson's 1991 Theory of Caring • Study utilized an evidence-based intervention with multi-phased testing and mixed method evaluation • Randomization of groups and repeated measures design **Limitations:** • Study was limited since it required an experienced maternity advanced practice nurse to carry out the intervention • Small overall sample sizes (i.e. Phase I, n=8 and Phase II, n=24)

neonatal death) recruited from obstetric practices in central and western New York (Phase I, n=8; Phase II, n=24). Exclusion criteria: women with medical conditions or fetal diagnoses that precluded any chance of a healthy baby, multiple gestation past twins and uncontrolled medical or mental illness. Phase II criteria were the same as Phase I with the exception of participants were recruited before feeling fetal movement. **Johns Hopkins Evidence Appraisal** **Strength: I** **Quality: Good**	topics of interest, and upholding confidence in the woman's capability to focus on positive events, reduce anxiety and endure through the pregnancy. Data was collected from all participants in Phase II at baseline, 22-24 weeks' gestation and 32-34 weeks' gestation.	and daily fetal movements (2.43). **Conclusion:** Caring-based home visits where women are provided with tools and taught skills to help reduce their anxiety provide a feasible and acceptable intervention for pregnant women who have previously experienced a pregnancy loss.	• Most study participants were Caucasian, therefore, generalizability is limited • The intervention, home visits, were time consuming
Author Recommendations: While caring-based home visits may provide pregnant women who have previously experienced a perineal loss, valuable skills to cope with the feelings of anxiety related to a new pregnancy, further research is needed on diverse pregnant women who have previously experienced a pregnancy loss; as well as, measurement of women's confidence with their pregnancy during the intervention.			

Implications:

- Caring-based home visits provided by an experienced obstetric advanced practice nurse may be a feasible and acceptable intervention for women with a previous pregnancy loss
- Additional ways to support women who have experienced a pregnancy loss might include:
  - Teaching anxiety-reducing skills
  - Utilizing the caring process
  - Continuity of care and providing care with consistent providers
  - Acknowledging pregnancy anxiety, listening and providing support to women following loss to help normalize experience

Source: Johnson, J. E., Price, A. B., Kao, J. C., Fernandes, K., Stout, R., Gobin, R. L., & Zlotnick, C. (2016). Interpersonal psychotherapy (IPT) for major depression following perinatal loss: A pilot randomized controlled trial. *Archives of Women's Mental Health, 19*(5), 845–859. doi:10.1007/s00737-016-0625-5			
Purpose/Sample	**Design (Method/Instruments)**	**Results**	**Strengths/Limitations**
Purpose: To examine the feasibility, acceptability and preliminary efficacy of an adapted interpersonal psychotherapy (IPT) in women who have experienced perinatal loss who have preexisting major depressive disorder (MDD). **Sample/Setting:** Convenience sample of women (n=50) between the ages of 18 and 50 who had been previously diagnosed for MDD and had experienced a perinatal loss in the last 2 weeks to 18 months. **Johns Hopkins Evidence Appraisal:** **Strength:** I **Quality:** Good	Randomized control pilot study. Participants were randomly assigned to either an intervention group that received IPT customized for perinatal loss or the control group that received a generalized cognitive behavior treatment focused Coping with Depression (CWD). Both groups received 2 individual and 12 group treatment sessions. Assessments using the listed instruments occurred for both groups at baseline, during treatment weeks 4 and 8, immediately post treatment and 3 and 6 months after treatment ended. Instruments: • Data measuring *rates of attendance, support person attendance,* and *drop out* • *Client Satisfaction Questionnaire-Revised (CSQ)*	CSQ treatment satisfaction scores were higher in the IPT than in the CWD group (p=0.001, 95 % CI). End of Treatment Questionnaire scores were significantly higher scores in the IPT than in the CWD group (p=0.03). HRSD scores increased significantly in both groups over time ($p<0.001$); however, there were no significant differences between the groups when HRSD and BDI scores were averaged over the study. SAS social role impairment scores decreased significantly (p=0.001), and MSPSS social support scores improved trend-significantly (p=0.06) from baseline to 6-month follow-up in IPT; neither of these improved in CWD.	**Strengths:** • First study of its kind that looked specifically at providing and evaluating treatment for MDD to women who have experienced perinatal loss • Comprehensive study that examined many aspects including feasibility, acceptability, time to MDD recovery, depressive symptoms, grief, social and interpersonal variables **Limitations:** • Pilot study, not a fully powered study • Small sample size

	• *End treatment Questionnaire* • *Longitudinal Interval Follow-up Examination* • *Hamilton Rating Scale for Depression (HRSD)* • *Beck Depression Inventory-II* • *Multidimensional Scale for Perceived Social Support (MSPSS)* • *Social Adjustment Scale (SAS)* • *Dyadic Adjustment Scale (DAS)* • *Perinatal Bereavement Grief Symptoms (PBGS)* • *Inventory of Complicated Grief (ICG)*	PBGS and ICG scores significantly increased over time in both IPT and CWD groups (all ps<0.001). DAS scores did not change significantly over the study in either group. **Conclusion:** IPT adapted for women with MDD following a perinatal loss was feasible and acceptable therapy and demonstrated higher satisfaction and some evidence of preliminary effectiveness in regards to quicker recovery, decreased depression and grief symptoms, and increased social support and functioning when compared to CWD for the participants in this study.	
Author Recommendations: To develop an efficacious treatment specific to women who suffer MDD and have experienced a perinatal loss, further study should include a full-scale RCT.			
Implications: IPT recognizes a personal problem or a traumatic event and addresses it by helping the individual improve their communication skills, change relationship expectations and build their support system through the use of education, personal exploration, communication, and self-reflection. IPT can be adapted specifically for perinatal loss and may be a helpful therapy for persons with major depressive disorder.			

Source: Johnson, O. P., & Langford, R. W. (2015). A randomized trial of a bereavement intervention for pregnancy loss. *Journal of Obstetric, Gynecologic & Neonatal Nursing, 44*(4), 492–499. doi:10.1111/1552-6909.12659			
Purpose/Sample	**Design (Method/Instruments)**	**Results**	**Strengths/Limitations**
Purpose: To determine if implementing a structured bereavement intervention immediately following miscarriage decreases grieving. **Sample/Setting:** Convenience sample of women (n=40) who were experiencing a miscarriage between 12 and 19 6/7 weeks gestation, able to read and write English or Spanish, and able to complete all study forms with minimal assistance who sought care at an obstetric emergency department of 350-bed county hospital in a large city in the south-central United States	Randomized control trial. Participants were randomly assigned to either a control group or the intervention group who received a bereavement intervention including: (1) prompt identification and marking of the participant's room and chart for acknowledgement of the loss, (2) offer of spiritual or religious support services, (3) respect of special requests such as prayer, baptism, ceremony, (4) a flower seed packet of remembrance to be planted at home, (5) plush teddy bear, (6) other physical mementos, if applicable, (7) participation in a naming ceremony and (8) a sympathy card. The intervention group also received a 15-minute phone call a week later where the bereavement intervention was reinforced, their loss was validated, and they were reminded to seek	Women in both the control and the intervention groups showed levels of grief in the moderate range (M=111.7, SD=22.9) and there was no difference between the groups regarding active grieving and difficulty in coping. However, results concerning levels of despair showed a statistically significant difference between the two groups, whereas, the treatment group exhibited significantly decreased intensities of despair ($p<.001$). **Conclusion:** Instituting a structured bereavement program which is implemented immediately when a woman seeks care for a miscarriage may benefit women by helping them work through the grieving process and result in prevention of despair.	**Strengths:** • Study included diverse racial and low-income sample • Intervention was structured protocol which utilized standardized guidelines • RCT • Intervention was immediate • Results of intervention were measured soon after the intervention **Limitations:** • Small sample • There was no further follow up after the two-week clinic visit to determine longitudinal effects of intervention over time

Johns Hopkins Evidence Appraisal: Strength: I **Quality:** Good	support. The control group only received the usual, routine ED care focusing on pain management and physical stability. The Perinatal Grief Scale (PGS) was administered two weeks later at routine clinic follow up appointment to both groups. *PGS* is a 33-item tool to screen for intense grief. It is divided into 3 subscales: (1) Grief, (2) Difficulty coping, and (3) Despair that contain 11 items each		
Author Recommendations: Study should be replicated using a larger, more diverse sample from numerous settings over a longitudinal time period. A national registry of fetal losses should be established and maintained, so there is a greater understanding of the extent of the problem. Bereavement support programs should be instituted in all settings were women experiencing pregnancy loss are cared for and staff caring for these women should be educated on bereavement care.			
Implications: Perinatal loss is a very personal experience. Research shows that women who experience a perinatal loss at an early gestation may experience loss and levels of grief similarly to women who experience loss at later gestations or of a neonate. Women of all gestations can benefit from receiving support through the employment of a structured bereavement program.			

Source: Haghparast, E., Faramarzi, M., & Hassanzadeh, R. (2016). Psychiatric symptoms and pregnancy distress in subsequent pregnancy after spontaneous abortion history. *Pakistan Journal of Medical Sciences*, *32*(5), 1097–1101. http://doi.org/10.12669/pjms.325.10909			
Purpose/Sample	**Design (Method/Instruments)**	**Results**	**Strengths/Limitations**
Purpose: To assess the implications of a spontaneous abortion history has on women's psychiatric symptoms and pregnancy distress in subsequent pregnancy less than one years after spontaneous abortion. **Sample/Setting:** Pregnant women from Babol city (N=100) with spontaneous abortion history during a year prior, between September 2014 and May 2015. **Johns Hopkins Evidence Appraisal:** **Strength: Level II** **Quality: Good**	Case-Control Study. Comparison between two groups of women. One group having had a spontaneous abortion history one year prior and the other group having not had any spontaneous abortion history. Both Groups completed the Symptom Checklist-90-Revised (SCL-90-R) and pregnancy Distress Questionnaire (PDQ).	"Women with spontaneous abortion history had significantly higher mean of many subscales of SCL-90 (depression, anxiety, somatization, obsessive-compulsiveness, interpersonal sensitivity, psychoticism, hostility, paranoid, and Global Severity Index) more than women without spontaneous abortion history. Also, women with spontaneous abortion history had significantly higher mean of two subscales of PDQ concerns about birth and the baby, concerns about emotions and relationships) and total PDQ more than women without spontaneous abortion history." **Conclusion:** Pregnant women with less than a year after spontaneous abortion history are at risk of psychiatric symptoms	**Strengths:** The data supported the conclusion that pregnancy distress was higher in women with spontaneous abortion history than controls. **Limitations:** The cross-sectional nature of the study prevents any conclusion regarding causality. The study did not assess psychiatric disorders in terms of clinical significance, but only in relation to specific pregnancy concerns that women are experiencing.

		and pregnancy distress more than controls. This study supports those implications for planning the post spontaneous abortion psychological care for women, especially women who wanted to be pregnant during the 12 months after spontaneous abortion."	
Author Recommendations: None			
Implications: Pregnant women with spontaneous abortion history reported higher psychiatric symptoms and pregnancy distress than women without spontaneous abortion history. Because spontaneous abortion may put in doubt a women's sense of self-worthiness; women who are pregnant after spontaneous abortion can have the feeling of loss of control; approximately 50% of women who have spontaneous abortion may conceive within a year following their loss. Psychotherapy can reduce the complications of pregnancy.			

Source: Cheung, C., Chan, C., & Ng, E. (2013). Stress and anxiety-depression levels following first-trimester miscarriage: A comparison between women who conceived naturally and women who conceived with assisted reproduction. *BJOG: An International Journal of Obstetrics & Gynaecology, 120*(9), 1090–1097. doi: 10.1111/1471-0528.12251			
Purpose/Sample	**Design (Method/Instruments)**	**Results**	**Strengths/Limitations**
Purpose: In women who have had a miscarriage the purpose was to compare the psychological impact between those who conceived naturally and those who conceived with assisted reproduction. **Sample/Setting:** Sample N=150 women (75 after natural conception; 75 after assisted reproduction); Setting at a university-affiliated tertiary referral hospital at their reproduction clinic and their general gynecological unit **Johns Hopkins Evidence Appraisal:** **Strength: Level III**	Prospective cohort study Semi-structured interviews using two standard questionnaires at 1, 4, and 12 weeks after diagnosis of first-trimester miscarriage: • 12-item General Health Questionnaire (GHQ-12). • 22-item Revised Impact of Events Scale (IES-R).	There were significantly higher scores (GHQ-12 and IES-R) in the assisted reproductive group than the scores in the natural conception group at both 4 weeks and 12 weeks after miscarriage. They also indicate significantly higher hyperarousal symptoms at 4 and 12 weeks in the assisted reproduction. This further indicates the traumatic effect miscarriage in women who have had miscarriages after assisted reproduction. **Conclusion:** Subfertile women who conceived after assisted reproduction had higher stress and anxiety-depression levels and experienced more traumatic impact from the first-trimester miscarriage, than those women who had a miscarriage after natural conception.	**Strengths:** There was consistency in using a single designated research nurse in all recruitment, completion of the questionnaires, and follow-up interviews. The subjects were all followed-up by telephone interviews when unable attend in person, as scheduled. All women were subjected to the same standardized questionnaire. Interviews may have a positive impact on enhancing their psychological wellbeing after the pregnancy loss as psychological intervention was offered to women who were at risk of developing long-term morbidity. **Limitations:** There were variations in the two groups of women in terms of age, marital status, and duration of pregnancy. The government policy only offered assisted reproduction treatment to legally married couples. Women in the assisted reproduction group were generally older, and had been married longer, as they generally had a longer duration of subfertility. Women in the assisted reproduction group were

Quality: Good		Faster and greater psychological intervention and support would be beneficial in women who have had a miscarriage after assisted reproduction.	arranged to have follow-up ultrasounds for viability after successful treatment per protocol which usually resulted in the diagnosis of miscarriage made earlier in this group. The length of the follow-up period was not long enough in this study to show a long-term impact and the study was isolated to Chinese women only.
Author Recommendations: In order to draw a better conclusion for differences in recovery after a miscarriage it would be important to study a longer duration for follow-up. A longitudinal observation would be helpful to gain a better understanding of the extent of the stress response and draw better conclusions.			
Implications: Health care providers should be aware of the increased negative impact on psychological well-being and quality of life when there are unsuccessful outcomes from assisted reproduction treatments. Psychological assessments should be added to typical medical follow up after a miscarriage. Further, bereavement and grief issues should be considered and explored with women following up after miscarriage, and referral for support groups and psychological therapy may beneficial, especially around 4 weeks after diagnosis of the miscarriage.			

Source: Diamond, R. M., & Roose, R. E. (2016). Development and evaluation of a peer support program for parents facing perinatal loss. *Nursing for Women's Health, 20*(2), 146–156. doi:10.1016/j.nwh.2016.02.001			
Purpose/Sample	**Design (Method/Instruments)**	**Results**	**Strengths/Limitations**
Purpose: To understand and document the perspectives of peer parents giving support and parents receiving support within a peer support program for perinatal bereavement. **Sample/Setting:** Sample of peer support parents (n=13) and parents receiving support (n=11) from a perinatal support program of a midsized level III hospital with 3 referring hospitals in a suburban area of a large midwestern city in the United States **Johns Hopkins Evidence Appraisal Strength:** **III** **Quality:** **Good**	Data was collected using a qualitive manner via personal interview and written survey methods. Peer parents (n=13) were invited to an in-person focus group to discuss their experiences and completed a short survey at the end of the group. The peer parents that were unable to attend the focus group (n=7) and all the participant parents receiving support, (n=11) a survey of open-ended questions was completed either online or over the phone. Questions for peer parents focused on contact between parents (type and frequency, experience participating in the program, recommendations for improving the program and advise participants would give to new peer parents. Questions for participants receiving support focused on the above questions in addition to perceived helpfulness of the	Data was analyzed qualitatively using descriptive thematic analysis by the study's first author and confirmed by the study's second author. Four overlying themes appeared for both the peer parents and parents receiving support including: (1) contact, (2) positive aspects of engaging in the peer support program, (3) difficulty engaging in the peer support program and (4) suggestions for the peer support program. **Conclusion:** Findings from the study imply perinatal bereavement peer support programs benefit both parents receiving support and those giving it, as well as provide clinicians and nurses an effective way to help parents who are experiencing or have experienced perinatal loss.	**Strengths:** • Qualitative manner of the study allowed for experiences and opinions of participants to be understood • New information has been gained since no other known study provides feedback of peer parents and parents receiving support in peer perinatal bereavement programs **Limitations:** • Generalizations cannot be made to a wider population due to qualitative nature of study and due to fact that most of the participants were female • Since the peer support program studied was complementary to the hospital's overall perinatal bereavement program, other organizations with a different structure may report different finding and

	program and the peer parents.		perceptions of participants • Only peer parents who participated in the focus group and survey were included in the study

Author Recommendations:
Peer support perinatal bereavement programs can offer parents another option for receiving supportive services. Suggestions based on study findings for developing a peer support perinatal bereavement program include: (1) plan for face-to-face contact, (2) provide options for preferred contact, (3) plan for continued communication between program coordinators and parents, and (4) conduct targeted recruitment of fathers.

Implications:
- Peer support can be an effective means of providing support-enhancing interventions to improve the quality of care and outcomes
- Effective peer support programs provide structured training and support for volunteers, initial personal contact for peer parents and parent participants, flexibility for contact, ongoing support for volunteers and include fathers in outreach
- Pregnancy or perinatal loss is often not felt or perceived by other, which may leave parents feeling alone
- Share Pregnancy & Infant Loss Support, Inc. (SHARE) is a national organization for perinatal bereavement care that has developed a peer support program that educates and prepares parent volunteers to provide peer support to families experiencing loss called, Caring Companion

Source: Ellis, A., Chebsey, C., Storey, C., Bradley, S., Jackson, S., Flenady, V., Heazell, A., … Siassakos, D. (2016). Systematic review to understand and improve care after stillbirth: A review of parents' and healthcare professionals' experiences. *BMC Pregnancy and Childbirth*, *16*(1). doi:10.1186/s12884-016-0806-2			
Purpose/Sample	**Design (Method/Instruments)**	**Results**	**Strengths/Limitations**
Purpose: To determine themes in order to inform research, training and improve care for patients who experience stillbirth. **Sample/Setting:** N= 52 studies (qualitative, quantitative, and mixed-method summaries) of parents and healthcare professional experiences of care after stillbirth in high-income westernized countries (Europe, North America, Australia, and South Africa). **Johns Hopkins Evidence Appraisal:** **Strength: Level III** **Quality: Good**	Systematic review of qualitative, quantitative, and mixed-method studies using meta-summaries studies of parents' and healthcare workers' experience of maternity bereavement care for stillbirth. Search terms formulated using SPIDER framework.	Findings show that behaviors and actions of staff have a memorable impact on parents (53%) whilst staff described emotional, knowledge and system-based barriers to providing effective care (100%). Parents reported distress being caused by midwives hiding behind doing and ritualizing guidelines whilst staff described distancing themselves from parents and focusing on tasks as coping strategies. Both parents and staff identified need to improve training, continuity of care, supportive systems & structures, and clear care pathways. **Conclusion:** The understanding of the experiences of both parents and healthcare workers of stillbirth can help improve training, care, and provide ideas for areas in further research.	**Strengths:** High amount of inclusivity using multiple research studies and types of research. Limited location of studies to improve usefulness and relevance in high-income western settings similar to areas desired to improve patient care for bereaved through fetal loss. **Limitations:** Limited to high-western studies does not transfer results and generalize to other areas. Created large themes that may represent aims of studies more than importance to parents.

Author Recommendations: Additional research is needed to determine the benefits and impact of specific training and implementation of care in families after fetal loss.
Implications: The creation of training and service provisions based on common themes could help improve psychological outcomes of parents.

Source: Giannandrea, S. A., Cerulli, C., Anson, E., & Chaudron, L. H. (2013). Increased risk for postpartum psychiatric disorders among women with past pregnancy loss. *Journal of Women's Health*, *22*(9), 760–768. http://doi.org/10.1089/jwh.2012.4011			
Purpose/Sample	**Design (Method/Instruments)**	**Results**	**Strengths/Limitations**
Purpose: To compare the depression and anxiety risk factors in post-partum women less than 14 months after delivery, without prior pregnancy loss, with pregnancy loss, and with multiple pregnancy losses. **Sample/Setting:** Mothers (>/= 18 years old) of infants under 14 months of age (N=192), at first year well-visit in an an urban pediatric clinic **Johns Hopkins Evidence Appraisal:** **Strength: Level III** **Quality: Good**	Cross-sectional study SCID (Semi-structured Clinical Interview) for diagnostic for DSM-IV for diagnosis of depression, anxiety, PTSD, obsessive-compulsive disorder, panic disorder, social phobia, acute stress disorder, specific phobia, other anxiety disorders, or substance abuse disorders. Descriptive analysis was conducted using: • SPSS 18 - T-tests for comparison of continuous variables between the women with and without pregnancy loss. • Bivariate analysis using chi-square to examine the sociodemographic and mental health diagnosis between those with and without a history of pregnancy loss & women who had suffered one loss compared with those who	49% of participants reported a previous pregnancy loss (miscarriage, stillbirth, and/or induced abortion). Of those who reported a loss, 51% had more than one loss. Having a prior pregnancy loss increased the rate of having major depression and those with multiple loss had an increase rate of major depression and/or PTSD diagnosis. There was no correlation between type of loss, only the number of losses increased anxiety and depression. **Conclusion:** Urban women of low-income experience high rates of pregnancy loss and often have more than one loss with more than one type of loss. Those women who have a history of previous pregnancy loss are at a greater risk of developing anxiety,	**Strengths:** The research was based on mothers in a postpartum well child visit and not a mental health setting which may result in greater generalization to low-income urban mothers than other studies that based it on psychiatric or high-risk obstetrical patients. The instrument used was the SCID which is the gold standard for diagnosing psychiatric disorders. This helps determine clinically the specific actual diagnosis rather than using symptoms found in other similar studies that use self-diagnosing tools. There was variability in the women who were seen in the timing from their prior loss and/or the timing of the first year of the baby's life making this study more clinically diverse. This study included loss in order to focus on psychiatric issues making it less likely for losses to be

	suffered more than one loss. • A multivariate logistic regression to examine what variables predict major or minor depression in the first postpartum year.	depression, and PTSD, after the birth of a child.	underreported due to stigma of type of loss. **Limitations:** Not a longitudinal study as women were interviewed at one point so findings cannot infer causation. There was no verification by medical records as data was self-reported making the information subject to recall and reporting bias. limited ability to determine if factors, such as having another child between the loss and another child, modify a women's risk for perinatal depression.
Author Recommendations: Additional research and longitudinal studies and qualitative interviews are advised to determine if previous pregnancy loss is associated with further anxiety and postpartum depression in this set of women, and what feelings these women have about their losses during postpartum periods and subsequent pregnancies.			
Implications: The trauma from a previous pregnancy loss can add to the stress during a following pregnancy creating additional distress and potential of postpartum psychiatric disorders. Because of this increased risk healthcare providers should inquire into the reproductive and mental health history of all women of childbearing age. Assessment of psychiatric disorders should be assessed early and there should be more aggressive treatment for depression and anxiety in women who have had a loss or other trauma with follow up visits scheduled during times of increased vulnerability.			

Source: Gravensteen, I. K., Helgadóttir, L. B., Jacobsen, E., Rådestad, I., Sandset, P. M., & Ekeberg, Ø. (2013). Women's experiences in relation to stillbirth and risk factors for long-term post-traumatic stress symptoms: A retrospective study. *BMJ Open, 3*(10). doi:10.1136/bmjopen-2013-003323			
Purpose/Sample	**Design (Method/Instruments)**	**Results**	**Strengths/Limitations**
Purpose: To determine the hospital care experiences of women who have had a stillbirth; to assess the level of post-traumatic stress syndrome (PTSS) after stillbirth; and to identify risk factors for PTSS in these women. **Sample/Setting:** N=379 women with a verified stillbirth diagnosis of greater than 23 weeks or a birth weight of greater than 500 g in either a singleton or twin pregnancy. **Johns Hopkins Evidence Appraisal:** **Strength: III** **Quality: Good**	Retrospective study using the Impact of Event Scale (IES) questionnaire to assess post-traumatic stress symptoms (PTSS) before, during, and after stillbirth.	In Women who have had a stillbirth, 98% saw their baby and 82% held their baby. 85.6% felt healthcare professionals supported them during the delivery. 91.1% received short term follow up. 1/3rd had long-term significant PTSS. **Conclusion:** Although most women in the study were satisfied with their care during the time of their stillbirth, they maintain a high level of PTSS after 5-18 years with 1/3rd of participants having clinically relevant symptoms. Risk factors that increased PTSS were young age, induced abortion prior to stillbirth, higher parity. Mothers that held the baby at the time of stillbirth had less PTSS.	**Strengths:** Use of a validated instrument to assess PTSS, and for the first time, risk factors for PTSS have been evaluated in a large group of non-pregnant women many years after stillbirth. **Limitations:** There was a low response rate (31%). This could mean an underestimation of mean score for the avoidance subscale. There is a risk of recall bias of descriptive variables due to the retrospective design.

Author Recommendations: Healthcare professionals should continue to provide the opportunity and encourage women to have contact with their stillborn baby.
Implications: PTSS can continue in women who have had a stillborn even 5-18 years after the loss. PTSS is reduced in women who had the opportunity to hold their stillborn baby.

Source: Hennegan, J. M., Henderson, J., & Redshaw, M. (2018). Is partners' mental health and well-being affected by holding the baby after stillbirth?: Mothers' accounts from a national survey. *Journal of Reproductive and Infant Psychology, 36*(2), 120–131. doi:10.1080/02646838.2018.1424325			
Purpose/Sample	**Design (Method/Instruments)**	**Results**	**Strengths/Limitations**
Purpose: To assess the behavior and mental health of the partner to the mother who had a stillborn baby. **Sample/Setting:** N= 455 partners of women (age 16 and older) who had a stillbirth in England in 2012. These women were identified by Office for national statistics (ONS) 6-9 months after their stillbirth. Women answered questions about their partners' behavior, perceptions of care, mental health and well-being at three and nine months after the stillbirth." **Johns Hopkins Evidence Appraisal:** **Strength: Level III** **Quality: Good**	Qualitative comparison study based on secondary analyses of questionnaires sent to the partners of women who had a stillbirth Instrument used was the SPSS version 22 with bivariate comparisons, chi-square statistics and logistic regressions to compare the mental health and well-being of those partners who had and had not held their stillborn child.	92% of partners saw the stillborn child with 82% of partners holding the stillborn. Those partners outside of the UK were less likely to hold their stillborn baby. Factors that increased the rate of the partner holding the stillborn baby were greater gestational age, shorter time period between death and delivery, and the mother had held the baby. At three months, partners reported as holding their stillborn baby had 2.72- and 1.95-times higher odds of depression and PTSD-type symptoms **Conclusion:** Moms at three and nine months postpartum and their partners, who had held their baby, reported to have substantially higher rates of mental health and relationship difficulties than those who had not held their baby. At the three-month post-partum point, partners that had held their stillborn	**Strengths:** This is the first study to quantitatively evaluate the impact of parents holding their baby after stillbirth and the affect it has on their mental health and well-being. There was a wide variance in demographics and characteristics of care to compare and differentiate groups in analysis. Sample was not skewed toward specific organizations as population based postal questionnaires were used. **Limitations:** There may be a limited generalizability in the sample due to low response rate and a more advantaged response group. Issues with recall due to the type of study being a retrospective survey may reduce accuracy in data due to poor recollections. Report based on self-reporting and reporting of partner that could be modified or under-reported in order to protect partners feelings over stigma with mental health and behaviors or relationship issues.

		baby had higher odds of depression and PTSD-type symptoms.	Partners reports of themselves may not be consistent as what the mother reports of them. The study lacked power for sub-group analyses.
Author Recommendations: It would be important to have a large prospective study to analyze the impact of holding stillborn babies that include a validated outcome measurement and a greater level of detail with the partners experience being assessed more directly. It would be advisable to have the partners anxiety assessed before the stillbirth to determine changes with mental health and behavior after stillborn.			
Implications: Although holding a stillborn baby may affect a partner's mental health and behavior in the three to nine months postpartum, parents continue to value the interaction, and are satisfied with the decision to hold their baby. Those parents who do not hold their baby often regret it at a later time. When assisting parents who have had a stillborn it is important to consider all these factors to determine what the most appropriate action is for the bereaving parent.			

Source: Hutti, M. H., Armstrong, D. S., Myers, J. A., & Hall, L. A. (2015). Grief intensity, psychological well-being, and the intimate partner relationship in the subsequent pregnancy after a perinatal loss. *Journal of Obstetric, Gynecologic & Neonatal Nursing, 44*(1), 42–50. doi:10.1111/1552-6909.12539			
Purpose/Sample	**Design (Method/Instruments)**	**Results**	**Strengths/Limitations**
Purpose: To investigate the validity of the Perinatal Grief Intensity Scale (PGIS) and relationship of grief intensity with quality of intimate partner relationships and psychological well-being in women who have experienced a perinatal loss in a subsequent pregnancy. **Sample/Setting:** Convenience sample of pregnant women (n=227) who have previously experienced a perinatal loss recruited from the internet. **Johns Hopkins Evidence Appraisal:** **Strength:** III **Quality:** High	A correlational, descriptive research design that collected data in a cross-sectional web-based study. Participants were recruited from internet websites focused on women's health and perinatal loss where links and messages lead them to the study website, where demographic information was collected and the following instruments were self-administered: *Pregnancy Outcome Questionnaire (POQ):* 15-item scale measuring pregnancy-specific anxiety *Impact of Event Scale (IES):* a 15-item tool measuring subjective stress related to a previous traumatic life event *Center of Epidemiologic Studies-Depression Scale (CES-D):* 20-item scale measuring depressive symptoms during the past week	Greater grief intensity was associated with increased pregnancy-specific anxiety ($r=.32$, $p<.0001$); depression symptoms ($r=.34$, $p<.0001$); post-traumatic stress ($r=.29$, $p<.0001$); unbidden, intrusive thoughts, strong emotions, troubled dreams and repetitive behavior ($r=.30$, $p<.0001$); denial of the meaning and consequences of the loss ($r=.16$, $p<.05$) and poorer quality of intimate partner relationship ($r = -.25$, $p=.001$). **Conclusion:** Construct validity was exhibited by the PGIS with pregnancy-specific anxiety, post-traumatic stress, depressive symptoms, and in the quality of the intimate partner relationship. Further study should investigate its validity for predicting future intense grief when utilized close to the time of perinatal loss.	**Strengths:** • Instruments were reliable • Sufficient sample size for study design • Recommendations are consistent and based on current review of literature **Limitations:** • Convenience sample which sought out study website; therefore, the participants grief may have been more intense than other women in the same situation • Majority of participants were white • No men participated in the study • English fluency may have influenced understanding of the instruments

	Autonomy and Relatedness Inventory (ARI): a 30-item tool measuring the quality of intimate relationships *PGIS:* a 14-item questionnaire measuring grief intensity after neonatal loss		
Author Recommendations: Authors recommend further investigation of the PGIS so that cutoff scores can be determined which could help healthcare providers predict patients' intense grief and identify those who need further follow-up. In addition, the authors suggest further evaluation of PGIS's scoring system to determine if simplification is warranted.			
Implications: The findings in this study highlight the need for healthcare providers to routinely screen all women who have experienced a perinatal loss for depression, anxiety, PTSD and relationship issues in a subsequent pregnancy.			

Source: Hutti, M. H., Myers, J. A., Hall, L. A., Polivka, B. J., White, S., Hill, J., … Kloenne, E. (2018). Predicting need for follow-up due to severe anxiety and depression symptoms after perinatal loss. *Journal of Obstetric, Gynecologic & Neonatal Nursing, 47*(2), 125–136. doi:10.1016/j.jogn.2018.01.003			
Purpose/Sample	**Design (Method/Instruments)**	**Results**	**Strengths/Limitations**
Purpose: To evaluate risk factors in eight week postpartum women, who have had perinatal loss, in order to predict anxiety and severe depression symptoms three months later. **Sample/Setting:** Women 8 weeks postpartum (N=103) who had experienced perinatal loss recruited from hospitals in Louisville, KY via the Internet. **Johns Hopkins Evidence Appraisal:** **Strength: Level III** **Quality: Good**	Prospective survey Data were collected using the • PGIS, Perinatal Grief Intensity Scale - 14-item questionnaire created to screen for grief intensity and predict future grief intensity and need for follow-up after miscarriage, stillbirth, or neonatal death. • Beck Anxiety Inventory. The 21-item BAI - to assess anxiety at the T2 follow-up • Center for Epidemiologic Studies Depression Scale - 20-item CES-D used to measure depression symptoms experienced in the past week, with measurement occurring at the T2 follow-up. Logistic regression, odds ratios, and receiver operating characteristic curve analysis were used.	"The PGIS had 97.9% sensitivity and 29.6% specificity to predict severe depression symptoms and 95.2% sensitivity and 56.2% specificity to predict intense anxiety at T2. A baseline PGIS score greater than or equal to 3.53 predicted severe depression symptoms (odds ratio ¼ 1.82, 95% confidence interval [CI] [1.46, 2.18], p ¼ .014) and intense anxiety (odds ratio ¼ 1.43, 95% CI [1.07, 1.82], p ¼ .029) at T2. The PGIS performs well at predicting severe depression symptoms (area under the curve ¼ 0.86, 95% CI [0.79, 0.94], p < .001) and intense anxiety (area under the curve ¼ 0.86, 95% CI [0.78, 0.93], p < .001) after perinatal loss." **Conclusion:** The Perinatal Grief Intensity Scale (PGIS) accurately predicts intense anxiety and severe	**Strengths:** "Our Cronbach's alpha coefficients still ranged from good to excellent." The study was able to recruit a larger group of participants in a shorter period of time using social media (Facebook). **Limitations:** Our instruments were lower than usual when compared with most previous research in which these instruments were used. It is possible that this method (Facebook) of data capture does not perform as well as in-person or interviewer-assisted data collection.

		depression at 3-5 months after a perinatal loss. This assessment told may be useful for providers in order to identify the need for additional mental health evaluation in women who have had a perinatal loss.	

Author Recommendations:
The greatest type of assistance used by the participants were the online groups. More research would be recommended to assess the benefit of online support and other types of support interventions for those experiencing grief after a perinatal loss.

Implications:
The use of the Perinatal Grief Intensity Scale (PGIS) can help health care providers determine what women are more likely to have severe depression and anxiety after suffering a perinatal loss and create a dialog and treatment plan earlier in postpartum care.

Source: Hutti, M. H., Myers, J., Hall, L. A., Polivka, B. J., White, S., Hill, J., … Grisanti, M. M. (2017). Predicting grief intensity after recent perinatal loss. *Journal of Psychosomatic Research, 101*, 128–134. doi:10.1016/j.jpsychores.2017.07.016			
Purpose/Sample	**Design (Method/Instruments)**	**Results**	**Strengths/Limitations**
Purpose: To assess the reliability of the Perinatal Grief Intensity Scale (PGIS) to predict potential intense grief based on a PGIS score acquired following a perinatal loss. **Sample/Setting:** A convenience sample of international English-speaking women who experienced a recent perinatal loss (n=103) (i.e. miscarriage, stillbirth or neonatal death within the prior 8 weeks recruited at hospital discharge from 2 large hospitals or by the internet at sites targeted to women who had recently experienced perinatal loss. **Johns Hopkins Evidence Appraisal:** **Strength:** III	Prospective observational study. Baseline data was collected 1-8 weeks post-loss (time 1: T1) and follow up data was collected 3-5 months post loss (time 2: T2). Reliability and validity of the PGIS was compared at both data points to the gold standard tool, the Perinatal Grief Scale (PGS). *PGIS:* 14 item scale designed to screen for grief intensity and need for follow up post perinatal loss. Items are rated on 4-point Likert scale, ranging from 4 strongly agree to 1 strongly disagree. The three subscales measured by the PGIS include: Reality (6 items), Congruence (4 items) and Confront others (4 items). *PGS:* 33 item scale used to identify highly intense or disturbed grief reactions to perinatal loss using a 5-point Likert scale. PGS measures 3 subscales using 11 items: Active	No significant difference noted between the PGIS identifying intense grief compared to the PGS ($p = 0.754$) or in predicting intense grief at the follow-up (AUC =0.78, 95% CI 0.68–0.88, $p < 0.001$). A PGIS score ≥3.53 at baseline was associated with increased grief intensity at Time 2 (PGS: OR =1.97, 95% CI 1.59–2.34, $p < 0.001$). Cronbach's alphas were ≥0.70 for both the PGIS and the PGS. The ideal cutoff recognized for the PGIS was 3.535. **Conclusion:** The PGIS is able to reliably and validly identify existing grief intensity and predict future grief intensity associated with perinatal loss. Additionally, it yields comparable results to the PCS with less	**Strengths:** • Data analysis included descriptive statistics, Cronbach's alpha, receiver operating characteristic curve analysis and confirmatory factor analysis • PGIS was developed using theoretic framework **Limitations:** • Sample consisted of homogenous group of predominately English-speaking, white, well-educated, middle- and upper-class women • Sample was not randomly selected • Study was limited to women *(due to above 3 factors, study cannot be generalized to larger population)*

Quality: Good	grief, Difficulty coping and Despair.	questions for patients to answer and is easier to score.	
Author Recommendations: Further study on the PGIS should focus on diverse groups including: men, people of lower income, racial and ethnic diversity as the results of this study could not be generalized to these groups.			
Implications: The PGIS is an easy to administer screening tool that can help healthcare providers identify and predict women whom may experience intense grief following perinatal loss so support and interventions can be initiated in a timely manner. Further, it is free to download and administer, available as an app electronically and gives providers interventions to focus on dependent upon the patient's score.			

Source: Kinsey, C. B., Baptiste-Roberts, K., Zhu, J., & Kjerulff, K. H. (2013). Effect of Previous Miscarriage on the maternal birth experience in the first baby study. *Journal of Obstetric, Gynecologic & Neonatal Nursing, 42*(4), 442–450. doi:10.1111/1552-6909.12216			
Purpose/Sample	**Design (Method/Instruments)**	**Results**	**Strengths/Limitations**
Purpose: *Primary aim:* To see how having a previous miscarriage would affect the birth experience in primiparous women *Secondary aim:* To see if there is relationship between a history of miscarriage and maternal fear in the intrapartum period **Sample/Setting:** 2854 Primiparous, English or Spanish speaking women, aged 18-35 carrying a singleton pregnancy recruited from venues throughout Pennsylvania for the First Baby Study (FBS), of which participants had either had a history of a previous miscarriage (n=453) or did not (n=2401)	A secondary analysis of data from the FBS. The FBS was a cohort study that looked at delivery mode for first childbirth and relationship to subsequent pregnancy and birth. Maternal birth experience and fear of an adverse birth outcome were measured through a phone interview conducted at 1-month postpartum and compared between the groups. *FBS Birth Experience questionnaire* – a 16-item questionnaire created by the investigators of the FBS. Items were rated on a 5-point scale; whereas, a high score was indicative of a positive birth experience. The scale was comprised of items from 4 areas of the birth experience: (1) emotional adaptation, (2) physical discomfort, (3) fulfillment, and (4) negative emotional	The only significant difference between the two groups in regards to demographics was that women in the miscarriage group with significantly older ($p<.001$). There was no significant difference between the birth experience scores for women in both groups; the miscarriage group had a mean score of 68.5 and the group with no prior miscarriage had a mean score of 68.7 ($p=.50$). Women with a history of miscarriage reported that they feared an adverse birth outcome for themselves or their newborn more often than those who had no history of miscarriage (52.1% vs. 46.6%; $p=.033$); however, after adjustment was made for confounders, the relationship was not significant.	**Strengths:** • Participants were not recruited because they had experienced a perinatal loss • Large sample size **Limitations:** • Participants in the FBS were not representative of the primiparous population of Pennsylvania (i.e. participants tended to be older, educated, higher household incomes, and non-Hispanic white) • Demographics of participants in the study may not be representative of population of women who have experienced miscarriage (i.e. fetal mortality rate is higher for black and Hispanic women than for non-Hispanic white women) • Investigators of the FBS created the outcome measures and they had not been previously used in any other studies

Johns Hopkins Evidence Appraisal: **Strength:** III **Quality:** Good	experience. Possible scores ranged from 16 to 80. Cronbach's alpha for the scale was 0.74	**Conclusion:** Women in the FBS with a history of miscarriage who successively gave birth to a healthy baby did not perceive their birth experience more negatively or have any greater fears of adverse outcomes during birth than those women who had not previously experienced a miscarriage.	
Author Recommendations: The findings in this study contradict those of previous studies, as previous researchers have reported increased fear in women who have experienced perinatal loss; therefore, further research is needed to examine how women with a previous perinatal loss experience a subsequent birth.			
Implications: It is important for providers to acknowledge a previous perinatal loss and the potential concern it may cause a woman in a subsequent pregnancy and in the intrapartum period. Providers should be mindful of possible fear and anxiety in this population, so that they can keep an open dialogue, use therapeutic communication (active listening, empathy, and validation), and provide detailed information, reassurance and support.			

Source: Moore, S. E., & Côté-Arsenault, D. (2017). Navigating an uncertain journey of pregnancy after perinatal loss. *Illness, Crisis & Loss, 26*(1), 58–74. doi:10.1177/1054137317740802			
Purpose/Sample	**Design (Method/Instruments)**	**Results**	**Strengths/Limitations**
Purpose: To examine women's experiences of pregnancy after perinatal loss as self-documented across pregnancy. **Sample/Setting:** Convenience sample of women pregnant after a perinatal loss (n=19) recruited from obstetric offices and a perinatal loss support group from Central and Western New York. **Johns Hopkins Evidence Appraisal:** **Strength:** III **Quality:** Good	Qualitative data analysis of data collected from participants journals in a previous two-phase study. Phase 1: pilot phase in which a caring-based home visit intervention was administered by a nurse to pregnant women who had experienced a prenatal loss with previous pregnancy and participant provided feedback for phase 2. Phase 2: RCT of a caring-based home visit intervention. After study ended, photocopies of the journals were made and a rigorous process of inductive thematic analysis was performed. *Journal:* a 3-ring binder designed with illustrations and quotations that concentrated interchangeably on development and changes in pregnancy and with a baby; it had open space for pregnancy history, expression of events	Six themes transpired from the journal entries and within the metaphor: *(1) Staying Alert: Noting Physical Symptoms:* decreased symptoms=distress, symptoms=reassurance baby alive *(2) Dealing with Uncertainty: Expressing Emotions:* positive = anticipation, excitement, confidence, happiness; negative = anxiety, fear; progression in pregnancy = increase in positive and decrease in negative *(3) Dreaming of the Destination: Evolving Thoughts of Baby:* an initial self-protection, delayed preparations; then as pregnancy progressed, hope and bonding occurred *(4) Traveling Together: Connecting with Others:* support was selective and added as needed *(5) Moving Forward: Reflecting on Sense of Self:* women recognized and conscious of changes in self after loss	**Strengths:** • Study provided unique insight into the experiences of women pregnant after experiencing a perinatal loss • Study examined entire pregnancy, not just certain points • There were no time constraints for data collection, since the women were free to journal when it was convenient for them **Limitations:** • Data came from a preexisting study, so researchers were not able to check in with participants and clarify findings • Since the data came from an intervention study, it is unclear was impact the intervention had on the data • Only women who were receiving prenatal care were included in the study • Small, non-diverse sample • Low literacy level could exclude journaling as an

	and feelings as daily entries and a weekly summary during the pregnancy and through the birth of the baby.	The interaction of several themes is: (6) *Staying on Track: Navigating through Pregnancy:* Ups and downs were noted in journals as symptoms and feelings changed **Conclusion:** Journaling or keeping a diary during pregnancy after experiencing a perinatal loss was found to be helpful in dealing with the anxiety and fear that can accompany a subsequent pregnancy for the women in this study.	intervention for some women
Author Recommendations: The authors recommend healthcare providers suggest interventions such as journaling to help women who are pregnant after a perinatal loss cope with the rollercoaster of emotions they may feel during their pregnancy. An area of further study suggested by the authors is journaling in a more structured manner.			
Implications: Healthcare providers can better serve pregnant women who have experienced a prior prenatal loss by: (1) identifying and assessing them by listening to stories of their past pregnancies, (2) addressing and monitoring their anxiety levels during visits, even if they don't appear anxious, (3) provide anticipatory guidance about commonality of anxiety and dealing with it, (4) assessing prenatal attachment and help them balance self-protection with forming a bond, (5) validating their feelings and remind them that they are not alone, (6) inform support persons of common trends in pregnancy following a perinatal loss, (7) suggest interventions that may help them cope such as journaling, reading books or journals on this topic, attending support groups and or doing self-care activities.			

Source: Nakano, Y., Akechi, T., Furukawa, T. A., & Sugiura-Ogasawara, M. (2013). Cognitive behavior therapy for psychological distress in patients with recurrent miscarriage. *Psychology Research and Behavior Management*, *2013*(6), 37–43. http://doi.org/10.2147/PRBM.S44327			
Purpose/Sample	**Design (Method/Instruments)**	**Results**	**Strengths/Limitations**
Purpose: To assess the use Cognitive Behavior Therapy (CBT) in reducing psychiatric symptoms for women who have depression and/or anxiety suffer from recurrent miscarriage (RM). **Sample/Setting:** Women with anxiety and depression who have had recurrent miscarriages of five or more (N=14) at the outpatient care at Nagoya City University Hospital during the period of April 2008 to September 2010 **Johns Hopkins Evidence Appraisal:** **Strength: Level III** **Quality: Good**	Open label study with no control group. Women with recurrent miscarriages (RM) and depression and/or anxiety were given CBT treatment then assessed post therapy with: • Beck Depression Inventory-2nd Edition – self reporting screening scale • State-Trait Anxiety Inventory – self reporting screening scale.	There were 14 women who met criteria and received CBT therapy. The mean number of intervention times was 8.9 sessions. "The average Beck Depression Inventory-Second Edition and State–Trait Anxiety Inventory–state anxiety scores, self-report screening scales for depression/anxiety, decreased from 13.6 (SD, 8.2) and 49.0 (SD, 7.1) at baseline to 5.2 (SD, 4.4) and 38.0 (SD, 10.2) posttherapy, respectively." It was determined that these results were statistically significant. **Conclusion:** CBT is a potentially useful intervention in treatment of women who suffer from RM depression and/or anxiety. Using CBT is useful in providing future psychological support for women with RM.	**Strengths:** The first study to provider psychological support using CBT for patients with RM. The study provides confirmation that use of CBT is beneficial in patients with RM and can decrease anxiety and or depression in patients with RM. **Limitations:** As this was an open label study it had no control group. There is no guarantee that the depression and/or anxiety did not decrease on its own over time or related to another cause and is unrelated to the CBT treatment because of the lack of a control group. There is no ability to discuss the process of improvement because assessments were only done twice, once before treatment and once afterwards.

Author Recommendations: Patients with RM who are suffering from depression and/or anxiety would benefit from a psychological support program such as CBT. This could be done via the web to improve access or to determine if it would be appropriate for engaging in individual CBT program. Once this program is established it would be important to conduct a randomized control trial to provide better causation.
Implications: This preliminary study indicated that there is a decrease in depression and anxiety in patients who suffer from RM by using the individual CBT interventions. The authors feel this is the first step in "creating a comprehensive psychological support system for RM".

Source: Nuzum, D., Meaney, S., & O'Donoghue, K. (2018). The impact of stillbirth on bereaved parents: A qualitative study. *Plos One, 13*(1). doi:10.1371/journal.pone.0191635			
Purpose/Sample	**Design (Method/Instruments)**	**Results**	**Strengths/Limitations**
Purpose: To assess the impact and meaning of stillbirth on bereaving parents. **Sample/Setting:** Parents who have experienced perinatal (N=17) at a tertiary university maternity hospital in Ireland **Johns Hopkins Evidence Appraisal:** **Strength: Level III** **Quality: Good**	Semi-structured in-depth interviews analyzed by Interpretative Phenomenological Analysis (IPA) Qualitative semi-structured interview using an interview schedule.	Stillbirth had a profound and enduring impact on bereaved parents. Four superordinate themes relating to the human impact of stillbirth emerged from the data: • Maintaining hope, • Importance of the personhood of the baby, • Protective care and • Relationships (personal and Professional). Parents who have experienced perinatal loss recalled their experiences in vivid detail. Time of diagnosis to delivery was an important factor in determine meaning for parents. **Conclusion:** Parents of stillborn babies are greatly impacted by the loss and they grieve. The way they are cared for and treated during this time affects their experience and how they remember it.	**Strengths:** The study can focus in depth on how the stillbirth death affects bereaved parents. There is a benefit to using the qualitative method to fully absorb the experience and meaning parents have after having a stillborn baby. This gives greater insight for research and helps providers positively affect their care. **Limitations:** This was a small qualitative study from one health care sources and may not be able to generalize to other areas. As fathers were found through their partners, this may determine the level of participation by bereaved fathers that would be different if the fathers were sought out first.

Author Recommendations: Maternity healthcare providers can learn from their bereaved patients. It is recommended that there is a continuation in the overall care provided for patients who have had distress.
Implications: "For every stillborn baby, in addition to the loss of that baby in society, there are grieving parents who carry this loss for the rest of their lives. Maternity healthcare professionals caring for parents when their baby has died can learn valuable lessons from the voices of bereaved parents" (Nuzum, Meaney, & O'Donoghue, 2018).

Source: Ockhuijsen, H. D. L., van den Hoogen, A., Boivin, J., Macklon, N. S., & de Boer, F. (2015). Exploring a self-help coping intervention for pregnant women with a miscarriage history. *Applied Nursing Research, 28*(4), 285–292. https://doi.org/10.1016/j.apnr.2015.01.002			
Purpose/Sample	**Design (Method/Instruments)**	**Results**	**Strengths/Limitations**
Purpose: To examine if a Positive Reappraisal Coping Intervention (PRCI) and Daily Record Keeping (DRK) chart, which were originally developed for use with the fertility treatment population, would be suitable to use with in pregnant women who have a history of miscarriage. **Sample/Setting:** Convenience sample of women with a history of miscarriage (n=13) from a university hospital in the Netherlands. **Johns Hopkins Evidence Appraisal:** **Strength:** III **Quality:** Good	Mixed methods study. Participants used both the PRCI and DRK daily for 3 weeks after confirmation of a positive pregnancy test. Quantitative data was then acquired by reviewing DRK data and analyzed via reporting frequencies and means. Qualitative data was gathered via interviews and analyzed using thematic analysis. *PRCI:* a handheld card with 10 affirmative reappraisal statements and a handout with a detailed explanation about this coping method *DRK:* a daily self-administered scale where participants rate their emotions and reactions. There are 46 potential reactions to a waiting period including: 20 emotions, optimism and pessimism about pregnancy, 12 physical symptoms, 5 appraisals and 7 coping strategies.	Analysis of the DRK indicated that the participants had higher scores on positive emotions versus negative ones (mean=16 out of 21 days). The women reported a positive effect on 6 out of the 21 days after reading the PRCI. None of the women reported the PRCI as having a negative effect. The study showed that the women adapted how often and how they used the PRCI and the DRK based on their perception of the result of the interventions, how they felt and if they felt it was beneficial to them or not. Most of the participants reported both the PRCI and DRK practical and easy to use. **Conclusion:** Offering the PRCI to pregnant women with a history of	**Strengths:** • Mixed method design that examined both quantitative and qualitative data • The study provided valuable information for potential future randomized clinical trials • The interventions were self-administered; thus, could be cost effective interventions to offer women with a history of miscarriage **Limitations:** • Small, non-diverse sample size • Study did not identify or address limitations • Intervention was only done for a small amount of time • Longitudinal effects of intervention were not studied

		miscarriage when they are feeling anxious and uncertain with a subsequent pregnancy may be beneficial; however, further research should be done to study the effect of utilizing this intervention on this population.	

Author Recommendations:
Women with a history of miscarriage frequently suffer symptoms of uncertainty and anxiety immediately after the miscarriage, when trying to become pregnant, and in a subsequent pregnancy. Providing interventions such as counseling and frequent ultrasounds, while reassuring and helpful can be time consuming and costly. Thus, there is a need for time- and cost-effective interventions that healthcare providers can offer this population. The PRCI and DRK meet both of these criteria and no harm has been found in offering them to this population; however, further research should be done to confirm their effect.

Implications:
The authors utilized a self-help Positive Coping Intervention that was originally developed to help women during uncertain waiting periods associated with fertility treatments with the idea that the anxiety and uncertainty that women experience during this waiting time is similar to that as women who are trying to become pregnant or pregnant after experiencing a miscarriage. The interventions were easy to use, cost- and time-efficient and beneficial for the small sample in this study.

Source: Schreiber, C. A., Chavez, V., Whittaker, P. G., Ratcliffe, S. J., Easley, E., & Barg, F. K. (2016). Treatment decisions at the time of miscarriage diagnosis. *Obstetrics and Gynecology*, *128*(6), 1347–1356. http://doi.org/10.1097/AOG.0000000000001753			
Purpose/Sample	**Design (Method/Instruments)**	**Results**	**Strengths/Limitations**
Purpose: To determine what factors patients and physicians find important in miscarriages that happen in the first trimester and what creates satisfaction with care during this time. **Sample/Setting:** Women with first trimester fetal demise or anembryonic gestation (N=55) and (N=15) obstetricians at the Hospital of the University of Pennsylvania **Johns Hopkins Evidence Appraisal:** **Strength: Level III** **Quality: Good**	Convergent parallel mixed-methods design Qualitative and quantitative data are collected simultaneously and interpreted once the two data streams are merged. Semistructured interview script with standardized prompts. Evaluations included Kruskal-Wallis and Wilcoxon rank tests and logistic regression.	In women who had experienced fetal demise, 34 women (62%) received surgical management, 19 women (35%) received medical, and two women (4%) received expectant. In women who had previous pregnancy there was a greater management preference with less likeliness of changing course of treatment than women with no previous pregnancies. "Physicians favored patient-centered decisions and patients chose the treatment that they thought would least affect other responsibilities." Those who had surgical management had higher incomes (adjusted OR 1.30, 95% CI 1.04–1.63, P5.023) and more social support (adjusted OR 2.45, 95% CI 1.07–5.61, P5.035) than the medical group. Those who had the surgery were more accepting of their loss and had a more	**Strengths:** Although our sample size was small, the distribution of our population was diverse, and our use of purposive sampling allowed us to describe a wide range of experiences, and attaining thematic saturation enabled us to distill the range of ideas in the population. Given that we found class differences in miscarriage experience and management choice, regional differences may also occur. **Limitations:** All patient participants were recruited from a single clinical research site and all participants were English-speaking to maximize integrity of the linguistic subtleties during data interpretation, so our results may not be generalizable. The physicians we interviewed were all obstetricians and gynecologists, so may not be representative of all

		favorable perception of surgery. Those patients that chose the medical intervention did so, desiring a more intimate setting, or an aversion to surgery or a perceived preservation of fertility. Satisfaction was ultimately linked with a supportive clinical team and expeditious resolution. **Conclusion:** In women who have experienced fetal demise, having a had a prior pregnancy, having obligations, and/or sociodemographic factors may influence management of miscarriage. It would be helpful to have structured counseling, especially in primigravid patients, to improve management with miscarriage.	pregnancy care providers
Author Recommendations: A specific decision tool would be helpful to aid in patient counseling and shared decision-making between patients and providers.			
Implications: Primigravidity could be an alert that a patient may require more in-depth guidance on miscarriage management decision-making.			

Source: Siassakos, D., Jackson, S., Gleeson, K., Chebsey, C., Ellis, A., & Storey, C. (2017). All bereaved parents are entitled to good care after stillbirth: a mixed-methods multicentre study (INSIGHT). *BJOG: An International Journal of Obstetrics & Gynaecology, 125*(2), 160–170. doi:10.1111/1471-0528.14765			
Purpose/Sample	**Design (Method/Instruments)**	**Results**	**Strengths/Limitations**
Purpose: To examine experiences of bereaved parents of stillborn infants, challenges of their healthcare providers, and discover in what way their care can be enhanced and improved. **Sample/Setting:** Convenience sample of parents of stillborn infants, including women (n=21) and their partners (n=14) and their obstetricians and midwives (n=22) from 3 hospitals in the South West of England. **Johns Hopkins Evidence Appraisal:** **Strength:** III **Quality:** Good	Multi-center case study. In person semi-structured interviews were conducted with parents after their postpartum follow up visit (~8 weeks after hospital discharge). Topics for discussion questions included: *diagnosis* and *breaking the bad news*, *mode of birth*, *post-mortem discussions*, and *follow-up period* and *consultation*. In addition, the topic of *signs and symptoms preceding the stillbirth leading to seeking care at the hospital* emerged for parents. Information from obstetric providers was conducted using same topic questions for bereaved parents; however, information was gathered in focus groups, not personal interviews. Additionally, the themes of emotional aspects of care and training also emerged for providers.	Themes: *Presentation:* Both parents and staff need education; systems need to be in place to support training *Diagnosis:* All relevant staff need to be trained in U/S, communication and empathy *Birth:* Providers need education in discussing mode of birth with bereaved parents, acknowledging that even if the baby has died, it is still a baby *Post-mortem:* Discussions with providers have influence over the decision parents make regarding post-mortem exams *Follow-up:* Inferior care marked with delays and lack of continuity is preventable by standardizing care and informing parents of what to expect after they go home Staff training: Training for	**Strengths:** • First study to examine and triangulate with a detailed outline of experiences and suggestions of bereaved parents and the providers who care for them • Study revealed misconceptions that were previously unreported (e.g. mode of birth) • Study offers recommendations for improvements to care such as standardized processes and staff education to better address bereaved parents' needs **Limitations:** • Discussions in the provider focus group could have been inhibited by the presence of certain members of the group • Data gathered from parents was based on memory recall; gathering information at different points in

	Information was then transcribed from audio recordings and thematic analysis using a six-stage process was done. Findings from the data sets were then triangulated looking for data that was agreed upon, complementary, contradictory and issues that one group discussed but not the other group.	providers is essential and should include implementation of an evidence-based and parent-centered care pathway **Conclusion:** There are variations in how parents receive bereavement care after stillbirth. Providers with an awareness of parents' needs and understanding of why they may ask for a cesarean birth, will facilitate provider-patient partnership and patient-centered decision making.	time may have offered a more detailed account • Small, non-diverse sample
Author Recommendations: Author recommendations to improve bereavement care include interventions of an Integrated Care Pathway (ICP) and staff training on how to utilize the ICP so that bereavement care is standardized and harm is prevented.			
Implications: Parents need to be gently educated on signs and symptoms of stillbirth. Care needs to be standardized for bereaved parents. Providers need training on diagnosis, ultrasound, communication and empathy so a diagnosis can be given efficiently and with understanding. Further, providers need to be prepared to discuss mode of birth and post-mortem care; as well as, seek understanding for why a patient may desire a particular mode. Training should also include a focus on the current pregnancy and to respect the baby that has passed.			

Source: Üstündağ – Budak, A. M., Larkin, M., Harris, G., & Blissett, J. (2015). Mothers' accounts of their stillbirth experiences and of their subsequent relationships with their living infant: an interpretative phenomenological analysis. *BMC Pregnancy and Childbirth*, *15*(263). http://doi.org/10.1186/s12884-015-0700-3			
Purpose/Sample	**Design (Method/Instruments)**	**Results**	**Strengths/Limitations**
Purpose: To focus on the meaning of the stillbirth experience to women and its influence on the subsequent pregnancy and subsequent parenting from the mothers' own experiences. **Sample/Setting:** A purposive sample of women (N=6) who experienced a stillbirth during their first pregnancy and who then went on to give birth to a living child (age at the time of the study between 4 months and 4 years) after a further pregnancy. Women were recruited with approval from University of Birmingham and was carried out on social media websites.	Qualitative semi-structured interview. An interview was completed to gain the account of the mothers' experience. Written accounts were then analyzed using interpretative phenomenological analysis (IPA)	Analysis of written accounts led to the development of three Principle themes: • "Broken Canopy" • "How This Happen" • "Continuing Bonds" The patients "revealed an ongoing process where women accepted a new 'unsafe' view of the world, re-evaluated their view of self and others, and established relationships with both the deceased and the living infant". **Conclusion:** Mothers of stillborn babies struggle with "accepting the existence of her deceased baby (this baby once lived) while being aware of the nonexistence (this baby)". For the moms, being able to meet their stillborn child was critical in their being able to process their grief. There is significance in the importance	**Strengths:** "The findings of this study provide an insight into the stillbirth experience of mothers and its meaning to them with an existential focus. It highlights the dilemmas and difficult decisions that women face in their experiences. It also provides evidence for the importance of a continuing maternal bond, how the stillbirth experience influences the mother's subsequent pregnancy and parenting. This study reveals that the mothers' struggles to accept the existence of her baby while being aware of the non-existence of her baby, as she has no shared or memories other than those of the pregnancy and birth". **Limitations:** This is a small sample due to it having a qualitative design so generalizations of the findings are limited Women in this study

Johns Hopkins Evidence Appraisal: **Strength: Level III Good** **Quality: Good**		understanding that each mother has differences in dealing with stressful situations as was highlighted in terms of attachment strategies. "Subsequent parenting experiences of mothers were very much influenced by their own previous experiences. Although some mothers managed to integrate this trauma into their life some remained very concerned and anxious about future and this anxiety then translated into their parenting experiences".	were recruited on web based social networks which may not be representative of all mothers.
Author Recommendations: Findings may benefit providers regarding the need for "awareness of stillbirth and a better stillbirth bereavement care (e.g. available information, support in difficult decisions) and that individual differences in response should be taken into consideration". Attention should be given to ensure women who feel isolated because of their grief experience from their stillborn so they are given appropriate care and interventions.			
Implications: Providers should place emphasis on the acceptance of the dead baby and the existence of other feelings and experiences. Having the family include the deceased baby into the family and its narrative can help to integrate her stillborn baby into her life and help her to accept the death of her baby. Women should be allowed to grieve and honor their bond with the baby and further to stay in touch with the baby's memory. The continuation of this bond should be supported and validated to help in the psychological support process. Each mother should have her own individual needs considered and she should be allowed to express her feelings			