

The Effects of Nursing Care on the Patient Experiencing a Stillborn Birth

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Abstract

Childbirth has the potential of being one of the most joyous and fulfilling experiences a woman goes through in her entire life. Being a mom, driving the kids to soccer practice, and sitting around the Christmas tree with the family can easily be seen as an ideal life. Conversely, the negative experiences with childbirth are rarely discussed. There is an overlooked category: moms who conceive but lose the baby in the womb. Not only are these women overlooked, but also the hospital care they receive proves inconsistent with the latest research. Nurses and doctors should be aware of the latest research showing the most effective way to treat moms and dads who have just experienced a stillbirth. The immense responsibility of being present for the patient physically, emotionally, and spiritually should not be lost on the nurse. A woman is bringing both death and life into the world simultaneously. Whatever the cause of the premature death, the pain remains long after the tragic loss. Although the loss of a neonate is undoubtedly a delicate and uncomfortable situation, it is for these reasons this topic needs to be addressed.

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It is often said there is nothing more painful than losing a child. Many times, a parent's mind might wander to the death of their child, perhaps their daughter. Feelings of sadness and worry take over. The parent begins to think their adored daughter might not live to walk down the aisle or experience the joys of creating her own family. But when thinking of the death of a child, it is rare, unless it has been experienced first hand, that one might think of having to deliver a stillborn child (Frederik, Cacciatore, McClure, Kuti, & Jokhio, 2011). The pain of having to go into the hospital surrounded by families elated to be taking home a bundle of joy is something that cannot be described, only experienced. On an average, in the United States, 100 babies are delivered still born per day. That is, one out of every 100 deliveries end in stillbirth (Cacciatore, 2007). The number of patients affected by this loss is shockingly high, yet this type of loss can be overlooked in healthcare facilities causing long-lasting negative effects on the remaining family members. Having a baby die, whether in the womb or not, is a tragic, heartbreaking experience. Not only are patients filled with sadness, but they are also consumed by denial, frustration, questions, worry, and anger (Frederik et al., 2011). Health care providers need to be aware of the best way to respond to each unique situation of neonatal death to help the family with effective coping.

Many times when a child or adolescent passes away, the parents can attribute a specific cause to their child's death. It could be by means of a motor vehicle accident, a chronic disease, or an unintentional injury. But with a fetus or neonate, the parents cannot always have answers. Many parents who have a stillborn child never know the cause (Bukowski, Pinar, Reddy, Saade, Silver, Stoll, Varner, Willinger, Carpenter, Conway,

Coustan, Dudley, Goldenberg, Hogue, Koch, & Parker, 2011). With the family's consent, an autopsy can be done on the baby in hopes of finding some answers. On some occasions, the death can be attributed to a structural deformity or an acute disease. However, the death cannot be explained, thus causing major internal struggles for the family members. One study evaluated the postmortem examinations of 512 neonates. Of this population, only 312 had a probable cause of death (Bukowski et al., 2011). Moms and dads are natural protectors, but in this situation, helplessness abounds. They experience feelings of failure and believe they will never be good parents. Although each family can have different experiences with grieving the loss of their child, there is always one unifying theme: heartbreak.

So, how do and how should healthcare professionals, specifically nurses, handle these situations? What is the appropriate way to respond? Answering these questions is the goal of this paper. Because the loss of a neonate is an extremely fragile event, nurses have the opportunity to comfort, support, and grieve with the families who are going through this dreadful experience. Generally, when thinking of a labor and delivery unit, one envisions the excitement and joys associated with childbirth. Labor and delivery nurses are intimately familiar with this aspect of their care. But they also acknowledge and experience the heartbreak. When deciding to be a labor and delivery nurse, they must understand their job is to care for the patient in the happy times of birth and the devastating times of death.

The way nurses operate should be driven by evidence-based practice. A nurses' practice should be characterized by the implementation of recent research studies, experiments, and data. The desire for this thesis is to have an understanding of how

nurses should respond to cases of mortality in ways that have proved effective by evidence-based practice. Having a thorough knowledge of the physiological and psychosocial processes of pregnancy enables one to have a complete view of patient care.

Physiological Development

The complexity and intricacy of the physiological developments enveloped in pregnancy remains nothing short of a miracle. Fertilization is when the sperm and ovum join together, creating a zygote with maternal and paternal chromosomes. During the first 24 hours of fertilization, the unicellular organism grows into a two-cellular organism. Further mitosis occurs within 72 hours, creating a 16-cellular organism called a morula; this process is known as cleavage. While the morula is being formed, it flows down the oviduct to the uterus via peristalsis. Once the morula has finally entered into the uterus after about four days, it becomes a blastocyst, in which the outer layer creates the placenta and the inner layer creates the embryo. Two days later, the blastocyst attaches to the endometrium of the uterus resulting in the stage known as implantation, which occurs during the second week of gestational development (Porth & Matfin, 2009).

The embryonic stage begins after week two and lasts until week eight. During this stage, the baby forms an embryonic disk, which creates the ectoderm, mesoderm, and endoderm for the baby. The notochord forms, creating the axial skeleton. At the end of this stage, the upper limbs, fingers, toes, and intestines are forming. In the eighth week, the baby has open eyes and noticeable ears. From weeks nine to birth, the baby goes through the fetal stage of development. The head grows slowly, but body growth increases greatly. The sex can be determined during this stage. Quickening, which is when the mother feels the movement of the baby, typically occurs around week 20. The

skeleton begins to harden; the skin is covered by lanugo and vernix. The baby begins to mature in every system to prepare for birth, which usually occurs 38 weeks after fertilization (Porth & Matfin, 2009).

Next to puberty, pregnancy causes more psychological changes than any other point in a woman's life. A woman's ability to adapt to each circumstance the pregnancy provides has a great deal to do with her social, cultural, and family influences. Her ability to deal with stress in the past often mirrors the degree in which she will adapt to the new stressors of pregnancy. Throughout the course of pregnancy, a woman experiences and exhibits every emotion on the spectrum (Murray & Terry, 1999). The main hormones of pregnancy are estrogen, progesterone, human chorionic gonadotropin (hCG), human placental lactogen, relaxin, and the prostaglandins. Each hormone serves a specific purpose in the physiological process of pregnancy, but in combination, they all greatly contribute to the emotional lability of a woman during pregnancy (Pillitteri, 2010). When a woman experiences fetal loss, the normal pregnancy emotional state is compounded with grief, which increases her risk of developing depression, anxiety, and/or other psychological problems greatly.

Causes of Stillbirths

Between 15-30% of all pregnancies end in a spontaneous abortion. The first trimester remains the most susceptible time for loss of the pregnancy. The fragility of the first trimester is the result of the newly forming fetus, whose susceptibility to teratogens, chromosomal abnormalities, and inadequate implantation presents itself during the first 12 weeks of development (Pillitteri, 2010). A stillbirth is defined as intrauterine fetal death (IFD) after 20 weeks gestation. An intrauterine death before 20 weeks gestation is

known as a miscarriage. Often it is difficult to pinpoint exactly what caused the fetal death. However, it has been discovered there are certain risk factors predisposing women to having a stillborn birth (Davidson, London, & Ladewig, 2011).

Risk factors that cannot be modified include maternal race, age, and number of previous pregnancies. The mother's race is thought to play a major role in experiencing an IFD. The rate of IFD is 2.3 times higher in African American women than in Caucasian and Hispanic women (Davidson et al., 2011). In the African American population, certain racial disparities lead to increased risk factors. Studies have shown that there is less pregnancy education in this ethnic group contributing to inadequate prenatal care. Additionally, African Americans had increased preexisting health conditions that contributed to pregnancy complications (Fretts, 2010).

In addition to a woman's race, age plays a major part. A woman under the age of 15 is over two times as likely to have a stillbirth than someone between the ages of 25 and 29. If a woman is above 35 years of age, her risk of having a stillborn birth increases even more so. When medical conditions that could have caused a stillbirth were taken out of the equation, advanced maternal age was the number one culprit. In addition, a woman who has conceived twins is almost three times as likely to have a stillbirth as one with a singleton. At even greater risk is a woman with a triplet gestation, who is 4.6 times more likely to lose one or all of her children (Davidson et al., 2011).

Placental abruption can be a major contributing factor to a stillbirth. A placental abruption is the early separation of the placenta from the uterine wall. The placenta's functioning is absolutely vital to the survival of the infant. Because the placenta acts as the respiratory system, helps supply nutrients, and excretes waste, the baby cannot

survive without it while in the womb. Placental abruption accounts for 15% of all perinatal loss (Davidson et al., 2011).

Certain modifiable risk factors contribute to a woman's higher risk for having a placental abruption. It is thought that as gestational age of the fetus in an obese woman increases, the risk of having a stillbirth also increases. Obesity adds to placental dysfunction, a known cause of stillbirths (Davidson et al., 2011). Women who smoke, have multiple gestations, are of advanced maternal age, use cocaine, or have hypertension are also at a greater risk of having a placental abruption. In addition, trauma to the abdominal wall, violence, an over-distended uterus, alcohol consumption, a short umbilical cord, and fibroids are contributing factors to the likelihood of a placental abruption (Davidson et al., 2011). However, these are only risk factors, and the definitive cause of abruption presents difficulties when providing explanations to the family.

A placental abruption can be characterized by either being a marginal, central, or complete abruption. If there is only mild separation of the placenta and the woman is term, labor may be induced. Delay of birth puts the mom at a greater risk for hemorrhage, further compromising both mom and baby's health. A complete abruption results in a large amount of bright red blood exiting the vagina, often during the final stages of pregnancy. Complete abruption poses the greatest risk for fetal loss. As the fetus progresses into the third trimester, blood flow to the placenta through the sinuses decreases causing the placenta to abrupt. If separation occurs to more than 50% of the placenta, there is a 100% result in fetal mortality (Davidson et al., 2011).

In addition to placental abruption, infection is a major cause of stillborn births. Although it might commonly be thought that developing countries have a lower risk for

intrauterine infection, research shows that developed countries have an increased incidence of IFD due to infection. Infection accounts for 10 to 20% of all fetal demises. Infection has a multifold effect on the pregnancy by compromising the health of the mom or spurring the mom into preterm labor, with the possibility of the fetus dying during or shortly after delivery. Infection can invade the placenta, consequently decreasing the oxygen and nutrients to the baby. If the infection connects with the fetus, it could cause certain congenital defects that could result in heart or brain damage. *Escherichia coli*, *Ureaplasma urealyticum*, group B streptococci, parvovirus, and coxsackievirus can have these fatal effects. In addition, untreated syphilis contributes to high stillborn birth rates (Davidson et al., 2011). Although the causes of the loss may vary, the standard of care provided by nurses should be uniform.

Psychological Responses to Pregnancy

An uncomplicated pregnancy resulting in a healthy neonate often brings much joy to the parents. However, postpartum blues and postpartum depression happen more frequently than one might expect. The risk of developing a form of postpartum depression substantially rises with the loss of a baby. Women who experience the “baby blues” go through periods of mild depression with interspersed feelings of happiness. Unlike postpartum depression, the disease is self-limiting and should not affect the women’s ability to function on a day-to-day basis. Feelings of mild depression surface around 3-5 days after birth and can last upwards of three weeks (Tomaselli, 2008).

Primipara mothers experience the blues more often than multiparous women. After birth, estrogen, progesterone, and prolactin levels alter rapidly which contributes to the emotional instability of the woman. To further contribute to

her emotional status, the new mom has just undergone a major lifestyle alteration, causing constant fatigue and new stressors to surface. Postpartum blues exhibit themselves by tearfulness and rapid mood changes without a specific reason (Davidson et al., 2011). Anticipatory guidance plays a vital role in patient education in regards to the blues. The nurse's patient education is essential for parents so that they know that having feelings of anxiety, confusion, and sadness are normal after first bringing the baby home. The nurse should advise the mother that if these feelings increase in intensity and last for more than a few weeks, she should seek medical attention.

Postpartum depression (PPD) looks clinically similar to major depression. It affects up to 15% of mothers (Pearlsetin, Salisbury, & Zlotnick, 2012). A woman's susceptibility is greatest during the first four postpartum weeks. With PPD, the woman experiences sadness, frequent crying, insomnia, or excessive sleeping, appetite changes, and difficulty concentrating. Specific to PPD, the woman feels as if she is a failure as a parent and completely inadequate to take care of this new baby. Because of these feelings, the patient often stops taking care of herself, either by eating too much or eating nothing at all. Sometimes the desire lacks to get out of bed in the morning (Pearlsetin, 2012). As PPD progresses, she can have increasing feelings of loss of control. The ability to make simple choices is lost and helplessness overtakes her everyday life. The disease

process varies by patient, but PPD lasts a minimum of six months. Depending on the severity of the case, mild or moderate antidepressants may be prescribed.

The primary education for PPD is guarding the safety of the mother and child.

Because of the woman's ability to get frustrated and apathetic towards the child, she needs to learn to step away from the baby and the situation to take a deep breath and relax. Having a friend or family member in the area help with the new baby also alleviates some of the stressors and triggers (Davidson et al., 2011). Although with a stillborn birth there is no child physically present, the mothers experience feelings of postpartum depression. Knowing the clinical picture helps medical professionals be aware of signs of depression in their grieving patients.

The relatively high incidence of PPD in women who deliver a healthy child is alarming. However, when considering the traumatic events surrounding a stillbirth, handling this patient with genuine, gentle care greatly contributes to the emotional stability in the days, weeks, and months following the delivery. What happens in the clinical setting greatly affects the potential long-term complications that can be a result of stillbirth. Healthcare providers have the ability to either help or hurt patient care (Cacciatore, 2010). Examining the evidence and the outcomes of physical and psychosocial care helps shape future evidence-based nursing practice.

Evidenced-Based Practice

Dr. Joanne Cacciatore teaches at the University of Arizona and counsels those experiencing the effects of traumatic child death. Additionally, she is president of the MISS foundation, a nonprofit organization to help families cope with child loss. Experiencing the death of her own daughter in 1994 spurred her to devote her life to those who experience losses of their own. She dares to delve into how healthcare providers can either help or hurt the healing process of those who have had a stillbirth (Cacciatore, 2010).

Nursing care has advanced in every aspect throughout the past 20 years. There are new medicines, new procedures, and new electronic tools that help promote more efficient and accurate care (Chaudhry, Wang, Wu, Maglione, Mojica, Roth, & Shekelle, 2006). However, the care of a grieving mother and father will never have the option of receiving a medical “quick fix.” One-on-one sensitive, responsible nursing care stands as the primary goal for a successful outcome.

While at the hospital, a mother has the option of whether or not to receive handprints, photos, clothing, and other mementos to help commemorate and substantiate the birth of the infant. In addition to emotions associated with the profound finality in the child’s death, the parents are faced with numerous decisions about the remains of the body. Although a highly debatable topic, the issue of whether or not to hold and/or see the neonate after delivery has a profound effect on mom and dad on both a short-term and long-term basis. On one side of the spectrum, some researchers explain that holding the child can lead to serious psychological effects down the road, but the other side of the spectrum argues that it can be a somewhat cathartic experience necessary for closure (Cacciatore, 2010).

Each patient handles a traumatic situation in a different way and care can rarely be predicted. The emphasis of patient-care needs to be characterized by less of a focus on following a particular protocol, and more focused on the particular patient. The nurse's priority needs to be forming a relationship and worrying less about requirements. Going "by the book" has the potential to be one of the most detrimental attitudes a nurse can express. Case management allows the patient and his/her needs to come first. Forcing a family member to grieve in a specific way, at a specific rate, at a specific time creates unrealistic expectations for both the nurse and the patient (Trulsson & Rådestad, 2004).

Cacciatore (2010) cites a study done by Rådestad et al. in 1999 on postpartum women, both with live births and still-births. Many of the mothers who had a stillbirth had grievances with how the healthcare providers handled the situation. The women stated they needed more care. Cacciatore explained that one of the building blocks, in addition to forming a trusting relationship, is informing the parents of the procedures, the pathophysiology, and the psychology of what the process entails. The main motive of this particular article is emphasizing the necessity of intertwining evidence-based practice and patient-centered care. In order for healthcare providers to effectively do their job, Cacciatore recommended that they follow the doctor-patient model so that they can accumulate information to understand the patient and develop a strong, trusting relationship with the patient, and emphasize psychoeducation. Broadly put, the nurse should focus on the cognitive, emotional, and psychomotor areas of patient-centered care (Cacciatore, 2010).

Although it may seem like common sense, in order to get to know a patient it is essential to understand their history, their family dynamics, their culture, their religion,

and their past medical and emotional history. Active listening is the proposed solution in hopes that a trusting relationship will be fostered. In addition, continuity of care greatly influences the experience for the patient. Interdisciplinary communication between all members of the healthcare team remains an integral part of the patient care. If the same directions, information, and questions are consistently repeated to the family by staff, the family will begin to feel frustrated. Open communication between all people involved serves to facilitate a more healing, affirming, and consistent environment of care (Trulsson & Rådestad, 2004).

A study conducted on how narrative intervention was used to decrease the anxiety and depression levels of postpartum women, specifically those with stillborn children. The results concluded that as little as 30 minutes of individual counseling significantly improved mental and emotional outcomes after the event. Another program that counseled women starting 72 hours after discharge and continuing for three months post-delivery showed drastically decreased depression levels in patients (Cacciatore, 2010).

Being mentally present, having an open posture, proceeding in an unrushed attitude, allowing silence when appropriate, and therapeutic touch, all aid in the patient's experience. The combination between the sincere verbal and tender nonverbal communication can be perceived easily by the patient. Cacciatore and Bushfield (2007) further suggested that a grief-training course should be required of all hospital staff. Avoiding cliché phrases helps establish credibility and sincerity in the patient's eyes. In addition, hospitals should pair up with non-profit organizations to provide "postvention" counseling to moms who experience a stillbirth (Cacciatore & Bushfield, 2007).

Gold (2007) methodically researched the care offered to patients after perinatal death. This research study included births that were lost in the second and third trimester or in the neonatal period (up to 28 days). This article is a review of over 1,100 articles written since 1996. Overall, the article analyzed the different healthcare communication systems that break down along the way, causing negative effects of perinatal death on parents. An important aspect of care that Gold focuses on is where the care is to be offered. Generally, the initial thought would be to put the parents on the labor and delivery unit because mom will be delivering a child. However, as noted in the research, being surrounded by healthy, crying infants is not therapeutic for a comforting and healing process for parents causing them to be dissatisfied with their care. Gold and colleagues (2007) emphasizes that mother and father should have the option to choose from which unit they would like to receive care. However, rarely were such choices offered (Gold, Dalton, & Schwenk, 2007).

Care and Contact after Delivery

In the mid-20th century, hospitals were in primary control of the nursing management of stillbirths. With this type of care, patients did not have the option of holding, seeing, or commemorating their child. The baby was taken away immediately so that the mother would not have to endure the traumatic event of looking at the child. Emmanuel Lewis, a physician in the late 1970s, recognized that this avoidant care was not beneficial for patients. Lewis fueled the fire for a more patient-centered healthcare system, specifically for those experiencing perinatal loss (Cacciatore, Rådestad, & Frøen, 2008).

The most recent research contrary to Lewis' philosophy is a study performed in 2000, by Hughes et al. The research examines the psychological trauma of holding and seeing the stillborn child after delivery. The study concludes that mothers who saw the child had much higher rates of developing traumatic stress syndrome. Additionally, having a funeral and keeping mementos are noted to inhibit a stable grieving process. Because of this research, numerous subsequent studies have been done to further understand the effects of contact with the baby after delivery (Hughes, Turton, Hopper, & Evans 2002). When examining the most recent research in this field, the article composed by Hughes et al. has not been replicated.

Anticipatory guidance remains an essential nursing intervention for this stage of patient care. If the family members decide to see the child, they need to be made aware of what the child might look and feel like. Depending on the parent's preferences, the family may or may not want the child to be given its first bath prior to being seen by the parents. However, research has noted that many families find it therapeutic to care for the infant. Before the mother delivers, depending on the age of the baby, the nurse should explain how the infant might appear after delivery. Many parents might expect to see a baby that looks normal, but it just does not move. That mindset is often far from the truth. If the mom was in her first or second trimester, the child will not look like a typical newborn. The stillborn child's skin may appear waxy and, if at a young gestational age, may even be transparent. Extremities may be misshapen. Although each case differs, preparing the family members and giving them appropriate expectations helps achieve a therapeutic viewing and grieving process (Cacciatore et al., 2008).

When discussing the issue of seeing the infant after birth, studies offered conflicting evidence about what conditions (i.e., trimester, macerations, deformities) would influence whether or not the mom and dad decided to hold the infant. If the child had deformities, the mother was like likely to want to see him or her. Mothers often have a more difficult time seeing a child that is younger in gestational age, rather than a child that is older (Cacciatore et al., 2008). The decision to see the child lies solely in the hands of the parents. Respecting the delicacy of this issue is of the utmost importance.

From 2004-2005, Cacciatore organized a study to determine the long-term effects on holding or seeing the infant after delivery. Cacciatore used an online questionnaire for women who had experienced a stillbirth. There were a total of 3,519 reported stillbirths from the site; 95% of these women saw their newborn infant, and 90% of the women held the infant. Only a small portion of these women reported regret and remorse as a result from the experience. However, of the women who did not see their infant, 80% of them had feelings of regret in not seeing the child. Of the women who did not see their infant, 10.3% explained that they felt pressured not to see him or her (Cacciatore et al., 2008). Concurrent with latest research, Cacciatore makes the claim that often women choose, out of fear and pressure of others, not to see their stillborn child. Cacciatore believes that the clinician can and should step in and help the mom make a rational, informed decision (Cacciatore, 2010).

Over half of the women who saw their infant reported higher levels of anxiety and depression than those who did not see the child. Women who were older in age and spent more time with the infant versus the other participants experienced less anxiety and depression. When women took the study soon after their loss, they were more likely to

report depressive symptoms than women who took the survey a year after her stillbirth. If a woman was married, had a loss during her third trimester, and had a birth after the loss, she was more likely to report less depressive symptomology than unmarried women who experienced an earlier loss and had no subsequent pregnancies. Although one might think a woman would have more depressive symptoms after losing the child in the third trimester, rather than the second trimester, research shows otherwise. The correlation is most likely due to the fact that mothers more often held their child in the third trimester because of increased bonding; this bonding helped with the loss and was not noted to be experienced by as many moms who were in their second trimester. In the 20th century, women not only have the option of seeing their baby, but also they often have the opportunity to wash and dress the child. A substantially high percentage of women who did not participate in washing or dressing the baby expressed regret in not spending that potentially precious time with their child. Discouraging or ignoring the choice of infant contact substantiated more psychologically harmful effects for the women (Cacciatore et. al., 2008).

Additionally, a study conducted researched the nursing care following a stillbirth in relation to increased long-term feelings of depression. In this study, 32% of the patients, who did not see the infant for as long as they preferred, reported increased feelings of depression. In comparison, only 10% of the women who stayed with the child for the time they desired experienced feelings of depression (Surkan, Radestad, Cnattingius, Steineck, & Dickman, 2008). The research shows consistently that parents, even though they might have been initially hesitant, were grateful to have taken the time with their infant. Interestingly, parents who decline the option of holding their child, later

reported that if they were asked more than once by staff they would have held the child. According to the research evaluated by Gold and colleagues, holding and seeing the infant is an essential step to the healing process of dealing with a perinatal death (Gold et al., 2007). The research suggests that seeing the child and seeking closure through that experience positively affects the psychological outcome of the mother.

Instant Bonding

To someone who has never experienced a stillbirth, the presented research might seem odd, even inaccurate. How can holding a child who is not and will not ever breathe or move, be more therapeutic than letting the child go and not having that picture stuck in one's mind forever? Trying to explain the reasoning without experiencing the pain is a difficult feat. Conclusive research by Rådestad et al. (2009) helps shed light on why seeing the infant is more therapeutic than it is traumatizing. Rådestad and researchers performed a study in 2001 with 57 women who experienced stillbirth in Stockholm, Sweden. All 57 mothers saw their baby; two did not hold their baby. Only one of the two regretted not holding her child. Of the 55 women who held their baby, all 55 felt tenderness, 29 felt warmth, and 25 experienced pride. Feelings of grief were unanimous among all the women. As consistent with previous data, if the child was born before 28 weeks, there was more fear and insecurity with the child than if the child was born after 28 weeks (Rådestad, Saflund, Wredling, Onelov, & Steineck, 2009).

Most women experienced fear and insecurity before holding their child. Although the anticipation was fearful, research clearly states that the process is therapeutic.

Rådestad explains that the process of maternal and infant bonding is a strong bond, even if the child is not alive. The majority of moms are natural nurturers, so this bonding experience helps them fulfill a piece of their motherhood, even if only for a short time. Parents reported that the most valuable time for bonding was the first 30 minutes after delivery. In this time period, the baby is still warm and has color. After those 30 minutes the color begins to fade and the skin becomes cooler. In the study, only three women felt uncomfortable when holding the infant. In conjunction, parents can sense when a nurse or medical personnel feels uncomfortable. A nurse should never treat the deceased baby any differently than a living baby. If the nurse feels unnatural holding the infant, it is more likely that the mother will feel unnatural and awkward towards the infant (Rådestad et al., 2009). Giving the family and the newborn the same care that one would give any other “normal” patient, is the nurse’s primary job.

Future Plans

The fact that a person, no matter how small, is a person, should not be lost on the staff. Talking about post-mortem care proves to be a sensitive subject. Explaining that a trained professional will examine the child with the intention of determining the cause of death, is necessary teaching. Although some would rather not know the cause, the examination could be helpful if the couple potentially wants to get pregnant again. If the cause can be prevented or certain precautions need to be taken in the next pregnancy, this information will be beneficial. The uniqueness of each case means that there are no guarantees that a definitive cause will be discovered. Post-mortem care cannot be conducted without the consent of the guardian. When discussing the logistical decisions, the issue of registering the infant’s death must be addressed. By law, any infant born after

24 full gestational weeks must be registered. The parents will receive a stillbirth certificate; the document can contain as little or as much information as desired. The name, length, weight, and time of birth are all optional components (“Stillbirth: Surviving,” 2011).

In addition, the nurse needs to respectfully discuss the plans and preparations for the commemorating of the child. The patient should not perceive the nurse’s personal opinions at anytime. The recognition and remembrance of this loss remains completely in the parents’ hands. Hospitals, for the most part, provide services to help recognize and celebrate the life of the child. Parents have the option of getting pictures taken and footprints molded. Some hospitals take pictures of every infant, so that if, in time, parents decide they do want keepsakes, the hospital will have them on record. Parents might also want to keep a lock of the baby’s hair (“Stillbirth: Surviving,” 2011).

Research has supported that publically recognizing the loss therapeutically contributes to a stable grieving process. In some countries, families will purchase large monuments to solidify the impact of their child’s life. In the Netherlands, between 2000 and 2009, over 150 monuments for children were constructed in graveyards. These monuments are for groups of infants that the Catholic Church buried in prior years without name or recognition. These statues act as a symbol for the social status of the unborn. Bereaved parents are speaking out against the injustice. These parents recognize that each child, should at the very least, be awarded a name. These monuments are dedicated to reversing the past (Peelen, 2009). At a dedication ceremony of one of the monuments in a Dutch cemetery, a bereaved mother spoke these powerful words:

A scream. Silence. More silent than ever. Buried without a name. As if

you had never existed. After that, silence, no words spoken, forgotten. Silent pain forever, lifelong. But from now on you are part of us. Once your life started in the womb. It was not able to mature. Not developed and yet developed. You are not forgotten. The silence is over. For ever. (Peelen, 2009, p. 174)

As society progresses, looking and holding the stillborn infant no longer causes shame. Now, in the United States and even around the globe, stillborn infants have a voice. They are no longer lost in time, but their memory is sealed in stone. When the nurse has the head knowledge of how deep the pain can bury itself, her heart will be aware and able to provide care that will help promote long-term healing.

When a nurse makes it a priority to be aware of the cultural, religious, and social values of the primary family members, it helps the family to effectively communicate their preferences regarding end of life care. A stillborn infant is not different from an adult death in that he or she can be cremated or buried. Depending on the religious and cultural beliefs of the patient, they may want a priest to christen and bless the infant. Having a memorial and/or funeral service provides acknowledgement of the importance of the infant's life and closure of the infant's death. Social workers and chaplains in the hospital are often helpful in arranging the ceremony ("Stillbirth: Surviving," 2011). All of the decisions that need to be made after the delivery have the potential to be extremely overwhelming for the parents. The fragility in this time contributes to the intense susceptibility of the mom or dad suffering from depression and other mental health problems. Because of the nurse's powerful influence on the family, he or she has a high impact on how the emotional scale will balance after discharge.

Grieving Process

Each set of parents and each family react differently to loss. Culture, income, and educational level have proven to be contributing factors to the magnitude of the effects of the stillbirth. Families that have a low income and low educational level tend to report feelings of depression and distress for an extended amount of time. In addition, there remains a consistent correlation between studies showing that mothers grieve for a lengthier period of time than fathers. For both mother and father, the ability to cope effectively with life stressors either helps or hinders the grieving process (Murray & Terry, 1999). The healing process partly depends upon past experiences, healthy or unhealthy coping mechanisms, and the environmental and personal resources present. For example, if a woman has an intense and severe response to the initial loss, it is correlated with longer amounts of distress. Furthermore, families experiencing concurrent losses, whether monetary, familial, or relational, are much more susceptible to increased suffering and grief for longer amounts of time (Riley, LaMontagne, Hepworth, & Murphy, 2007).

Although the list of negative contributing factors seems lengthy, the possibility of coping and grieving well with a loss is not insurmountable. Having a supportive, loving, and understanding partner has proven to be one of the major influences on a healthy grieving process. Parents overall, cope with child loss in one of two ways: emotion-focused or problem-focused. Emotion-focused coping attempts to stop the negative and burdening feelings that arise after a loss. For instance, a father feels like a failure because he could not do anything to save his son, so, in an effort to make himself feel better, he turns to alcohol and drugs to mask the pain and produce a false sense of euphoria (Riley, LaMontagne, Hepworth, & Murphy, 2007).

Conversely, problem-focused coping emphasizes on trying to fix the actual problem, not the feelings associated with the loss (Murray & Terry, 1999). The problem is the loss of the child; the response would be accepting the loss and realizing that the couple must unite to help overcome this tremendous obstacle, together. An optimistic attitude has consistently proven to be an essential asset to grieving families. By focusing on the problem, rather than the emotions, the nurse supports a healthier grieving process (Riley et al., 2007).

A Father's Grief

Because of the stigma associated with men outwardly expressing emotion, males often get overlooked when it pertains to grief and mourning over a stillborn. For example, in 2006, William Badenhorst et al. published a literature review on psychological effects of stillbirths on fathers. The literature review focused on work published between 1996 and 2005. When examining the research, he found that the majority of the research published about this subject matter was inconsistent and irrelevant. He concluded that more research needed to be conducted to even examine what the psychological status of a bereaved father looks like (Badenhorst, Riches, Turton, & Hughes, 2006). The bulk of research concludes that more research needs to be performed. The lack of evidence proves difficult for nurses to provide evidence-based practice.

Although lacking in evidence, personal testimonies of fathers who have experienced this loss prove to be helpful in understanding nursing care. Brett O'Neill and his wife experienced the loss of their child seven months into the pregnancy. Devastation followed and the grieving process was extensive. O'Neill (1998) explained that "the care that nurses provide can make a difference. I think I remember their actions

more than their words” (p. 33). His experience encompasses both good and bad actions. The cold, impatient nurse during the night shift stands out just as strongly as the sweet, day shift nurse for O’Neill. After discharge, he felt ignored, while everyone was concerned solely about his wife. A nurse used to come over to their house to assess how the wife was doing; O’Neill was grateful for that, but he wished she had asked how he was coping (O’Neill, 1998). Nurses can use this information and recognize that the father copes along side of the mother. This fact may not seem evident because men often try to be strong for the woman. However asking the father questions and supporting him as well as his wife, are practical steps for nurses to implement in an effort to enhance care.

Postvention Programs

Discharge teaching remains a critical aspect in the effort to help alleviate enduring emotional instability. One of the most essential programs to emphasize is that of a bereavement support group. A worthwhile idea is that of developing postvention programs to help deal with the pain after the incident. Implementation of an intentional program that aids in the recovery of women, who have gone through a stillbirth, can drastically contribute to the family’s psychological recovery. It has been researched that women who go to a support group experience substantially fewer traumatic stress symptoms than those who forgo this care. Women who did not regularly attend a support group showed very little improvement in both the crisis and long-term stages of the grieving process. Experiencing the loss of a stillborn child creates a bond between women that cannot easily be broken. As the same group continues to meet month after month, the participants find they are able to laugh and love in a way they had not experienced since the loss. As new members join, the group begins to nurture the

mother's broken heart (Cacciatore, 2007). It is a beautiful picture that those who came seeking help, become the helpers. Hospitals can aid the recovery process by partnering with nonprofit organizations and local counseling centers to offer specialized and consistent stillborn birth support groups.

Not only do postvention programs prove beneficial for the mother, but also groups for fathers have shown to be an effective way of coping with this loss. Aho et al. (2010) recognized there was a gap in the system for male stillborn support groups. The team used action research to establish an effective and reliable postvention plan for fathers. Parents were given a support package at the time of discharge with handwritten notes from hospital personnel and informational brochures. A week after the loss, if the father gave consent, an outside organization would visit the man to provide support and aid in emotional recovery. Before discharge, the health care staff set up a date, around one month after delivery, for the father to come back to the hospital to meet with supportive personnel (Aho, Åstedt-Kurki, Tarkka, & Kaunonen, 2010). Although extensive research has not been conducted on the effectiveness of this intervention, preliminary results show many positive benefits for grieving fathers.

Moving Towards the Future

Depending on the circumstances, the couple may decide to have subsequent children. Grief for a stillborn child never dissolves, but it slowly lessens as time passes. Parents can come to terms with the tragedy and healthily move on to the next pregnancy. However, unresolved grief greatly contributes to the likelihood of having more emotional and mental difficulties (O'Leary, 2004). If the mother consistently feels guilty for the loss of the stillborn baby, then she is going to have a difficult time being excited about a

future pregnancy. A bereaved mother spoke these impactful words, “I guess in a lot of ways, it’s about grief management, because being pregnant again is the biggest reminder of the greatest loss a mother will ever experience” (O’Leary, 2004, p. 10). Some might even believe that it would be better to not have children. However, research has shown that depression can be three times higher for women who do not conceive another child (Surkan et al., 2008). Often, having another child aids in the healing process.

This dreadful experience begs the question, how will this tragic loss affect their future as parents? Undoubtedly, throughout the following pregnancy parents will experience elevated anxiety and fear. To an extent, worrying and nervousness is normal. However, the fear experienced through gestational development can translate into infant, child, and adolescent development in the form of an overprotective parent. Because of the helplessness they felt due to the miscarriage, parents overcompensate by attempting to control everything surrounding the child. This is often not a conscious choice, but a subconscious defense mechanism. The attachment styles between mother and father have the potential of becoming unhealthy (O’Leary, 2004). In conjunction with previous evidence, this research again points to the necessity of implementing EBP into stillbirth nursing care in hopes that long-term relational, emotional, and spiritual difficulties will be evaded.

Conclusion

Infant death, without contest, stands as one of the hardest experiences a mother and father will ever have to endure. Attempting to celebrate an innocent life in the face of a tragic death produces more pain than many can bear. To say the agony of this loss will be eradicated with time is a falsity. However, through the healing process, the hope

remains that this pain will be alleviated. The pivotal point of care for patients who have just delivered a dead baby remains with the nursing staff. Nursing professionals have the ability to be either helpful or harmful. A soft touch on the hand has a much greater impact than four hours of aimless, “comforting” speech. Nurses need to recognize that their care directly affects the long-term emotional outcome of this specific patient population.

Research, education, and implementation by health care personnel are critical steps that must be taken for the well being of these patients. Any person with “RN” behind his or her name can perform the basic requirements of a nurse. Nurses need to go beyond the requirements. Patients’ lives are saved, changed, and healed when nurses stop looking at their job description as a task, and they start focusing their heart, time, and energy on a hurting, broken patient.

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