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Review of the Literature: The Emotional and Mental Distress
Experienced by Women in a Pregnancy after a Perinatal Loss

Jana Sund, CNM

University of Utah

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Perinatal loss is a devastating, complicated and shattering experience for women and their families. In a pregnancy that ends unexpectedly with a perinatal death, the woman not only loses her baby but faith in pregnancy overall. These losses are often followed by a period of intense grieving for the lost child, mourning over the loss of innocence about pregnancy and damage to a woman's self-confidence about her ability to carry a child and become a mother (Côté-Arsenault & Morrison-Beedy, 2001). Taking care of women who are pregnant after experiencing a perinatal loss can be complicated, as these women have physical and emotional needs that must be addressed to cope effectively with their pregnancy. An important role for the provider is to anticipate and care for the holistic needs of the woman experiencing a new pregnancy.

Clinical and Educational Problem

Stillbirth, miscarriage and neonatal death are defined as perinatal loss and are the result of an estimated 25% of all pregnancies (Côté-Arsenault & Marshall, 2000). Many women who experience perinatal loss go on to become pregnant again. Various studies have reported that 50-98% of women will have a pregnancy after a loss (Côté -Arsenault & Marshall, 2000). This is a critical time for pregnant women, as these pregnancies are often filled with high anxiety and stress. Researchers have demonstrated that pregnancy after perinatal loss may lead to serious sequelae such as anxiety, depression, vulnerability, fear (Côté-Arsenault, Morrison-Beedy, 2001; Armstrong, 2004) post-traumatic-stress disorder (Hughes, Turton, Hopper, & Evans, 2002) and possibly decreased emotional attachment to the fetus (Armstrong & Hutti, 1998).

A pregnancy that occurs after a perinatal loss is often mentally, emotionally and physically draining. It is important for providers who are taking care of women who are experiencing a subsequent pregnancy to understand how to meet the needs of these women from a holistic perspective. Evidenced based practice exists for providers when attempting to understand the expected emotional and mental distress that women go through on a daily basis. After ~~the~~ reviewing the literature, it is evident that these findings will help the provider facilitate a holistically healthy pregnancy that will not only benefit the patient but her infant as well.

Theoretical Framework

Lazarus' Theories on Emotions, Stress, Coping and Adaptation have been used time and again to understand the emotional and mental aspects of human behavior. Swanson (2000), a principal researcher in the field of miscarriage, researched depressive symptoms after miscarriage through a path analysis based on the Lazarus theory of emotions and adaptation. This theory was also used by Côté-Arsenault (2007), another primary researcher in this field, as she described threat appraisal, coping and emotions in a pregnancy occurring after a perinatal loss. This theory provides an effective framework when attempting to understand perinatal loss on human emotions. As affirmed by Swanson (2000), Lazarus' theory holds considerable promise for understanding the variability in women's responses to miscarriage.

Lazarus and Folkman wrote this theory first in 1984. They theorized that appraisal of situations occurs in three phases: primary, secondary and reappraisal. Events are appraised differently based on the constraints, demands and resources surrounding the event at the time and as time passes (Swanson, 2000). Primary appraisal is seen as "what is at stake for the person" and secondary appraisal is that person's "evaluation of coping options" (Lazarus & Folkman, 1984, p. 315). As primary appraisal is occurring, the event is either viewed as benign or

stressful. Perinatal loss is a significantly stressful event; these painful past pregnancy experiences have taught women that loss is a realistic possibility in their current pregnancy and therefore secondary appraisal occurs in order to cope with their current situation.

Secondary appraisal is focused on the coping mechanisms to get through, or manage the situation. There are two forms of coping: active and passive. Active coping may include seeking support, problem solving, changing the situation or changing something about the self in order to deal with the situation. Passive coping may involve wishful thinking, ignoring the situation and self blaming (Swanson, 2000).

Reappraisal occurs with the passage of time or other significant events in a person's life. In the situation of perinatal loss, these events could be the passing of months or even years, multiple losses, or successful pregnancies. According to this theory, the woman who is experiencing a pregnancy after a perinatal loss will inevitably encounter primary appraisal, secondary appraisal and reappraisal ~~of her situation~~ as it relates to the emotional aspect of being pregnant in a volatile state. Lazarus' theory on emotion and adaptation has been used as a framework in researching and understanding the expected emotional distress that occurs in a pregnant woman who has experienced a previous perinatal loss. As a result, I have used this framework to guide the evidence for this topic.

Literature Search

In order to evaluate the expected emotional and mental distress that occurs in a pregnancy following a perinatal loss, I conducted a literature search to identify any available evidence related to this topic. The search strategy included PubMed, CINAHL, National Guideline Clearinghouse (NGC), Cochrane Collaboration, Eccles Library catalog and Google Scholar. The search had no date limitations and used the following key terms: "previous perinatal loss",

“miscarriage”, “stillbirth”, “current pregnancy”, “anxiety”, “depression”, “emotional distress” and “evidence based practice”. These key terms were used in combinations with each other in attempt to [locate](#) appropriate studies. Inclusion criteria included peer reviewed studies published in English. ~~I also reviewed. The search strategy also included reviewing each~~ article’s reference list and evaluated and located additional studies [in that manner](#). The ~~The~~ NGC and [the Cochrane Collaboration](#) did not provide any current policies and procedures or recommendations for practice; and there was no meta-analysis found on this topic.

Literature Review

I initially reviewed ~~Specific aspects were considered when selecting studies for this review. The studies had to focus on the impact of perinatal loss on a current pregnancy. twenty-three studies and retained ,with fourteen remaining for final analysis. The remaining studies were chosen as because~~ they specifically focused on the mental and/or emotional aspects of a pregnancy after a perinatal loss experienced by women. Two of the studies focused [ed](#) on support groups or childbirth education ~~and are pertinent when understanding the implications for practice for this population. --~~ The final fourteen studies, [two literature reviews and 12 non-experimental quantitative and qualitative studies](#); ~~were analyzed and then ranked according to their strength of evidence which is seen in the hierarchical table of evidence (see Appendix A). Of the fourteen studies that were reviewed, two were literature reviews, and the remaining 12 were non-experimental quantitative and qualitative research.~~

The first literature review done by Robertson & Kavanaugh (1998) was conducted to explore [what was known about](#) pregnancy following a perinatal loss and to examine the implications for practice when taking care of this population of women. Four recurring issues were identified: subsequent pregnancy and the grief response, parents’ behaviors during a

subsequent pregnancy, the replacement child syndrome and the vulnerable child syndrome and parenting the subsequent child after perinatal loss. Robertson & Kavanaugh found that having a subsequent pregnancy and child may be a part of the healing process of perinatal grief, however, maternal anxiety may continue for months after the child is born and may manifest as over protectiveness toward the subsequent pregnancy. The researchers also found that mothers have a heightened sense of anxiety during a subsequent pregnancy after a loss. As a result, providers should accept any outward lack of acceptance to the child, as this may be a self-protective mechanism of coping with the current pregnancy. The authors also found that during prenatal visits it is important to explore what the loss means to the patient and, if appropriate, ask to see remembrances of the lost child. It is also important to be aware of crucial milestones in the pregnancy. The authors encouraged providers to validate the patients' heightened anxiety and to recognize fears as normal. Robertson & Kavanaugh also recommended providers to urge patients to attend childbirth classes and/or a support group intended for a pregnancy after a perinatal loss.

Another literature review done by Lamb (2002) found the same recurring themes as Robertson & Kavanaugh (1998). These themes are: the effect of the grief process on the subsequent pregnancy, parental coping mechanisms during the subsequent pregnancy, replacement or vulnerable child syndrome, and parenting issues with the subsequent live-born child. Specific implications for practice were discussed with an emphasis on the need for holistic care, including the psychosocial needs of the patient experiencing a pregnancy after a perinatal loss. Lamb also recommended a special childbirth education class or a support group intended for this group of women. She suggested additional support be given by the by the healthcare provider through frequent prenatal visits and longer scheduled visits if pregnancy-specific

anxiety is identified. Lamb recommended an in-depth exploration of what the loss meant to the parents, as this sheds light on how it may affect the current pregnancy and offers reassurance that the loss was real. Recognizing the past loss also assists in building a supportive, trusting relationship. The author also discussed the importance of providers recognizing milestones of critical points in the pregnancy and that all staff responsible for their care becomes aware of the woman's previous history and the heightened anxiety levels.

Armstrong (2002) conducted a three group comparison, cross-sectional design with a survey, consisting of 103 couples all in their second trimester of pregnancy. Forty couples had a previous perinatal loss in a pregnancy, 33 couples were pregnant for the first time and 30 couples had a history of prior successful pregnancy. The purpose of this study was to evaluate the association of a previous perinatal loss with levels of depressive symptoms, pregnancy specific anxiety and whether or not these affected prenatal attachment. The findings of this study showed that couples with a history of perinatal loss had higher levels of depressive symptoms and pregnancy specific anxiety compared with couples who had a past successful pregnancy as well as those with no prior experience of a loss. Armstrong also found that mothers had higher levels of depressive symptoms and pregnancy-specific anxiety than the fathers in all three groups. The level of prenatal detachment did not differ in any of the groups. Armstrong suggested specific implication in the prenatal period; providers should evaluate the patients' prior obstetrical history and examine the influence of a prior loss on anxiety and depression in a subsequent pregnancy. Armstrong emphasized the importance of creating an environment where parents feel free to discuss their fears, validate their losses and separate their past experiences from the current pregnancy. Armstrong found the importance of addressing the emotional distress of the current pregnancy and to refer patients to mental health specialists if needed.

Another study conducted by Armstrong (2004) ~~is was~~ a cross-sectional survey ~~of 40 couples~~ in an attempt to evaluate the ~~effect of~~ previous perinatal loss on depressive symptoms, pregnancy-specific anxiety, and prenatal attachment for parents in a subsequent pregnancy. ~~The sample for this study was 40 couples who experienced a previous loss and were currently in their second trimester of pregnancy.~~ The ~~results of the study~~author found that mothers reported higher levels depressive symptoms, pregnancy-specific anxiety and prenatal attachment in the current pregnancy than the fathers did. The author did not find a relationship between the psychological distress in pregnancy after perinatal loss and prenatal attachment. The author stated that these findings should heighten awareness of the mixture of hope and fear expectant parents' experience. Armstrong encouraged counseling patients ~~in about~~ the possibility of increased emotional distress in a subsequent pregnancy. The use of short assessment tools, such as the Center for Epidemiologic Studies-Depression Scale and the Pregnancy Outcome Questionnaire may be utilized to indicate parents who need further counseling during the pregnancy. The author also recommended evaluating the patients' obstetrical history and examining the influence of past traumatic experiences on anxiety and depressive symptoms. Providers should create an environment that helps validate the woman's previous loss, and begin to separate the past from the current pregnancy. ~~Again a~~ support group ~~was recommended~~ ~~intended~~ for this population ~~was also recommended by Armstrong.~~

Côté-Arsenault & Marshall (2000) did a qualitative study of 13 women to gain insight into women's pregnancy after perinatal loss experiences, including major features and helpful provider responses. Data were generated through three focused groups and two individual interviews. An overall metaphor of "One Foot In—One Foot Out" was established by the data analysis. The authors found four contexts while doing this research; (a) reliving the past, (b)

trying to find a balance in the present, (c) recognizing their changed reality and (d) living with wavering expectations. The researchers also found themes that characterized the navigation of the woman's pregnancy after a loss, which are the following: setting the stage, weathering the storm, gauging where I am, honoring each baby, expecting the worst, supporting me where I am and realizing how I've changed. The researchers stated that care during a pregnancy after perinatal loss must be given within the context of past pregnancy experiences, including those of perinatal loss. Providers should acknowledge the loss by giving women the opportunity to tell their own story. The researchers also found that the patients who named the baby who died, preferred providers to refer to the baby by name. The women in this study were quite clear about what would be personally helpful, so providers should respond when appropriate to the woman's requests.

In 2001 Côté-Arsenault, Bidlack & Humm performed a study with a survey design of 73 women in a pregnancy after loss support group to determine the specific emotions and concerns of women who are pregnant after a loss. In this study the most frequently reported emotions were anxiety, nervousness and fear. The researchers also identified eight categories of profound concern: (a) losing another baby, (b) overall health of the baby, (c) emotional stability of self, (d) impact of another loss on my future, (e) lack of support from others, (f) fear of bad news, (g) own impact on the baby, (h) worries never end. The researchers noted that most women also experienced some positive emotions. The authors found that women pregnant after a loss are skeptical about pregnancy, and the women's concerns are ongoing. The authors recommended that providers be cognizant of the array of emotions that occur, acknowledging that anxiety is a real concern prior to prenatal testing such as ultrasounds. The authors concluded that responsive

care can be provided by asking women about their concerns throughout the entire pregnancy and to assume that these pregnancies are stressful.

Côté-Arsenault & Morrison-Beedy (2001) conducted a study to describe women's experiences of pregnancy after loss and the long-term effects of perinatal loss. This study was an interpretive, cross-sectional study with a phenomenological approach consisting of 21 women separated into three focus groups. The [findings of this study authors](#) stated that women did not feel emotionally safe in their pregnancies after loss and were fearful that their baby in the current pregnancy would die too. Many women viewed pregnancy as a time of high anxiety and had difficulty getting through each day. The authors found six themes in this study: (a) dealing with uncertainty, (b) wondering if the baby is healthy, (c) waiting to lose the baby, (d) holding back their emotions, (e) acknowledging that loss happened and that it can happen again, and (f) changing self. The authors suggested that providers should acknowledge a woman's previous loss when providing prenatal care and address their concerns in the current pregnancy.

Côté-Arsenault & Freije (2004) did a study of two established pregnancy after loss (PAL) support groups in an attempt to understand this [level-kind](#) of support for pregnant women who have experienced a previous loss. [This was](#) [They conducted](#) a qualitative study with an ethnographic focus; data were collected through participant observation of meetings, individual interviews, questionnaires and artifacts. The researchers found five paradoxes that reflect a conflict between common cultural expectations and women's perspectives about pregnancy. The paradoxes are the following: (a) birth/death, (b) pregnancy equals/does not equal baby, (c) head/heart, (d) public/private and (e) hope/fear. The results of this study found that support groups provide a safe place where the fears and anxieties in a pregnancy after a loss could be addressed in an open, caring environment. PAL support groups offered a place to heal, grow,

share, and learn. It is a place where grief and loss were acknowledged, worry was accepted as normal, new coping strategies were encouraged, and women felt understood, validated and helpful to one another.

In 2006, Côté-Arsenault, Donato & Earl performed a study to understand women's early pregnancy after loss experiences, to document the timing and frequency of common discomforts, and to explore changes in these over time. This study was a longitudinal, qualitative descriptive, triangulated design consisting of 82 women pregnant after a past perinatal loss. The women partook in interviews, surveys and used a calendar to capture specific events in their pregnancy. In this study the researchers identified five themes: (a) growing confident, (b) fluctuating worry, (c) interpreting signs, (d) managing pregnancy and (e) having dreams (this theme did not reach saturation). The authors found that frequent calls and visits to the providers are a common and comforting way for women to decrease their anxiety. The authors also noted that an absence of questions or statements of calm may be a coping mechanism to help the women get through their pregnancy. The authors recommend that care providers be sensitive and responsive to the patients' needs as this may help stabilize emotions. The authors also found that women with a previous perinatal loss want to know every detail about their pregnancy. Their fears are real, based on a distrust of pregnancy rather than a distrust of healthcare professionals.

The most current study by Côté-Arsenault (2007) is a predictive correlation study, with a prospective longitudinal design consisting of a sample of 82 women who completed repeat assessment at 10 week intervals. The purpose of this study was to test a theoretical model (Lazarus' theory of stress, coping and emotions) and to examine the patterns of threat appraisal, coping and emotional states of women across pregnancy after perinatal loss. Côté-Arsenault found that pregnancy after loss was perceived as a threat, and threat appraisal strongly predicted

pregnancy anxiety. Anxiety levels were reported as moderate on average; however, the anxiety decreased over time during the pregnancy. Threat appraisal, coping and other emotions were stable across the entire pregnancy. Coping styles did not change over time, which Lazarus' theory predicts. Côté-Arsenault suggested that pregnancy anxiety should be anticipated as a normal aspect of any pregnancy after a loss. The author concluded that anxiety should be addressed at each prenatal visit, especially in the early stages of the pregnancy. The author also recommended that past losses be acknowledged, as they play a major role in the experience of the current pregnancies and therefore can impact parenting and infant emotional development.

Franché & Burlow (1999) did a study on the impact of a subsequent pregnancy on grief and emotional adjustment following a perinatal loss. The focus of this study was on parental grief components consisting of active grief, difficulty and despair. The study was a cross-sectional design comparing the "pregnant loss" group which consisted of 25 women and 24 of their partners who had suffered a perinatal loss and were pregnant again, and the "loss" group of 25 women and 18 of their partners who were not pregnant after experiencing a loss. The ~~results~~ [of this study](#) authors found that mothers who were not pregnant experienced significantly higher levels of despair and difficulty coping than the mothers who were pregnant. The authors found that a new pregnancy has a beneficial effect on the mourning process for women who have experienced a previous perinatal loss; this is believed to be due to a decrease in despair and coping. Regardless of this finding, grief intensity remained high in both groups, suggesting that a new pregnancy may help the mourning process. The authors stated the importance of understanding that grief continues despite a current pregnancy and that pregnancy after loss could have a positive impact on psychological adjustment, as it helps reduce the grief intensity.

Franché & Mikail (1999) conducted a study to compare the emotional adjustment of pregnant couples with and without a history of perinatal loss. This was a cross-sectional design with 31 women (28 men) pregnant with a history of loss, and 31 women (23 men) pregnant without a history of loss. Data collection occurred during the 10th and 24th weeks of gestation with five different measurement tools (see Appendix A). The results of this study showed that couples with a history of perinatal loss had significantly more depressive symptoms and pregnancy-specific anxiety than couples in the comparison group. Women also reported more depressive symptoms than the men. Depressive symptoms were associated with high levels of self-criticism. In the women with a history of loss, pregnancy-specific anxiety is associated with the belief that their own behavior affects the health of their fetus. While the women in the comparison group had pregnancy-specific anxiety associated with the belief that health professionals' behavior affects the health of the fetus. The authors also found that mood alterations are found in the early stages of pregnancy for the couples who have experienced a previous perinatal loss. The authors encourage providers to attend to signs of anxiety early in the pregnancy as there has been a link between anxiety and prematurity. The authors also encourage providers to recognize and target self-critical attitudes as they can lead to the development of depressive symptoms.

Franché (2001) conducted a study to determine if psychologic constructs of self-criticism and marital adjustment were significant predictors of grief during a pregnancy after a perinatal loss. This was a cross-sectional design with a sample of 60 pregnant women with a previous loss and 50 of their partners. Franché found that high levels of self-criticism, prolonged time between conception and loss and a later gestational age at the time of a loss are predictors of increased grief during a subsequent pregnancy. The researcher found that women may interpret

loss as a personal failure, whereas men may be more sensitive to the effects of the loss on their relationship. Franche encouraged couples to focus on optimizing psychologic and marital functioning, rather than focusing on a time-frame of when to attempt another pregnancy. The author also recommended a referral to a mental health professional if a patient is highly self-critical, as this may help in coping with a subsequent pregnancy.

~~The final study that was reviewed was done by~~ Turton, Hughes, Evans & Fainman's (2001). ~~The purpose of this~~ study was done to assess the incidence, correlates and predictors of PTSD during and after the pregnancy following stillbirth. This was a prospective cohort study of a group of 66 women whose previous pregnancy ended in a stillbirth; 54 women remained in the study at one year. The results of this study showed that PTSD symptoms were prevalent in women experiencing a pregnancy following a stillbirth. The authors found that case-level PTSD was associated with depression, state-anxiety and a conception that occurred closer to the loss. However, the authors also found that the symptoms of PTSD generally resolved within one year post-partum or with the birth of a healthy baby. The authors recommended that providers understand that women are vulnerable to PTSD in the pregnancy subsequent to stillbirth, particularly when conception occurs soon after the loss. The researchers also found that having strong emotional support is protective ~~of for~~ PTSD symptoms.

Interpretation of the Evidence

A single emotion cannot adequately portray the holistic experience that each woman goes through during a pregnancy after a perinatal loss. The arrays of emotions are diverse, and they are continually shifting throughout the course of a subsequent pregnancy. In this review of literature, anxiety and psychological distress were the themes that emerged throughout the studies.

Anxiety. Anxiety can be a normal component of any pregnancy; however, heightened anxiety has been reported throughout the literature on pregnancy after perinatal loss. Many of the researchers referred to this form of anxiety as pregnancy-specific anxiety. Of the 14 studies that were reviewed, 12 of the studies (Lamb, 2002; Robertson & Kavanaugh, 1998; Armstrong, 2002, 2004; Côté-Arsenault & Marshall, 2000; Côté-Arsenault, 2007; Côté-Arsenault, Bidlack & Humm, 2001; Côté-Arsenault, Donato & Earl, 2006; Côté-Arsenault & Morrison-Beedy, 2001; Franche & Mikail, 1999; Franche & Burlow, 1999; Turton & Hughes, 2001) described pregnancy-specific anxiety as a key element in the findings of this population.

In the quantitative studies pregnancy-specific anxiety was measured by the Pregnancy Outcome Questionnaire and/or the State-Trait Anxiety Inventory (Armstrong, 2004; Armstrong, 2002; Franche & Mikail, 1999; Franche & Burlow, 1999; Turton et al., 2001). In the qualitative studies pregnancy-specific anxiety was measured-identified through the personal explanations of the women about losses. Perinatal loss was an unexpected occurrence and taught women that pregnancy does not come with an assurance of a healthy, live baby. As a result, emotional distress was manifested as pregnancy-specific anxiety that continued throughout the subsequent pregnancy. The research conducted by Côté-Arsenault (2007) found that pregnancy-specific anxiety decreased as the next pregnancy progressed. This finding is valuable because women who are pregnant after a loss gain confidence in their baby being born healthy and therefore anxiety levels are decreased.

Psychological distress. Psychological stress was a recurring theme throughout the literature on this topic. The most frequent symptoms described by the researchers were symptoms of depression and heightened self-criticism. Depressive symptoms were measured through the Center for Epidemiologic Studies-Depression Scale, Multiple Affect Adjective

Checklist, Depressive Experiences Questionnaire-Self Criticism subscale and the Beck Depression Inventory (Armstrong, 2002, 2004; Côté-Arsenault, 2007; Franche & Mikail 1999; Franche, 2001). Depressive symptoms that occur in pregnancy after perinatal loss often occurred hand in hand with anxiety. The research that was conducted on couples found the mothers to have significantly higher depressive symptoms than the fathers who experienced perinatal loss (Armstrong, 2004; Armstrong, 2002; Franche & Mikail, 1999; Franche & Burlow, 1999).

Self-criticism is another theme seen in various portions of the literature. Franche & Mikail (1999) found an association with depressive symptoms and high levels of self-criticism. Franche (2001) also found a self-critical attitude to be an important predictor of a women's grief intensity during a pregnancy after a loss. A manifestation of self-criticism is self-blame, which is considered to be a salient characteristic of this population of women (Franche, 2001). Women who have experienced perinatal loss often feel that their body failed, or something they did caused the loss of the baby. These feelings of guilt, self-criticism and self-blame have been known to be more problematic to resolve than the actual loss itself (Franche & Mikail, 1999).

Recommendations

After conducting an in depth review of the literature related to pregnancy after perinatal loss, [I identified](#) many recommendations for practice [are identified](#). These recommendations are imperative for healthcare providers to implement when caring for their patients who are stressed mentally and emotionally after a perinatal loss.

One major recommendation [visible throughout the literature](#) is the need for [the availability of](#) support groups for women who are currently pregnant after a perinatal loss. [Many of the experts found support groups specifically intended for this population of women to be beneficial for the well-being of the mother.](#) [Côté-Arsenault & Freije \(2004\)](#) specifically

~~researched pregnancy after loss support groups and found these groups to provide a safe place for women to express their fears and anxieties.~~ Support groups are a place where grief and loss are acknowledged and coping strategies are encouraged. ~~Many of the experts on this topic found support groups specifically intended for this population of women to be beneficial for the well-being of the mother.~~ The power of a support group is being surrounded by other mothers and fathers who know exactly what each person is living through, what the anxiety feels like and how to cope with the current pregnancy. On-line support groups exist and may be as beneficial as face to face support groups for women in these circumstances; currently these support groups have not been evaluated by scientific research. However, if a support group is available ~~to the public~~ locally or on-line, providers should recommend a group in order to facilitate the holistic care that is needed by women going through their pregnancy.

Another recommendation ~~for practice is seen throughout the literature was the emphasis on~~ acknowledging the past pregnancy. The provider has an important role in caring for a current pregnancy in the context of a past loss. The past perinatal loss is on the forefront of the patient's thoughts even if it is not verbalized by the patient. An in-depth exploration of what the loss meant to the woman may help the provider understand the current level of emotional and mental distress that is occurring. Discussing the loss also offers reassurance that the perinatal loss was real and assists in building a trusting relationship that may be of critical importance if pregnancy related anxiety occurs (Robertson & Kavanaugh, 1998; Lamb, 2002). Providers can also validate the previous loss by asking about the details of the past pregnancy and offering to share in any remembrances of their patients' baby, such as mementos or pictures. Allowing the patient to discuss openly their previous experience and the uniqueness of the loss can help them look

forward to the new baby as a separate infant and the pregnancy as a separate event (Armstrong & Hutti, 1998).

Another recommendation for practice is to recognize critical milestones in the pregnancy and planning longer scheduled appointments during these times to allow for further discussion of their concerns (Robertson & Kavanaugh, 1998; Lamb, 2002). Some patients may need more frequently scheduled prenatal visits and additional testing to help alleviate pregnancy related anxiety.

Côté-Arsenault & Marshall (2000) found that there was not a right way to “do” pregnancy, and often the individual woman knew what was best for her. Providers can help by accommodating the needs of these women through prenatal visits, testing and by asking the woman directly what would be most helpful in her through the current pregnancy.

Limitations

~~As with any review of literature and analysis, the~~ Two limitations ~~that~~ are evident in this review. The first limitation is due to the nature of this topic; perinatal loss is a tragic and unexpected occurrence. Most of the studies chosen for this review were non-experimental studies, including descriptive, correlational, and qualitative research. This type of research is respectively in the same tier of evidence and lacks the strength seen in meta-analysis’ and randomized controlled trials.

A second limitation seen in this review was the homogeneity of the sample population used throughout the studies. Throughout much of the research a convenience sample of white, married and educated patients were studied. This limitation may have an impact on the generalizability of the findings. Another limitation related to the sample population of the studies was the possibility that people who chose to participate in the study may have been

Comment [LAB1]: You are confusing different things that might could be studied about some problem. For example, maybe you want to predict which pregnancies will result in a loss and which one won't. Now that probably would be a difficult question. But trying to understand what women feel after a loss has occurred...that issue is not so hard. And why couldn't you do trails testing possible interevtions designed to decrease anxiety in a subsequent pregnancy?

psychologically different ~~healthier~~ than those who did not ~~participate~~. The research did not discuss the possible subpopulations of women, such as those who have lost a pregnancy after infertility treatments, or those who have experienced multiple losses, women with one loss who never attempted a second pregnancy or women from a different culture.

Comment [LAB2]: I think you can also comment about nothing being known about subpopulations....infertility treatment patients, previous unwanted pregnancies, multiple losses, people with one loss who never even attempt a second pregnancy, other cultures

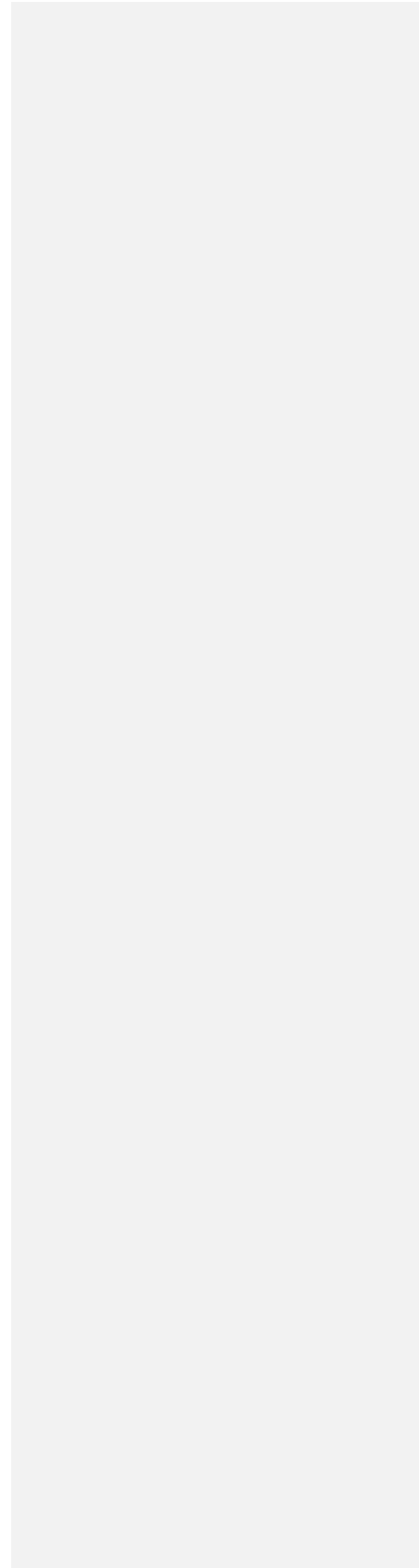
Conclusion

The loss of a pregnancy, regardless of the gestation, is a significant life crisis. ~~It is evident from the research that~~ Women who become pregnant after a perinatal loss have increased physical, mental and emotional needs during their pregnancy. Research on this topic has made significant progress in recognizing the woman's needs and helping her cope with pregnancy specific emotional and mental distress. Lazarus' theoretical framework on emotions and adaptation has been effectively used to guide practice when caring for this group of women. According to this theory, women may use an active or passive coping strategy as a mechanism for regulating emotional responses to a difficult event (Swanson, 2000). The active coping strategies include seeking a support group, requiring information or increased prenatal testing and changing behaviors to actively cope with their loss. The passive coping strategies encompassed self-blame, wishing it would all go away and grieving without support.

~~Throughout the research the implications for practice encourage providers to help patients actively cope with their pregnancy loss which facilitates emotional healing~~ ~~Providers can help women actively cope with~~ their pregnancies after a perinatal loss ~~by taking measures intended to promote emotional healing~~. Providers should encourage their patients' to attend a support group, recognize the milestones of the current pregnancy, acknowledge the previous loss with the utmost of care and educate their patients' about the feelings of anxiety, depression and self-blame. ~~Providers are in a unique position when taking care of women who are pregnant after~~

~~experiencing a perinatal loss; it can be emotionally complicated and physically draining.~~

Providers who give care with a holistic perspective and encourage active coping are continually promoting healing in a pregnancy after a perinatal loss.



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Turton, P., Hughes, P., Evans, C. D. H., & Fainman, D. (2001). Incidence, correlates and predictors of post-traumatic stress disorder in the pregnancy after stillbirth. *British Journal of Psychiatry*, 178, 556–560.

Appendix A

Robertson, P.A., Kavanaugh, K. (1998). Supporting parents during and after a pregnancy subsequent to a perinatal loss. <i>The Journal of Perinatal and Neonatal Nursing</i> . 12(2). 63-71.					
Purpose	Study Design, Sample & Setting	Data Collection and Measurement	Results	Limitations	Implications for Practice
Review of the Literature.	Literature Review	<p>It is not clear how the literature was reviewed and what the key words were in their search.</p> <p>Topics Discussed:</p> <p>(a). Subsequent pregnancy and the grief response.</p> <p>(b). Parents' behaviors during a subsequent pregnancy.</p> <p>(c). The replacement child syndrome and the vulnerable child syndrome.</p> <p>(d). Parenting the subsequent child after perinatal loss.</p>	<p>Having a subsequent pregnancy and child may be a part of the healing process of perinatal grief.</p> <p>Mothers have a heightened sense of anxiety during a subsequent pregnancy after a loss.</p> <p>Maternal anxiety may continue for months after the child is born and may manifest in over protectiveness toward the subsequent pregnancy.</p>	The ambiguity in the method used to review the literature.	<p>Nursing Interventions Recommended:</p> <p>Prenatal—explore what the loss means. Ask to see remembrances of the lost child. Be aware of crucial milestones. Validate their worry and anxiety. Recognized fears as normal. Accept any outward lack of acceptance to the child (self-protective mechanism) Urge to attend childbirth classes. Support groups.</p>

Lamb, E.H. (2002). The impact of previous perinatal loss on subsequent pregnancy and parenting. <i>The Journal of Perinatal Education</i> . 11(2). 33-40.					
Purpose	Study Design, Sample & Setting	Data Collection and Measurement	Results	Limitations	Implications for Practice
To explore the literature regarding pregnancy following a perinatal loss and to examine implications for practice.	Literature Review	<p>Studies were identified through a key word search of Medline, CINAHL, Pubmed and MedPulse.</p> <p>Key words: loss and pregnancy, miscarriage and pregnancy, perinatal loss and subsequent pregnancy, and pregnancy and psychosocial effects.</p>	<p>Four recurring issues were identified:</p> <p>(a) the effect of the grief process on the subsequent pregnancy, (b) parental coping mechanisms during the subsequent pregnancy, (c) replacement or vulnerable child syndrome, and (d) parenting issues with the subsequent live-born child.</p>	<p>The entirety of this paper does not necessarily fit with the topic of expected emotional distress on a pregnancy after perinatal loss. However, (a) and (b) are appropriate to evaluate.</p>	<p>Additional support by healthcare providers; done through more frequent prenatal visits, longer scheduled appointments if anxiety is occurring.</p> <p>In-depth exploration of what the loss meant to the parents and how it may affect their current pregnancy.</p> <p>Recognize milestones of critical points in the pregnancy.</p> <p>Staff responsible for care be made aware of previous history and the heightened anxiety levels. Special childbirth preparation class or a support group. Holistic care, including psychosocial needs.</p>

Armstrong, D.S. (2002). Emotional distress and prenatal attachment in pregnancy after perinatal loss. *Journal of Nursing Scholarship*, 34(4), 339-345.

Purpose	Study Design, Sample & Setting	Data Collection and Measurement	Results	Limitations	Implications for Practice
The purpose of this study was to evaluate the association of previous perinatal loss with parent's levels of depressive symptoms, pregnancy-specific anxiety and whether these higher levels of anxiety and depression were associated with prenatal attachment.	<p>This study design is a three group comparison, cross-sectional design through a survey.</p> <p>The sample had a total of 103 couples who were all in their second trimester of pregnancy: 40 couples had a perinatal loss in a previous pregnancy, 33 couples were pregnant for the first time and 30 couples had a history of prior successful pregnancies.</p>	<p>Structured questionnaires (in person and telephone) were used to measure the following:</p> <ol style="list-style-type: none"> 1. Depressive Symptoms: Center for Epidemiologic Studies-Depression Scale (CES-D). 2. Pregnancy Specific Anxiety: Pregnancy Outcome Questionnaire (POQ). 3. Prenatal Attachment: Prenatal Attachment Inventory (PAI). 	<p>The findings of this study show that couples with a history of perinatal loss had higher levels of depressive symptoms and pregnancy specific anxiety than did couples with a past successful pregnancy and those with no prior experience with a loss.</p> <p>Mothers had higher levels of symptoms than the fathers in all three groups.</p> <p>The level of prenatal detachment did not differ in any of the groups.</p>	<p>The volunteer sample might not be representative of the whole.</p> <p>Homogenous sample.</p> <p>The design of the study did not allow for a look at the variables over the length of the pregnancy.</p>	<p>Evaluating prior ob history.</p> <p>Examine influence of prior loss on anxiety and depressive symptoms in a subsequent pregnancy</p> <p>Support and referral to mental health as needed.</p> <p>Create an environment where parents feel free to discuss fears, validate their losses and separate their past experiences from the current pregnancy.</p> <p>Addressing the emotional distress may influence the course of the current pregnancy as well as future parent-infant relationship for developing families.</p>

Armstrong, D.S. (2004). Impact of prior perinatal loss on subsequent pregnancies. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, 33(6). 765-773.

Purpose	Study Design, Sample & Setting	Data Collection and Measurement	Results	Limitations	Implications for Practice
The purpose of this study was to evaluate the previous perinatal loss on depressive symptoms, pregnancy-specific anxiety, and prenatal attachment for parents in a subsequent pregnancy.	<p>Cross-sectional survey design.</p> <p>Sample: 40 couples who experienced a previous loss and were currently in their 2nd trimester of a pregnancy.</p> <p>One structured interview was conducted and the mentioned surveys were filled out.</p>	<p>1. Influence of Loss: Impact of Event Scale (IES).</p> <p>2. Depressive Symptoms: Center for Epidemiologic Studies-Depression Scale (CES-D).</p> <p>3. Pregnancy Specific Anxiety: Pregnancy Outcome Questionnaire (POQ).</p> <p>4. Prenatal Attachment: Prenatal Attachment Inventory (PAI).</p>	<p>The results of the study found that mothers reported higher levels of these measures than the fathers did. This study did not find a relationship between the psychological distress in pregnancy after perinatal loss and prenatal attachment. The author stated that these findings should heighten awareness of the mixture of hope and fear expectant parents' experience.</p>	<p>Decreased generalizability due to self-selected volunteer sample. May not be representative of all parents with a history of perinatal loss.</p> <p>Not a diverse sample.</p>	<p>Counsel in the possibility of increased emotional distress.</p> <p>Short assessment tools may indicate parents who need further counseling during the pregnancy.</p> <p>Evaluate obstetric history and examine influence of past traumatic experiences on anxiety and depressive symptoms.</p> <p>Create an environment that helps validate fears, their loss and begin to separate the past from the current pregnancy.</p> <p>Support group.</p> <p>Encourage parental control over choices.</p> <p>Encourage fathers to play an active role.</p>

Cote-Arsenault, D., & Marshall, R. (2000). One foot in-one foot out: Weathering the storm of pregnancy after perinatal loss. <i>Research in Nursing and Health</i> . 23(6). 473-485.					
Purpose	Study Design, Sample & Setting	Data Collection and Measurement	Results	Limitations	Implications for Practice
Gain insights into women's pregnancy after perinatal loss experiences, including major features and helpful provider responses.	<p>This was a qualitative study.</p> <p>Sample of 13 women with various obstetrical backgrounds.</p> <p>Setting: support group forum and individual interviews.</p>	<p>Data collection was accomplished through three focused groups and two individual interviews.</p> <p>Data collection continued until saturation was achieved.</p>	<p>An overall metaphor of "One Foot In—One Foot Out".</p> <p>Four contexts were found:</p> <p>(a) relieving the past, (b) trying to find a balance in the present, (c) recognizing their changed reality, (d) living with wavering expectations.</p> <p>Seven themes were characterized as their navigation of their pregnancy:</p> <p>(1) setting the stage (2) weathering the storm (3) gauging where I am (4) honoring each baby (5) expecting the worst (6) supporting me where I am, (7) realizing how I've changed.</p>	None found for the contexts of this study.	<p>Care during a pregnancy after perinatal loss must be given within the context of past pregnancy experiences, including those of perinatal loss.</p> <p>Clinicians should acknowledge the loss, whether during prenatal visits, testing or antepartum care, and refer to the dead baby by name.</p> <p>Give women the opportunity to tell their own story.</p> <p>Each women in this study were quite clear about what would be helpful for her personally, so providers need to respond to women's requests.</p>

Côté-Arsenault, D., Bidlack, D., & Humm, A. (2001). Women's emotions and concerns during pregnancy following perinatal loss. *MCN: American Journal of Maternal/Child Nursing*, 26(3), 128-134.

Purpose	Study Design, Sample & Setting	Data Collection and Measurement	Results	Limitations	Implications for Practice
The purpose of this article was to determine the specific emotions and concerns of women who are pregnant after a loss.	The design of this study was a survey. Sample: Convenience, 73 completed the survey in a pregnancy after loss support group.	Data collected through a mailed questionnaire using an open response format. Analysis of data was through two trained research team members.	The most frequent emotions reported in this study were the following: anxious, nervous and scared. They also noted that most women had a positive emotion, indicating some mixed emotions about the pregnancy. Eight categories of profound concern were identified: (a) losing another baby, (b) overall health of the baby (c) emotional stability of self (d) impact of another loss on my future (e) lack of support from others (f) fear of bad news (g) own impact on the baby (h) worries never end.	Sample is a minority of women who were currently pregnant. All the women were participants in support groups, could create a bias in their grief process.	Women pregnant after a loss are skeptical about pregnancy. Clinicians should be cognizant of the array of emotions that occur, this enables supportive prenatal care. The women's concerns are ongoing, responsive care should include asking about concerns throughout the entire pregnancy. Anxiety is a real concern prior to prenatal testing, such as US. Care providers need to assume that these pregnancies are stressful.

Côté-Arsenault, D., Morrison-Beedy, D. (2001). Women's voices reflecting changed expectations for pregnancy after perinatal loss. *Journal of Nursing Scholarship*. 33(3). 239-244.

Purpose	Study Design, Sample & Setting	Data Collection and Measurement	Results	Limitations	Implications for Practice
To describe women's experiences of pregnancy after loss and their long-term effects of perinatal loss.	<p>This was an interpretive, cross-sectional study with a phenomenological approach.</p> <p>Sample: 21 women.</p> <p>Setting: Three separate focus groups lasting 90-120 minutes.</p>	<p>Discussions were audiotaped and field notes were taken.</p> <p>A debriefing session was held after each focus group during which predominant themes, content, and procedures were discussed.</p> <p>Audiotapes were transcribed verbatim and were verified by two team members. Copies of the findings were sent to participants for review.</p> <p>Data analysis was guided by Colaizzi's procedural steps.</p>	<p>The findings of this study were that women did not feel emotional safe in their pregnancies after loss and were fearful that their baby in the current pregnancy would die too. They found six themes in this study:</p> <p>(a) dealing with uncertainty, (b) wondering if the baby is healthy, (c) waiting to lose the baby, (d) holding back their emotions, (e) acknowledging that loss happened and that it can happen again, and (f) changing self.</p> <p>Many women viewed pregnancy as a time of high anxiety and had difficulty getting through each day.</p>	<p>Sample was white, married and educated women.</p>	<p>Acknowledge a women's previous loss when providing prenatal care.</p> <p>Ask women what would be most helpful to them and address their concerns in the current pregnancy.</p> <p>Recognize the potentially lifelong effect perinatal loss may have on these women.</p>

Côté-Arsenault, D., Freije, M.M. (2004). Support groups helping women through pregnancies after loss. *Western Journal of Nursing Research*. 26(6). 650-670.

Purpose	Study Design, Sample & Setting	Data Collection and Measurement	Results	Limitations	Implications for Practice
To explore several pregnancy after loss support groups.	<p>The study design was a qualitative study with an ethnographic focus.</p> <p>Sample: Two established PAL support group programs operating in large metropolitan areas. One in the Midwest and one in the Northwest.</p>	<p>Data was collected through participant observation of meetings, individual interviews, questionnaires and artifacts.</p> <p>Five paradoxes were identified reflecting conflicts between common cultural expectations and the women's own perspectives about pregnancy.</p> <p>(a) birth/death (b) pregnancy equals/does not equal baby. (c) head/heart (d) public/private (e) hope/fear</p>	<p>The authors found that the support groups provided a safe place where the fears and anxieties in pregnancy after loss could be addressed in an open, caring environment.</p> <p>PAL offered a place to heal, grow, share, and learn; where grief and loss were acknowledged, worry was accepted as normal, new coping strategies were encouraged, and women felt understood, validated and helpful to one another.</p>	Only two support groups were studied, however the nature of the study allows for good rich evidence even with only two groups.	Support groups for pregnancy after a loss are very beneficial for the well-being of the mother.

Côté-Arsenault, D., Donato, K.L., & Earl, S.S. (2006) Watching & worrying: Early pregnancy after loss experiences. *MCN: American Journal of Maternal/Child Nursing*. 31(6). 356-363.

Purpose	Study Design, Sample & Setting	Data Collection and Measurement	Results	Limitations	Implications for Practice
The purpose of this study was to understand a women's early pregnancy after loss experiences and to document the timing and frequency of their common discomforts and events, and to explore changes in these over time.	<p>The study design was a longitudinal, qualitative descriptive and triangulated design.</p> <p>Sample: 82 women pregnant after a past perinatal loss, (these women participated in a larger study of threat, appraisal, coping and emotions across PAL) who were followed until their 25th week. Setting: home, provider office, public place or phone. Calendars and surveys were mailed in.</p>	<p>Field notes were taken on all women.</p> <p>75 women recorded events of their pregnancy through text and stickers on an investigator-supplied calendar.</p> <p>Analysis was done from field notes and hand-written calendar entries; content analysis was conducted on sticker entered events and symptoms.</p>	<p>Themes were identified in this study:</p> <p>(a) growing confident (b) fluctuating worry (c) interpreting signs (d) managing pregnancy (e) having dreams (did not reach saturation).</p> <p>Recognize that women's scrutinizing and worrying about the many documented symptoms and events is normal.</p> <p>Frequent calls and visits are a common and comforting way to decrease anxiety.</p> <p>An absence of questions or statements of calm may be a coping mechanism.</p>	Varying degrees of calendar use from the participants.	<p>Women with a previous perinatal loss want to know every detail about their pregnancy.</p> <p>Women and their partners have great concern and anxiety as they proceed cautiously through their pregnancies.</p> <p>Their fears are real, based on a distrust of pregnancy rather than a distrust of healthcare professionals.</p> <p>Sensitive, responsive caregiving may help them keep their emotions more stable and more positive.</p>

Côté-Arsenault, D. (2007). Threat appraisal, coping, and emotions across pregnancy subsequent to perinatal loss. *Nursing Research*, 56(2), 108-116.

Purpose	Study Design, Sample & Setting	Data Collection and Measurement	Results	Limitations	Implications for Practice
The purpose of this study was to test a theoretical model (Lazarus' theory of stress, coping and emotions) in this population to examine the patterns of threat appraisal, coping and emotional states of women across pregnancy after perinatal loss.	<p>This was a predictive correlation study, with a prospective longitudinal design.</p> <p>Sample: 82 women were followed and measures were completed at 10 week intervals.</p>	<ol style="list-style-type: none"> 1. Background info (medical and obstetrical history) collected upon entry into the study. 2. Assignment of Fetal Personhood (how the mother and others in society view the dead fetus) 3. Stress (VAS-visual analogue scale) 4. Threat Appraisal of Pregnancy (Moneyham threat index) 5. Coping (Ways of Coping checklist-revised WCCL-R) 6. Emotional States (Multiple Affect Adjective Checklist – Revised & Pregnancy Anxiety Scale) 	<p>Pregnancy after loss was perceived as a threat and threat appraisal strongly predicted pregnancy anxiety. Anxiety levels were reported as moderate on average; however the anxiety decreased over time. Threat appraisal, coping and other emotions were stable across pregnancy.</p> <p>Coping styles did not change over time.</p>	<p>Generalizability is decreased due to convenience sampling, a white, married and educated sample.</p>	<p>Pregnancy anxiety should be anticipated as a normal aspect of any pregnancy after a loss.</p> <p>Anxiety should be addressed at each prenatal visit, especially in the early stages of the pregnancy.</p> <p>Past losses should not be ignored; they play a major role in the experience and stress level of current pregnancies and therefore can impact parenting and infant emotional development.</p>

Franche, R. L., & Bulow, C. (1999). The impact of a subsequent pregnancy on grief and emotional adjustment following a perinatal loss. <i>Infant Mental Health Journal</i> . 20(2). 175-187.					
Purpose	Study Design, Sample & Setting	Data Collection and Measurement	Results	Limitations	Implications for Practice
Examine the impact of a subsequent pregnancy on emotional adjustment associated with a previous perinatal loss. Focusing on the following parental grief components— active grief, difficulty and despair.	<p>Cross-sectional design comparing two groups.</p> <p>Sample: 25 women and 24 of their partners who had suffered a perinatal loss within the last 3 years and were pregnant (Pregnant Loss group) 25 women and 18 of their partners who were not pregnant after their loss (Loss group).</p>	<p>The groups completed the following questionnaires</p> <ol style="list-style-type: none"> 1. Beck Depression Inventory 2. State-Trait Anxiety Inventory 3. Abbreviated Dyadic Adjustment Scale 4. Perinatal Grief Scale. <p>This study measured depressive symptoms, anxiety, marital adjustment, active grief, despair, and difficulty coping</p> <p>All participants completed a personal information form assessing basic demographics and circumstances to loss.</p>	<p>Mothers who were not pregnant experienced significantly higher levels of despair and difficulty coping than the mothers who were pregnant.</p> <p>A new pregnancy may be associated with a beneficial effect on the mourning process of women with a previous perinatal loss; this is believed to be due to a decrease in their despair and coping.</p> <p>Grief intensity remained high in both groups, suggesting that a new pregnancy may not hinder the mourning process.</p>	<p>People who choose to participate in the study may be psychologically healthier than those who did not participate.</p> <p>Marriages may be healthier in the couples who chose to participate.</p> <p>Small sample size.</p> <p>Homogeneity of participants with respect to socioeconomic status and marital adjustment of participants limit generalizability.</p>	<p>Grief does continue despite a current pregnancy.</p> <p>Pregnancy after loss could have a positive impact on the psychological adjustment, helps reduce grief intensity.</p> <p>This information may help to alleviate the anxieties about their level of readiness for a subsequent pregnancy and their fear of not adequately mourning their lost pregnancy.</p>

Franché, R.L., & Mikail, S.F. (1999). The impact of perinatal loss on adjustment to subsequent pregnancy. *Social Science and Medicine*. 48(11). 1613-1623.

Purpose	Study Design, Sample & Setting	Data Collection and Measurement	Results	Limitations	Implications for Practice
To compare the emotional adjustment of pregnant couples with and without a history of perinatal loss.	<p>The design of this study was a cross-sectional design comparing two groups, one who has experienced loss and one who has not.</p> <p>Sample: 31 pregnant women with history of loss and 31 pregnant women with no history.</p> <p>Partners: 28 men in loss group. 23 men in comparison group.</p>	<p>They were assessed during their 10th and 24th weeks of gestation.</p> <ol style="list-style-type: none"> 1. Pregnancy Outcome Questionnaire (POQ). 2. Fetal Health Locus of Control Scale (FHLCS) 3. Beck Depression Inventory (BDI) 4. Abbreviated Dyadic Adjustment Scale (ADAS) 5. State-Trait Anxiety Inventory (STAI) 	<p>Couples with a history of loss reported significantly more depressive symptoms and pregnancy specific anxiety than couples in the comparison group. Women reported more depressive symptoms than men. Pregnancy specific anxiety for women who had experienced a previous pregnancy loss was associated with the belief that their own behavior affects the health of the fetus.</p> <p>The comparison group pregnancy specific anxiety was associated with the belief that health professional's behavior affects the health of their fetus. The findings also suggested that alterations in the mood of couples who have experienced pregnancy loss are apparent in the early stages of pregnancy.</p>	<p>Generalizability of the sample.</p> <p>Specificity of measures to pregnancy</p> <p>Design issues</p>	Attend to signs of anxiety early in the pregnancy as alterations in mood are apparent in the early stages of pregnancy for both women and men who have experienced a loss.

Franché, R.L. (2001). Psychologic and obstetric predictors of couples' grief during pregnancy after miscarriage or perinatal death. *Obstetrics & Gynecology*. 97(4). 597-602.

Purpose	Study Design, Sample & Setting	Data Collection and Measurement	Results	Limitations	Implications for Practice
The purpose of this study was to determine if psychologic constructs of self-criticism and marital adjustment were significant predictors of grief during a pregnancy after a miscarriage or perinatal death	This was a cross-sectional design Sample: 60 pregnant women with a previous loss and 50 of their partners.	Data Collection was done between the 10 th and 19 th week of gestation. The participants completed 1. Perinatal Grief Scale, 2. Depressive Experiences Questionnaire-Self Criticism subscale 3. Abbreviated Dyadic Adjustment Scale. 4. Personal information form	The results of this study found that high levels of self-criticism and later gestational age at time of loss are predictors of increased grief during a pregnancy after a perinatal loss. Increased time between conception and loss are also predictive of increased grief for women. Women may interpret loss as a personal failure, men may be more sensitive to the effects of the loss on their relationship.	Homogeneity of the sample, potential sampling bias and the potential "healthy participant" effect decreases generalizability of the results.	By assessing patients typical level of self-criticism the clinician can gain valuable information about a patient's future adjustment to a pregnancy after a loss. Referral to a mental health professional may be helpful if a patient is highly self-critical. Encourage optimizing psychological and marital functioning in patients who have experienced loss, rather than focusing on a time-frame of when to attempt another pregnancy.

Turton, P., Hughes, P., Evans, C. D. H., & Fainman, D. (2001). Incidence, correlates and predictors of post-traumatic stress disorder in the pregnancy after stillbirth. *British Journal of Psychiatry*. 178(6). 556–560.

Purpose	Study Design, Sample & Setting	Data Collection and Measurement	Results	Limitations	Implications for Practice
To assess incidence, correlates and predictors of PTSD during and after the pregnancy following stillbirth.	<p>Cohort study of a group of women whose previous pregnancy ended in a stillbirth</p> <p>Sample: 66 women.</p> <p>54 women remained in study at one year.</p>	<p>Depression, anxiety and symptoms of PTSD were assessed in the third trimester and at 1 year post-partum.</p> <p>Various instruments were used to collect the data:</p> <ol style="list-style-type: none"> 1. Demographic questionnaire, 2. Edinburgh Postnatal Depression Scale, 3. Beck Depression Inventory, 4. Spielberger State-Trait Inventory 5. PTSD-I interview 	<p>The results of this study showed that PTSD symptoms were prevalent in the pregnancy following a stillbirth.</p> <p>Case-level PTSD was associated with depression, state-anxiety and a conception that occurred closer to the loss.</p> <p>The symptoms of this PTSD generally resolved within one year post-partum or with the birth of a healthy baby.</p>	<p>Further longitudinal research is needed to monitor remission and recurrence of symptoms, particularly in subsequent pregnancies.</p> <p>A larger cohort would permit the evaluation of risk factors not reaching significance in this study.</p>	<p>Women are vulnerable to PTSD in the pregnancy subsequent to stillbirth, particularly when conception occurs soon after the loss.</p> <p>Having good emotional support is protective.</p> <p>Remit of PTSD symptoms is seen by one year Post partum or the birth of a baby.</p>

