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## Nurses' Reported Use of Therapeutic Interventions Surrounding a Stillbirth Event

Sonya Woo  
*Dominican University of California*

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Nurses' Reported Use of Therapeutic Interventions Surrounding a Stillbirth Event

Sonya Woo

Spring 2020

NURS 4998 Honors Directed Research

Dr. Kathleen Beebe PhD, RNC-OB

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Special thanks goes to my mother who inspired me to research this thesis topic. Being the only child of five pregnancies, I am thankful for her efforts and the result of becoming her daughter.

### **Abstract**

Psychological alterations and therapeutic interventions utilized for mothers who have suffered a stillbirth have been assessed and addressed in prior literature. This researcher reviewed ten articles highlighting the depression, grief, guilt, stress and concerns that can arise and interventions that were initiated within weeks immediately following stillbirth, during the time of a subsequent pregnancy, and a few years after having a subsequent child. An increased utilization of healthcare and health care provider presence have shown to positively influence the psychological effects of stillbirth. This researcher looked into the frequency and variety of which these interventions are being implemented in a quantitative descriptive research study. 14 registered nurse participants provided subjective data of the frequency and variety of intervention utilized on a five point Likert Scale. Out of 23 evidenced based practice interventions listed in the survey, 75% of the interventions were being utilized at a high frequency of frequently (4) to always (5). Each participant utilized around 20 interventions at a high frequency. This study shows that interventions are being implemented at a high frequency and variety. Further research can be done to obtain objective data on the frequency and variety of interventions on a larger sample size and additional research on the effectiveness of interventions that participants have suggested in this study.

*Keywords:* stillbirth, psychological effects, nursing interventions, frequency, variety

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## Nurses' Reported Use of Therapeutic Interventions Surrounding a Stillbirth Event

### **Introduction**

About 24,000 babies are stillborn each year in the United States (Centers for Disease Control and Prevention, 2019). Meaning at least 24,000 mothers, fathers, partners, and families are suffering bereavement and the psychological impacts of losing their child in utero. In the delivery room, most mothers and partners are congratulated for the successful delivery of a breathing baby after six to ten months of anticipation and dedication throughout the pregnancy. When the pregnancy does not end with the howl of a baby or the cry for celebration, the mother's year-long purpose is deemed a failure. Some mothers shoulder the unsuccessful birth with guilt, self-blame, and shame. Instead of experiencing excitement while anxiously awaiting for another baby to arrive, a recent study showed that during the third trimester of pregnancy, women who become pregnant after a stillbirth are more likely to experience anxiety and depression, as compared to women with a previous live birth or women expecting their first child (Massachusetts General Hospital Center for Women's Mental Health, 2018).

### **Problem Statement**

According to the Centers for Disease Control and Prevention (CDC) (2019), stillbirth is fetal death before or during delivery after 20 weeks of gestation. Stillbirth can be categorized as early, late, and term. An early stillbirth is loss between 20 and 27 weeks of gestation; a late stillbirth occurs between 28 and 36 weeks of gestation; and a term stillbirth takes place between 37 or more weeks of gestation (CDC, 2019).

Care is concentrated in providing medical surveillance of potential adverse outcomes in the subsequent pregnancy rather than addressing the emotional tolls that the woman experiences

from the stillbirth. Ironically, the psychosocial risks after stillbirth are more prevalent than the medical risks (Boyle et al., 2016). Mothers will develop attachment difficulties, guilt, anxiety, fears, and concerns but there is a lack of opportunities to grieve and work through these processes. Health care providers (HCPs) have to address the grief and other psychological impacts these women face with sensitivity and empathy by personalizing care with appropriate consideration. Care not only needs to focus on the methods, processes, and resources to help mothers cope with psychological impacts during the phase of pregnancy, but also interventions to help mothers and families heal in postpartum.

According to Curt Sandman, present professor emeritus at the University of Irvine-Department of Psychiatry and Human Behavior and researcher of how the mother's psychological state affects a developing fetus, states, "We believe that the human fetus is an active participant in its own development and is collecting information for life after birth. It's preparing for life based on messages the mom is providing" (Association for Psychological Science, 2011, pp. 1). So when looking at a fetus in a subsequent pregnancy, the message from these women would be their unaddressed risk for anxiety and depression compared to women with a previous live birth and nulliparous women (Gravenstein, 2017). With this literature review, I am trying to answer what psychological processes do mothers who have suffered a stillbirth experience and whether there are successful interventions that have shown to be beneficial for decreasing these psychological alterations.

### **Literature Review**

This researcher has reviewed ten articles on the topic of the psychological effects of stillbirth. These articles highlighted different psychological effects that can arise within weeks immediately following stillbirth, during the time of a subsequent pregnancy, and a few years

after having a subsequent child. Three of the ten articles are systematic reviews that looked at a total of 11,247 abstracts combined. The findings of all ten articles are interconnected to one another, giving a strong basis of how HCPs can provide care to address the variety of needs and psychological processes that mothers with a history of a loss will experience. An increased utilization of healthcare allows the HCP, the hospital, and the community to influence the psychological effects of stillbirth on top of the actual loss of the mother. Articles were obtained from Google Scholar, BMC Pregnancy and Childbirth, and Semantic Scholar ranging from 2014 to 2019.

### **Psychological Effects**

Campbell-Jackson, Benzance, and Horsch (2014) studied the experience of mothers by conducting in-depth interviews with seven couples who have a history of stillbirth during a subsequent pregnancy and up to two years after the birth of the subsequent baby. The psychological effects of stillbirth came to light as all mothers described experiencing high levels of anxiety during their subsequent pregnancy and after that child was born (Campbell-Jackson et al., 2014). For many of the mothers, the fear of threat of death continued throughout the subsequent pregnancy (Campbell-Jackson et al., 2014). As a result, mothers described limiting their bonding time with the unborn baby in order to protect themselves from repeated distress and this added guilt and self-blame further impacting mental health. Attachment difficulties, guilt, anxiety, fears, and concerns need to be discussed in order to connect with the subsequent child. However, both parents report a lack of opportunities to grieve or work through these psychological processes (Campbell-Jackson et al., 2014). This indicates that these seven couples were unaware of support groups and services available to them or that there are no accessible



resources for this specific population. Therefore this study suggests that HCPs need to start providing information and resources to parents in the hospital or right after experiencing a loss, in order for parents to start learning and become mentally prepared for the psychological alterations that a stillbirth may cause during a subsequent pregnancy and subsequent child rearing.

### **Increased Healthcare Utilization**

Burden et al. (2016) conducted a systematic review and meta-summary on 2619 abstracts and extracted 144 studies to evaluate closer in the final analysis. Articles were taken from Medline, PUBMED, Embase, Scopus, Amed, BNI, CINAHL and PsycINFO, Royal College of Obstetricians & Gynecologists (RCOG) and International Stillbirth Alliance (ISA) from January 2000 to February 2015 (Burden et al., 2016). The goal was to summarize current evidence of the psychosocial impact of stillbirth has on parents and family. Findings show that stillbirth is associated with emotional, depressive, and other negative psychological symptoms causing mothers to avoid activities and carry these psychological processes into subsequent children care (Burden et al., 2016). Activities include changes in religious practices, sexual activities, work, and social media (Burden et al., 2016). Mothers alter their activity as a way to cope or a means to give themselves time away from others to grieve (Burden et al., 2016). During subsequent pregnancies, the mother's sense of identity, self-esteem, and sense of control is altered: they do not feel "whole" (Burden et al., 2016). However, Burden et al.'s (2016) research shed light on the psychological growth mothers can achieve. Some mothers found themselves to be more compassionate, caring, thoughtful, and fostered parental pride after a previous stillborn (Burden et al., 2016). These mothers were also motivated to engage in health promoting activities. This

article shows that although there are many negative psychological consequences that result from stillbirth, positive outcomes can also present. HCPs can take this opportunity to nudge mothers with altered psychological statuses toward health promoting activities such as antenatal care, counseling, and support groups in order to tackle the negative psychological effects.

### **Influence of Care**

Nuzum, Meaney, and O'Donoghue's (2018) qualitative study examined the impact of stillbirth and the quality of professional care can have on bereaved parents. The researchers interviewed parents of 12 babies and later recorded and transcribed the responses. Four themes emerged from the study that affected the parents' experience and later the parents' psychological processes: the maintenance of hope that the doctors were wrong about the diagnosis of stillbirth, the understanding that this baby was a unique person, the need to protect themselves and/or their baby, and the relationships the parents make with each other, the baby, and the staff. For instance a couple expressed great distress when speaking about signing a post-mortem consent form and yet not knowing the details of what they were consenting to because the hospital staff did not explain it. A month after the stillbirth, the unprepared couple went to the hospital to pick up their baby's organs and bury them at home in the middle of the night; causing the parents to relive the whole traumatic experience of the stillbirth again. All the participants emphasized the lasting impressions they received from the staff, especially about their communication and care. This shows the importance of open, clear, and honest communication of directions, consent forms, and the proceedings following a stillbirth. The legal commitments the parents have to take after birth is not what parents would have been expecting after delivering their child. Having a multidisciplinary team present at the hospital immediately after the stillbirth will provide a

logistically less stressful environment for the parents to grieve during this pivotally emotional time. Even though devastating news may not change, HCPs can offer therapeutic communication and sensitive care to help parents adjust to the reality of the situation.

Boyle et al.'s (2016) studied the perception of 2716 parents from 40 countries on the care they received during their first pregnancy after stillbirth. Boyle et al.'s (2016) research showed that 67% of the participants received antenatal care visits and ultrasound scans however only 27% were given contact information for care providers and 10% received bereavement counselling. This study highlights that care is concentrated in providing medical surveillance of potential adverse outcomes in the subsequent pregnancy rather than addressing the emotional tolls the woman experiences from the stillbirth. Ironically, the psychosocial risks after stillbirth are more prevalent than the medical risks (Boyle et al., 2016).

Parents were also found more likely to receive extra care services if the baby was stillborn later (>30 weeks of gestation) in the pregnancy compared to earlier (<29 weeks of gestation) (Boyle et al., 2016). Previous studies have shown that women who conceive within 1 year of a stillbirth will have higher risk of depression and anxiety in the subsequent pregnancy than those who delay conception, while those who conceive after a year from the stillbirth may develop fear and feelings of failure (Boyle et al., 2016). There should be the same amount of resources available and care provided regardless of the length of pregnancy since all mothers would suffer some form of psychological burden regardless of its intensity. The care and resources provided also need to be communicated to the parents effectively.

According to Boyle et al.'s (2016) research, out of the 55% of participants who received a post-mortem examination of their baby, 90% of these parents recalled having received some

kind of information on the examination but did not specify what information was given. This evidence indicates that parents remember the information and experiences they encounter, therefore parents would also retain and benefit from improvements in patient teaching and antenatal support programs to address psychosocial needs.

### **Influence of the Community**

Postgraduate student, Human (2014) looked at room for improvement in the guidelines for social workers using crisis intervention. Human (2014) explored the experiences of 25 mothers during 6-18 months after stillbirth after receiving crisis intervention within a week of the loss. Crisis intervention consisted of practical support of making contact with employers and family, emotional support to help the mother express her feelings and concerns of the stillbirth, and social support to encourage family and friends to check up on the mother. The psychological effects Human (2014) observed were that 84% of the participants were afraid to conceive again, 48% of the participants were afraid to conceive even 6 months after stillbirth, 24% of the participants had the fear of losing another baby or of not being able to have a baby again, and one mother (4%) who suffered a subsequent loss after stillbirth and is now avoiding pregnancy. However, 64% of the respondents found the crisis intervention to be emotionally beneficial, 8% wished there was more support, and 28% liked the idea of crisis intervention is good but felt the timing of when they received this care was overwhelming (Human 2014). This study shows that crisis intervention is understood to be beneficial and it is observed to be beneficial in the majority of the participants, however the timing of when to offer these services can be individualized and adjusted to meet the mother's needs.

Human's (2014) study observed that mothers often neglected to address their surviving children's emotional needs as they were focusing on their own fears, anger, denial, and guilt. Feelings of worthlessness was also fueled by the community's lack of support for the mother during this period of time; 72% of mothers said to have been teased and avoided (Human 2014). Society is not allowing these mothers to grieve or mourn their loss, unlike the loss of a child who is publicly acknowledged. Not only do mothers need to be educated on the psychological alterations a stillbirth may cause, the community also needs to start applying practices of crisis intervention and supporting the mother. With the community available to contribute to the mother's healing process, more resources and support are presented to the mother for her to take advantage of whenever she feels ready to. So for those who are not ready for crisis intervention immediately after stillbirth have a safe environment to grieve.

Meredith, Wilson, Branjerdporn, Strong, and Desha (2017) performed a qualitative interview-based research study that focused on finding evidence supporting the importance of perinatal services for mothers who experienced perinatal loss. The researchers looked at 10 mothers who had a stillborn child and later attended Mater Mothers' Pregnancy after Loss Clinic (PALC) during their subsequent pregnancy. PALC is a multidisciplinary team consisting of midwives, counsellors, sonographers, registrar, and consultant obstetrician that provides the mother with emotional and medical care that is collaborative and considerate of a mother's individualized needs (Meredith et al., 2017). The study found PALC to be very effective as the participants found comfort in developing rapport with consistent care providers and appreciated the flexibility and accessibility of the appointments and services. One mother described the strong emotional relationship she had developed with the PALC midwives, "...feeling that

you're there, kind of, talking to a friend, someone who really does genuinely care about you and about your pregnancy and about the baby that you've lost" (Meredith et al., 2017). Although these mothers are appreciative of the services they have been provided, the participants reported the lack of support from their communities and families, causing them to feel isolated (Meredith et al., 2017). The mothers interviewed also indicated a desire to support other mothers in the same situation as them, so perhaps this is a way for mothers to support other mothers in the community outside of PALC. Mothers would also take guidance from those who understand or had overcome the same hardships rather than a healthcare professional who is unaware of the mother's situation. So not only do health care providers need to become more understanding and empathetic toward the mothers' situation, but also create opportunities for mothers to express their experiences with other mothers within the community.

### **Impact of Healthcare Providers**

Ellis et al. (2016) performed a systematic review of 52 studies, out of 4488 articles obtained, researching HCPs' and parents' experience of care after stillbirth in Europe, North America, Australia, and South Africa. The aim was to analyze the experiences of both medical professionals' and parents' perceptions during a stillbirth in order to improve care and appropriately train staff. Parents want to be involved in the decision making process and are given the options and time to consider them (Ellis et al., 2016). HCP should provide support and give information on how the birth of a stillborn baby will proceed as well as offer the parents time and consideration for them to hold and make memories with the baby (Ellis et al., 2016). Immediately after the birth and upon discharge home, emotional support from the healthcare system are greatly appreciated by parents (Ellis et al., 2016). Debriefs and follow-up

appointments help parents to resolve uncertainty for subsequent pregnancies (Ellis et al., 2016). This shows how the level of empathy HCPs give when addressing the needs of the parents throughout the stillbirth and till the subsequent pregnancy affect the parents' decision making, sense of control over the situation, and ability to cope with the loss. Parents remember the circumstances surrounding their stillbirth. Therefore, parents notice when HCPs hide behind medical guidelines and processes during the delivery of a stillbirth in order to cope with their own anxieties and system-based barriers (Ellis et al., 2016). HCPs would need to address their own emotional barriers before helping to address the parents.

### **Evidence Based Practice**

Campillo, Meaney, McNamara, and O'Donoghue (2017) authored a systematic review to study the effect of non-medical stress reduction interventions on pregnant women with a history of miscarriage (rather than stillbirth). Interventions included counselling and support for stress, anxiety, and depression. This was an empty systematic review in that no results were concluded from 4140 articles screened because the articles did not fit the criteria of being a randomized controlled trial (RCT), having used non-medical stress reduction interventions instead of medical interventions, the participants being pregnant during the time of research, or participants having miscarriages that were no later than 24 weeks of gestation (Campillo et al., 2017). RCTs are key to understanding if one treatment is comparable to another in its effect on a better outcome. This data showed that there needs to be more attention and research created for this vulnerable population in the form of RCTs. What has been concluded from this systematic review is miscarriages increase a woman's level of stress after a single experience and can be considered to be an aggravating factor for stress in a subsequent pregnancy (Campillo et al., 2017).

Although more research needs to be done to propose that the levels of stress due to miscarriage is similar to the level of stress experienced by having a stillborn child, the need for psychological interventions to improve pregnant women's psychological well-being is apparent for both populations. This systematic review brings greater awareness to health care professionals of the necessity of finding and creating effective non pharmacological interventions that can be offered to women for stress relief during subsequent pregnancies with a history of loss.

Gravensteen (2017) researched a retrospective and prospective study of 106 women who have had previous stillbirths, 262 women with live births, 174 women pregnant after a stillbirth, 362 women pregnant after live birth, and 365 nulliparous women. This researcher's objective was to gauge the anxiety and depression during and after subsequent pregnancy. Results from these two studies indicated that in the subsequent pregnancy, women who suffered a stillbirth had a higher risk of anxiety (22.5%) and depression (19.7%) compared to women with a previous live birth (4.4% and 10.3% respectively) and women who were nulliparous (5.5% and 9.9% respectively) (Gravensteen, 2017). Adding on, women with a history of stillbirth had a substantially higher risk of developing long-term post-traumatic stress symptoms (PTSS) (Gravensteen, 2017). However, Gravensteen (2017) observed that mothers who have held their stillborn baby appeared to be protected from PTSS. Therefore, these results support the notion of holding and interacting with the stillborn child in order to decrease the psychological effects brought upon by stillbirth. Nurses can immediately utilize this evidence based practice at the bedside after the mother has been given the news of a stillborn or has had an unexpected stillbirth. This is also a good opportunity to apprise the partner and family about the



psychological processes that the mother is at risk of going through immediately after stillbirth and in the subsequent pregnancy.

Meaney, Everard, Gallagher, and O'Donoghue (2016) authored a qualitative study using semi-structured interviews with 15 parents (ten mothers and five fathers) to gain insight of accommodations to consider when caring for parents in the weeks following a stillbirth. Meaney et al. (2016) looked at earlier research that recommended clinicians to encourage parents to conceive immediately following a stillbirth, while some recent studies suggest parents to take time to recover emotionally before becoming pregnant again. However, this study supports the idea that when conceiving is the mother's personal choice and HCPs should be more focused on addressing relevant concerns mothers are having following a stillbirth. The most relevant concerns that Meaney et al.'s (2016) research found was the fear of potential loss of another baby and feelings of isolation throughout the grieving process. Unhelpful societal responses like being told, "You are young and will have plenty of opportunities to have more children" contributed to the anxiety that both parents have built up over the loss of their baby. Although both parents were expressing fear, the mothers were focused on planning for a future pregnancy, while the fathers were reluctant to have another child again. Emphasizing the need for honest, empathetic, and consistent communication within the hospital to support the mother and father in their subsequent pregnancy is crucial for decreasing her anxiety caused by the previous stillbirth and negative societal factors. This study shows that providing additional antenatal visits and consults with a multidimensional approach will help address and ease each parent's specific anxieties, concerns, and fears.

**Conclusion**

This review shows that mothers who have suffered a stillbirth will experience anxiety, depression, guilt, fear, concerns, and stress. Fortunately, mothers also report to be more satisfied with care and have less psychological alterations when interventions are implemented in a timely manner. The process of stillbirth is a memorable experience for the mother and partner. Not only do mothers remember the emotional impact of the loss, but the care provided to them from the point of being diagnosed with a stillbirth and thereon. Mothers who received resources from the hospital appreciated the clear and informative directions in how to proceed with burial arrangements and subsequent pregnancy planning. Participants also expressed the comfort and self-control they had over the situation when their concerns and psychological alterations were addressed. Mothers value the support of HCPs and services even more when they provide empathetic and considerate care. Several supportive interventions have produced positive results. However, there is a lack of research on the frequency with which specific therapeutic measures are taken to address mothers' concerns and emotional responses to stillbirth. And since there is a substantial research-practice gap where research results may take more than a decade to be implemented in clinical practice (Kristensen, Nymann, & Konradsen, 2016), it is vital for healthcare organizations to provide up to date interventions to optimize patient wellbeing. Therefore, my research question is are evidenced based nursing interventions for mothers who have suffered a stillbirth currently being implemented in everyday practice at a high frequency and variety?

## **Research Study**

### **Introduction**

Being at the bedside, nurses may have the closest and most frequent interactions with patients, so they are ideally positioned to assess emotional and physical needs that arise in the intra- and post-stillbirth period. Asking nurses who have been exposed to cases of stillbirth events about their patient-care practices will gauge how often interventions are implemented to result in beneficial outcomes that have been shown in recent literature. My research approach is to quantify the number of interventions that nurses are frequently implementing and its variety. This is also an opportunity to see what other interventions nurses are performing that I did not mention in the study.

### **Theoretical Framework**

Ida Jean Orlando's Nursing Process Theory focuses on nurse actions that address a patient's needs based on his or her behavior through patient-nurse interactions. If the needs are not met, the patient becomes distressed and needs nursing care (Haapoja, 2014). If the patient can not express her own needs and/or the nurse did not interpret the patient's behavior correctly this can cause distress also (Haapoja, 2014). This shows the importance of proper assessment. The nurse has to properly identify, without assumptions, the needs to carry out interventions beneficial to the patient. After actions have been performed, the nurse observes the patient's behavior again and evaluates the outcomes. If the patient is still distressed, the process starts again. This framework allows nurses to understand patients from a nursing perspective.

### **Methods**

This is a descriptive study that attempts to collect quantifiable information to be used for statistical analysis of the population sample. The target population and inclusion criteria for data collection is nurses who have interacted with mothers who have recently suffered a stillbirth during the time of care. The researcher solicited participation from registered nurses (RN), nurse practitioners (NP), and certified nurse- midwives (CNM), who work in intrapartum and postpartum units via snowball sampling from connections with experienced maternity nurses, specifically accessed by my research advisor, Dr. Kathleen Beebe. Subjects were selected through non-probability convenience sampling.

**Ethical Considerations.** The researcher recruited using an online survey created on Qualtrics and sent out through email. The survey link embedded in the email permitted potential participants to make a private and independent choice about participation. After reading the letter of introduction content on the first page of the survey, participants consented to filling out the survey by clicking to the next page. No identifying information was elicited, only the data gathered. Only Dr. Kathleen Beebe and the research has seen the data. No reimbursement or compensation of any value is provided to the participants for their participation in this research. The costs to participants include the time needed to fill out the survey and the effort of recalling a difficult experience. There is risk for some emotional distress relating to past patient care experiences involving stillbirth and parental grief. This is a voluntary survey that participants can withdraw from at any time or choose not to answer certain items.

**Operational Definitions.** “Psychological effects of stillbirth” is dealing with the function of awareness, feeling, or motivation surrounding a stillbirth. “Stillbirth” is the delivery of a baby who has died after the 20th week of pregnancy. “Frequency” is the number of occurrences of a

repeating event per unit of time. “Variety” is the state of diversity. “Assessment” is the evaluation of the nature, quality, or ability of someone or something.

**Instrument.** The survey designed for data collection included questions regarding demographics, a five point Likert scale to rate 24 given nursing interventions, and a free response for the participant to mention any additional nursing interventions. The demographic questions included provider type, practice setting, length (years) of practice, and the number of mothers who have suffered a stillbirth the participant has carried for. On the Likert scale, participants rated from 1 (never) to 5 (always) for each evidenced based nursing intervention that the research has found. There were 23 current up to date interventions that have shown to be beneficial to the mother while there was 1 intervention that was an older practice. See Appendix A for the survey template. The survey was created and distributed with the software Qualtrics that could be completed on a mobile device or on a computer. The survey was approved by the Institutional Review Board (IRB), approval number 10886, at Dominican University of California.

**Validity and Reliability.** The instrument was designed by the researcher to provide appropriate data to answer the research question. This study was approved by the IRB, Dr. Andrea Boyle (Department Chair of Nursing at Dominican University of California), Dr. Kathleen Beebe, Dr. Patricia Harris, and Dr. Luanne Linnard-Palmer.

**Procedure.** First, this study was approved by the IRB at Dominican University of California. Participants were then solicited through email through connections accessed by Dr. Kathleen Beebe. An email was sent to them with a letter of introduction to the survey and the link to the survey. Maternity nursing faculty at Dominican University of California were also

specifically contacted and was asked to pass on the survey to those who would like to participate. The researcher used Qualtrics Data and Analysis function and Microsoft Excel to compare and compile data into graphs and charts and to interpret this data. Data was kept for a maximum of three months until being permanently deleted. The researcher discussed the results and made conclusions from the literature review and data analyzed. Research and conclusions were presented virtually to fellow nursing peers and advisors through a Zoom call in May 2020.

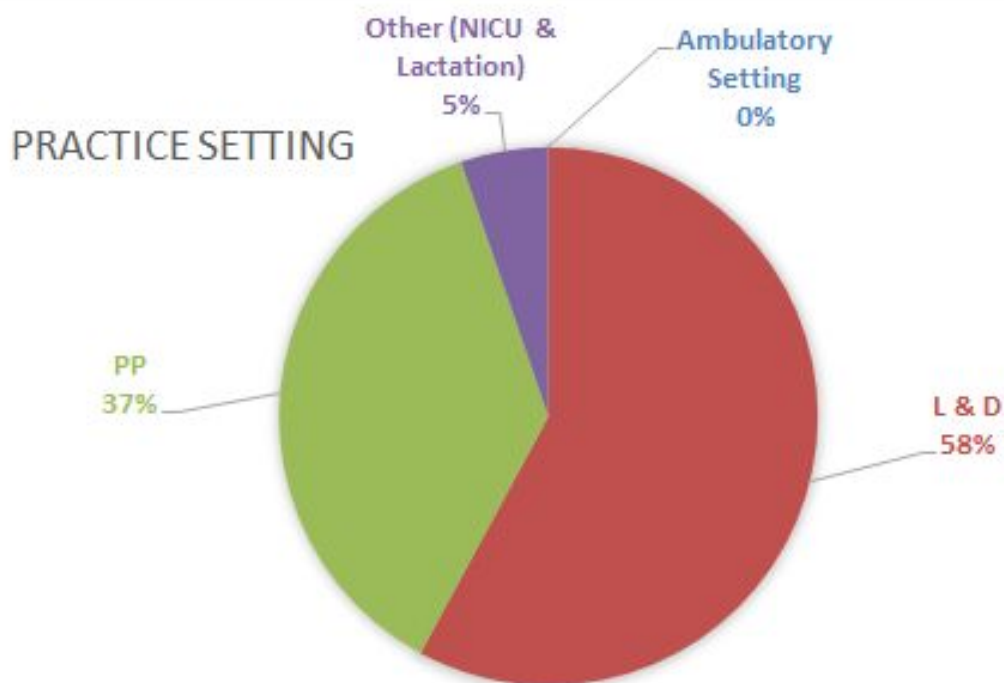
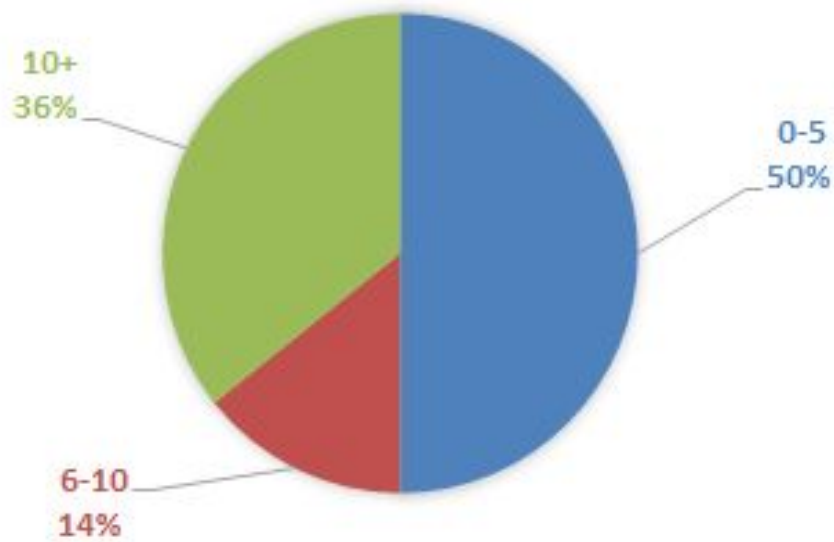
### **Analysis**

I established the association between the variables: length of practice, number of mothers that the participant has cared for, practice setting, and a list of interventions that I had the participants answer on a Likert scale from never to always. I used Bivariate analysis to compare mean differences and Cross Tabulation to quantitatively analyze the relationship between the multiple variables. The purpose of this study is to explore the type and frequency of interventions used by nurses when working with patients experiencing stillbirth. I hypothesized that during the intrapartum and postpartum periods, nurses implement a large variety of up-to-date interventions at a high frequency for mothers who have suffered stillbirth.

### **Results**

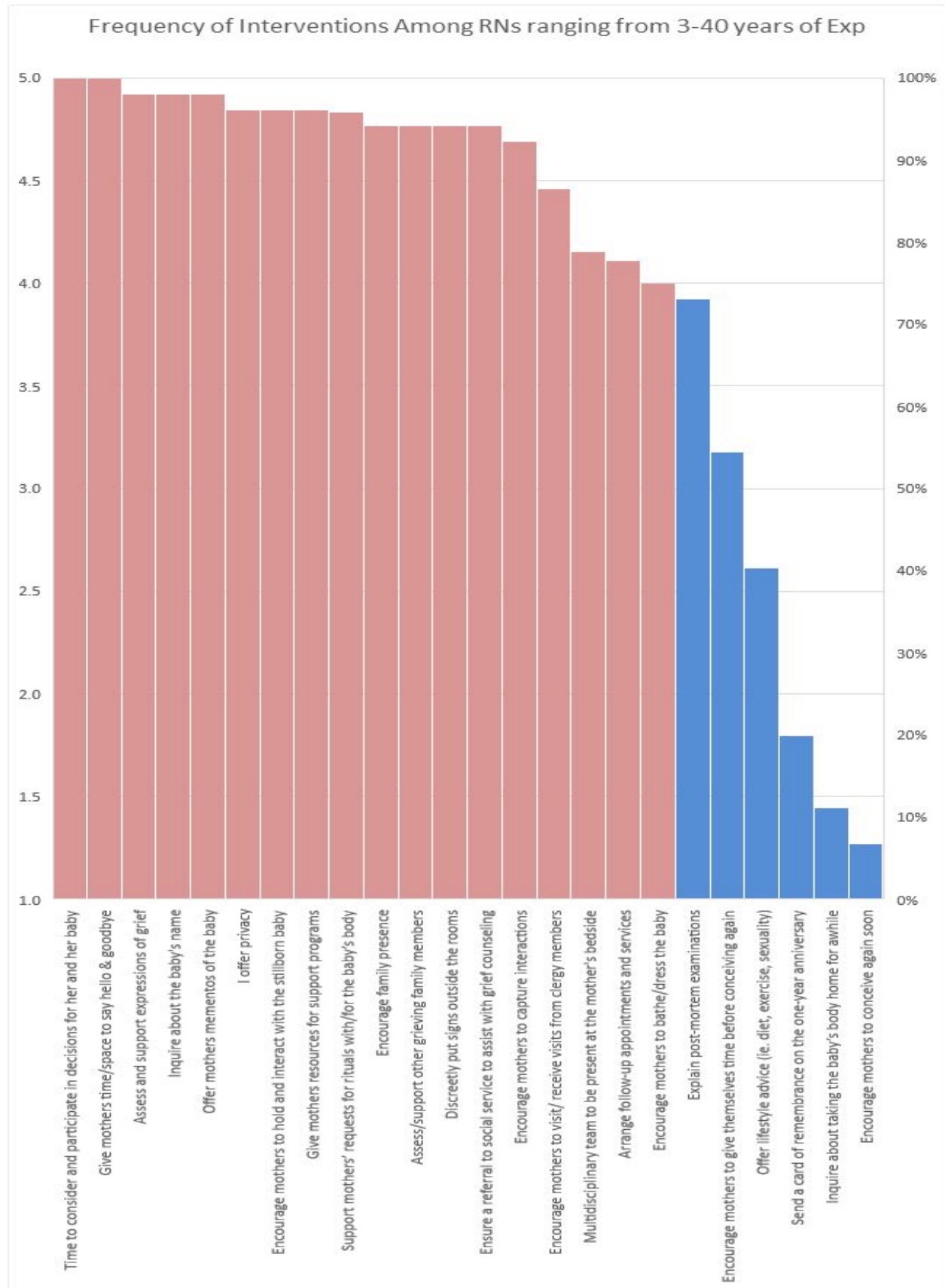
There were 14 respondents, all of which were registered nurses RNs from the Labor and Delivery (L & D), Postpartum (PP), or Neonatal Intensive Care Unit (NICU) & Lactation setting. The participants ranged from less than 1 year to 40 years of experience. The following pie charts show the percentage of the RNs who took care of 0-5, 6-10, and 10+ mothers with stillbirths, and the percentage of the RNs practicing in which settings. Demographics are in disregard of age, race, ethnicity, or gender.

### # OF MOTHERS WHO HAVE SUFFERED A STILLBIRTH THE PARTICIPANT HAD CARED FOR

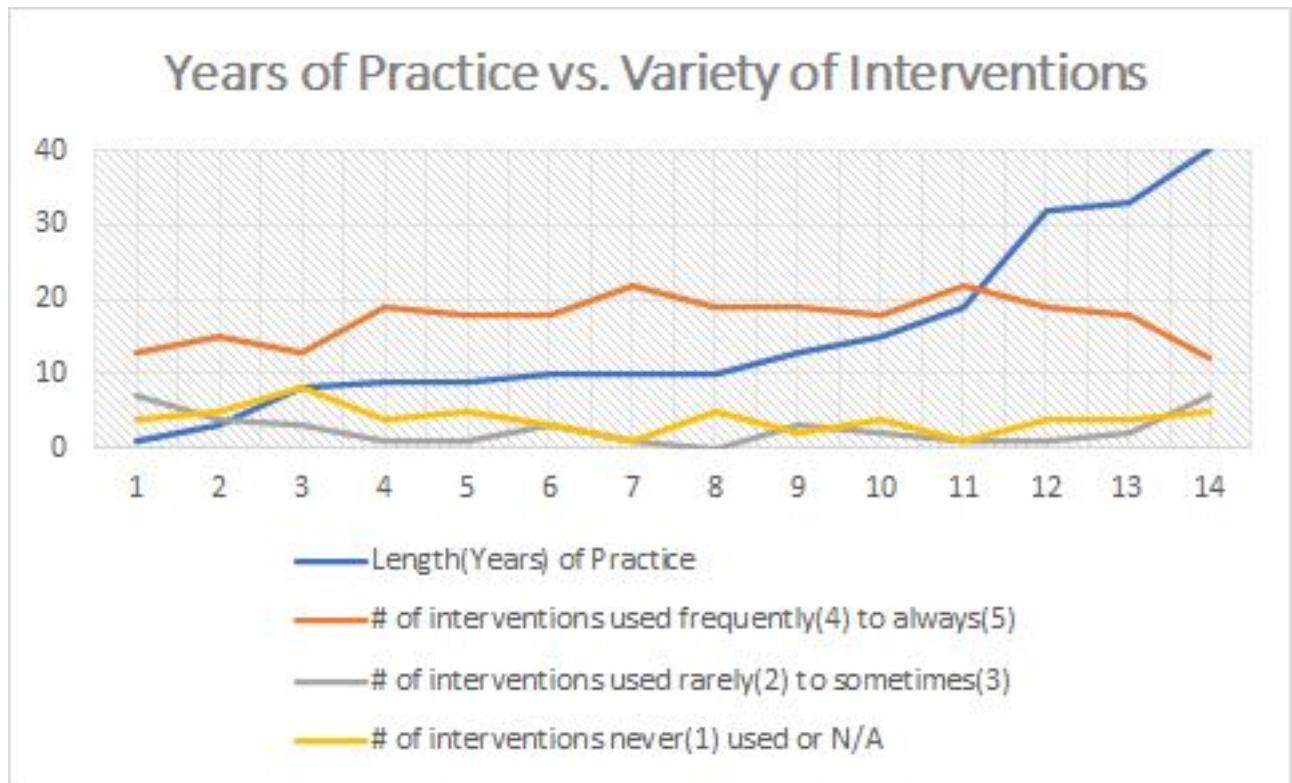


**Graph A.** The average frequencies of each intervention were compared in disregard of the RN's specific practice setting, length of years in practice, and number of mothers cared for. Out of the 24 evidenced based practice interventions, 18 are being used at a high frequency of frequent (4) to always (5) implemented. The top two interventions that have an average of always (5) implemented were: "I allow mothers time to consider and participate in decisions for her and her baby" and "I give mothers time and space to say hello and goodbye." There were five therapeutic interventions that averaged to be sometimes (3), rarely (2), to never (1) used: "Explain post-mortem examinations, Inquire about taking the baby's body home for awhile, Encourage mothers to give themselves time before conceiving again, Offer lifestyle advice (ie. diet, exercise, sexuality), and Send a card of remembrance on the one-year anniversary." The least used intervention was "Encourage mothers to conceive again soon" that was rarely (2) to never (1) used is an old practice that is not supported anymore. This data was compiled and shown in the following bar chart. In pink are the interventions frequently (4) to always (5) used and in the blue are the interventions sometimes (3), rarely (2), to never (1) used.





**Graph B.** When looking at the variety of interventions utilized, the research looked at the relationship between years of practice versus the interventions each participant utilized.



For this line graph, the 14 participants in this study were shown on the x axis. The blue line represents the number of years each RN has been in practice, increasing from the left to right. The orange line represents is the number of interventions that have been frequently (4) and always (5) used by each participant.

**Table A.** The table below shows the participants' years in practice and how many mothers they have cared for during that time. The five participants who have cared for 10+ mothers are also the ones with the most years in practice in this study.

Years in Practice	Number of Mothers Cared For
1	0-5
3	0-5
8	6-10
9	0-5
9	0-5
10	6-10
10	0-5
10	0-5
13	0-5
15	10+
19	10+
32	10+
33	10+
40	10+

**Table B.** The following table lists additional therapeutic interventions that participants wrote in the free response section of the survey.

Other Therapeutic Interventions
<ul style="list-style-type: none"> <li>♦ “I utilized therapeutic communication , lots support,emphasized with mother and family”</li> <li>♦ “Assist in selecting funeral home, contact funeral homes about free services for stillborns,.”</li> <li>♦ “I am a specialist in Perinatal Loss, so I offer a lot of options. I also encourage them to reach out to safe internet sites such as Compassionate Friends and The Ruthie Lou Foundation.”</li> <li>♦ “Tons of emotional support.”</li> <li>♦ “We are trying to get an annual day of remembrance at our hospital to invite all our families that have experienced fetal losses,”</li> <li>♦ “To do skin to skin with baby. To have siblings come and say goodbye to baby if mother ask for this ...allow mom and dad to hold baby as long as she desires ...”</li> <li>♦ “Baptizing the baby, praying with the family. arranging a hospital bed outside the maternity unit for postpartum stay”</li> <li>♦ “Some mothers find solace in expressing breastmilk in remembrance of their baby. Some call this “legacy milk”. I offer resources, encouragement and support”</li> <li>♦ “At my hospital we do a memory box. So we take pictures of the baby on a dslr camera and have every nurse sign a grievance card. There’s always a social consult ordered for mom and we offer pastoral services, if requested. I don’t cry when mom delivers a fetal demise, I try to keep my emotions in check for the patient.”</li> <li>♦ “Silent listening. Just being there in the room with the family. Offering my presence (when appropriate) and be there. Also therapeutic touch. Each patient (and family) is different when it comes to how they cope either their loss. It’s imperative for the nurse and medical staff to assess how the patient and her family want to be cared for during their time in the hospital.”</li> <li>♦ I hug my patient and encouraged her to cry and offered to be there for her as much as she needed me. I also offered a massage with lavender lotion that I personally used.”</li> </ul>

## Discussion of Results

Graph A shows that the majority (75%) of the interventions the research listed were utilized at a high frequency. One older intervention was included to see if these participants are implementing an old intervention while implementing up to date interventions and these results indicate that they have stopped utilizing the out of date intervention of “Encourage mothers to conceive again soon.”

When looking at the Graph B, the higher the orange line is located on the graph, the greater the variety of interventions performed. The orange line is shown at the 20 mark indicating that around 20 out of the 23 current therapeutic interventions possible are being utilized by each participant. This indicated a high variety of interventions used by each nurse. Since it is the orange line and not the gray or blue line, this high variety of interventions are being implemented at a high frequency. From this the research could also see if the variety and frequency of interventions increase with the increased length of practice and mothers cared for. As the number of years in practice (blue line) of each participant increased, the number of interventions (orange line) each participant frequently utilized remained constant in variety and frequency. Therefore length of practice and number of mothers cared for do not correlate with the variety of interventions utilized.

RNs with varying years of experience in different practice settings are taking considerate care in providing mothers with evidenced based practices to address their psychological alterations. Interventions that have shown to be beneficial in the past 5 years are being implemented now at a high frequency and variety by RNs. Looking at the interventions that

participants answered never and N/A to could indicate a number of reasons that further research should look into.

1. Did not have the opportunity to perform this intervention
2. personal aversion
3. against hospital policy
4. against personal beliefs
5. not applicable for the mother's behavior

However, this does not mean the interventions are not known and practiced but further research needs to be done to understand why some interventions were not used.

**Limitations.** This research included a small sample size which can affect the average rating for the frequency each intervention is utilized so the population may not be accurately represented. This research does not indicate which countries or year these interventions were implemented. Age and ethnicity of the participant or the mothers cared for were specified so this research does not address any cultural implications that may affect the frequency and variety of the listed interventions utilized. Finally, RNs were rating their own frequency of use creating largely subjective data with the lack of objective data that would better represent the general population.

**Strengths.** Orlando reminds us that although how accurate or inaccurate the nurse's perceptions might be, once expressed to the patient, it opens a situation for communication where it is easier for the patient to express her own view (Orlando, 1990, 45). Participants have an opportunity to reflect on a difficult situation that was experienced and may be experienced again in their career. The participants are able to reevaluate what worked in the care. By drawing

attention to this specific event on the Intrapartum and Postpartum floor, participants may feel inspired to reassess the resources provided at the hospital and instill curiosity to keep up to date on the latest therapeutic techniques and resources. These results may be useful in pinpointing areas for further research on the effectiveness of the interventions participants suggested in this study.

### **Conclusion**

The literature review highlights the psychological needs that mothers experience and interventions to address them. This study shows that interventions are being implemented at a high frequency and variety. Interventions that address the mother's psychological alterations (anxiety, depression, guilt, fear, concerns, stress) are being implemented. This could also indicate that nurses are assessing their patient's behaviors at a high frequency and implementing interventions to address the patient's needs according to the nursing process. When participants filled out N/A or never, this could further support the fact that nurses are individualizing their care before implementing excessive and unnecessary interventions. Careful assessment of what the patient needs in her difficult situation surrounding a stillbirth is vital to implementing a variety of therapeutic interventions which will improve patient care and result in a positive impact on her mental health.

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**Appendix A- Research Instrument**

Nurses' Reported Use of Therapeutic Interventions  
Surrounding a Stillbirth Event Research Survey

1. Provider Type (please list your usual clinical practice role)

- ☐ Nurse Practitioner (NP)
- ☐ Registered Nurse (RN)
- ☐ Certified Nurse Midwife (CNM)

2. Practice setting (select all that apply)

- ☐ Birthing Unit (Labor and Delivery)
- ☐ Postpartum (Mother-Baby Unit)
- ☐ Ambulatory Setting (Clinic, Office, Home)
- ☐ Other (please specify) \_\_\_\_\_

3. Length (Years) in professional practice

\_\_\_\_\_

4. I have cared for \_\_\_\_\_ mother(s) who had experienced a stillbirth.

☐ 0-5

☐ 6-10

☐ 10+

5. On a scale of 1 (never) to 5 (always), indicate how often you have used each intervention with a patient who experienced a stillbirth.

	Never	Rarely	Sometimes	Frequently	Always	N/A
I allow mothers time to consider and participate in decisions for her and her baby						
I advocate for a multidisciplinary team to be present at the mother's bedside immediately after the stillbirth						
I offer privacy						
I assess and support expressions of grief						
I encourage family presence						
I encourage mothers to hold and interact with the stillborn baby						
I give mothers time and space to say hello and goodbye						
I assess and support other grieving family members						
I inquire about the baby's name						
I discreetly put signs outside the rooms of mothers who suffered a stillbirth for other nurses to identify						
I encourage mothers to capture interactions in						

photographs and videos						
I encourage mothers to bathe and dress the baby						
I give mothers resources for support programs addressing psycho-social needs after stillbirth						
I prepare and offer mothers mementos of the baby (hand and footprints, blanket, hat, baby bracelets, booties, etc.)						
I explain post-mortem examinations						
I inquire if mothers would like to take the baby's body home for awhile						
I encourage mothers to give themselves time to grieve before conceiving again						
I encourage mothers to conceive again soon						
I arrange follow-up appointments and services						
I encourage mothers to visit or receive visits from clergy members if deemed appropriate						
I support mothers' requests for rituals with/for the baby's body						
I offer lifestyle advice (ie. diet, exercise, sexuality)						
I ensure a referral to social service to consult with the patient or assist with grief counseling before discharge						
I send a card of remembrance on the one-year anniversary of the baby's birth/death						

6. What are other therapeutic interventions have you utilized or are thinking of utilizing with mothers that have experienced a stillbirth event?

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