

# Strategy for Mental Health Improvement of Iranian Stillborn Mothers From Their Perspective: A Qualitative Study

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Received 2014 June 29; Revised 2014 September 8; Accepted 2014 September 29.

## Abstract

**Background:** Mothers got stressed when they are informed about the occurrence of stillbirth. Many researchers believe that the failure to provide the required care by health teams during this hard time is the main determinant of maternal mental health in the future. In other words, psychosocial support by medical care providers can significantly improve mental outcomes of mother after stillbirth.

**Objectives:** This study aimed to explore stillborn mothers' suggested strategies to provide maternal mental health in the experience of stillbirth.

**Patients and Methods:** Twenty women who had experienced stillbirths participated in this qualitative content analysis study. They were selected through purposeful sampling method. Data were gathered by individual interviews recorded on audiotapes, transcribed and then analyzed. Then, transcriptions were coded and classified. Finally, 3 main categories and 9 subcategories were emerged.

**Results:** Analysis of participants' viewpoints and their opinions about strategies to provide maternal mental health in the experience of stillbirth lead to development of 3 main categories: "before delivery strategies" with 3 subcategories, "during labor strategies" with 3 subcategories, and "postpartum strategies" with 3 subcategories. Analyses of findings showed that, health care providers can mitigate some of the long-term negative mental outcomes of stillborn mothers by spending extra time with grieving mothers, facilitating bonding, and validating their emotional expressions.

**Conclusions:** According to the results, revision and modification of the care plan in the experience of stillbirth seems necessary to improve mental health in these mothers. According to suggested strategies, midwives and health care providers are health professionals who can effectively and properly care for stillborn mothers.

**Keywords:** Mental Health, Stillbirth, Strategy, Qualitative Content Analysis

## 1. Background

Parents form emotional bond with their fetus, even during the first stages of pregnancy period (1). Stillbirth is a grave tragedy that disrupts the emotional attachment formed between the fetus and the parents (2). Stillbirth is an unexpected phenomenon and imposes significant changes on parents' life. Regardless of its cause, stillbirth can have long-term destructive impacts on parents (3).

Prenatal death is of specific characteristics that differentiates it from other types of death. These characteristics include closeness to the date of birth, youngness of parents when experiencing the loss, unexpectedness of the death, and a death which is the first one experienced by the parents in their joint life (4).

When parents mourn for their lost child, the depth of their sorrow overwhelms them and defines a new identity for them formed on their sorrow resulting from still-

birth (5). Stillbirth is not easier than the death of a live child for these parents. Such families usually experience extreme sorrow, as well as psychological and social problems (6).

Stillbirth can trigger stress and contention between the couple that may ultimately affect negatively their relationship (7). It can even deteriorate their marital and sexual relationship leading to tensions in their life, sexual desires, communication as well as dispute between the couples (8).

Mother's distress can even affect her other kids and create a stressful environment for them (9). De Frain et al. (10) studied the psychological effects of stillbirth on the siblings. The adult siblings remembered the stillbirth that their mother had experienced 26 years ago. The son said he remembered how his parents felt those days and

they could not laugh or play (10).

Studies of the recent decades show that ignoring the stillbirth event can lead to parents' failure in passing through the psychological stages of mourning, and ultimately result in an increase in parents' anxiety and depression (11). Thus, the psychological management of stillbirth has undergone a gradual change. Some countries have adopted some methods such as parents seeing and hugging the dead baby, taking baby's photo, and conducting the funeral procession for supporting the mourning parents (12). Cacciatore et al. (13), in their study entitled "Fatherhood and suffering: A qualitative exploration of Swedish men's experiences of care after the death of a baby" stated that mothers who had experienced stillbirth were thankful to the caregivers who had provided them the chance to see the baby, conduct the funeral procession, and take the baby's picture. Moreover, the caregivers reported a gradual decrease of long-term negative psychological effects on the mourning parents (13). To this end, many researchers believe that inadequacy of supports and cares provided by the healthcare professionals during hard days of post death is the main determiner of mothers' psychological state in the future (14). That is why healthcare professionals are in a special situation and must be able to help these people get over their sorrow (15).

An appropriate care environment conforming to standard protocols, for helping parents get over their loss in stillbirth events, is currently part of the standard post-natal care services provided in developed countries (16). Global care instructions used for stillbirth events emphasize supporting parents so they can think and decide about their best move after such a tragic experience (17). The needs of these parents should be addressed sympathetically and delicately by healthcare professionals and through offering targeted and accessible information so the parents can choose the most convenient option conforming to their values (18).

National institute for health and care excellence (NICE) also recommends that research works should be conducted on societies for identifying parents' characteristics and exclusive components of care conforming to the culture of those societies (19).

Considering the difference between cultural and social norms of Iran and other countries in dealing with the sorrow of fetus loss, compilation of health improvement solutions for Iranian women experiencing stillbirth for preparing a semi-professional care guideline is necessary for providing appropriate healthcare services. Therefore, even though prevention of stillbirth is difficult, the psychological effects of the event on parents can be reduced to some extent through appropriate training programs, consultation, and prenatal cares (20).

Thus, the current study attempts to recommend localized solutions for enhancing women's psychological health that can be adopted in the healthcare system for Iranian women and their families experiencing stillbirth.

## 2. Objectives

This study aimed to explore strategies suggested by stillborn mothers to provide maternal mental health in the experience of stillbirth.

## 3. Patients and Methods

The study was conducted with a qualitative content analysis method in Isfahan, Iran (21). The study conducted with purposive sampling method with the most variant samples. Participants consisted of 20 married women who had experienced stillbirth. Inclusion criteria were willingness to participate in the study, approved and registered by the gynecologist with at least one stillbirth experience in the medical record, and no history of mental illness. Samples were selected from patients with known and unknown causes of stillbirths. Declining study in any phase was considered as exclusion criterion.

The participants were interviewed separately. In the beginning, purposive sampling was conducted on volunteers and that it changed into sampling with maximal variation. The participants were identified through their files in healthcare centers and were invited to the project via phone call. During the phone conversation, the researcher introduced himself and a summary of research objectives was provided. The data were gathered through in-depth semi-structured interviews. The venue and time of interviews were determined as per participants' preferences. The objectives of the research were explained to the participants before the commencement of the interview and their informed consent was obtained too. The interviews started with a question on their psychological needs after their experience. The interviews lasted 30 - 60 minutes that were recorded by a voice recorder. Data gathering was continued up to the point no new data were gained. Along with data gathering, they were analyzed through qualitative content analysis. The interviews were then transcribed verbatim in Microsoft Word by the researcher and the analysis unit was formed this way by 3 university professors, a PhD holder in Reproductive Health, a psychiatrist, and a PhD holder in Nursing. To analyze the data, Graneheim and Lundman analysis were used. In this method, data collection and analysis were conducted simultaneously and through minimization of qualitative data and categorization, identify the themes existing in the data (21). The extracted text from each interview was coded. First, the data were read line by line, the important sentences and phrases were determined and underlined and their codes were named. The similar codes were then merged and the preliminary categorization was performed. Categories were also compared, and if required, integrated. The minimization procedure continued in all interviews. In some cases, one category was divided into two or more subcategories, or code of a category was changed to that of another category, and eventually, main categories were obtained.

To ensure of the rigor in qualitative research, conformability, dependability, and transferability qualities were examined (22). The researcher employed the following methods to obtain results that reflect participants' real statements. Credibility was attained through review of the interview transcriptions by participants. This meant that after coding, interview texts were returned to some participants to ensure of codes correctness and their interpretations. Eventually, codes that did not reflect participants' views were modified. The conformability was gained through complete logging of researcher's activities of data gathering, analysis, and presentation of interview text clips for each category. Additionally, the transcription of interviews and extracted categories were provided to fellow researchers familiar with qualitative analysis procedures, and not part of the research team, so as to obtain their confirmation on the deducted meanings. To confirm transferability, the resulting categories were also shared with non-participating women, who approved the suitability of results.

The study was approved by the ethics committee of Is-

fahan university of medical sciences. The code of ethical approval was 392472. The ethical considerations were taken into account by obtaining participants' informed written consent and offering freedom to withdraw from the project whenever they wished and referring them to psychiatrists upon identifying any probable psychological side effects. All participants were informed about the method and goals of the study. Moreover, the participants were reassured that their responses would be confidential.

#### 4. Results

The participants consisted of 20 women with stillbirth experience who were selected through purposive sampling considering maximal variation in terms of age, stages of pregnancy, and child-bearing experience (Table 1).

Three main categories with their subcategories were extracted based on participants' statements. The main categories were first introduced and then the subcategories were identified as per participants' statements (Table 2).

**Table 1.** Personal Characteristics of Participants

Number of Participants	Number of Kids	Fetus Gender	Occupation	Pregnancy Duration, wk	Education	Age, y
P1	0	Male	Housewife	37	Diploma	27
P2	0	Male	Employed	22	Diploma	30
P3	1	Female	Housewife	23	Primary School	33
P4	1	Female	Employed	35	University Education	18
P5	2	Female	Employed	30	University Education	23
P6	0	Female-Male	Housewife	24	Primary School	31
P7	0	Male	Housewife	26	Diploma	28
P8	1	Male	Housewife	28	Diploma	27
P9	0	Female	Employed	26	University Education	24
P10	1	Male	Housewife	28	University Education	25
P11	0	Female	Housewife	25	Primary School	27
P12	1	Male	Employed	24	Diploma	27
P13	1	Female	Housewife	22	University Education	23
P14	0	Female-Male	Housewife	38	Diploma	26
P15	1	Male	Housewife	26	Primary School	26
P16	0	Female-Female	Housewife	33	Diploma	29
P17	0	Male	Employed	29	University Education	28
P18	3	Female	Housewife	24	Primary School	35
P19	2	Male	Housewife	33	Diploma	32
P20	1	Male	Employed	27	Diploma	29

**Table 2.** Main Categories and Subcategories of Strategy for Mental Health Improvement of Stillborn Mothers in Prenatal Period

Main Categories/ Subcategories	Number
<b>Strategy for mental health improvement of stillborn mothers in Prenatal period</b>	
How to report the death of the fetus to the mother	10
Trainings on the method of parturition	6
Providing the opportunity for understanding and acceptance	15
<b>Strategy for mental health improvement of stillborn mothers at birth</b>	
Provision of family-based cares	11
Respecting patients' privacy	18
Treating them like other mothers	10
<b>Strategy for mental health improvement of stillborn mothers in Postnatal period</b>	
Offering appropriate training	7
Studying the sexual and marital problems	6
Offering spiritual supports and consultations	9

#### 4.1. Strategy for Mental Health Improvement of Stillborn Mothers in Prenatal Period

The main category of psychological healthcare enhancement which was mentioned by women upon their confrontation with the stillbirth event was related to those solutions pertaining to the prenatal period, a time between the stillbirth news to the moment of delivery in hospital. Most of the participants stated that the way the disturbing news of stillbirth was told to them by the healthcare professionals was very important in their acceptance of the event. The participants mentioned that, as their mental tension builds upon hearing about the stillbirth, inadequacy of the supports and necessary trainings by the healthcare professionals during these hard times would determine mother's future psychological conditions.

The participants suggested that the healthcare professionals could facilitate the mourning process and mothers' acceptance of the event through appropriate educational measures and consultation at critical times of stillbirth.

##### 4.1.1. How to Report the Death of the Fetus to the Mother

Most of the participants mentioned that healthcare professionals are not usually aware of the way they report the news to the mothers. They usually break the news suddenly without setting the context. Thus, the mothers lack the necessary professional advice on their deceased child. Breaking the stillbirth news to patients' companions and informing the family members of the possible cause of fetus death can help the family and mothers' companions to prepare the mother for the news, deliver the news gradually, and thus make the situation more bearable. The participant number 1 recalled:

"When I went to the clinic for check-up, the related staff listened to the heartbeat of the fetus and told me that its heart is not beating and I should perform sonography. I didn't understand how I reached the sonography unit. As

soon as the doctor started the sonography, she said that the fetus was death. My whole world came crashing down on me and I was going to die of shock. We all know that one should not break such death news suddenly. I wish they had delivered the news to my companion so she could inform me little by little."

Most participants mentioned that the death news was quite sudden and unexpected, and emphasized the necessity of training programs for healthcare professionals on sympathizing techniques and identifying mothers' emotional needs at such circumstances. The participant number 11 said:

"Thank God my husband was with me at the time I was informed of the death of the fetus. Because he was aware of my emotional status, paved the way for such shattering news, and shared the issue with me little by little."

##### 4.1.2. Training on the Methods of Parturition

Many participants stated that they knew they had to refer to the hospital immediately after getting aware of their stillbirth, but they had no idea what was going to happen to them then. They wondered whether the dead child should be delivered naturally and whether the death of the fetus would risk mother's life. They were transferred to the hospital without any trainings or information. In fact, participants mentioned that providing adequate information to mothers and their families on delivery method, providing consultancy for decreasing mothers' fear of childbirth, respecting patients' right to comprehensible information on treatment of mothers' anxiety would reduce their fear of labor and later pregnancies.

##### 4.1.3. Providing the Opportunity for Understanding and Acceptance

Many participants mentioned that their emergency hospitalization and unawareness of delivery procedure

did not present any opportunities to them to accept the issue. In fact, pregnancy loss can immediately cause psychological vulnerability and common care services may deteriorate the effects of this event. The participant number 17 had this to say:

“I wish they let me go home so I could cry it out so my anger would drain, and say goodbye to my child and then go back to the hospital. I was shocked when I went to the hospital without having any chance to accept the situation.”

#### 4.2. Strategy for Mental Health Improvement of Stillborn Mothers At Birth

Many participants mentioned their need of family support during these hard times and mourn stages such as denial, anger, and crying. On the other hand, treating all women who give birth to either a dead or alive baby the same way would help them not feel left out, ignored, and incapable of childbearing.

##### 4.2.1. Provision of Family-Based Cares

Participants expressed their concern about their families and companions' health as well as their overlooked rights by healthcare professionals. They stated that, considering the worries of companions waiting behind the doors of maternity hospital, they needed to contact their companions through phone. Some participants mentioned that the presence of one companion during labor was soothing and reduced the fear and stress resulting from labor that doubled at such conditions. In this regard, participant number 4 said:

“My companions were restless behind the door as they thought the death of the fetus was also threatening me. I wish I could tell them that I was fine. I wish the medical professionals could understand my companions and how they felt then and wish they could treat them more mildly.”

##### 4.2.2. Respecting Patients' Privacy

Some participants mentioned that they needed to be separated from mothers giving birth to live babies, as the pain they were through was a sweet and hope-giving pain of seeing their babies, while the participants' pain was a fruitless and futile pain. The participants number 9 recalled:

“My heart broke every time the nurse came and listened to the fetus heartbeat of the mother lying on the next bed. I wanted to cry then but I didn't want that mother think I was jealous. It was a painful moment which is still in my mind and annoys me.”

##### 4.2.3. Treating Them Like Other Mothers

Some participants mentioned that the personnel of maternity hospital paid less attention to them and cared less about them compared to the mothers giving birth to live babies. They stated that it was necessary to provide a fair level of services to all mothers and avoid discrimination

between mothers giving birth to live babies and dead babies. The participant number 13 said:

“The nurses frequently measured their blood pressure, adjusted their serum, but paid no attention to me. It seemed like my health was not important, as I had lost my baby. I wish I had gone with her as well.”

#### 4.3. Strategy for Mental Health Improvement of Stillborn Mothers in Postnatal Period

Many participants mentioned appropriate educational programs for enhancing mothers' adaptability to and acceptance of their condition as the main solutions for the postnatal psychological healthcare of women. They also stated that training mothers on their physical and mental changes after delivery would prepare them for the event and will help them revert faster to their prenatal condition. Additionally, awareness of the cause of fetus death would help reduce mothers' stress and anxiety in their future pregnancy and would ease their guilt. They also mentioned that supportive services such as consultancy would facilitate their recovery.

##### 4.3.1. Offering Appropriate Training

Many participants were concerned about being blamed by their family, so training the families on the cause of stillbirth and how families should behave toward mothers would facilitate their recovery process. Trainings on regular caring would reduce mothers' stress in their future pregnancies. In this regard, participant number 20 said:

“I liked to know the cause of my fetus death but I didn't know where I should take it and what kind of tests should be run on it. The hospital gave us the dead fetus wrapped in a cloth and asked us to bury it somewhere. If I knew the cause, I would not have much stress in my later pregnancies.”

##### 4.3.2. Studying the Postnatal Sexual and Marital Problems

Some participants stated that they could not carry out their marital responsibilities due to their postnatal mental condition. Some who blamed their husband for having intercourse with them during their previous pregnancy avoided having intercourse with their husband. This could ruin their marital life and cause depression in some. Thus, the healthcare professionals are recommended to address patients' sexual problems, especially after delivery.

##### 4.3.3. Offering Spiritual Support and Consultations

Many participants stated that healthcare professionals' main focus was on providing physical cares to mothers and spiritual aspects and consultations were ignored. They mentioned that consultation and such spiritual supports for training mothers how to deal with their concern of the reoccurrence of the event, how to deal with

the increased fear of pregnancy, the appropriate time for the next pregnancy, the prenatal cares, and how to behave toward kids after home coming play a vital role in reducing mothers' stress at present and in future. The participant number 5 said in this regard:

"I didn't know when the appropriate time was for the next pregnancy, and if there were anything special I had to do. I wish they had told me such things or had given me an educational brochure when discharging me from the hospital."

## 5. Discussion

This research is the first study conducted in Iran attempting to identify psychological healthcare enhancement solutions after stillbirth from Iranian women's viewpoint. The extracted categories indicate appropriate healthcare interventions that enhance Iranian women's psychological health after their stillbirth experience and support them in returning to their normal life.

The obtained results showed that the stress starts from the moment the news of fetus death was delivered and thus healthcare professionals should possess adequate skills and expertise for providing necessary supports and care in these hard times so mothers could deal better with the event and suffer less mental damages in the future. Lalor et al. (23) and McCreight (24) maintained that the news of fetus death had its special problems as it was quite sudden and unexpected. One of the difficult components is identifying mothers' emotional needs as well as those of their companions'. One solution to this sympathetic approach is identifying their thoughts and wishes without trying to form them. Mothers experiencing stillbirth, as well as their companions, would appreciate others' understanding of their emotions and excitements (23, 24).

The obtained results indicate that these mothers need some training on postnatal changes and cause of fetus death, and these trainings reduce significantly their distress. Turton stated that these mothers needed to be trained on stillbirth trauma and effective interventions such as provision of support services or psychotherapy (25). The results also showed that participants wished to be in touch with their companions as they mentioned that the presence of companions at such hard times was necessary as a spiritual support. According to DeFrain (26), all family members may be affected by this tragedy. In his 10-year study on 843 parents of an extended family who had experienced stillbirth, he concluded that the most common reaction of grandparents is their great need of supporting their children. This study showed that grandparents needed information on how to support their children, how long the mourning process took and the difference between men and women's response to this tragedy (26).

The study results indicate that mothers experiencing stillbirth like to have the same care provided to normal

mothers giving birth to live babies, and resent being ignored or receiving unfair services. Radestad et al. (27), in their study on 636 mothers and their postnatal condition, among which 314 mothers had given birth to dead babies and 322 mothers had given birth to live babies, showed that the birth process became more difficult and painful physically and psychologically when the mother knew her baby was dead. These researchers stated that the mothers of the former group had spent less time in hospital and received fewer services and were mostly dissatisfied with the quality of services (27).

The results of the study showed that most women encountered postnatal sexual and marital problems. Necessary consultations would be an appropriate solution for enhancing their psychological health and their recovery after the stillbirth experience. As indicated by Turton et al. (25), stillbirth increased the negative psychological effects in future pregnancies and postnatal periods. They found out that side effects such as depression, post-traumatic stress disorder and break-up between the parents had increased more significantly in mothers with stillbirth than mothers giving birth to live babies (25). Fletcher (8) also stated that the death of a baby had devastating effects on the relationship between the parents and led to challenges in life, their sexual desire, their communication with others, and ultimately results in contentions between the couples. A study of the main categories extracted in this research indicate that the current approach of healthcare provision to Iranian mothers who experienced stillbirth needs to be changed and improved toward the condition when all aspects of mothers' psychological needs are fulfilled, their psychological health is enhanced, and their family foundations are strengthened.

Thus, healthcare service programs, especially for mothers with stillbirth experience, should focus on consultation services and trainings with a sympathetic approach from the moment the mothers become aware of the fetus death to the time they recover from the incident psychologically. These programs can be implemented by information dissemination and appropriate trainings and coordination between consultation centers. Moreover, it is recommended that performance studies be planned for compiling healthcare guidelines for training caregivers about appropriate psychological consultations and interventions for psychological health enhancement of mothers and Iranian families with stillbirth experience. The weak point of the study was its only investigating tool, interviewing women, which showed the results from women's perspectives, provided that there were no obstacles in interviewing their spouses. The strong point of the study was having the maximum variance in samples regarding their selection from patients with known and unknown causes of stillbirths at any age of pregnancy, and referring them to psychiatrists upon identifying any probable psychological side effects. Limitation of this study is that its findings are not applicable to all

communities, but with broad researches in different cities this problem can be solved.

## Acknowledgments

We express our gratitude to Isfahan university of medical sciences for funding this project and all participants who helped us in this study.

## Footnotes

**Authors' Contribution:** Study concept and design: Maryam Allahdadian and Alireza Irajpour; acquisition of data: Maryam Allahdadian, Alireza Irajpour, and Ashraf Kazemi; analysis and interpretation of data: Maryam Allahdadian, Alireza Irajpour, Ashraf Kazemi, and Gholamreza Kheirabadi; drafting of the manuscript: Maryam Allahdadian and Alireza Irajpour; data analysis: Maryam Allahdadian, Alireza Irajpour, and Ashraf Kazemi; study supervision: Alireza Irajpour, Ashraf Kazemi, and Gholamreza Kheirabadi.

**Funding/Support:** This study was funded and supported by department of research and technology, Isfahan university of medical sciences.

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