



Review Article

# From Darkness to Light: Accompanying Women Giving Stillbirth in a Public Hospital

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Citation: Goldberg M, Sberro-Cohen S, Tamsot N, Valid TB, Kasten C (2024) From Darkness to Light: Accompanying Women Giving Stillbirth in a Public Hospital. Int J Nurs Health Care Res 7:1526. DOI: <https://doi.org/10.29011/2688-9501.101526>

Received Date: 27 March, 2024; Accepted Date: 04 April, 2024; Published Date: 08 April, 2024

## Abstract

**Problem:** Stillbirth is a traumatic event with lasting emotional and psychological impacts on women and partners. However, stillbirth care and support are often insufficient, leading to negative experiences and prolonged grief. **Background:** Despite the prevalence of stillbirth, there is a lack of guidance on meeting the needs of affected individuals. Healthcare professionals rely on personal experiences, resulting in inconsistent and inadequate care. The psychological effects of stillbirth also extend to relationships beyond immediate family. **Aim:** This article examines stillbirth experiences and evaluates care practices to enhance support and address emotional, psychological, and social aspects. **Methods:** A literature review and investigation of protocols at Assuta Ashdod Hospital in Israel, known for its comprehensive approach to stillbirth care. **Findings:** Inadequate communication and lack of support from healthcare teams were common issues reported by individuals who experienced stillbirth. Social isolation, insensitive comments, and a lack of support groups intensified emotional distress. Assuta Ashdod Hospital's study emphasized personalized support, respectful rituals, and provision of memory items. **Discussion:** Healthcare professionals need to deliver compassionate and individualized care, addressing emotional and spiritual needs. Creating mementos and preserving memories can aid the grieving process. **Conclusion:** Improving post-stillbirth care and support is crucial for emotional well-being and navigating grief. Healthcare professionals should receive training and support to provide compassionate care. Implementing comprehensive care protocols, including respectful rituals and memory items, can aid healing and coping with loss.

## Statement of Significance (SOS)

**Issue:** Inadequate care and support after stillbirth result in negative experiences and prolonged grief for women and partners. Existing guidance fails to meet the needs of individuals, leading to inconsistent and insufficient care.

**What is Already Known:** Stillbirth impacts beyond immediate family, affecting relationships with friends and extended family. Inadequate communication and support from healthcare teams contribute to emotional distress.

**What this Paper Adds:** This paper examines stillbirth experiences and evaluates care practices. It emphasizes compassionate and individualized care to address emotional and spiritual needs. Assuta Ashdod Hospital's study highlights effective comprehensive care protocols, including personalized support, respectful rituals, and memory items.

In summary, this paper adds to the existing knowledge by shedding light on the inadequacies of current care practices and proposing improvements to enhance support and address the emotional, psychological, and social aspects of stillbirth. It emphasizes the significance of individualized care, respectful rituals, and memory preservation in promoting healing and facilitating the grieving process.

## Introduction

The World Health Organization defines stillbirth as a baby born with no signs of life at 22 or more completed weeks of gestation. For international comparisons, 28 or more weeks of gestation is used [1]. A position paper prepared by the Association of Midwives and Gynecologists in Israel defined stillbirth as the birth of a fetus without any sign of life at week 20 or beyond of pregnancy, or a fetus weighing 500 grams or less if the week of pregnancy is unknown. Stillbirths as a result of planned abortions are not included in this definition [2].

The birth of a dead fetus is a traumatic event for women and their partners. It is known to significantly affect women's emotional state [3] in that it contradicts the natural life cycle of birth, maturation and death [4]. Stillbirth is not a rare event. Estimates suggest that it can occur in 5-6 out of every 1000 births. The factors contributing to fetal death can be categorized into fetal factors, placental factors, and maternal factors. Nevertheless, in 20-40% of all cases, it is impossible to identify the reasons for stillbirth, despite extensive medical investigation [2].

### Review of the Literature on Stillbirth

Because stillbirth is a sudden event, women and their family circles cannot prepare for it in advance [5]. The shock of losing their foetus and the emotional trauma of stillbirth delivery can leave women feeling overwrought [6]. A 2019 Canadian study [7] examined the experiences of 569 family members who received medical care and support for their loss. Most respondents stated they had not received complete information or enough support from the care teams. They also noted that the caregivers did not have sufficient skills to provide optimal treatment. Almost half the respondents stated they had felt that communication with these teams made their emotional state worse. By contrast, the empowering experiences were associated with the timing of meetings with the treatment team, and compassionate and personally adapted treatment.

The families recommended that medical teams should engage in greater efforts to make information and explanations accessible, in particular about the discharge process and follow-up treatment, including options for continued support. The authors noted that health professionals can bring about a positive change

by identifying the significance and magnitude of loss for couples, reduce their sense of loneliness and uncertainty, provide ongoing support adapted to the changing needs of couples throughout the process starting with the bad news to the follow-up after hospital discharge, and planning the next pregnancy. Most respondents also referred to the loneliness they experienced following their loss. They felt they were excluded from certain social groups (parental groups on social networks), and a sense of detachment. These feelings were expressed in particular by fathers and partners in single sex families. Women mentioned that their partners tended to "disappear" and felt they had no source of supportive discourse. LGBT families stated that most support groups were gendered and were intended more for mothers who had lost a foetus than their partners. Bereaved fathers noted that they felt helpless when they found no sources of support and in addition to their own grief were forced to be strong for their partners.

Research examining the psychological effects of stillbirth on women and their families has found that these women experience grief and a sense of guilt over the loss. These negative feelings are exacerbated by inappropriate treatment by healthcare systems, a breakdown of communication with friends and family, a weakening of relationships with partners, and financial problems. Many families noted that family members also experienced depression and emotional distress. Women reported insensitive comments from family members, friends and neighbors that led to more social isolation to avoid having to face the stigma of 'failed motherhood' or 'bringers of bad luck' [5].

A 2019 study conducted in two hospitals in Spain examined the perceptions and experiences of parents who had experienced foetal loss in the previous five years [6]. Interviews with 13 mothers and 8 fathers dealt with views of care and expecting a dead baby, the emotional overload created by the shock of loss and emotional pain of stillbirth, and the need to provide an identity for their baby and prove that the grief surrounding stillbirth was legitimate. [6] concluded that post-stillbirth recovery involves social, psychological, physiological and spiritual factors. Their interviewees reported that foetal death led to social changes at familial level and had a negative effect on parent-child relationships with other children in these families. Foetal death was not seen as the equivalent of the death of a baby. The respondents reported

that they received incorrect information, at the wrong times, and were confronted with inappropriate attitudes on the part of care teams. The participants stated how much they appreciated an opportunity to part with their baby, and receive a footprint or picture. Respondents who did not get this opportunity pointed to greater suffering.

There is a great deal of information on the topics of women's health and midwifery in World Health Organization databases, but little direct guidance on caring and meeting the needs of women and their partners after stillbirth. Nurses who work with women and their partners after stillbirth mostly draw on their personal and professional experience, their cultural and social background, and their position in their healthcare institution. One study reported that team members felt a lack of confidence about the quality of care they provided and considered that treatment was insufficient [4].

Treating patients after abortions and stillbirth is emotionally challenging and leads to stress among caregivers which is likely to affect care teams and the quality of care provided. Researchers have used the expression 'care in the dark' to describe these teams' experiences, where 'dark' represents the emotional state of the woman and her partner as well as the challenges facing care teams [8]. 'Care in the dark' has five components:

1. Factors turning off the light, such as a lack of organizational support, lack of preparation and knowledge prior to treatment, and the emotionally draining nature of treatment. Staff feel uncomfortable treating patients after stillbirth because they do not know how to react and are scared of hurting bereaved parents even more.
2. Strength to enter the darkness in the form of support and accompaniment. Analysis of previous cases is likely to help cope with care during stillbirth.
3. Avoiding failure: since nurses and midwives try to provide the most professional care possible, they are likely to focus on physical tasks to avoid establishing an emotional connection with patients.
4. Fumbling about in the darkness in an attempt to provide better care in terms of physical presence for these patients, by talking about feelings, being calm, giving patients the sense that they are in good hands. This requires finding a personal approach to every patient and every case specifically.
5. Hurt after coping with the darkness, where nurses and midwives reported feelings of sadness, emotionality, anger and helplessness after treating stillbirths.

Medical teams have also reported they encountered organizational hurdles after treating women after IUFD, which made goal-focused care and emotional connection with the

patients hard. One of these researchers' key conclusions was the importance of training medical staff about ways to treat women after stillbirth, providing support for caregivers, and establishing values. Professional support for couples who experience stillbirth is essential, and nursing staff are at the forefront. Support must focus not only on the women's physical condition, but also their emotional and spiritual state, in contradistinction to the widespread approach today that focuses solely on the physical condition [8].

### **The Stillbirth Experience at Samson Assuta Ashdod Hospital**

The Samson Assuta Ashdod public hospital located in southern Israel was founded in 2017 and today serves about half a million residents. In 2022, there were approximately 6,300 births in the Department of Obstetrics and Midwifery, with a stillbirth rate of 3.3 for 1,000 births. This number includes planned abortions carried out in the obstetrics department. Stillbirths fall into two main categories. The first includes women who did not know that their fetus was dead before they went to the hospital. On the whole, these women present at the obstetrics emergency room because they no longer feel fetal movements or are referred by their family doctors. This group also includes women who come to the hospital after experiencing contractions, where examination reveals no fetal pulse. Upon arrival, these women are examined by midwives and if there is still no fetal pulse, they are examined again by a doctor. The second group covers women referred to hospitals for an abortion because fetal malformations were discovered in the late stages of pregnancy. In these cases, the women undergo comprehensive tests and receive authorization to abort from the Termination Committee, as stipulated by Israeli law.

At Samson Assuta Ashdod hospital, women admitted to the obstetrics ward with a diagnosis of IUFD to induce labor are first seen by the nursing staff. Patients receive a detailed explanation of the ward, the staff members they will encounter during their hospitalization, the ward structure, the protocol, as well as how labor is induced, and future medical procedures, all of which significantly reduce fear. During their ward stay, the medical team, nurses and social workers accompany and support patients and their partners to enable these women to cope with grief, loss and loneliness.

The hospital has set up an efficient and intentional parting protocol to lessen depression, anxiety, PTSD, suicide, panic and phobia, in particular since these issues also place an additional economic burden on the health system [9]. To allow for the best conditions for parting, all Assuta midwives who treat women for stillbirth are trained to contain (in the psychotherapeutic sense of the word), and show considerable mental resilience, empathy, and compassion. As part of their training, they learn to respect and accept these women's demands with sensitivity and understanding. Midwives accompany these women from the moment the loss is discovered through to when the fetus is delivered. As part of their

support, the midwives address the timing of birth, the nature of the birth, pain reduction, physical parting and inquire into the family's willingness to conduct post-mortem tests and/or autopsy [10].

The second category of stillbirths relates to fetal malformations identified during pregnancy through scans or other tests which forces couples to make the very difficult decision of whether to continue the pregnancy and bring a disabled child into the world, or terminate the pregnancy. When the fetal malformation is discovered, the couples are given a full explanation of their options. They are given the right to make the decision that best suits them. If they decide to end the pregnancy, the woman is admitted to the obstetrics ward for an abortion. Patients receive all the support and empathy they need, especially when the fetal pulse is stopped, and throughout their stay in hospital.

There is strict segregation in the delivery room to save these women from having to hear the background noises from other births and family happiness. Before the woman is taken to her room, all sensitive equipment associated with new-borns is removed. The door of the room has a butterfly insignia to alert the staff. The midwives assigned to stillbirths have all undergone training and acquired the tools to cope with and support these women and their families. Doctor's visits are restricted in number and take place with a permanent team of caregivers.

Ramirez et al. [11] noted that creating visual memories such as photographs at birth create a permanent and tangible legacy, legitimize grief, and start the process of healing after loss. [12,13] described the importance of creating mementos from the birth process to help cope with grief. They suggested encouraging parents to see the baby and hold it, take pictures, and also wash and dress the baby as is customary in delivery rooms, choose a name, write and listen to a poem, engage in the family parting, print the palms and soles and give the baby to a caregiver who then deals with the final parting. Specific culturally-dictated bereavement and grief customs are respected [14].

During their stay, the staff give the woman and her partner a memory box decorated with optimistic pink motifs to help contain their sadness and preserve mementos while coping with the loss. The box contains a detailed instruction sheet including information about parting, physical and emotional post-birth coping, national insurance rights, dealing with sadness and pain, mementos such as a picture of the baby in swaddling clothes and a bonnet, and a footprint of the baby's palm and sole as a visual legacy and an album to document reactions, experiences, feelings, fears and even new hopes. Some parents prefer not to see their baby at all, and all parents choose which items in the box they want to use.

The staff also helps acknowledge the loss to the family but also to the couple. Each couple receives a range of informative booklets on ways to explain the loss to children and family

members, the experiences of other women who have undergone a similar experience, and a book especially for fathers about ways to cope [15]. After the birth process is complete and the women have recovered in the delivery room, they are taken to the obstetrics ward for further hospitalization. The women are hospitalized in a separate room to provide maximum privacy. In the obstetrics ward, women hospitalized after stillbirth have the right to a chosen companion, who most often is the partner who has also experienced a profound loss. The only contacts that the women and their partners have after the birth, prior to returning home is with care staff.

Prior to discharge, the women are seen by a nurse who carries out routine tests as well as an emotional assessment with compassion and empathy. She also recommends talking to a social worker. All staff visits to patients' rooms are compassionate, respectful and sensitive, and provide each woman with the opportunity to express her grief in her own way. Patients are given space to talk if they so desire, or silence if they do not want to share their feelings.

Meeting patients' expectations is one of the most significant factors affecting the process of loss. Providing a service to women in a period of grief is especially challenging. Patients' expectations of medical services are made up of different factors such as their emotional and physical condition, and a variety of social needs which require coordination [16] in particular in cases of IUFD. Likewise, it is important to provide information in the right place at the right time. There is no clear protocol as to the right words to say to women at any given moment during an IUFD, and it is not really possible to write such a protocol, since every case is different and each patient carries a whole world within. Thus, the nursing staff's ability to provide emotional support to women giving birth and their families depends on background, empathy, compassion and sensitivity. If a woman is not willing to talk, does not want to receive information or guidance because of her emotional state and stress, the ward staff will arrange to meet at another time.

The social worker is an integral member of the multidisciplinary team accompanying women after stillbirth. Each woman reacts and copes differently so that the role of social workers is to allow her to talk, grieve, be angry, express emotions, or find a place of solace [17]. The social workers' role is to legitimize a range of normative genuine feelings and enable sharing and venting. Unlike family and friends who generally try to avoid emotional upsets, these professionals allow these women to talk, cry, and go through the processes they need in order to grieve and rehabilitate [18].

This response during and after hospitalization still leaves women with a great void and unfinished business, since there are fears, thoughts, and the need for more answers. To ease the loss, Assuta provides accompaniment after discharge in the form

of workshops. These workshops are available as a function of the participants' dynamics and needs. Most consist of 6 to 8 ninety-minute sessions. Depending on the number of women who have undergone an IUFD at Assuta Hospital Ashdod, these workshops are offered semi-annually. The head of social work services contacts women who experienced stillbirth during this time. She presents the aims of the workshop, its structure, and dates. At times, women express their concerns about multiculturalism and prejudice. They are informed that the sessions are respectful, sensitive and appropriate for all.

The workshops are led by a social worker and a nurse from the obstetrics ward. The core content covered in the workshop includes how to communicate the loss, touch on sensitive issues, ways to integrate family members and those close to them, building support circles to cope with loss, hosting other women who have undergone stillbirth to share their experiences with the group, planning and coping with the next pregnancy and its implications for the women personally, as a couple, and on the familial-social level. The workshops are held in a neutral place in the training hospital center located in the administration building, not in the obstetrics ward, but with staff members who accompanied them during their hospitalization.

From 2020 to 2022, 28 women participated in these workshops, constituting 56% of those who had undergone a stillbirth in this period. Four women dropped out. The women who chose not to participate stated that the traumatic experience was behind them and they preferred to move on and not bring it up again. During these workshops, the group was also flooded with participants' corrective experiences, for example, the birth of a healthy child. This support group has now become part of the services offered to women who experienced stillbirth at the hospital.

A recent extension of these workshops is called 'Enveloped'. This emotional care project includes tailored accompaniment for women who have experienced traumatic events in general such as sexual abuse and post-trauma following previous births, not only stillbirths. These women are referred to the project to process birth experiences and build a strong foundation to create a positive impact and neutralize fears in preparation for their next birthing experience. Staff leading the project are trained to provide customized responses to the needs of these women.

## Discussion and Conclusion

In our work at Samson Assuta Ashdod Hospital, we identified the need to support women undergoing stillbirth. The care protocol starts when the woman arrives at the hospital and continues for her and her partner throughout every stage of the process. Trained dedicated staff support these couples until discharge and also later in a support group that enables them to plan the next pregnancy,

cope with fears and prepare for the next birth. Roughly half of the women who experienced a stillbirth return to give birth at Samson Assuta Ashdod Hospital and report that the care they received provided a corrective and powerful experience during this challenging period.

IUFD and the stillbirth are difficult and traumatic events for couples. Coping is both physical and emotional. Bad news during diagnosis and the grief that follows birth do not only affect couples, but also their relationship. A professional and empathic attitude on the part of treatment staff can reduce suffering significantly for these couples. It is extremely important to train the treatment staff in optimal care of IUFD at all phases. At diagnosis, it is critical to provide couples with information openly, avoid uncertainty, and show empathy. During delivery, individual care, and giving the couple time to decide how to part is equally important. Post-delivery care on the ward also plays a significant role. Care staff must show empathy, compassion, and provide maximum privacy to these women and their partners. Staff must also provide treatment, supply information at the right time, and demonstrate great sensitivity and understanding when couples are not able to digest information. Social workers' involvement is crucial from the outset. Accompaniment during and after the event in a support group gives patients the feeling that they are not alone, provides them with opportunities to talk about what happened, get to know other women who have a similar story, and share feelings. The support groups at Samson Assuta Ashdod Hospital have had positive effects on patients' emotional state, and helped them move from darkness to light. These results have also been significant for the staff caring for IUFD cases.

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