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Review Article

Parents experiences of pregnancy following perinatal loss: An integrative review

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ABSTRACT

Background: Pregnancy following perinatal loss has a profound effect on parents and may contribute to intense psychological distress including grief, post-traumatic stress disorder, anxiety and depression. The subsequent pregnancy may also be perceived as more stressful due to the fear of recurrent loss. Midwives and other health care professionals need to be sensitive and empathetic to the needs of these parents when providing care in a pregnancy subsequent to a loss.

Methodology: The aim of this integrated literature review was to explore parents' experiences of pregnancy following a previous perinatal loss using a systematic approach. This is presented in a five-stage process that includes problem identification, literature search, data extraction and evaluation, data analysis and presentation of results. A systematic search of seven electronic databases was conducted (Jan 2009 -Jan 2023) to identify relevant primary research which addressed parents' experiences of pregnancy following a previous perinatal loss. Seven papers met the eligibility criteria and were assessed for quality using Crowe's Critical Appraisal Tool (CCAT). Thematic analysis identified two themes.

Findings: The key themes identified from the literature were; the psychosocial needs and challenges faced by previously bereaved parents in subsequent pregnancies; and the need for specialist care and support in a subsequent pregnancy. Psychological needs and challenges included continued grief, depression, anxiety, and disparities in the grief process between men and women. The importance of specialist care with an increased level of support from competent, confident and compassionate health care providers was highlighted.

Conclusion: The experience of pregnancy following a perinatal loss can be a complex emotional experience for parents. The review identifies the need for post pregnancy loss debriefing and counselling and care pathways specific to caring for women and their partners in a pregnancy subsequent to a perinatal loss. Care in pregnancy subsequent to loss should be provided by empathetic, competent health care providers and include additional antenatal clinic appointments, pregnancy monitoring and psychological support in order to meet the needs of these expectant parents.

Introduction

Perinatal loss is defined as the loss of a pregnancy any time prior to or during birth, or the death of a new-born within the first month of life (Charrois et al., 2020) and incorporates miscarriage, stillbirths and neonatal death. Miscarriage refers to the loss of a pregnancy prior to 24 weeks' gestation and is the most common form of perinatal loss occurring in approximately 15% of all pregnancies (Hutcherson, 2017). Stillbirth is a loss occurring after 24 weeks' gestation (Smith et al., 2020), with a global rate currently estimated at two million stillbirths annually (Peven et al., 2021). Neonatal death is defined as the death of an infant in the first 28 days of life (Cnattingius et al., 2020) with an annual rate of approximately 2.7 million (Leisher et al., 2016). Miscarriage, stillbirth and neonatal death are often examined together under the standardised definition of perinatal loss (Allanson et al., 2016; Steen, 2015). The interpretation of data on perinatal loss is however, hindered by definitions varying globally (Lee et al., 2017). The experience of pregnancy following a perinatal loss may not be fully reflected in the literature as losses in pregnancy may go unreported because medical support has not been accessed or where maternity services are not available (Allanson et al., 2016; Steen, 2015;

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Cousens et al., 2011). Nevertheless, a pregnancy loss can be devastating for women and their partners irrespective of the circumstances or gestation (Wenzel, 2014).

The literature acknowledges the impact an experience of perinatal death has for parents on subsequent pregnancies (Thomas et al., 2021; Lee et al., 2017; Hunter et al., 2017; Meredith et al., 2017; Gaudet et al., 2010). Adverse effects on subsequent pregnancies may include grief, post-traumatic stress disorder, anxiety and depression (Lee et al., 2017; Hunter et al., 2017). Therefore, health care professionals encountering women and families who have previously experienced perinatal loss must be aware of the significance such a loss may have on the following pregnancy, in order to provide supportive and empathetic care (Meaney et al., 2016).

To help midwives and other relevant healthcare professionals recognize and provide appropriate and optimal care to parents who have experienced perinatal loss, a review of the literature pertaining to parents' experiences of pregnancy and childbirth following perinatal loss was undertaken. By examining and synthesising literature from a number of sources knowledge gaps can be addressed to guide future practice of healthcare professionals in caring for affected parents (Majid et al., 2011).

Methodology

The aim of this integrated literature review was to explore parents' experiences of pregnancy following a previous perinatal loss, using a systematic approach pioneered by Cooper (1998) and later modified by Whittemore and Knafl (2005). An integrated review has relevance to midwifery practice as the incorporation of quantitative and qualitative evidence provides a well-balanced overview of complex issues (Dixon-Woods et al., 2006). The methods of review are presented in a five-stage process which include problem identification, literature search, data evaluation and extraction, data analysis and presentation of results (Whittemore and Knafl, 2005).

For this integrative literature review the population-outcome-exposure (PEO) framework was employed (Bettany and Saltikov, 2012), Table 1.

Systematic searches of seven electronic databases Academic Search Complete: AMED, Medline, Cinahl and Social Sciences Full Text, Psych Articles, Psych Info (EBSCO) were performed from 1st of Jan 2009–5th of Oct 2021 and an updated search was completed in January 2023 to ensure currency of findings. Once databases were accessed the Boolean method was applied in each search (Wakefield, 2014). The Boolean phrases used for the purpose of this review were; stillbirth OR loss OR perinatal death OR perinatal loss OR bereavement OR miscarriage OR intrauterine death OR intrauterine loss AND subsequent pregnancy OR subsequent birth OR pregnancy following OR current pregnancy AND experiences OR perceptions OR attitudes OR views OR feelings. Table 2 identifies the inclusion/exclusion criteria that were used to set the boundaries of this review. A hand search of the reference lists of included studies was conducted to ensure an extensive and comprehensive search (Whittemore and Knafl, 2005).

The results of the complete search are presented in Fig. 1 using the preferred reporting items for systematic reviews and meta analyses (PRISMA) format as devised by Page et al. (2021).

Table 1
PEO tool.

Population and their problem	Parents who experienced perinatal loss
Exposure	Subsequent pregnancy
Outcomes	Experiences/Views/Perceptions/Feelings

Table 2
Inclusion/ exclusion criteria.

Inclusion criteria

- Primary, peer reviewed research.
- Studies relevant to the research question.
- Studies published between 1st of Jan 2009- 27th of Jan 2023.
- Studies published in English.

Exclusion criteria

- Secondary research and non-peer reviewed studies.
- Studies which do not address the review question, e.g., experiences of health care professionals dealing with parents in pregnancies subsequent to a loss.
- Studies published before 2009.
- Studies published in languages other than English.

The first author (AA) conducted searches of seven databases which identified 290 studies for title and abstract screening. A further two studies were identified via reviewing references of the included studies. ($n = 292$). A total of 162 studies remained following exclusion of duplicates. A review of the title and abstracts of the remaining citations excluded a further 134 papers as they did not address the research question. The remaining 28 papers were subject to full text review and 7 studies were deemed to meet the review criteria. The quality of the review was enhanced by the involvement of the co-authors (BB and CC), who provided consultation around the analysis and interpretation of findings.

Data evaluation and analysis

Eligible studies were appraised using the Crowe Critical Appraisal Tool (CCAT) (Crowe et al., 2012). All seven studies achieved a quality score of 75% and above and were included in the review. The CCAT is considered a more reliable means of appraising research papers when compared to informal appraisal as it reduces the rater effect and the subject matter knowledge effect (Crowe and Sheppard, 2011).

A four-step thematic analysis of the data as described by Lucas et al. (2007) was performed and involved the extraction of data relevant to the review question from the findings section of the eligible studies. This iterative process of continually engaging with the relevant data from the primary studies was conducted by AA in consultation with BB and CC and involved the formulation of themes from each study which were synthesised to two final themes. As themes were identified the data was continuously reviewed and cross referenced by the first author to clarify the final themes, which were verified by the co-authors. This method of analysis has been critiqued for the lack of emphasis placed on research quality (Bearman et al., 2013). However, thematic analysis was used in conjunction with a quality appraisal tool (CCAT) which focused on the quality and limitations of the reviewed studies (Crowe et al., 2012).

Data extraction

The characteristics and findings of the studies included in this integrated literature review are presented in a data extraction table (Table 3) which summarises the research design, the findings of the research and limitations of the studies. Two broad themes were identified from the data which are detailed in the findings.

Findings

There were four qualitative and three quantitative studies identified which addressed the review question. The studies emanated

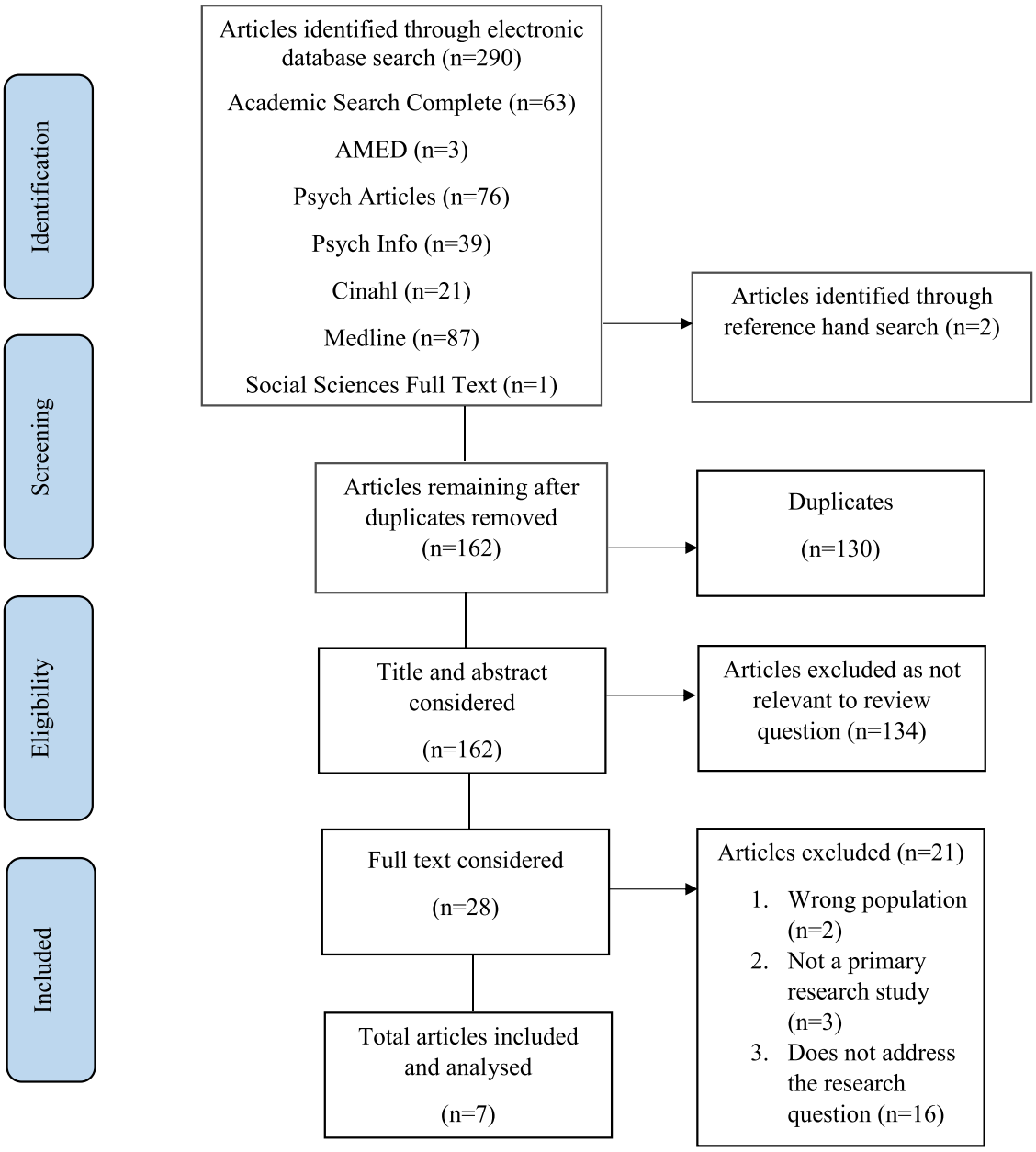

Fig. 1. Adapted PRISMA flow diagram of search results (Page et al., 2021).

from Turkey (1), UK (3), Canada (2) and France (1).The methodological approaches employed varied; three studies used interpretative phenomenological analysis (Campbell-Jackson et al., 2014; Simmons and Goldberg, 2011; Phelan, 2020), one used modified grounded theory (Lee et al., 2013), one used post-hoc power analysis (Gaudet et al., 2010),one used descriptive statistical analysis and comparative analysis (Thomas et al., 2021) and one used a cross sectional descriptive design (Yilmaz and Beji, 2013). Of the seven studies reviewed, six focused on the woman's experience of pregnancy following loss (Simmons and Goldberg, 2011; Lee et al., 2013; Gaudet et al., 2010; Yilmaz and Beji, 2013; Phelan, 2020;Thomas et al., 2021) and one study included both men and women(Campbell-Jackson et al., 2014 (n = 14, 7 women, 7 men). The number of participants across all seven studies was 652 and varied from six (Phelan, 2020) to 342 participants (Yilmaz and Beji, 2013). There were slight variations in relation to the type and definition of loss experienced in the reviewed papers. Three studies (Lee et al., 2013; Campbell-Jackson et al., 2014; Phelan, 2020) examined pregnancy subsequent to stillbirth. Two of these studies classified stillbirth as a loss after 24 weeks' gestation (Lee et al., 2013; Campbell-Jackson et al., 2014) and one study defined stillbirth as the death of an infant with a gestational age of more than 20 weeks or a weight of 500 gs or more (Phelan, 2020). Two studies (Gaudet et al., 2010; Simmons and Goldberg, 2011) examined pregnancy after perinatal loss which included early or late miscarriage, termination of pregnancy and neonatal death. Gaudet et al. (2010) examined early neonatal death including the death of an infant from birth to six days old and Simmons and Goldberg (2011) examined the death of a neonate within the first 28 days of life. Yilmaz and Beji (2013) considered perinatal loss from 20 weeks' gestation to seven days' post-partum. Thomas et al. (2021) referred in broader terms to perinatal loss as the death of a baby before or shortly after birth.

Table 3
Data extraction table.

Author Year	Title	Aim	Participants	Setting	Study Design & Data collection	Quality assurance & Limitations	Key Findings
Campbell-Jackson et al. (2014) *BMC Pregnancy and Childbirth*	A renewed sense of purpose: Mothers' and fathers' experiences of having a child following a recent stillbirth	Explore mothers and fathers experiences of pregnancy and having a child after a recent stillbirth	7 couples (14 participants) with a history of perinatal loss	United Kingdom	Phenomenological approach Semi structured interviews	Liaised with research team and credibility checks completed No limitations identified	High levels of anxiety and complex emotions were reported by both men and women. Coping strategies were employed by both groups through distraction, delaying preparation for the new-born and monitoring fetal movements and seeking reassurance. There were differences identified in the grieving process between men and women. Difficulties with prenatal attachment were reported.
Gaudet et al. (2010) *Journal of reproductive and infant psychology*	Pregnancy after perinatal loss: association of grief, anxiety and attachment	Explore women's experiences of pregnancy following perinatal loss and investigate link between distress and attachment	96 women with history perinatal loss Control group of 74 women (no history of loss)	France	Post hoc power analysis Several questionnaires which measured feelings of perinatal grief (PGS), anxio-depressive symptomology (HADS), acceptance of pregnancy, identification with maternal role (PSEQ) and perinatal attachment (MAAS)	Control group used. Validated psychological assessment tools used.	In pregnancy following perinatal loss women experienced significantly higher levels of grief and anxio-depressive symptoms. These symptoms had a negative effect on prenatal maternal attachment in comparison to the control group.
Lee et al. (2013) *Midwifery & Women's Health*	Women's decision making and experiences of subsequent pregnancy following stillbirth	Understand thoughts and feelings about pregnancy subsequent to stillbirth and influencing factors in decision making	11 women (eight of whom were pregnant)	United Kingdom	Modified grounded theory Semi structured Interviews	Constant comparative method used to clarify developing themes and credibility checks which were verified by senior author. No limitations identified.	Timing of subsequent pregnancies was influenced by aspirations of having a family, perception of coping skills, and the need to honor the stillborn infant's memory. Grief, anxiety and guilt were often reported. Strategies to cope with the complex emotions included support and reassurance, maintaining hope and protecting oneself.
Phelan (2020) *Canadian Journal of Counselling & Psychotherapy*	Experiences of pregnancy following stillbirth: A phenomenological inquiry	To identify experiences and needs surrounding pregnancy following stillbirth	6 women	Canada	Interpretive phenomenological approach Semi structured interviews	Good validation for methods used. In depth interviews to collect experiential narrative material to understand an experience with a lack of previous research material. Themes identified validated by 5 of the 6 participants Small sample size with little ethnic diversity.	Participants reported feelings of grief, isolation, anxiety, fear, guilt and hopelessness. Some saw the experience of loss as transformative. Disparities in the male and female grief process were identified. A need for frequent medical review was found as well as the importance and challenges of offering social and medical support and reassurance. Prenatal attachment was often influenced by history of perinatal loss.

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Table 3 (*continued*)

Author Year	Title	Aim	Participants	Setting	Study Design & Data collection	Quality assurance & Limitations	Key Findings
Simmons and Goldberg (2011) *Midwifery*	High risk pregnancy after perinatal loss: understanding the label	To explore women's experiences of being labelled as a 'high risk' pregnancy following perinatal loss	7 women	Canada	Phenomenological approach Semi structured interviews	Phenomenological thematic analysis	High risk label was positively embraced due to increase in surveillance and access to specialised health care professionals. Women perceived the support and information they received as essential in reassuring them and gaining a sense of control.
Thomas et al. (2021) *BMC Pregnancy & Childbirth*	Measures of anxiety, depression and stress in the antenatal and perinatal period following a stillbirth or neonatal death: a multicentre cohort study	To describe levels of anxiety, depression, stress and quality of life during pregnancy and the early postnatal period following a perinatal loss	100 women	United Kingdom	Cohort Study: Descriptive statistical and comparative analysis. Questionnaire containing the Cambridge Worry Score (CWS), Edinburg Postnatal Depression Score (EPDS, Generalised Anxiety & Depression Score 7 item score (GAD-7), EuroQoL-5 dimension (EQ-5D-5 L), EQ-5D Visual Analogue Scale and Hair Cortisol Measurements	Validated psychological assessment tools used. Did not employ a comparative design. Not all women completed questionnaires at all three time points.	Stress, anxiety, and depression was reported, with a reduction in symptoms as the pregnancy progressed. The lowest levels of stress, anxiety and depression were reported at 6 weeks postnatal. Participant's perceptions of their health and quality of life were lowest in late pregnancy and highest in the postnatal period. Hair cortisol levels were reduced in the late pregnancy compared to the first trimester.
Yilmaz and Beji (2013) *Midwifery*	Effects of perinatal loss on current pregnancy in Turkey	Explore how a history of perinatal loss affected women psychologically in subsequent pregnancy	128 women whom experienced loss previously 214 women with no history of pregnancy loss.	Perinatology Unit, Istanbul University	Quantitative cross sectional descriptive study. Questionnaire consisting of 27 questions and analysed using the prenatal attachment inventory (PAI), the center for Epidemiological studies' depression scale (CES-D) and the scales of ways of coping with stress (SWCS).	Similar sociodemographic factors in both sample groups. Results cannot be generalised to whole population.	Increased surveillance and contact with obstetrician and health care professionals following loss was experienced and valued by women in pregnancies subsequent to a loss Complex emotions including fear, anxiety, worry and hopelessness at beginning of pregnancy and throughout were reported by respondents. High depressive symptoms in pregnancy following loss were also reported. No differences in fetal attachment or ways of coping with stress between groups.

Summary of findings

Campbell Jackson et al. (2014) identified feelings of uncertainty, fear, continued grief, guilt and isolation in pregnancy following loss, noting disparities between men and women in their grieving process. Feeling misunderstood by society and health care professionals, difficulties with prenatal attachment, and a need for reassurance and more frequent monitoring of the pregnancy was reported.

Gaudet et al. (2010) found that a history of perinatal loss among women was associated with an increase in grief, anxiety and depression in subsequent pregnancies. The complexity of their emotional experiences interfered with the intensity and quality of prenatal attachment in subsequent pregnancies.

The decision to conceive following perinatal loss was influenced by a woman's aspirations to have a family, their perceived ability to cope and the need to honor the memory of the stillborn baby in Lee et al. (2013). Grief, anxiety, and guilt were commonly reported. In order to cope, support was key as well as trying to find hope and the need to protect oneself from fear of recurrent loss (Lee et al., 2013).

Phelan (2020) highlighted complex emotional challenges such as grief, anxiety, isolation, guilt, and fear of recurrent loss. Reassurance and increased monitoring from health care professionals and social support was helpful, although sometimes challenging due to a sense of hopelessness experienced by the bereaved women. Women also reported that their grief process differed from that of their partners which they found challenging. Women reported a transformative effect was also experienced by themselves and their partners, where their trauma led to positive growth and new strength (Phelan, 2020).

Simmons and Goldberg (2011) found that women appreciated access to specialist obstetric led care and increased monitoring in pregnancies following a loss. The women felt this empowered them and gave them a greater sense of control, which facilitated their coping with the risk of recurrent loss.

Thomas et al. (2021) demonstrated that women experiencing pregnancy following a previous perinatal loss reported high levels anxiety, depression, and stress. These symptoms were more significant at the beginning of pregnancy and decreased as the pregnancy progressed, with lowest levels reported in the postnatal period. Participants perceived their health status and quality of life was at a lower level in their third trimester and reported highest levels at six weeks postnatal.

Yilmaz and Beji (2013) found higher levels of complex emotions were experienced by women with a history of pregnancy loss in comparison with a control group who had not experienced a loss. These emotions included depression, fear, anxiety, and lower levels of happiness and joy. Women with a history of pregnancy loss expressed a greater desire for frequent access to monitoring in pregnancy and individualised care from health care professionals.

The findings were then analysed using a thematic analysis framework (Lucas et al., 2007) described earlier and two themes were identified: The psychosocial needs and challenges faced by previously bereaved parents in subsequent pregnancies and the need for specialist care and support in a subsequent pregnancy.

The psychosocial needs and challenges faced by previously bereaved parents in subsequent pregnancies

The first theme, psychosocial needs and challenges, was identified in all seven studies (Campbell-Jackson et al., 2014; Gaudet et al., 2010; Lee et al., 2013; Thomas et al., 2021; Phelan, 2020; Simmons and Goldberg, 2011; Yilmaz and Beji, 2013). Complex grief symptomology such as depression and anxiety were more common in women with a history of pregnancy loss (Gaudet et al., 2010; Yilmaz and Beji, 2013; Thomas et al., 2021). Anxiety was associated with a feeling of uncertainty about the infant's wellbeing in the subsequent pregnancy and the fear of recurrent loss (Lee et al., 2011; Simmons and Goldberg, 2011), which can continue once the child has been born (Campbell-Jackson et al., 2014; Phelan, 2020; Thomas et al., 2021). Concerns over how their anxiety may affect their subsequent child's wellbeing were voiced (Campbell-Jackson et al., 2014; Phelan, 2020) or how anxiety might affect their relationship with their subsequent child (Lee et al., 2013). Disparities in the grieving process and different ways of coping between men and women was challenging (Phelan, 2020), but a strengthened bond was reported by parents in two studies after experiencing the loss together (Campbell-Jackson et al., 2014; Phelan, 2020). Some men felt their grief was lesser than their partners (Campbell-Jackson et al., 2014). Challenges with prenatal bonding and attachment during the subsequent pregnancy were identified (Campbell-Jackson et al., 2014; Gaudet et al., 2010; Lee et al., 2013; Phelan, 2020). Grief continued during the subsequent pregnancy (Lee et al., 2013; Phelan, 2020) and often persisted beyond this and after the child had been born (Campbell-Jackson et al., 2014). Guilt was experienced among women who struggled to enjoy their subsequent pregnancy while simultaneously honouring the loss of their previous baby (Lee et al., 2013; Phelan, 2020) or guilt due to self-blame (Campbell-Jackson et al., 2014; Phelan, 2020).

The need for specialist care and support in a subsequent pregnancy

The second theme, the need for specialised care and support for bereaved parents during pregnancy following perinatal loss was also apparent in six of the reviewed papers. The need for more practical medical advice on how to physically prepare for a subsequent pregnancy was identified (Lee et al., 2013). Information sharing and emotional support from healthcare professionals, peer groups and partners were identified as important, in providing reassurance and coping with complex emotions, although the feelings of reassurance were sometimes transient (Lee et al., 2013; Phelan, 2020; Simmons and Goldberg, 2011). An increase in monitoring and access to specialised obstetric care was requested and valued (Phelan, 2020; Simmons and Goldberg, 2011; Yilmaz and Beji, 2013). However, inappropriate medical and psychological follow up following loss resulted in greater difficulty coping with grief in a subsequent pregnancy (Gaudet et al., 2010). In addition, an absence of sensitive and knowledgeable health care professionals compounded complex negative emotions experienced and further challenged the transition to parenthood for bereaved parents in a subsequent pregnancy (Campbell-Jackson et al., 2014). Unhelpful societal opinions and a lack of awareness of the significance of the loss also hindered bereaved parents' adjustment to a subsequent pregnancy (Campbell-Jackson et al., 2014; Lee et al., 2013; Phelan, 2020).

Discussion

The experience of pregnancy following a perinatal loss is individualised and may evoke a number of challenges for bereaved parents. An understanding of parents emotional and specialised care needs is essential for health care professionals to help alleviate these challenges which parents may experience in a subsequent pregnancy following a loss.

One of the issues articulated within the review was the complex continued grief symptomology and associated depression and anxiety, experienced by bereaved parents in subsequent pregnancies (Campbell-Jackson et al., 2014; Gaudet et al., 2010; Lee et al., 2013; Thomas et al., 2021; Phelan, 2020; Simmons and Goldberg, 2011; Yilmaz and Beji, 2013). This phenomenon of continued grief was also highlighted by Tseng et al. (2017), who found that although the acute level of grief at the time of loss decreased in

intensity at three months and six months, there was no significant difference in grief intensity between 6 and 12 months post loss (Tseng et al., 2017). Similarly, a study by Krosch and Shakespeare-Finch (2017) reported high to moderate levels of grief and post-traumatic stress, over four years after perinatal loss. Considering that many women will conceive again within the year following loss (Lee et al., 2013), it is likely that these women may be experiencing juxtaposing emotions of grief and simultaneous joy in their subsequent pregnancies. It is therefore important that midwives and relevant health care providers be aware of this and provide appropriate, sensitive, and empathetic care.

Campbell-Jackson et al. (2014) identified disparities in the grieving process experienced by men and women. Phelan (2020) agreed, with bereaved women experiencing relationship difficulties which they attributed to gender differences in their grieving. However, most felt that navigating the challenging experience of loss also strengthened their relationship with their partners (Phelan, 2020).In addition, men did not report the same level of debilitating worry and anxiety as their partners during a subsequent pregnancy (Campbell-Jackson et al., 2014). Armstrong (2004) likewise indicated higher level of depressive symptoms among women pregnant following perinatal loss in comparison to their male partners. When grief is not experienced by both partners in tandem, anxiety and depressive symptoms may be exacerbated in women due to perceptions of a lack of understanding by their partners and feelings of isolation (Badenhorst and Hughes, 2007). Evidence that suggests men are not affected as profoundly as their partners when loss is experienced may relate to men expected to play a supportive role for their partners, with their own mourning often postponed (Martínez- Serrano et al., 2019; Jones, K et al. (2019); Obst et al., 2021). Emotional recognition of loss is often desired by fathers but entangled with the notion of masculinity and the need to be perceived as strong and supportive (Rosenberg, 2009). A father's grief may be overlooked due to societal beliefs that grief following stillbirth is less significant for men than women (Bonnette and Broom, 2012) and the supportive role many men adopt (Martínez-Serrano et al., 2019; Jones, K et al. (2019)). Midwives and healthcare professionals therefore need to recognize possible gendered grieving processes. An awareness of the potential for different grieving processes according to gender may facilitate healthcare providers to deliver individualised care. However, it may be challenging to adequately counsel and care for men as their focus on their practical responsibilities may mask or obscure expression of their grief (Obst and Due, 2019).

Depressive symptoms may be influenced by the gestation at the time of loss or the type of perinatal loss experienced. Therefore, the grief intensity in a subsequent pregnancy following loss may also be influenced. Gaudet et al. (2010) for example reported increased grief and depression experienced by women who have experienced loss in later gestations, with women who experienced a neonatal loss having higher depression scores. These findings are also reflected by Hunter et al. (2017) and Vance et al. (1995) where the type of perinatal loss affected the experience of depression, with women experiencing neonatal loss more likely to experience depression than those experiencing a loss at an earlier gestation. Maternal identity following a stillbirth is often unacknowledged by society and consequently disenfranchised grief is commonly reported (Burden et al., 2016). This disenfranchised grief may also be experienced by women following loss at an earlier gestation. Rowlands and Lee (2010) found that family members, society and health care providers often failed to acknowledge the emotional impact of miscarriage on the grieving women. This lack of social support and understanding resulted in women feeling isolated and exacerbated their grief further. However, Mills et al. (2014) suggest that grief does not differentiate between gestation and age, whether a stillbirth or a later infant/child death, with a profound sense of grief experienced regardless.

High levels of pregnancy specific anxiety amongst women during pregnancy following perinatal loss is reported across the studies (Lee et al., 2013; Gaudet et al., 2010; Campbell-Jackson et al., 2014; Phelan, 2020;Thomas et al., 2021). This finding is consistent with earlier literature with increased anxiety more prevalent in women with a history of pregnancy loss (Armstrong and Hutti, 1998; Wallerstedt et al., 2003; Cote- Arsenault and Mahlangu, 1999; Cote-Arsenault, 2003; Cote- Arsenault and Dombeck, 2001). Nansel et al. (2005) found that the anxiety among women previously bereaved stemmed from their lack of belief in the physiological process of pregnancy and reduced confidence in their ability to achieve a healthy pregnancy. Bereaved parents' perceptions of pregnancy as a time of anxiety and fear of recurrent loss are juxtaposed with that of a society which perceives pregnancy as a natural process (Meaney et al., 2016; Lee et al., 2013). As the pregnancy progressed, Thomas et al. (2021) found that levels of anxiety began to reduce. Campbell- Jackson et al. (2014) found that this reduction in anxiety was associated with a greater acceptance of uncertainty. This is confirmed by Fertl et al. (2009) who found that anxiety and pregnancy related fear was higher in women with a history of pregnancy loss, peaking in the first trimester and gradually declined as the pregnancy progressed. However, Phelan (2020) found that for many participants, anxiety did not resolve following the birth of a subsequent child with women often worried about the impact their anxiety would have on their subsequent child during and following pregnancy. An increase in anxiety due to a history of perinatal loss may also result in an increase in vigilance and caution among women and therefore improve pregnancy outcomes (Fertl et al., 2009). Earlier research suggests that pregnancy for some women following loss can actually alleviate anxiety and have a positive effect on their psychological wellbeing, including fulfilment of their desire to have a baby and addressing fertility concerns (Turton et al., 2006; Theut et al., 1990).

Knowledge and information sharing such as receiving post-mortem results helped parents to understand the likelihood of a recurrent loss in a subsequent pregnancy (Lee et al., 2013). Likewise, a lack of knowledge or information can exacerbate the sense of hopelessness women experience in subsequent pregnancies, e.g., when the cause of stillbirth is unknown (Phelan, 2020). Debriefing following perinatal loss and pre-pregnancy counselling, including practical information from medical professionals was identified as being helpful for parents considering a subsequent pregnancy (Meaney et al., 2016). Women in Phelan's (2020) study identified the need for more tailored pre pregnancy counselling following perinatal loss. This discussion may be appropriate at an early stage and healthcare professionals should anticipate this and be responsive to the parent's needs (Dyer et al., 2019). Medical professionals have been criticised for not meeting the emotional needs of individuals following loss and deficient information giving to these women on planning future pregnancies has been reported (Rowlands and Lee, 2010). Jones (2019) recommended that all parents are provided with structured follow up after perinatal loss with counselling regarding future treatment options and psychological support which follows through to the subsequent pregnancy. This continuity from health care specialists ensures that care is tailored to specific clinical and emotional needs as requested by women in Phelan's (2020) study. Robson and Leader (2010) likewise, recommended continued follow up for women following a perinatal loss into the subsequent pregnancy. These authors suggest that this follow up may offer the opportunity to identify and correct potential risk factors, reducing the risk of recurrent loss and address the associated fear and anxiety experienced by women. A word of caution however,

counselling couples on the risk of recurrent loss may be challenging if the cause of the previous loss is unknown.

Access to specialised care and an increased level of monitoring and surveillance had a positive effect on women's perceptions of quality of care in pregnancy subsequent to perinatal loss (Simmons and Goldberg, 2011; Lee et al., 2013; Phelan, 2020). Participants, valued for example, being transferred to a high-risk antenatal clinic as they felt they had greater access to specialised care and monitoring of their pregnancies. This women felt, optimised their chances of a healthy pregnancy and increased their sense of control (Simmons and Goldberg, 2011). Likewise, Meredith et al. (2017) found that women, able to access specialised clinics in pregnancies after experiencing a previous loss, reported high levels of satisfaction with the care they received. These women also appreciated the emotionally supportive relationship offered by specially trained health care practitioners within this clinic (Meredith et al., 2017). In contrast to these findings Stahl and Hundley (2003) suggested that labeling a pregnancy as high risk following a previous pregnancy loss may cause parents to be concerned for the infant's wellbeing. Women derived the greatest solace from ultrasound scans, perceived as more tangible evidence of fetal wellbeing (Simmons and Goldberg, 2011). In contrast, Phelan (2020) found that ultrasounds may induce anxiety for some women due to an association of an ultrasound with the previous loss, a view corroborated by Jones, K et al. (2019). Wojcieszek et al. (2018) reported an increase in antenatal visits and frequent ultrasound scans, but women rarely had additional emotional support in pregnancy subsequent to loss. Similarly, Mills et al. (2014) found that where guidelines existed for the provision of care in pregnancy following loss, greater emphasis was placed on increased monitoring than psychological care and support. However, within this review women expressed satisfaction with interventions and support provided by healthcare professionals, which alleviated their anxiety and contributed to their own sense of control (Simmons and Goldberg, 2011; Lee et al., 2013; Phelan, 2020).

Confident, competent health care professionals who delivered compassionate care were highly valued in this review. Women were more confident in subsequent pregnancies when their care givers had experience of dealing with complex pregnancies (Simmons and Goldberg, 2011). Supporting this, parents felt misunderstood when cared for by health care professionals who lacked experience or knowledge of stillbirth, adding to parents' feelings of isolation (Campbell-Jackson et al., 2014). Jones (2019) suggests that the quality of care experienced by bereaved parents can deteriorate due to insensitive and dismissive attitudes of health care professionals. This was supported by Cullen et al. (2017) who found that a lack of empathy and insensitive terminology used by health care professionals added to parents' distress following a loss. Conversely, Smith et al. (2020) found that empathetic health care professionals who used appropriate terminology positively impacted complex grief emotions in bereaved parents. Staff who are inexperienced may distance themselves from providing care to those who have suffered a loss, further compounding the situation (Hughes and Goodhall, 2013), perhaps contributing to the bereaved parents feeling dismissed or their loss unacknowledged Jones, K et al. (2019). Midwives corroborated that inexperience and lack of clinical skills prevented them providing appropriate care for families experiencing perinatal loss (Sheehy and Baird, 2022). Midwives suggested that this was as a result of lack of clinical exposure to loss and limited education on perinatal loss in their undergraduate education (Sheehy and Baird, 2022). The participation of midwifery students in bereavement workshops supported them in building confidence and self-awareness in providing bereavement care (Doherty et al., 2018). Specialist bereavement midwives play an important role in supporting bereaved parents through subsequent pregnancies and supporting and educating health care professionals in caring for these parents with specific emotional needs (Power et al., 2017). Hughes (2013) however recommend training and support to address the needs of bereaved parents should be available to all midwives, who are the key healthcare professionals providing care for these women. It was noted that limited research has explored health care professionals' knowledge and competence to provide psychological care to women during a pregnancy subsequent to a loss.

Implications for practice

The review revealed complex psychosocial needs and challenges as well as specialist care needs experienced by parents in pregnancy following loss. The findings have significant implications for maternity services, education and training and for future research.

Women should receive early debriefing following loss that continues throughout the postnatal period and encompasses pre pregnancy and antenatal counselling and practical information. This information sharing and emotional support from pregnancy loss to the birth of a subsequent child could help to navigate psychosocial challenges such as grief, depression, anxiety and fear of recurrent loss.

Health care professionals must acknowledge and validate previous perinatal loss and have an informed understanding of the profound psychosocial impact this has on parents in a subsequent pregnancy. Bereavement education and training for all health care professionals who care for women and their families at the time of loss as well as during a subsequent pregnancy will ensure clinical competence as well as emotional sensitivity. Specialist bereavement leads may also support health care professionals to deliver sensitive and empathetic care to previously bereaved families.

Specialist care pathways specific to pregnancy subsequent to a loss may be useful in guiding practice for both health care professionals and families. Pathways should be individualised and responsive to parent's needs offering an increase in monitoring and additional support in pregnancy following perinatal loss which could reduce the debilitating anxiety and facilitate coping.

It is essential that further research is carried out exploring parents' experience of pregnancy following a previous perinatal loss given the few studies available for review. Further investigation of midwives experiences of providing care to these families may help determine midwives' education and training needs and ultimately enhance the care provided to women and their partners.

Conclusion

In conclusion, the complex emotional and practical challenges facing parents in pregnancy following perinatal loss has been summarised in this review of the literature. A blend of support and specialised support may help alleviate stress and anxiety for these women and their partners and facilitate the development of coping mechanisms. These findings can contribute to the development of guidelines and individualised care pathways within maternity services which could enhance the quality of care these women receive. Awareness of the heighted sense of anxiety among these women and their partners, often complicated by continued grief for their previous loss can facilitate appropriate interventions including counselling to alleviate concerns and potentially minimize risk (Robson and Leader, 2010).

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CRediT authorship contribution statement

Gemma Donegan: Conceptualization, Methodology, Formal analysis, Writing – original draft, Writing – review & editing. **Maria Noonan:** Supervision, Formal analysis, Writing – review & editing. **Carmel Bradshaw:** Supervision, Formal analysis, Writing – original draft, Writing – review & editing.

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