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Exploring parents' experiences and holistic needs following late miscarriage: a narrative systematic review

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ABSTRACT

Background: Up to 2% of all pregnancies result in pregnancy loss between 14 + 0 and 23 + 6 weeks' gestation, which is defined as 'late miscarriage'. Lack of consensus about definition of viability paired with existing multiple definitions of perinatal loss make it difficult to define the term 'late miscarriage'. Parents who experience late miscarriage often have had reassuring scan-milestones, which established their confidence in healthy pregnancy progression and identity formation, which socially integrates their baby into their family. The clinical lexicon alongside the lack of support offered to parents experiencing late miscarriage may disclaim their needs, which has potential to cause adverse psychological responses.

Aim: To review what primary research reports about parents' experiences and their perceived holistic needs following late miscarriage.

Methods: A narrative systematic review was carried out. Papers were screened based on gestational age at time of loss (i.e. between 14 + 0 and 23 + 6 weeks' gestation). The focus was set on experience and holistic needs arising from the loss rather than its clinical care and pathophysiology. Studies were selected using PRISMA-S checklist, and quality assessed using the *Critical Appraisal Skills Program* (CASP) tool. Thematic analysis was used to guide the narrative synthesis of findings.

Results: Six studies met the inclusion criteria. Three main themes emerged: communication and information-giving; feelings post-event; and impact of support provision.

Conclusion: Literature about the experience of late miscarriage is scarce, with what was found reporting a lack of compassionate and individually tailored psychological follow-up care for parents following late miscarriage. Hence, more research in this arena is required to inform and develop this area of maternity care provision.

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KEYWORDS

Late miscarriage; second trimester pregnancy loss; perinatal loss; systematic review; perinatal bereavement

Introduction

The loss of a baby during pregnancy represents a deeply emotional and traumatic event for women, partners and families (Bilardi et al., 2021; Simmons et al., 2006). Maternity care is bound by ethical boundaries and in particular age of viability, which

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is dictated in the UK *by law* (Human Fertilisation and Embryology Act, 1990), with viability defined by gestational age, fetal weight and signs of life (Pignotti, 2010). Between countries, there is no universal consensus regarding fetal viability, with the World Health Organization (WHO) setting the threshold at 22 + 0, and the UK at 24 + 0 weeks' gestation (Human Fertilisation and Embryology Act, 1990; Quenby et al., 2021). Extending from the concept of *viability* originates a broad vocabulary surrounding definitions, which includes perinatal loss, postnatal death, stillbirth and miscarriage (MBRRACE-UK, 2021). Although necessary, such vocabulary may not align with the feelings or expectations of those who are suffering perinatal loss (Cullen et al., 2017; Smith et al., 2020). Consequently, some parents who have their experience labelled as 'late miscarriage' may struggle to recognise their experience as 'fitting' into a particular category.

Late miscarriage

In the UK, miscarriage is defined as loss of a baby before 24 completed weeks' gestation (Royal College of Obstetricians and Gynaecologists, 2016), with incidence reported to be around 30% of all pregnancies (Wang et al., 2003). Most perinatal losses occur before 13 + 6 weeks' gestation and are referred to as 'early miscarriage' (Royal College of Obstetricians and Gynaecologists, 2016). In contrast, 'late miscarriage' occurs less frequently and is defined as loss of a baby between 14 + 0 and 23 + 6 weeks' gestation (Royal College of Obstetricians and Gynaecologists, 2016), with incidence varying from 0.6% to 2% of all pregnancies (Mulvihill & Walsh, 2014; Royal College of Obstetricians and Gynaecologists, 2016). The experience of visually 'meeting the baby' at the first scan instigates early bonding, and can help develop fetal identity and presence as a new member of the family (Ramos Guerra et al., 2011; Roberts, 2012; Skelton et al., 2023). Hence, when miscarriage occurs following one or multiple scans, lack of formal death certification and use of certain terminology may reject established child identity (National Bereavement Care Pathway Scotland, 2020; Smith et al., 2020). In particular, failure to acknowledge fetal identity following late miscarriage may contribute towards developing psychological sequelae. With this in mind, the aim was to review what primary research reports about parents' experiences and their perceived holistic needs following late miscarriage.

Method

A narrative systematic review was carried out to explore what primary research reports about parents' experiences and holistic needs following late miscarriage. This method was selected to evaluate studies of different methodological nature, with a view to including papers that capture quantitative, qualitative and mixed-methods approaches. It was deemed appropriate to perform a literature review in a

Table 1. Concepts and synonyms.

Subject	Late miscarriage	Experience	Needs	Type of research
Woman/ Mother	Foetal/Fetal death Perinatal death	Trauma Grief	Support Peer Support	Quantitative Qualitative
Parents	Spontaneous miscarriage	Perinatal	Counselling	Mixed-methods
Not Father (only)	Not Termination of pregnancy for lethal anomaly Not Stillbirth Not Early miscarriage Not Foetal/Fetal loss at limit of viability defined by foetal/ fetal weight Not Extremely Preterm baby born alive Not Risk Factors Not Aetiopathogenesis	Bereavement PTSD Depression Anxiety Stress Not Recurrent Miscarriage Not Infertility Not Assisted Reproduction Treatment Not Pregnancy following pregnancy loss	Psychotherapy Compassionate care Not Physical clinical needs such as lactation suppression	Peer-reviewed Primary Research Not Grey Literature such as opinion pieces, books chapters Not Dissertations

systematic manner and conduct a narrative synthesis of its findings as described by Popay et al. (2006) (CASP, 2018; Noyes et al., 2019).

Sampling the literature

Concept mapping was chosen as the starting point in developing the search strategy (Booth et al., 2022), with the iterative nature of concept mapping resulting in development of a table of concepts and synonyms (Table 1).

The search strategy was refined according to critical discussion between the primary researcher, two senior researchers and a subject librarian. A final list of inclusion and exclusion criteria was established (Xiao & Watson, 2019) (Table 2). Specifically, this literature review focused upon:

- Pregnancy loss between 14 + 0 and 23 + 6 weeks’ gestation, regardless of the lexicon used to describe it (miscarriage, stillbirth or pregnancy loss).
- Studies which investigated the *experience and needs* of parents who suffered such loss and not the physical clinical management or risk factors which may have led to a late miscarriage.

Search strategy

Electronic searches were performed and updated between 3 November 2021 and 28 March 2023. Searches were performed on relevant bibliographic databases from the platform EBSCOhost: CINAHL with full text, Medline, PsycInfo and Psychology and Behavioural Sciences Collection. The searches on single themes were saved and combined using Boolean operators (Table 3), with subsequent searches run through the different databases with necessary adjustments made.

Table 2. Inclusion and exclusion criteria.

Aspect	Inclusion	Exclusion	Rationale
Year of publication	Studies from 1990	Studies prior to 1990	The terms of viability were reviewed and amended (from 28 weeks to 24 weeks) in the review of the Human Fertilisation and Embryology Act (1990) Author only fluent in those languages
Language of publication	English/Italian	Any other languages	
Country study performed in	Any country	None	To analyse studies from as many different cultural backgrounds as possible
Type of research	Primary research	Non-primary research	To only analyse studies whose data has been collected from the original source
Methodology	Any: qualitative, quantitative or mixed	None	To identify a comprehensive number of studies constructed on different approaches
Quality of study	Peer-reviewed	Non-peer-reviewed	To analyse only high-quality studies
Population/demography of the study	Women/couples experiencing pregnancy loss between 14 + 0 and 23 + 6 weeks of gestation.	Women/couples experiencing pregnancy loss: <ul style="list-style-type: none"> ● Up to 13 + 6 weeks of gestation ● After 24 + 0 weeks of gestation. and Midwives'/Clinicians' perspective Fathers' perspective only	To investigate the population identified in the research question
Focus of study	Focus on either: <ul style="list-style-type: none"> ● the lived experience of late miscarriage ● the psycho-social consequences of late miscarriage from the parents' perspective ● the psychosocial interventions and treatment in support of those families and their outcomes 	Focus on: <ul style="list-style-type: none"> ● physical outcomes following late miscarriage ● risk factors for late miscarriage ● clinical management and treatment of late miscarriage ● late miscarriage in the context of recurrent pregnancy loss ● TOP for fetal anomalies ● Perinatal loss/bereavement studies where less than 50% participants had a late miscarriage or where the gestational age at time of loss was unspecified. ● Pregnancy following miscarriage 	To focus on the relevant studies identified by the research question

Table 3. Literature search strategy.

Miscarriage (14–23 + 6 weeks)	Type of support	Outcomes from miscarriage experience	Subject
(MH 'Abortion, Spontaneous') OR 'Miscarriage' OR (MH 'Perinatal Death') OR 'Fetal loss'	(MH 'Midwives') OR (MH 'Counseling Service (Saba CCC)') OR (MH 'Bereavement Support (Saba CCC)') OR (MH 'Psychosocial Care (Saba CCC)') OR (MH 'Peer Group') OR (MH 'Support Groups') OR (MH 'Psychology') OR (MH 'Psychotherapy') OR (MH 'Psychoanalysis') OR (MH 'Patient Centered Care') OR (MH 'Holistic Care') OR (MH 'Support, Psychosocial')	(MH 'Trauma') OR (MH 'Psychological Trauma') OR (MH 'Stress, Psychological') OR (MH 'Grief') OR (MH 'Bereavement') OR (MH 'Stress') OR (MH 'Life Change Events')	
miscarriage or abortion spontaneous or pregnancy loss or fetal loss or foetal loss or second trimester miscarriage or 2nd trimester miscarriage or late miscarriage or perinatal loss	Counsel*or therap* or psychotherapy* or treatment or psycholog* or CBT or cognitive behavior* therapy or cognitive behavior* treatment or compassionate care or compassion or CMT or compassionate mind training or Eye Movement Desensitization Reprocessing Therapy or EMDR therapy or psychoanalysis	trauma or ptsd or post-traumatic stress disorder or traumatic events or traumatic experience* or grief or loss or perinatal bereavement or anxiety or depression or stress or mental health or wellbeing or well-being or well-being or psychological trauma	+ (woman or women or mother* or parents) OR TI (woman or women or mother* or famil* or parents) OR AB (woman or women or mother* or famil* or parents)

Table 4. Articles found by databases.

Database	Articles found	Potentially relevant
CINAHL	800	334
Medline	712	66
PsycInfo	452	216
Psychology and Behavioural Science Collection	216	78
	Tot: 2180	Tot: 694

The resulting 2180 studies were further assessed for relevance based on title/abstract and duplicates articles were removed (Table 4).

Study selection

The remaining articles were further screened by the primary researcher to assess eligibility based on gestational age (between 14 + 0 and 23 + 6 weeks of gestation). As a result, a further 252 studies were found not relevant based on title/abstract only. The 442 articles left were assessed by the primary researcher and discussed with two senior researchers in the research team. The screening process is described in Table 5.

Table 5. Categories identified from screening process.

Categories	Description	Number of articles
Relevant	Articles which refer to late miscarriage as: <ul style="list-style-type: none"> ● pregnancy loss between 14 + 0 and 23 + 6 weeks of gestation ● 50% or more of the participants had pregnancy loss between 14 + 0 and 23 + 6 weeks of gestation. 	6
Miscarriage	Articles referring to miscarriage such as: <ul style="list-style-type: none"> ● early miscarriage (up to 13 + 6 weeks of gestation) ● gestation unspecified ● mean gestational age at loss before 14 + 0 weeks 	29
Stillbirth	Articles referring to stillbirth such as: <ul style="list-style-type: none"> ● gestation unspecified ● more than 50% of participants had loss after 24 + 0 weeks ● mean gestational age at time of loss after 24 + 0 weeks 	44
Perinatal loss	Articles referring to perinatal loss such as: <ul style="list-style-type: none"> ● gestation unspecified ● more than 50% of participants had loss before 14 + 0 weeks, or after 24 + 0 weeks, or postnatally ● mean gestational age at time of loss outwith late miscarriage gestational age bracket 	96
Physical not Psychological	Articles which focus on the physical physiopathology, risk factors, clinical care outcomes and clinical follow-up of miscarriage.	23
Clinician perspective	Articles which explore the effects of miscarriage from the clinicians' (midwives, obstetricians, nurses) point of view.	31
Non-primary research	Articles such as literature reviews, book chapters, guidelines and protocols.	38
Dissertations	Articles which refer to dissertations, therefore not peer-reviewed.	30
Recurrent miscarriage	Articles which explore the psychosocial effect of recurrent miscarriage (3 or more miscarriages) with unspecified gestation at time of loss.	15
TOP for lethal anomaly	Articles which explore the psychosocial effect of TOP for lethal anomaly, with or without mention of gestational age.	2
Grey literature	Articles such as specialised magazines pieces, opinion pieces, pamphlets, interviews, personal accounts, web pages.	102
Pregnancy following loss	Articles which explore the psychosocial effect of the subsequent pregnancy following a loss with or without mention of gestational age at time of loss.	21
Fathers only perspective	Articles which explore the psychosocial effects of miscarriage from the fathers' point of view only.	1
Not found	Articles not found despite being requested through the Interlibrary Loans system of Edinburgh Napier University.	4

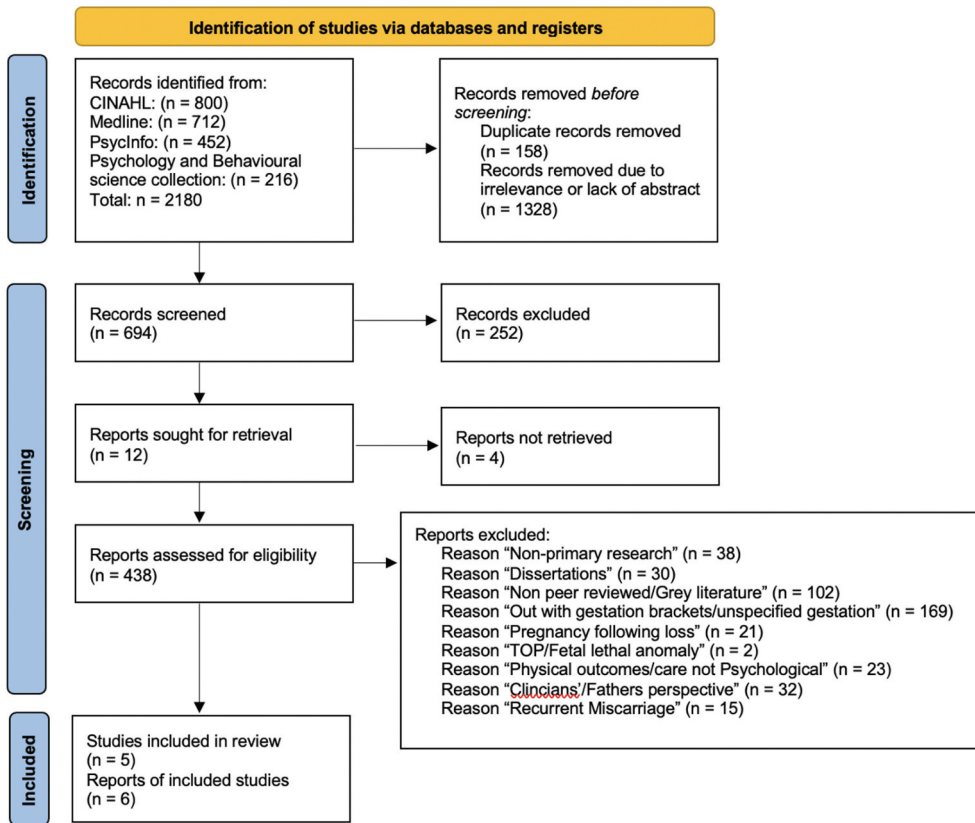
To retrieve potential additional relevant articles the reference lists of the studies selected were also screened.

To ensure clarity, validity and auditability of paper selection, the PRISMA-S checklist in conjunction with PRISMA 2020 process was charted (Page et al., 2021; Rethlefsen et al., 2021), which resulted in development of a PRISMA flow diagram (Figure 1).

Quality assessment

The Critical Appraisal Skills Program (CASP) was chosen to appraise quality of selected studies, because it provides checklists designed to assess both qualitative and quantitative methods (CASP, 2022).

The 'CASP Qualitative Studies Checklist' was used for five qualitative studies and the 'CASP Cohort Study Checklist' for one quantitative study included. The papers selected were found to be of moderate to high quality. All papers adequately articulated the relevance of the topic addressed. Four out of the six papers explicitly stated the aim of the research.



From: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *BMJ* 2021;372:n71. doi: 10.1136/bmj.n71

Figure 1. Prisma flow diagram.

All studies used appropriate methodologies and gained the local ethics committee’s approval. Four out of the five qualitative papers omit to critically evaluate the role of the researcher in relation to the formulation of the study design, the recruitment of participants and the events related to data collection and/or analysis. Only one paper mentions researcher reflexivity practices. Three papers were considered of high quality and three were considered of moderate quality.

Method of narrative synthesis of findings

The narrative synthesis of findings was performed following the steps described by the Economic and Social Research Council (ESRC) (Popay et al., 2006), which includes:

- A preliminary synthesis of data in the form of tabulation guided by the CASP checklist (Table 4).

Table 6. Appraisal of articles selected following CASP qualitative studies and CASP cohort study checklists.

Author, title, date, location.	Participants	Aims	Method	Findings	Value
Cullen, S., Coughlan, B., McMahon, A., Casey, B., Power, S., & Brosnan, M. Parents' experiences of clinical care during second trimester miscarriage. 2018 Ireland	Sample size: 14 parents - 9 mothers and 5 fathers. Recruitment strategy: Purposive sampling. Parents contacted 6-24months following second trimester miscarriage. Bereavement midwife contacted families and obtained consent to provide information to researcher. Researcher obtained consent form prior to interview. Recruitment continued until data saturation achieved.	Aim: explore parents' experience of second trimester miscarriage clinical care from diagnosis through to follow up Rationale: assess if existing literature on perinatal loss relates to the experience of second trimester miscarriage Relevance: expand knowledge of experience of second trimester miscarriage.	Method: Qualitative Design: Ethnography Data collection: Semi-structured interviews audio recorded and transcribed verbatim. Bias/Reflexivity: Researcher kept reflective diary to reduce bias. There is mention of ethical values of research process. Ethical considerations: Ethical approval obtained from both Hospital and University committee. There is evidence of protocol to support participants in case of emotional distress.	Data analysis: Thematic network to extract basic themes, organising themes and global themes. Focus: 'Clinical care needs' Clear statement of findings: Five organising themes are listed: 'medical treatment received during the miscarriage', 'pain relief', 'length of hospital stay', 'going home to prepare for the delivery' and 'follow-up appointment'. Discussion of findings: Each organising theme is discussed reporting participants own words and against available literature. -Effective analgesia for labour and birth in second trimester. -Waiting at home for induction of labour adds to psychological stress and trauma. Also, gives chance to come to terms with loss and prepare for birth. -Reason for miscarriage and clear communication gives parents sense of closure. -Value of being cared for in an area away from crying babies.	Relationship with existing knowledge: findings concur with those of previous studies in regards of pain relief options, waiting time before induction of labour, clear communication and being separate from crying babies. Applicability to different population: study conducted in one hospital in Ireland. Caution is advised in applying finding in other contexts. Implications for further research: suggested further research on pain relief options and parents' experiences of going home after diagnosis of second trimester miscarriage. Limitations: study conducted in one hospital in Ireland. Researcher experience as influencing factor in analysis – reflexivity practices mentioned.

(Continued)

Table 6. (Continued).

Author, title, date, location.	Participants	Aims	Method	Findings	Value
Mulvihill, A., & Walsh, T. Pregnancy loss in rural Ireland: An experience of disenfranchised grief. 2014 Ireland	<p>Sample size: 8 participants. 10 initial volunteers, 2 withdrew.</p> <p>Recruitment strategy: Purposive sampling stratified according to gestation.</p> <p>Participants information: participants demographic information such as: age, gestational age at time of loss, marital status, existing children/previous pregnancy loss, occupation reported. 50% of participants (4) had late miscarriage (between 15 and 19 weeks of gestation).</p>	<p>Aim: understand pregnancy loss through constructivist epistemology approach.</p> <p>Rationale: obtain better understanding of 'essential nature' of pregnancy loss.</p>	<p>Method: Qualitative</p> <p>Design: Interpretative Phenomenological Analysis (IPA)</p> <p>Data collection: Semi-structured interviews audio recorded and transcribed verbatim.</p> <p>Bias/Reflexivity: Not mentioned.</p> <p>Ethical considerations: Ethical approval obtained from Hospital involved in the study.</p>	<p>Data analysis: Thematic findings following IPA approach.</p> <p>Clear statement of findings: Three dominant themes are listed: 'communication', 'hospital's physical environment' and 'presence of disenfranchised grief'.</p> <p>Discussion of findings: Each theme is discussed and explored reporting participants own words and against available literature.</p> <p>-Communication: sensitivity in breaking bad news, timely provision of information, professionals not aware of history.</p> <p>-Hospital physical environment: preferences re Ward type, lack of privacy as additional stressor, waiting areas shared with pregnant women</p> <p>-Disenfranchised grief: social isolation as people feel unable to breach the topic of loss, managing grief with the partner support, coping with other pregnant women in their network.</p> <p>-Follow up support: all participants received medical follow up. Only 1 participant received emotional support following discharge. The majority of participants wishes for structured emotional follow up support.</p>	<p>Relationship with existing knowledge: findings concur with those of previous studies in regards of empathetic communication, appropriate information giving, disenfranchised grief, meaning of pregnancy more significant than length of pregnancy, effect of other pregnant women in patient network, emotional follow-up to normalise grief responses.</p> <p>Applicability to different population: study conducted in one hospital in Ireland. It is suggested that all Irish hospitals should offer support following pregnancy loss.</p> <p>Implications for further research: Not mentioned.</p> <p>Limitations: study conducted in one hospital in Ireland. Voluntary participation: participation is more likely from whom had overall positive experience rather than negative. Only women experience.</p>

(Continued)



Table 6. (Continued).

Author, title, date, location.	Participants	Aims	Method	Findings	Value
Corbet-Owen, C., & Kruger, L.-M. The health system and emotional care: Validating the many meanings of spontaneous pregnancy loss. 2001 South Africa	<p>Sample size: 8 participants. English or Afrikaans speakers. Recruitment strategy: Purposive sampling. Participants were recruited to represent a range of different circumstances including 3 participants who described the pregnancy as 'unwanted'. Health professionals' referral and individuals requesting to participate as a result of word of mouth. Participants completed biographical questionnaire and informed consent form. Participants information: participants demographic information reported in 2 tables.</p> <p>Table 1: age, race, home language, religious context, financial class, marital status Table 2: age at time of loss, number of children, desire for pregnancy, plans for pregnancy, reported quality of relationship with partner, number of losses, sex of child lost, stage of pregnancy at loss. 5 participants (62.5%) reported loss between 16 and 24 weeks of gestation)</p>	<p>Aims: determine the meaning of pregnancy loss had for participants, explore their emotional need following loss, assess if and how health professional recognise and address those needs. Rationale: explore how women in particular social contexts construct their experiences of pregnancy loss. Relevance: expand knowledge of patient experience and on doctor-patient relationship in the context of pregnancy loss.</p>	<p>Method: Qualitative Design: Social Constructionist Theory Data collection: open-ended interviews with added specific questions regarding their interaction with medical personnel. Interviews were audio recorded and transcribed verbatim. Bias/reflexivity: Afrikaans interviews translated in English and translated back to Afrikaans by a different translator to ensure accuracy. Reflexivity not mentioned. Ethical considerations: No mention of Ethical approval obtained. There is evidence of resources to support participants in case of emotional distress. One patient referred for psychological counselling following the interview.</p>	<p>Data analysis: Constructionist grounded theory approach. Steps of coding described. Clear statement of findings: Three themes are explored: how participants understood and experienced pregnancy and pregnancy loss, participants' emotional needs and the role of medical personnel in fulfilling those needs. Discussion of findings: Each theme is discussed and explored reporting participants own words and against available literature. -Emotional impact of pregnancy and pregnancy loss: Difference between wanted and unwanted pregnancy: motherhood as part of identity, loss associated with sense of 'being defective', guilt and failure reported in the context of couple. Unwanted pregnancy: pregnancy as a joyless event sometimes related to abusive/unhappy relationship, loss accepted with relief but also shame and regret, taboo of not being happy about pregnancy. Immediate needs from medical personnel: validation of feelings, avoid assumptions, feeling disempowered, information as a tool for empowerment, need for compassion. Women's Long term: mourning the loss, creating memories, instilling hope, need for connection, search for meaning.</p>	<p>Relationship with existing knowledge: findings concur with those of previous studies regarding the need for clinicians to provide sensitive, compassionate without making assumptions. Applicability to different population: participants not representative of a specific community or of women in general. Implications for further research: Similar study may be conducted on other communities of women. Limitations: not all participants had a late miscarriage.</p>

(Continued)

Table 6. (Continued).

Author, title, date, location.	Participants	Aims	Method	Findings	Value
Cullen, S., Coughlan, B., Casey, B., Power, S., & Brosnan, M. Exploring parents' experiences of care in an Irish hospital following second-trimester miscarriage. 2017 Ireland	<p>Sample size: 14 parents - 9 mothers and 5 fathers.</p> <p>Recruitment strategy: Purposive sampling.</p> <p>Bereavement midwife contacted families and obtained consent to provide information to researcher. Researcher obtained consent form prior to interview.</p> <p>Participants information: participants demographic information reported: age range for women, gestational age, obstetric history such as first pregnancy, previous miscarriage, one or more children.</p>	<p>Aim: explore parents' experience of compassionate care following second trimester miscarriage.</p> <p>Rationale: inform the development of bereavement care services for families who experience a second trimester miscarriage.</p> <p>Relevance: expand knowledge of experience of second trimester miscarriage.</p>	<p>Method: Qualitative</p> <p>Design: Ethnography</p> <p>Data collection: Semi-structured interviews audio recorded and transcribed verbatim.</p> <p>Bias/Reflexivity: There is mention of ethical values of research process. No mention of reflexivity practices.</p> <p>Ethical considerations: Ethical approval obtained from both Hospital and University committee.</p> <p>There is evidence of protocol to support participants in case of emotional distress.</p>	<p>Data analysis: Thematic network to extract basic themes, organising themes and global themes.</p> <p>Focus: 'relational and social experiences of miscarriage'</p> <p>Clear statement of findings: One organising theme 'compassionate care' drawn of the basic themes of 'empathy' and 'sensitivity'</p> <p>Discussion of findings: Each theme is discussed reporting participants own words and against available literature.</p> <p>-Empathy or its lack impacts positively or negatively on the overall experience of miscarriage.</p> <p>-Sensitivity: professionals aware of loss, care of the baby following delivery, terminology such as 'abortion pill' may be upsetting.</p>	<p>Relationship with existing knowledge: findings concur with those of previous studies in regards of the importance of compassionate care particularly when caring for the bereaved.</p> <p>Empathy and sensitivity from staff significantly impact parents' experience.</p> <p>Applicability to different population: study conducted in one hospital in Ireland.</p> <p>Implications for further research: suggested further research on: -barriers to providing compassionate care for bereaved parents and how to overcome them.</p> <p>-health professionals' training needs to providing care to bereaved parents.</p> <p>Limitations: study conducted in one hospital in Ireland. Researcher experience as influencing factor in analysis - reflexivity practices not mentioned.</p>

(Continued)



Table 6. (Continued).

Author, title, date, location.	Participants	Aims	Method	Findings	Value
Smith, L. K., Dickens, J., Bender Atik, R., Bevan, C., Fisher, J., & Hinton, L. Parents' experiences of care following the loss of a baby at the margins between miscarriage, stillbirth and neonatal death: a UK qualitative study. 2020 UK	Sample size: 38 parents – 18 parents' pairs and 10 mothers. One further parent was interviewed but lost on follow up. Recruitment strategy: Maximum variation Purposive sample. Participants recruited through parent support associations and clinicians involved in the study. Information regarding the study was given to those interested in participating and consent was obtained before interview, before analysis and before publication. Participants information: participants demographic information not reported.	Aim: explore parents' experience of healthcare following loss of a baby between 20+0 and 23+6 weeks of gestation. Rationale: identify ways to improve healthcare provision. Relevance: expand knowledge of parents' experience of loss of a baby at the limit between definitions of 'miscarriage', 'stillbirth' and 'neonatal death'.	Method: Qualitative Design: Thematic analysis Data collection: Semi-structured narrative interviews audio/video recorded and transcribed verbatim. Interviews lasted between 39 minutes and 2 hours and 45 minutes. Parents were given the chance to review the transcripts. Transcripts were anonymised and analysed using NVivo9. Bias/Reflexivity: Reflexivity practices and peer debriefing mentioned. Ethical considerations: Ethical approval obtained. Involvement of parents, clinicians and parents' advocacy groups to overlook design and interpretation of findings.	Data analysis: Modified grounded theory approach. Clear statement of findings: Overarching theme: terminologies used by health professionals has significant impact on parents' experience. Key themes identified: Preparedness for the birth experience, seeing the baby term wellbeing, validating loss in absence of legal documentation. Discussion of findings: Each theme is discussed reporting participants own words. Terminology: the term 'miscarriage' does not align with parents' experience. Labour and birth: the use of the term 'miscarriage' does not associate with experience of labour and birth resulting in unexpected and traumatic experience. Seeing the baby: term 'miscarriage' did not prepare parents to meet/hold baby. Memory-making: important step in validating existence of baby. Lack of formal documentation perceived as denial of experience. Post-natal experience: managing a 'cruel body'. Longer-term emotional experiences: using the term 'losing a baby' rather than having a 'miscarriage' helps in processing loss and in sharing experience with family and friends- reducing sense of isolation.	Relationship with existing knowledge: discussed in interpretation of findings. Findings concur with those of previous studies in regards of language as cause of enhanced suffering, importance of memory making to validate the identity of lost child, terminology may increase sense of isolation. Applicability to different populations: not mentioned. Implications for further research: not mentioned. Limitations: Parents who choose to participate in the study may have been more likely to choose to use term 'baby' and 'parent', while other eligible participants who did not participate may refer to their experience as a pregnancy loss or miscarriage.

(Continued)

Table 6. (Continued).

Author, title, date, location.	Participants	Aims	Method	Findings	Value
Johnson, O. P., & Langford, R. W. A randomized trial of a bereavement intervention for pregnancy loss. 2015 USA	<p>Sample size: 40 women who experienced complete miscarriage in first or second trimester.</p> <p>62.5% of participants (25) had miscarriage between 14–19 weeks.</p> <p>Recruitment strategy: Inclusion criteria defined.</p> <p>Participants' contact initiated in emergency department, consent obtained and women re-contacted a week before a scheduled return clinic visit.</p> <p>Women enrolled completed detailed informed consent.</p> <p>Participants were randomly assigned to treatment (bereavement intervention) or control group (usual standard care).</p> <p>Participants information: participants completed demographic questionnaire including information such as: age, race, marital status, education, income, gravidity, parity, prenatal visit frequency and pregnancy loss.</p> <p>Ethical considerations: Ethical approval obtained from both Hospital and University committee.</p>	<p>Aim: examine the effect of a secondary bereavement intervention on grieving women who experienced a miscarriage between 12–20 weeks of gestation.</p> <p>Rationale: identify ways to improve healthcare provision.</p> <p>Relevance: reducing effect of complicated grief/despair following pregnancy loss.</p>	<p>Method: Quantitative</p> <p>Design: Experimental, posttest only, control group.</p> <p>Intervention: Treatment group received: -1 hour bereavement intervention focused on emotional care while in the emergency department</p> <p>-15 minutes phone call 1 week following loss</p> <p>Control group received: -routine care focused on physical stability and pain management.</p> <p>Measures: Perinatal Grief Scale (PGS) providing results on three subscales: active grief, difficulty coping and despair.</p> <p>Demographic questionnaire.</p> <p>Bias: n/a</p> <p>Confounding factors: not mentioned.</p> <p>Follow up: completed 2 weeks post-loss.</p>	<p>Data analysis: Chi-square and <i>t</i> test were used to check the differences between treatment and control group. MANOVA was used to examine the differences between the 2 groups and the 3 PGS subscales. Bonferroni adjustment was applied to the alpha value. Assumption for MANOVA were checked with no evidence of violation.</p> <p>Results: women in both groups displayed moderate levels of overall grief. Treatment group displayed significantly lower levels of despair in comparison to control group. No significant difference found between the two groups in relation to active grief and difficulty coping.</p>	<p>Relationship with existing knowledge: Findings concur with those of previous studies in regards of high level of active grieving for both groups in the period immediately following loss, bereavement intervention lower grief and despair.</p> <p>Applicability to different population: not applicable as small sample and majority of participants is Hispanic, with no health insurance.</p> <p>Implications for further research: not mentioned.</p> <p>Limitations: Small sample non generalizable. Follow-up after loss only 2 weeks which does not allow to determine the long term effect of the intervention.</p>

- A thematic analysis of each study, as described by Braun and Clarke (2006), followed by the exploration of relationships in the data by developing a concept map of emergent themes and a narrative synthesis of findings.
- The assessment of robustness of the synthesis, which is obtained by critical reflection on the overall synthesis process and evaluation of study quality.

Results

As reported in the PRISMA flow diagram (Figure 1), the literature search identified six articles that fitted the set inclusion/exclusion criteria. Of these six articles, two represent different reports on the same study. In accordance with CASP guidance, the studies were assessed based on their participants, aims, method, findings and value. Those variables were critically appraised and charted by the primary researcher with the support of two senior researchers. A synthesis of the data reported from the final selected papers is reported in Table 6. The tabulation was developed following CASP Qualitative Studies and the CASP Cohort Study Checklist.

A synthesis of the participants' demographic data from the articles selected is reported in Table 7.

Findings

Findings from each study were analysed and summarised as per the thematic analysis approach described by Braun and Clarke (2022) (Figure 2).

After familiarisation with the data and noting ideas, initial codes were generated (Figure 3).

Further analysis established relationships between codes and groupings under overarching themes. Three main themes emerged from the data: *communication and information-giving*, *feelings post-event*, and *impact of support provision*. Given the complex sensitive nature of the topic, some of the core concepts are shared between overarching themes (Figure 4).

The following narrative synthesis has been structured to relate to the themes identified in the concept map (Figure 4).

(a) *Communication and information-giving*

The topic of communication has been raised in all six papers, with reports dichotomous. On one hand, findings highlight quality issues surrounding healthcare professionals' communication to women and partners, which include: (a.1) their choice and use of terminology and whether this aligned with parents' need for compassionate care; and (a.2) their ability to effectively inform parents about proceeding events. On the other hand, findings report (a.3) parents' difficulty in expressing and communicating effectively their feelings and needs to healthcare professionals and also family and friends.

(a.1) *Powerful terminology*

Examples include healthcare professionals' use of medical vocabulary.

Table 7. Description of participants' characteristics.

	Cullen, S. <i>et al.</i> Parents' experiences of clinical care during second trimester miscarriage.	Mulvihill, A., & Walsh, T. Pregnancy loss in rural Ireland: An experience of disenfranchised grief.	Corbet-Owen, C., & Kruger, L.-M. The health system and emotional care: Validating the many meanings of spontaneous pregnancy loss.	Smith, L. K., <i>et al.</i> Parents' experiences of care following the loss of a baby at the margins between miscarriage, stillbirth and neonatal death: a UK qualitative study.	Johnson, O. P., & Langford, R. W.A. A randomised trial of a bereavement intervention for pregnancy loss.
Number of participants	14 4 women alone 5 couples 9 women	8	8	38 18 women alone 10 couples 28 women	40 40 Women
Gender	5 men (who participated with their partner)	8 Women	8 women	10 men (who participated with their partner) Not reported	
Age at time of loss	30–42 years	30–42 years	18–30 years	Not reported	18–42 years
Marital status	Not reported	8 Married	5 Married 2 Separated 1 Widowed	Not reported	15 Single 11 Living together 7 Married
Ethnicity	9 Irish 2 Asian	Not reported	4 White South African 4 South African persons of color	Not reported	7 Separated/Divorced 21 Hispanic/Latino 9 African American 7 White 3 Other
Religion	Not reported	Not reported	6 religious 2 not religious	Not reported	
Gestational age at time of loss	15–19 weeks	10–19 weeks 4 participants between 14–19 weeks	5–40 weeks 6 participants between 16–22 weeks	20–23 + 6 weeks	8–20 weeks 25 (62.5%) suffered a loss between 14 and 19 weeks
Time since loss	6–24 months	10–14 months	Not reported	6 weeks – 25 years	
Mother's obstetric history					
First pregnancy	3	1	0	Not reported	6
Previous loss	5	4	4	Not reported	Not reported
One or more living children	5	6	4	Not reported	34



Figure 2. Thematic analysis as described by Braun and Clarke (2022).

	Impact of physical/social environment	Lack of support/isolation	Talking about the experience	Sense of closure	Why me?	Information as a tool to avoid self-blame	Compassionate care	Powerful language/terminology	Acknowledging the baby	Validation of feelings and experience	Reduce the impact of grief	Memory making	Fathers' pain	Feeling safe/in control	Avoid assumptions
Cullen, S., Coughlan, B., McMahon, A., Casey, B., Power, S., & Brosnan, M. (2018). Parents' experiences of clinical care during second trimester miscarriage. <i>British Journal of Midwifery</i> , 26(5), 309–315.	✓	✓	✓	✓	✓	✓									
Cullen, S., Coughlan, B., Casey, B., Power, S., & Brosnan, M. (2017). Exploring parents' experiences of care in an Irish hospital following second-trimester miscarriage. <i>British Journal of Midwifery</i> , 25(2)							✓	✓	✓	✓	✓				
Johnson, O. P., & Langford, R. W. (2015). A randomized trial of a bereavement intervention for pregnancy loss. <i>Journal of Obstetric, Gynecologic, & Neonatal Nursing: Clinical Scholarship for the Care of Women, Childbearing Families, & Newborns</i> , 44(4), 492–499.		✓	✓						✓	✓	✓	✓	✓		
Mulvihill, A., & Walsh, T. (2014). Pregnancy loss in rural Ireland: An experience of disenfranchised grief. <i>British Journal of Social Work</i> , 44(8), 2290–2306.			✓		✓	✓			✓	✓	✓				
Smith, L. K., Dickens, J., Bender Atik, R., Bevan, C., Fisher, J., & Hinton, L. (2020). Parents' experiences of care following the loss of a baby at the margins between miscarriage, stillbirth and neonatal death: a UK qualitative study. <i>BJOG: An International Journal of Obstetrics and Gynaecology</i> , 127	✓	✓						✓	✓	✓		✓		✓	
Corbet-Owen, C., & Kruger, L.-M. (2001). The health system and emotional care: Validating the many meanings of spontaneous pregnancy loss. <i>Families, Systems, & Health</i> , 19(4), 411–427.	✓					✓	✓		✓	✓		✓		✓	✓

Figure 3. Concept map of emergent themes.

The use (or misuse) of certain terminology was reported as distressing by some parents. Terms such as ‘product of conception’ (Mulvihill & Walsh, 2014, p. 2296), ‘abortion pill’ (Cullen et al., 2017, p. 113) and ‘miscarriage’ (Smith et al., 2020, p. 870) were statements perceived to be insensitive and incongruous. Smith et al. (2020) report that use of sensitive language which aligns with parents’ perceptions plays a key part in reducing feelings of fear and isolation (Smith et al., 2020), avoiding disenfranchised grief (Mulvihill & Walsh, 2014) and development of long-term psychological sequelae (Smith et al., 2020). Smith et al. (2020) also report that use of sensitive language bestows a sense of *candidacy* to reach out to support services, which works towards improving both personal and social understanding of what they are experiencing. In addition, being provided with information was viewed as empowering by parents.

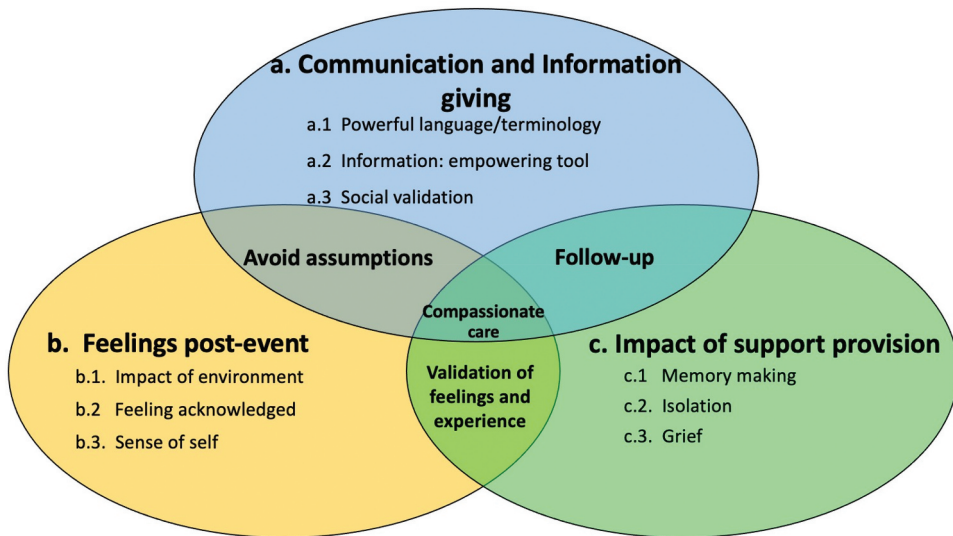


Figure 4. Concept map of emergent themes.

(a.2) Information: empowering tool

There is no explanation ... all of those questions inside of me ... (Corbet-Owen & Kruger, 2001, p. 420)

Parents highlighted that being given clear information about clinical care provision and reason for their loss worked towards reducing the impact of self-blame and enhanced feelings of being safe and in control (Corbet-Owen & Kruger, 2001; Cullen et al., 2018). In addition, timely provision of information, being given the opportunity to ask questions, and a collaborative approach towards decision-making surrounding care were reported to be key elements in perceptions of 'feeling heard' and being provided with the support needed to move forward following loss (Corbet-Owen & Kruger, 2001; Cullen et al., 2018; Mulvihill & Walsh, 2014; Smith et al., 2020).

(a.3) Social validation

Women and couples reported that lack of understanding from their social circles left them unable to talk about their loss and reduced their feelings of isolation (Smith et al., 2020). The following quote emphasises this point:

Nobody called me. Nobody ever called me ... I went back to work and nobody mentioned anything. Nobody said anything to me. (Mulvihill & Walsh, 2014, p. 2296)

This woman's need to mourn her loss and have her experience acknowledged and validated clashed with avoidance or downplaying reactions of her family, friends and work colleagues (Corbet-Owen & Kruger, 2001; Mulvihill & Walsh, 2014). The taboo that surrounds pregnancy loss and being denied the opportunity to talk about it may result in parents experiencing disenfranchised grief and it is

associated with longer-term psychological complications (Corbet-Owen & Kruger, 2001). In contrast, parents who experienced support from family and friends found that sharing mementos of their baby provided them with valuable affirmations (Smith et al., 2020).

(b) Feelings post-event

Parents' emotional responses are explored in the literature in relation to the circumstances surrounding 'late miscarriage'. These include feelings surrounding: (b.1) clinical care provision whilst in hospital; (b.2) acknowledgement of the loss; and (b.3) sense of self.

(b.1) Impact of environment

The physical hospital environment has been reported to affect parents' feelings and experiences of late pregnancy loss. For example, parents expressed the need to be separated from pregnant women and 'crying babies' to circumvent additional distress (Cullen et al., 2018, p. 312; Mulvihill & Walsh, 2014). Others also reported how transitioning from a gynaecological ward to a maternity ward changed their care from 'being a woman with a pile of tissue in her uterus' to a 'pregnant woman with a baby' (Smith et al., 2020, p. 870), which addressed their need to have their loss and baby acknowledged.

(b.2) Feeling 'acknowledged'

Having the baby and loss acknowledged is a core need recognised within the literature. This is threaded throughout all the described themes, and represents one of the stepping stones in dealing with emotional and psychological consequences of pregnancy loss (Corbet-Owen & Kruger, 2001).

Some women report that having their experience 'dismissed' and experiencing a sense that *'it was as if nothing had happened'* (Corbet-Owen & Kruger, 2001, p. 419) inhibited their ability to speak about their loss. These feelings occurred in relation to both health-care professionals and family members and led to feelings of disempowerment and isolation (Corbet-Owen & Kruger, 2001; Mulvihill & Walsh, 2014). In addition, Smith et al. (2020) describe how lack of formal certification of the baby's death before 24 weeks' gestation negatively impacted some parents who felt they were being denied their baby's existence and rights to parental leave and maternity pay. There is consensus in the literature that validating parents' experiences and feelings facilitates them to grieve and lowers the risk of them developing disenfranchised grief, anxiety and depression (Johnson & Langford, 2015; Mulvihill & Walsh, 2014; Smith et al., 2020).

(b.3) Sense of self

Some women reported a sense of empowerment and fulfilment in being pregnant, which is substituted with feelings of being defective and abnormal following a fetal demise (Mulvihill & Walsh, 2014). As expressed in the quote *'your body is so, so cruel'* (Smith et al., 2020, p. 871), as motherhood becomes part of personal identity and status in society, the pregnancy loss induces in some women feelings of being powerless and 'cheated' by their own body at both a personal and a social level (Mulvihill & Walsh, 2014; Smith et al., 2020). Hence, clear communication is an essential part of re-establishing women's sense of

feeling both safe and in control. Some primiparous women who were gestationally too early to attend antenatal classes felt unprepared for their labour and birth. However, these women reported feeling reassured and cared for when healthcare professionals took time to explain how labour and birth would feel, and what options would be available for pain relief (Cullen et al., 2018; Smith et al., 2020). Hence, the opportunity to be their own storyteller, rather than being assessed only on the basis of their physical symptoms, and being listened to with sensitivity and empathy by healthcare professionals, helped them to feel safe and in control (Corbet-Owen & Kruger, 2001, p. 419; Cullen et al., 2017).

(c) Impact of support provision

Another key point identified in the literature is the need for parents to feel supported. Quality support provision should essentially be offered to all women, partners and families as emphasised in the following quote:

It's hard to ask for support isn't it . . . I think it's easier to accept the offer than to go look for it yourself. (Mulvihill & Walsh, 2014, p. 2297)

As support provision is not an all-encompassing formula that can be 'applied' to all, parents are advocating for healthcare professionals to empathetically listen and respond to their personal support needs, and refrain from making assumptions (Corbet-Owen & Kruger, 2001; Smith et al., 2020). The studies included in this theme, explored under different lenses aspects of (c.1) *memory-making*, (c.2) *isolation* and (c.3) *grief*.

(c.1) Memory-making

Memory-making consists of both the opportunity for parents to spend time with their baby, and the creation and collection of keepsakes by which to remember the baby. Parents responded positively to the guidance of midwives in relation to creating mementos. For example, some parents reported that being provided with an opportunity to see pictures of their baby before meeting them prepared and reassured them about what to expect (Smith et al., 2020). Similarly, others appreciated when midwives took pictures of their baby and stored them in the case notes, thus providing an opportunity for future viewing should they change their mind (Cullen et al., 2017; Smith et al., 2020). Conversely, other parents expressed frustration and anger when they were denied an opportunity to create memories (Corbet-Owen & Kruger, 2001; Mulvihill & Walsh, 2014; Smith et al., 2020), with the quote that follows illustrating such feelings:

It nearly drove me insane that I never saw that baby. (Corbet-Owen & Kruger, 2001, p. 422)

As such, memory-making represents a tool to validate the baby's existence and establishes identity of both the 'lost child' and the woman and partner's roles as 'parents' (Cullen et al., 2017; Smith et al., 2020). Accordingly, lack of mementos is reported to play a part in parents developing responses, such as complicated or disenfranchised grief (Mulvihill & Walsh, 2014; Smith et al., 2020).

(c.2) Isolation

Although most parents report having received empathetic and sensitive care whilst in the hospital, some reported receiving lack of emotional and/or psychological support once

discharged home (Corbet-Owen & Kruger, 2001; Mulvihill & Walsh, 2014). Signposting parents towards opportunities to connect with peers or support groups who have experienced similar situations, may help to ease their sense of isolation and play a role in processing loss of their baby (Corbet-Owen & Kruger, 2001). In one account from Mulvihill and Walsh (2014), a woman describes how follow-up support can help:

'[it] shows that you are not just a number, you are a person and you're going to be looked after'. (Mulvihill & Walsh, 2014, p. 2297)

Some bereaved parents benefit from tailored follow-up designed to meet their individualised needs, which may include a schedule of phone calls and/or home visits (Mulvihill & Walsh, 2014). Parents interviewed in the Mulvihill and Walsh (2014) study go as far as defining an ideal timeframe that involves a scheduled appointment 2-months post-loss, which provides sufficient time for parents to process their emotions and also represents a time when family and friends' support starts to naturally diminish.

(c.3) Grief

The term '*grief*' in a perinatal bereavement context is defined as a dynamic physiological process, which includes 'psychological, behavioural, social, and physical reactions' following the loss of a baby (Hollins Martin & Martin, 2016, p. 603). In order to reduce the impact of grief, it is important for parents to progress straightforwardly through natural stages. Kübler-Ross (1969) describes the grieving process in five stages: denial, anger, bargaining, depression and acceptance, which represents keynote literature on the psychoanalysis of grief. During the process, failure to naturally progress through these stages of grief can lead to pathologies, such as postnatal depression or complicated grief (Hollins Martin & Martin, 2016).

Empathy and sensitivity are described as instrumental tools for alleviating pain from a second-trimester loss, which may impact parents' longer-term ability to adjust throughout the stages of grieving (Cullen et al., 2017; Smith et al., 2020). Johnson and Langford (2015) highlight how women who receive quality emotional bereavement care show reduced levels of grieving and despair. In their study, despair is defined as a maladaptive response during the grieving process. Given that follow-up consisted of a 15-minute telephone call 2-weeks post-loss, it could be argued that 'a little goes a long way'. In response, implementation of bereavement protocols which schedule quality follow-up may work towards enhancing the 'emotional healing' of those experiencing pregnancy loss (Johnson & Langford, 2015).

Discussion

The body of literature that has investigated parents' experiences of perinatal loss, which includes miscarriage, stillbirth and postnatal death, has grown significantly in the last two decades (Farren et al., 2018). However, there is a paucity of studies that have explored parents' psychological needs post experiencing late or second-trimester miscarriage. Out of the 6 papers retrieved, only 3 specifically investigated parents who had experienced loss between 14 + 0 and 23 + 6 weeks of gestation (Cullen et al., 2017, 2018; Smith et al., 2020). The other three studies assessed the effects more broadly and used the terms 'miscarriage' or 'perinatal loss', with gestations at time of loss varying from 8 to 32 weeks;

within this bracket, more than 50% of participants were referred to as having experienced a late miscarriage (Corbet-Owen & Kruger, 2001; Johnson & Langford, 2015; Mulvihill & Walsh, 2014).

The arising psychological needs surrounding 'late miscarriage' are similar to those related to miscarriage in its broader definition, with the findings of this narrative literature review validated by another literature review that focused on women who had experienced miscarriage up to 20 weeks' gestation Robinson (2014). Robinson (2014) also describes the impact of information provision, acknowledgement of loss and use of appropriate medical terminology, as protective factors against developing psychological complications; for example, complicated grief and/or depression. Clearly, and in relation to miscarriage, the need for support is highlighted by many researchers (Lok & Neugebauer, 2007; Robinson, 2014), and there seems to be inconsistency in actual uptake of available interventions such as cognitive behavioural therapy and peer support (Robinson, 2014; Séjourné et al., 2010). The hesitance in partaking in support interventions could be particularly significant in reference to parents who have experienced late miscarriage. Within the framework of attachment theory, it is suggested that the use of ultrasound scanning intensifies parental–fetal bonding, and particularly during the second trimester (Righetti et al., 2005). Also, parents who suffer second-trimester loss may have had multiple scans before the fetal demise. As such, health care professionals may anticipate differences in the incidence of psychological complications and engagement with support services within this group (Lok & Neugebauer, 2007). Emphasising this point about engagement with support services, the literature highlights that parents who have experienced late miscarriage often wrestle with the idea of joining support groups specifically focussed upon either miscarriage or stillbirth, simply because they struggle to identify their own loss as fitting into either of these groups (Smith et al., 2020).

The topic of follow-up support following late miscarriage arises in all six papers identified and is also mentioned in the Robinson (2014) review. Parents appreciate being given information about their loss and the possible reasons why it might have occurred, straightforwardly, because it represents a way to validate and make sense of their experience (Corbet-Owen & Kruger, 2001; Cullen et al., 2018; Smith et al., 2020). Parents also report lack of routine emotional and psychological follow-up support from local health services, along with a failure to effectively signpost available support organisations and/or counselling services. These findings are echoed in a study about support provision for women following miscarriage by Bilardi et al. (2021), which reports that more than half of women are not offered information about available support options, nor actual follow-up emotional or psychological care post-loss, despite stating that they would have liked this. Evidence of reported '*practice mismatch*' between what women desire in terms of support and type of care they receive (Bilardi et al., 2021) is corroborated by findings of the Robinson (2014) study about follow-up care provided post-late miscarriage.

A Cochrane review by Murphy et al. (2012) about the efficacy of providing psychological support post-miscarriage concludes that there is insufficient evidence to confirm that support provision is effective at reducing pathological sequelae (e.g. anxiety, depression and complicated grief). Also, as the Murphy et al. (2012) Cochrane review included studies with largely different datasets, they suggest that further research is required. In addition, a recommendation is made that those who have experienced miscarriage

should guide the development of design and the assessment of future support services (Murphy et al., 2012).

In addition, Kong et al. (2014) suggest that psychological counselling should be offered to a selected group of women at high risk of developing psychological morbidity. A review of 27 studies conducted by Farren et al. (2021) concludes that women who receive less support and/or have a history of psychiatric illness, recurrent pregnancy loss, or infertility, and/or who are left childless following loss, are at higher risk of developing symptoms of anxiety, depression and post-traumatic stress disorder (PTSD) following early pregnancy loss.

Working on the premise of avoiding assumptions and the requirement that every woman should receive person-centred care, differences may be drawn regarding the subgroup of women who have suffered late miscarriage. The literature retrieved highlights a need for providing compassionate emotional care following a second-trimester loss. Parents interviewed by Mulvihill and Walsh (2014) expressed a desire to receive routine emotional care, which is initiated whilst in hospital and followed-up with phone contact and/or home visits especially around 2 months post-loss. In response, Tseng et al. (2017) found a significant decrease in levels of grief from 3 to 6 months following perinatal loss, which suggests that routine follow-up care could be beneficial in this particular time period.

Implications for future research

This literature review reveals a paucity of investigations that have addressed women's and their partners' experiences of late miscarriage. It has been ascertained that most of the literature that focuses on the topic of pregnancy loss gathers the event 'late miscarriage' under the umbrella of miscarriage or perinatal loss. Although some themes that have emerged from the literature about miscarriage and stillbirth are mutual, there are aspects distinctive to the experience of late miscarriage, which have been overlooked in both clinical and social contexts. These aspects include the use of particular terminology and lack of acknowledgement of loss, which includes memory-making and formal certification and a lack of tailored emotional support. Neglecting these aspects of psychological care may impact parents' interest in engaging with follow-up support, which in turn may increase the risk of developing psychological morbidity (Corbet-Owen & Kruger, 2001; Smith et al., 2020). This review emphasises the need to implement compassionate, timely and effective emotional/psychological follow-up support post-late miscarriage, which are points highlighted in the latest guidelines for healthcare professionals developed by the National Bereavement Care Pathway Scotland (2020). However, these guidelines omit to detail who should take charge of planning and delivery of follow-up support, and how the services should work towards effectively addressing the needs of those affected by perinatal loss. Also, in order to deliver high-quality person-centred care, personnel involved in delivering perinatal bereavement care require appropriate training in how to provide compassionate care (Beaumont & Hollins Martin, 2016; Cullen et al., 2017; Hollins Martin et al., 2021).

In addition, the results of this literature review illustrate that further qualitative research is required to investigate the support needs of parents who have suffered late miscarriage, which would inform the implementation of training resources in compassionate care for healthcare professionals (Hollins Martin et al., 2021). Also, the development of a compassionate follow-up support service that effectively addresses the specific needs of parents who have experienced late miscarriage could be of benefit (Beaumont & Hollins Martin, 2016).

Implications for practice

As evidence remains insufficient regarding the needs and follow-up care appropriate for parents who have suffered a late miscarriage, clinicians and individuals involved in providing care should be aware of the uniqueness of this experience, the importance of sharing information about the loss, and be compassionate and responsive to women's preferences and signpost them to available support services.

Limitations

One limitation of this review is that only three articles included investigated 'late miscarriage'. Due to differences in defining categories of perinatal loss in terms of gestational age, this means that part of the data utilised may originate from parents who have sustained a perinatal loss within a different gestational bracket. Additionally, there is an abundance of articles about perinatal loss and miscarriage that do not report gestational age at time of loss, and because of this lack of focus they were excluded from the review. Nonetheless, this review has reported new findings, which the conclusion now summarises.

Conclusion

This review has identified three aspects of parental dissatisfaction with care provision following the experience of late miscarriage, which include: (a) communication and information given; (b) feelings post-event; and (c) impact of support provision. Also, this review has highlighted a dearth of compassionate, tailored, emotional and follow-up psychological care, which implies that the development of specific late miscarriage support services is required. A recommendation is also made that more in-depth, high-quality, qualitative research that focuses on the needs of parents who have experienced late miscarriage would appropriately inform both training needs in bereavement care and the development of more effective follow-up support services, as is advocated by the Murphy et al. (2012) Cochrane review.

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