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Review

Stillbirth at Term: Grief Theories for Care of Bereaved Women and Families in Intrapartum Settings

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Death in intrapartum settings poses a paradox for providers, whose expertise may be limited in assisting bereaved women and families facing the trauma of stillbirth. Many providers are familiar with Kübler-Ross' stage theory of grief; however, more recent theories augment her early work in care of bereaved persons. Through an evolving case study of a couple for whom pregnancy ends in stillbirth at term, 4 theories of grief—loss of the assumptive world, the dual process model, continuing bonds, and complicated grief—are presented to assist intrapartum care providers toward more comprehensive understanding of the complexities of grief responses not fully explained by simple stage theory. These 4 theories are not prescriptive, nor are they comprehensive; however, they are highly relevant and foundational for current understanding of responses and needs of bereaved women and families for whom pregnancy ends in death.
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INTRODUCTION

Stillbirth, the death of a fetus before or during labor after 20 weeks' gestation, occurs in approximately 1% of all pregnancies, or 24,000 times annually in the United States.[1] Stillbirths are more common among women who are black; are older than 35 or younger than 20 years; smoke during pregnancy; have obesity, hypertension, diabetes or other chronic condition(s); have low income; are pregnant with 2 or more fetuses; and/or have had a pregnancy loss in the past.[1,2] Term stillbirth, occurring at 37 or more completed weeks of pregnancy, occurs less frequently than does early (20-27 weeks' gestation) stillbirth; however, unexplained stillbirths (those without a known cause) are more likely to occur later in pregnancy.

Sudden, unexpected death can be particularly traumatizing,[3] and thus a term stillbirth in a pregnancy that otherwise had no evidence of complications may be especially painful. The traumatizing aspects of stillbirth increase women's risks for negative long-term social and psychological outcomes, including anxiety, loneliness, pain syndromes, and relational and attachment problems,[4] which have implications for future pregnancies and parenting. Complex developmental tasks of pregnancy include what Rothman described as "making mothers,"[5(p 254)] a role and identity replete with expectations to protect one's child.[6] An unexplained, sudden fetal death threatens a woman's newly developing identity of mother of this particular child (even if she has other children) because she may feel she could not protect her baby from dying.

Theories, or collections of ideas (ie, concepts) linked together to explain a phenomenon, are useful in practice because they can increase a health care provider's understanding of various aspects of a complex situation. *Paradigms*, *models*, *frameworks*, and *theories* are distinct entities that move from highly abstract to more concrete conceptualizations of phenomena. This article uses *theory* as a general term in presenting 4 collections of ideas useful in understanding responses to loss in general (loss of the assumptive world, the dual process model, continuing bonds, and complicated grief) and which have specific utility when death occurs in intrapartum settings. Clinical practice shaped by theory gives providers a mechanism to understand more clearly what they are encountering in their patients and helps create the opportunity for more targeted and thus useful interventions.

Despite having expertise in care of pregnant women, families, and newborns, intrapartum care providers encountering the paradox of death in birth settings may feel less confident in meeting the challenges of care of grieving persons. Although death in birth settings can occur in many ways (eg, maternal death, sequelae of extreme prematurity or severe congenital conditions), an unexpected term stillbirth serves as a useful example of a traumatic, but not entirely uncommon, situation encountered by intrapartum care providers. After defining common terms related to bereavement care, this article presents an evolving case study of a woman with a stillbirth at term, each segment is followed by discussion of a grief theory useful in understanding the needs of bereaved women and their families in this difficult situation.

THE LANGUAGE OF LOSS, BEREAVEMENT, AND GRIEF

Intrapartum care providers are comfortable with language and terms specific to their area of expertise; however, the

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Quick Points

- Although pregnancy is typically anticipated to end at term with birth of a healthy newborn, death can occur unexpectedly and without explanation, posing a challenge for intrapartum care providers for whom understanding of the needs of grieving women and families may be limited.
- Kübler-Ross' 5-stage theory of grief was groundbreaking in moving discussions about death and dying into public discourse; however, over time, other theories have provided a more comprehensive understanding of responses to the processes of grief.
- Theories such as loss of the assumptive world, the dual process model, and complicated grief explain and describe responses of bereaved persons, whereas continuing bonds theory undergirds many of the interventions of perinatal palliative care services.
- Sensitive informed care early after a loss can assist newly bereaved persons to determine what they need, when, and by whom as they move through difficult days and months to make meaning of and come to terms with their loss.

occurrence of death in intrapartum settings requires that providers be at least familiar with, if not expert in, the lexicon of grief care.

Loss refers to an experience when a "valued person or object can no longer be seen, touched, heard, known or otherwise experienced."[7(p 806)] The terms *perinatal loss* and *reproductive loss* describe a broad array of losses across the childbearing trajectory, including infertility, miscarriage, diagnosis of a life-limiting fetal defect, stillbirth, and neonatal death. *Bereavement* is derived from the word *bereft*: deprived of, absent from, or torn away from. Typically used in reference to the loss of a valued person, bereavement refers to a state of being in the aftermath of a significant loss. Bereaved persons may observe a period of mourning, denoting traditions and rituals associated with loss, particularly a death. Mourning rituals include culturally meaningful observances, such as wearing of certain clothing and participating in religious rites; families may have customs and traditions associated with death that are distinct from socially or culturally prescribed acts. Persons in mourning are often relieved from their daily activities and expectations such as work and social interactions.

Grief has 2 meanings. First, grief is the emotion experienced by bereaved persons, specifically the feeling of profound sadness and even despair accompanying loss (ie, being grief-stricken). Second, grief is characterized as a process through which a bereaved person moves to make meaning of and incorporate a loss into their lives. Importantly, experiences of grief as both emotion and process are individual, social, and relational[8] and hence not fully captured by any one theory to explain the unique characteristics of an individual's reactions to a loss. This article presents the concept of grief and current grief theories to help intrapartum care providers understand more completely the experiences of bereaved persons and thus deliver care for persons experiencing a loss so their needs are addressed sensitively and in an informed way.

BEYOND KÜBLER-ROSS: AN EARLY MODEL OF GRIEF

In 1969, psychiatrist Elizaseth Kübler-Ross published *On Death and Dying*, her groundbreaking work in which she explained a model of stages of grief. At the time of publication, discussions of death were a longstanding taboo in American life, but Kübler-Ross, a champion for care of the dying, sought to bring the discourse surrounding dying into the public sphere. Her work made an indelible imprint on thinking about grief, and health care providers are still often taught her 5 DABDA stages: denial, anger, bargaining, depression, and acceptance.[9] Notably, although her work is often used to explain responses of grieving persons, Kübler-Ross' work was about dying persons specifically and their psychological preparation for death.

The 5 stages Kübler-Ross described were, and remain, a comprehensible explanatory theory of grief, although current understanding of grief acknowledges the shortcomings of this model. The primary shortcoming of this (and any) stage model is that human responses are such that a person rarely moves through defined stages linearly, that is, in a predictable sequence and in a prescribed time. Critics of Kübler-Ross' stage model note that the grief process cannot be adequately explained or predicted easily because persons process grief unpredictably, revisiting stages repeatedly and unpredictably.[10]

LOSS OF THE ASSUMPTIVE WORLD: WHEN ORDER AND PREDICTABILITY FAIL

Case Study, Part I

Jane and Michelle are a married couple for whom becoming parents was challenging. Jane became pregnant via in vitro fertilization (IVF) twice but had late miscarriages around 15 weeks' gestation. Subsequently Michelle, despite never desiring to become pregnant, agreed to IVF so they could raise a child together. At 38 weeks' gestation during a routine prenatal visit, her midwife was unable to auscultate fetal heart tones. Michelle described lack of fetal movement for 2 days, thinking their baby was "getting ready to be born." After fetal death was confirmed in the intrapartum unit where her midwife practiced, Michelle turned to her side and stared at the wall for hours, not crying but barely moving. She repeated several times, "This was not supposed to happen." In response to Michelle's behavior, a

nurse commented that Michelle "skipped straight from denial right to depression."

Discussion

The nurse, educated in and (mis)applying the Kübler-Ross model, could not see the complexity and meanings of the circumstances surrounding the devastating death of Michelle and Jane's expected child and Michelle's response. A theoretical and more comprehensive explanation of Michelle's reaction may be the loss of the assumptive world. First introduced by Parkes in 1971,[11] the *assumptive world* refers to a person's beliefs that the world operates in an orderly and predictable way. Parkes understood these beliefs as a way of organizing one's reality both physically and temporally, that is, "the ordering principle for the psychological or psychosocial construction of the human world."[12(p 2)] Without an assumptive world, human experience would be fraught with uncertainty and unpredictability. As a simple example, a person sits on a chair assuming its structural soundness and ability to sustain their weight, thus preventing them from falling on the floor. Beyond the assumptions that certain physical principles operate without fail (eg, gravity), assumptive worlds are "believed worlds"[12(p 3)] constituted by the way persons understand themselves and the world around them, the "normative constancy of experience and belief."[12(p 2)]

Loss of the assumptive world, then, is the traumatic loss of what one believes to be real and certain. Traumas are experiences testing the limits of coping, requiring persons to adjust to an unexpected shift in expectations and meaning of a situation or event.[13] Meaning is an essential element of human experience;[14] a crisis affects the need to adjust meaning and make sense of a new, unexpected and unwanted reality.

Loss of the assumptive world is central to understanding responses to childbirth-related deaths. Pregnancy as a biological event is assumed to last approximately 40 weeks, ending in birth of a healthy newborn. Although the current technologized environment of pregnancy and prenatal testing may suggest that pregnancy is highly susceptible to genetic and/or intrapartum disaster, women and their partners enter into pregnancy seeking to become parents, usually with the assumption that pregnancy will be uneventful. When a fetal death occurs, their assumptive world is lost, constituting a trauma disrupting their understanding and expectation of an event (the birth of their child) that is supposed to end differently.

Loss of the assumptive world is not a prescriptive theory but rather is a perspective explaining the trauma of pregnancy-related death. In the scenario, Michelle, confronted with confirmation of fetal death at term, experienced the loss of her assumption that she would give birth to the child she and Jane would raise together. Her response of lying on the bed staring at the wall may reflect her confrontation with the traumatizing loss of her assumptive world, not easily captured in a formulaic stage theory such as Kübler-Ross' ("skipped right from denial straight to depression"). Helping Michelle make meaning of her loss requires time, patience, and gentle care from her intrapartum care providers, who are most likely to be helpful by taking a posture of accepting Michelle's need to withdraw as she began to make sense of her (formerly) predictable world now disrupted traumatically and without warning. The temptation is strong to ascribe simple explanations for behaviors in the immediate aftermath of a traumatic loss; however, these explanations may serve to assuage, at least in part, the discomfort of providers who may be confused by the bereaved person's reaction. Providers may want to do something for someone in pain; in this case, giving Michelle space and time to wrestle in her own way with her baby's death, and more broadly the loss of her assumptive world, may in fact be the most helpful act providers can do at this vulnerable moment. Simple considerations such as bringing water, providing tissues, and a maintaining an unintrusive presence can signal support and respect for the bereaved person's experience.

DUAL PROCESS MODEL: LOSS, RESTORATION, AND OVERLOAD

Case Study, Part II

Jane arrived in tears. She sat at Michelle's bedside, crying quietly as Michelle, sobbing, apologized for "losing our little girl." Their nurse respected their privacy, assuring them she was nearby and would check on them in an hour, after which Michelle was composed, dressed in her street clothes, and asked to be discharged home. Jane explained they wanted to go out for dinner and then home to "work through all of this." The nurse was surprised, but notified Michelle's midwife, who ascertained that Michelle's laboratory results and vital signs were normal. After spending several minutes with the couple, the midwife understood their need to leave, ordering Michelle's discharge, with a clinic follow-up visit in 3 days if labor had not started. Moments later, the couple walked out holding hands, thanked the providers for their care, and indicated they were going to their favorite restaurant for a "ridiculously expensive meal." The nurse commented to her midwife colleague that although she did not understand their plan, she saw that getting away from the hospital was important; her colleague responded, "People have to find their own way through tragedy."

Discussion

The dual process model is a useful theoretical perspective by which to understand complex and sometimes perplexing behaviors of grieving persons. Described by Stroebe and Schut in 1999 and again in 2010, the dual process model is a simple mechanism to describe how grieving persons make sense of and cope with a significant loss. Stroebe and Schut noted 2 orientations, loss and restoration, between which bereaved persons oscillate.[15,16] When a person is oriented to loss, they experience intrusion of grief and its attendant work to cope with the loss; furthermore, persons may seek to break bonds of attachment, physically change locations (ie, move) or otherwise avoid reminders of their painful loss, and seek ways to avoid restorative processes. Strobe and Schut noted that grief work—what they refer to as the "essence of grieving"—occurs

in the loss orientation phase, and in bereaved families may occur concurrently across individuals.[17]

When a person oscillates to the restoration orientation, they may seek to distract themselves from the pain of loss and even actively avoid feelings of grief. They may seek new opportunities to occupy them, including new work, roles, and/or relationships. Oscillation can occur quickly, with no defined temporal limits on how long, if, and when a person might move between orientations. Acts associated with the restoration phase may themselves become sources of stress that are not specific to the loss itself but are results of the loss.[15,16]

Oscillation is a mechanism by which persons take a break from the exhausting work of coping. Both loss and restoration orientations involve coping that may become burdensome and from which the bereaved person seeks respite by oscillating into the other orientation for a while. More recently, Stroebe and Schut acknowledged that the original dual process model had a significant shortcoming in that it did not acknowledge *overload*, that is, subjective feelings of being overwhelmed either by the work of grief (loss orientation) or the work of restoration.[17] Overload results in psychological stressors such as anxiety and also physical complications associated with intense and prolonged grief. To balance the difficult processes associated with both loss and its attendant grief work and with restoration, Stroebe and Schut endorsed an earlier suggestion by Dyregrov and Dyregrov[18] to encourage bereaved persons to be direct and honest about what they need in their grief, which, although difficult at times, may reduce their burden of expectations by others and thus increase their effectiveness in managing grief-associated stressors.[17] Oscillation may explain what grieving persons often describe as an emotional roller coaster during bereavement.

Michelle's and Jane's responses can be explained by the dual process model. Without warning, they found themselves facing the emotionally devastating and confusing reality in which their expected child would be stillborn. Michelle's initial response of simply staring at the wall might be explained in part by overload, in which, without the presence of her supportive wife, she simply could not process the news. Although her behavior was mistaken by the nurse for depression in the Kübler-Ross model, Michelle waited until her wife arrived, the person with whom she felt most safe at a time of intense vulnerability. By asking to go home, they honored their own emotional needs, and by going out to dinner together, they sought respite from the overwhelming effort of the loss orientation, even early in their grief. Given that women and their partners in this circumstance will need to notify important others in their community with their sad news, oscillating to a restorative orientation even soon after the diagnosis may be adaptive, giving them time to consider how to move forward and to buffer themselves, if only temporarily, from the painful reality they now inhabit.

When intrapartum care providers do not understand this movement between loss and restoration orientations, they may be confused by behaviors of women and families in the hours after an intrapartum death. For example, a woman who has experienced a stillbirth after a long labor may want to shower and put on fresh clothes, have a meal brought in, and even laugh some with close friends or relatives. She is seeking some element of restoration, moving from what may be overwhelming sadness in a loss orientation. This does not mean she is denying, trivializing, or ignoring her loss; it may simply mean she needs a break from her sadness and is addressing her own needs. Furthermore, bereaved persons might not be comfortable with profound expressions of grief even in the presence of trusted providers, waiting until they are in the safety and privacy of their homes or the presence of supportive others in their community to express the depth of their grief.

CONTINUING BONDS: MAINTAINING A CHANGED RELATIONSHIP

Case Study, Part III

Michelle gave birth 2 days later to Zoe, a well-grown newborn with no apparent defects or conditions to explain her intrauterine death. The institution's perinatal palliative care team social worker met with Michelle and Jane during labor, helping them identify what they wanted from their birth experience and in the hours after Zoe's birth. Although their own mothers were present during labor, Michelle and Jane asked for privacy during the birth, wanting time alone with Zoe's body until they felt they wanted to include others. They had brought baby clothes and a special book they had looked forward to reading to Zoe. A baby dress was the one Jane had worn home as a newborn. The couple spent an hour alone with Zoe's body after the birth, after which they invited their mothers in to see and hold their granddaughter's body. The women took photos, shared stories, made phone calls, and with the help of the perinatal palliative care team social worker and nurse, collected a lock of hair, footprints, a mold of Zoe's hands, and sealed into a plastic bag the cap placed on her head after birth. The perinatal palliative care team members worked with Michelle and Jane to make arrangements for Zoe's cremation with a funeral home that had served their families for generations and to plan a memorial service, followed by scattering of her ashes and placement of a stone in her memory in Jane's family cemetery. After 12 hours, Michelle and Jane felt ready to relinquish Zoe's body, which they had bathed and dressed in the clothing they had planned for her to wear home. After they each held and kissed Zoe's head, Michelle and Jane told her they would love her forever, thanked her for her life, and together placed her body into the arms of the funeral director.

Discussion

Late pregnancy losses are highly complex, juxtaposing the paradoxical events of birth and death. With only a short time in the presence of their newborn's physical body, parents often seek ways to incorporate their stillborn child into their family's history. Grounded in attachment theory, continuing bonds is a useful framework by which to assist parents who face birth and death simultaneously. Without the possibility of physical proximity to their deceased newborn, parents may seek ways to maintain psychological proximity as they adapt to their loss and reorganize their expectations of life after their child's death.[19]

Continuing bonds theory reflects the need of survivors to maintain a relationship, albeit a changed one, with the deceased person. Key to understanding parental responses to stillbirth is the question posed by Klass: "Who is this child to you?"[20(p 199)] This question is significant because the meaning of a pregnancy and expected child can vary widely. For instance, some pregnant women may not experience themselves as mothers until the time of birth, whereas other women feel like mothers as soon as they recognize they are pregnant. Highly idiosyncratic, bonds of attachment to a developing fetus vary widely across pregnant women and their partners and are shaped by personal, social, and cultural beliefs.[21] Assisting women and families in the intrapartum setting requires great sensitivity to cues that answer the (unasked) question "Who is this child to you?" Intrapartum care providers should avoid preconceived ideas as to the degree and importance of attachment a pregnant woman and her family may have regarding the developing fetus.

The use of transitional objects reflects the continuation of bonds with the deceased. Transitional objects are those memorabilia and other remembrances that serve to connect the deceased person to his or her survivors. For instance, the *ofrenda* in Mexico marking *Día de Muertos* (Day of the Dead) is a collection of photos and objects belonging to a deceased person, displayed in an elaborate annual ritual that connects that person to the present. For families whose child is stillborn, few opportunities and little time exist for the accumulation of materials that will serve as transitional objects. Perinatal palliative care providers assist families in collecting transitional objects (eg, newborn's hair, clothing, cap, armbands, footprints, hand molds). Not simply remembrances, for some families these objects connect their child's life with theirs and serve to both establish and continue bonds of attachment after the child's death.

Not all birth settings have a dedicated perinatal palliative care team; however, intrapartum care providers can offer bereaved women and families similar memorabilia and support. This can begin with a simple explanation: "Some parents appreciate having their baby's armbands and a lock of hair. Is that something I can help you with?" This statement helps in 3 ways. First, at a time when women and families may feel isolated in their loss and grief, it acknowledges that other persons have had the same experience. Second, it acknowledges their role as parents of their deceased child. Third, by offering a short list of simple items, parents are not overwhelmed by making decisions about what they might want to keep. Over time, the provider can offer to take photos and to get footprints, hand molds, and other items. A key point in assisting bereaved families in any setting is that their ability to take in information or make decisions may be diminished. In low-risk birth settings, working with bereaved families may be rare; however, keeping a small space stocked with items these families might appreciate having is useful. Interested providers can consider taking training through Resolve Through Sharing (Gundersen Health System, La Cross, WI; www.gundersenhealth.org/resolve-through-sharing). *Bereavement Training: Perinatal Death* is a 2-day educational experience that benefits providers across disciplines who encounter persons facing the wide range of perinatal losses (eg, miscarriage, ectopic pregnancy, stillbirth, neonatal death).

For Michelle and Jane, continuing bonds theory explains several of their behaviors and decisions related to Zoe's birth and death. First, they brought clothes in which to dress her, including the outfit Jane herself wore home as a newborn, a tangible link of her infancy to that of their expected daughter. Reading her a favorite book reflected what they had anticipated would become a nighttime ritual; they created a memory by carrying out this act of parenting. With the perinatal palliative care team's help, they collected physical memorabilia of Zoe through her footprints and hand molds, photos, and clothing. By sealing her cap in a plastic bag, they hoped to preserve her scent, an important sensory element of memory evoking strong emotional responses. Furthermore, they incorporated Zoe's life into their family's history by using a familiar funeral home, scattering her ashes among her ancestors' graves, and placing a marker stone in the family cemetery. For settings without a perinatal palliative care team, a thoughtful, respectful discussion with a trusted intrapartum care provider in advance of labor (when possible) can be useful in assisting bereaved expectant parents to anticipate and plan for what they may want to do during labor and birth.

COMPLICATED GRIEF: RISK FACTORS ASSOCIATED WITH PERINATAL LOSS

Case Study, Part IV

Later that evening, the midwife stopped by Michelle's room and found her alone, crying inconsolably. When the midwife asked Michelle if she would like for her to sit with her, Michelle nodded, and the midwife took a seat in silence. As Michelle's sobs quieted, the midwife simply said, "Tell me . . . ," to which Michelle responded, "I never wanted to be pregnant. I hated it. I did it for Jane." She went on to explain how hard Jane's miscarriages had been for them, but that she had always known that she herself would "be really okay" without children. As the midwife listened quietly, Michelle admitted her fear: "I think the baby might have known I didn't want to be pregnant. There's no other reason she would have just died. It's my fault and I can't tell Jane. She would hate me forever." The midwife responded, "This is so hard. I am so sorry you are going through this."

Discussion

Despite the adaptive behaviors Michelle demonstrated after the diagnosis and labor and birth, she had deep feelings of guilt related to Zoe's demise. Without a clear cause of death, Michelle inferred that her negative feelings may have been related to the death, even to the point of causing it. *Ambiguous loss* refers to loss (in this case death) without a clear understanding of its cause.[22] Without a reason for the death, survivors are left with unanswered questions that can complicate their grief.

Complicated grief is the manifestation of grief that varies significantly from more predictable grief trajectories in length and/or intensity, although prediction of any individual's grief trajectory is uncertain at best. The concept of complicated grief has been debated among health care providers and scholars who study bereavement and grief. Although there is not full agreement as to what constitutes complicated grief, it is

defined currently as a prolonged response that prevents or impairs a person's return to his or her usual daily activities and is characterized by chronicity, preoccupation with the deceased, and intrusive thoughts, among others.[23,24] Perinatal losses are traumatic losses,[25] which increase susceptibility to complicated grief. Furthermore, women at increased risk for stillbirth are often negatively affected by social determinants of health: poverty, poor nutrition, less education, lack of access to health care, and other issues that decrease the likelihood of healthy neonate born at term. The accumulation of stressors with the additional burden of stillbirth may create a circumstance for women in which their grief is intense or unrelenting.

Several factors are present in Michelle and Jane's story that may complicate their grief. First, as a couple, Jane and Michelle have now had 3 pregnancies end in fetal loss, a combined reproductive history that will shape their decisions and experiences in the future if they decide to pursue pregnancy again. Second, although same-sex parenting has become increasingly common and accepted, some same-sex couples may struggle with being judged or marginalized in their attempts to become parents. Same-sex couples necessarily must bring a third party into their efforts to achieve pregnancy, such as a fertility specialist, a sperm donor, or gestational carrier (surrogate), hence starting their journey to parenthood where heterosexual couples end theirs, by including others into the most intimate confines of their lives.[26] Third, pregnancy for Michelle was marked by deep ambivalence as a function of her self-identity. Michelle's emotional confession to the midwife laid bare her deep fear that she caused Zoe's death by her ambivalence toward being pregnant. Importantly, Michelle appeared unable or unwilling to share her despair with Jane, fearful of her response.

Although not predictive, the accumulation of factors surrounding this situation place Michelle and Jane at risk for complicated grief. Michelle's willingness to share her feelings with the midwife is evidence of their trusting relationship and can serve as a foundation for Michelle's and Jane's healing over time. Health care providers who witness profound events in person's lives can have a significant role in helping them move through the first difficult hours and days and into the future. In this case, the midwife's simple invitation "Tell me…" was not judgmental or authoritative, but demonstrated her openness to what Michelle needed to say. Her response avoided trivializing Michelle's fear and simply acknowledged her pain with a genuine expression of sorrow.

CONCLUSION

Although not comprehensive, this presentation of grief theories with application to care in intrapartum settings gives providers insight into ways to understand their patients' responses when confronted by the paradox of death occurring at birth. The traumatizing aspects of stillbirth set into motion a highly complex response with implications for future childbearing, parenting children already in the home, intimate relationships, and physical and emotional health. By avoiding prescriptive or predictive formulations of when and how persons should move through their grief, providers are better positioned to help their bereaved patients understand and work through their grief in their own distinct ways.

Importantly, as a function of their work setting, intrapartum care providers may have limited time with women and families experiencing a stillbirth or other type of loss. What happens during that limited time, however, is highly significant. Supportive providers who understand the idiosyncratic nature of grief are well positioned to assist their bereaved patients and families in moving forward in finding their own ways of coping and healing through this painful time. In her caring theory developed from research with women experiencing miscarriage, Swanson described one caring category as "being with," that is, a posture of emotional presence that indicates to patients that their experience matters.[27(p 355)] Being with is characterized by availability of the provider using authentic presence, attentive listening, and reflective responses.

Intrapartum care providers occupy a privileged position in their witness of both the birth and death of an expected child. Through supportive care of the grieving woman, her partner, and family, providers can be instrumental in assisting them in determining their own meaning and responses to loss, rather than ascribing a set of expectations or behaviors in which a grieving person should engage. Stillbirth sets into motion a journey across the emotionally difficult terrain of grief. Even in the early hours and days of grief, however, the caring presence and openness of nurses, midwives, and other providers who bear witness to the experience, and who understand that responses to loss vary greatly across individuals, may buffer the bereaved woman and family from expectations of how to grieve. This instead creates the space and time for bereaved persons to determine their own needs and desires as they mourn, grieving the death of their expected child.

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