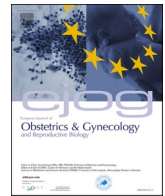




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## Review article

# Availability and effectiveness of interventions to support healthcare professionals exposed to patient pregnancy and neonatal loss: a systematic review

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## ABSTRACT

**Background:** Healthcare professionals (HCPs) exposed to pregnancy and neonatal loss experience considerable emotional and psychological burden; however, the availability and effectiveness of interventions to support them remain unclear.

**Objective:** This systematic review aimed to identify interventions for staff exposed to pregnancy and neonatal loss and examine their acceptability and effectiveness.

**Search strategy:** Conducted in accordance with PRISMA guidelines and registered with PROSPERO (CRD420251090187), MEDLINE, Embase, PsycInfo and CINAHL were searched from 2000 to 28 July 2025.

**Selection criteria:** Qualitative, quantitative and mixed-methods studies conducted in high-income countries were eligible.

**Data collection and analysis:** Data were synthesised narratively and presented using forest plots and an evidence gap map. Qualitative findings were analysed using thematic synthesis.

**Main results:** Forty-seven studies were included. Eight formal interventions and multiple intervention components were identified, including training, peer support, debriefing, organisational support, coping strategies and interventions promoting compassion satisfaction. Quantitative evidence consisted primarily of cross-sectional studies. Qualitative synthesis generated seven themes: acceptability of intervention packages; organisational support and workplace context; personal coping strategies and informal support; peer support; meaning making and compassion satisfaction; Every experience helps with the next: building preparedness for bereavement care; and debriefing and reflective practice;

**Conclusions:** HCPs exposed to pregnancy and neonatal loss require both preventative and post-event support. Interventions that enhance preparedness, peer support and compassion satisfaction delivered within psychologically safe workplaces, show promise but implementation must be supported by psychologically safe workplace environments.

## Introduction

The psychological wellbeing of the healthcare workforce has become

an increasingly prominent concern within the UK National Health Service (NHS), particularly in clinical settings characterised by repeated exposure to distress, death, and loss [1]. Pregnancy and neonatal loss

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affect a substantial proportion of pregnancies in the

United Kingdom (UK). Miscarriage alone is estimated to occur in one in four recognised pregnancies, while around 1 in 250 births results in stillbirth and thousands of families each year experience neonatal death or termination for fetal abnormality [2]. While the emotional impact of pregnancy loss for parents is widely acknowledged, considerably less attention has been paid to staff providing care during these events [3–6].

Healthcare professionals (HCPs) and support staff working in in maternity and neonatal services must balance clinical responsibilities with significant emotional demands, often supporting grieving families while managing their own emotional responses [4]. Emerging evidence suggests that exposure to pregnancy loss may contribute to emotional exhaustion, moral distress, compassion fatigue, and burnout, particularly when support is inadequate or when exposure is frequent [7,8]. These outcomes are significant not only for individual wellbeing but also for workforce sustainability, as they are associated with increased sickness absence, staff turnover, and reduced job satisfaction [9].

National initiatives, including the NHS People Plan and findings from the NHS Staff Survey [10], increasingly recognise stress, anxiety, and depression as key drivers of workforce attrition, sick leave and absence from the workplace. Within maternity care, the Royal College of Midwives' *Caring for You* campaign [11] highlights the emotional toll of supporting families through pregnancy loss and advocates for improved psychological support and compassionate workplace cultures. However, while some interventions (e.g., debriefing, counselling, structured supervision) have been proposed or implemented in local settings, their availability and effectiveness remain inconsistent. Furthermore, support staff are frequently overlooked [4].

Despite growing recognition of the psychological impacts of pregnancy and neonatal loss on healthcare staff, there has been no comprehensive synthesis of the interventions available to support them or of the evidence underpinning these approaches. Understanding what support is accessible, acceptable and effective is therefore essential for informing workplace wellbeing initiatives and improving the sustainability of bereavement care services.

This review aimed to identify: 1) the interventions available to staff exposed to patient pregnancy and neonatal loss; and 2) what interventions and intervention components are acceptable and effective in helping staff cope with the impact of exposure to patient pregnancy and neonatal loss.

## Methods

This systematic review was conducted in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines [12]. The review protocol was developed a priori and registered with PROSPERO (# CRD420251090187).

**Eligibility criteria:** Eligibility criteria were defined using the Population, Intervention, Comparator, Outcomes, and Study design (PICOS) framework.

**Population:** Studies were eligible if they focused on HCPs, or support staff in high income countries exposed to patient pregnancy and neonatal loss as part of their job role. Studies that reported a mixture of event types were excluded if the results for pregnancy or neonatal losses could not be separated, unless pregnancy or neonatal losses made up more than 50% of all reported events. Studies focusing on staff without direct or indirect exposure were excluded.

**Interventions:** The review included interventions designed to support staff exposed to patient pregnancy loss. Interventions could be delivered at an individual or group level and included psychological, behavioural, or social approaches, either alone or in combination.

**Comparators:** For the first review question concerning intervention availability, no comparator was required. For studies examining intervention effectiveness, eligible comparators included usual care, no intervention, or alternative active interventions. Studies comparing different intervention components or formats were also eligible.

**Outcomes:** Primary outcomes for intervention effectiveness included psychological outcomes (e.g. stress, anxiety, depression) and occupational or social outcomes (e.g. burnout, compassion fatigue, staff turnover). Secondary outcomes included staff views and experiences of support.

**Study design:** Qualitative, quantitative and mixed-methods studies of any design.

**Information sources and search strategy:** A comprehensive literature search was conducted across MEDLINE, Embase, PsycInfo, and CINAHL - (28 July 2025) (see [Appendix S1](#)) to identify literature published since 2000.

**Study Selection:** All identified records were imported into Rayyan, a web-based software program that facilitated title and abstract screening [13]. Titles and abstracts were independently screened by three reviewers (MW, CH & DJ) using Rayyan, with reviewers blinded to each other's screening decisions. Full texts were subsequently screened, also using Rayyan, (in priority order) by two reviewers (MW & SD). Following each stage of screening, reviewers compared their decisions and met to discuss any discrepancies, which were resolved through consensus. Rayyan was therefore used to facilitate independent screening, record decisions and identify discrepancies between reviewers, while all inclusion and exclusion decisions were made by the reviewers based on the predefined eligibility criteria. Only studies published in English were included.

**Data Extraction:** Data were extracted by MW and SI and included study characteristics (e.g. design, country, setting, sample size), methods (quantitative, qualitative, mixed methods and analytical details), participant characteristics (age, staff role and seniority, duration in role, type of perinatal loss), intervention characteristics (e.g. type or individual components), outcomes assessed, key findings, summary statistics (quantitative studies) quotes and themes (qualitative studies).

**Quality appraisal:** CH & HF completed the quality appraisal and risk of bias (RoB) using the CASP for studies reporting qualitative outcomes, and MW assessed RoB for studies reporting quantitative outcomes based on the Newcastle-Ottawa Scale (NOS).

**Data Synthesis:** For the first review question, data relating to the availability and characteristics of interventions were summarised narratively and as an evidence gap map showing different intervention components according to type of HCP. The components were identified iteratively based on both qualitative and quantitative evidence.

For the second review question, findings relating to intervention effectiveness and acceptability were synthesised narratively. Quantitative studies were restricted to those with a multivariable (adjusted) analysis or RCTs. A meta-analysis was not undertaken because of clinical heterogeneity in intervention characteristics, and outcome measures. Forest plots facilitated visual comparison of effect estimates across studies.

For the qualitative findings, thematic synthesis was undertaken [14]. Initially, CH and HF independently conducted inductive coding of all relevant qualitative data. Codes were then compared and discussed, before being grouped inductively into analytical themes.

## Results

**Fig. 1** shows the PRISMA review flowchart. In total 4344 records were retrieved, of which 1192 duplicates were removed. The remaining 3152 studies were screened by title and abstract, after which 70 full text articles were retrieved and 23 were excluded (see [Supplementary Table S2](#) for excluded papers with reasons). In total 47 met the inclusion criteria and were included in the review (see [Supplementary Table S2](#)).

### Characteristics of the included studies

**Supplementary Table S2** presents the characteristics of the included studies. Studies were conducted in 12 countries: UK (n = 11), USA (n = 13), Australia (n = 5), Ireland (n = 5), New Zealand and Australia (n =

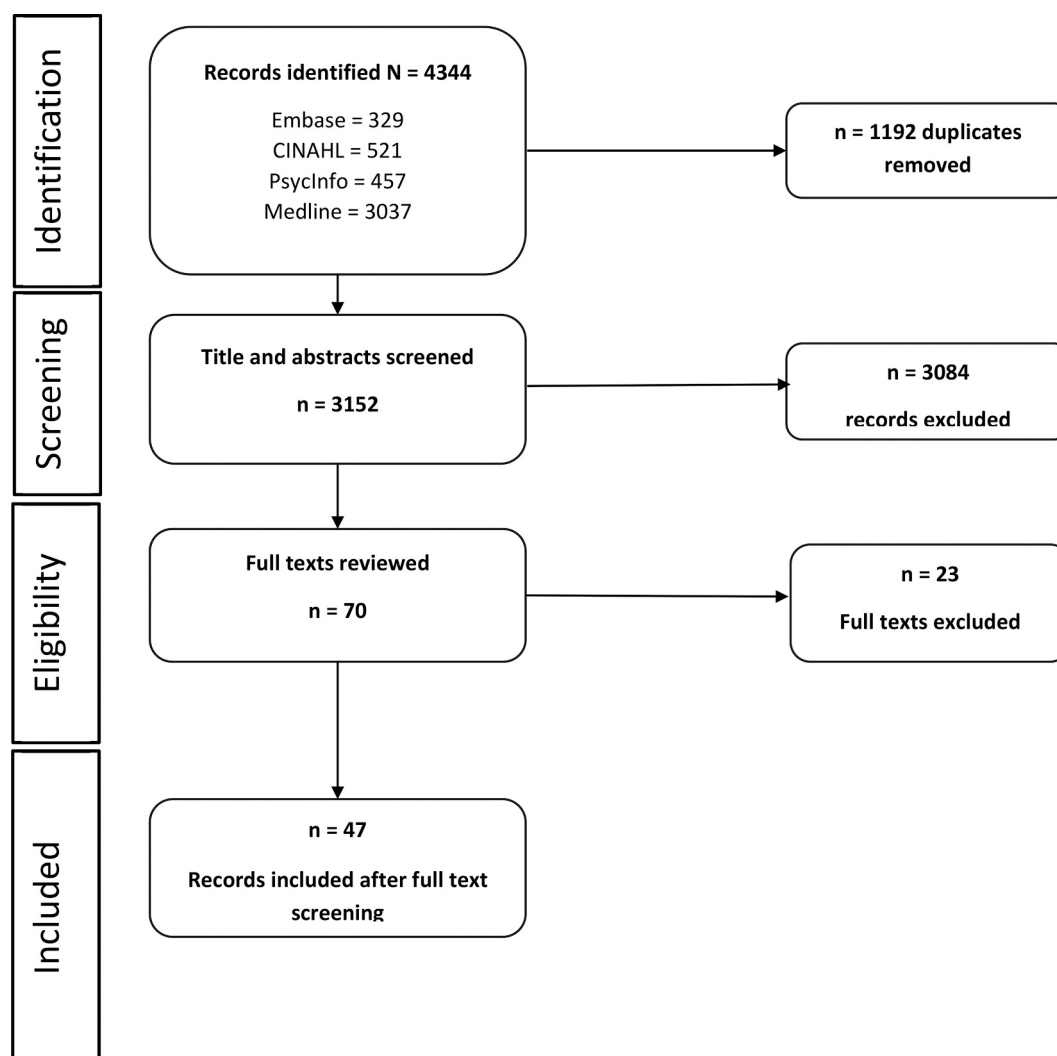


Fig. 1. Prisma flowchart detailing the process of identification, screening and eligibility for the systematic review.

2), Japan (n = 2), Italy (n = 2), Spain (n = 2), New Zealand (n = 1), Austria (n = 1), Turkey (n = 1), Norway (n = 1), Malta (n = 1). Participants included midwives, student midwives and nurses, obstetricians and gynaecologists, sonographers (each group reported separately, sometimes within the same study), and Neonatal Intensive Care Unit (NICU) staff and multidisciplinary staff (combinations of the above HCP and sometimes others, e.g., social workers, support staff, psychologists, anaesthetists). Twenty-two studies were qualitative, 13 mixed methods, and 12 quantitative. Four quantitative studies did not report multivariable analysis [15–18] and two studies used the same dataset [19,20]

#### Study selection risk of bias (RoB)

The results of the study quality assessments for the studies reporting qualitative findings are presented in [Supplementary Table S3](#). Three studies were assigned a high [21–23] RoB and three moderate [24–26] with the remaining assigned a low RoB. Risk of bias assessments for quantitative studies reporting multivariable regression analysis are presented in [Supplementary Table S4](#), conducted separately for different interventions in three studies [27–29]. Two studies were assigned moderate risk of bias for their training interventions [27,29], six high/moderate [27–32] and two high [33,34].

#### Availability of interventions and components

Most evidence related to intervention components rather than whole interventions. The most frequently reported components were peer support (28 studies) [18–20,22,23,25,27,29,32,34–52], training (20 studies) [22,23,25,27,28,31,32,38–40,42,45,47,49,50,53–57], coping strategies (23 studies) [17,18,20,22,23,27–29,31,32,35,37,39,42,43,45, 48,49,51–53,57–59] and debriefing (14 studies) [15,22,34,35,39, 41–43,45,52,53,57–59]. Organisational support was commonly identified as influential but was less frequently evaluated as a discrete intervention (eight studies) [19,20,27,33,36,38,43,58]. Similarly, the emerging ‘enabling compassion satisfaction’ component (10 studies) [20,24,25,27,28,32,36,38,42,43,51]. Formal intervention programmes were comparatively few (nine studies) [15,16,21,26,60–63]. [Supplementary Table 5](#) reports an evidence gap map (EGM) for different intervention components according to staff roles. [Supplementary Table 5](#) shows most interventions and intervention components to have been evaluated among midwives (14 studies) [19,20,28, 33,36,38,39,43,45,48,50,56–58] with fewer studies addressing sonographers (three studies) [25,42,60], NICU staff (four studies) [18,22, 55,61,64] and multidisciplinary teams (eight studies) [16,26,27, 32,34,35,40,60,65]. Coping strategies, debriefing and training were the components most widely evaluated across staff groups, whereas organisational support (eight studies, seven in midwives) and enabling

compassion satisfaction (10 studies, five in midwives) showed a less even distribution, with gaps particularly for nurses, obstetricians/gynaecologists and NICU staff.

Quantitative results: Interventions and intervention component effectiveness

No longitudinal or randomised studies evaluated intervention or component effectiveness. Eight cross-sectional studies examined associations between intervention components with outcomes using multi-variable analyses [27–29,31–34]; some interventions were analysed in a nested retrospective cohort study within the cross-sectional study [27,29].

Studies reported a range of outcome measures, either as continuous outcomes: Coping with death scale (CDS) [27], , Compassion fatigue [28], Impact of Event Scale (IES) (subjective distress in patients following a specific stressful event) [32],and IES-revised [29], Turnover Intention [33], Absenteeism [33], Global Negative Repercussion Score (depression/anxiety, PTSD symptoms, work problems) [34]; or as dichotomous outcomes: ‘stillbirth takes large emotional toll’ [31], Maslach Burnout Inventory - emotional exhaustion [29,30], ‘worrying about disciplinary or legal action when cause of death was unknown’ [31]. With the exception of the CDS, these are all negative outcomes representing psychosocial stress, and we grouped these together in the same analysis, but as separate subgroups, for each of the continuous and dichotomous outcomes. For the CDS the direction was reversed.

Intervention components were grouped into two broad categories: (1) preventative approaches (i.e. preparing the HCP before exposure through education, training, simulation and interventions promoting compassion satisfaction) and (2) post-event approaches (i.e., mitigating distress following exposure to pregnancy or neonatal loss: through debriefing, counselling, reflective practice and organisational support). Forest plots summarising these findings are presented in Figs. 2–6

Among preventative approaches (see Fig. 2), training in coping with death was generally associated with less negative staff outcomes. Higher levels of compassion satisfaction were consistently associated with lower psychological distress following pregnancy or neonatal loss.

In contrast, avoidant coping strategies, including emotional distancing, were associated with poorer outcomes (see Fig. 3).

Evidence for post-event interventions was more limited (See Fig. 4). For self-care activities it suggested less negative associations with staff distress in some studies, whereas the effectiveness of organisational support appeared to depend on the availability and quality of implementation (See Fig. 4).

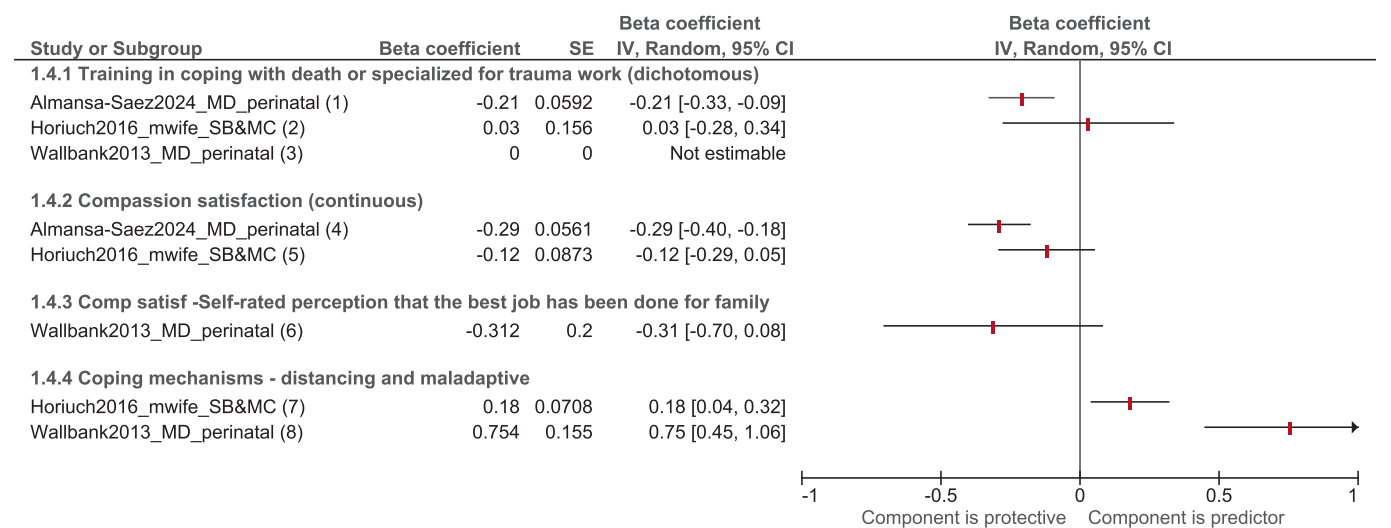
Five studies also explored other risk factors (See Fig. 5). Findings across two studies suggested negative repercussions of perinatal loss are worse for non-physicians than for physicians, especially midwives, but within the physician category, consultants were more likely to experience a large emotional toll following stillbirth (See Fig. 5).

Two studies explored other factors associated with psychological negative outcomes (See Fig. 6). Findings were inconsistent across two studies for years of professional experience, and one study indicated that number of perinatal loss experiences increased stress (See Fig. 6).

Qualitative results: Analytic themes relating to acceptability of interventions

While participants in included studies consistently described substantial emotional impacts associated with pregnancy and neonatal loss, they also identified a range of formal and informal strategies that helped staff cope with, prepare for and recover from these experiences. The following themes describe staff experiences and views regarding these different forms of support.

Seven themes were developed: 1) acceptability of intervention packages; 2) organisational support and workplace context; 3) personal coping strategies and informal support (usual care); 4) peer support



Footnotes

(1) Coping with Death Scale (9-63) - reversed, training in coping with death (dichotomous)

(2) Compassion fatigue (0-85) o/c; specialized training in trauma work (+perinatal loss); dichotomous

(3) 'Formal training' - not significant in correlation analysis

(4) Coping with Death Scale (9-63) - reversed, continuous factor

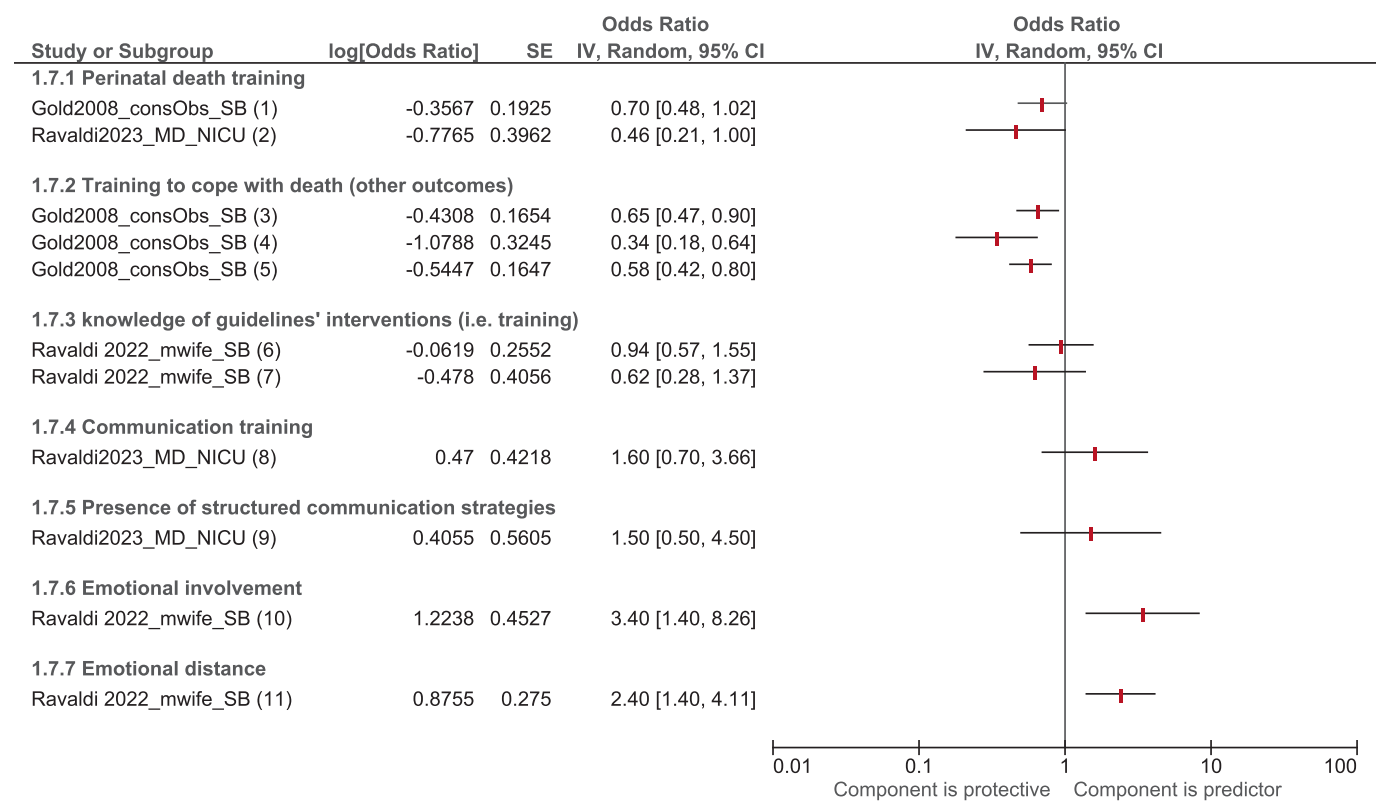
(5) Compassion fatigue o/c, compassion satisfaction continuous factor, multiple regression

(6) IES continuous o/c; best job for family assumed dichotomous

(7) Compassion fatigue outcome; distancing

(8) IES o/c; Maladaptive coping - self-distraction, denial, venting, disengagement, substance use, self-blame

Fig. 2. Preventative intervention/component associations with psychosocial negative outcomes (continuous). Key : MD = multidisciplinary, mwife = midwife, SB = stillbirth, MC = miscarriage.



**Footnotes**

(1) adequate training to cope with fetal and infant death; o/c stillbirth takes large emotional toll

(2) Maslach Burnout Inventory, subscale emotional exhaustion o/c

(3) adequate training to cope with fetal and infant death; o/c considered giving up obstetric practice

(4) adequate training to cope with fetal and infant death; o/c considered giving up obstetric practice

(5) adequate training to cope with fetal and infant death; o/c worry about disciplinary or legal action

(6) MBI burnout emotional exhaustion o/c; 41-50 vs <40

(7) MBI burnout emotional exhaustion o/c; >50 vs <40

(8) MBI emotional exhaustion o/c.

(9) MBI emotional exhaustion o/c. Presence of structured communication strategies

(10) high levels of IES (>30) (distress caused by traumatic events) o/c

(11) IES outcome (distress caused by traumatic events) o/c

**Fig. 3.** Preventative intervention/component associations with psychosocial negative outcomes (dichotomous). Key: consObs = consultant obstetrician, MD = multidisciplinary, mwife = midwife, SB = still birth, MC = miscarriage.

(usual care and organisational enabled support); 5) Meaning-making and compassion satisfaction (preventative support); 6) Every experience helps with the next: building preparedness for bereavement care (preventative support); and 7) Debriefing and reflective practice (post-event support).

1) Acceptability of intervention ‘packages’

Nine interventions were identified including the Experiential Learning Model [60] (UK), Perinatal Bereavement Care Simulation [63] (USA), Neonatal Simulated Bereavement Session [24], the Bereavement Debriefing Programme [30] (USA), the Applied Drama Workshop [54] (Ireland), Actor-based bereavement simulated scenario [62], the Bereavement Care Training and Protocol intervention [55] (Italy), the workbook Bereavement care for childbearing women and their families [54] (UK) and the M-HELP programme [16] (Australia).

Overall, interventions were perceived as acceptable when they combined practical bereavement education with opportunities for emotional support and reflection. Educational interventions, including the Perinatal Bereavement Care Simulation, Applied Drama Workshop, Bereavement Care Training and Protocol intervention, and M-HELP programme, were consistently reported to improve confidence, communication skills, preparedness and self-awareness. The

Bereavement Debriefing Programme and Maternity Bereavement Support Worker intervention were valued for facilitating emotional support, reflection and continuity of care, although engagement was often limited by workload and lack of protected time. The Experiential Learning Model highlighted the importance of mentorship and supported clinical experience in developing competence.

2) Organisational support and workplace context

Organisational and environmental factors emerged as fundamental influences on staff wellbeing, shaping both the provision of compassionate bereavement care and engagement with support interventions. Participants described supportive workplaces as those in which leaders acknowledged the emotional impact of pregnancy and neonatal loss [25,44,45,48,50,52,66,67], had procedures in place [35], proactively checked in with staff following difficult experiences, [25,37,39,57], and facilitated openness, trust and time out to process or spend time with bereaved families [25]. Participants valued opportunities to access specialist psychological input and discuss challenging cases within multidisciplinary teams [25]; however, utilisation of these services was low despite their perceived value [25].

*“In the few cases where I have been directly involved, I have asked the affected doctor to go home. It is akin to a train driver witnessing a suicide*

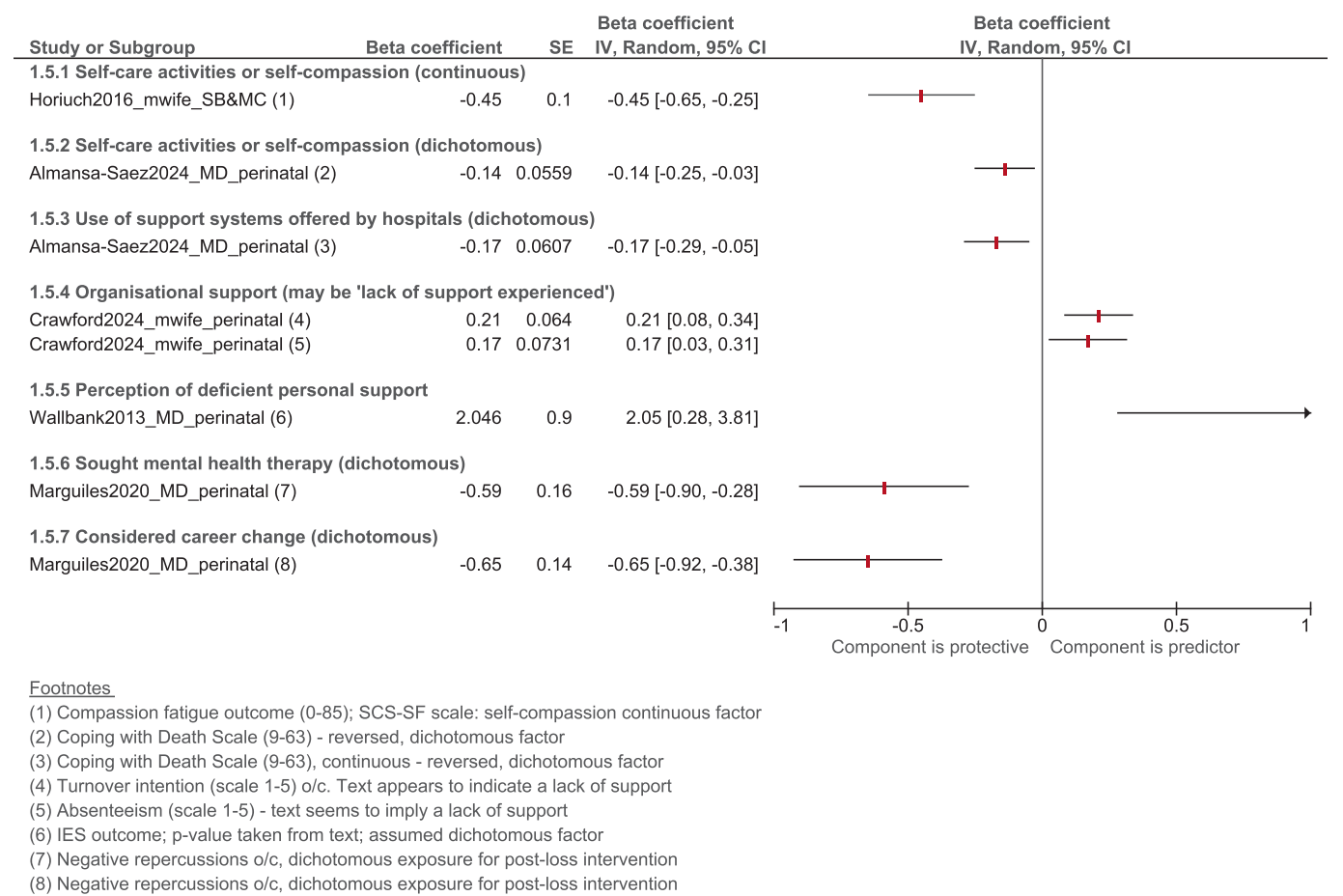


Fig. 4. Post-event intervention/component associations with psychosocial negative outcomes (continuous). Key: MD = multidisciplinary, mwife = midwife, SB = still birth, MC = miscarriage.

jump or crashing a car into a pedestrian. We would never expect people to work normally after these events so why should doctors?" [45]  
"She takes time to see how you're all going, what your thoughts on it are, how you're feeling about it, rather than just going, "OK, this is your caseload, get on with it," like others might" [50]

Participants frequently described organisational support as inadequate, inconsistent, insufficiently tailored to the unique demands of exposure to patient pregnancy and neonatal loss or reliant on individual managers rather than embedded in systems. Structural constraints including insufficient staffing [37,48], workload and time pressures [42,48] lack of protected time for reflection and debriefing [25,39,42,43,47,58] absence of bereavement protocols [37] and expectations that staff return to work following distressing events [42,46], limited opportunities to process emotional experiences.

"I find it heartbreaking. I feel I lacked resources and time to appropriately care for families experiencing loss" [37]  
"You weren't allowed to be just a little bit down or you had to put on the show for the next patient" [42]

Organisational cultures that normalised emotional suppression, failed to recognise the emotional demands associated with bereavement care, or prioritised service demands over staff wellbeing, created barriers to help-seeking and support utilisation [37,42,67]. A lack of privacy and inadequate facilities for delivering bad news and bereavement care [39,42,58] and absence of dedicated spaces for reflection were perceived to compound the emotional burden and reduce opportunities for recovery [38]. One participant described having:

"There is no place to talk to unburden our souls" [38]  
"There is no privacy for staff... no set up where you can go and talk to a person" [58]

3) Personal coping strategies and informal support (usual care)  
Staff reported drawing on a range of personal coping strategies and informal sources of support to manage the emotional impact of pregnancy and neonatal loss. These approaches were typically self-initiated and developed through experience rather than being formally introduced by organisations. Common strategies included emotional distancing [40,42,48,52], journaling and reflective practices [37], physical activity and music [51], and support from friends and family [37,44,46,48,51,59]. Participants also described drawing on faith and spirituality, prayer, mindfulness, acceptance, and reflection as ways of processing difficult experiences and managing emotional distress [37,43,59]:

"You just want to go home and get out of there and do something totally unrelated, something to distract you, like go for a boat ride or spend time with your family or go to a movie" [52]  
"You have to learn to distance yourself because otherwise if you take it too much on board you just fall apart" [48]

Alongside these participants described drawing on personal qualities such as inner strength, maturity, and commitment to professional values [36,37,50,58,60]. Experience was viewed as a resource in itself, with repeated exposure to bereavement care helping staff develop confidence and emotional coping capacity, to navigate challenging situations [23,35,37,44,48,60].

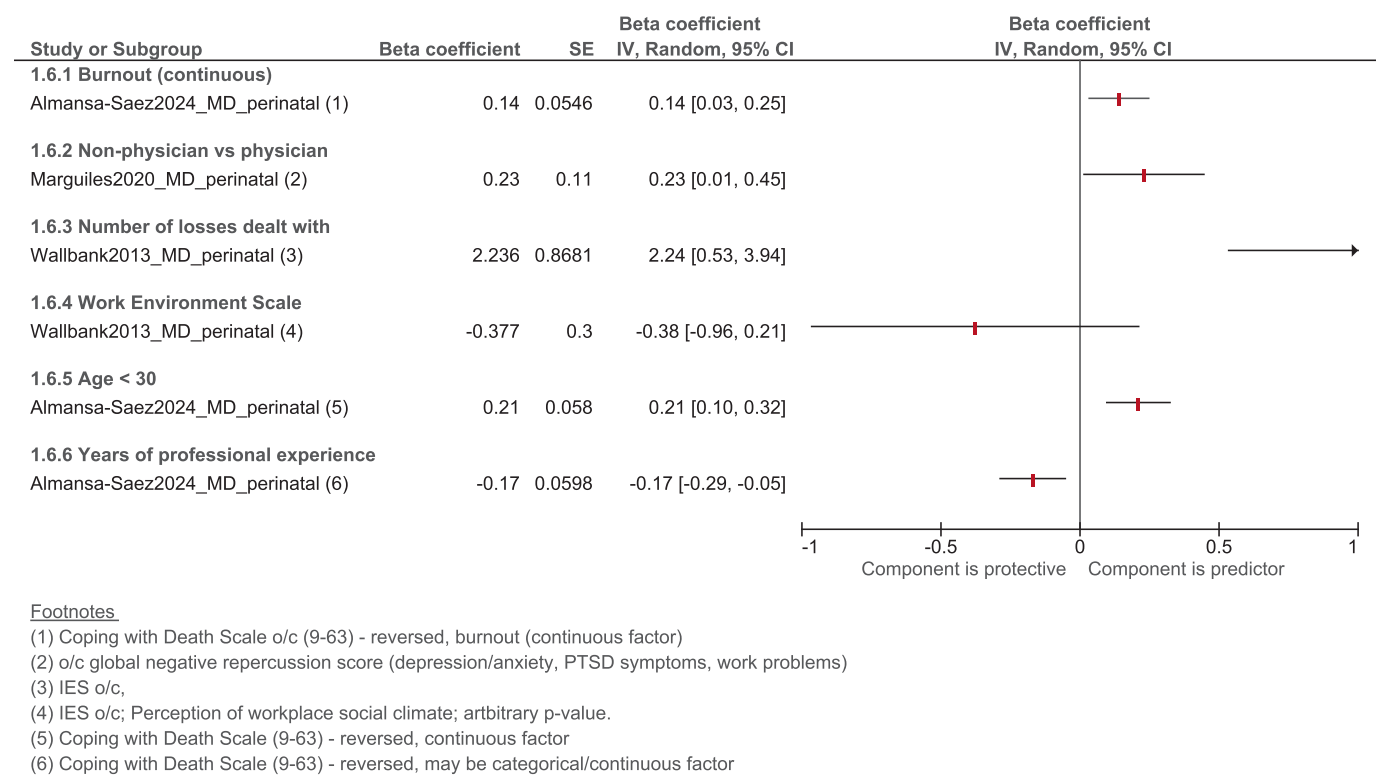


Fig. 5. Other factor associations with psychosocial negative outcomes (continuous). Key: MD = multidisciplinary.

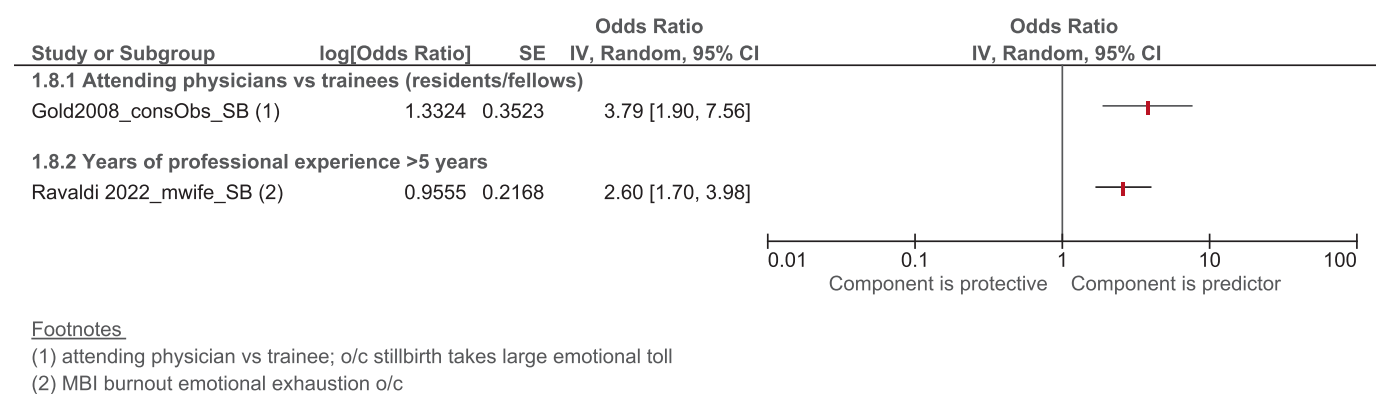


Fig. 6. Other factor associations with psychosocial negative outcomes (dichotomous). Key: consObs = consultant obstetrician, mwife = midwife, SB = still birth.

“It’s with experience you learn” [48]

4) Peer support (usual care and organisationally enabled support)

Peer support emerged as the most consistently valued and frequently utilised source of support across studies [25,35–47,50,51,57,59].

The value of peer support stemmed from shared experiences and a mutual understanding of the emotional realities of bereavement care. Peers “walked in the same shoes”, providing emotional validation, empathy, and practical guidance that family and friends outside the workplace were often unable to offer [36,37,44,48,52,57].

“What I need, I think, is to be able to tell someone about it. And that brings relief. And I think, unfortunately I have to admit it, that it’s important that this person be a woman, and it’s wonderful if she is a midwife, that is, someone who walks in the same shoes as me” [57].

“The best support mechanism is to go to another colleague”[46]

Peer relationships also served important professional and educational functions. Staff frequently described learning through observing experienced colleagues, discussing difficult cases, and seeking advice

from trusted peers [37,42,47]. More experienced colleagues were viewed as important role models who helped develop confidence, communication skills, and preparedness for bereavement care. Team-based approaches to care further strengthened opportunities for mutual support, shared decision-making, and collective responsibility when managing emotionally challenging situations [42,47].

“I think the duration of time it takes to overcome an event is inversely proportional to the level of collegiality and team spirit that exists in the place of work” [45].

Peer support was found to function not only as an informal coping resource but also as a key mechanism through which staff accessed emotional validation, practical knowledge, and professional resilience.

5) Meaning-making and compassion satisfaction (preventative support)

Alongside personal coping strategies, participants described experiences of meaning-making and compassion satisfaction that helped them navigate the emotional challenges of pregnancy and neonatal loss. Staff

frequently reported deriving a sense of fulfilment from providing compassionate care, being true to oneself, being fully dedicated and present for patients, meeting family's needs, and knowing they had made a positive difference during a profoundly difficult experience [21,36,37,41,43,46,47,50,52,60].

For many participants, this aspect of bereavement care was closely linked to professional identity and values. Supporting families through loss was often described as a privilege despite the emotional burden involved, with some staff reporting personal growth, increased confidence and a deeper understanding of compassionate care as a result of these experiences [37,44,60].

*"I had the privilege and the honour to be present [as a student] and it made me a stronger midwife because I had practised it at uni, and it made me think it is so important to be woman-centred" [50]*

*"The woman is the centre of my care and focus, it is her space" [36]*

Participants' accounts suggest that meaning making and compassion satisfaction were not simply individual characteristics but could be actively fostered through supported clinical exposure, mentoring, reflective practice, education and opportunities to witness the positive impact of their care.

6) Every experience helps with the next: building preparedness for bereavement care (preventative support)

Experience, education, and preparation were identified as important factors in helping staff develop confidence and competence in providing bereavement care. Across studies, participants described learning as an ongoing process that was shaped by repeated exposure to pregnancy and neonatal loss, observation of experienced colleagues, reflective practice, and formal training [21,41–45,47,50,60]. Many participants reported that experience enhanced their clinical knowledge, communication skills, and ability to manage the emotional demands of bereavement care, contributing to increased confidence over time [26,35,37,42,63].

*"So I think personally I've benefited a lot by watching different sonographers" [42]*

*"Every experience helps with the next" [43].*

*"To gain knowledge on how to handle these consultations by learning from experienced colleagues" [47]*

Across studies, preparedness was described as developing through a combination of formal learning and supported exposure to bereavement care. Participants consistently emphasised that experience alone was insufficient; rather, learning was most effective when opportunities for practical exposure were combined with mentorship, observation and structured education.

Conversely, lack of preparation was associated with feelings of distress, uncertainty, and inadequacy, particularly among less experienced staff such as student midwives, nurses and newly qualified practitioners [36,37,44,50].

*"I felt utterly unprepared as a new nurse" [37]*

Formal education and training were also viewed as important but often insufficiently available or inadequately integrated into routine practice [23,30,42,48,52]. Although experiential learning was highly valued, participants reported that much of their learning occurred informally through observing and consulting more experienced colleagues rather than through structured educational programmes [41,42,47,60]. Participants highlighted a need for ongoing and accessible training, including simulation, counselling skills, and bereavement-specific education [25,47] to improve preparedness, foster reflective practice, and increase confidence in their ability to manage such situations [30,47]. Participants emphasised the importance of learning how to break bad news, what language and terminology to use, and what to say, or avoid saying, to bereaved parents [16,26,40,42,47]. Being forewarned about caring for a family experiencing loss and having time to prepare mentally and practically were also identified as important facilitators of effective care [36,47].

*"Some training on communication... when we join maternity services would be really beneficial and potentially prevent some of this trauma" [26]*

*"Frequent courses help and foster reflective practice" [47]*

## 7) Debriefing and reflective practice (post-event support)

Frequent opportunities for debriefing for all staff groups were recommended [21,25,26,29,30,35,41–43,48,50]. Participants generally viewed debriefing as a desirable, acceptable and appropriate form of support following exposure to pregnancy and neonatal loss [25,26,30,47,50,61]. However, several studies reported that opportunities for debriefing were rare, or inadequate [35,36,39,46,49,50,58].

*"There is nothing specific for debriefing here for us" [36].*

*"Informal and inadequate due to lack of privacy" [58].*

*"My manager didn't reach out to me for about two weeks. Having a conversation, a lot earlier would've been supportive, and there was no debrief after it either. I think having my manager come to me sooner and check in and see if I needed to take time off or tell me how to access the hospital counsellor would've been a lot more supportive" [50].*

When available, debriefing was perceived to support both immediate and longer-term coping by providing opportunities to express emotions, share experiences, receive validation, and access further support [21,39,44,46,52,61]. Participants described debriefing as helping them process difficult events before returning home and reducing the accumulation of unresolved grief and sadness [36,39,61].

*"There was no formal debriefing but an informal debriefing that was very valid and actually very timely as I hadn't gone home and sat worried about it all night" [46]*

Several studies highlighted reflective practice as an important component of debriefing, whether undertaken individually or with colleagues [42]. Suggested approaches included incorporating debriefing within broader staff pathways [43] as well as structured models such as Balint groups [41] and Schwartz rounds [48]. However, there was little consensus regarding optimal format. Participants differed in their preferences for formal versus informal approaches, mandatory, versus voluntary participation and whether discussions should involve managers, senior clinicians or peers [45].

Across studies, the perceived value of debriefing appeared to depend less on the specific model employed and more on the presence of psychologically safe conditions. Barriers included lack of privacy, approaches that were not responsive to staff needs, and discomfort discussing emotions with colleagues [49,58]. Participants emphasised the importance of a supportive, non-judgemental, and no-blame environment that was clearly distinct from incident reviews or investigations [45].

## Discussion

This review identified a range of interventions and intervention components intended to support staff exposed to patient pregnancy and neonatal loss. The evidence suggests three broad categories of support. First, staff relied on usual care strategies, including personal coping mechanisms and informal support. Second, preventative approaches aimed to prepare staff before exposure through education, training and simulation and development of compassion satisfaction. Third, post event approaches seek to mitigate emotional distress after a loss event through debriefing, counselling, reflective practice and organisational support.

An important consideration is how approaches to supporting HCPs and support staff exposed to pregnancy and neonatal loss appear to have evolved over time, as reported in the included studies. This is illustrated in Supplementary Figs. S1 and S2. Earlier studies tended to emphasise staff experiences, informal coping and learning through exposure [23,35,44,60], whereas more recent work has increasingly explored

structured approaches such as simulation [63], applied drama and formal training [55,62]. Organisational support, debriefing and approaches to enabling compassion satisfaction, have increased proportionately more in the last ten years (Figs. S1 and S2). Importantly, the evidence suggests that experience alone may not be sufficient to build preparedness. Rather, learning appears to be most beneficial when practical exposure is accompanied by observation of experienced colleagues, mentorship, reflection and structured education [42,47]. This distinction is important because quantitative findings regarding years of professional experience were inconsistent [27,29], and greater exposure to perinatal loss was associated with increased stress in one study [29]. Thus, the emerging direction of the evidence may be less about increasing exposure and more about ensuring that experience is supported and translated into learning within psychologically safe environments. This is consistent with the qualitative evidence in this review, which describes repeated exposure as helping to build confidence and coping capacity but also identified mentorship observation and structured education as important in developing competence [27,29].

A key implication is that support for healthcare professionals and allied/support staff cannot be understood solely in terms of individual interventions. Across the evidence, the availability and perceived value of training, debriefing, reflective practice and peer support were shaped by wider organisational conditions including leadership, staffing, protected time and workplace culture [25,34,37,39,57,66]. Psychologically safe environments therefore appear to be a prerequisite for staff to engage with and benefit from available support. Staff frequently described relying heavily on colleagues for emotional and professional support, highlighting the importance of shared understanding and collegial relationships. These findings suggest that interventions can be implemented: both to prepare HCPs for future perinatal loss experiences, to help them develop professionally through enabling meaning making and compassion satisfaction, and also to support HCPs when they experience adverse outcomes. All these things require broader organisational support and buy-in.

Peer support may be particularly important within this wider organisational context. It was the most consistently valued and frequently utilised source of support across the qualitative evidence, reflecting the value of shared experience and mutual understanding [25,35–47,50,51,57,59]. However, peer support should not be viewed as a substitute for organisational responsibility. Mentoring, team-based care and protected opportunities for reflection may strengthen peer support, but their availability remains dependent on staffing, leadership and workplace culture. Peer support may therefore function as a bridge between individual coping and formal organisational support, provided that organisations create the conditions in which collegial support can occur.

The convergence between qualitative and quantitative findings also provides some insight into which approaches may be most promising. Training in coping with death and higher compassion satisfaction were associated with more favourable psychosocial outcomes [31], while emotional distancing was associated with poorer outcomes [30,56]. This suggests that approaches that build preparedness and support positive aspects of professional identity may be more beneficial than strategies based primarily on emotional disengagement. However, the evidence for post-event support was less consistent, with organisational and personal support showing variable associations across quantitative studies. This reinforces the importance of considering not only whether support is available, but how and within what organisational context it is delivered.

The findings are consistent with evidence from other occupational groups exposed to traumatic events, including emergency responders and healthcare workers in high-stress environments. Previous reviews suggest that support is most effective when interventions are tailored to staff needs, embedded within supportive organisational cultures and build upon existing peer support structures [68]. Similarly, workplace acceptance and commitment therapy interventions have demonstrated

reductions in psychological distress among HCPs through improvements in mindfulness and value-based action [69], suggesting opportunities to adapt approaches from adjacent fields to maternity and neonatal services.

The apparent importance of compassion satisfaction within this review may be particularly relevant. Participants described professional fulfilment, meaning making and the privilege of supporting families during profoundly difficult experiences. Similar concepts are increasingly recognised in burnout and resilience literature as protective factors that can coexist alongside exposure to emotionally demanding work. This suggests that support should not focus solely on reducing distress, but also on strengthening positive aspects of professional identity and the sense of meaning that staff may derive from bereavement care. Future interventions should therefore focus not only on reducing distress but also on actively fostering positive aspects of professional identity and bereavement care.

## Strengths and limitations

To our knowledge, this is the first systematic review to synthesise evidence relating specifically to interventions that support healthcare staff exposed to pregnancy and neonatal loss. The review included both quantitative and qualitative evidence, enabling examination of intervention effectiveness alongside staff experiences and perceptions of support. However, the evidence base was limited by the cross-sectional design, variation in populations and type of perinatal loss, complexity in interventions, and differences in outcome measures. Most studies relied on self-reported experiences and perceptions, and no RCTs were found. The risk of bias concerns also mean that the reported associations between intervention components and outcomes, and some qualitative themes, should be interpreted with caution and cannot support causal claims about intervention effectiveness.

## Recommendations

The findings suggest/indicate a multi-level approach to supporting HCPs and support staff exposed to pregnancy and neonatal loss. Organisations should embed bereavement care education, communication skills training, simulation-based learning, mentorship and opportunities for supported clinical exposure throughout professional training alongside timely access to psychologically safe opportunities for debriefing, reflection and peer support.

Support should be embedded within organisational cultures that acknowledge the emotional impact of pregnancy and neonatal loss. Supportive leadership, protected time, adequate staffing and clear separation of supportive debriefing from incident investigation or performance management may be important in enabling staff to access and benefit from available support.

Future research should prioritise theory-informed interventions evaluated using robust study designs, with particular attention to preparedness, peer support and compassion satisfaction and greater consistency in the measurement of staff wellbeing outcomes.

## Conclusion

HCPs and support staff exposed to pregnancy and neonatal loss experience substantial emotional burden and require support that prepares them for bereavement care and responsive support following distressing events. Support should not be viewed as a single intervention but as a system of interconnected individual, peer and organisational resources. Interventions that enhance preparedness, peer support and compassion satisfaction, show promise but their implementation requires psychologically safe workplace environments characterised by supportive leadership, protected time and opportunities for reflection and peer connection.

## CRedit authorship contribution statement

**China Harrison:** Writing – review & editing, Writing – original draft, Funding acquisition, Formal analysis, Data curation, Conceptualization. **Maggie Westby:** Writing – review & editing, Writing – original draft, Formal analysis, Data curation. **Hannah Family:** Writing – review & editing, Writing – original draft, Formal analysis. **Sharea Ijaz:** Formal analysis, Data curation. **Sarah Dawson:** Formal analysis, Data curation. **Madeleine Holland:** Writing – review & editing, Writing – original draft. **Debbie Johnson:** Writing – review & editing, Writing – original draft. **Sarah Newell:** Writing – review & editing, Writing – original draft.

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## Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

## Appendix A. Supplementary data

Supplementary data to this article can be found online at <https://doi.org/10.1016/j.ejogrb.2026.115456>.

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