The Impact of Stillbirth on Maternal Wellbeing

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KEYWORDS

• Still birth • Maternal wellbeing • Mental health • Education • Rainbow babies

KEY POINTS

- During pregnancy loss, families are often left with a sense of physical and emotional emptiness and may lack access to mental health care.
- Feelings of guilt and shame are common in bereaved mothers because their child's death occurred within their bodies.
- Patients should be encouraged to engage in follow-up care with their clinicians, and additional check-ins should be scheduled.

INTRODUCTION

This article is an invitation; it is the start of a conversation that can last far into the future, an invitation to learn how we as clinicians can best support parents who have experienced stillbirth. We discuss an inside look at stillbirth and its impact on the mental health and grief process of bereaved parents. In order to best support bereaved parents, we must understand the context created by historic and current research. This research can inform our understanding of where we have been, what we are currently doing, and our future direction. Lastly, this article will address the differences between grief and mental health and how our care must be tailored toward the specific needs of the bereaved. We have based this information on our clinical experience working with patients affected by stillbirth. Some of us have navigated stillbirth as parents or family members ourselves and appreciate that this life event presents unique challenges for both health care providers and patients. It is our sincere desire that the information here will help in providing compassionate and meaningful care to those who are living with the heartache of stillbirth and help instill comfort and hope for them.

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HISTORIC RESEARCH

Before the 1990s, there was limited research about the prevalence of stillbirth and its impact on parents, families, and communities. In the 1970s, researchers first described the importance of the bond between parents and their baby.[1] Until this time, it was uncommon for parents to spend time with their baby. For parents affected by stillbirth, this lack of presence affected parents' ability to reconcile the anticipated baby with the reality of the loss of their baby. This early research highlights the importance of physical presence and the mental consequences of limiting or denying parents the ability to be in their child's presence and parent them through acts of memory-making.

Additional support surrounding the importance of physical presence came in the early 1980s and pointed to a mother's instincts. Mothers instinctually search for their babies and desire to be in their presence; often, this need was left unacknowledged as clinicians discouraged or denied parents an opportunity to be with their stillborn baby.[2] Ultimately, this research provided a better understanding of how the care received in the hospital would impact parents' ability to process their grief.

Stillbirth has historically been greeted with silence, self-blame, and shame, with many clinicians believing that a lack of discussion and recognition would allow the family to move on from their loss quickly and effectively.[3] It was common for clinicians and hospital personnel to immediately separate parents from the stillborn baby. Often, parents were not allowed to view or hold their baby, or to engage in parental rituals with their child. Alternatively, parents were moved as soon as medically possible, away from other mothers, to an isolated portion of the hospital until discharge. Cognitive dissonance was prevalent amongst clinicians, who indicated that they were less likely to remember the families who experienced stillbirth compared to those who gave birth to a living baby.[4] Clinicians and society as a whole often failed to recognize the need to assist parents in mourning these losses.[3]

This failure, combined with the lack of socially acceptable grieving time, created consequences for both parents' mental health and their ability to form relationships with subsequent children.[4] Many of the socially acceptable elements of grief were missing; it was uncommon for parents to hold a funeral, garner social or familial support, or engage in memory sharing. In almost all other areas of grief, the bereaved are surrounded by the support of family and friends and an abundance of memories that help fill the void. They may also be provided psychiatric services in these circumstances. In the case of pregnancy loss, families are often left with a sense of physical and emotional emptiness and may lack access to mental health care.

Additionally, research in the 1980s gave us insight into the positive impacts of allowing bereaved mothers to bond with their stillborn babies after delivery. Mothers who were granted time with their baby and allowed to parent them through bathing, touching, and picture-taking reported satisfaction with that experience and a lack of regret over the time spent with their baby.[5] In many ways, the experience of parenting their child initiated the grieving process for both parents. Parents who spent time with their child also created memories that could eventually be shared with others and alleviate the overall grieving process.[5] Memory-making following a stillbirth allows parents to embrace their child's personhood and recognize their child's birth as an important event in their lives and also the world.[4]

Finally, it is important to recognize how stillbirth and grief were historically viewed through the lens of gender. From research and practical experience, we know that women are more likely to share their grief and emotions with others, while men traditionally maintain a more closed-off and subdued temperament while grieving.[6]

Unfortunately, this grieving difference has led to assumptions, which have, in turn, led to diminished care and may have unintended consequences of the parents being unable to provide comfort and support for each other. This difference has, in some ways, led researchers to believe bereaved mothers experience greater grief intensity than fathers.[6] Even research scales show bias toward maternal grief. Scales like the perinatal grief scale routinely show a higher degree of grief intensity amongst mothers, and at the same time, many scale questions lean toward maternal grief expression.[6] The differences between maternal and paternal grief are well-documented, and yet these differences have given way to a perception that maternal grief is greater than a father's grief. These perceived differences have influenced how society views and reacts to grieving fathers. As clinicians, we should not make assumptions about which parent grieves more deeply; rather, we should understand how we can best support both parents unique needs.

CURRENT RESEARCH

More recent research has evaluated how miscarriage and stillbirth impact the self-esteem of bereaved parents. Often, there is a sense of personal responsibility that accompanies stillbirth and pregnancy loss. Feelings of guilt and shame are common in bereaved mothers because their child's death occurred within their bodies. The loss of self-esteem that accompanies stillbirth is not seen in other areas of loss and indicates the extent to which bereaved parents internalize feelings of responsibility, guilt, and shame.[7] Ultimately, this can result in a negative shift in self-image.[7]

Additionally, researchers have found the reverse to be true: high levels of self-esteem were positively correlated with higher levels of functioning following a traumatic loss or event.[7] Often, parents who experience stillbirth recount feeling invalidated or dismissed by family, friends, and clinicians when they expressed concern about the loss. This dismissal can ultimately impact a parent's self-esteem and trust in themselves. This research highlights the importance of listening to patients and, whenever possible, compassionately and thoroughly addressing their concerns.

Lastly, research has recently shown us the degree to which pregnancy and infant loss are predictors of depression, anxiety, and post-traumatic stress disorder. Perhaps more importantly, it shows how that risk can be mitigated through the care provided to bereaved parents. In many ways, this research brought some of the early works full circle, showing that mothers who engaged in parenting activities subsequently acknowledged lower levels of depression and anxiety.[8]

GROWTH AND IMPROVEMENT IN CARE

Differentiating Grief and Mental Health

The degree to which mental health and grief intersect has been debated for years, resulting in a divide among clinicians. In part, this divide has been caused by a lack of education on grief and loss, both in medical school and for mental health providers. As many clinicians know, the topic of grief and mental health is not an in-depth discussion in medical school, leaving many clinicians feeling ill-equipped to recognize and differentiate grief and depression properly. Perhaps more surprising is the number of mental health providers who have no formal or required coursework in grief, bereavement, or thanatology. It is no wonder we struggle to fully understand grief and how it differs from mental health concerns. This lack of formal training and education can leave clinicians feeling helpless in the face of grief following stillbirth. We provide simple tools and information to aid in working with bereaved families.

In recent years, it has become common for bereaved mothers to receive a mental health diagnosis and/or medication upon or shortly after discharge from the hospital. It is in these situations that clinicians run the risk of adding trauma on top of trauma, leading the patient to feel misunderstood and increasing the risk of misdiagnosis.[9] When bereaved parents receive a mental health diagnosis without meeting the criteria, there is a risk of isolation, stigmatization, and further trauma. There is also an unstated message of silence and secrecy attached to the bereavement.

In providing improved care to bereaved parents, simple steps can be taken to ensure that we are caring for these individuals in a way that is congruent, compassionate, and accurate. We can begin by differentiating between grief and mental health. As stated earlier, all too often, parents are discharged with a mental health diagnosis and medication in hand. It is not uncommon for a grieving parent to be given a diagnosis of major depressive disorder, generalized anxiety, or prolonged grief disorder, many having received this diagnosis within days or weeks of their child's death. Each of these diagnoses comes with a very specific timeline that must be followed for proper diagnosis; for major depressive disorder, patients cannot be diagnosed until they have consistent symptoms for at least 2 w, generalized anxiety disorder, 6 mo, and prolonged grief disorder, 1 y.

Clinicians, regardless of their background, have a deep desire to help their patients; wanting them to feel better, heal, and get on to live their lives. These are honorable desires, and at the same time, those desires fail to take into account the irreversible and profound pain and grief that accompanies stillbirth. It is important that clinicians evaluate the optimal way to make patients feel better without leading to them feeling disenfranchised, isolated, and stigmatized.

A 2014 study of online support group participants showed that 37.4% of parents were prescribed psychiatric medication following the death of their child.[10] More important, perhaps, is the timeframe in which these medications were prescribed. OBGYNs wrote most of these prescriptions, with over 32% written within 48 h of loss and 43% within the first week.[10] Not only were patients unable to meet the criteria for a diagnosis in this timeframe, but only 25% of patients reported a historic diagnosis that would have warranted the consideration of these medications at such an early time. Thus, 75% of bereaved parents were prescribed medication for a disorder without a prior history and without the related diagnosis criteria.[10]

While clinicians may have a personal desire to help patients recover, there must be a recognition that such a desire can actually lead to blindness from the realities of grief. Grief and depression are not the same thing; even though they do have symptoms that overlap, they are not the same. If the child had been born alive, the symptoms they are experiencing would not exist. A parent whose child has died is not depressed; rather, they are grieving. In contrast, pre-existing depression symptoms would remain and would be unchanged by a different outcome. It is important to acknowledge that depression and grief can exist at the same time. It is equally as important to understand that the loss of a child does not require that a parent be diagnosed with depression.

Grief is an expression of our humanity, a pain associated with loss, and one that cannot be lessened or eliminated through the use of medication alone. Pausing before diagnosing or prescribing does not mean clinicians are left helpless in their support of patients. Rather, it requires that different tools should be utilized for expressing compassion and showing support.

Educating and Setting Expectations

One element of improved care must include educating not only clinicians caring for such patients but also educating patients on the symptoms of grief, the symptoms

of postpartum mood, and anxiety disorders, and how to tell the difference between the 2. How grief can present itself is as vast as the number of people who have experienced the feeling. Yet, we know grief can impact us emotionally, physically, cognitively, and spiritually. Physical reactions, including headaches, poor appetite, difficulty sleeping, increased desire to sleep, dizziness, exhaustion, gastrointestinal issues, and general aches and pains, are common.[11] Emotionally, a range of feelings may be experienced. Emotions such as anger, guilt, helplessness, sadness, yearning, emotional blunting, fear, anxiety, self-blame, and apathy may present themselves.[11] Bereaved parents may experience a host of cognitive symptoms associated with grief; these may include brain fog, difficulty concentrating, inability to grasp what is happening, depersonalization, memory loss, and vivid dreams.[11]

Stillbirth may present parents with challenges specific to spirituality or faith. Not only may there be a struggle to find meaning in loss, but the experience of stillbirth is shattering to the core beliefs of many parents. These core beliefs are often connected with an individual belief in a higher power. Stillbirth shatters the very core of our belief system, a belief that says, "babies don't die." When individuals are in the midst of grief and the shattering of beliefs, they may seek to find a way to explain and come to terms with what has happened. For many, anger and resentment toward God or a higher power become an element of the grief process. Clinicians must be aware and accept that sometimes, the anger and resentment may also be directed toward them even when they are trying to help the parents and families. Anger and resentment for some may be a way of coming to terms with what has happened, and for others, it may permanently change how they view life, faith, and fairness.

All of these symptoms (and more) may impact a parent's ability not only to function normally at home, work, and school but also to provide support for the partner who is also grieving. It is important to remember everything has changed for these parents, and they are trying to reconstruct their lives 1 piece at a time. Appropriate resources, referrals, and support systems can be put in place to assist parents in their search for a new normal.

Research tells us that birthing persons who experience stillbirth are more likely to experience postpartum mood and anxiety disorders (PMAD).[12] In distinguishing the difference between grief and PMADs, clinicians must evaluate the symptoms experienced and the root of those symptoms. Patients should be encouraged to engage in follow-up care with their clinicians, and additional check-ins should be scheduled. These can be offered as in person visits or by telehealth interactions and can be tailored to the parents' wishes. Many opportunities to assess a postpartum mother's well-being occur at well-child visits. These opportunities simply do not exist for bereaved mothers. Clinicians must ensure that opportunities are created to assess how patients are doing post-discharge and in the following weeks.

BETTER CARE = BETTER OUTCOMES

So, how do clinicians better care for these patients and families? What follows, will be areas in which clinicians can implement change to their policies and procedures. They are tangible things that we can do to positively impact how patients experience their care and form their loss story. These areas require open mindedness, vulnerability, and compassion on the clinician's part; they require that the clinician becomes part of their story, a story of loss, heartache, and love and also of hope.

Self-reflection

Before we can support our patients to move forward after a stillbirth, we have to understand ourselves. We must recognize our own implicit biases based on our personal

experiences with grief and death. If we enter into a hospital room or counseling session, and we are not prepared to join our patients in their grief, we may make unnecessary mistakes or omit important interventions and interactions. We run the risk of adding trauma to an already traumatic event. Many of us live in a death-denying society, and grief and the emotions that accompany it are uncomfortable and perhaps foreign. To provide compassionate support to our patients, we must become comfortable with the grief that surrounds stillbirth, and we can only do that by completing our own grief work. The work is never done; we must constantly evaluate and reflect on our own experiences, perceptions, and needs as they pertain to death and grief. We must become experts on our history and our grieving process. This may require assistance from therapists, mentors, colleagues, and may also include incorporating available medical literature. When we do our own work, we can reframe grief and death and we can begin to see grief as an expression of love and longing. Ultimately, we can see grief as the process by which we heal.

Our self-reflection must also include an honest assessment of our education on mental health and grief. Clinicians should acknowledge their strengths, as well as any knowledge gaps that may present an opportunity to learn. We can no longer assume that what we know will be enough. A genuine desire to grow and learn must be expressed. Grief associated with infant and pregnancy loss is unique and demands a willingness to grow as a clinician and meet patients where they are. We must give up the fear of not knowing and instead embrace the knowledge, experience, and information that will ultimately improve our patient's experience and possibly their overall outcomes.

Becoming a Part of Their Story

Perhaps the most powerful and difficult tool clinicians have is the choice to become part of our patient's story. As each parent navigates the early hours and days of their child's death, it is important to remember that their imagined life has shattered, what was expected is now gone, and they begin to move forward in a life that may feel foreign and lonely. From the moment of their child's death, they begin to write (and live with) a new story. They will compile pieces that will make up their story, the story of their child. You will be part of the story and get to decide what role you play in it. The clinician's ability to meet the parents and families wherever they find themselves in their time of grief will help foster a healing relationship and may hasten their progress recovery toward normalcy, even though it may be a new normal for them.

When we become part of our patients' stories, it is natural to feel some fear and discomfort. Becoming part of the story involves vulnerability and the acceptance that you may not always have the proper knowledge to say or do the right thing. It involves a willingness to feel the loss differently than them but to acknowledge the feeling all the same. We, as clinicians, need to recognize that we do not need to be perfect, but we do need to be human. We should communicate openly with them and not be afraid to ask them about their child. Ask if they have named their baby, and then use their baby's name. Acknowledge the child's place in the family, as a sibling, son, daughter, grandchild, nephew, and niece. Reinforce their child's beauty and importance in their family, community, and the world. Parents want nothing more than to know their child is beautiful and important. Allow them to see you caring for their child in the same beautiful ways you would care for their living child. Acknowledge the importance and existence of their emotions, both positive and negative ones. Encourage them and support them in the place where they are in their grief process, without making them hasten to move forward. Allow them to set their own pace in the grieving and healing process.

Common Language

Within the medical field, we become accustomed to using formal language. This language makes sense within our professional circles but may seem cold and unfeeling to the patients we serve. When working with bereaved parents, it is important to mirror the language that the parents use. Parents who have experienced a loss often may not identify with terms such as "fetus," "fetal demise," "products of conception," or "spontaneous abortion." The use of medical terms has its place and purpose, but while working with patients, these terms may harm the therapeutic alliance between providers and our patients. Use the words and language that families use, and refer to their loss the way they refer to it. There is no need to correct terms, because these terms may have special meaning to them. When a mother refers to her 18-w loss as a stillbirth, she is using that language for a reason. Instead, we should seek to understand the meaning behind it.

It is important to remember that you would not always say the right thing; you will not always do the right thing. Leave fear at the door, as it will do you no favors. You do not need to be perfect; you simply need to allow compassion and love to partner with your medical knowledge in leading you for the care of your patient.

Acknowledge and accept the different cultural and personal norms that patients and their families will bring to the situation. These may sometimes even manifest as refusal for a medical intervention or treatment. Remain flexible so that you can be respectful of their desires, without doing harm.

Open Communication

How we communicate with parents will have a lasting impact on their care experiences. As we communicate with our patients, we must remember their needs and capacity to take in new information. For many parents, this is their first experience with stillbirth. Thus, we should ensure that we offer helpful information as they navigate all the choices that lie ahead. They should be given ample time to absorb information and the space to ask questions. They should be allowed to refuse or modify care if doing that would not cause harm.

Honor the silence and spoken words. Some families may not have words to describe what they are feeling or what they need. It is ok to sit with them in the silence. While there may not be words, there is almost certainly loneliness and a sense of loss. The physical and emotional presence of the clinicians caring for such patients, even when silent, reaffirms that they are not alone and that the clinicians for a time, are walking this path with them along with all possible medical knowledge in order to help them in the grieving and recovery process.

Each family and individual will have their own unique culture and expression of their culture. We do not need to be experts on everything; we simply need to allow our patients to be the experts. Ask the patients about cultural or religious needs. Give them the space to speak about what is important to them and what we as clinicians can do to help fulfill those needs.

Memory Making

Research shows that the process of memory-making is not only important within the grief process but also decreases the incidence and longevity of depression and anxiety symptoms among bereaved parents.[13] Give parents every opportunity to make memories and parent their baby whenever possible. These parenting opportunities should include, but not be limited to, holding, bathing, and dressing the baby. In

addition, there are countless options for tangible keepsakes, including molds, prints, baby blankets, measuring tapes used for their baby, ID bracelets, locks of hair, diapers, and so on. Understandably, some parents are hesitant about taking photographs. Allow patients the option to take photos at a later date. Patients can choose not to take pictures; they cannot, however, go back in time and have photos taken. In many ways, clinicians can become the keepers of memories. Some families will not be ready to take keepsakes home; if possible, create a space where these items can be kept until the parents are ready.

Invite parents into the memory-making process and allow them to be as involved as they wish. For some parents this may involve active participation in creating hand- and foot-prints or other items. At the same time, other parents may prefer to observe these activities. Remember, there is no right or wrong way for parents to be involved; even if they decline, offer the options anyway. Inform them that their decisions are not necessarily final and that they can choose to re-visit decisions that they may have made early in the grieving process.

Many patients who have experienced loss have expressed heartfelt and sincere thanks to their medical team for the care they took in preparing and sending home keepsakes. These are items they treasure decades after the death of their child. Sadly, the opposite is true as well. Remember, there will be no second chance at capturing memories or keepsakes. Respect patients' autonomy, and allow them to decide what they will keep and for how long.

Making Appropriate Referrals

While providing appropriate referrals, it is important to recognize some patients may never have anticipated the need for such referrals and there may be varying responses to your efforts to connect patients with resources. Compassionate referrals to funeral homes are essential. Bereaved parents have likely never considered what funeral home or burial rituals they would like for their child, and your recommendation will set the tone for the care that comes after discharge. Pastoral and spiritual care referrals are essential for many patients. Pastoral care in the hospital setting may be important for some patients, so making this available to those who desire it can add support and a connection to a place of faith.

Seek out good referrals to group and peer support. These can be incredibly healing opportunities for bereaved parents. These referrals remind parents that they are not alone rather that they are seen and understood. Referral to quality grief counselors, who are highly trained in grief counseling, is important. Optimally, patients should have an opportunity to work with someone who specializes in perinatal grief, who can hold them in their grief, and bear witness to both the love and pain stillbirth brings. Lastly, remember you do not have to be good at everything. Whatever role you provide for a family, do that well and gently offer referrals to people who will walk the next part of the road with them. This journey is long, but it does not have to be lonely. Referrals can make all the difference.

Stillbirth of an Abnormal Baby

Holding a baby after stillbirth even if there are fetal congenital and structural abnormalities has been shown to have benefits similar to those seen with normal appearing stillbirths. No known adverse psychologic sequelae have been reported. Thus, this option should be offered, and the parents should not be discouraged from this action, if they so choose. Ceronsky and colleagues[14] surveyed 272 parents regarding holding versus seeing their stillborn baby. Of these, 196 (72.1%) held their baby and 27.9% did not. Of the ones who did not hold their baby, 73.7% saw the baby without holding them. The

majority felt that holding the baby was a positive experience. There were no differences between the groups of receiving a memory box, or having a memorial service.

Navigating Pregnancy after Loss: Rainbow Babies

Approximately two-thirds of patients will become pregnant again after stillbirth.[15] These babies are referred to as "rainbow babies" to symbolize great beauty and hope after a dark time. These patients will have unique medical, mental health, and social needs, including conflicting feelings of hope, joy, and excitement intertwined with anxiety, nervousness, and fear. Patients often describe the daunting feeling of "expecting the worst and hoping for the best" regarding outcomes during their future pregnancies.[16] Those who underwent a complete workup and received a probable explanation for the stillbirth may feel more reassured in future pregnancies if this event is unlikely to recur.[17] Some parents share a sense of dread at the gestational age when their previous stillbirth occurred. Therefore, all efforts must be made to reassure them and accommodate this fear by offering/allowing them the opportunity to talk about their fears, obtain additional visits including ultrasounds, and so on. Regardless of recurrence risk, clinicians should recognize and make every effort to address specific triggers that may exist throughout prenatal care (eg, ultrasounds, lack of continuity of care), labor, and delivery (eg, specific labor rooms or clinicians), and the postpartum period. The vast majority of patients want to discuss adverse life events with their clinicians,[18] and several resources exist to help clinicians initiate conversations that validate patients' concerns and goals.[19] When possible, patients can be referred to dedicated rainbow clinics that incorporate trained staff and trauma-informed care, and early research suggests these clinics may even improve pregnancy outcomes.[20] Although the full spectrum of optimal pregnancy management after pregnancy loss is beyond the scope of this article, we hope to empower clinicians to provide tailored and compassionate care for patients affected by pregnancy loss and their "rainbow babies."

Negative Symptoms	Interventions
Grief, stigma, shame, anger, envy self blame, withdrawal, drug seeking, poor coping, poor parenting, poor work performance, toxic behaviours, stress, hypochondria, sleep disturbance, poor personal hygiene, PTSD, poor self confidence, hopelessness, marital difficulties	individual therapy, group therapy, family therapy, crisis intervention, buddy system with other grieving parents/families, role modelling, role playing, anger management, social and financial support, desensitization, marriage therapy
Positive Symptoms	
Desire to help others wisdom, maturity, finding new meaning on life, acceptance, desire for future fertility	organ donation, activism, advocacy charity, mentoring, starting new projects/ventures, role modelling

Fig. 1. Symptoms and interventions for grief/loss.

SUMMARY

Pregnancy and infant loss forever changes those that we serve, and in some ways, it changes us as providers. *"Bereaved parents are forever changed by infant and pregnancy loss. Each person they come in contact with becomes interwoven into their story, their child's story. We cannot change what has happened, but each of us, from the first contact to the last, can shine a small light into the darkest of days. To say, you are not alone, we are here, and we remember."*[21] While we cannot prevent the occurrence of stillbirth, we can control how these losses shape us and impact our care in the years to come. We should be cognizant of the many different ways that the grief and loss may manifest and should make efforts to provide resources, therapy and interventions to assist the parents and their families (**Fig. 1**).

FURTHER RESOURCES

We recommend the following resources for readers interested in learning more about grief, care of the bereaved, and stillbirth.

1. Push Pregnancy https://www.pushpregnancy.org/
2. Star Legacy Foundation https://starlegacyfoundation.org/
3. Rainbow Clinic https://www.mountsinai.org/care/obgyn/services/high-risk-pregnancy-fetal-medicine/rainbow-clinic
4. The International Stillbirth Alliance https://www.stillbirthalliance.org/
5. Tommy's and NHS England https://www.tommys.org/pregnancy-information/health-professionals
6. Flutter Care https://www.fluttercare.com/
7. Pregnancy Loss and Infant Death Alliance https://www.plida.org/
8. Resolve Through Sharing https://www.resolvethroughsharing.org/
9. Pregnancy After Loss Support https://pregnancyafterlosssupport.org/
10. Postpartum Support International https://www.postpartum.net/
11. IMPROVE E-learning Modules from the Australian Stillbirth Center of Research Excellence https://stillbirthcre.org.au/researchers-clinicians/education-and-workshops/improve-elearning-and-workshops/
12. New York Times Series "Stillbirth: Your Stories" https://www.nytimes.com/interactive/2015/health/stillbirth-reader-stories.html
13. ProPublica "Stillbirth" Series https://www.propublica.org/series/stillbirths
14. Natalie Foundation https://campanha.nataliefoundation.org/home

CLINICS CARE POINTS

- Clinicians caring for patients who have experienced stillbirth play a critical role in the grieving process and in connecting patients with appropriate behavioral health resources.
- The majority of patients who experience a stillbirth will become pregnant again. Tailored prenatal care that addresses a history of stillbirth may improve pregnancy outcomes.

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