



Pregnancy Loss and Infant Death Alliance

Support :: Advocacy :: Awareness :: Education

Position Statement:

Offering the Baby to Bereaved Parents

When a baby dies, parents should be offered their baby within the context of an empathic relationship, where the health care provider engages parents in periodic conversations, eliciting their thoughts and feelings about spending time with their baby, and then supports the parents in doing what they believe is best, whether or not they elect to spend time with their baby.

Summary

- When a baby dies during pregnancy, birth, or following delivery, health care providers have the unique opportunity to support parents in their desire to spend time with their baby.
- Parents vary widely on how much time, if any, they want to spend with their baby, as well as when they'd like to see their baby, with whom, and what they would find meaningful and nurturing to do.
- Rather than having a single approach for all families or making sure that all bereaved parents spend time with their baby, the provider should engage in multiple conversations with the parents about their thoughts and feelings regarding their baby and the opportunity to see their baby, and then support them in doing what they believe is best for themselves.
- To support parents as they figure out what to do and how to make the most of this irreplaceable time, the provider should offer unbiased information and individualized guidance, including exploring the options and possibilities, offering reassurances for their concerns, and letting them know their baby continues to be freely available to them.
- Health care providers have a responsibility to make the baby freely available to parents for the duration of the hospital stay, as most parents are grappling with shock upon their baby's death and need plenty of time and support to consider their options. Some reluctant parents may change their minds, and knowing that their baby continues to be available gives them the freedom to reconsider.
- Whether parents want to be with their baby or not, parents need an experienced, knowledgeable, compassionate bereavement care provider to offer a safe and sacred space where they can do what is emotionally and spiritually meaningful to them.
- Cultivating an empathic relationship with the parents is what enables the provider to ask them about their unique emotional, physical, cultural, and spiritual needs, and to be responsive to them.

Background and Professional Literature

In the past few decades, increased awareness and sensitivity to the special needs of perinatally bereaved parents has changed hospital-based intervention— from *shielding* parents from the death of their baby to *supporting* parents through the experience. As a result, the modern standard of care is to encourage and offer grieving parents repeated and extended opportunities to have close contact with their baby. Most parents value the time spent with their baby, as well as the photographs and keepsakes from this time. Particularly for the mother, such contact can satisfy a strong and natural

desire to provide ongoing care for the baby in whom she is emotionally invested and psychobiologically oriented.

However, this intervention has recently come under scrutiny. It is sometimes carried out insensitively or inconsistently, as some health care providers feel unsupported, unsure, or uncomfortable about accompanying parents through this experience. Some parents report being given little choice regarding their care, and a lack of communication and support from their providers. There have also been questions raised about the long-term benefit to parents, particularly as there are some parents who do not want to see their baby after death, and there is no published empirical evidence that warrants insisting that reluctant parents do so. Finally, poor outcomes may be more likely for parents who do not receive adequate or appropriate follow-up care, underscoring the parents' need for information and long-term support around the grieving process as well as subsequent pregnancy and parenting. Understanding the complexities of parental bereavement requires further systematic research.

In the meantime, how can the health care provider navigate these tensions, and accommodate the parents who desire contact and stand to benefit *as well as* the parents who wish to decline time with their baby? And how can the provider work to ensure a better experience *and* outcome for all parents? The answer lies in focusing not on protocol, but process— or *how the intervention is carried out*.

Because many parents embrace the opportunity to spend time with their baby and report that they benefit, providers are justified in offering and supporting parents through this experience. But offering the baby needs to be more than a direct or one-time query. Most parents are in shock, unfamiliar with the concept, and unable to weigh their needs on the spot. Instead, offering the baby should happen in the context of creating a caring relationship with the parents, where the provider engages parents in periodic, open-ended conversations regarding their thoughts and feelings about their baby and about spending time with their baby's body. These conversations can help parents move through their shock, ask their questions, get reassurance for their fears, consider their options, and identify their needs. When parents decide to see their baby, these conversations also allow the provider to help them figure out how they want to spend this time. When one or both parents remain satisfied with their choice to *not* see their baby, the provider can support this decision and remain available to listen to parents talk about their baby and their grief. When a parent remains undecided, this indicates the need for more time and more dialogue. By remaining unbiased, openly exploring ideas and feelings, and letting them know their baby remains freely available, the provider can know that there is truly informed consent, whatever the parents decide to do.

Protocols and checklists, when used in the context of caring relationships, are important implements for promoting and guiding care. Protocols and checklists ensure choices and opportunities are offered to all parents regardless of the time of day, day of the week, or who is working. The health care provider must also individualize care, engaging parents in conversations about their options, enlisting each parent's right to make decisions, accommodating a variety of grief reactions, and regarding the uniqueness of each parent, family, need, and circumstance. Cultivating a caring relationship with parents is what makes this individualized care possible.

In short, implementation of this intervention requires an experienced, knowledgeable, and compassionate bereavement care provider who sensitively engages parents around the opportunity to spend time with their baby, and then supports parents in proceeding at their own pace and in their own way. This focus on building relationships is known as *relationship-based care*, and is a way to ensure parent satisfaction with care during this tragic time.

For more information, guidance, and support around implementation, please refer to the *PLIDA Practice Guidelines: Offering the Baby to Bereaved Parents*.

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References

Armstrong DS. Perinatal loss and parental distress after the birth of a healthy infant. *Adv Neonatal Care*. 2007 Aug;7(4):200-6.

Barnsteiner JH, Gillis-Donovan J. Being related and separate: A standard for therapeutic relationships. *Maternal Child Nursing Journal*. 1990;15(4):223-4;226-8.

Capitulo KL. Evidence for healing interventions with perinatal bereavement. *MCN Am J Matern Child Nurs*. 2005 Nov-Dec;30(6):389-96.

Carlson R, Weber-Dennigmann K, Lammert C. *Sharing and Caring: Establishing and Maintaining an Effective Share Program*. St. Charles, Missouri: Share Pregnancy and Infant Loss Support, Inc., 2007.

Davis DL, Stewart M, Harmon RJ. Perinatal loss: providing emotional support for bereaved parents. *Birth*. 1988 Dec;15(4):242-6.

Davis DL. *Empty Cradle, Broken Heart: Surviving the Death of Your Baby*. Rev. ed. Golden, CO: Fulcrum, 1996.

Davis, DL. Reflections on the Lancet Stillbirth Study. *The Forum, Association for Death Education and Counseling*. 2004;30:2, 4-5.

Gold, KJ. Navigating care after a baby dies: a systematic review of parent experiences with health providers. *J Perinatol*. 2007 Apr;27(4):230-7.

Gold K, Dalton V, Schwenk T. Hospital care for parents after perinatal death. *Obstet Gynecol*. 2007;109(5):1156-1166.

Hughes P, Turton P, Hopper E, Evans CD. Assessment of guidelines for good practice in psychosocial care of mothers after stillbirth: a cohort study. *Lancet*. 2002 Jul 13;360(9327):114-8.

Hughes P, Riches S. Psychological aspects of perinatal loss. *Cur Opin Obstet Gynecol*. 2003;15:107-111.

Kavanaugh K, Hershberger P. Perinatal loss in low-income African American parents. *J Obstet Gynecol Neonatal Nurs*. 2005 Sep-Oct;34(5):595-605.

Kavanaugh K, Moro T. Supporting parents after stillbirth or newborn death: There is much that nurses can do. *Am J Nurs*. 2006 Sep;106(9):74-9.

Kobler K, Limbo R, Kavanaugh K. Meaningful moments: The use of ritual in pediatric and perinatal death. *MCN Am J Matern Child Nurs*. 2007 Sept-Oct;32(5):288-96.

Koloroutis M. (Ed.) *Relationship-Based Care: A Model for Transforming Practice*. Minneapolis, MN: Creative Health Care Management, 2004.

Leon IG. Providing versus packaging support for bereaved parents after perinatal loss. *Birth*. 1992 Jun;19(2):89-91.

Leon IG. Perinatal loss. A critique of current hospital practices. *Clin Pediatr (Phila)*. 1992 Jun;31(6):366-74.

Limbo RK., Wheeler SR, Hessel ST. *When a Baby Dies: A Handbook for Healing and Helping*. Rev ed. LaCrosse, Wisc: Gunderson Lutheran Medical Foundation, Inc., 1998.

Meert KL, Thurston CS, Briller SH. The spiritual needs of parents at the time of their child's death in the pediatric intensive care unit and during bereavement: a qualitative study. *Pediatr Crit Care Med*. 2005 Jul;6(4):420-7.

O'Leary J. Grief and its impact on prenatal attachment in the subsequent pregnancy. *Arch Womens Ment Health*. 2004 Feb;7(1):7-18.

Saflund K, Sjogren B, Wredling R. The role of caregivers after a stillbirth: views and experiences of parents. *Birth*. 2004 Jun;31(2):132-7.

Swanson, KM. Nursing as informed caring for the well-being of others. *Image J Nurs Sch*. 1993;25(4):352-7.

Walling, AD. Tips from other journals: Should mothers see their infants after stillbirth? *Amer Fam Phys*. 2002 Nov 15: <http://www.aafp.org/afp/20021115/tips/17.html>

Workman E. Guiding parents through the death of their infant. *J Obstet Gynecol Neonatal Nurs*. 2001 Nov-Dec;30(6):569-73.

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