

REVIEW

Unravelling the grief of involuntary pregnancy loss: A meta-ethnography of midwives' and nurses' emotional experiences

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Abstract

Background: Parents who experience involuntary pregnancy loss encounter nurses and midwives when requiring care. But the environment in which this attention is provided turns it into a stressful and challenging event that favours the concealment of emotions. Literature supports the development of compassion in nurses and midwives who tend to parents who experience pregnancy losses.

Aim: To synthesise the emotional experiences of midwives and nurses when caring for parents who have suffered an involuntary pregnancy loss.

Method: This is a synthesis of qualitative studies following Noblit and Hare's interpretive meta-ethnography. Eleven studies met the research objective and inclusion criteria.

Results: An overarching metaphor, 'Unravelling the grief of loss', accompanied by four major themes provided interpretive explanations to the experiences of midwives and nurses in caring for involuntary pregnancy losses: 'Pulling the thread' – looking for the meaning of loss; 'Yarn entanglement degree' – determinants for grief expression; 'Detangling tools' – focusing on the loss; and 'Fraying the thread' – moving away from the loss.

Discussion: The provision of whole care to these parents requires midwifery and nursing training and continued education. Furthermore, the organisational culture should prioritise the health and well-being of midwives and nurses.

Conclusion: Midwives and nurses encounter the parents' loss in care and personally in various ways and give meaning to the loss conditioned by personal and professional determinants. They unravel the grief of loss by looking for the meaning, expressing their grief, focusing and moving away from the loss.

KEYWORDS

grief, midwives, miscarriage, nurses, qualitative research, stillbirth

INTRODUCTION

Involuntary pregnancy loss, defined as the spontaneous demise of a pregnancy [1], is a relatively common occurrence, and midwives and nurses are very likely to find a significant number of families who have experienced a pregnancy loss in a current or previous pregnancy [2]. Midwives and nurses are the healthcare professionals who tend to parents during pregnancy losses [3]. Encounters with these parents require care that goes beyond tasks, establishing a caring relationship and conceiving people as an indivisible entity that includes body, soul and spirit [4]. This study is part of a larger international research project on involuntary pregnancy loss [5, 6].

Under an unsupportive organisational culture, lack of preparation or knowledge and an emotionally demanding care, caring for these parents is a stressful and challenging event [3, 7]. This, together with a marked professional code of emotional expression, may require these professionals to set aside their own emotional responses and focus on the tasks demanded by their work context and the parents [5, 6, 8]. Despite being forced to conceal their emotions, the literature supports the development of grief in midwives and nurses who care for pregnancy losses [9, 10].

Grieving a loss is a universal human experience of particular relevance in nursing practice [11]. The literature relates grief to a normal reaction to the loss of a significant person [12]. But healthcare professional's loss and grief related to patient deaths differs from loss and grief related to the death of a loved one [13, 14]. Studies support that a variety of work situations can cause mourning for healthcare professionals. Midwives and nurses experience suffering, loss and death situations as part of their work [10, 15]. Multiple recurrent patient deaths with inadequate opportunity to address each one can result in nurses becoming overloaded with loss and grief [11, 16]. Despite nursing or midwifery deal with care situations that involve joy and life, the exceptional nature of these losses makes them events with significant repercussions for healthcare professionals. These losses are characterised by multiple losses for both parents, midwives and nurses, occurring, in many cases, acutely and suddenly [17, 18]. On the other hand, not only are these midwives and nurses required to process this loss, they also have to witness and support the grief of bereaved parents [19, 20].

Meaning-making is a subjective experience by which we perceive and give meaning to reality; reality is always interpreted by the meanings we attribute to our experiences. It is an essential process, especially if a particular death threatens our view of ourselves or the world, generating emotions of danger, anxiety, confusion, injustice, unfairness, betrayal or guilt. To manage these emotions, we seek to redefine and rebuild our worldview in a way

that makes sense to us [21]. This process is integral to grief and vital when we are exposed to multiple deaths [18].

While literature on midwives' and nurses' experience of grief is scarce [10], more in-depth research on this topic is demanded [5, 6], since it would provide important keys for the care of parents following an involuntary pregnancy loss. Besides, in understanding this grieving process, the nursing faculty, administrators and leaders can create better learning opportunities and provide a more supportive practice environment for midwives and nurses [22]. Thus, this meta-ethnography aimed to synthesise the emotional experiences of midwives and nurses when caring for parents who have suffered an involuntary pregnancy loss.

This research is based on Katie Eriksson's Theory of Caritative Caring [4], for which caring implies not only performing professional nursing duties, but also a motive. This motive consists of alleviating suffering and promoting health and life. Care includes *caritas*, love and charity, the respect of health professionals for the dignity of the person, and a strive for genuine communion and understanding of the unique human being. Caritative caring thus involves an encounter in which suffering and caring humans are active participants in their own lived worlds of experiences and wishes.

Concepts from the grieving literature consistent with this theory [21], the Dual Process Model of Coping with Bereavement [23] and the Model for Professionals' Grieving Process [13, 18] were used for meaning reconstruction. These perspectives created a theoretical tapestry that allows to explore new areas that may shed new light both on the studied phenomenon and the theory.

METHODS

This is a meta-synthesis of qualitative studies with a meta-ethnographic approach [24]. Its goal is to combine results interpretively, rather than aggregately, via an inductive process, constituting a systematic translation. This study followed Noblit and Hare's seven phases of synthesis [24]: (1) getting started, (2) deciding what is relevant to the initial interest, (3) reading the studies, (4) determining how the studies are related, (5) translating the studies into one another, (6) synthesising translations and (7) expressing the synthesis. This meta-ethnography complies with the eMERGe meta-ethnography reporting guidelines [25].

Search methods

Developed by the first author, a comprehensive systematic search strategy – without time limitations and filtered for the English, Portuguese and Spanish languages – was undertaken in PubMed, Scopus, CINAHL, PsychINFO and

Web of Science in August 2019 and updated in June 2020. Back-and-forth tracking and manual searches were also conducted [26].

Medical Subject Headings, CINAHL descriptors and free terms were used as search terms, based on the phenomenon of interest (involuntary pregnancy loss), purpose of the study (care experiences), sample (midwives and nurses) and type of research (qualitative research). They were combined using Boolean operators and truncations to ensure a broad search.

Search outcomes

The article selection process took place on phase 2 of the meta-ethnography. Original qualitative or mixed articles considered adequate for the research objective, whose sample comprised nurses and midwives and whose type of loss was miscarriages and stillbirths, were included.

Initial database searches resulted in 742 records, of which 281 duplicate articles were removed. The titles and abstracts of 517 retrieved papers were assessed against the inclusion and exclusion criteria. Of these, 35 articles were read in full and examined in relation to those

criteria, where 25 papers were excluded for sample reasons, phenomenon of interest, type of loss, methodology and type of paper. The final sample comprised 10 articles, to which one more result was added after the search was updated [27] (Figure 1). The entire selection process was conducted by SFB and in team sessions with MJMF and CC, to reach consensus.

Quality appraisal

Quality assessment of each article included in the sample was performed in team sessions by SFB, CC and MJMF using the Joanna Briggs Institute Qualitative Assessment and Review Instrument (QARI) [28]. General assessment showed a high quality of the articles included regarding their goals, designs, analyses and results, providing useful knowledge on the topic (Table 1).

Data extraction and synthesis

Data extraction and synthesis were led by SFB, but meetings between all authors were held during all the

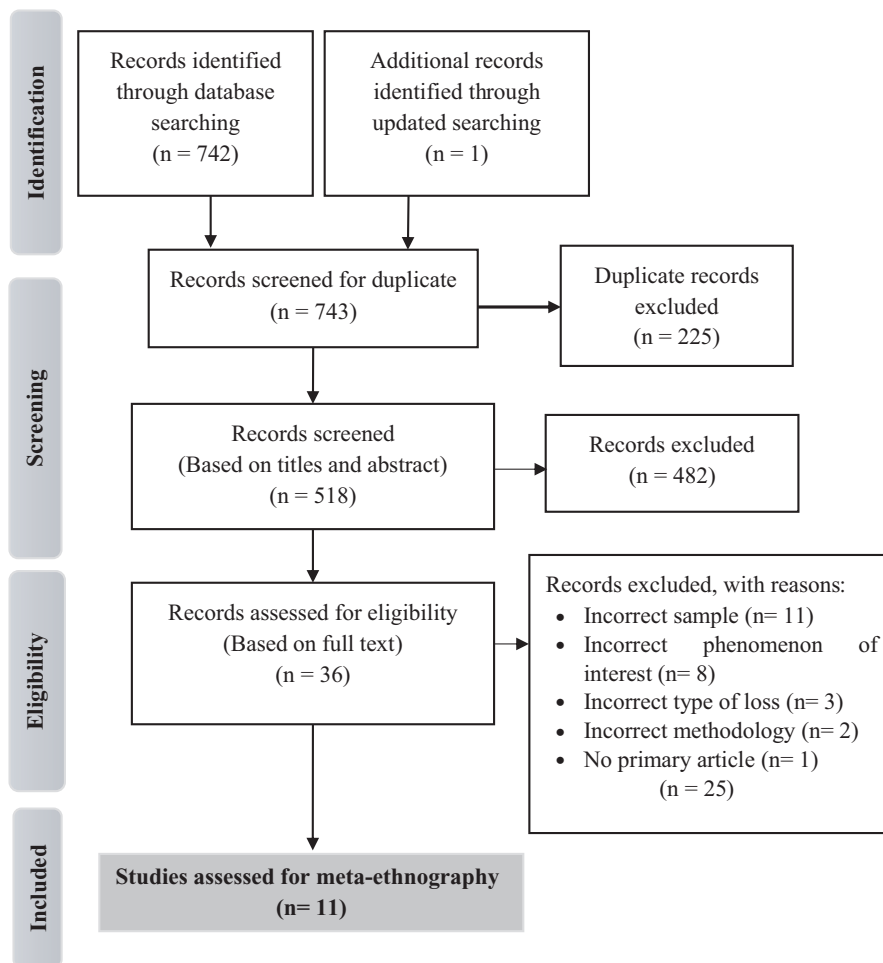


FIGURE 1 PRISMA flow chart

TABLE 1 Quality assessment of included studies [28]

Article	Questions									
	1	2	3	4	5	6	7	8	9	10
Beaudoin and Ouellet (2018)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Hutti (2016)	-	✓	✓	✓	✓	✓	✓	✓	✓	✓
Jonas-Simpson, et al. (2010)	✓	✓	✓	✓	✓	✓	-	✓	✓	✓
Jones and Smythe (2015)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Lappeman and Swartz (2020)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Martinez-Serrano, et al. (2018)	✓	✓	✓	✓	✓	✓	-	✓	✓	✓
McCreight (2005)	✓	✓	✓	-	✓	✓	✗	✓	✓	✓
Nallen (2006, 2007) ^a	✓	✓	✓	✓	✓	✓	✗	✓	✓	✓
Nash (2018)	✓	✓	✓	✓	✓	✓	-	✓	✓	✓
Roehrs, et al. (2008)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Willis (2019)	✗	✓	✓	✓	✓	✓	✗	✓	-	✓

✓Yes – Unclear ✗No; Critical appraisal questions: (1) Is there congruity between the stated philosophical perspective and the research methodology? (2) Is there congruity between the research methodology and the research question or objectives? (3) Is there congruity between the research methodology and the methods used to collect data? (4) Is there congruity between the research methodology and the representation and analysis of data? (5) Is there congruity between the research methodology and the interpretation of results? (6) Is there a statement locating the researcher culturally or theoretically? (7) Is the influence of the researcher on the research, and vice versa, addressed? (8) Are participants, and their voices, adequately represented? (9) Is the research ethical according to current criteria or, for recent studies, and is there evidence of ethical approval by an appropriate body? (10) Do the conclusions drawn in the research report flow from the analysis, or interpretation, of the data?

^aTwo parts of the same study.

processes. First, the authors extracted information regarding the aim, sample, method, type of loss, data collection methods and key findings of the study (Table 2), which allowed providing context for the interpretations and explanations of each paper.

Then, by reading the articles (phase 3), the first author became familiar with the content and detail of the included studies, which began with Nallen's article [29, 30], the richest regarding data. First-order (participants' quotations) and second-order (authors' interpretations) concepts [31] were extracted across the full primary studies, recorded in a table. In phase 4, concepts were compared intra- and inter-study in search of similarities and contrasts, which led to the formation of new concepts and the adoption of existing concepts. In phase 5, the findings were incorporated from the studies into one another by analogous (concepts in one study can incorporate those of another) and refutational (concepts in different studies contradict one another) translations to form new third-order concepts [31]. The analysis process was iterative and involved moving back and forth in the data, comparing and contrasting the findings from the individual studies and translating them into one another. Finally, in step 6, a new understanding of the phenomenon was developed, being the basis for the lines of argument synthesis,

where a metaphor with sufficient comprehensiveness and abstraction emerged to connect the findings [25, 32]. All the authors agreed on the themes and the overarching metaphor.

Finally, the obtained findings were evaluated using the Confidence in the Evidence from Reviews of Qualitative research (CERQual) tool [33], which allows showing the degree of confidence in the review findings (Table 3).

RESULTS

The sample comprised 11 qualitative primary articles, belonging predominantly to hospital settings in western countries and included a total of 129 midwives and nurses, who mostly cared for stillbirths. Table 2 presents more detailed information on the items included.

Four themes emerged from the translation process, where the lines of argument synthesis are visualised in Figure 2. The metaphor '*Unravelling the grief of loss*' symbolises midwives' and nurses' emotional experiences when caring for parents who have suffered an involuntary pregnancy loss. Following a pregnancy loss, midwives and nurses face a tangle of emotions they have to manage. They symbolically attempted to untangle the ball of yarn

by pulling on the thread, which represents their meaning-making process. The tangle, however, is conditioned by determinants that influence grief and meaning-making, which are symbolically represented as the *Yarn entanglement degree*. The healthcare professionals managed to lean on tools to facilitate unravelling (*'Detangling tools'* – focusing on the loss) and thus were able to provide care and avoid or minimise entanglement by *fraying the tangled thread*.

CERQual assessment showed high confidence on all themes except one, which showed moderate confidence. This implies that the results are a (highly) reasonable representation of the phenomenon of interest (Table 3).

'Pulling the thread' – Looking for the meaning of loss

Caring for parents who have suffered a pregnancy loss involves a personal cost to midwives and nurses, who have to deal with draining emotions. Pulling the thread symbolises choosing a thread to pull on and undo the emotional entanglement, that is the meaning-making process of the loss.

Midwives and nurses reported that caring for and encountering these parents were hard, emotionally draining and required significant involvement on their part [34–37]. These losses affected their personal lives: for several days they remembered the encounter with the parents and felt depressed and physically and mentally exhausted [38, 39].

It's one of the most emotional and deep, profound experiences that I can have. They take a lot out of me, but I find it personally rewarding, especially if I'm able to meet [the parents'] needs. [35]

Their explanations for the losses helped them deal with these emotions and demands. Many professionals focused their thoughts on how their care contributed to the parents' well-being and that they provided care to the best of their abilities [34, 40]. Feeling useful, valued and proud of themselves offset the emotional demand that caring entailed [35, 40, 41].

In some, this reasoning relied on faith and religion [34]; others based it on clinical aspects, where death is understood as the best alternative. Specifically, midwives and nurses found pregnancy losses where foetal abnormalities were later observed easier to cope with [29, 30]. In services such as maternity, pregnancy losses constituted a result opposite to that expected and the midwives related the losses to a failure in the care process [39].

'Yarn entanglement degree' – Determinants for grief expression

The degree of entanglement metaphorically represents the determinants by which the grieving process and meaning-making can be influenced.

Grief education and training were key in making midwives and nurses comfortable to care for a grieving family [34, 37, 40]. Such training can be provided by mentoring by other experienced colleagues, by attending study days with parents' participation, and by reading information packs [34, 37, 41].

Besides training, previous professional experience also contributed to feelings of confidence and comfortability. Those prior care experiences enriched their practice and provided a better understanding of the care situation, increased their knowledge, decreased their stress and allowed them to go beyond care techniques [29, 30, 37, 40, 41]. Exposure to such situations, even as students, is essential to generate feelings of control and confidence on facing pregnancy losses [40].

The more experience that you have caring for these patients gives you confidence. I feel that you are able to read people easier and care for them in the way that they need to be cared for. [40]

Conversely, being recognised as the experienced professional with this situation encouraged others to delegate care to them, which can lead to fatigue in professionals [29, 30]. On the other hand, feelings of apprehension may emerge when previous care experiences were negative [41].

Explicit and implicit system of values and assumptions about the care, and the set of rules prescribing midwives' and nurses' behaviour also constitute important determinants. For example, one rule stipulates that midwives and nurses should not show their grief before parents, which left them conflicted. Hiding one's own emotions is thus understood as appropriate professional behaviour. Some professionals managed to contain those emotions, show emotional disconnect, care in an automatic way or express their emotions privately. Others found it hard to contain those emotions, especially when they built an emotional bond with the parents or their personal beliefs and values conflicted with the parents' choices. In some cases, emotional connection was understood as important, helping professionals be in tune with the parents' emotions [29, 30, 37, 40–43].

It was about them not about me...you're trying to hold back all of these emotions. That's why I let rip in the tea room. You can't get

TABLE 2 Paper characteristics

Authors (Year)	Location	Sample and setting	Type of loss	Methodology	Data collection methods
Beaudoin and Ouellet (2018)	Canada	Seven obstetric nurses three managing nurses	Perinatal loss (Death of a baby during the pregnancy (>20 gestational week) or a few days to a few weeks after childbirth)	Fourth-generation constructivist evaluative method	Semi-structured interviews
Hutti (2016)	USA	28 obstetric, surgery, and emergency nurses	Foetal loss (Included miscarriages (<20 gestational week) and stillbirths (from >20 gestational week to birth))	Not mentioned	Focus group
Jonas-Simpson, et al. (2010)	Canada	Nine obstetrical nurses	Stillbirth (>20 gestational week)	Exploratory qualitative descriptive method	In-depth face-to-face structured interview
Jones & Smythe (2015)	New Zealand	Five self-employed midwives	Stillbirth (Death of a baby before or during birth, from the 20 gestational week onwards, or weighing 400 g or more at birth)	Hermeneutic interpretive phenomenology	Individual interviews
Lappeman & Swartz (2020)	South Africa	Seven labour nurses	Stillbirth (Baby born with no signs of life at or after 28 weeks of gestation)	Free Association Narrative Interview Method	Open-ended questioning
Martinez-Serrano, et al. (2018)	Spain	17 hospital midwives and one primary health centre midwife	Late foetal death (≥ 1000 g birth weight, ≥ 28 gestational week and ≥ 35 cm body length)	Hermeneutic-interpretative phenomenological approach	Three focus groups
McCreight (2005)	Ireland	14 gynaecological nurses	Pregnancy loss	Not mentioned	Semi-structured in-depth interviews
Nallen (2006, 2007)	Ireland	18 hospital midwives	Perinatal death	Descriptive qualitative methodology	Three focus groups
Nash, et al. (2018)	Ireland	Eight midwives (maternity hospital)	Early pregnancy loss (< 13 gestational week)	Descriptive qualitative design	Face-to-face semi-structured interviews

Aim	Key findings
To explore the factors influencing the practice of nurses with families experiencing perinatal loss in a secondary obstetric care centre in the Quebec region	Five themes were identified: the quality of the relationship between the nurse and the bereaved family, the nurse's personal characteristics, the emotions felt by the nurse, work organisation on the hospital unit, and the context in which nursing care is provided to families. These themes draw attention to the importance of building a solid relationship of trust with bereaved families in which honesty, empathy, human warmth and listening have a central place
To examine the experiences of, meaning for, and personal consequences for obstetric, emergency and surgical nurses caring for women after foetal death and to determine how these nurses use Swanson's caring processes in providing such care	Swanson's caring processes were used as a way to describe the unified experiences of nurses who care for families after a perinatal loss. All nurses, regardless of specialty, used Swanson's caring processes, but they used them preferentially according to situational exigencies and level of rapport developed with each patient
To explore their experience of caring for families whose babies were born still or who died shortly after birth	Findings revealed that caring for bereaved families is a difficult and yet meaningful experience valued by the nurses in this study. Connecting and supporting bereaved families with their babies was identified as an essential part of practice. Understanding from colleagues as well as time and space for reflection were helpful. Nurses offered mothers anticipatory guidance and described thinking about the mothers, even years later
To explore, understand and appreciate the lived experience of midwives who have cared for parents whose baby has been stillborn	Two themes were identified. This paper focused on the theme 'A pocketful of grief' which is made up of three sub-themes: 'Shockwave', 'Self-protection' and 'Blameworthiness'. The death of a baby is a significant event for the midwife providing care
To explore how the nurses feel and talk about their work in the labour ward, specifically as it relates to stillbirths	Three core themes emerged that spoke directly to the objective of the study. Specifically, the exploration of how the nurses feel and talk about stillbirths in the labour ward centred on cultural identification, overcoming their own trauma and removing pain and suffering
To explore the experiences of midwives regarding the attention given during labour in late foetal death	Two main themes were identified: Professionals for Life Not Death; and Organizing the Work Without Guidelines. Midwives felt there is a lack of social awareness related to the possibility of antepartum death that keeps the mourning hidden and affects the midwives' practice during the late foetal death process. Midwives recognise difficulties in coping with a process that ends in death: organisations are not prepared for these events (not suitable rooms), there is lack of training to cope with them, and lack of continuity in the attention received by the parents when they are discharged
To collaboratively explore with gynae nurses how they constructed meanings through their narratives in relation to the professionally defined, but personally experienced, event of pregnancy loss	Emotion can be conceived of as a valid resource for professionals when integrated into a nurse's matrix of professional understandings. The study also demonstrates that value should be attached to emotional work, which may not be fully visible, particularly for nurses working in gynaecological units. The emotional needs of nurses need to be fully acknowledged through recognition of the importance of managed emotion in the construction of professional knowledge
To explore midwives' views regarding the provision of bereavement support to parents affected by perinatal death	The findings centred on five major themes which emerged from the data: role recognition, prerequisites to bereavement support, perceived barriers to bereavement support, coping strategies and spiritual support
To explore the perceptions of midwives caring for women experiencing early pregnancy loss	Themes identified were as follows: 'coping with the experience of early pregnancy loss', 'compassionate care for women and midwives' and 'what midwives found difficult'

(Continues)

TABLE 2 (Continued)

Authors (Year)	Location	Sample and setting	Type of loss	Methodology	Data collection methods
Roehrs, et al. (2008)	USA	10 labour nurses	Perinatal loss (between >20 gestational week and 7 days old)	Descriptive qualitative methodology	Online surveys and follow-up interviews
Willis (2019)	USA	Nine labour and delivery nurses	Perinatal loss (>20th gestational week to 1-month post birth)	Descriptive qualitative methodology	In-depth interviews

Abbreviations: USA, United States of America.

your head around the fact and then be left to catch this little baby. [43]

In Hutti's et al. study [34], an implicit rule of exemption from care of these cases was extended to pregnant colleagues. Services such as gynaecology, in turn, tended to minimise and marginalise the emotional aspects of care, prioritising technical care interventions [37].

On the other hand, having experienced an involuntary pregnancy loss or loss of a loved one gave professionals closeness to the experience, favouring empathy and the recognition of care needs [38, 40]. Exposure to this type of care could trigger complex issues, due to unresolved personal trauma, or deep concerns, for instance if the professional was pregnant [37, 44]. Having children could both facilitate empathy with the parents and to making them more emotionally affected [41]. Lappeman and Swartz's study [44], however, points out that even when lacking these personal experiences, one can empathise with them for the depth of those emotions.

'DETANGLING TOOLS' – FOCUSING ON THE LOSS

Peer support, support from the close social circle and faith were tools midwives and nurses used to *untangle the thread*. They also performed retrospection and reflection, faced with questions from parents or with caring for the next pregnancy or childbirth of this parents.

Peer support constituted an important tool to midwives and nurses [29, 30, 34, 38]. Talking to close or more

experienced colleagues, assistant head midwives or nurses and the lead physician proved to be a source of support and guidance, aimed at establishing closeness with families and facilitating care [41]. As these professionals were better positioned to understand and recognise how painful and hard it is to care for these parents, with them midwives and nurses managed to disconnect from the care situation [29, 30, 35, 37, 38, 40–42, 45,]. In some services, as highlighted by Martinez-Serrano et al. [45], understanding the personal cost this type of care implies for oneself enhances a feeling of protection among all the colleagues who are on duty.

The team sticks together... Come on, who is going to do it? You, come on, and everyone here with you, we are going to be keeping an eye on you. [45]

In some situations, however, these colleagues prove to be an obstacle for some by asking questions out of curiosity, making them even sadder or providing unhelpful comments [38, 40, 41].

Talking or sharing their emotions with their partners, family or friends helped midwives and nurses disconnect and cope with the situation. Some managed to give meaning to the loss and see that their care contributed to improving an emotionally delicate situation for the parents [29, 30, 34, 38, 40, 42].

Sometimes you find yourself talking to the people at home about it just to go over it or, you know, it might be troubling you, it might be something keeping you awake at night but

Aim	Key findings
To describe support needs and comfort level of labour nurses caring for families experiencing perinatal loss	Nurses are generally comfortable but find it difficult to provide perinatal bereavement care. Strategies for coping include focusing on needed care, talking to nursing peers, and spending time with their own family members. Nurses take turns providing care depending on 'who is best able to handle it that day' and prefer not to be assigned a labouring patient in addition to the grieving parents. Developing clinical expertise is necessary to gain the comfort level and the skills necessary to care for these vulnerable families. Orientation experiences and nursing staff debriefing would help
To describe the experience of caring for women with a perinatal loss from the perspective of the nurse and to determine the extent to which the response to perinatal loss reflects a process	Several themes depicting nurses' experience were identified: struggling with emotions, carrying on in the moment, being present for the patient, expressing conflict and taking care of self. A process was identified by nurses describing their response to perinatal loss. The process began with recognition of the loss and progressed through phases including the recognition of their emotional impact, connecting with the mother, dealing with emotions, acting professionally, preparing to return to work and never forgetting the woman

you know you do take your work home with you and that's for sure. [38]

Praying, attending the prayer service or leaning on faith to find meaning in loss was also reported [29, 30, 40, 42]. Other tools included retrospection and reflection, and confronting parents and their questions again, allowing to justify and reaffirm before them that the care provided had no contribution in the pregnancy loss [29, 30, 43]. Cases where they attended the next pregnancy or delivery provided them with closure [34].

'Fraying the thread' – Moving away from the loss

Fraying aimed at avoiding and minimising the repercussions these losses had for midwives and nurses. This resulted in task-focused care, where professionals were emotionally disconnected from parents or where loss was minimised. Avoid talking or sharing emotions with others, distract themselves with unrelated activities or consume alcohol moderately were other strategies.

Avoidance behaviour in care such as focusing on tasks and being emotionally disconnected from parents allowed them to avoid personal suffering, while providing them with a feeling of wholeness to continue caring [34, 38, 40, 42]. As Hutti et al. [34] show, some nurses depersonalise the baby to minimise the emotional burden of the loss.

I've dealt with adults passing away, and this is my duty, this is my responsibility. I'm the professional, and I feel like this is what I'm here

to do. So, I just needed to find ways to deal with it, but to take the products of conception to the lab is a lot more difficult than taking a gall bladder or an appendix. [34]

Carrying out unrelated tasks or activities, being distracted by their children, taking a break or a few days off from work and consuming alcohol moderately provided them with an escape route to relax and avoid thinking about loss [34, 35, 40].

Finally, avoid talking and sharing emotions allowed professionals to maintain a facade to pretend and prevent suffering from re-remembering the loss [43].

A midwife at the hospital, looking at me and looking like all she wanted to do was give me a cuddle. I said "You can't look at me like that because I am going to burst into tears". I didn't want that at all. Everyone would look at you and be thinking "I am so sorry". Sometimes sympathy is really hard. People would show it in their eyes. [43]

DISCUSSION

Emerging from the 11 primary qualitative articles analysed, the '*Unravelling the grief of loss*' metaphor (Figure 2) represents the lines of argument synthesis of the emotional experiences of midwives and nurses when caring for parents following an involuntary pregnancy loss. This care triggered a set of emotions that midwives and nurses had to manage. The meaning given to the loss allowed them

TABLE 3 CERQual evidence profile

Summary of review findings	Studies contributing to the review findings	Methodological limitations	Coherence
'Pulling the thread' - Looking for the meaning of loss	[29, 30, 34–41]	Minor concerns regarding methodological limitations due to lack of clarity regarding the influence of the researcher in the investigation, and vice versa	Minor concerns regarding coherence (data consistent within and across studies)
'Yarn entanglement degree' - Determinants of grief	[29, 30, 34, 37, 38, 40–44]	Minor concerns regarding methodological limitations due to lack of clarity regarding the influence of the researcher in the investigation, and vice versa	Very minor concerns regarding coherence (data very consistent within and across studies)
'Detangling tools' - Focusing on the loss	[29, 30, 34, 35, 37–44]	Minor concerns regarding methodological limitations due to lack of clarity regarding the influence of the researcher in the investigation, and vice versa	Very minor concerns regarding coherence (data very consistent within and across studies)
'Fraying the thread' - Moving away from the loss	[34, 35, 38, 40, 42, 43]	Minor concerns regarding methodological limitations due to lack of clarity regarding the influence of the researcher in the investigation, and vice versa	Moderate concerns regarding coherence

Definitions of levels of confidence from the CERQual evaluation [33]:

- (1) High confidence: It is highly likely that the review finding is a reasonable representation of the phenomenon of interest.
- (2) Moderate confidence: It is likely that the review finding is a reasonable representation of the phenomenon of interest.
- (3) Low confidence: It is possible that the review finding is a reasonable representation of the phenomenon of interest.
- (4) Very low confidence: It is not clear whether the review finding is a reasonable representation of the phenomenon of interest.

to process those emotions and continue to provide care. However, professional and personal aspects determined the tangle of emotions and the meaning of the loss. In this situation, and needing to continue the care, midwives and nurses unravel the grief of loss by looking for the meaning, expressing their grief, focusing and moving away from the loss, which also contributed in the meaning-making.

Caring for parents following an involuntary pregnancy loss involved dealing with an unsupportive organisational environment, lack of preparation or knowledge and an emotionally demanding care [5, 6, 46]. Still, some midwives and nurses find reasons to care for and meet the suffering of these parents. This readiness is an essential aspect of caritative caring [4]. According to the *Caritative Caring Theory* [4], apart from competencies and support, the basic motive for caring is *caritas*, the unconditional love constitutive of care. But the provision of caritative care assumes a personal, sometimes lasting, cost for midwives and nurses [5, 6, 9]. For these professionals caring for pregnancy losses is an emotionally demanding experience that impacts their lives, triggering

various physical, social, psychological, cognitive and behavioural reactions.

Stroebe and Schut [23] describe grief as a process in which the bereaved experiences various stressors and copes by oscillating between two contrasting coping processes. Loss-orientation involves actively grieving over the loss of a loved one in an attempt to reconcile with what happened and attribute meaning to experiences. Restoration-orientation refers to meeting the challenges and accomplishing the tasks one must perform to adjust to the new reality created by the loss. This dual-model helps illuminate the two processes – focusing on or moving away from loss – and the oscillatory movement between them; but it fails to capture the unique features of health-care professionals. Their grief does not always involve the reconstruction of shattered assumptions, or major re-organisations of their world view or identity. Nor does it imply adaptation to a changed reality.

In this regard, the *Model for Professionals' Grieving Process* [13, 18] offers a more in-depth reflection on these professionals' grief experience. Here, this experience is understood in light of social interactions and the values,

Relevance	Adequacy of data	Overall CERQual assessment of confidence	Explanation of decision
Very minor concerns regarding relevance (All studies included nurses and midwives as a sample, focused on pregnancy loss and were relevant to the review)	Minor concerns about adequacy of data. There were rich data to support the finding across all the studies.	High confidence	Minor concerns regarding methodological limitations, coherence and adequacy of data; very minor concerns regarding relevance
Very minor concerns regarding relevance (All studies included nurses and midwives as a sample, focused on pregnancy loss and were relevant to the review)	Minor concerns about adequacy of data. There were rich data to support the finding across all the studies.	High confidence	Minor concerns regarding methodological limitations and adequacy of data; very minor concerns regarding relevance and coherence
Very minor concerns regarding relevance (All studies included nurses and midwives as a sample, focused on pregnancy loss and were relevant to the review)	Very minor concerns about adequacy of data. There were rich data to support the finding across many studies.	High confidence	Minor concerns regarding methodological limitations; very minor concerns regarding relevance, coherence and adequacy of data
Minor concerns regarding relevance (One study included self-employed midwives as a sample)	Moderate concerns as the data were partially rich	Moderate confidence	Moderate concerns regarding coherence and adequacy of data; minor concerns regarding methodological limitations and relevance

beliefs and rules that determine the expected grief behaviours within the social context in which one works. Our results, following this model, indicate meaning-making as the central axis of the grieving process for midwives and nurses, which is conditioned by different aspects.

On the one hand, oscillating between focusing or moving away from loss is a necessary, adaptive and healthy coping process, as it allows professionals to acknowledge losses and set them aside to function properly without being overwhelmed. This oscillation enables attributing meaning to experiences related to death and perceived losses. In this sense, death is an objective event, but it may or may not be perceived as a loss. How intensely midwives and nurses are personally involved depends on this [13, 18]. For instance, when they bond with the parents, evoke previous personal trauma or losses, identify with the bereaved parents or perceive death as a failure in the care process, the grief experience turns into an individual and unique process. Meaning-making, in turn, is not only an individual process, but also a social one. Sharing experiences with colleagues and co-workers contributes to

build collective meanings, which implies an opportunity to frame a new reality [13, 18]. Our results showed that while colleagues prove to be essential, for they are better equipped to understand and recognise the loss experience the most, they can also be unhelpful; as can close social circles. Which may result from the cultural environment of denying pregnancy losses and because loss is the antithesis of what was expected from their work [9].

Finally, our results unravelled the interactive social process of this experience. The institutional context and cultural environment laid the foundations for the explicit and implicit system of goals, values and assumptions on the care provided and the set of rules that prescribe midwives' and nurses' behaviours. The concept of emotional labour allows us to better understand the work put in by midwives and nurses in balancing the needs of the self and the other, with the demands of healthcare organisations. Hochschild [47] defines emotional labour as the effort a worker puts in inducing or suppressing certain feelings to express the expected emotions, which can be explained by this context. When interacting with parents, midwives and nurses can use emotional labour as a tool to display

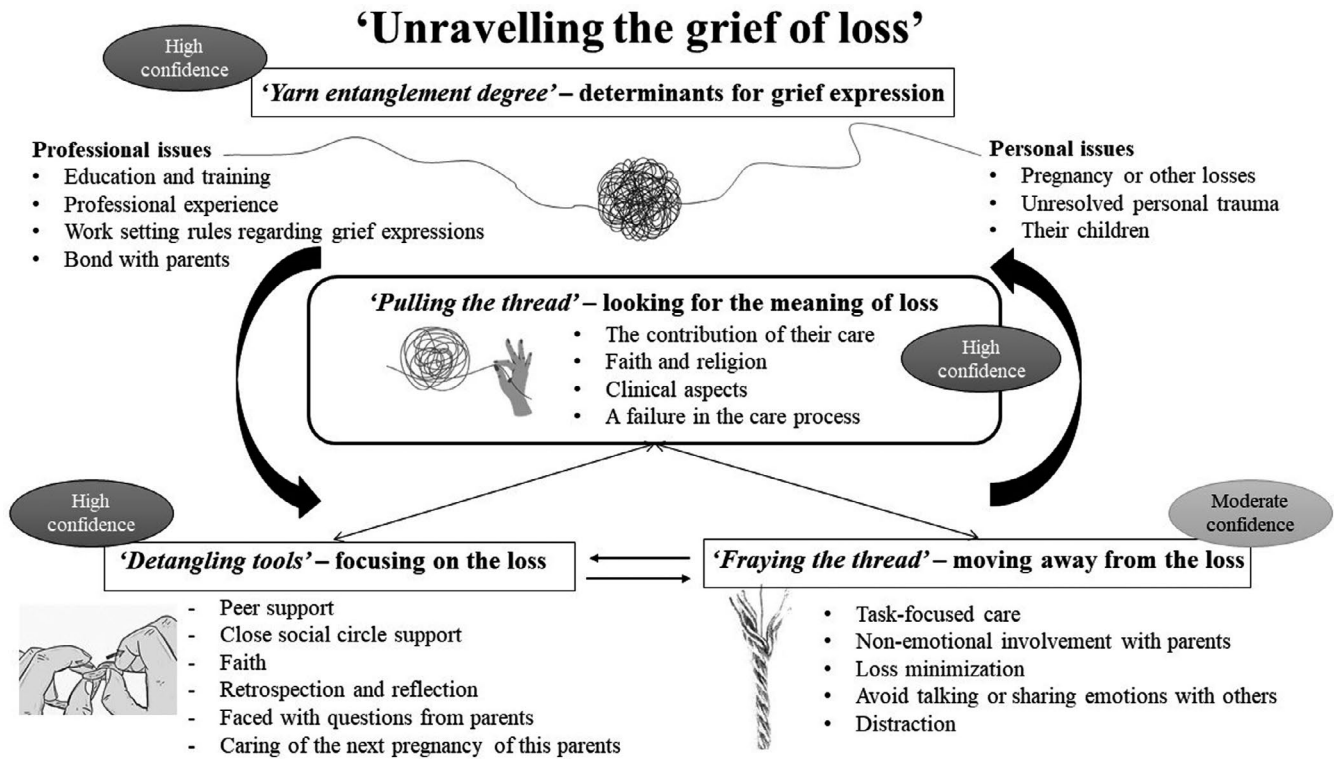


FIGURE 2 The lines of argument synthesis *Unravelling the grief of loss*

emotions socially recognised as appropriate, but not the ones they actually feel. But this emotion management or control process can contribute to emotional exhaustion and professional burnout [48].

In contexts where organisational norms of professionalism prevails, a rationalised emotional distance in caring and expressing mourning is enhanced [49]. Our results showed emotional conflict regarding grief expression. Many professionals understood the loss as not theirs and that expressing their emotions could be seen as a lack of professionalism. This ties in with Doka's [50] concept of disenfranchised grief, which refers to those whose loss cannot be openly acknowledged, publicly mourned or socially supported because their relationship with the deceased is not or cannot be recognised. Such aspect favours avoidance behaviours in care by providing task-focused care and sharing midwives and nurses. *Grief hierarchy* where acceptable parental grief expression depends on the type of loss, can also manifest itself in nursing professionals, which may relate to the meanings they give to losses based on clinical aspects [7, 51, 52].

Implications and further research

This meta-ethnography investigated the emotional complexity of the personal and professional experienced by

midwives and nurses when caring for parents following an involuntary pregnancy loss.

Midwifery and nursing training and continued education should form the basis of change. Our results suggest the need to promote active learning for students, allowing them to approach these situations. Simulation-based learning could help students, and Registered Nurses, learn how to care for and manage their emotions and to provide whole care in situations of high emotional demand. These simulation sessions should prioritise post-practice debriefing discussions as a central element, since this is where students and nurses could be aware of their difficulties or weaknesses, and work to strengthen them. Training for the development of emotional intelligence can help future nurses to recognise the meaning of emotions and their relationships and to use them as a basis to interact with patients. Mentoring by more experienced colleagues, attending study days with parental participation and developing information packs to guide professionals should also be encouraged. The existence of care guides could provide both a unified and individualised care. Besides, learning allows for developing skills such as reflection and resilience, and provides tools to help professionals extract personal and professional growth from these experiences.

Regarding clinical practice, its organisational culture should prioritise the health and well-being of midwives and nurses by promoting a supportive climate for their

needs and deficiencies. It is on leaders to foster spaces where midwives and nurses can express and share their experiences in a non-judgmental and non-critical environment, such as debriefing sessions.

Finally, we suggest further research in two axes: in educational contexts, to inquire on the care experience and its impact on nursing students or new graduates; and in different cultural contexts, to expand our knowledge regarding involuntary pregnancy losses.

Strengths and Limitations

The use of meta-ethnography contributes to identify research gaps, inform the development of primary studies and provide evidence for developing, implementing and evaluating health interventions. This methodology allows for conceptual development, providing a fresh contribution to the literature beyond the narrative and systematic literature reviews [53].

This meta-ethnography study followed the original approach developed by Noblit and Hare [24] and the eMERGe reporting guidelines [25], and our findings were evaluated using CERQual [33], confirming their transparency and reliability. These two elements contribute to forming a robust evidence to base political and practical decision-making, and to improving the trustworthiness and applicability of the results in the clinical setting and future research. Moreover, the included studies were evaluated using the QARI criteria [28].

Building a comprehensive search strategy enabled including articles in English, Spanish and Portuguese, although without results in these last two languages. This search was carried out in three moments: a first one limited to the bibliography of the last ten years; a second without time limits, which was then updated. This allowed for triple checking the existing literature. The team represented various perspectives and professions while the majority were nurses. The differences allowed fruitful discussions.

Our main limitation refers to sample composition. First, the cultural contexts of primary articles are located almost exclusively in western countries. Second, the sample of the primary articles is almost exclusively female and mostly belong to the hospital environment. New empirical research addressing these limitations is needed.

CONCLUSIONS

The ‘Unraveling the grief of loss’ metaphor symbolises the grieving process midwives and nurses experience when caring for parents following an involuntary pregnancy

loss. This care triggered a tangle of emotions that midwives and nurses had to manage. While meaning-making allowed the professionals to process their emotions, these and the meaning of the loss were conditioned by professional and personal aspects. In such context, and needing to continue caring, midwives and nurses unravel the grief of loss by looking for the meaning, expressing their grief, focusing and moving away from the loss, which also contributed in the meaning-making process. These findings promote a change in clinical practice, and in the education and training of future nursing professionals.

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CONFLICT OF INTEREST

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

ETHICAL APPROVAL

Not applicable.

AUTHOR CONTRIBUTIONS


SFB, MJMF, CC and TB contributed to conceptualisation; SFB, MJMF, CC and TB contributed to methodology; SFB, MJMF, CC and TB contributed to formal analysis; SFB contributed to investigation; SFB, MJMF, CC and TB contributed to resources; SFB contributed to data curation; SFB contributed to writing—original draft preparation; SFB contributed to writing—review and editing; SFB contributed to visualisation; MJMF, CC and TB contributed to supervision. All authors have read and agreed to the published version of the manuscript.

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SUPPORTING INFORMATION

Additional Supporting Information may be found online in the Supporting Information section.

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