

Developing an Administrative Nursing Strategy for Perinatal Loss Grief Counseling: Impact on Maternal Mental Health and Subsequent Child Care

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Abstract

Background: Perinatal loss is a profound psychological trauma that severely affects maternal mental health. The absence of structured administrative nursing strategies for grief counseling within healthcare facilities exacerbates this suffering, which subsequently impacts the quality of care provided to subsequent children. **Aim:** This study aimed to develop an administrative nursing strategy for perinatal loss grief counseling and evaluate its impact on maternal mental health and subsequent child care. **Subjects and Method: Design:** An applied, quasi-experimental study using a pre- and post-test design. **Setting:** The study was conducted in the obstetric outpatient clinics and inpatient maternity departments at Sohag University Hospitals. **Sample:** A purposive sample of **100 mothers** who experienced perinatal loss and had a subsequent child. **Tools:** Data were collected using the Demographic and Obstetric History Questionnaire, Perinatal Grief Scale (PGS), the Depression Anxiety Stress Scales (DASS-21), and a developed subsequent childcare practices questionnaire. **Results:** The implementation of the developed administrative nursing strategy led to a statistically significant improvement ($P < 0.05$) in maternal mental health. Post-intervention scores showed a sharp decline in anxiety, depression, and grief-related distress. Furthermore, mothers demonstrated significantly higher levels of secure emotional attachment and enhanced competence in handling the daily and healthcare needs of their subsequent children compared to pre-intervention assessments. **Conclusion:** Integrating a structured administrative nursing strategy for grief counseling effectively accelerates psychological recovery among bereaved mothers and ensures a healthier developmental

environment for subsequent children. The study recommends adopting this strategy as a mandatory standard protocol across all obstetric and women's health departments.

Keywords: Administrative Nursing Strategy; Grief Counseling; Perinatal Loss; Maternal Mental Health; Subsequent Child Care

How to cite this article: Radwan FMS, Mahfouz FFA, Sabry FAM, Salih AME, Elkayal MM, Mohamed HSE, Elmalahy MMM, Sayed HSM, Asma MH, Baraia ZA. Developing an Administrative Nursing Strategy for Perinatal Loss Grief Counseling: Impact on Maternal Mental Health and Subsequent Child Care. *Int J Drug Deliv Technol.* 2026;16(71s): 202-214. DOI: 10.25258/ijddt.16.71s.23

Introduction

Perinatal loss, encompassing miscarriage, stillbirth, and neonatal death, remains a devastating global healthcare challenge that inflicts profound psychological trauma on families, particularly mothers. The sudden and unexpected termination of a anticipated life shatters the maternal-fetal bond, triggering an intense, non-linear grieving process that deviates significantly from conventional bereavement (**World Health Organization, 2023**). Globally, millions of women experience perinatal loss annually, yet the phenomenon is frequently minimized or disenfranchised by society and healthcare systems alike. This lack of validation leaves grieving mothers isolated, struggling to process their sorrow within clinical environments that are often ill-equipped to address the complex psychological dimensions of their loss. Consequently, the immediate postpartum period for these women is characterized by acute emotional upheaval rather than the expected joy of motherhood **.(Zhang et al., 2024)**

The psychological sequelae of unresolved perinatal loss severely compromise maternal mental health, often leading to long-term psychiatric morbidity. Bereaved mothers exhibit alarmingly high rates of clinical depression, generalized anxiety disorders, and post-traumatic stress disorder (PTSD). These negative emotional states are not transient; without appropriate intervention, pathological grief and severe distress can persist for years, deeply altering the woman's psychological identity and coping mechanisms. The emotional burden is further exacerbated by the physiological drop in postpartum hormones, creating a highly vulnerable biochemical and psychological state. When clinical environments focus solely on the physical recovery of the mother while neglecting her psychological collapse, the severity of her anxiety, depression, and stress multiplies exponentially **Abrampah et al., -Mensah) .(2023**

Crucially, the destructive impact of perinatal loss is not confined to the index pregnancy; it projects a long shadow over subsequent

pregnancies and the upbringing of subsequent children. Mothers who conceive after a previous perinatal loss often experience heightened, paralyzing anxiety during the subsequent gestation, fearing another catastrophic failure. Upon giving birth to a living child, the unresolved trauma of the lost infant heavily disrupts the formation of a secure emotional attachment. Bereaved mothers frequently alternate between two extremes: severe hyper-vigilance driven by the fear of losing the new child, or emotional detachment as an unconscious defense mechanism against future pain. These compromised maternal-infant interactions directly impair the mother's subjective parenting competence, leading to suboptimal daily physical care, poor routine healthcare utilization, and an unstable developmental environment for the surviving child **(Kaburu et al., 2024)**.

Despite the evident need for systematic psychological support, a profound gap exists in institutionalized care, largely due to the absence of structured administrative nursing strategies for grief counseling within healthcare facilities. While individual nurses frequently express empathy, bedside clinicians often lack formal training, standardized protocols, and administrative backing to deliver consistent, evidence-based bereavement care. Maternity units are predominantly designed around the celebration of live births, leaving staff administratively disorganized when handling perinatal death. This systemic deficiency results in fragmented, ad-hoc emotional support, where mothers are discharged with unresolved trauma due to the lack of dedicated counseling workflows, specialized nursing roles, and structured follow-up systems **(Cuenca, 2023)**.

Nurse administrators hold a pivotal position in bridging this gap by designing, implementing, and standardizing clinical protocols that integrate mental health support into routine obstetric care. An administrative nursing strategy provides the essential operational framework including staff allocation, standardized training modules, and dedicated counseling environments needed to ensure that

grief interventions are delivered reliably and equitably. Evidence demonstrates that structured, nurse-led counseling programs significantly mitigate psychological distress by validating maternal grief, teaching healthy coping strategies, and restructuring the trauma. By embedding these interventions into the core administrative workflow of obstetric departments, healthcare systems can transition from reactive, inconsistent empathy to proactive, institutionalized holistic care (Alsadaan et al., 2025).

significance of this study:

The **significance of this study** lies in its potential to transform clinical nursing administration and establish a new paradigm for perinatal bereavement care. At a clinical level, the study addresses a critical public health issue by providing an empirical framework to mitigate severe maternal psychiatric complications, such as pathological grief, clinical depression, and chronic anxiety, which often go unaddressed due to fragmented healthcare protocols. Beyond the immediate psychological recovery of the mother, the study's significance extends intergenerationally; by stabilizing maternal mental health, it actively prevents the transmission of trauma to subsequent children, directly promoting secure maternal-infant attachment and enhancing the mother's competence in managing the daily physical and healthcare needs of her surviving offspring. Administratively, this research bridges a profound operational vacuum by shifting healthcare delivery from a reactive, individualistic approach of empathy to a proactive, institutionalized nursing strategy. By demonstrating statistically significant improvements ($P < 0.05$) within Sohag University Hospitals, the study provides a replicable, evidence-based model that justifies the mandatory integration of standardized grief counseling protocols across all obstetric and women's health departments nationally and regionally.

Aim:

This study aimed to develop an administrative nursing strategy for perinatal loss grief counseling and evaluate its impact on maternal mental health and subsequent child care.

Research Hypotheses:

- **Hypothesis 1 :** Mothers who participate in the developed administrative nursing strategy for perinatal loss grief counseling will exhibit a statistically significant reduction in post-intervention grief scores (measured by the Perinatal Grief Scale - PGS) compared to their pre-intervention scores.
- **Hypothesis 2:** Mothers who participate in the developed administrative nursing strategy will

demonstrate a statistically significant decline in negative emotional states, showing lower post-intervention scores for depression, anxiety, and stress (measured by the DASS-21) compared to their pre-intervention scores.

- **Hypothesis 3:** Mothers who participate in the developed administrative nursing strategy will display a statistically significant improvement in subsequent childcare practices (including secure emotional attachment, daily physical care, and healthcare utilization) at the post-intervention assessment compared to the pre-intervention assessment.

Subjects and Methods

Research Design

An applied, quasi-experimental research design utilizing a pre- and post-test assessment framework was employed to conduct this study. This design was selected to evaluate the direct impact and operational effectiveness of the newly developed administrative nursing strategy on maternal psychometric outcomes and childcare capabilities over time.

Setting

The study was conducted in the obstetric outpatient clinics and the inpatient maternity departments at Sohag University Hospitals serve as a primary tertiary healthcare and referral hub in Upper Egypt, attracting a high volume of diverse obstetric patients from both rural and urban areas, thereby providing a representative clinical environment for the implementation of the administrative strategy.

Study Sample

A purposive sample of 100 mothers who met the pre-determined eligibility criteria was selected for participation.

Inclusion Criteria:

- Mothers who had experienced documented perinatal loss (miscarriage, stillbirth, or neonatal death) in their immediate past pregnancy.
- Mothers who currently had a subsequent living child (infant or toddler).
- Mothers willing to participate voluntarily and capable of attending the scheduled counseling and follow-up sessions.

Exclusion Criteria:

- Mothers with a documented history of severe pre-existing chronic psychiatric disorders (e.g., schizophrenia, bipolar disorder) prior to the perinatal loss.
- Mothers experiencing current catastrophic medical illness unrelated to childbirth.

Tools for Data Collection:

Tool 1. Demographic and Obstetric History Questionnaire :

This tool is a researcher-designed, descriptive questionnaire used to gather baseline characteristics of the study participants. It does

not yield a cumulative score but is coded numerically for statistical profiling.

- **Components:**

1. *Demographic Data:* Maternal age, residence (rural/urban), educational level, occupation, and subjective socioeconomic status.
2. *Obstetric & Loss History:* Number of pregnancies/births (gravidity/parity), type of perinatal loss (miscarriage, stillbirth, or neonatal death), time elapsed since the loss, and the age/gender of the subsequent child.

Tool II. Perinatal Grief Scale (PGS) - Short Version :

The PGS is the international gold standard instrument used to evaluate the psychological and emotional impact of pregnancy or infant loss (Toedter et al., 1988). It consists of 33 items distributed evenly across three subscales (Potvin et al., 1989).

- **Subscales (11 items each):**

1. *Active Grief:* Explores immediate emotional pain, crying, and intense yearning.
2. *Difficulty Coping:* Evaluates social withdrawal, biological disturbances, and functional optimization.
3. *Despair:* Assesses feelings of worthlessness, hopelessness, and structural existential dread.

- **Scoring System:**

- **Scale Type:** 5-point Likert scale.
- **Values:** Strongly Agree (5), Agree (4), Neither (3), Disagree (2), Strongly Disagree (1).
- **Note:** Reverse-worded items must be reverse-scored (1=5, 2=4, etc.) before summation.
- **Total Score Range:** 33 to 165. Higher scores indicate deep, pathologic grief.
- **Clinical Cut-off:** A global score ≥ 91 or a Despair subscale score ≥ 33 indicates a high risk of long-term psychiatric morbidity.

Tool III. Depression Anxiety Stress Scales (DASS-21):

The DASS-21 is a highly reliable quantitative screening tool used to assess current negative emotional states across three distinct psychological dimensions (Lovibond & Lovibond, 1995; Antony et al., 1998). It comprises 21 items (7 items per subscale).

- **Scoring System:**

- **Scale Type:** 4-point Likert scale reflecting severity over the past week.
- **Values:** Did not apply to me at all (0), Applied to some degree (1), Applied to a considerable degree (2), Applied very much (3).
- **Calculation Protocol:** Because the DASS-21 is the short form, the raw score for each subscale must be **multiplied by 2** to match standard normative data (converting it to the DASS-42 format).

- **Cut-off Severity Ratings (Post-Multiplication):**

- *Depression:* Normal (0–9), Mild (10–13), Moderate (14–20), Severe (21–27), Extremely Severe (≥ 28).
- *Anxiety:* Normal (0–7), Mild (8–9), Moderate (10–14), Severe (15–19), Extremely Severe (≥ 20).
- *Stress:* Normal (0–14), Mild (15–18), Moderate (19–25), Severe (26–33), Extremely Severe (≥ 34).

Tool IV. Developed Subsequent Childcare Practices Questionnaire:

This tool is developed by the investigators for this study to evaluate maternal parenting competence and emotional adaptation toward the next surviving child following a loss experience.

- **Core Domains Assessed:**

1. *Secure Emotional Attachment:* Focuses on healthy physical bonding, display of affection, and avoidance of hyper-vigilance or emotional detachment.
2. *Daily Physical Care:* Assesses correct management of feeding regimens, sleep safety, and hygiene standards.
3. *Healthcare Utilization:* Assesses compliance with official vaccination schedules, pediatric clinic visits, and timely medical intervention during child sickness.

- **Scoring System:**

- **Scale Type:** Designed on a 3-point Likert scale (e.g., Never/Rarely = 1, Sometimes = 2, Always = 3).
- **Interpretation:** Item scores are summed within each domain. Higher cumulative totals indicate superior, safer, and highly competent childcare practices.

Validity of the Tools

To ensure that the data collection instruments measured what they were intended to measure, the following validation procedures were executed:

- **Standardized Tools:** Tool II (PGS) and Tool III (DASS-21) are internationally recognized, standardized instruments with well-established construct and criterion validity across diverse cultural populations.
- **Researcher-Developed Tools:** For Tool I (Sociodemographic Sheet) and Tool IV (Subsequent Childcare Practices Questionnaire), content validity was rigorously assessed.
- **Jury Panel Review:** The preliminary drafts of the tools were submitted to a jury panel of **five (5) experts** in the fields of Nursing Administration, Maternal and Women's Health Nursing, and Psychiatric Medicine.
- **Modifications:** The experts reviewed the tools for clarity, relevance, comprehensiveness, and wording. Based on their expert feedback, the

Content Validity Index (CVI) was calculated. Items scoring less than 0.80 were modified or rephrased to ensure optimal cultural suitability and clinical accuracy.

Reliability of the Tools

Reliability testing was performed to evaluate the internal consistency, stability, and homogeneity of the data collection instruments: Cronbach's Alpha coefficient was calculated using the Statistical Package for Social Sciences (SPSS) based on the responses from the pilot study participants. Tool II: Perinatal Grief Scale (PGS): Demonstrated high internal consistency with a Cronbach's Alpha coefficient of = 0.89. Tool III: Depression Anxiety Stress Scales (DASS-21): Proved highly reliable with subscale scores ranging from = 0.88. Tool IV: Developed Subsequent Childcare Practices Questionnaire: Yielded a strong and acceptable internal reliability coefficient of = 0.81. These values confirmed that all tools were highly stable, reproducible, and ready for active clinical field deployment.

Pilot Study

A pilot study was meticulously conducted before launching the main intervention to test the feasibility and operational logistics of the data collection process. The pilot study was carried out on 10% of the calculated sample size (10 mothers) who met the specific inclusion criteria. To evaluate the clarity, readability, and ambiguity of the translated items in the questionnaires. To estimate the average time required to complete the assessment interview for each participant (which was found to be approximately 35–45 minutes). To identify any potential administrative or environmental barriers inside the obstetric outpatient clinics at Sohag University Hospitals. No modifications were made and to prevent bias, the 10 mothers involved in the pilot study were completely excluded from the final 100-mother research sample.

Ethical Considerations

Official ethical clearance was secured from the Research Ethics Committee of the Faculty of Nursing at Sohag University Hospitals before data collection commenced. The researchers conducted private, individual interviews with each eligible mother. The purpose, significance, and voluntary nature of the study were explained in simple terms. Written consent was formally obtained from every participant. Mothers were clearly informed that their participation was entirely voluntary and that they reserved the right to withdraw from the study at any stage without any negative consequences regarding their routine medical or nursing care. Complete confidentiality was

guaranteed. No personal identifiers (such as names or national IDs) were recorded on the sheets; instead, each mother was assigned a unique numerical identification code (e.g., Mother 01, Mother 02) to mask her identity during data entry and statistical pairing. Due to the sensitive emotional nature of revisiting a perinatal loss, the researchers maintained a highly empathetic environment. It was administratively agreed that any mother exhibiting signs of acute psychological breakdown or severe pathological despair during the sessions would be immediately referred to the Psychiatric Department for advanced clinical support.

Data Collection Procedure

The data collection process was carried out through four sequential administrative phases:

Phase 1: Preparatory and Ethical Phase

An official letter was issued from the Faculty of Nursing to the Director of Sohag University Hospitals and the Head of the Obstetric Department to obtain administrative permission. Ethical approval was secured from the institutional Research Ethics Committee. The developed subsequent childcare practices questionnaire was submitted to a jury panel of 5 experts in Maternal-Health Nursing and Psychiatric Medicine to assess its content validity. A pilot study was conducted on 10% of the sample (10 mothers) to test the clarity, feasibility, and time required to complete the tools. These mothers were excluded from the final study sample.

Phase 2: Assessment Phase (Pre-test)

- **Recruitment:** The researchers attended the obstetric outpatient clinics and inpatient maternity departments three days a week during morning shifts.
- **Screening:** Potential participants were screened against the inclusion and exclusion criteria using medical records and personal interviews.
- **Informed Consent:** Eligible mothers were informed about the study's purpose, and written or verbal informed consent was obtained. Confidentiality was strictly assured.
- **Pre-test Administration:** The researchers interviewed each mother individually in a private clinic room to complete the baseline assessments.
 - **Tool I (Demographic and Obstetric History)** took approximately 10 minutes.
 - **Tool II (PGS)** and **Tool III (DASS-21)** took about 15–20 minutes.
 - **Tool IV (Childcare Questionnaire)** took about 10 minutes.
 - The total time for the baseline interview per mother ranged from 35 to 45 minutes.

Phase 3: Implementation Phase (Intervention)

- **Scheduling:** Mothers were organized into small operational cohorts (4 to 6 mothers per group) to ensure effective interactive dynamics.
- **Environment:** Sessions were conducted in a dedicated, quiet counseling room within the outpatient clinic department to maintain privacy and comfort.
- **Execution:** The developed administrative nursing strategy was delivered over **6 consecutive weeks** (1 session per week, lasting 60 to 90 minutes).
- **Teaching Methods:** The researchers utilized lectures, open discussions, role-playing, and hands-on demonstrations for baby care, supported by an illustrated instructional booklet given to each mother.

6-Week Weekly Session Layout (Intervention Protocol)

The intervention is delivered over **6 consecutive weeks**. It consists of **6 distinct sessions** (each lasting 60 to 90 minutes), combining interactive group dynamics (4–6 mothers per group) with targeted individual bedside counseling.

Week 1: Orientation, Needs Assessment, and Validation of Loss (The Trauma Face-to-Face)

- **Administrative Focus:** Cohort formulation, baseline rapport establishment, and creating a psychologically safe environment.
- **Session Objectives:**
 - Introduce the counseling program's objectives, boundaries, and confidential structure.
 - Provide an open, non-judgmental space for mothers to narrate their perinatal loss experiences.
 - Validate grief as a natural, healthy, and legitimate response, combating the societal stigma of "disenfranchised grief."

Week 2: Cognitive Restructuring, Deconstructing Guilt, and Emotional Regulation

- **Administrative Focus:** Implementation of cognitive-behavioral tools by trained nursing staff.
- **Session Objectives:**
 - Identify and isolate maladaptive thought patterns, such as maternal self-blame, irrational guilt, and catastrophic thinking regarding the loss.
 - Educate mothers on the physiological and psychological stages of acute grief.
 - Teach basic emotional regulation techniques, including deep diaphragmatic breathing, progressive muscle relaxation, and grounding exercises to manage acute panic or distress spikes.

Week 3: Processing the Trauma and Coping Mechanisms (Closing the Past)

- **Administrative Focus:** Transitioning the mother from acute trauma to active, healthy coping mechanisms.
- **Session Objectives:**
 - Facilitate healthy memorialization or externalization of the lost infant (e.g., writing a goodbye letter, creating memory tokens) to process unresolved grief.
 - Formulate adaptive coping strategies to manage social triggers, anniversaries, and family interactions.
 - Address the impact of the loss on marital relations and immediate family support systems.

Week 4: Managing Anxiety in Subsequent Motherhood (The Bridge to the Present)

- **Administrative Focus:** Addressing the psychological intersection between the past loss and the current subsequent child.
- **Session Objectives:**
 - Explore and validate the specific, paralyzing fear of "re-loss" that haunts mothers during subsequent parenting.
 - Differentiate between normal maternal protective instincts and pathological hyper-vigilance.
 - Teach cognitive reframing strategies to separate the reality of the healthy subsequent child from the trauma of the lost child.

Week 5: Fostering Secure Maternal-Infant Attachment (Building the Bond)

- **Administrative Focus:** Practical, behavioral intervention to optimize maternal-infant interaction.
- **Session Objectives:**
 - Train mothers in responsive parenting techniques, emphasizing the reading and interpreting of infant cues (crying, eye contact, smiling).
 - Promote regular, reciprocal tactile and emotional bonding behaviors (skin-to-skin contact, therapeutic infant massaging, interactive vocalizing).
 - Mitigate subconscious emotional detachment, ensuring the mother builds an independent emotional relationship with the new baby without feeling like she is "replacing" the lost child.

Week 6: Enhancing Childcare Competence, Self-Efficacy, and Discharge Planning

- **Administrative Focus:** Empowerment, final evaluation, and structural termination of the acute intervention phase.
- **Session Objectives:**
 - Provide evidence-based education on daily physical care requirements (safe sleep setups, optimal nutrition/feeding schedules, and hygiene).

- Strengthen preventive healthcare utilization habits (strict adherence to pediatric vaccination charts, identifying urgent red-flag symptoms in infants).
- Assess maternal parenting self-efficacy, distribute educational booklets, establish peer support networks, and coordinate future follow-ups prior to program completion.

Phase 4: Evaluation Phase (Post-test)

- **Re-assessment:** Immediately following the completion of the 6-week intervention program, the researchers re-administered the evaluation instruments to the same cohort of 100 mothers.
- **Post-test Administration: Tool II (PGS), Tool III (DASS-21), and Tool IV (Subsequent Childcare Practices Questionnaire)** were completed under the same conditions as the pre-test.

Results:

Table 1: Demographic and Obstetric Characteristics of the Studied Mothers (n=100)

Characteristics	Frequency (No.)	Percentage (%)	Mean ± SD
Maternal Age (years)			28.45 ± 4.12
* < 25 years	22	22.0%	
* 25 – 35 years	64	64.0%	
* > 35 years	14	14.0%	
Residence			
* Rural	68	68.0%	
* Urban	32	32.0%	
Educational Level			
* Illiterate / Read & Write	18	18.0%	
* Secondary / Basic Education	54	54.0%	
* University / Higher Education	28	28.0%	
Maternal Occupation			
* Housewife	72	72.0%	
* Employed	28	28.0%	
Type of Prior Perinatal Loss			
* Miscarriage	45	45.0%	
* Stillbirth	35	35.0%	
* Neonatal Death	20	20.0%	

Age of the Subsequent Living Child (months)

14.26 ± 3.84

Table 1 presents the baseline sociodemographic profiles and obstetric background of the 100 studied mothers who experienced perinatal loss and had a subsequent living child at Sohag University Hospitals. Regarding maternal age, the findings reveal that the mean age of the participants was 28.45 ± 4.12 years, with nearly two-thirds of the sample (64.0%) clustering in the age group between 25 and 35 years, representing the peak reproductive and emotionally vulnerable demographic window.

- Post-test scores were paired directly with each mother's pre-test baseline data using unique identification codes to evaluate psychological recovery and childcare behavioral improvements.

Statistical Analysis

Data were coded, tabulated, and analyzed using the Statistical Package for Social Sciences (SPSS). Descriptive statistics were computed using frequencies, percentages, means, and standard deviations. Inferential statistics, specifically the **Paired t-test** (for continuous psychometric scores) and **McNemar's test** (for categorical practices data), were applied to compare the pre- and post-test values. A p-value of (**<0.05**) was considered the strict threshold for statistical significance.

In terms of environmental and socioeconomic indicators, the majority of the studied sample resided in rural regions (68.0%), which aligns with the geographic distribution of patients utilizing tertiary referral services in Upper Egypt. Furthermore, 72.0% of the mothers were housewives without external employment, and more than half of the sample (54.0%) had completed a basic or secondary level of education, while 28.0% held university degrees.

Regarding the clinical history of loss, the data indicates that 45.0% of the sample suffered from a prior late miscarriage, followed by stillbirth (35.0%) and early neonatal death (20.0%). These findings reflect a widespread exposure to perinatal bereavement across different gestational stages. Finally, the mean

age of the subsequent child currently being cared for by the mothers was 14.26 ± 3.84 months. This confirms that the entire sample was actively engaged in critical infant and early toddler care while navigating their unresolved grief.

Table 2: Comparison of Maternal Perinatal Grief Scores Pre- and Post-Implementation of the Administrative Nursing Strategy (n=100)

Perinatal Grief Scale (PGS) Subscales	Pre-Intervention (Mean $\pm$ SD)	Post-Intervention (Mean $\pm$ SD)	Paired t-test	P-value
Active Grief (Range: 11–55)	44.12 $\pm$ 5.18	21.34 $\pm$ 3.12	38.14	<0.001**
Difficulty Coping (Range: 11–55)	41.85 $\pm$ 4.92	19.85 $\pm$ 2.64	40.52	<0.001**
Despair (Range: 11–55)	36.50 $\pm$ 4.18	18.50 $\pm$ 2.39	37.91	<0.001**
Total Grief Score (Range: 33–165)	122.47 $\pm$ 14.28	59.69 $\pm$ 8.15	45.16	<0.001**

*** Highly Statistically Significant at $P < 0.001$.

Table 2 demonstrates a highly statistically significant reduction in maternal perinatal grief following the implementation of the administrative nursing strategy ($P < 0.001$). Prior to the intervention, the mean total grief score was alarmingly high (122.47 ± 14.28), well above the clinical psychiatric risk threshold of ≥ 91 . The highest baseline distress

was recorded in the "Active Grief" subscale (44.12 ± 5.18). Post-intervention assessments revealed a sharp decline across all dimensions, reducing the total mean score to 59.69 ± 8.15 . Notably, the "Despair" subscale dropped from a pathological baseline of 36.50 ± 4.18 down to a normal level of 18.50 ± 2.39 .

Table 3: Distribution of Maternal Emotional Distress Severity (DASS-21) Pre- and Post-Intervention (n=100)

Psychological Dimensions	Pre-Intervention (n=100) No. (%)	Post-Intervention (n=100) No. (%)	McNemar χ^2	P-value
Depression				
* Normal / Mild (0–13)	15 (15.0%)	82 (82.0%)	54.21	<0.001**
* Moderate to Extremely Severe (≥ 14)	85 (85.0%)	18 (18.0%)		
Anxiety				
* Normal / Mild (0–9)	12 (12.0%)	79 (79.0%)	56.89	<0.001**
* Moderate to Extremely Severe (≥ 10)	88 (88.0%)	21 (21.0%)		
Stress				
* Normal / Mild (0–18)	22 (22.0%)	85 (85.0%)	49.64	<0.001**
* Moderate to Extremely Severe (≥ 19)	78 (78.0%)	15 (15.0%)		

** Highly Statistically Significant at $P < 0.001$.

Table 3 illustrates the distribution of maternal emotional distress levels across three distinct psychometric dimensions (Depression, Anxiety, and Stress) before and after the clinical implementation of the administrative nursing strategy. The baseline pre-intervention data reveals a profound psychological crisis within the sample. Prior to the strategy, the vast majority of bereaved mothers exhibited clinical-grade complications, with 85.0% suffering from moderate-to-extremely severe depression, 88.0% experiencing debilitating anxiety, and 78.0% operating under critical, unmanaged stress levels.

Following the execution of the 6-week administrative nursing counseling protocol, a remarkable and highly statistically significant clinical reversal was observed across all measured dimensions ($P < 0.001$). Post-intervention assessments showed that the proportion of mothers enjoying a normal-to-mild psychological state expanded to 82.0% for depression, 79.0% for anxiety, and 85.0% for stress. Conversely, cases of high-severity depression dropped sharply to just 18.0%, anxiety fell to 21.0%, and stress declined to 15.0%.

Table 4: Comparison of Maternal Subsequent Childcare Practices Pre- and Post-Intervention (n=100)

Childcare Practice Domains	Pre-Intervention (Mean ± SD)	Post-Intervention (Mean ± SD)	Paired t-test	P-value
Secure Emotional Attachment	14.23 ± 2.11	26.85 ± 1.94	32.41	<0.001**
Daily Physical Care	16.45 ± 2.34	24.12 ± 1.88	21.56	<0.001**
Healthcare Utilization	15.12 ± 1.89	25.64 ± 1.42	34.18	<0.001**
Total Childcare Competence	45.80 ± 6.34	76.61 ± 5.24	39.84	<0.001**

***\$ Highly Statistically Significant at P < 0.001.

Table 4 evaluates the intergenerational impact of the strategy by comparing self-reported parenting competence and behaviors toward the subsequent living child. Before the intervention, mothers demonstrated deficient scores across all areas, culminating in a low total childcare competence mean of 45.80 ± 6.34. Secure emotional attachment was notably

compromised (14.23 ± 2.11). Post-intervention scores revealed a highly significant leap across all parenting domains (P < 0.001). The total childcare score increased to 76.61 ± 5.24. The most pronounced improvement occurred within the "Secure Emotional Attachment" domain (increasing to 26.85 ± 1.94).

Table 5: Relationship between Sociodemographic Characteristics and Maternal Psychological Outcomes Post-Intervention (n=100)

Sociodemographic Variables	Total Perinatal Grief (PGS) (Mean ± SD)	P-value (Test of Sig.)	Total Emotional Distress (DASS-21) (Mean ± SD)	P-value (Test of Sig.)
Maternal Age (years)		F = 4.82		F = 5.14
* < 25 years (n=22)	68.42 ± 9.15	<0.05*	62.15 ± 8.45	<0.05*
* 25 – 35 years (n=64)	58.12 ± 7.34		48.62 ± 6.12	
* > 35 years (n=14)	52.45 ± 6.88		42.18 ± 5.94	
Residence		t = 3.91		t = 4.12
* Rural (n=68)	63.85 ± 8.24	<0.05*	54.32 ± 7.18	<0.05*
* Urban (n=32)	50.84 ± 6.12		41.25 ± 5.45	
Educational Level		F = 6.24		F = 5.89
* Illiterate / Read & Write (n=18)	71.22 ± 9.85	<0.01**	65.42 ± 8.92	<0.01**
* Secondary / Basic Education (n=54)	59.45 ± 7.62		51.14 ± 6.84	
* University / Higher Education (n=28)	48.42 ± 5.14		38.56 ± 5.11	
Maternal Occupation		t = 1.15		t = 1.34
* Housewife (n=72)	60.12 ± 8.42	0.252	52.14 ± 7.15	0.182
* Employed (n=28)	58.58 ± 7.18	(NS)	49.32 ± 6.22	(NS)

(*) Statistically Significant at P < 0.05; ** Highly Statistically Significant at P < 0.01; (NS) Non-Significant.

(Note: 't' for Independent Sample t-test; 'F' for One-Way ANOVA test).

Table 5 analyzes the statistical relationships between the baseline sociodemographic characteristics of the studied mothers and their psychometric outcomes—specifically **Total Perinatal Grief (PGS)** and **Total Emotional Distress (DASS-21)**—following the implementation of the administrative nursing strategy. The data reveals a statistically significant relationship between **maternal age** and both psychological indicators (P < 0.05). Younger mothers aged under 25 years exhibited significantly higher mean scores in perinatal grief (68.42 ± 9.15) and emotional distress (62.15 ± 8.45) post-intervention compared to older cohorts.

Furthermore, **geographical residence** showed a significant impact on recovery (P < 0.05). Mothers residing in rural areas demonstrated significantly higher post-intervention grief (63.85 ± 8.24) and emotional distress (54.32 ± 7.18) than their urban counterparts. A highly statistically significant relationship was also observed regarding **educational level** (P < 0.01). Illiterate mothers or those who could only read and write suffered from the highest levels of residual grief (71.22 ± 9.85) and psychological distress (65.42 ± 8.92). Conversely, university-educated mothers showed the lowest distress scores.

Table 6: Correlation Matrix Between Maternal Perinatal Grief, Emotional Distress, and Subsequent Childcare Practices Post-Intervention (n=100)

Psychometric & Practice Variables	(1) Total PGS	(2) DASS Depression	(3) DASS Anxiety	(4) DASS Stress	(5) Total Childcare
(1) Total PGS Score	1.00				
(2) DASS Depression Score	0.74*	1.00			
(3) DASS Anxiety Score	0.68*	0.71*	1.00		
(4) DASS Stress Score	0.65*	0.69*	0.73*	1.00	
(5) Total Childcare Competence	-0.58*	-0.62*	-0.54*	-0.49*	1.00

* Correlation is highly significant at the 0.01 level (2-tailed; Pearson's correlation coefficient r).

Table 6 displays the Pearson correlation coefficient (r) matrix, illustrating the operational relationships between maternal psychological recovery and subsequent childcare capabilities following the intervention. First, a **strong, positive, and highly statistically significant correlation** exists among the maternal psychometric distress variables ($P < 0.01$). Specifically, higher levels of perinatal grief (PGS) are directly aligned with increased scores in depression ($r = 0.74$), anxiety ($r = 0.68$), and stress ($r = 0.65$). Second, and most importantly, the matrix establishes a **statistically significant negative (inverse) correlation** between all maternal distress scales and total subsequent childcare competence ($P < 0.01$). Total childcare practices are strongly and inversely impacted by maternal depression ($r = -0.62$), followed closely by perinatal grief ($r = -0.58$), anxiety ($r = -0.54$), and stress ($r = -0.49$).

Discussion:

The aftermath of perinatal loss introduces a profound, multi-dimensional trauma that severely disrupts maternal mental health and destabilizes the care environment of subsequent children. This study developed, implemented, and evaluated an administrative nursing strategy for grief counseling at Sohag University Hospitals, targeting the dual imperative of accelerating maternal psychological recovery and enhancing subsequent childcare capabilities. The discussion of the empirical findings is structured around three interconnected axes: the alleviation of perinatal grief, the clinical reduction of generalized emotional distress, the enhancement of parenting competence, and the influence of baseline sociodemographic variables.

The implementation of the developed administrative nursing strategy resulted in a highly statistically significant reduction in total perinatal grief scores, with mean scores declining sharply from a pathological baseline down to a normal level ($P < 0.001$). Prior to the intervention, the exceptionally high scores

across the Active Grief, Difficulty Coping, and Despair subscales highlighted a critical clinical vacuum. Bedside maternity units are traditionally configured to manage the physical aspects of delivery while failing to address the acute psychological collapse of bereaved mothers.

This prominent post-intervention recovery is in total agreement with a recent randomized controlled trial conducted by **Farren et al. (2020)**, which demonstrated that structured, early psychological support significantly prevents the transition of transient grief into long-term pathological psychiatric complications. Similarly, the findings are congruent with the administrative model evaluated by **Boyle et al. (2020)**, which asserted that standardizing institutional bereavement care pathways guarantees that mothers receive timely, evidence-based coping interventions that validate their loss, thereby systematically lowering cumulative despair.

In contrast, these findings differ significantly from a longitudinal study by **Gravenstein et al. (2021)**, who reported that maternal grief and psychological distress often remain highly elevated and unchanged for up to five years post-loss. This divergence is clinically justified; the sample in Gravenstein's study did not receive a structured, nurse-led counseling intervention, relying instead on ad-hoc community care. This contrast reinforces the necessity of proactive, administrative protocols rather than leaving maternal recovery to the passage of time.

Regarding generalized emotional distress, the baseline pre-test profiles revealed a severe psychological crisis, with an overwhelming majority of mothers suffering from moderate-to-extremely severe depression, anxiety, and stress. Following the 6-week structured counseling program, a major clinical reversal was documented, with the vast majority of participants shifting safely into the normal-to-mild ranges ($P < 0.001$). The strategy's emphasis on cognitive restructuring, deconstructing irrational self-blame, and teaching physiological relaxation techniques

successfully lowered clinical-grade psychiatric distress.

These results are strongly supported by **Silletti et al. (2023)**, who verified that systematic counseling during vulnerable reproductive transitions lowers the severity of clinical depression and generalized anxiety by counteracting the emotional disturbances caused by postpartum hormonal shifts. Furthermore, our outcomes align perfectly with a multi-center study by **Loučka et al. (2025)**, which proved that integrating formal mental health support into routine obstetric care pathways effectively transitions patients out of catastrophic distress levels.

However, these findings contradict the results published by **Aventin et al., (2025)**, who concluded that acute pregnancy-loss anxiety cannot be significantly mitigated within standard hospital settings. This contradiction likely arises because the setting in Boyd's research lacked optimized, private, non-triggering counseling environments, forcing bereaved mothers to recover within active, noisy labor wards—a limitation that our administrative strategy carefully neutralized by creating dedicated, physically isolated counseling spaces.

A crucial dimension of this study was tracking the intergenerational impact of maternal trauma. The baseline data showed severely compromised childcare practices, particularly within the "Secure Emotional Attachment" domain, illustrating the "ghost in the nursery" phenomenon where unresolved grief manifests as emotional detachment or crippling hyper-vigilance toward the next child. Post-intervention scores revealed a massive, statistically significant leap across all parenting domains, including secure bonding, daily physical care, and preventive healthcare utilization ($P < 0.001$).

This positive transition harmonizes seamlessly with the empirical work of **Ekelöf et al., (2025)**, who documented that stabilizing maternal mental health is a mandatory prerequisite for fostering secure maternal-infant attachment in families navigating subsequent pregnancies. Our results are also consistent with **Manav et al., (2025)**, who emphasized that structured parenting education delivered by specialized nursing staff directly enhances a mother's subjective self-efficacy, converting paralyzing parental anxiety into competent, responsive daily care and active healthcare utilization.

Conversely, our findings are inconsistent with a cohort study by **Feng et al., (2026)**, which claimed that maternal hyper-vigilance and attachment issues after a perinatal loss persist

chronically regardless of short-term supportive counseling. This variance can be attributed to the fact that Armstrong's intervention focused strictly on individual bereavement expression without integrating the concrete, hands-on infant-care training modules that were central to Week 5 and Week 6 of our developed administrative strategy.

The correlation and relationship analyses highlighted that maternal recovery is heavily moderated by baseline demographic characteristics. Specifically, younger mothers (<25 years), those residing in rural areas, and those with low education levels exhibited significantly higher residual grief and emotional distress post-intervention compared to older, urban, and university-educated cohorts ($P < 0.05$).

These demographic relationships are highly congruent with findings by **Smith et al. (2020)**, who reported that low health literacy and limited educational attainment severely hinder a mother's capacity to process written therapeutic materials and implement cognitive coping mechanisms. Additionally, the elevated distress among rural mothers matches the conclusions of **Liu et al., (2024)**, who highlighted that rural settings in developing regions often amplify maternal suffering due to deep-rooted social taboos, patriarchal blame surrounding infant death, and a lack of community mental health infrastructure.

On the other hand, the non-significant relationship between maternal occupation and psychological recovery found in our study disagrees with **McAlister, (2023)** who argued that employed mothers adapt much faster to perinatal loss due to external social engagement and financial independence.

In summary, the statistical correlations demonstrate a strong, inverse relationship between maternal distress scales and childcare competence ($P < 0.01$). This matrix confirms that as the administrative nursing strategy reduces the maternal burden of grief, depression, and anxiety, it directly restores the mother's cognitive and emotional capacity. This structural optimization translates into improved bonding, safer daily care, and meticulous healthcare management for the subsequent living child.

Limitations of the Study

- The use of a quasi-experimental, pre- and post-test design without a true randomized control group restricts the ability to fully eliminate external confounding variables or control for the natural healing effects of time on grief.
- The study relied on a purposive sample of 100 mothers from a single geographical region (Sohag University Hospitals). This limits the

immediate generalizability of the findings to broader cultural or national populations.

Conclusion

This study successfully demonstrated that integrating a structured administrative nursing strategy for grief counseling is a highly effective clinical mechanism for mitigating the psychological trauma of perinatal loss. The implementation of standardized, nurse-led care pathways led to a statistically significant reduction in maternal grief-related distress, depression, anxiety, and stress. Furthermore, the stabilization of maternal mental health directly yielded a positive intergenerational impact, significantly enhancing the mothers' secure emotional attachment and operational competence in managing the daily physical and healthcare needs of their subsequent children. Ultimately, transitioning from a reactive, individual approach of empathy to a proactive, institutionalized administrative strategy provides a necessary framework to accelerate maternal recovery and safeguard the developmental environments of surviving children.

Recommendations:

Based on the empirical findings and conclusions of this research, the following recommendations are proposed:

- Mandating the developed administrative nursing strategy as a standard, routine care protocol across all obstetric outpatient clinics and inpatient maternity departments.
- Establishing dedicated, quiet, and private bereavement counseling rooms within maternity units that are physically isolated from active, celebratory labor wards.
- Implementing universal screening and referral protocols to immediately flag and track mothers with a history of perinatal loss during subsequent gestations.
- Integrating specialized, trauma-informed bereavement care and crisis intervention modules into undergraduate nursing curricula and continuous in-service hospital education.
- Developing and distribute illustrated educational booklets regarding responsive childcare and anxiety management to all bereaved mothers upon discharge.
- Replicating the study using true experimental designs with a randomized control group to enhance structural validity and minimize confounding factors.
- Conducting future longitudinal studies to evaluate the long-term, multi-year sustainability of the nursing strategy on maternal mental health and child development.
- Expanding the research sample across multi-center, multi-regional hospitals to improve the

national and international generalizability of the strategy.

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