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Title	“How do I navigate the joy and the grief at the same time?” – Mothers' postnatal experiences following care in a specialist pregnancy after loss clinic: A qualitative study
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"How do I navigate the joy and the grief at the same time?" – Mothers' postnatal experiences following care in a specialist pregnancy after loss clinic: A qualitative study

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ABSTRACT

Background: In a subsequent pregnancy after perinatal death, mothers likely experience anxiety, depression, grief, and post-traumatic stress. Personalised antenatal care at a specialist clinic supports mothers; however, little is known about their experiences after birth. Mothers may have anxiety and fear postnatally, and face challenges transitioning from specialist antenatal care to standard postpartum care, however this transition remains unstudied.
Aim: To explore mothers' postnatal experiences in a subsequent pregnancy after previously experiencing perinatal death.
Methods: A qualitative study using semi-structured interviews of 28 mothers 3–6 months after birth. Interviews were transcribed and analysed using thematic analysis.
Findings: Three overarching themes were identified: 'End of personalised care' which included two subthemes describing mothers losing connections to trusted healthcare professionals, and changes to the quality of care. 'Navigating emotions' which consisted of three subthemes describing how mothers experienced high anxiety; fluctuations between grief, joy, and guilt; and how emotions impacted their partner. 'The responses of others' which described the impact of other people on mothers' postnatal experience; which included three subthemes: the taboo of baby loss, justification that the baby was not a replacement, and gestures of acknowledgment.
Discussion: Many mothers who have previously experienced perinatal death experience grief, anxiety and isolation postnatally. The quality of postnatal maternity care varies and many mothers feel unsupported by standard maternity services after previously receiving supportive specialist antenatal care.
Conclusion: Postnatal maternity care pathways should be developed and resourced to deliver trauma-informed care to parents who have previously experienced perinatal death.

Statement of Significance

Problem or Issue

Little is known about the maternity care experiences and support needs of mothers who have experienced a perinatal death and have subsequently given birth to a live baby. This paper explores mothers' postnatal experiences after receiving specialist antenatal care at a pregnancy after loss clinic.

What is Already Known

Mothers who have experienced a perinatal death are likely to experience symptoms of anxiety, depression, grief, and post-traumatic stress (PTS) in a subsequent pregnancy which may continue into the postnatal period. However, more research is needed to explore how mothers experience symptoms postnatally to inform their maternity care needs and to make

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recommendations for integrating a trauma-informed care approach into routine postnatal care.

What this paper adds

This study highlights gaps in the provision of psychosocial support and the absence of specialist services and models to deliver trauma-informed postnatal care to bereaved parents after the birth of a live baby. Tailored and specialised education and training is needed for healthcare professionals to address bereaved parents' needs postnatally. To improve maternity care, specialist and general antenatal services would benefit from workforce investment to extend support to parents after the birth of a live baby.

1. Introduction

1.1. Background

In 2022, there were 4 stillbirths and 2.9 neonatal deaths for every 1000 babies born in England and Wales [1]. A perinatal death refers to a stillbirth or neonatal death, and is defined as a death occurring at or over 22 weeks of gestation, during birth, or in the first 7 days of life [2]. Over 60% of mothers will become pregnant again within a year of the death of their baby [3]. Mothers who experience a perinatal death are at greater risk of anxiety, depression, and post-traumatic stress disorder (PTSD) than mothers who gave birth to a live baby [4], and are likely to experience high levels of anxiety, depression, grief, and post-traumatic stress (PTS) in a subsequent pregnancy following their loss [5–9]. In addition, mothers' symptoms of anxiety, depression and PTS have been found to remain at elevated levels through pregnancy, and do not significantly differ from the second to the third trimester [5]. Mothers also report an increased awareness of risk in a subsequent pregnancy, feelings of isolation, and have doubts that they will deliver a live baby [10,11]. The lack of support from friends, family and healthcare professionals during a subsequent pregnancy also worsens mothers' emotional distress [10].

Mothers who receive antenatal care at a specialist pregnancy after loss clinic feel protected in the safe environment of the clinic, and form relationships with healthcare professionals who know their background and acknowledge their loss [11]. However, mothers attending the antenatal clinic have identified postpartum care as needing improvement [12], although it is unclear which improvements need to be made to provide better care. It is likely that mothers who have experienced loss need psychosocial support in the postnatal period as they may be at risk of experiencing symptoms of depression and anxiety [5,13], PTS [5], and have difficulties bonding with their new baby [14,15]. However, specialist postnatal support tailored to families who have previously experienced a perinatal death is not routinely available in the UK, and the emotional support provided to parents by healthcare professionals at specialist antenatal clinics is generally discontinued after the birth of a live baby.

There is a lack of evidence exploring the postnatal experience of mothers who have previously received personalised antenatal care at a specialist pregnancy after loss clinic. This qualitative interview study aims to expand previous research, which described mothers' experience whilst attending a specialist antenatal clinic [11], to explore mothers' postnatal experiences in a pregnancy following a perinatal death. The findings will enable us to make recommendations for improving postnatal maternity care for mothers who have previously experienced a perinatal death.

2. Method

2.1. Design

This study was the qualitative component of a mixed-methods study [5,16]. The research team adopted an interpretive approach to this research design [17], assuming that bereaved mothers' postnatal experience is subjective and constructed by mothers through their experiences and how they make sense of them. A qualitative research design was used to identify, analyse, and report themes in the data, and interview data was collected to provide rich and in-depth details of mothers' experiences [18]. This study addresses a specific qualitative aim, to explore mothers' postnatal experiences, within our broader mixed-methods study which aimed to identify the support needs of partners and mothers in a pregnancy following a perinatal death. The research was granted ethical approval by South Central–Berkshire B Research Ethics Committee (Ref 22/SC/0108).

2.2. Recruitment

Mothers were recruited from a tertiary hospital in the North-West of England from a specialist antenatal clinic, the Rainbow Clinic. Mothers were eligible for inclusion if they had a previous second trimester pregnancy loss, neonatal death, stillbirth or late termination of pregnancy and were receiving care from the Rainbow Clinic in their current pregnancy. Potential participants were excluded if they were younger than 16 years of age, lacked the capacity to consent or could not read English.

2.3. Setting

In the North-West of England there were 74,646 live births in 2024 [19]. Approximately 250 mothers receive antenatal care at the Rainbow Clinic site, where mothers were recruited from, every year. There are more than 25 Rainbow Clinics in the UK. The Rainbow Clinic offers personalised care which involves enhanced physical monitoring such as detailed ultrasounds (e.g., placental blood flow, fetal growth) and psychological support from the same specialist healthcare team to improve wellbeing and pregnancy outcomes. Families are eligible for specialist care at the clinic if they have experienced a late termination of pregnancy ($\geq$ 16 weeks), a second trimester pregnancy loss, stillbirth or neonatal death; the clinic follows the consensus statement on the management of pregnancies subsequent to stillbirth and perinatal death [20]. Unlike standard antenatal care, the Rainbow Clinic offers care plans which address the cause of the previous loss, and it provides psychological support from healthcare specialists trained in bereavement.

The maternity care from the Rainbow Clinic team ends when a baby is born, and mothers receive care on the general postnatal wards, and from their community care team when they return home. There is currently no routine postnatal care from the Rainbow Clinic for mothers after they have given birth. However, a Rainbow Clinic midwife will aim to visit the family in the hospital after birth (if the Rainbow Clinic is in the same hospital as the birth) or provide a follow-up phone call to the family after they have returned home. The Rainbow Clinic specialist midwives, however, are not always able to contact families (e.g., if mothers do not answer the phone) or they may have limited time to provide follow-up care during busy clinic periods.

2.4. Procedure

At their initial 23-week Rainbow Clinic appointment, 70 mothers were approached by a member of the clinical care team (a Rainbow Clinic midwife or obstetrician) to ask if they would like to participate in the mixed-methods study. The Rainbow Clinic midwives and obstetrician who approached mothers for consent were part of the study team. All mothers who were approached agreed to participate and gave their informed written consent; only mothers' contact information (not demographic information or pregnancy history) were collected at this stage. Three months after the birth of their baby, mothers who had given their informed written consent were contacted via email to ask if they would participate in an interview. The interviews were conducted on

Zoom or via phone from June 2023 to May 2024 by two researchers JB and DS.

Mothers were asked about the experience of their current pregnancy with a focus on their postnatal care experience. There were 5 interview questions with relevant and general prompts (see Supplementary Table S1). The questions asked mothers to describe their experiences, maternity care, feelings, and support that they received during pregnancy; they were open-ended and designed by the research team to allow mothers to provide a detailed account of their experiences. The questions were not piloted due to the time and funding constraints of the study. The interviews were digitally audio-recorded and transcribed verbatim by JB and were deleted after each interview was transcribed. The transcripts were not offered to participants for review and editing to reduce the burden on them and to prevent any further distress that may be caused from revisiting their experience. Demographic information and pregnancy history were collected by a member of the clinical care team [healthcare professionals' initials] after mothers had completed their interview.

2.5. Sample

Mothers who had received antenatal care at the Rainbow Clinic were approached as research participants as their first-hand accounts would give detailed insights into their experiences and support needs after antenatal care has ended. Seventy mothers gave their informed written consent, and 60 mothers were invited to interview. Mothers were not invited if they did not give consent for the interview to be recorded, had a preterm birth $\leq$ 30 weeks' gestation, or could not be contacted by the research team after birth (Fig. 1). One participant withdrew shortly before the interview began due to being unwell; she did not contact the research team to reschedule the interview. One participant had to leave soon after the interview began to care for her children. The interviews lasted between 15 and 85 min (M = 50; SD = 17.82). All the participants had attended the Rainbow Clinic on at least one occasion. The age, ethnicity, marital status and pregnancy history of participants are summarised in Table 1. All mothers gave birth to a live baby between 35 and 41 weeks' gestation.

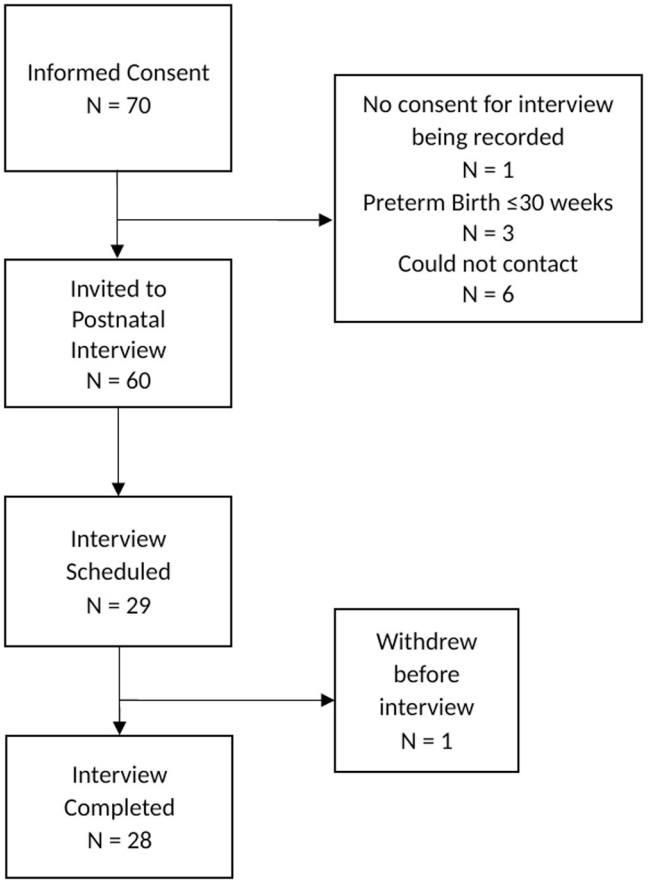


Fig. 1. Flow chart showing participant inclusion and exclusion from the study.

2.6. Researcher positionality

A Psychology Researcher (JB), a Health Psychologist DS, and a Senior Consultant Obstetrician AH were involved with data collection and analysis. JB and DS had previous research experience exploring partners' experiences in pregnancy after perinatal death: JB had no other previous experience of researching perinatal death, and DS has previous research experience within this area. AH runs a specialist clinical service for parents who have experienced a stillbirth in a previous pregnancy and has extensive experience researching stillbirth. The research team view perinatal death as a major life event in a parent's life.

2.7. Analysis

To enable the researchers to become actively engaged with the data

Table 1
Ethnicity, marital status, and pregnancy history for mothers (n = 28).

Demographic characteristic	Mothers *N*
Maternal Age	Mean 34.6 (Range 26-42 years)
Ethnicity	
White British	22
White – any other White background	2
Asian or Asian British – Pakistani	1
Asian or Asian British – Chinese	1
Mixed – White and Asian	1
Black or Black British – African	1
Marital Status	
Married	20
Living with Partner	8
Parity	
1	2
2	16
≥3	10
Interpregnancy Interval (Months)	
≤12	10
13-36	3
≥37	3
Unknown	2
Mode of Stillbirth	
Vaginal Delivery	24
Emergency Caesarean Section	3
Unknown	1
Gestation at Time of Loss (Months)	
16-23	11
24-32	5
33-41	11
Unknown	1
Type of Loss	
Second Trimester Loss	8
Antepartum Stillbirth	16
Termination for Medical Reasons	2
Neonatal Death	2
Mode of Live Birth	
Vaginal Delivery	9
Elective Caesarean Section	15
Emergency Caesarean Section	4

and discover meaningful concepts and themes embedded in the transcripts, Braun and Clarke's reflexive thematic analysis was followed [21]. The researchers followed six steps involved in the framework: (1) transcribing, reading and re-reading the data to ensure data familiarisation and immersion; (2) generating initial codes by highlighting chunks of text and assigning codes that summarise the feature; (3) sorting and collating and related codes into potential themes; (4) reviewing and revising themes to ensure themes accurately describe the codes, and the themes produced are an accurate representation of the meanings evident in the whole dataset; (5) define and naming themes, and identifying the sub-themes; (6) writing up the analysis. The analysis (stages 1–4) was conducted independently by JB and DS who had interviewed participants. JB and DS met on several occasions to discuss and refine the themes (stage 5). AH was involved with theme contextualisation (stage 5). JB, DS, and AH all contributed to writing up the thematic analysis (stage 6).

3. Results

Twenty-eight mothers were interviewed about their experiences. Three themes were generated from mothers' accounts which describe their postnatal experiences, namely: (1) End of personalised care: *"'It wasn't like the level of care that I was used to prior",* (2) Navigating emotions: "*It's a very emotional time and again it's a bit like a roller coaster,"* and (3) The responses of others: *"It was like the elephant in a room"* (see Fig. 2). The three themes are detailed further below with relevant subthemes using pseudonyms and verbatim quotes.

Theme 1: End of personalised care: *"'It wasn't like the level of care that I was used to prior"*

Mothers described the postnatal period as a *'cliff drop'* (Sarah) as personalised maternity care from the Rainbow Clinic ended immediately following the birth of their baby; this left mothers' feeling unsupported without the tailored care (e.g., a contact for emotional support, continuity of care) they had become used to during pregnancy.

> *"I mean everyone was lovely and very, very nice but it wasn't like, you know, the level of care that I was used to prior."* (Kate)

Two subthemes further describe these feelings of surprise and uncertainty: *'End of emotional support from healthcare professionals'* where mothers described losing the connection to trusted healthcare professionals at the Rainbow Clinic, and *'Variation in quality of care received'* where they described changes in the quality of their maternity care from specialist antenatal care to standard postnatal care.

3.1. Sub theme 1: End of emotional support from specialist healthcare professionals

The emotional support given by the bereavement midwife and/or healthcare professionals at the specialist antenatal clinic helped mothers throughout their pregnancy. Mothers described being able to phone the specialist midwives at the clinic if they had any anxieties or concerns about their baby, and they had the opportunity to go to the clinic for extra reassurance scans. The specialist healthcare professionals also created birth plans with the parents, so they felt they had a degree of control over the birth and, where possible, facilitated preparation for the birth at the hospital (e.g., booked couples a private room, gave them a tour of the facilities). Mothers described forming strong connections with these individuals.

> *"I probably got quite attached to them and they really helped me through one of the most difficult periods of my life."* (Annabelle)

However, support from these healthcare professionals ended after

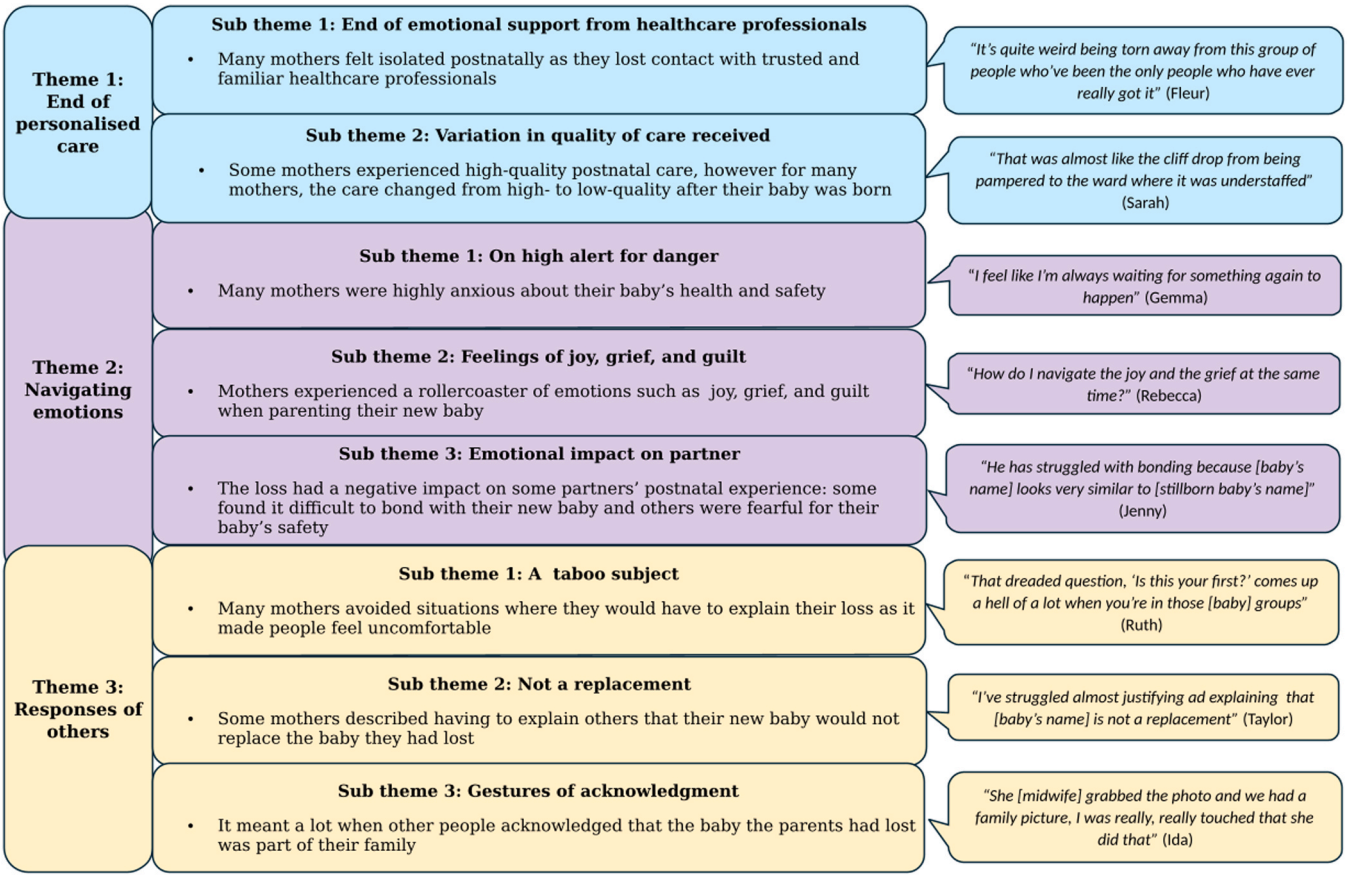


Fig. 2. Themes and sub-themes from the thematic analysis accompanied by a short exemplar quote.

birth and many mothers expressed sadness over the ending of the relationships and their unease at *'being torn away from this group of people who've been the only people that really ever got it'* (Beth). Some mothers wanted the specialist healthcare professionals to *'reach out'* (Sue) to them after the birth (e.g., via phone call) to connect with them again; they also wanted the opportunity to thank the specialist healthcare professionals for their support during pregnancy. Mothers who received contact after their baby was born from a healthcare professional at the Rainbow Clinic who supported them antenatally were grateful for the contact.

> *"But she [specialist midwife] did phone us and she said, 'I'm just checking that everything's okay.' And that meant a lot to me actually because, you know, just that we were remembered… I think just when you're just going through the worst thing it's them little gestures, and then that phone call, you know, it's nice."* (Gemma)

A few mothers visited the Rainbow Clinic after birth to introduce their baby to the specialist healthcare professionals. Mothers who had contact with the specialist healthcare professionals postnatally appreciated having the opportunity to thank the team for their support during pregnancy.

3.2. Sub theme 2: Variation in quality of care received

A few mothers described instances of high-quality postpartum maternity care in the hospital and at home. For instance, mothers felt supported if they were listened to, visited/checked regularly, appointments were not rushed, and if they saw familiar, empathetic healthcare professionals who were aware of their background. In addition, many mothers reported being signposted to support services (e.g., breastfeeding support) in the hospital and at home.

> *"You know, all the visits from the community midwives felt like they had quite a lot of time, and I think they all did seem to know about my previous baby as well. And also the health visitor, she knew about him as well and she basically kind of keeps coming back and giving me support."* (Jane)

However, the quality of maternity care for many mothers deteriorated after birth as they described being left alone on postnatal wards that were understaffed. Several mothers described being *'very lonely'* (Ruth) and explained that they received little help caring for their baby. Some mothers also received conflicting advice (e.g., with breastfeeding) as every person they asked was '*saying something different, so it was quite difficult'* (Jane). In addition, staff were not always aware of the parents' background so many mothers often had to explain their history which they found stressful and upsetting. When returning home, some mothers spoke about rushed visits from different healthcare professionals who lacked empathy.

> *"It just always felt like a tick box exercise. It was like, I've just got to ask you these questions, a lot related to physical health, and then, that's it… Yeah, you could see on the sheet itself that they're just going through… There was nothing bespoke about it. There was nothing personalised, there was no genuine care."* (Annabelle)

Mothers felt supported if their postnatal care was of a similar quality to the specialist antenatal care that they had previously received. However, for many mothers, the quality of maternity care was unlike the level of personalised care they received at the Rainbow Clinic.

3.3. Theme 2: Navigating emotions: "It's a very emotional time and again it's a bit like a roller coaster."

Mothers explained that their feelings were influenced by their previous loss and they were experiencing a rollercoaster of positive and negative emotions; this can be further explained by three subthemes: *'On high alert'*, *'Feelings of joy, grief, and guilt'* and *'Emotional Impact on partner'*.

3.4. Subtheme 1: On high alert for danger

Due to their previous experience of loss, mothers were protective of their baby and aware of potential danger in the postnatal period. Some mothers also worried about the safety of their other children. These worries led to a decrease in the enjoyment of parenting for many mothers as they were *'constantly on high alert'* (Kate). Mothers had also been able to contact a specialist midwife at the Rainbow Clinic when they felt anxious during pregnancy, however postnatally many mothers had no trusted professional to contact who they could discuss their anxieties with.

> *"I still feel like I'm gonna get to that point where she's going to be taken away from me. It's trying to push through that, and I feel like sometimes it's that side people don't see. It's like it's so much up to the point of having the baby that worry of losing baby doesn't go away*." (Rebecca)

Many mothers expressed that they would have liked support to deal with their anxieties postnatally. Help from professionals, such as a counsellor, was favoured along with having the opportunity to connect with other bereaved mothers to have a *'safe space to talk to somebody about the anxieties'* (Kate). A few mothers mentioned that they were using online websites or forums to discuss their anxieties with other parents who had been through baby loss. Some mothers reported using devices to monitor their baby's breathing or heart rate as well as seeking reassurance and support from healthcare professionals.

> *"We had more health visitor appointments if we wanted them. And we had things like we had our own set of scales so that we could monitor his weight because that was one thing that I was really anxious about. And we had a breathing monitor to put in his cot…. Basically we just kind of had closer access to the health visitor. I think I saw her like every fortnight for like the first probably 4 months that [baby's name] was home. Which was really helpful because I was extremely anxious during that time period."* (Jenny)

A few mothers also spoke about receiving Cognitive Behavioural Therapy (CBT), Eye Movement Desensitisation and Reprocessing (EMDR), and counselling which helped them to manage their anxieties in the postnatal period.

3.5. Subtheme 2: Feelings of joy, grief, and guilt

Mothers described experiencing conflicting emotions in the postnatal period. Many mothers spoke about feeling happy that they had their baby; this led to feelings of guilt for experiencing positive emotions as they were not able to share experiences with the baby they had lost. Mothers' grief continued after birth and many still felt *'an emptiness of the loss there'* (Gabrielle) which surprised a few mothers.

> *"It is also dealing with some of the like guilt of feeling so happy that we've got [baby's name]… And if [stillborn baby] was born, we would never have had [baby's name]… and it's kind of like going between the guilt, the sadness, the happiness."* (Taylor)

Some mothers said that they would have liked to have been informed during pregnancy about the mixed emotions they would likely experience after birth. For mothers who had been accessing professional bereavement support, such as counselling or therapy before their baby was born, many drew on this support again when maternity care ended.

> *"I think I found it quite difficult kind of when she [health visitor] fell off the radar a little bit, like who do I turn to? So the fact that I've had [counsellor's name] there a little bit has been helpful because I know I've got somebody else that I can speak to."* (Rebecca)

Mothers expressed that managing conflicting emotions was difficult as they felt an absence of emotional support through losing connections to trusted healthcare professionals at the Rainbow Clinic.

3.6. Subtheme 3: Emotional impact on partner

Several mothers discussed how the loss was negatively impacting their partner postnatally. For instance, some partners found it difficult to bond with their new baby, and a few partners feared that they were going to lose their baby.

> *"So almost every night he wakes up and he thinks that our daughter is dead basically. So he wakes up, he wakes me up, and he's asking if she's alive and where is she. So obviously it would be nice to have support for that."* (Chloe)

The offer and provision of support for partners was varied with some receiving professional support in the postnatal period (e.g., counselling), some not being offered support, and others knowing how to access support but not drawing on it. This contrasts with the reassurance and support partners were given alongside the mothers during pregnancy when receiving specialist antenatal care at the Rainbow Clinic.

3.7. Theme 3: The responses of others: "It was like the elephant in a room"

Mothers described how peoples' responses in relation to their loss impacted on their postnatal experience. Parents often wanted to talk about the baby they had lost but explained that most people did not know how to speak to them about their baby. Three subthemes further explain this theme: *'A taboo subject', 'Not a replacement', and 'Gestures of acknowledgment.'*

3.8. Subtheme 1: A taboo subject

Many mothers wanted to talk about the baby they had lost however they felt that this made people feel uncomfortable as baby loss was a *'taboo subject'* (Gemma). When receiving specialist care at the Rainbow Clinic, mothers became accustomed to specialist healthcare professionals comfortably speaking about their baby. However, postnatally mothers were more likely to encounter healthcare professionals who did not acknowledge their loss or did not know how to speak about it. For instance, one mother described a photograph of her stillborn baby by her hospital bed as being like *'the elephant in a room'* (Sarah) as healthcare professionals ignored the photo to avoid upsetting her. Mothers explained that when people spoke about the baby they had lost, this made them feel understood and at ease.

> *"It's nice to know that people are confident enough to talk about it without being self-conscious, I think. Like, it makes you feel there's more of a level of trust emotionally and kind of there's a social security I think when someone knows how to speak about it and is confident enough to speak about what happened. And knows to ask questions about, how big was he? Like, what's his name?"* (Zoe)

Many mothers explained that attending baby classes or groups in the postnatal period was a '*daunting prospect'* (Ida), and they spoke about avoiding social situations where they would have to explain that they had lost a baby. As such, mothers' described feelings of loneliness in the postnatal period.

> *"It was hard when I first took [child's name] [to a baby group] because people would be like, 'Oh is he your first?' And I'd be like, 'No.' And then it'd bring up this whole, well I lost a baby and then they sort of stop speaking to me. So then I was like, oh do I need to not say it? But I don't want to not acknowledge him because that's not my feelings. So then I was sort of in this place of do I want to acknowledge my child, or do I want the approval of these other mums?"* (Ivy)

A few mothers described feeling less isolated when they attended baby groups which were organised by their perinatal healthcare team or a charity; they felt people were less likely to ask questions, and they could have *'frank and honest conversations'* (Jenny) with other parents who had experienced loss. Many mothers explained that they would be more open to attending baby groups with other mothers who had also lost a baby or had been through a similar experience.

3.9. Subtheme 2: Not a replacement

A few mothers explained that other people believed that by having another baby the parents would be *'cured'* (Fleur), and they wanted parents to be happy that they had their new baby. Some mothers described a lack of understanding from others that they would still be grieving for the baby they had lost.

> *"The complications with family around that then wanting me to feel a certain way because we've got a new baby and that almost like, 'Well you've got this new baby here now so don't worry about everything else."* (Rebecca)

Mothers found it hard to explain and justify to others that their new baby would not replace the baby they had lost, something mothers felt that they did not have to do before the birth in conversations with specialist healthcare professionals at the Rainbow Clinic.

3.10. Subtheme 3: Gestures of acknowledgment

Mothers said they wanted people to acknowledge the baby they had lost and were used to receiving this acknowledgment from healthcare professionals at the Rainbow Clinic during their pregnancy. They described the ways healthcare professionals who delivered their postnatal care showed their acknowledgment such as by saying their baby's name and commenting on photographs.

> *"We've got like a picture up of [stillborn baby's name] and she [health visitor] was like acknowledging that… It's little things like that that just I think when you've lost especially just mean a lot to you."* (Gemma)

Some mothers also spoke about friends and family acknowledging the baby they had lost through talking about them or making gestures such as organising fundraising events in memory of their baby.

> *"So we helped raise money to the [suite name] that's at [local hospital], and my friend put that together who has never been through anything like that… And yeah, so yeah I think, I don't know, there's something to be said for just having people there who just want to…. who have never understood it because they haven't been through it, but they want to understand it because they love you."* (Silvia)

Mothers valued people acknowledging that the baby they had lost was still part of their family; this helped mothers feel understood and supported postnatally.

4. Discussion

This study supports previous research showing that mothers who receive personalised maternity care at a dedicated pregnancy after loss clinic feel supported through their pregnancy [11,16]. It also extends this work to show that many mothers feel unsupported and isolated postnatally as specialist care ends after the birth of a live baby. Mothers' high levels of anxiety and hypervigilance postnatally related to the safety of their baby support the quantitative findings from this work showing that 1 in 3 mothers had significant anxiety and 1 in 5 mothers had high levels of PTS (of which hypervigilance is a central feature) 6 weeks after birth [5]. Mothers' descriptions of partners' anxiety and fear also align with findings from this quantitative work showing that partners' anxiety levels did not fall after the birth of a live baby and that 1 in 5 partners also had high levels of PTS postnatally [5]. Whilst this study did not explore mothers' experiences when their child was older than 6 months, high parental anxiety may continue throughout the early years of parenting an infant following a previous stillbirth [14] and negatively impact a child's development increasing the risk of emotional and

behavioural issues [22]. However, it is unclear if the anxiety and hypervigilance symptoms of mothers in this study reduced, with or without support, as their child grew older.

Most mothers (and partners of mothers) in our study were not drawing on professional support to manage high levels of anxiety and hypervigilance postnatally. The few mothers who did receive postnatal support (e.g., extra visits from the health visitor, counselling, EMDR therapy) spoke positively about the impact this had on their wellbeing. Healthcare professionals working in postnatal care can play an important role in offering positive social support to mothers [23]. However, mothers are reluctant to discuss their emotional state with staff involved in their postnatal care if there is a lack of positive interactions with healthcare professionals (e.g., rushed visits, seeing different people) [23]; this may mean that many mothers in our study did not discuss their anxieties and emotional state with healthcare professionals so the opportunity was missed to signpost to support services or offer extended support (e.g., increased visits). In addition, partners who have previously experienced a perinatal death describe the absence of support and signposting to services by midwives and health visitors during community postnatal care [16] even though they would likely benefit from drawing on support.

The 2024 UK national enquiry of birth trauma describes mothers being left alone on postnatal wards with little attention given to their needs [24] which is congruent with some of the descriptions given by mothers in our study. Being left unsupported after birth may also exacerbate the sense of abandonment that mothers' feel when transitioning from highly supportive specialist antenatal care to standard postpartum care. However, mothers' accounts of inadequate postpartum care in our study were not universal; some mothers described high-quality, supportive care. Both positive and negative accounts of postpartum care in our study may indicate that the quality of maternity care varies by location [24] with some hospitals being equipped with enough staff to support mothers, and others being under resourced. In addition, the different community care experiences of mothers in this study, with some feeling supported in their postnatal interactions and others not, likely reflects the unequal delivery of postnatal care within overstretched health services [25].

Western society fails to recognise the significance of perinatal death and the subject is considered taboo [26]. The lack of social recognition that parents would continue grieving after birth, worsened mothers' feelings of loneliness and distress. The disconnection mothers felt from the specialist clinic also contributed further to mothers' sense of isolation as they now felt a lack of recognition for their grief from people outside of the specialist healthcare team. Our findings are consistent with the theory of disenfranchised grief [27] as the loss of a stillborn baby is often not acknowledged, socially supported or publicly mourned by society [26]. Most mothers avoided mother-baby groups as they felt mothers who had not experienced perinatal death would not understand or support them which further contributed to their lack of social support and isolation. The lack of postnatal social support for mothers who have previously experienced a perinatal death is concerning considering that postpartum mothers who have previously experienced pregnancy loss need more social support than mothers who have not experienced pregnancy loss to prevent postpartum depression [28].

Peer support from others who have experienced stillbirth (e.g., from online communities) has shown to be an important source of support for mothers in a subsequent pregnancy after previously experiencing a stillbirth [29]. However, most mothers in our study were not engaging with support from peers with shared experience postnatally even though they wanted to; this indicates that the existence of peer support networks or groups in the UK for pregnancy after perinatal death is non-existent or limited. The interviews were conducted several years ago, however, and new peer support networks may have been established since then. For instance, in 2024, a WhatsApp peer support network for baby loss (Branch) [30] was launched in the UK where bereaved parents can connect by joining a chat group related to their baby loss experience (e.g., parenting Rainbow babies); this network also allows members to offer support to each other online and provides them with the opportunity to meet up with other members who live locally. It is currently unknown to what extent Branch positively impacts parents in a subsequent pregnancy after perinatal death; however, it is likely an important way for parents to receive and offer emotional support to each other in the postnatal period.

5. Implications for clinical practice

There is currently no structured postnatal support for parents who have experienced a pregnancy following a previous perinatal death. To address this gap, changes can be suggested and recommendations made to improve clinical care. Parents who have previously experienced a traumatic birth, such as a previous perinatal death, are at risk of experiencing the onset or exacerbation of PTSD symptoms (e.g., hypervigilance) after the birth of a subsequent baby [31]. To provide the best care, healthcare professionals caring for bereaved parents in a subsequent pregnancy (in the hospital or community) need to receive training in Trauma Informed Care (TIC) [32]; this would give healthcare professionals the knowledge and confidence to understand how a previous loss may be impacting on parents' postnatal experience, communicate effectively with parents, and signpost or refer to relevant support services where appropriate (e.g., counselling, peer support) [33]. Healthcare professionals (e.g., midwives or a health visitor) could also routinely screen for trauma in parents who have previously experienced a perinatal death by using standardised tools or asking a single question to open conversation [33]. In addition, healthcare providers need to invest in workforce expansion to ensure that there are enough hospital staff to give mothers the appropriate practical help (e.g., with looking after their baby) and emotional support they need after birth [24].

Mothers who have a healthcare professional as a first point of contact for their postnatal care are able to ask questions, express concerns, and feel heard and valued [34]; Continuity of care is a key feature in the delivery of trauma-informed care [33] and is valued and appreciated by mothers in antenatal maternity care after experiencing a previous perinatal death [16]. Healthcare providers should ensure that mothers who have previously experienced a perinatal death have access to the same healthcare professional as a point of contact in the postnatal period. Ideally, the support provided by the Rainbow Clinic midwives could be extended so that parents are given emotional support postnatally by the same midwives (e.g., a point of contact, telephone calls, opportunities for face-to-face meetings with the team). However, a major barrier for the implementation of follow-up care is likely to be inadequate staff resourcing [35] which would need to be addressed to allow midwives to continue to support parents.

Finally, healthcare professionals (e.g., a health visitor) can encourage parents to effectively communicate with their family and friends about their feelings and experiences [32] to help family and friends understand that parents will continue to grieve after birth. For instance, they could suggest that parents write family and friends a letter to tell them how they can offer help and emotional support [32]; if parents are then understood and supported by their friends and family, as well as healthcare professionals, this may reduce feelings of loneliness and isolation in the postnatal period. Healthcare professionals can also signpost parents to peer support groups, such as Branch Baby Loss Network [30], to enable parents to connect with other parents who have also experienced a perinatal death.

6. Strengths and limitations

This study makes an important, novel contribution by describing mothers' postnatal experiences and perceptions of standard postnatal care following specialist antenatal care at a pregnancy after loss clinic. However, limitations need to be considered and used to propose directions for future studies. First, participants were women who attended

a specialist clinical service for pregnancy after loss, therefore we cannot assume that mothers who do not receive specialist antenatal care will have similar postnatal experiences. For instance, mothers who do not receive specialist care would likely not lose connections with trusted healthcare professionals after their baby is born. It is likely, however, that many mothers who have lost a baby experience anxiety, isolation, and grief in the postnatal period after giving birth to a live baby, regardless of the type of antenatal care they have received. Second, the sample does not adequately capture the experiences of mothers from minority ethnic groups therefore we cannot assume that findings extend to these individuals; future studies could aim to recruit mothers from these groups to capture their experiences.

Third, the study describes mothers' experiences in the first 6 months after birth, however mothers' emotions, thoughts and behaviours may change as their child grows older. Future studies could consider interviewing mothers at different timepoints to explore the postnatal experience over extended periods of time. More studies are also needed to explore partners' and fathers' experiences as they may have different support needs after the birth of a live baby. Finally, to establish trustworthiness and rigour, two researchers coded the data: one coder had limited experience in researching perinatal death, and the other had been researching the field for several years. However, the authors' previous research experience and pre-understanding in this area may have influenced the coding and analysis. For instance, the researchers recently interviewed partners about their experiences in pregnancy after loss [16], and partners descriptions may have influenced the analysis of data (e.g., partners described mothers being highly supported by specialist antenatal care so this may have biased the researchers towards its importance and significance). To enhance researcher reflexivity, the study would have been improved if researchers had kept notes or a journal to reflect on how their biases and preconceptions may have shaped the research process and analysis [36].

7. Conclusion

Mothers who have experienced the death of a baby are likely to experience symptoms of anxiety, PTS, grief in a subsequent pregnancy in the postnatal period. Highly supportive specialist antenatal care positively impacts mothers' wellbeing during pregnancy, however the disconnection from specialist healthcare professionals after birth exacerbates mothers' feelings of isolation. Mothers receiving maternity care on understaffed postnatal wards felt isolated, and practically and emotionally unsupported. Connecting with other bereaved parents and contact from specialist healthcare professionals who delivered their antenatal care is valued and desired by mothers postnatally. Mothers feel emotionally supported if they receive continuity of care after birth from familiar, compassionate midwives and health visitors who acknowledge parents' loss and deliver trauma informed care. Further research is needed with minority ethnic groups and mothers who have not received specialist antenatal care.

Ethical approval

The study was granted ethical approval by the Health Research Authority, South Central - Berkshire B Research Ethics Committee (Ref 22/SC/0108).

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AI use declaration

AI not used in the preparation of this work.

Declaration of Competing Interest

All authors declare that they have no competing interests.

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Appendix A. Supporting information

Supplementary data associated with this article can be found in the online version at doi:10.1016/j.wombi.2026.102210.

Data availability

Due to the sensitive nature of the study participants were not asked to give permission for data sharing. anonymised, unlinked data are available from the authors on request.

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