**Applying Swanson’s Caring Theory to Pregnancy Loss**

Ila Olaski, Joanne Ta, Reem Boudali

Faculty of Nursing, University of Windsor

NURS2920

Professor Natalie Giannotti

March 5, 2021

**Applying Swanson’s Caring Theory to Pregnancy Loss**

Pregnancy can be a beautiful and terrifying journey that may lead to some of the happiest and most memorable times in one's life. Women become physically and emotionally connected to the human being growing inside of them—they can have conversations with the fetus and feel their movements—so when they lose this connection, it is normal to be deeply affected by it. There is a growing concern over the issues of recovery faced by these women in society: many women who experience stillbirths report poor emotional support from healthcare workers when seeking treatment (Bellhouse et al., 2019). A review of literature suggests that families who have lost their pregnancy will be challenged with identity, relationship, and self-image crises (Wilson, 2016). Effective support measures must address and maintain maternal identity, reduce stigma, and provide ongoing and supportive care to aid families with the grieving process. The purpose of this paper is to outline the care of families dealing with a lost pregnancy by incorporating the stages of Swanson’s caring theory: knowing, being with, doing for, enabling, and maintaining belief (Swanson et al., 2009). Swanson et al. (2009) explain that ‘knowing’ refers to understanding the patient and the issue, ‘being with’ means being present, ‘doing for' refers to nursing interventions, ‘enabling’ is giving the patient options for care, and ‘maintaining belief’ is the support and encouragement the nurse provides to the patient. Nurses can adapt their care to match these stages in three steps: recognizing and understanding the issue, taking action to address the short-term issues, and supporting the patient and family for a stable recovery in the long term.

**Recognizing and Understanding the Issue**

The first step nurses can take to provide efficient care for patients who experienced a lost pregnancy is to recognize and understand the issue that the patient is enduring. A loss of pregnancy can either be a miscarriage or a stillbirth; they just differ in time. A miscarriage is the loss of a baby before the 20th week of gestation, while a stillbirth is anytime afterwards (Centers for Disease Control and Prevention, 2020). Either circumstance can be a traumatic event for families that can have long term effects. Therefore, it is important for nurses to understand the stages of the Swanson’s caring theory to provide appropriate care for the patient. The first step is recognizing: acknowledging that the patient is experiencing physical and psychological stressors such as shock, intense grief, isolation, and anger (Bellhouse et al., 2019). The authors explain that the feelings of grief and distress are not only associated with the death of a child, but also the loss of hope or dreams that the family associates with parenthood. Similarly, Wilson (2016) explains the internal conflicts that occur when families experience a pregnancy loss. For example, a family may be fearful of future pregnancies due to the trauma of their loss, yet still yearn for the joy of raising a child. Nurses should be able to recognize these internal conflicts and modify their care to fit the needs of the families. Ravali et al. (2018) emphasize the importance of providing support for parents from the admission period to their discharge, as it can help with the mourning process. During the initial stages of shock, the patient’s memory process is enhanced and they will be able to remember significant details for years after the traumatic event (Ravali et al., 2018). This emphasizes the importance of care during the acute phase. For nurses, the ultimate goal of Swanson's caring theory is to support clients through their initial emotional responses and provide appropriate comfort measures (Kavanaugh et al., 2010). Once the nurses have fully assessed the extent of the damage, they can begin implementing care.

**Interventions for the Duration of Hospital Stay**

Phases two through four (being with, doing for, and enabling) of Swanson’s caring theory highlight the importance of healthcare workers taking action to address acute issues faced by parents. This includes processing the situation, feelings of guilt, and decreased self-confidence (Nurse-Clarke et al., 2019). Immediately following the loss of pregnancy, it can take some time to fully register the event. This timeframe is a moment of vulnerability for parents because of negative changes to their pregnancy and parenting plan. Pollock et al. (2020) note that parents may feel guilt or anger, and misdirect unwarranted blame toward a partner. In reality, factors that result in miscarriages and stillbirths are often uncontrollable (The American College of Obstetricians and Gynecologists, 2020). Therefore, staff should work with families to promote healthy coping mechanisms and provide empowering information to the family. Nurses should ensure that they are actively present and mindful throughout this process, as many women report negative experiences due to staff’s desensitization to miscarriage (Bellhouse et al., 2019).

Parents who have experienced the loss of a child in the hospital express their want of sensitivity from hospital staff; nurses should realize that the parents have been through a traumatic experience and should make sure that they acknowledge the grief throughout care (Peters et al., 2015; Farrales et al., 2020). Peters et al. (2015) further stress that timing is key in these situations; nurses should assess patients’ readiness to learn before proceeding with education and discharge planning. For example, in the case of stillbirths, nurses should first ask the parents whether they would like to see their child, and if so, they should proceed by preparing the baby as though it was any other birth—bathing the baby, dressing the baby, and providing adequate time for the parents to interact with their child before saying goodbye (Ravaldi et al., 2018). One resource that facilities can make use of are “CuddleCots”. These devices cool the baby to prevent early decay of the body (Flexmort, n.d.). The use of CuddleCots can help extend the time the family has to spend with their child before being sent to the funeral home. Only when the parents state that they are ready, should staff move onto the next step of long-term recovery planning.

**Recovery and Long-term Interventions**

The final stage of Swanson's caring theory (maintaining belief) includes the long-term support for the family and providing resources to assist with the return to a state of health and well-being. It must be acknowledged that women face stigma and shame associated with the loss of their infants (Simelela, n.d.). As noted by Bellhouse et al. (2019), some mothers experience self-blame, even if the death was unforeseen nor preventable. This self-blame can affect confidence with future pregnancies. One mother states, “I just didn’t trust my body not to kill another one of my children” (Bellhouse et al., 2019). Stigma from sources outside the partnership can occur if a person close to the family assigns fault or blame for the death of the infant (Lowdermilk et al., 2004). Even well-placed intentions can harm the family; individuals may feel that they are sparing parents pain by avoiding any discussions about the stillbirth or miscarriage. On the contrary, many parents experience feelings of isolation and frustration, often thinking loved ones have forgotten about the deceased infant (Lowdermilk et al., 2004). Lowdermilk et al. (2004) recommend that families and nurses work together to create a baby memory box, complete with infant handprints and footprints, ultrasound pictures, and the baby’s unworn first outfit. These articles can aid the commemoration of the infant’s brief life and validate the child’s existence.

Strong efforts are needed within communities to encourage difficult conversations to raise awareness and improve education surrounding the topic of stillbirths and miscarriages to prevent stigmas. Ongoing care also includes the resumption of a sexual relationship between partners. To help redefine aspects of the sexual relationship, healthcare professionals should facilitate open communication between partners. Relationship intimacy can aid important conversations, such as the exploration of how the individuals grieve, as partners may not grieve in the same way (Castanheira et al., 2020). For example, one partner may need to talk about a troubling situation, whereas the other partner avoids any discussion of the issue. Overall, nurses should validate the emotions and experiences of both partners to facilitate their recoveries.

**Conclusion**

In summary, miscarriages and stillbirths are emotionally traumatizing events with long-lasting effects on individuals and families. Swanson’s caring theory provides a guideline for how healthcare providers should provide care in these situations. Firstly, nurses must fully assess the physiological and psychological issues associated with the loss. Then, they should provide sensitive and emotionally competent care and allow the families the opportunities to physically let go of the child. Finally, nurses should support the family and connect them to available local resources. Current outpatient and community resources in the Windsor-Essex Region include The Canadian Mental Health Association, Sunnybrook Pregnancy and Infant Loss Network, and the Melo Clinic and Pregnancy Center, all of which offer counselling services. However, many of these services are only provided in either English or French which leaves a gap for couples requiring resources and support in other languages. Another issue with care is that it primarily focuses on the mother and excludes the other partner. Further research should be conducted to suggest methods to make the healthcare system more inclusive for non-traditional family forms, various cultural backgrounds, and the spouse. It is health care providers’ duty to support healthy bereavement in families experiencing loss to ensure that families do not experience a lack of empathy or poor support. In the family’s most vulnerable times, nurses should step forward to empower the patient and ensure that they recover from such a devastating experience.

**References**

Bellhouse, C., Temple-Smith, M., Watson, S., & Bilardi, J. (2019). “The loss was traumatic… some healthcare providers added to that”: Women’s experiences of miscarriage. *Women and Birth, 33*(2), 137-146. https://doi.org/10.1016/j.wombi.2018.06.006

Castanheira, E., Correia, P., Costa, V., Graça Pereira, M., Moreira, L., & Ribeiro, D. (2020). Predictors of emotional distress in pregnant women: The mediating role of relationship intimacy. *Journal of Mental Health, 29*(2), 152–160. https://doi-org.ledproxy2.uwindsor.ca/10.1080/09638237.2017.1417545

Centers for Disease Control and Prevention. (2020). *What is Stillbirth?* https://www.cdc.gov/ncbddd/stillbirth/facts.html

Farrales, L. L., Cacciatore, J., Jonas-Simpson, C., Dharamsi, S., Ascher, J., & Klein, M. C. (2020). What bereaved parents want health care providers to know when their babies are stillborn: A community-based participatory study. *BMC Psychology, 8*(1), 18. https://doi.org/10.1186/s40359-020-0385-x

Flexmort. (n.d.). *The Flexmort CuddleCot gives grieving parents the gift of time.* https://flexmort.com/cuddle-cots/

Kavanaugh, K., Moro, T. T., Savage, T., & Mehendale, R. (2006). Enacting a theory of caring to recruit and retain vulnerable participants for sensitive research. *Research in Nursing & Health, 29*(3), 244–252. https://doi.org/10.1002/nur.20134

Lowdermilk, D., & Perry, S. (2004). Grieving the loss of a newborn. *In Maternity & Women’s Health* (8th ed.)*.* (p.1150-1164). Evolve.

Nurse-Clarke, N., DiCicco-Bloom, B., & Limbo, R. (2019). Application of caring theory to nursing care of women experiencing stillbirth. *MCN, The American Journal of Maternal/Child Nursing, 44*(1), 27-32. doi:10.1097/NMC.0000000000000494

Peters, M. D., Lisy, K., Riitano, D., Jordan, Z., & Aromataris, E. (2015). Caring for families experiencing stillbirth: Evidence-based guidance for maternity care providers. *Women and Birth: Journal of the Australian College of Midwives, 28*(4), 272–278. https://doi.org/10.1016/j.wombi.2015.07.003

Pollock, D., Ziaian, T., Pearson, E., Cooper, M., & Warland, J. (2020). Understanding stillbirth stigma: A scoping literature review. *Women and Birth: Journal of the Australian College of Midwives, 33*(3), 207–218. https://doi.org/10.1016/j.wombi.2019.05.004

Ravaldi, C., Levi, M., Angeli, E., Romeo, G., Biffino, M., Bonaiuti, R., & Vannacci, A. (2018). Stillbirth and perinatal care: Are professionals trained to address parents' needs? *Midwifery, 64*, 53–59. https://doi.org/10.1016/j.midw.2018.05.008

Simelela, N. (n.d.). *The unacceptable stigma and shame women face after baby loss must end.* World Health Organization. https://www.who.int/news-room/spotlight/why-we-need-to-talk-about-losing-a-baby/unacceptable-stigma-and-shame

Swanson, K. M., Chen, H. T., Graham, J. C., Wojnar, D. M., & Petras, A. (2009). Resolution of depression and grief during the first year after miscarriage: A randomized controlled clinical trial of couples-focused interventions. *Journal of Women's Health, 18*(8), 1245–1257. https://doi.org/10.1089/jwh.2008.1202

The American College of Obstetricians and Gynecologists. (2020). Management of stillbirth. *Obstetrics & Gynecology, 135*(3), 110-132. doi:10.1097/AOG.0000000000003719

 Wilson, D. (2016). Parse’s nursing theory and its application to families experiencing empty arms. *International Journal of Childbirth Education: The Official Publication of the International Childbirth Education Association, 31*(2), 29-33. https://www.researchgate.net/publication/313914864\_Parse%27s\_Nursing\_Theory\_and\_its\_Application\_to\_Families\_Experiencing\_Empty\_Arms