Environmental Impacts of the Labor Ward on Bereaved Families

Lauren Blackwell & Joanna Heyes

Abstract: This article explores narratives of eight mothers who experienced a stillbirth in an NHS labor ward between February, 2016, and May, 2020. Core stories were developed for each participant. Aspects of environment within core stories were compared and contrasted across participants to develop five meta-stories. Meta-stories explored the psychological safety of the labor ward, the perception of the changing status of patient for mothers of stillborn babies, the incomprehensible physical and emotional pain of stillbirth for the mothers, stillborn mothers' perceptions of worth and the impact of rooms designed for typical birthing experiences. The findings are discussed alongside limitations of the study before suggestions for future research are drawn.

Keywords: stillbirth, stillborn, mother, NHS labor ward, narrative

Each day in the United Kingdom approximately eight babies are stillborn and are unable to be resuscitated (Tommy's, 2021). Unless delivery via caesarean section is medically necessary, gestational parents whose babies die in utero typically give birth vaginally under the care of the maternity unit (National Health Service, 2018). The facilities available within maternity units is currently hospital dependent (Sands, 2016), including the availability of specifically designated bereavement spaces.

In 2015, a major review of maternity care in the UK was announced as part of the NHS Five Year Forward View (NHS, 2021). The National Maternity Review report was subsequently published in February 2016. Within the report the vision for the future of maternity services was outlined, including a consideration of the care provided for parents when a baby dies.

Bereaved families consulted on the report, sharing that the environment in which they experienced stillbirth made a difference to them. When asked to share their experiences as bereaved parents, they

Lauren Blackwell is a Clinical Psychologist working in Midlands Partnership Foundation Trust (NHS). This research was completed as part of Lauren's Professional Doctorate in Clinical Psychology qualification. Contact: lauren.blackwell@mpft.nhs.uk
Dr Joanna Heyes is a Clinical Psychologist and the Course Director for the Professional Doctorate in Clinical Psychology and Principal Lecturer in Clinical Psychology at Staffordshire University. Contact: Joanna.heyes@staffs.ac.uk, 01782 294774. Both authors are affiliated with Staffordshire University.

disclosed that being near other families in the labor ward who were not experiencing stillbirth "greatly added to their trauma and distress" whereas families who were cared for in private spaces, such as bereavement suites, shared their appreciation of this (National Health Service, 2016).

The report published recommendations to be implemented as part of the transformation of maternity services. Where stillbirth was concerned, it was recommended that staff "ensure that the care families receive is compassionate and does not further add to their grief" (National Health Service, 2016). Despite an acknowledgement that the physical spaces in which families are cared for following a stillbirth have the potential to impact their experiences, there was not a specific recommendation made with regards to the environment in which women experience stillbirth. As such, some families continue to be cared for in the same environment as those undergoing a typical birthing experience. The most recent audit of bereavement facilities within the NHS demonstrated that 11% of trusts have no dedicated bereavement room in which to care for families, 26% have a bereavement room in at least one maternity unit but not all, and 63% have a dedicated room in each maternity unit (Sands, 2016).

The justification for the thoughtful consideration of where bereaved families are cared for during a stillbirth has been consistently demonstrated within existing literature, with findings continually reporting that lack of a supportive and dedicated stillbirth environment can add to the distress of bereaved parents. As described within the National Maternity Review (2016), the proximity to other families, and the sights and sounds associated with this, can and does cause trauma for families experiencing stillbirth (Nuzum et al., 2017; Redshaw et al., 2014). For example, the sounds of other parents laboring has been found to be "heartbreaking" to hear (Due et al., 2018; Kelley & Trinidad, 2012), "furthering the experience of grief" (Norlund et al., 2012). The noises associated with typical labor environments are often in direct contrast to the silence associated with stillbirth (Kelley & Trinidad, 2012), frequently inviting bereaved parents to draw comparisons between their own circumstances and those of others (Mulvihill & Walsh, 2014). The witnessing of the celebrations associated with birth can also contribute to feelings of sadness for bereaved families (Gopichandran et al., 2018), which adds to overall suffering (Ellis et al., 2016).

While existing literature has provided an understanding of which aspects of the stillbirth environment have the potential to further the distress felt by bereaved parents, there is not currently an understanding of exactly how these factors impact parents. This paper develops a deeper understanding of specifically how the environment in which a stillbirth occurs impacts bereaved mothers following the death of their baby. Within this research study, eight mothers were invited to share their stories of

their stillbirth. The authors hope that an understanding of how stillbirth environment impacts bereaved parents may provide a richer understanding of this experience and may be a first step in providing trauma-informed care for bereaved families of stillborn babies. First the authors disclose their method, discussing their own positionality as researchers and the ethical considerations of this project. The authors then move to examine their procedures and analyze the data pulled from the ten interviews of eight mothers who experienced stillbirth in a UK labor ward that had no specific bereavement unit (or was unavailable at the time).

Method

The researcher is a trainee clinical psychologist with a professional interest in baby loss and stillbirth who holds a constructivist epistemological position, believing that meaning is made from the engagement humans have with their realities (Moon & Blackman, 2017). In the context of this research, the researcher believed gestational parents could develop meaning of their own stillbirth through their environment.

The researcher's lack of personal experience in stillbirth in part influenced the decision to utilize event-focused Labovian analysis (1972) to achieve a better understanding of the impact of stillbirth environment as this allows for a single event to be considered with a clear framework to aid narrative construction. Labov's structured approach provides a framework for the experience of events to be considered (Patterson, 2013). The verbal aspects of storytelling are the focus, with meaning being conveyed through spoken language within storytelling. Epistemologically, the constructivist position of the researcher and Labov's analysis suggest that reality and meaning made from lived experience is both conveyed and shaped through words during storytelling.

As listeners become part of the meaning making process for storytellers, there was a potential for both data collection and subsequent analysis to be influenced by the researcher. A reflexive diary was kept to encourage reflections on this process. The researcher interpreted the results. Two drafts of the paper (including results interpretation) were reviewed by the second author (JH). This reduced the potential for biases and guarded against over-interpretation within the framework of the first author.

Design

A narrative approach was used to better understand how women made sense of the impact of their stillbirth environment. In narrative research, the meaning people make from their experiences is understood through the stories that they tell (Holloway & Freshwater, 2007; Moen, 2006). Through storytelling, the internal representation of events, thoughts, and feelings are expressed externally, with the act of storytelling enabling the storyteller to organize and summarize their experience and co-construct the meaning of this with their audience. The co-construction within narratives depends upon the social context in which stories are heard, with story performance differing within different contexts (Squire, 2013). For example, a person may describe their working day differently to their colleagues than they would to their friends. The role of co-construction can however be overlooked by event focused analyses, presenting stories as personal constructions of events.

In narrative research, stories are told freely, without interruption (Kartch, 2017) to allow for a recounting of events and the meaning made from them. Following storytelling, the listener may generate discussion about aspects of the story, but introduce no new material. Narrative research is therefore unrestricted by predetermined research questions, allowing data collection to be directed by participants' storytelling. Given the lack of literature focused on stillbirth environment, the flexibility offered by narrative research was considered more appropriate than other qualitative methodologies, such as Grounded Theory. The use of unstructured interviews supported the elicitation of personal opinions and experience in great depth, however semi-structured interviews may have been advantageous in the containment of storytelling (Jamshed, 2014).

Service User Involvement

People with lived experience of stillbirth and emotional difficulties were consulted with throughout this research project. A member of the Staffordshire University Clinical Psychology Service User and Care Consultant Committee contributed in discussions with the researchers as to whether the proposed research was meaningful. An individual with lived experience of stillbirth reviewed language sensitivity of advertisements and shared these on social media. Families of stillborn babies reviewed language sensitivity and terminology via voting on open polls on Instagram.

Ethical Considerations

Ethical approval for the research was granted by both Staffordshire University and the Integrated Research Application System (IRAS). Mothers who expressed an interest in the research were provided with a Participant Information Sheet outlining what they could expect

from participating in the study. Informed consent was obtained before individuals were confirmed as participants. Due to the potential for interviews to be distressing, participants were required to provide an emergency contact. All participants were guaranteed anonymity, were debriefed upon completion of their interview, and were provided with resources they could access should they have needed further support.

Recruitment

Participants who met inclusion and exclusion criteria were invited to learn more about the research project. The minimum time parameter of six months was set to allow time for the grief process between loss and interview. A review of literature in relation to grief in general suggested that after six months the majority of individuals do not suffer significant impairment in functioning as a result of their loss (Jordan & Litz, 2014). The maximum time parameter was set at February 2016 in line with the publication of the National Maternity Review, which allowed the researchers to compare the experiences of women with the recommendations that had been published.

Participants were required to have given birth in a labor ward in order to allow the experience of being near other families who were not experiencing a loss to be better understood. As such, bereaved families who gave birth in private rooms away from the labor ward were excluded from the project. The requirement to be 18 years or older was a stipulation of ethical approval for the project. The mothers in this study were required to be at least 24 weeks gestation before the birth of their baby to meet NHS criteria of their experience being classified as a stillbirth.

The study was advertised on Mumsnet—an online blogging forum for mothers—and the social media networks, Facebook and Instagram. Forty-three mothers expressed an interest in the project and were sent a Participant Information Sheet. All were informed that confirmation of meeting eligibility criteria was required before consent forms could be sent. Twenty-two of the initial respondents did not respond following this. Of the 21 mothers who did respond, 13 did not meet eligibility criteria: five mothers gave birth outside of the set date parameters, four mothers had not reached the 24th week of pregnancy and four mothers gave birth in a bereavement suite. A total of nine mothers met eligibility criteria and returned completed consent forms. One of these mothers did not respond to communication to book an interview. All eight remaining mothers participated in the project. A summary of participants is presented in Table 1.

Table 1

Pseudonym	Baby	Delivery	Subsequent children
Jenny	1st	Induced after identification of no heartbeat.	Yes
Sophie	1st	Induced due to HELLP syndrome. Baby was stillborn.	Unknown
Nelly	1st	Induced after identification of no heartbeat.	Yes
Delilah	1st	Spontaneous labor. No heartbeat found at hospital.	Yes
Sharon	1st	Induced after identification of no heartbeat.	Yes
May	2nd	Induced after identification of no heartbeat.	Unknown
Jane	2nd	Induced after identification of no heartbeat.	No
Ruby	2nd	Induced after identification of no heartbeat.	Yes

Table 2: Summary of participants

Procedure

The researcher completed interviews over an NHS-compliant (HIPPA-compliant) version of Skype. Prior to the interview session, participants were encouraged to ask any questions. The researcher advised participants that there were no specific questions within the interview. Instead, participants would be encouraged to begin sharing their story of stillbirth. Participants were informed they were not required to answer follow-up questions and were encouraged to take breaks. Participants were advised they could end their interview at any time.

During the interview, participants shared their experience of stillbirth. Though the researcher did not attempt to guide the conversation, all eight mothers began their story at the point where either they or professionals deemed something to be "wrong" with their baby. While listening, the researcher noted the occasions where participants referenced their environment. After storytelling, the researcher generated discussions around the mentioned aspects of environment. Following this, the interview was brought to an end by the researcher.

After the interview, participants were debriefed and emailed sources of psychological support. Where storytelling had not been completed or all aspects of environment had not been discussed, second interviews were arranged for the following week in line with participant availability. Two participants were interviewed twice, and six participants were interviewed once. Combined interview times ranged from 20-81 minutes. Two interviews featured poor sound quality. Where necessary, these participants were asked to return to parts of their stories to ensure that all data was captured.

Data was in the form of audio recordings transcribed using Trint software. Transcript accuracy was confirmed by playing recordings and reading transcripts simultaneously. Errors were corrected by the researcher by hand. All speech was included on transcripts so as to include all collected data.

Discussion

Meta-stories are presented to allow for discussion of the specific environmental aspects of stillbirth experience raised by participants in their individual core stories. Meta-stories consider the researcher's interpretation of core stories both on an individual basis and in the context of other participants' stories and are discussed alongside relevant literature.

Meta-Story 1: Stories of identity

When telling their stories, the eight participants communicated how they had perceived and made meaning of their identities as mothers of stillborn children and patients on the labor ward. Identity development is typically based on an individual's relationships to both internal and external factors. In their stillbirth stories, participants described how the external environment of the ward conflicted with their internal perceived identities.

Some participants recalled how being able to follow their birth plan gave them a sense of normality, "[it was] normal in a way…what I had envisaged… I just felt like the room was just filled with love… I hadn't thought it could be a positive experience." By being treated in the same way as other birthing people on the ward, participants reflected how this gave them an experience similar to that which they had imagined before learning that their baby had died, appearing to confirm the identities of mother and patient on the labor ward. Supporting mothers of stillborn babies to engage in decision making has the potential to reduce distress and confusion for the bereaved family (Malm et al., 2011). Collaborating in care with bereaved families could confirm the patients' identities. Contrastingly, some participants felt that being cared for on the labor ward meant that staff viewed them in the same way as the other patients in the ward, resulting in less empathy. They expressed confusion as to how staff could care for their unique needs while also caring for others on the ward, suggesting a perceived distinction between the needs of mothers and mothers of stillborn babies. This distinction is perhaps indicative of a perceived difference in identity.

When participants were treated differently from other patients on the ward not experiencing stillbirth, they described feeling conflicted. One mother described how using the back corridor "was nice and horrible at the same time…because it shouldn't be that way…the whole thing just felt unfair…we didn't do anything wrong." Participants' language suggested a connection between being treated differently and wrong-doing, a shared blame and stigma felt by bereaved mothers (Horton & Samarasekera, 2016; Pollock et al., 2020). Similarly, when describing the need to ask to see their babies, participants spoke of feeling like burdens, implying that despite having similar post-delivery recovery requirements to other patients on the ward they did not consider themselves to have valid healthcare needs. It could be that the distinct differences in the experiences of mothers and stillborn mothers led participants to view their identities on the ward as being distinctly different, leaving them feeling like burdens instead of patients. Scholars have explored the change in status as mother following baby loss (Hsu et al., 2004; Wonch Hill et al., 2016), including whether bereaved parents ought to be defined as either mothers or patients (Lovell, 1983). In the context of environment, existing findings have suggested that isolation from the labor ward brings challenges to the status of patient for bereaved mothers (Brierley et al., 2014). The narratives in this research suggest that this is also present for women on the labor ward.

Meta-Story 2: Incomprehensible pain: The silence and noise

Within their stories participants referenced the proximity of other families on the labor ward, specifically describing how hearing other women and babies and seeing other families contributed to their emotional pain.

When describing hearing other women in labor, participants supported existing literature identifying stillbirth as a traumatic event (Gravensteen et al., 2013), drawing distinctions between the sounds of life and death (Kelly and Trindad, 2012). For instance, one mother shared, "You're giving birth to death…but then you can hear everyone else giving birth to life." Similes and metaphors were used to convey the depths of pain that this experience engendered, likened to being a punishment, suggesting a consequence of wrongdoing. Narratives indicated that the proximity to other women contributed to the development of the feelings of guilt and shame reported in existing literature (Burden et al., 2016; Gold et al., 2017). The mothers used metaphors of physical pain to describe emotions, such as, "It really hurt, like a physical, mental pain. It was too much to bear… it was like being stabbed. It was this massive pain… like an attack." It has been interpreted that the emotional pain was considered to be incomprehensible to those who have not experienced stillbirth by participants when telling their stories, leading to the use of

metaphorical examples that were believed to be more accessible to the average audience (Semino, 2010). The difficulty in articulating emotional pain resulting from stillbirth is perhaps a reflection of the disenfranchised grief often reported by bereaved mothers (Golan and Leichtentritt, 2016). When participants described their emotional responses to hearing other laboring mothers they described dissociating in an attempt to reduce their distress: "[It] made me go more into a shell and shut down… made me feel even more detached from the situation and I couldn't get those emotions out." While detaching is indicative of a trauma response (Lanius, 2015), being unable to express emotion is perhaps an indication of 'stuckness': being unwilling to connect with emotions while simultaneously being unable to move past them.

In contrast, when participants described their responses to hearing babies crying, they recalled how these noises brought their own experiences into focus: "[It] cuts through the kind of shock that you're feeling…(making your experience) so much more stark and difficult to handle." These participants directly asserted that hearing babies made their overall experience worse by compounding their grief, "adding levels of trauma that were not necessary." When storytelling considered the present, some participants shared how the cries of newborn babies still impact them and described a belief that their memories of these sounds were 'trauma' memories. Participants' narratives suggest that the presence of other babies within a stillbirth environment can result in the trauma processing associated with Post Traumatic Stress Disorder (Ehlers, 2010), potentially leading to the development of long-standing, pervasive mental health difficulties.

Some participants summarized the effect of the combined sounds of mothers and babies as being akin to a nightmare, because "your world has ended…you don't want to be listening to people start theirs… like some really cruel, horrible joke." The likening to jokes and nightmares suggests a sense of disbelief, perhaps relating to existing findings regarding the shocking nature of stillbirth (Crawley et al., 2013) due to the direct reversal of the expectation that children outlive their parents (Edwards and Palmer, 2015). It may be that the proximity of other women and babies provides juxtaposition to participants' experiences, contributing to the shock reported.

The witnessing of other families' celebrations, in the words of one of the participants, was "very painful," because "everything else around you is moving at pace…this totally life altering event for you is just slotted between [other babies being born]. You want the whole world to stop and understand the magnitude of what's happened." While storytelling, some participants used embedded evaluations and intensifiers to demonstrate the impact of witnessing life continuing amidst a personal, major loss

unrecognized by others. It may be that being located on the labor ward left participants feeling immersed in an environment which afforded little time or space to grieve for their babies given the continuous reminder of what ought to have been.

Meta-Story 3: The realities of the room

When telling their stories, participants described the settings they took place in and the inferences they had made about these. Participants' descriptions of the rooms they were cared for in support existing literature that suggests stillbirth care is often conducted in rooms designed for typical birth experiences (Kelly and Trinidad, 2012). One participant suggested that their location impacted their sense of importance on the ward, describing a feeling that their specific needs had not been considered by staff who placed them in typical birthing rooms, leading them to conclude that "being the mother of a living child is more important than when you're the mother of a dead child." While seven participants attributed the decision making regarding their location to staff on the ward, in the absence of a specifically designated bereavement space this is more a reflection of commissioning and societal recognition of the possibility of stillbirth. Previous research has indicated that parents of stillborn babies believe their identity is unrecognized by society due to them being a parent without a child (Burden et al., 2016). It is possible that being cared for on a labor ward in a typical labor room contributes to the development of this belief.

Some participants described the specific details of their rooms and how they contrasted with their experiences. The contrast between reality and the room contributed to participants' pain, making the desired psychological 'escape' difficult to achieve. These details included pictures on the walls, a feature not yet present within existing literature, demonstrating how narrative research can identify important aspects of meaning making that may be missed without listening to stories. One participant shared, "[The picture of the baby on the wall] didn't match [my experience]. It reinforced… what I thought I should be giving birth to. Afterwards, I felt like he was mocking me." Similarly, one participant spoke of the unfairness of seeing their babies decompose under harsh lighting, "It just wasn't fair… it makes it far too real." Both the reminders of the experiences that ought to have been taking place in addition to the direct reality of what was happening confirmed how real participants' experiences felt and how painful they were. While literature suggests seeing and holding stillborn babies is beneficial to the future wellbeing of bereaved parents (Kingdon et al., 2015), the specific environmental influences, such as lighting, is not discussed within the literature.

Meta-Story 4: Stories of worth

Participants described their perceptions of the facilities and resources available to them as mothers of stillborn babies. Five shared how when facilities were not available, or were prioritized for other mothers on the ward not experiencing stillbirth, they believed this indicated that both they and their babies were less worthwhile than others on the ward.

When staff took equipment such as baby cots and baby care units from participants' rooms to use elsewhere, one participant recalled this as feeling, "quite traumatic... I couldn't cope very well…but I felt so numb I struggled to speak up. [Keeping it in my room] would have given me hope." They described feeling as though staff were suggesting "your baby's dead so we don't need this anymore…like another kick in the gut." This mother continued, explaining that she felt "we weren't important anymore and that other women were more important because they were having live babies...it just made me feel really shit. I just thought, 'they don't want us here, they're not looking after us.'" Researchers suggest that mothers of stillborn babies can feel discriminated against by healthcare providers following a stillbirth (Pollock et al., 2021). The stories from participants in this research support this, suggesting that the sharing of equipment resulted in feelings of lesser importance, with other mothers on the ward being perceived as being more worthy of the care available.

Participants spoke of the amenities that were available on the ward. In some stories, amenities that are specific to the experience of stillbirth, such as cooling units (or cold cots, which allow parents to spend more time with their deceased baby) were notably absent. For some participants, the language used by staff to describe the cold cots was an indication of how their babies were viewed. For example, one staff member described this as a freezer and a mother shared, "no mum wants to think of her little one being put in a freezer." Others described the lack of amenities as meaning their babies were unable to be kept in the same room as them, impacting their perception of closeness with them. Literature has suggested that there is a disparity of 'personhood' for deceased babies, with a lack of recognition for stillborn babies as people with their own identities (Hockey and Draper, 2005). This denial of personhood (Lovell, 1983) and denial of amenities is in direct contrast to how society would expect a newborn baby to be treated, further contributing to participants' perceptions of worthiness of both themselves and their babies.

Other stories featured absent facilities that were not specific to the experience of stillbirth but had a unique impact on the stillborn mother. For example, the lack of an ensuite bathroom meant some bereaved parents had to use a communal toilet. One mother shared, "All

you wanted to do was just hide in your room away from anything else that was happening in the world, but that was made more difficult because…you have to step out of the room." Existing literature has demonstrated a need to balance privacy needs of the mother of a stillborn baby between the extremes of intrusiveness and isolation (Brierley-Jones et al., 2014), however participants' stories offer a unique perspective of where facilities, or lack thereof, force an engagement with the outside world. It is possible that the absence of facilities that could offer psychological protection for bereaved mothers through adequate privacy left participants querying their worthiness of a place on the ward, in some cases leading to leaving early to grieve at home.

Meta-Story 5: Stories of psychological safety

While participants' stories detailed the specific aspects of their environment that impacted their overall experience, some stories suggested that the labor ward in general left them feeling psychologically unsafe. One mother spoke of being, "in an environment where I couldn't let myself be vulnerable," because "there's just something about that set up and environment that doesn't feel…right." Another mother corroborated this feeling, sharing that she felt left, as if she had "been spun into this world that you're never going to recover from." In their storytelling, two participants conveyed how they understood that they were undergoing a life-altering event while it was happening, yet felt unable to emotionally process this experience while still in the hospital. Participants described the contrast of being somewhere where they had little choice or control over their circumstances with the desire to be at home, which was described as being both safe and secure.

Participants' discussions around psychological safety suggest that their experiences did not involve trauma-informed care (Fallot and Harris, 2006). While literature has yet to focus on trauma-informed care in the context of stillbirth, findings relating to traumatic births have demonstrated the significance of the role of staff in contributing to the overall traumatic birth experience (Reed et al., 2017) and their ability, or lack thereof, to facilitate psychological safety during times of distress. It is possible that where participants chose to describe how a combination of environmental factors left them feeling unsafe without hope of recovery, the staff who cared for them were unable to facilitate emotional safety throughout numerous environmental aspects of their experiences.

Clinical Suggestions

The results of this qualitative research project may provide clinical suggestions for the labor ward and beyond. For labor wards, there

may be justification for a consideration of the environments in which bereaved families experience stillbirth. In the absence of dedicated bereavement rooms, spaces in which bereaved families are cared for could be thoughtfully reviewed, including room decoration, furnishings, available equipment, and soundproofing.

Participants' stories acknowledged how a lack of trauma-informed care contributed to longer standing emotional difficulties, and how their overall care directly impacted perceived changes in their status as mothers and patients, and their babies' status as a person. Staff on maternity units may benefit from being offered training to facilitate a better understanding of trauma-informed care in the context of stillbirth.

Clinical psychologists and bereaved families could be helpful consults for proposed changes to maternity units. Beyond the labor ward, the case studies in this paper suggest that a deeper understanding of environmental impacts in which bereaved families experience stillbirth can impact them in the months and years following. The eight mothers in this paper were allowed to reflect on both their experiences and the meaning made from them. Where bereaved mothers and gestational parents go on to seek support through psychological therapies, psychologists may better understand the contextual impact of the stillbirth environment, leading to the development of meaningful treatment plans and goals.

Limitations

This is an initial qualitative research report, and the findings indicate that further research could help substantiate the claims explored here. In this study, the primary researcher conducted the interviews and produced the writing, while the second researcher examined the research for biases. Future research would benefit from additional researchers examining the work. Furthermore, this research focused on mothers who went into labor with full knowledge that they were experiencing a stillbirth. Additional research needs to be conducted around what can be done with the environment to support families who experience stillbirth during labor without prior knowledge. Some participants expressed concerns that they may have 'blocked out' aspects of their experience on account of how painful those experiences were. It is therefore possible that certain aspects of stillbirth environment have not been remembered by participants and subsequently not been included within findings.

The Labovian method of narrative analysis is event focused, meaning the social construction of narratives is not considered. It is possible that in the context of stillbirth, participants focused on telling the 'event' rather than the experience due to a lack of encouragement to

consider existing cultural narratives around stillbirth. The restructuring of events that occurs through storytelling (Patterson, 2013) is not accounted for in Labov's model. This brings limitations both in the content of the stories told by participants, and how these stories have been understood by the researcher.

Finally, a focus on the 'spoken' story means Labov's analysis neither considers the non-verbal aspects of storytelling nor the requirement for researchers to organize stories told non-chronologically, both of which have implications for stories of trauma (Frank, 1995) and stillbirth.

Conclusion

The initial findings from this qualitative study have enabled more questions, including whether mothers of stillborn babies identify as patients when being cared for on a labor ward. This research looked at aspects of stillbirth environment through the experiences of eight participants in their postpartum period. The authors examined how bereaved families react to the proximity of other birthing families, ward resources, and space suitability. Further environmental impacts that are not currently present in literature were raised by participants, including the challenges to the identity of patient, perceptions of worthiness and the lack of perceived psychological safety on the ward. This qualitative study indicates that further research is warranted to see how maternity services could consider where changes can be made in order to reduce negative environmental impacts for bereaved families in the future.

References

Brierley-Jones, L., Crawley, R., Lomax, S., & Ayers, S. (2014). Stillbirth and stigma: The spoiling and repair of multiple social identities. *OMEGA – Journal of Death and Dying, 70*(2), 143—168.

Burden, C., Bradley, S., Storey, C., Ellis, A., Heazell, A.E.P., Downe, S., Cacciatore, J., & Siassakos, D. (2016). From grief, guilt, pain, and stigma to hope and pride – a systematic review and meta-analysis of mixed-method research of the psychosocial impact of stillbirth. *BMC Pregnancy and Childbirth, 16*(9), 1—12.

Crawley, R., Lomax, S., & Ayers, S. (2013). Recovering from stillbirth: The effects of making and sharing memories on maternal mental health. *Journal of Reproductive and Infant Psychology, 31*(2), 195—207.

Due, C., Obst, K., Riggs, D.W., & Collins, C. (2018). Australian heterosexual women's experiences of healthcare provision following a pregnancy loss. *Women and Birth, 31*(1), 331—338.

Edwards, L., & Palmer, J. (2015). *Facing the death of your child.* Children's Cancer and Leukaemia Group.

Ehlers, A. (2010). Understanding and treating unwanted trauma memories in posttraumatic stress disorder. *Zeitschrift fur Psychologie [Journal of Psychology], 218*(2), 141—145.

Ellis, A., Chebsey, C., Storey, C., Bradley, S., Jackson, S., Flenady, V., Heazell, A., & Siassakos, D. (2016). Systematic review to understand and improve care after stillbirth: A review of parents' and healthcare professionals' experiences. *BMC Pregnancy and Childbirth, 16*(16), 1—19.

Emden, C. (1998). Conducting a narrative analysis. *Collegian, 5*(3), 34—39.

Fallot, R.D., & Harris, M. (2006). *Trauma-informed services: A self-assessment and planning protocol.* Community Connections.

Frank, A. (1995). *The wounded storyteller: Body, illness, and ethics.* University of Chicago Press.

Golan, A., & Leichtentritt, R.D. (2016). Meaning reconstruction among women following stillbirth: A loss fraught with ambiguity and doubt. *Health and Social Work, 41*(3), 147—154.

Gold, F.J., Sen, A., & Leon, I. (2017). Whose fault is it anyway? Guilt, blame, and death attribution by mothers after stillbirth or infant death. *Illness, Crisis and Loss, 26*(1), 40—57.

Gopichandran, V., Subramaniam, S., & Kalsing, M.J. (2018). Psycho-social impact of stillbirths on women and their families in Tamil Nadu, India – A qualitative study. *BMC Pregnancy and Childbirth, 18*(109), 1—13.

Gravensteen, I.K., Helgadóttir, L.B., Jacobsen, E., Rådestad, I., Sandset, P.M., & Ekeberg, O. (2013). Women's experiences in relation to stillbirth and risk factors for long-term post-traumatic stress symptoms: A retrospective study. *BMJ Open, 3*(10), 1—10.

Hockey, J., & Draper, J. (2005). Beyond the womb and tomb: Identity, (dis)embodiment and the life course. *Body and Society, 11*(2), 41—57.

Holloway, I., & Freshwater, D. (2007). Vulnerable story telling: Narrative research in nursing. *Journal of Research in Nursing, 12*(6), 703—711.

Horton, R., & Samarasekera, U. (2016). Stillbirths: Ending an epidemic of grief. *The Lancet, 387*(10018), 515—516.

Hsu, M., Tseng, Y., Banks, J.M., & Kuo, L. (2004). Interpretations of stillbirth. *Journal of Advanced Nursing, 47*(4), 408—416.

Jamshed, S. (2014). Qualitative research method-interviewing and observation. *Journal of Basic and Clinical Pharmacy, 5*(4), 87—88.

Jordan, A.H., & Litz, B.T. (2014). Prolonged grief disorder: Diagnostic, assessment and treatment considerations. *Professional Psychology: Research and Practice, 45*(3), 180—187.

Kartch, F. (2017). *Narrative interviewing.* In M. Allen, (Ed.), *The SAGE Encyclopaedia of Communication Research Methods.* (1073—1075). SAGE.

Kelley, M.C., and Trinidad, S.B. (2012). Silent loss and the clinical encounter: Parents' and physicians' experiences of stillbirth – A qualitative analysis. *BMC Pregnancy and Childbirth, 12*(137), 1—15.

Kingdon, C., Givens, J.L., O'Donnell, E., & Turner, M. (2015). Seeing and holding baby: Systematic review of clinical management and parental outcomes after stillbirth. *Birth Issues in Perinatal Care, 42*(3), 206—218.

Labov, W. (1972). *Language in the inner city: Studies in the Black English vernacular*. Basil Blackwell.

Lanius, R.A. (2015). Trauma-related dissociation and altered states of consciousness: A call for clinical, treatment and neuroscience research. *European Journal of Psychotraumatology, 6*(1), 1—9.

Lovell, A. (1983). Some questions of identity: Late miscarriage, stillbirth and perinatal loss. *Social Science and Medicine, 17*(11), 755—761.

Malm, M.C., Radestad, I., Erlandsson, K., & Lindgren, H. (2011). Waiting in no-man's land – Mothers' experiences before the induction of labour after their baby has died in utero. *Sexual and Reproductive Healthcare, 2*(2), 51—55.

Mishler, E.G. (1986). The analysis of interview-narratives. In T.R. Sarbin (Ed.), *Narrative Psychology: The Storied Nature of Human Conduct.* Praeger.

Moen, T. (2006). Reflections on the narrative research approach. *International Journal of Qualitative Methods, 5*(4), 56—69.

Moon, K., & Blackman, D. (2017). A guide to ontology, epistemology, and philosophical perspectives for interdisciplinary researchers. *Integration and Implementation Insights.* https://i2insights.org/2017/05/02/philosophy-for-interdisciplinarity/

Mulvihill, A., & Walsh, T. (2014). Pregnancy loss in rural Ireland: An experience of disenfranchised grief. *British Journal of Social Work, 44*(1), 2290—2306.

National Health Service. (2016). National Maternity Review – better births: Improving outcomes of maternity services in England. *NHS.* https://www.england.nhs.uk/ourwork/futurenhs/mat-review

National Health Service. (2018). What happens if your unborn baby dies. *NHS.* https://www.nhs.uk/conditions/stillbirth/what-happens/

National Health Service. (2021). National Maternity Review. *NHS.* https://www.england.nhs.uk/mat-transformation/implementing-better-births/mat-review/

Norlund, E., Börjesson, A., Cacciatore, J., Pappas, C., Randers, I., & Rådestad, I. (2012). When a baby dies: Motherhood, psychosocial care and negative affect. *British Journal of Midwifery, 20*(11), 780—784.

Nuzum, D., Meaney, S., & O'Donohue, K. (2017). Communication skills in obstetrics: What can we learn from bereaved parents? *Irish Medical Journal, 110*(2), 512.

Patterson, W. (2013). Narratives of events: Labovian narrative analysis and its limitations. In M. Andrews, C. Squire, & M. Tamboukou (Eds.), *Doing Narrative Research* (pp. 27—46). SAGE.

Personal Narratives Group. (1989). *Interpreting women's lives: Feminist theory and personal narratives.* Indiana University Press.

Pollock, D., Pearson, E., Cooper, M., Ziaian, T., Foord, C., & Warlund, J. (2020). Voices of the unheard: A qualitative survey exploring bereaved parents' experiences of stillbirth stigma. *Women and Birth, 33*(2), 165—174.

Pollock, D., Pearson, E., Cooper, M., Ziaian, T., Foord, C., & Warlund, J. (2021). Breaking the silence: Determining prevalence and understanding stillbirth stigma. *Midwifery, 93*(1), 1—8.

Redshaw, M., Rowe, R., & Henderson, J. (2014). Listening to parents after stillbirth or the death of their baby after birth. Hunts – Paper and Pixels.

Reed, R., Sharman, R., & Inglis, C. (2017). Women's descriptions of childbirth trauma relating to care provider actions and interactions. *BMC Pregnancy and Childbirth, 17*(21), 1—10.

Sands. (2016). Audit of bereavement care provision in UK maternity units. *Sands. https*://www.sands.org.uk/professionals/professional-resources/audit-bereavement-care-provision-uk-maternity-units-2016

Semino, E. (2010). Descriptions of pain, metaphor and embodied simulation. *Metaphor and Symbol, 25*(4), 205—226.

Sereshti, M., Nahidi, F., Simbar, M., Ahmadi, F., Bakhtiari, M., & Zayeri, F. (2016). Mothers' perception of quality of services from health centres after perinatal loss. *Electronic Physician, 8*(2), 2006—2017.

Squire, C. (2013). From experience-centred to socioculturally-oriented approaches to narrative. In M. Andrews, C. Squire, & M. Tamboukou (Eds.), *Doing Narrative Research* (pp. 27—46). SAGE.

Tommy's (2021). Stillbirth statistics. *Tommy's.* https://www.tommys.org/baby-loss-support/stillbirth-information-and-support/stillbirth-statistics

Wonch Hill, P., Cacciatore, J., Shreffler, K.M., & Pritchard, K.M. (2016). The loss of self: The effect of miscarriage, stillbirth, and child death on maternal self-esteem. *Death Studies, 41*(4), 226—235.