



Psychosocial impact of mothers with perinatal loss and its contributing factors: an insight*

Rosnah SUTAN[†], Rosnah Mohamad AMIN, Khatija Banu ARIFFIN,

Tang Zoun TENG, Mohd Faiz KAMAL, Rusli Zaim RUSLI

(Department of Community Health, University Kebangsaan Malaysia Medical Centre, Bandar Tun Razak, Cheras 56000, KL, Malaysia)

[†]E-mail: rosnahsutan@yahoo.com

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Abstract: Objective: To evaluate the psychosocial impact among mothers with perinatal loss and its contributing factors. Methods: A cross sectional study was conducted in University Kebangsaan Malaysia Medical Centre (UKMMC) from April 2008 to May 2009 using Edinburgh Postnatal Depression Scale (EPDS) and self administered questionnaire. Results: Sixty-two respondents were included and most of them were working mothers (77.4%). The mean age of the respondents was (31.0±5.6) years and a majority of the subjects aged between 20–34 years (77.4%). According to the EPDS score, 53.2% of the respondents had a psychosocial impact with a total score of >9, out of 30. There was a significant relationship between psychosocial impact after perinatal loss and support from friends ($P=0.019$). However, there were no significant differences between psychosocial impact and history of previous perinatal loss, ethnicity, occupation, educational level, age or total income. Conclusion: Mothers with perinatal loss should be screened for psychosocial impact and offered support when needed. Family and friends should continue to provide emotional support. People who have experienced similar problem before will be able to provide better support than those who have not.

Key words: Perinatal loss, Stillbirth, Neonatal death, Psychosocial impact, Edinburgh Postnatal Depression Scale (EPDS)
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1 Introduction

Perinatal loss may cause major emotional problems in adjustment during bereavement period. Feeling of unpreparedness to face painful reality of the loss, denial, and feeling that their world no longer makes sense are commonly expressed (Leonard *et al.*, 2000). Parents who have experienced perinatal loss may feel hardship and face difficult time during this period. Modiba and Nolte (2007) reported that mothers with perinatal loss expressed their wishes that people should acknowledge their losses, be considerate and sensitive, and give them a listening ear and

emotional support. It was also mentioned in the study that health workers should provide the mothers with appropriate support. Therefore, certain measures need to be taken to help those parents to cope with perinatal loss. Parents were encouraged to develop a birth plan so that their special needs and concerns are more likely to be met (Wallerstedt *et al.*, 2003). Health care providers must evaluate the significance of parent's perception on perinatal loss before starting an intervention, or else their assumptions in giving care will cause additional pain to these parents (Hutti, 1992). A study investigating loss during different stages of pregnancy showed no significant difference in the grief response between mothers losing a baby by miscarriage, stillbirth or neonatal death (Frazer and Cooper, 2003).

Hutti *et al.* (1998) mentioned that, by talking

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with the parents in evaluating their experience on the actual perinatal loss and comparing it to the “standard of the desirable,” those parents who are likely to feel angry and victimized should be screened. The “standard of the desirable” in his study was defined as “the way it ought to be, if I have to go through it” as been mentioned by Dougherty (1984). The standard develops as the experience unfolds, often in response to a negative event (Hutti *et al.*, 1998). Professional support interventions should be aimed as close as possible to “standard of the desirable” (Swanson, 1993; 1999). Some parents may experience prolonged grief reaction (Rowe *et al.*, 1978). It seems that those parents who had been followed up in person are more likely to be satisfied with the information they received. Usually, parents who have adequate understanding and have no prolonged grief will not have the need for any further follow-up.

Perinatal loss is a psychological trauma. A great number of studies have been done on the psychosocial impact of perinatal loss on mothers over the past 30 years. Studies on the impact of stillbirth on mothers, using a case-control community-based sample, had established that stillbirth is a significant risk factor for depression and anxiety when they are assessed during a subsequent pregnancy and puerperium (Swanson, 1993). With regards to the area of perinatal loss, many women experienced psychosocial problems during the bereavement period. Furthermore, it affects not only the mother, but also the father, who will experience the same problem. However, the father’s mourning was usually not expressed out.

Every year, there are over 6.3 million perinatal deaths in the world, of which almost all occur in developing countries and 27% of them in the least developed countries alone (WHO, 2007). Stillbirths account for over half of all perinatal deaths. One third of all stillbirths take place during delivery and are largely avoidable (MOH, 2000). According to the Malaysian Annual Report on Stillbirth and Neonatal Deaths 1998, perinatal death is defined as any death occurring after 22 weeks of pregnancy at birth or within the first 7 d of life (MOH, 2000). It also includes the deaths, of which the gestation is unavailable and the foetus or newborn weighs more than 500 g. University Kebangsaan Malaysia Medical Centre (UKMMC, 2006) classifies perinatal mortality according to birth weight and gestational age. There

were 53 perinatal deaths in the year 2006, making the crude mortality rate 7.96/1000 births, which was lower than that of the previous year (11.1/1000 births). There were 41 perinatal deaths booked in UKMMC, making the crude perinatal mortality rate in UKMMC 6.4/1000 births, which is lower than that of the previous year (9.3/1000 births) (UKMMC, 2006).

Wagner *et al.* (1997) stated that perinatal loss is one of the most difficult events for a couple. Couples who want children do not expect pregnancy to end as death. Previously, perinatal loss was thought to be less significant than other type of losses. The absence of the ‘object’ to mourn may have made the grieving process more difficult and complex. Grieving of parents, who had experienced loss of a baby but did not have the opportunity to know their baby, was different from other types of grieving (de Montigny *et al.*, 1999).

Armstrong (2001; 2002; 2007) showed that parents with previous losses had significantly higher antenatal anxiety on the outcome of the current pregnancy than the expectant parents with no history of perinatal loss. Couples who experienced the death of a baby were significantly more likely to have one or both partners distressed, compared to non-bereaved couples (Armstrong and Hutti, 1998; de Montigny *et al.*, 1999). Several studies have reported that father’s expression of grief was less intense than that of mother’s (Volker and Striegel, 1995; Badenhorst *et al.*, 2006; Turton *et al.*, 2006). A review done by Hughes and Riches (2003) stated that bereaved parents often experience a grief that is unexpectedly pervasive, intense and enduring. Over time, partners often experience increased difficulties in supporting each other due to gender differences in grief and coping, strained communication, and characteristic patterns of misunderstandings (Hughes *et al.*, 1999; 2002).

Matthey *et al.* (2001) reported that Edinburgh Postnatal Depression Scale (EPDS) is reliable to measure mood of fathers and it has been validated. However, the varied cut-off points of EPDS scores have been published from different cultures and genders. Matthey *et al.* (2001) in their study did recommend that it should be used routinely in all new mothers and that a cut-off of 5/6 should be used to screen for both depressive and anxiety disorders.

There are studies that demonstrated stillbirth as a major stressor associated with post traumatic stress

disorders (PTSD) (Hughes *et al.*, 1999; Turton *et al.*, 2001; 2009). These studies also mentioned that having good emotional support after the stillbirth may be a protective factor for PTSD. Alternatively the birth of a healthy baby after the next pregnancy had a curative effect for PTSD (Boyle *et al.*, 1996; Turton *et al.*, 2001).

Several large population-based studies related to perinatal loss have been conducted in many countries, but only few focused on the area of health assessment needs on parents with perinatal loss. Little is known about the impact of perinatal loss on the lives of those experiencing it in Malaysia. A variety of support groups exist in many countries, but there is no such support group available for parents with perinatal loss in Malaysia. It is well known that parents who experience perinatal loss will face some psychosocial problems after their losses. UKMMC as a government referral medical centre has been receiving many cases from neighbouring hospitals. Nevertheless, with the heavy workload and rapid turnover of patients in this hospital, it will raise the issue of adequacy and appropriate psychosocial support to those needing it. Therefore, the objective of this study was to assess the psychosocial impact of mothers with perinatal loss and its contributing factors in UKMMC.

2 Materials and methods

A retrospective cross sectional study was conducted in UKMMC from April 2008 to May 2009 in postnatal ward, postnatal clinic, and Neonatal Intensive Care Unit (NICU). This study has been approved by the UKMMC Research Ethics Committee (project code FF-293-2008). Data were collected through self-administered questionnaires and interviews using structured questionnaires on mothers who had experienced perinatal loss and had consented to be interviewed, while those who were unable or refused to be contacted either by home visit, telephone or emailing were excluded from this study. The mothers were interviewed between 6 weeks to 12 months after their loss. They had been instructed to give their answers that come closest to how they felt in the past 7 d. The demographic characteristics, effects of bereavement and perceived social support system of the mothers were also asked. Mothers with depressive

state during data collection time were referred for follow-up.

A total of 82 respondents were needed as decided according to Kish (1965), which is based on a 95% confidence interval and the prevalence of 9.8% of women developing postnatal depression (Suraiyah and Idris, 2007). The most recent published prevalence for overall postnatal depression in UKMMC was used to calculate the sample size because there have been no such data available in Malaysia.

In addition, two sets of questionnaires were used, and both were translated to Malay as they were self-administered questionnaires and needed to be filled up by the respondents unless they required assistance. The first set of questionnaire was to collect socio-demographic data, maternal condition, obstetrics history, foetal condition and psychosocial impacts of the respondents. The second set of questionnaire was derived from Cox *et al.* (1987), which is the EPDS, also known as Edinburgh Depression Scale (EDS). This questionnaire consists of 10 questions that are focused on assessing the respondent's current conditions. Items 1, 2, and 4 are the positive items, while 3, 5, 6, 7, 8, 9, and 10 are the negative ones and for each of these questions, respondent needed to choose one out of four choices that have been provided, which give scores between 0 and 3. Maximum score that each respondent may achieve is 30. One of the questions also includes suicidal thought, which assesses tendency of the respondent to do harm to herself.

Initially, Cox *et al.* (1987) designed EPDS to screen the emotional distress among the respondents during pregnancy and postnatal period, and a score of ≥ 10 was recommended to be an indication of the likelihood of depression, but not its severity. The EPDS score is designed to assist, not to replace, clinical judgement (Murray and Carothers, 1990). There was no diagnostic interview carried out after EPDS assessment form was given to the parents.

The EPDS form was in both Malay and English languages. The Malay language-translated version used has been validated with the result, showing good internal consistency (Cronbach alpha: 0.86) and split half reliability (Spearman split half coefficient: 0.83) as reported by Rushidi *et al.* (2002; 2003). The study done by Rushidi *et al.* (2003) also stated that using EPDS instrument showed satisfactory discrimination and concurrent validity as evidenced by the statistically

significant difference in EPDS scores between the depressed group and their non-depressed counterparts (Mann Whitney *U* test: 2 tailed *P* value <0.01) and good correlations between the instrument and each of the Malay version of Beck Depression Inventory-II and the Hamilton Depression Rating Scale (Spearman rank correlation coefficients of 0.78 and 0.88, respectively). With the cut-off point at 11/12, the method has its sensitivity of 100%, specificity of 98.18%, positive predictive value of 90%, negative predictive value of 100%, and misclassification rate of 1.56%. All data were analyzed using Statistical Package for Social Science (SPSS) Programme version 12.0 software.

3 Results

3.1 Socio-demographic factors

A total of 62 respondents were recruited and analyzed, 75.6% of the desired sample size (82). Table 1 shows the background information of the mothers with perinatal loss. The mothers ranged from 20 to 48 years old [mean (31.02±5.57) years old]. Mean total monthly household income was Ringgit Malaysia (RM) 4048.06±2600.97. Majority of the respondents were from Klang Valley and Selangor residential area, of Malay ethnicity, with tertiary education level and working.

Table 1 Percentages of socio-demographic factors

	Frequency (<i>n</i> =62)	Percentage (%)
Residential state		
Klang Valley & Selangor	58	93.55
Others	4	6.45
Race		
Malays	51	82.26
Others	11	17.74
Educational level		
Primary & secondary	27	43.55
College & university	35	56.45
Occupation		
Working	48	77.42
Not working	14	22.58

3.2 Medical conditions and obstetric history

Table 2 shows that most of the respondents were multipara (61.29%). Majority did not have underlying

medical problems and very few had conditions such as diabetes mellitus, asthma, or hypertension. Majority of the respondents had antenatal check up from specialists in government hospitals. Most common conditions occurred during recent pregnancy were preterm labour, hypertension, and vaginal bleeding. The mean gestational age was (32.27±5.21) weeks.

Table 2 Percentages of medical condition and obstetric history

	Frequency	Percentage (%)
Parity (<i>n</i> =62)		
First baby	24	38.71
Second baby	14	22.58
Third baby	13	20.97
Others	11	17.74
Current medical illness		
Diabetes mellitus (<i>n</i> =62)	3	4.84
Hypertension (<i>n</i> =62)	2	3.23
Asthma (<i>n</i> =62)	3	4.84
Places of antenatal care		
Health clinic (<i>n</i> =62)	7	11.29
Government hospital with specialist (<i>n</i> =62)	30	48.39
Government hospital without specialist (<i>n</i> =62)	4	6.45
Private hospital/clinic (<i>n</i> =62)	17	27.42
No antenatal/unknown (<i>n</i> =62)	4	6.46
Disease during pregnancy		
Hypertension (<i>n</i> =62)	11	17.74
Diabetes mellitus (<i>n</i> =62)	9	14.52
Vaginal bleeding (<i>n</i> =62)	11	17.74
Anemia (<i>n</i> =62)	2	3.23
Premature rupture of membrane (<i>n</i> =62)	1	1.61
Preterm (<i>n</i> =62)	12	19.35
Others (<i>n</i> =62)	3	4.84

3.3 Foetal condition

Majority of the foetuses were singleton males as shown in Table 3. The mean weight of the foetuses was (1667.79±856.56) g. Majority of the respondents discovered perinatal losses after hospital admission. Most of the deaths were caused by lethal congenital malformation, followed by normally formed macerated stillbirth, immaturity, and asphyxia conditions. The highest percentage of death classification was 35.48% for early neonatal death followed by 25.81% for macerated stillbirth, and 22.58% for fresh stillbirth.

Table 3 Percentages of foetal conditions

	Frequency (n=62)	Percentage (%)
Numbers of foetuses		
Singleton	52	83.87
Twins and above	10	16.13
Baby sex		
Male	35	56.45
Female	27	43.55
Time of perinatal loss		
Unknown	23	37.10
Before admission	11	17.74
After admission	28	45.16
Causes of baby death		
Lethal congenital malformation	16	25.81
Normal macerated form	14	22.58
Asphyxial condition	9	14.52
Immaturity	11	17.74
Infection	3	4.84
Others	5	8.06
Unknown	4	6.45

3.4 Psychosocial impact and support

Psychosocial impacts were explored by asking parents on how they described their feeling and experience following perinatal loss. Table 4 shows that the majority of the mothers experienced sadness after loss, being depressed, having nightmares, and being worried. Despite these emotions, majority still had a desire to carry another pregnancy in the future. Almost all respondents received support from husband after perinatal loss. Three quarters of them received support from their parents, and half of the respondents also received support from friends and siblings. Although most of them claimed that they had enough support, more than half still requested additional help in the mode of encouragement, counselling, and feeling expression sessions as well as group discussions.

3.5 Level of postnatal depression following perinatal loss

The respondents scored a maximum of 24 and minimum of 2 based on EPDS with the mean score of 10.82 ± 5.02 . Therefore, most of the respondents had some emotional distress as shown by mean of EPDS score ≥ 10 . There were 53.2% of total respondents who scored 10 and above. However, none had suicidal idea.

Table 4 Percentages of psychosocial impact and support

	Frequency	Percentage (%)
Feelings after loss		
Sad (n=62)	61	98.39
Depressed (n=62)	26	41.94
Happy (n=62)	2	3.23
Worried (n=62)	15	24.19
Scared (n=62)	7	11.29
Panic (n=62)	7	11.29
Tired (n=62)	6	9.68
Having nightmare (n=62)	17	27.42
No feeling (n=62)	2	3.23
Others (n=62)	1	1.61
Wish to have other child (n=62)		
Yes	53	85.48
No	9	14.52
Get any support (n=62)		
Yes	61	98.39
No	1	1.61
Who gave the support		
Husband (n=62)	58	93.55
Parent (n=62)	54	87.10
Sibling (n=62)	29	46.77
Children (n=62)	10	16.13
Friends (n=62)	33	53.23
Others (n=62)	3	4.84
Enough support (n=62)		
Yes	52	83.87
No	10	16.13
Want support group (n=62)		
Yes	42	67.74
No	20	32.26
Types of support		
Encouragement (n=62)	27	43.55
Counselling (n=62)	25	40.32
Express emotion session (n=62)	22	35.48
Group discussion (n=62)	19	30.65
Others (n=62)	3	4.84

3.6 Statistical analysis

Table 5 shows association between socio-demographic factors and EPDS score. There were no significant findings between the different groups of EPDS scores with parity, race, occupation status, educational level, residential state, previous history of perinatal loss, foetus' sex, or causes of deaths.

Table 5 Association between socio-demographic and obstetric history factors and EPDS score

Variables and category	Frequency		χ^2 value	P^*
	EPDS score <10 (n=29)	EPDS score >10 (n=33)		
Parity				
Primipara	9 (47.37%)	10 (52.63%)	0.004	0.580
Multipara	20 (46.51%)	23 (53.49%)		
Races				
Malay	24 (47.06%)	27 (52.94%)	0.009	0.923
Non-Malay	5 (45.45%)	6 (54.55%)		
Occupation				
Working	23 (47.92%)	25 (52.08%)	0.111	0.739
Not working	6 (42.86%)	8 (57.14%)		
Educational level				
Primary & secondary	11 (40.74%)	16 (59.26%)	0.699	0.403
College & university	18 (51.43%)	17 (48.57%)		
Residential state				
Klang Valley & Selangor	28 (48.28%)	30 (51.72%)	0.616	0.367
Others	1 (25.00%)	3 (75.00%)		
History of previous perinatal loss				
Yes	9 (52.94%)	8 (47.06%)	0.358	0.549
No	20 (44.44%)	25 (55.56%)		
Baby sex				
Male	16 (45.71%)	19 (54.29%)	0.360	0.849
Female	13 (48.15%)	14 (51.85%)		
Causes of death				
Lethal congenital malformation	5 (31.25%)	11 (68.75%)	5.783	0.448
Normal macerated formed	9 (64.28%)	5 (35.72%)		
Asphyxial condition	6 (66.67%)	3 (33.33%)		
Immaturity	5 (45.45%)	6 (54.55%)		
Infection	1 (33.33%)	2 (66.67%)		
Others	2 (40.00%)	3 (60.00%)		
Unknown	1 (25.00%)	3 (75.00%)		

* $P<0.05$, statistically significant

Table 6 illustrates the psychosocial impact among mothers with perinatal loss. There was a significant difference in EPDS scores between mothers who received support from friends and no support ($P=0.019$), although most of mothers who received support from friends were not having emotional distress. However, there were no significant differences based on EPDS score between groups who desired to carry another pregnancy, received some mode of support, and received support from husbands, parents, siblings, and their own children. There were also no significant differences based on EPDS scores be-

tween the group with sufficient support obtained and the group requiring for support.

Table 6 Association between psychosocial impact and support with EPDS score

Variables and category	Frequency		χ^2 value	P^*
	EPDS score <10 (n=29)	EPDS score >10 (n=33)		
Desire to have another pregnancy				
Yes	27 (50.94%)	26 (49.06%)	2.549	0.110
No	2 (22.22%)	7 (77.78%)		
Received support				
Yes	28 (45.90%)	33 (54.10%)	1.157	0.282
No	1 (100.00%)	0 (0.00%)		
Support from husband				
Yes	28 (48.28%)	30 (51.72%)	0.814	0.615
No	1 (25.00%)	3 (75.00%)		
Support from parents				
Yes	26 (48.15%)	28 (51.85%)	0.317	0.713
No	3 (37.50%)	5 (62.50%)		
Support from siblings				
Yes	16 (55.17%)	13 (44.83%)	1.543	0.214
No	13 (39.39%)	20 (60.61%)		
Support from children				
Yes	3 (30.00%)	7 (70.00%)	1.348	0.312
No	26 (50.00%)	26 (50.00%)		
Support from friends				
Yes	20 (60.61%)	13 (39.39%)	5.422	0.019
No	9 (31.03%)	20 (68.97%)		
Enough support				
Yes	26 (50.00%)	26 (50.00%)	1.348	0.312
No	3 (30.00%)	7 (70.00%)		
Need a support group				
Yes	18 (42.86%)	24 (57.14%)	0.802	0.307
No	11 (55.00%)	9 (45.00%)		

* $P<0.05$, statistically significant

Analysis of the EPDS score on the association between maternal age and income showed that there was no significant difference noted between mothers with emotional distress and normal group by mean age and total income of the family (Table 7).

Table 7 Association between age and income with EPDS score

	Age (year)	Income (RM)
EPDS score <10 (n=29)	31.14±5.62	4084.48±2501.18
EPDS score >10 (n=33)	30.91±5.59	4016.06±2723.91
t	0.160	0.103
P^*	0.873	0.919

* $P<0.05$, statistically significant

4 Discussion

In UKMMC, the prevalence of emotional distress among parents with perinatal loss was 53.2% and the mean EPDS score was 10.82 ± 5.02 . This result is much higher than that of general mother population previously reported by Rushidi *et al.* (2005). They found that, among the general postnatal mothers in the Northwest of Peninsular Malaysia, the relevant EPDS score was only 5.27 (standard deviation 4.63). It indicates that higher percentages of parents with perinatal loss would have emotional distress compared to general population. However, this could be a tip of an iceberg situation for Malaysia in general as this hospital (UKMMC) is a tertiary referral centre and located in a highly urban area. People who delivered in this hospital were normally well-prepared for their pregnancy outcome.

This study has its limitation in exploring factors contributing to psychosocial impact following the perinatal loss. A small sample size of respondents ($n=62$) may have affected statistical analyses. Only 1 out of 14 parameters assessed showed some association with emotional distress. The need for psychosocial support from friends was found to be significant in this study. Emotional support following perinatal loss is needed, which has been proven in this study. de Montigny *et al.* (1999) stated that friends should help relatives, siblings of the dead baby, and others who are close to the parents during bereavement period. Friends can become a decision maker regarding the funeral among many other things. They should counsel couples on the importance of sharing feelings, experience and needs in a non-threatening manner (Kroth *et al.*, 2004; Callister, 2006; Gold, 2007). Dakof and Taylor (1990) stated that support is often viewed as the most credible when it comes from someone who has previously experienced and successfully managed a similar crisis.

There were no significant relationships in depressive state of mothers surveyed in the present study among the following factors: previous perinatal loss, maternal age, total income, maternal educational level, race, occupation, maternal health condition, obstetric history, and foetal condition. However, other studies have reported that previous history of perinatal loss, higher maternal age, low socioeconomic status, and poor maternal and foetal health

conditions were significantly related (Leon, 1992; Armstrong and Hutti, 1998; Hughes *et al.*, 1999; 2002; Fetus and Newborn Committee, Canadian Paediatric Society, 2001; Armstrong, 2002; Kroth *et al.*, 2004). In this study, UKMMC is one of the biggest referral centres in Malaysia, therefore it caters most of complicated maternal and foetal condition cases. As a government hospital, cases referred in UKMMC also are subsidized partly by the government for the hospital fee. Therefore, there are no significant differences for socioeconomic status, maternal and foetal health conditions.

The majority of the respondents (82.26%) were Malay and it was the largest ethnic group proportion in Malaysia. Therefore, it helped in reducing the effect of multiracial and multicultural biases. Seeing that this is the first study done on psychological impact of perinatal loss, we will conduct another cohort study in the future to follow up all cases with perinatal loss until subsequent pregnancy.

Furthermore, the mothers were interviewed between 6 weeks to 12 months after their losses and this may have some effects on the result of this study. Mothers are normally given 2 months of full paid maternity leave in Malaysia. Most of them will be back to work immediately after maternity leave unless they have applied for unpaid breastfeeding leave. Usually, when mothers return to work and start interacting with their colleagues and become busy with their daily life, their sorrow of having perinatal loss may reduce. Therefore, a study that follows up mothers with perinatal loss before and after they return to work will be able to demonstrate the difference in their responses in coping with emotional distress following perinatal loss, which was not tested in this study.

5 Conclusion

Perinatal loss causes negative psychosocial impacts to the parents who experienced it. Therefore, it is crucial for health workers to intervene as early as possible so that it will not lead to serious negative health outcomes that will affect their mental health and other aspects of their life. The current study conducted in UKMMC showed that majority of the mothers who had perinatal loss hoped that there

would be an emotional support group to help them in coping with the emotional distress after perinatal loss. Therefore, there is a need to set up a perinatal loss support group in UKMMC.

Most of the perinatal loss mothers are working mothers who are highly educated and contributed to the national production. Hence, they need to be both physically and mentally well. In addition to that, this study also showed that friends play a significant role in supporting mothers who had perinatal loss, whereby those who received support from friends were less stressed. As a result, friends can be included as part of the support group so that they can share their similar experience with mothers who experienced perinatal loss. All pregnant mothers should be informed on the importance of emotional support before delivery. The EPDS form can be used as a screening tool to identify those who need psychosocial support.

Parents who are at greater risk for disordered mourning need to be accessed on ways to minimize their psychological morbidity. Psychosocial support group may give some potential answers to this problem but its effectiveness needs to be assessed. However, any women who just had perinatal loss need to be assessed for their psychological and social support availability among their immediate families for risk of a pathological outcome of bereavement. Employer and colleagues should be sensitive to this event and it would be extremely beneficial if more information could be disseminated to promote support group not only in hospital setup but also at work place and the community level.

As a referral centre, professional support would help to minimise the trauma of perinatal loss. However, with heavy workloads as seen at referral centres, parent with perinatal loss sometimes may not get proper support and explanation. Further studies are needed to assess the effectiveness of support and facilities for parent with perinatal loss.

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