A call for interdisciplinary bereavement care in miscarriage and stillbirth: a stepped-care model approach

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Background

Bereavement following pregnancy loss, such as miscarriage or stillbirth, profoundly affects individuals and families due to its sudden and traumatic nature. The emotional toll can manifest as grief, depression, anxiety, and post-traumatic stress disorder (PTSD), often exacerbated by uncertainty and a lack of preparedness. While healthcare primarily addresses the medical and surgical aspects of management, psychosocial support remains insufficient, leaving many individuals and families feeling isolated. Integrated perinatal bereavement care is needed across hospital and community settings. This article advocates for an interdisciplinary, stepped-care model to provide tailored emotional, psychological, and practical support. Embedding this framework within healthcare systems can effectively address the physical and psychosocial needs of bereaved individuals and families, promoting healing and overall well-being.

Definition and prevalence of miscarriage and stillbirth

Miscarriage, defined as the spontaneous loss of pregnancy before a specific gestational threshold, affects 15% to 20% of pregnancies globally,[1] with an estimated 23 million cases annually, equating to 44 cases per minute.[2] While the American College of Obstetricians and Gynecologists and the European Society of Human Reproduction and Embryology classify early pregnancy loss as occurring within the first 12 6/7 weeks of gestation,[3,4] the World Health Organization includes fetal weight criteria.[5] In Hong Kong, the Hospital Authority and the Hong Kong SAR Government define miscarriage as pregnancy loss before 24 weeks of gestation.[6] According to the Department of Health,[7] nearly 10 000 cases of spontaneous abortion, medical abortion, and other abortive outcomes were reported in 2023.

Stillbirth, defined as fetal death beyond a certain gestational age, affects approximately 1.9 million pregnancies each year, occurring at a global rate of 2.3 per 1000 births.[8] The World Health Organization defines stillbirth as fetal death at 28 weeks or later (or a weight of ≥1000 g if gestational age is unknown), whereas the United States sets the threshold at 20 weeks.[9] In Hong Kong, stillbirth is defined as fetal death at 24 weeks or later. A 20-year retrospective study analysing 128 967 deliveries between 2000 and 2019 recorded 429 stillbirths, with the perinatal mortality rate declining by 16.7%, from 5.52 per 1000 in 2000-2009 to 4.59 per 1000 in 2010-2019. The singleton stillbirth rate also slightly decreased from 3.27 to 2.91 per 1000 births.[10] These reductions are attributed to advancements in early prenatal screening and diagnosis of congenital and genetic conditions.

Psychological impact and psychiatric morbidity after pregnancy loss

Women who experience pregnancy loss are highly susceptible to the onset of psychiatric morbidities, including depression, anxiety, and PTSD.[11-14] Depression is particularly prevalent, with a systematic review reporting prevalence rates ranging from 5.4% (minor depression as defined by the Diagnostic and Statistical Manual of Mental Disorders [DSM], fourth edition) to 18.6% (depressive disorders as defined by the International Classification of Diseases, Tenth Revision).[13] For most women, depressive symptoms peak in the initial months following pregnancy loss and tend to decline over time. However, some women may also experience significant anxiety symptoms, including generalised anxiety and panic attacks, or

develop PTSD, particularly when the pregnancy loss is experienced as sudden, traumatic, or medically complex. When compounded by profound grief, these psychiatric responses can result in long-term mental health challenges, including chronic depression, suicidal ideation, and prolonged grief disorder. Some women continue to experience these symptoms even years after their loss.[15]

Grief following pregnancy loss is distinct and often marginalised, lacking public acknowledgement or support. This is particularly evident in cultures such as Chinese society, where early-stage pregnancies are commonly concealed.[16] Such cultural taboos can lead to isolated mourning, hindering emotional expression and processing of grief. This disenfranchisement intensifies the psychological burden, highlighting the need for specialised mental health interventions tailored to women coping with pregnancy loss.[17] Some individuals may even develop prolonged grief reactions or persistent complex bereavement disorder.[15] These conditions are characterised by intense and prolonged grief symptoms, impairments in daily functioning, and difficulties adapting to the loss, further complicating the emotional distress experienced by bereaved parents.

Clinical practice guidelines on management of pregnancy loss in various countries

Recent advances in bereavement care for pregnancy loss emphasise the integration of counselling and psychotherapy to address emotional needs. Guidelines from leading organisations such as the National Institute for Health and Care Excellence (United Kingdom)[18] and The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (Australia)[19] advocate for counselling, stigma reduction, respectful maternity care, and planning for future pregnancy. The RESPECT Study (Randomised Evaluation of Sexual health Promotion Effectiveness informing Care and Treatment) reinforces the global consensus on bereavement care.[20] Prioritising counselling and psychotherapy as integral components of bereavement care enables healthcare providers to offer tailored support to bereaved individuals.

Perinatal bereavement care: the Hong Kong context

Perinatal bereavement care offers emotional, psychological, and practical support to help families cope with grief following miscarriage, stillbirth, or neonatal death. Timely support is crucial for parents coping with pregnancy loss. While medical care primarily addresses complications and interventions such as medication or surgery, healthcare professionals can also play a role in facilitating meaningful memorial experiences, such as seeing and holding the baby, creating keepsakes, or capturing memories through photography. These practices help parents process grief and create lasting remembrances. Additional perinatal mourning resources are detailed in the Table.[21-23]

The Hong Kong SAR Government has made substantial progress in improving fetal burial and cremation services. Previously, fetuses miscarried before 24 weeks of gestation were classified as medical waste, limiting options for grieving parents. In 2017, the Government amended relevant regulations to permit cremation for these fetuses, and six private cemeteries now offer services for storing the remains.[24] The Hospital Authority has also updated its guidelines to promote the compassionate handling of fetal remains; however, legal and logistical challenges remain.

However, ongoing bereavement support often diminishes following hospital discharge, leaving parents feeling isolated and uncertain about how to seek emotional support or counselling. Integrating comprehensive bereavement care is essential to ensure continuous access to emotional support, counselling, and resources for navigating long-term grief.

A call for a stepped-care model in perinatal bereavement care

In recent years, stepped-care models have been widely adopted across global and local public health and mental health systems due to their tiered approach to care delivery, which has demonstrated positive outcomes and helped alleviate healthcare burdens.[25-28] Newman proposed a cost-effective method for identifying at-risk individuals and delivering stepped interventions based on standardised psychometric assessments.[29] This model begins with less intrusive, lower-cost options and escalates care as needed for individuals with greater mental health needs. Stepped care also accommodates a spectrum of interventions, from low-intensity self-help to specialised high-intensity therapies, ensuring timely and appropriate care.[30]

Perinatal bereavement care supports parents through the complexities of loss by providing clear, empathetic information about its causes, physical recovery, and emotional responses. Sensitive communication is crucial for addressing parents' emotional needs during this distressing time. A systematic review and meta-analysis found that stepped-care interventions were significantly more effective than usual care in reducing depression.[31] Incorporating a stepped-care model into bereavement support offers a structured framework, with varying levels of intervention tailored to the degree of psychosocial distress among bereaved parents. Comprehensive screening facilitates assessment of distress severity, guiding parents

TABLE. Hospital- and community-based bereavement support for miscarriage and stillbirth

	Miscarriage	Stillbirth
Hospital-based bereavement activities[21-23]		
Seeing and holding the baby	Not applicable due to early gestation	Encouraged for bonding and closure
Making keepsake footprints or handprints	Not applicable due to early gestation	Offered for later gestations
Taking photos of the baby	May depend on gestation and parental wishes	Encouraged as part of bereavement care
Dressing the baby in angel cloth	May depend on gestation and parental wishes	Hospitals may provide special gowns
Making plaster moulds of hands/feet	Not applicable due to early gestation	Hospitals may provide for parents who request keepsakes
Collecting mementos	Parents may keep ultrasound images, pregnancy test kits, or written notes	Parents may keep footprints, locks of hair, baby clothing, hospital ID bands, and baby blankets
Providing a memory box	Parents may keep ultrasound images, pregnancy test kits, or written notes	Parents may keep footprints, locks of hair, baby clothing, hospital ID bands, and baby blankets
Arranging religious and spiritual support	Available upon request (based on parents' religious and spiritual beliefs)	
Community-based bereavement interventions[42-44]		
Creating a memorial box	Parents may keep ultrasound images, pregnancy test kits, or written notes	Parents can keep baby clothing, footprints, and hospital keepsakes
Supporting burial and cremation arrangements	Provides guidance on options for respectful handling of fetal remains or the baby, including hospital protocols, legal considerations, and cultural or religious preferences. Assists parents in planning burial or cremation, including access to funeral services and rituals	
Psychoeducation videos	Provides guidance on the physical, psychosocial, and spiritual aspects of pregnancy loss to support coping and healing	
Expressive arts healing	Uses creative expressions such as scrapbooking, sand art, songwriting, horticultural therapy, pastel Nagomi art, and spiritual writing to process grief, foster healing, and create meaningful memorials	
Online support platform	Offers a virtual space for bereaved parents to access resources, connect with others, and receive emotional support	
Psychosocial intervention group	Facilitates shared experiences, emotional validation, and coping strategies among bereaved parents in a supportive community	
Individual and marital bereavement counselling	Supports couples in processing loss, navigating grief, and preparing for future pregnancies while addressing long-term trauma and family dynamics	
Sex therapy	Supports couples in addressing grief-related intimacy challenges, restoring sexual well-being, and reducing anxiety around future pregnancies	

towards the most appropriate level of support. This model fosters emotional healing and resilience, ensuring that bereaved parents receive the right care at the right time.

Step 0: Hospital-based psychological screening and follow-up

The provision of follow-up care through detailed information about the causes of loss, associated symptoms, recovery, and future pregnancy prospects empowers individuals to prioritise their health, make informed decisions, and navigate their grief. Discussions with bereaved parents should address the risks and benefits of future pregnancies, considering their physical and emotional readiness along with medical causes. This dialogue should also include available support services, such as preconception counselling and specialised high-risk pregnancy care.

Standardised psychological screening enables consistent assessment, effective triage, and appropriate referrals. A scoping review identified 93 studies involving 6248 women who had terminated pregnancies due to fetal anomalies, with the most commonly used psychological tools being the Perinatal Grief Scale (22%) and the Impact of Event Scale–Revised (18%).[32] Additional measures, such as the Hospital Anxiety and Depression Scale,[33] the Patient Health Questionnaire–9 (PHQ-9),[21] the Generalised Anxiety Disorder–7 (GAD-7),[22] and the Post-Traumatic Stress Disorder Checklist for DSM-5 (PCL-5),[23] have been utilised to assess emotional distress, anxiety, depression, and trauma-related symptoms. In Hong Kong, the 12-item General Health Questionnaire combined with the Structured Clinical Interview for DSM-IV Axis I Disorders identified psychiatric morbidity following miscarriage.[14,34]

Although grief is a natural emotional response to pregnancy loss, depression, generalised anxiety, and post-traumatic stress are clinically actionable screening parameters due to their prevalence, impact, and established treatment pathways.[35] Unlike grief which can vary in duration and intensity,

conditions such as depression, anxiety, and PTSD may become pathological, substantially impairing daily functioning, increasing the risk of suicidal ideation, and influencing future reproductive decision making.

Given time constraints, clinician workload and resource limitations, comprehensive psychological assessments may be impractical. A brief yet reliable screening tool is therefore more feasible for early identification and intervention. The PHQ-9, GAD-7, and PCL-5 have been validated and utilised across diverse and general populations and offer a practical approach to mental health screening.[36-41] The abovementioned Step 0 is conducted using these tools to assess depressive symptoms, generalised anxiety, and post-traumatic stress. Individuals with minimal distress (scores: PHQ-9 ≤4, GAD-7 ≤4, and PCL-5 ≤30) may not require immediate intervention, whereas those with elevated distress (scores: PHQ-9 ≥5, GAD-7 ≥5, or PCL-5 ≥31) should receive further psychological support and appropriate referrals. This structured screening process facilitates early identification of individuals in need of additional psychosocial support. The Figure illustrates the stepped-care framework, integrating psychological assessment into medical treatment to ensure that bereaved parents receive services tailored to their needs.

Steps 1 to 3: Community-based psychosocial support

Grief and emotional distress following pregnancy loss can vary, necessitating tailored support. Accessible, community-based care ensures that bereaved parents receive appropriate psychosocial assistance. Beyond medical and psychological interventions, connecting bereaved parents with non-governmental organisations and community resources is essential. These organisations provide guidance on burial or cremation arrangements, funeral services, and bereavement support, helping families to navigate their grief beyond the hospital setting (Table[42-44]). A stepped-care model based on PHQ-9, GAD-7, and PCL-5 scores enables structured intervention at varying levels of emotional distress, ensuring that individuals receive care aligned with their needs.

		Step	Areas of assessment*	Responsible parties	Venue of delivery	Core intervention	Means of delivery	Core element	
Access to care Diagnostics and treatment planning	Hospital-based psychological assessment	0	Psychological screening Scores: PHQ-9 ≤4, GAD-7 ≤4 or PCL-5 ≤30 PHQ-9 ≥5, GAD-7 ≥5 or PCL-5 ≥31	Doctor/nurse/ midwife	Ward	• Psychoeducation • Service coordination or referral	• Screening questionnaire	• Evidence-based information on pregnancy loss and grief reactions • Connecting bereaved parents with community bereavement care	
	Community-based bereavement counselling	1	General emotional distress Scores: PHQ-9: 1-4, GAD-7: 1-4 or PCL-5 ≤30	Social worker/ clinical psychologist/ counsellor	Community	• Self-help • Online support • Peer support • Counselling	• Online platform • Telephone consultation • Face-to-face consultation	• Self-help materials • Evidence-based information on grief and bereavement • Online support forums • Peer support groups • Individual counselling • Group psychotherapy	Step up/down
		2	Mild to moderate emotional distress Scores: PHQ-9: 5-14, GAD-7: 5-9 or PCL-5 ≥31	Social worker/ clinical psychologist/ counsellor	Community	• Integrated PB care • Online support	• Online platform • Telephone consultation • Face-to-face consultation	• Self-help materials • Evidence-based information on grief and bereavement • Online support forums • Peer support groups • Individual or marital counselling • Group psychotherapy aimed at addressing specific emotional concerns	
		3	Moderately severe to severe emotional distress Scores: PHQ-9 ≥15, GAD-7 ≥10 or PCL-5 ≥31	Social worker/ clinical psychologist/ counsellor/ psychiatrist	Community and/or hospital	• Integrated PB care • Online support	• Face-to-face consultation	• Self-help materials • Evidence-based information on grief and bereavement • Online support forums • Peer support groups • Individual or marital therapy • Trauma-informed care • Psychiatric treatment to manage symptoms of depression, anxiety, or other mental health challenges	Step up/down

FIG. A stepped-care framework for interdisciplinary perinatal bereavement care

Abbreviations: GAD-7 = Generalised Anxiety Disorder–7; PB = perinatal bereavement; PCL-5 = Post-Traumatic Stress Disorder Checklist for DSM-5; PHQ-9 = Patient Health Questionnaire–9

* Screening scores should be used as a basic reference and not as the sole determinant of care; clinical observation and professional judgement remain essential in assessing individual needs

Step 1: General emotional distress

For individuals experiencing general emotional distress (scores: PHQ-9: 1-4, GAD-7: 1-4, or PCL-5 ≤30), low-intensity support is recommended. Although clinical intervention may not be necessary, emotional validation, short-term counselling, online forums, self-help materials, and peer support can offer reassurance. Psychoeducational workshops on grief and coping may also be helpful. A brief follow-up via telephone or through primary care helps ensure timely support if distress increases.

Step 2: Mild to moderate emotional distress

For individuals experiencing mild to moderate emotional distress (scores: PHQ-9: 5-14, GAD-7: 5-9, or PCL-5 ≥31), structured psychosocial care is beneficial. Support may include individual or group therapy, bereavement counselling, expressive activities, and self-help tools such as journaling, art therapy, and mindfulness. Online mental health resources with guided self-help tools can also be valuable. Periodic reassessment ensures ongoing care and timely referrals if distress escalates, enabling appropriate intervention based on evolving needs.

Step 3: Moderately severe to severe emotional distress

For individuals experiencing moderate to severe emotional distress (scores: PHQ-9: ≥15, GAD-7: ≥10, or PCL-5 ≥31), a multidisciplinary approach is required. Psychological symptoms at this severity may impair daily functioning, strain relationships, or affect decision making regarding future pregnancies. Support may include individual therapy, trauma-informed care, family counselling, and psychiatric evaluation. Immediate intervention is crucial for those at risk of prolonged grief disorder, severe depression, or suicidal ideation. Close monitoring and coordinated care among hospital-based professionals, community grief services, and primary care providers help ensure continuity and timely support.

Capacity building for healthcare professionals

Enhancing healthcare professionals' capacity for perinatal bereavement care requires structured strategies. Key approaches include developing patient-centred bereavement care plans, training staff in grief support, and establishing dedicated teams. The integration of psychosocial assessments, mental health referrals, and staff support fosters compassionate care. Sensitivity, empathy, and ongoing training improve service quality. Strategies to provide follow-up care, referrals, and clear information empower families in decision making. By recognising the long-term impact of grief, sustained support can ensure continuity of care, thereby strengthening bereavement services within Hong Kong's healthcare system.

Conclusion

Ensuring continuity of care is essential in supporting families affected by pregnancy loss. Integrated bereavement care, delivered with empathy, acknowledges the profound impact on bereaved parents. A holistic approach addressing diverse emotional and practical needs is vital, supported by a structured care model grounded in evidence-based practices. Collaborations among medical doctors, psychiatrists, midwives, clinical psychologists, social workers, and counsellors are key, encompassing counselling and access to resources such as support groups. Prioritising continuity and interdisciplinary teamwork fosters healing and recovery from the profound grief of pregnancy loss.

Author contributions

Concept or design: CHY Chan.
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Drafting of the manuscript: CHY Chan, SS Zhang.
Critical revision of the manuscript for important intellectual content: CHY Chan, CNL Ng, EHY Ng, RHW Li, LM Yeung, KSF Wong.

All authors had full access to the data, contributed to the study, approved the final version for publication, and take responsibility for its accuracy and integrity.

Conflicts of interest

All authors have disclosed no conflicts of interest.

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