

Supplementary Material: Tables 1-6

Supplementary Material (Table 1): Example of a search strategy used.

Search Term

AB ("preterm birth" OR "premature birth" OR "prematurity" OR "gestational age" OR "neonate" OR "NICU" OR "neonatal intensive care unit" OR "low birth weight" OR "special baby care unit" OR "SBCU" OR "local neonatal unit" OR "special care unit" OR "SCU")

AND

AND AB ("neonatal death" OR "neonatal loss" OR "perinatal bereavement" OR "perinatal loss" OR "intrapartum stillbirth" OR "intrauterine death" OR "dead on arrival" OR "neonatal mortality" OR "fetal mortality" OR "fetal mortality" OR "fetal death" or "foetal death")

AND

AND AB ("postnatal anxiet*" OR "postpartum anxiet*" OR "maternal anxiet*" OR "perinatal anxiet*" OR "generalised anxiet*" OR "generalized anxiet*" OR "postpartum depress*" OR "maternal depress*" OR "perinatal depress*" OR "stress" OR "traumatic" OR "post-traumatic" OR "perinatal mental health" OR "maternal mental health")

Supplen	entary M	laterial (I	<i>Table 2):</i> I	Data extra	action for	[.] quantita	tive studi	ies.						
Author and Year	Study Title	Study Aim	Research Question	Study Setting	Populatio n Demogra phics	Gestation al Age	Age at which the baby died	Sample Strategy/S ize	Psychome tric Measure Used	Study Design	Method of Data Collection	Ethical Issues	Method of Analysis (incl. control for confounde rs)	Study Findings
Arach et al., 2020	Perinatal death triples the prevalence of postpartu m depression among women in Northern Uganda: A communit y-based cross- sectional study	Not given	Hypothese s: Women with perinatal death in Lira District were more likely to screen positive for postpartu m depressio than women without perinatal death	Lira, Northern Uganda	1124 (62.8%) had experience d perinatal death, 1392 (77.8%) primary education level, 913 (51.0%) parity between 1- 4, 1633 (91.3%) married	Gestationa 1 age of previous loss not given	Gestationa 1 age of previous loss not given	N= 1789 n=77 peripartum deaths, 37 were stillbirths and 40 were early neonatal deaths Convenien ce sampling	Edinburgh Postnatal Depressio n Scale ≥14 as a cut off	Cross- sectional (case control) The study was nested in a randomise d communit y-based trial, but for this study only PPD symptoms were compared among women with/witho ut perinatal death	Participant s who enrolled in the RCT and who gave birth at ≥28 weeks' gestation, and were available 50 days postpartu m were eligible Administe red via interview	Not given	Adjusted for maternal age, maternal education, parity, wealth status, marital status, and place of birth Multivaria ble analysis using Poisson estimator with log link	From the 77 women who experienced perinatal death, 48 (62.3%) [95%CI:50.81% ,72.61%]screene d positive for "probable depression" (EPDS scores ≥14)compared to 329 (19.21%)[95%C I:17.42%,21.15 %] out of 1712 women with live infants.

														Women who had experienced a perinatal death were three times as likely to have probable postpartum depression as those who had had a live infant at day 50 postpartum (adjusted prevalence ratio=3.45, [95%CI:2.67,4.4 8])
--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

			-					-	-		-		-		
	Armstrong & Hutti, 1998	Pregnancy after perinatal loss: the relationshi p between anxiety and prenatal attachment	To determine the difference between levels of pregnancy -specific anxiety and prenatal attachment in a group of pregnant women who previously had a late pregnancy loss and a group of primiparou s women of similar gestational age To determine the relationshi p (if any) between anxiety and	Not given	Medical offices, childbirth classes, and perinatal support groups and newsletter s - country not explicitly stated	Previous loss group: Mean age=31.5, mean years of education= 15.69, 56.3% employed First pregnancy group: Mean age=26, mean years of education= 14.67, 80% employed	Gestationa 1 age of previous loss not given	Gestationa l age of previous loss not given	Convenien ce sampling 31 mothers - 16 had experience d miscarriag e in the 2nd trimester, stillbirth, or early neonatal death during a preyious pregnancy - 15 experience d their first pregnancy of a similar gestational age	Prenatal Attachmen t Inventory Pregnancy Outcome Questionn aire	Comparati ve descriptive design (case control)	Questionn aires were mailed to participant s	None given	Kruskal- Wallis test was used to evaluate differences between groups for anxiety and attachment Spearman's correlation s were performed to determine the relationshi p between the levels of anxiety and prenatal attachment for the two groups, and the relationshi p between anxiety and attachment	Participants who had experienced loss had significantly higher levels of anxiety compared to participants who had not (p=.0482) No significant correlations
			p (if any) between anxiety and prenatal attachment in both											and attachment	
1			groups												

	Threat	To test	Not given	Not clear	Mean(SD)	Mean(SD)	Not given	N=82	Assignme	Longitudin	Data was	Not given	Pearson's	Pregnancy
	appraisal.	Lazarus'	0.00		age=30.2(gestational	0		nt of fetal	al	collected	0	correlation	anxiety was
	coping.	theory of			5.04).	age of one		Convenien	personhoo		at three		s were	significantly
	and	stress,			primarily	or more		ce	d		timepoints		analysed	correlated with
	emotions	coping,			married or	losses=		sampling -			(10 weeks		between	threat appraisal
	across	and			partnered,	11.1(5.15)		women 20	Stress -		of		all T1	(r=.728, p<.01),
	pregnancy	emotions,			average 2	. ,		years and	two visual		gestation,		measures	emotion-focused
	subsequent	and to			years			older with	analogue		20-25			coping (r=.419,
	to	understand			college			a history of	scales 0-		weeks of		One-way	p<.01), negative
	perinatal	the			education,			spontaneo	100		gestation,		repeated	affect (r=.522,
	loss	patterns of			majority			us	assessing		and 30-35		measures	p <u><</u> .01), positive
		threat			profession			pregnancy	stress in		weeks of		ANOVA	affect (r=359,
		appraisal,			als or			loss at any	life		gestation)		compared	$p \le .01$), and
		coping,			administra			gestational	excluding				each main	stress from
		and			tive staff,			age,	pregnancy,				variable	pregnancy
		emotional			88% white			without a	and stress				with all	(r=.582, p≤.01).
		states of						technologi	from				three	Threat appraisal
		women						cally	pregnancy				points -	was
		across						induced					post-hoc t-	significantly
		pregnancy						pregnancy,	Inreat				tests	associated with
		after						and prior	appraisal				D (1	the above
22		perinatal						to feeling	OI				Path	variables and
200		1088						retai	pregnancy				datarmina	inean gestational
ılt,								movement	MTI				the causal	age = 01 = 1088 (r = 222 = r < 05)
naı									WIII				effects	and fetal
rse									Coping -				amongst	nersonhood
A-3									The Ways				threat	(r=307 n<01)
Ôté									of Coping				appraisal	(1507, <u>p</u> .01)
C									Check List				coping.	A significant
									- Revised				and	effect of time
													emoitonal	was found with
									Emotional				states at T1	pregnancy
									states -				only	anxiety (F(2,
									Multiple					68)=12.95,
									Affect				Hierarchic	p<.001) -
									Adjective				al	follow-up t-test
									Checklist -				regression	revealed
									Revised &				calculated	pregnancy
									Pregnancy				for T1 data	anxiety
									Anxiety				only - IV=	significantly
									Scale				emotional	decreased over
													coping/pro	time. Time was
													blem	not significantly
													focused	associated with
													coping,	threat appraisal
													DVS=	(F(2,68)=1.02,
													pregnancy	p>.05),
													anxiety,	problem-
													negative	Tocused coping
	1	1	1	1	1				1	1	1	1	arrect,	$(\Gamma(2,0\delta)=2.3,$

										positive	p>.05), emotion-
	1									affect	focused coping $(E(2,68) - 0,18)$
	1						i I				(F(2,00)=0.10, p>05) relative
	1						i I				p > .05, relative coning (F(2.68)-
							i I				0.40 n>05)
							i I				negative affect
							i I				(F(2.68)=0.40,
							i I				p>.05), or
							i I				positive affect
							i I				(F(2,68)=0.08,
	1										p>.05)
	1										In the noth
							i I				analysis threat
							i I				anarysis, uncat
							i I				significantly
							i I				associated with
	1						i I				problem focused
	1						i I				coping $(p \le .05)$,
	1						i I				negative affect
	1						i I				(p<.05), positive
							i I				affect $(p<.05)$,
							i I				and pregnancy
	1						i I				anxiety (p<.05).
	1						i I				regression regults indicate
	1						i I				that threat
	1						i I				appraisal
	1						i I				significantly
	1						i I				predicts
							i I				pregnancy
	1						i I				anxiety
	1						i I				R2=.530,
	1						i I				adjusted
							i I				$K_{2}=.524,$
	1						i I				F(1,80)=90.32, p<001
	1			1							P <.001
	1										Problem-
	1			1		1					focused coping
	1			1		1					was the
	1 1			1		1					dominant form
	1			1		1					of coping at all
	1			1		1					time points
	1		1 1	1		1					(p<.01) - only
	1			1		1					contribution of
	1			1		1					emotion focused
	1			1		1				1	coping on
	1 '		1 1	1		1				1	pregnancy

				anxiety (R2=.18, p<.001) and dysphoria (R2=.10, p=.003) were significant

-										r		r		
	Maternal	Examine	1. How are	Private	50 (68%)	Between	1 years	N=74	State Trait	Descriptiv	Self-	None	Pearson's	Assignment of
	assignmen	the	state and	obstetrical	did not	17-28	since	women	Anxiety	e, cross-	administer	given	correlation	fetal personhood
	t	relationshi	pregnancy	offices	percieve	weeks'	last loss,	with	Inventory	sectional	ed		s were	was not related
	of fetal	р	anxiety in		their	gestation	56 (82%)	history of	(STAI)	study	questionna		obtained	to state anxiety
	personhoo	between	a current	Exact	pregnancy		gestational	one or two			ires were		for all of	for the frst or
	d to	state and	pregnancy	location	as high		age of loss	perinatal	Pregnancy		placed on		the	second losses
	previous	pregnancy	related to	not clear	risk, 31		1 between	losses	Anxiety		prenatal		main study	
	pregnancy	anxiety	maternal		(51%) 1		2-13		Scale		charts of		variables	The assignment
	loss:	and	assignmen		years since		weeks, 16	Convenien	(PAS)		eligible		to examine	of fetal
	relationshi	maternal	t of fetal		last loss,		(89%)	ce			women in		relationshi	personhood to
00	p to	assignmen	personhoo		56 (82%)		gestational	sampling	Fetal		eight		ps between	the first losswas
50	anxiety in	t of	d to her		gestational		age of loss		personhoo		obsetrical		those	positively and
ck.	the current	personhoo	lost fetus		age of loss		2 between		d not		offices		variables	signifcantly
lbe	pregnancy	d to the	and to (1)		1 between		2-13		measured					correlated with
on		fetus lost	the		2-13		weeks		using a					the amount of
D 2		in a	gestational		weeks, 16				validated					pregnancy
lt &		previous	age of the		(89%)				measure					anxiety a woman
au		pregnancy	fetus at the		gestational									was
sen			time of		age of loss									experiencing in
Ar			loss, (2)		2 between									the current
ìté-			the		2-13									pregnancy (r=
ũ			number of		weeks									.30; p<.01)
			perinatal											There was no
			losses, (3)											signifcant
			the time											relationship with
			since the											personhood of a
			perinatal											second loss
			loss, and											(r=.10, p≥05)
			(4) the											
			number of											
			living											
			children											

	Quality of	То	Not given	А	Previous	Gestationa	Gestationa	Convenien	Short	Analytical	Cases	Exclusion	SF-36	Anxiety
	life.	compare	8	University	adverse	1 age	1 age of	ce	Form-36	cross-	(women	criteria	from the	(p<.0001) and
	depression	the quality		clinic for	pregnancy	of	previous	sampling		sectional	who had	included	two groups	depression
	and	of		high risk	outcomes	previous	loss not	1 0	Hospital	(case	<u>></u> 3	multiple	compared	(p<.0001) were
	anxiety	life and the		pregnancie	(n=120):	loss not	given	N=240	Anxiety	control)	spontaneo	pregnancy,	using	significantly
	among	prevalence		s, a tertiary	Mean(SD)	given		(120 cases	and		us	polyhydra	Wilcoxon	higher in women
	pregnant	of		hospital,	age=30.3(who were	Depressio		successive	minos,	signed	with adverse
	women	symptoms		two	5.9),			receiving	n Scale		fetal losses	morbid	ranks test	pregnancy
	with .	of anxiety		municipal	Mean(SD)			specialist	(HADS)		before 20	obesity, or	ILAD	outcomes
	previous	and		nealthcare	number of			antenatal	Hoalth		weeks,	history of	HADS	
	pregnancy	amongst		Campinas	pregnancie			controls	Insurance		(death of a	disease	using chi-	
	outcomes	women		Brazil	s=			receiving	Experienc		product of	uisease	square	
	outcomes	with and		Diuzii	3.7(1.6).			routine	e		conception		square	
		without			88			care)			prior to			
		adverse			married,			between	Medical		complete			
		pregnancy			73 white,			18-24	Outcomes		expulsion			
		outcomes			32			weeks	Study		or			
					education						extraction			
					>10 years			Power			from its			
					Controls			calculation			irrespectiv			
6					(n=120)			was conducted			e of the			
000					Mean(SD)			conducted			duration of			
l., 2					age=27.6(pregnancy			
st al					5.9),), preterm			
to e					Mean(SD)						birth			
no					number of						(delivery			
0					previous .						before 37			
					pregnancie $a=1.4(0.6)$						weeks), or			
					s=1.4(0.0),						neonatal			
					married						death			
					70 white.						(death of a			
					46						live-born			
					education						baby			
					>10 years						within the			
											first seven			
											days of			
											life)			
											A.£			
											Al			
											nts			
											medical			
											records			
l .											examined			
											to check if			
											they had			
											previous			
											adverse			

		outco and i to tal in inter to o the d	omes nvited ke part an view collect ata	

	Anxiety	To assess	Not given	Michigan	Mean(SD)	Not given	Not given	Collaborat	Generalize	Longitudin	Using	None	Mental	70 bereaved
	disorders	the	ittot given	USA	maternal	ittor given	(authors	ion with	d Anxiety	al study of	hirth	given	health	mothers (19%)
	and	prevalence		CONT	age		accessed	the	Disorder	mothers	certifcates	given	outcomes	had a positive
	obsessive	of anxiety			age		either the	Michigan	Scale - 7-	with	and fetal		for	screen for
	compulsiv	disorders			delivery-2		baby's	Departmen	item	nerinatal	and infant		bereaved	moderate or
	e disorder	and			9(6) 214		fetal death	t of	IGAD-71 -	death -	death		ve	severe GAD
	9 months	obsessive			(35%)		or infant	Communit	scores of	defined as	certificates		nonbereav	164 (44%) for
	after	compulsiv			some		death	v Health -	10 or	either a	Michigan		ed mothers	social phobia 47
	nerinatal	e disorder			college but		certificate)	using	higher	stillbirth	Departmen		were	(12%) for panic
	loss	amongst			less than		but	informatio	indicative	(above 20	t of		analysed	disorder and 35
	1055	bereaved			Bachelor's		surveys	n from	of	weeks of	Communit		using γ^2	(9%) for OCD -
		and live-			degree		were	hirth fetal	moderate	gestational	v Health		and	these were lower
		birth			educated		completed	death or	or severe	age and at	sent		logistic	for nonbereaved
		mothers			483 (79%)		a median	infant	anxiety	least 400g)	mailings to		regression	mothers
		moulers			Caucasian		of 9	death	unifiery	or an early	900		after	moulers
					322(53%)		months	certificates	Mini	infant	bereaved		controlling	In the adjusted
					nast		after the	mothers	Social	death (first	mothers		for	analysis
					medical		loss	, moments	Phobia	28 days of	and 500		maternal	bereaved
					history of		1055	mailed	Inventory	life)	control		age race	mothers had
					any			with	IMINI-	iiic)	mothers		insurance	significantly
					psychiatric			informatio	SPINI - 6		mounors		type, level	more than twice
					disorder			n about the	or above as		Participant		of	the odds for
-					ansoraer			study	positive		s were		education	GAD (OR=2.39.
017								~	P		surveyed		and days	CI (1.10-5.18).
. 5								609	Primary		at 6, 14.		between	p=.028) and
al.								completed	Care		and 24		the	social phobia
l et								and	Evaluation		months		birth/loss	(OR=2.32, CI
olc								eligible	of Mental		after		and	(1.52-3.54),
0								women -	Disorders		delivery -		compeltio	p<.0005). Panic
								of these	[PRIME-		this study		n of the	disorder
								232 (46%)	MD] -		reports		survey	(OR=1.55,
								of mothers	Patient		results		2	CI(0.78-3.10),
								had a live	Health		from the 6		Additional	p=.214) and
								birth, 377	Questionn		month		covariates	OCD (OR=2.20,
								(42%) had	aire Panic		wave		were	CI (0.83=5.83),
								a perinatal	Module				added	p=.112) were
								death					based on	non-significant
									Obsessive				the	C C
									Compulsiv				literature	There was no
									e				(current	significant
									Inventory				depression	association
									(revised				, prior	between current
									version) -				psychiatric	pregnancy and
									21 or				disorder,	anxiety disorder
									above was				social	or OCD or
									a positive				support,	associations
									screen				intimate	with race
													partner	
													violence,	
													current	
													pregnancy	

						status and	
						status allu	
						mental	
						health	
						(bereaved	
						mothers	
						(anly)	
						omy))	
						Racial	
						differences	
						in positive	
						screens	
						and	
						treatment	
						rates of	
						different	
						subgroups	
						analysed	
						anaryseu	
						using χ^2	

	Anviety	То	Not given	Norway	Previous	In the	In the	Convenien	Honkins	Prospectiv	Postal	None	The	The aOR for
	depression	investigate	Not given	Norway	stillbirth	ni uic	ni ule	convenien	Symptom	a cohort	invitation	given	McNemar'	anxiety was 5 47
	and	the			(n-174)	otillhigth	otillhigth	ce	Chaptelist	e conort	invitation	given		anxiety was 5.47
		uie 1			(11=1/4):			sampning	Checklist	study	sent alter		s test was	compared with
	relationshi	prevalence			Mean(SD)	group, 115	group, 115	N. 001	F'		registering		used to	the previous live
	p	of anxiety			maternal	(68.0%)	(68.0%)	N=901	Five item		for a		analyse the	birth group
	satisfactio	and			age=31.18	>30 weeks	>30 weeks	total	version of		routine		differences	(95% CI= 2.90–
	n in the	depression			(4.63), 168	gestational	gestational		the		ultrasound		in	10.32,p< 0.001,
	pregnancy	in the			(97.7%)	age at	age at		Relationsh		examinatio		frequency	adjusted for age,
	following	pregnancy			married/co	stillbirth	stillbirth		ip		n at 17		of anxiety,	education, pre-
	stillbirth	following			habiting,				Satisfactio		weeks -		depression	pregnancy
	after the	stillbirth			67 (39.0%)				n Scale		part of a		and	smoking and
	birth of a	and assess			low						wider		relationshi	stressful life
	live-born	gestational			education,						Norwegian		р	events) and 4.97
	baby: a	age at			32 (18.4%)						Mother		satisfactio	compared with
	prospectiv	stillbirth			previous						and Child		n between	the previously
	e study	and inter-			miscarriag						Cohort		different	nulliparous
		pregnancy			e. 115						Study and		time points	group (95% CI
		interval as			(68%)						on records		F	2.68-9.24 p<
		individual			gestational						from the		Binary and	0.001 adjusted
		risk factors			age at						Medical		multivariat	for age and
		non nectors			stillbirth						Birth		e logistic	education)
~		To assess			230 weeks						Pagistry of		regression	cuucation)
01		the course			150 WCCKS						Norway		models	The aOR for
		of anviatu			Browious						Norway		models	depression was
al		depression			live birth								to estimate	1.01 compared
ı et		and			(n-262):								odds ratios	1.91 compared
ser		anu			(II=302). Maan (SD)								(OD) and	with the
nst		satisfactio			Mean(SD)								(OK) and	previous rive
vei		n with			maternal								adjusted	birth group
jra		partner			age=31.29								odds ratios	(95% CI 1.11–
U		relationshi			(4.14), 356								(aOR) for	$3.2^{\prime},p=0.019,$
		p up to 3			(98.3%)								anxiety	adjusted for age,
		years after			married/co								and/or	pre-pregnancy
		the birth of			habiting,								depression	smoking, BMI
		a live-born			104								in	and stressful life
		baby			(29.1%)								subsequent	events) and 1.91
		following			low								pregnancy	compared with
		stillbirth			education,								among	the previously
					55 (15.2%)								women	nulliparous
					previous								with a	group (95% CI
					miscarriag								previous	1.11-
					e								stillbirth	3.36.p=0.026.
					0								compared	adjusted for age
					Previously								with the	education and
					nullinarou								two	BMI)
					s $(n-365)$								reference	5
					$3^{\circ}(1=303)$. Mean(SD)								groups	The proportion
					maternal								Covariates	of women with
					200-2870								that were	both anxiety and
					age=20.70 (4.45) 245								unat were	doprossion in the
					(4.43), 343								distributed	third trimaster
					(93.0%)								hotre	unru unnester
			l		married/co				1				between	was 12.7%

			habiting,					the groups	among
			99 (27.9%)					(p< 0.1),	womenwith a
			low					associated	previous
			education					with the	stillbirth
			52(14,2%)					outcome	compared with
			52 (14.270)					variable in	2.6% in each
			previos					variable ili	3.0% III each
			miscarnag						reference group
			e					model (p<	(p< 0.001 for
								(0.1), and	both
								not	comparisons)
								strongly	
								correlated	The prevalence
								(correlatio	of anxiety and
								n	depression
								coefficient	decreased
								< 0.7),	significantly
								were	from first
								included in	assessment to 6
								the	months
								multivariat	postpartum
								e analyses	among women
								e analyses	with a previous
								For the	stillbirth (n
								atillbirth	0.001 for any joty
								sunon	0.001101 anxiety
								group,	domession) by
								separate	depression) - by
								binary .	six and 18
								regression	months
								models	postpartum,
								were used	respectively, the
								to test if	prevalence of
								gestational	depression and
								age at	anxiety was not
								stillbirth or	significantly
								interpregn	different
								ancy	between groups
								interval	
								were	From six to 36
								significant	months
								predictors	postpartum, the
								foranxiety	prevalence of
								or	anxiety and
								depression	depression
								in the	increased
								subsequent	significantly in
								programan	the stillbirth
								pregnancy	aroup $(r = 0.020)$
								1	group ($p=0.039$
								1	
								1	respectively)
								1	and the
1	1							1	prevalence of

							anxiety, but not
							depression,
							increased
							significantly in
							the nulliparous
							group ($p=0.039$)
							1. 26
							At 36 months
							postpartum, the
							posipilitanii, inc
							prevalence of
							anxiety and
							demassion was
							depression was
							higher among
							women with a
							women with a
							previous
							stillbirth
							sunonui
							compared with
							women with a
							wonnen with a
							previous
							livebirth but not
							iiveoirtii, out iiot
							compared with
							previously
							previously
							nulliparous
							women The
							prevalence of
							anxiety and
							depression in the
							depression in the
							third trimester
							differed among
							untered anong
							women with a
							previous
							previous
							stillbirth
							completing all
							completing un
							nve
							questionnaires
							acompand with
							compared with
							drop-outs at any
							point often 20
							point after 50
							gestational
							weeks (for
							weeks (101
							anxiety 15.2 vs
							32 1%
							52.+70,
							respectively,p=
							0.007 and for
							0.007 and 101
							depression12.1
							vs 20.7%
							1 1
							respectively,p=
							0.004)

-								-		1			-	
	Cognitive	Not given	1. How do	England,	Mean(SD)	Mean(SD)	Mean(SD)	Consecuti	Structured		Study	None	Pearsons	Both number of
	predictors		PISD	UK	age in	gestational	gestational	ve	Clinical		interviews	gıven	correlation	clinician-
	and risk		symptoms		years=	age at	age at	sampling -	Interview		- mixture		s and	reported and
	factors of		change		31.92(4.98	stillbirth=	stillbirth=	experience	DSM-IV-		of clinicial		multiple	frequency of
	PTSD		from 3 to 6),	34.09	34.09	d a	PTSD		and self-		regression	self-reported
	following		months		Mean(SD)	(5.95)	(5.95)	stillbirth at			report		models	reexperiencing,
	stillbirth: a		post loss?		number of			24 weeks	Posttraum					avoidance, and
	short-term		2. What		living			gestational	atic					arousal
	longitudin		are		children=			age or later	Diagnostic					symptoms
	al study		cognitive		0.51				Scale					decreased
	-		predictors		(0.81), 56			N=65						significantly
			of PTSD		(86.2%)				Posttraum					between 3 and 6
			symptoms		white UK				atic					months
			at 3 and 6		ethnicity.				Cognitions					
			months?		40 (61.5%)				Inventory					Higher scores
			3 Do		married									onperceived
			cognitive		Mean(SD)				Responses					social support
			factors		gestational				to					did not uniquely
			(appraisals		age at				Intrusions					predict a
			(appraisais		stillbirth-				Questionn					decrease inthe
			, dysfunctio		34.09				aire					number of
			uysiulicito p		(5.05)				ane					reavpariancing
6			II stratagias)		(3.93), Moon(SD)				Social					avoidence or
01:			of DTSD of		mean(SD)				Drovisions					avoluance, or
. 5			01 P1SD at		number of				Provisions					arousar
al			5 monurs		previous				Scale					(SCID) at 6
ı et			explain											(SCID) at 0
sch			changes in		s = 2.15									months (all
Ior			PISD		(1.41),									p=ns). Mother's
Ц.			symptoms		Mean(SD)									age uniquely
			at 6		number of									predicted a
			months		previous									decline in
			4. What		perinatal									number of
			are the		losses=									clinician-
			relationshi		0.38(0.80),									reported
			ps between		Mean(SD)									avoidance
			risk factors		history of									symptoms
			(percieved		perinatal									$(\beta =25, t = -2.02)$
			social		loss before									,df
			support,		stillbirth=									ad=54,p=.048).
			trauma		16 (24.6)									Having more
			history,											children
			obstetric											(β=32,t=-2.41
			history)											,dfad=42,p=.021
			and PTSD) and more
			at 3 and 6											previous
			months?											pregnancies
														(β=31,t=-2.59
														,dfad=55,p=.012
) predicted less
														clinician-
														reported

	1		1	1		1	1		
									avoidance
									symptoms at 6
									months. For self-
									reported
									frequency of
									DTCD 01
									PISD
									symptoms,
									higher total
									scores in
									perceived social
									support
									$(\beta =26, t = -2.24)$
									.dfad=46.p=.030
) predicted a
									decline in
									reavnarianaina
									reexperiencing
									symptoms,
									whereas higher
									income
									(β=29,t=-2.67
									,df
									ad=51,p=.010)
									predicted a
									significant
									decline in
									arousal
									symptoms
									symptoms

	Controlled	Hypothese	Not given	Netherland	Women	Exact	Exact	N=440	SCL-90	Cohort	Participant	None	Used both	Women shortly
	prospectiv	s: women		s and the Dutch-	who lost a	gestational	gestational	Convenien	(Dutch	study	s were	given	a MANOV	loss (approx 2.5
	study on	experience		speaking	(n=227):	previous	previous	ce	version)		surveys -		A and a	months) had
	the mental	d a loss		part of	100 (44%)	losses not	losses not	sampling			they were		MANCOV	more mental
	health of	would		Belgium	secondary	given	given	1 0			followed		A of post	health
	women	show more		-	education,	-	-				up at 12		delivery/lo	symptoms than
	following	depression			221 (98%)	Reproducti					weeks, 1,		ss scores	women who
	pregnancy	, anxiety,			married or	ve history:					6, 12, and		with	gave birth to
	loss	and			cohabiting	Woman					18 months		pretest	living babies $(E_{19} 42) DE_{4}$
		on			had one	who lost a					delivery		(first	$(1^{-10.45}, D1^{-4}, 395 \text{ p} < 0005)$
		on			living	baby:					denvery		assessment	higher
					child	132 (58%)					At the 1) as	depression
						no					month		covariates	(F=54.05, DF=1,
					Compariso	pregnancy					assessment		- history of	399, p<.0005),
					n women	loss, 83					, women		reproducti	anxiety
					(n=213):	(3/%)					if they had		ve loss	(F=32.45, DE=1.300)
					secondary	pregnancy					experience		first factor	p < 0.005
					education,	loss <20					d loss (and		and loss	somatisation
					209 (98%)	weeks, 12					they were		group vs.	(F=49.99, DF=1,
966					married or	(5%)					included in		compariso	399, p<.0005),
, 16					cohabiting	perinatal					the loss		n group as	and OCD
t al					, 108 (51%) had	$10ss \ge 20$					group)		factor	(F=11.05, DF=1, 399, p<001)
n ei					one living	WEEKS							Tactor	599, p<.001).
ISSE					child	Compariso								At 6 months,
Jar						n women:								women who had
						172 (81%)								experienced a
						no								loss had more
						loss 35								symptoms than
						(16%)								women who
						early								gave birth to
						pregnancy								living babies (F=
						loss <20								3.84, DF=4, 389,
						weeks, 6								p.004) including
						(3%)								nigner
						$\log >20$								depression
						weeks								(F=7.56, DF=1,
													1	392, p<.006),
													1	anxiety (F=6.14,
													1	DF=1, 392,
													1	p<.01), and
													1	(F=13.10 DF=1)
													1	392, p<.0005)
														, <u>r</u>
													1	At 12 and 18

		1		1		1	
							months the
							differences
							hetween groups
							between groups
							were no longer
							significant
							When the effect
							of time since the
							loss was taken
							into account,
							those women
							whose period of
							gestation had
							been relatively
							longer showed
							more symptoms
							of depression (r
							partial=0.19.
							DF=224
							p=0.004 one
							p=0.004, one-
							tailed), anxiety
							(r partial=0.19,
							DF=224,
							p=0.005. one-
							tailed)
							comparison (r
							partial=0.16,
							DF=224,
							p=0.01, one-
							tailed), and
							obsessive-
							compulsive
							hohovion (n
							cenavior (r
							partial=0.18,
							DF = 224,
							p=0.007, one-
							tailed) shortly
							after pregnancy
							loss
							1088

		Associatio	То	Not given	Florida,	Stillborn	N=8293	Not given	Utilised	Presentatio	Retrospect	Participant	Multiple	Multivaria	In the adjusted
		n between	determine		USA	singleton	stillborn at		data from	n to the	ive cohort	s were	gestation	ble logistic	model, the risk
		stillbirth	whether			≥23 weeks	≥23 weeks		the Florida	Emergenc	study	identified	excluded	regression	of readmission
		23 weeks	women			gestation:	gestation		State	у		from	from the	were	or Emergency
		gestation	have a			6354			Inpatient	Departmen		hospital	analysis	adjusted	Department
		and acute	higher risk			(76.6%)	N=		Database	t or		and state	Preexistin	for age,	encounter with
		psychiatric	of			aged 18-	1,194,758		and	readmissio		departmen	g	race/ethnic	coding for
		illness	experienci			34, 3189	liveborn		Emergenc	n to an		t databases	psychiatric	ity, payer,	psychiatric
		within 1	ng			(39%)	singleton		у	inpatient		using ICD-	illness	income	illness was
		year of	clinician-			black,			Departmen	hospital		9-CM	during	quartile by	almost 2.5 times
		delivery	diagnosed			3177			t Database	for		diagnosis	pregnancy	ZIP code,	higher after
			psychiatric			(38.9%)			of the	treatment		to identify	excluded	mode of	stillbirth at >23
			morbidity			white,			Agency	of an acute		participant		delivery,	weeks gestation
			in the year			2714			for	psychiatric		s,		maternal	(OR=2.47,
			after			(38.9%)			Healthcare	illness -		exposures,		medical	95%CI 2.20-
			stillbirth			income			Research	included		and		comorbidit	2.77)
			vs.			quartile 1			and	suicide		outcomes		ies, and	
			livebirth			(poorest)			Quality's	attempt,				severe	Women who had
									Healthcare	depression				intrapartu	experienced
						Liveborn			Cost and	, anxiety,				m	stillbirth had
						singleton:			Utilisation	psychosis,				maternal	higher risk of
	6]					970,842			Project	posttrauma				morbidity	depression
	20]					(81.3%)			from	tic stress					(OR=2.75, 95%
						aged 18-			2005-2015	disorder,				Cox	CI 2.31-3.26)
	et a					34,				acute				proportion	and anxiety
	tz e					602,944			N=8293	stress				al hazard	(OR=2.29,
	iwi					(51.2%)			stillborn at	reaction,				ratios	95%CI (1.93-
	vkc					white,			>23 weeks	adjustment				examined	2.70))
	er					313,859			gestation	disorder				the	
	_					(31.5%)			N=	a 1				associated	Women with
						income			1,194,758	Secondary				between	stillbirth had a
						quartile 1			liveborn	outcome				stillbirth	higher risk of
						(poorest)			singleton	included				and the	being coded for
										alcohol or				primary	drug or alcohol
										recreationa				outcome	use dependence
										I drug use				over the 12	both inpatient
										or				month	and in the
										dependenc				tollow up	Emergency
										e					Department
										D 1				Outcomes	(OK=2.41, 95%)
										Based on				also	CI 1.99-2.90)
										ICD-9-CM				changed to	Carr
										codes				include	COX
														only	proportional
														nospital	nazards was
														admissions	only not violated
														to analyse	when ionow-up
														of atill int	the first for
														of stillbirth	months (n. 1)
														innotiont	(p=.1)
1			1	1	1	1	1	1	1	1	1	1	1	mpatient	and 4-12 months

						psychiatric care	(p1) post discharge - development of the primary outcome after birth was significant for the first 4 months (HR=3.26 (95%CI 2.6- 4.04), and 4-12
							months (HR=2.42, 95%CI 2.13- 2.76) When
							Emergency Department encounters were excluded, inpatient hospitalisation was three times
							higher when women had experienced stillbirth (OR=2.81, 95%CI 2.37- 3.33) - risk of
							adjustment disorder (OR=4.46, 95%CI 2.86- 6.94) and PTSD nearly 4 times higher
							(OR=5.36, 95%CI 2.73- 10.51)

	Anxiety	To explore	Not given	Three	Mean(SD)	Gestationa	Perinatal	Used data	State Trait	Case-	The wider	None	Multiple	After adjusting
	and	the		Scandinavi	maternal	1 age	loss	from the	Anxiety	cohort	study	given	linear	for age, civil
	depression	association		can	age=28.48	of	grouped	Successive	Inventory	design	included		regression	status,
	in	between			(4.2), 1420	previous	and	Small-for-	(STAI)		interviews,		used to	education,
	pregnant	previous		Universitie	(97.4%)	loss not	included	Gestationa			questionna		assess the	occupation,
	women	perinatal		s in	married/co	given	spontaneo	1 Age	Centre for		ires, self-		association	economic
	who have	loss and		Norway	habiting,		us	Births	Epidemiol		study		between	situation, ability
	experience	anxiety/de		(Trondhei	755		abortion,	Study	ogical		forms, and		previous	to raise NOK
	d a	pression		m, Bergen)	(51.8%)		stillbirth,	(SGA)	Studies		clinical		perinatal	5000 in one
	previous	symptoms		and	high		or neonatal		Depressio		examinatio		loss and	week, smoking
	perinatal	in the		Sweden	school		death	N=1458;	n scale		ns at 17,		maternal	status, alcohol
3	loss: a	subsequent		(Uppsala)	educated,			cases=401	(CES-D)		25, 33, 37		mental	consumption,
02	case-	pregnancy			614			with			weeks'		health in a	pregnancy
	cohort				(42.1%)			previous			gestation,		subsequent	intention, and
t al	study from	To explore			part time			perinatal			and at birth		pregnancy	previous history
li e	Scandinavi	possible			work,			loss, non-					after	of mental health,
nal	ca	determina			1080			cases=105			Participant		controlling	there was a
Aai		nts of			(74.1%)			7 who did			s		for	positive
A A		maternal			smoking			not report			responded		confounde	association
		mental						perinatal			to the		rs	between
		health						loss			measures			previous
		during the									at 25			perinatal loss
		subsequent									weeks of			and total
		pregnancy,									the			depression score
		independe									subsequent			(β=0.90, 95%CI
		nt of									pregnancy			0.06-1.74) and
		previous												total anxiety
		perinatal												score (β =1.22,
		loss												95%CI 0.49-
														1.95)

	Postpartu	То	Not given	Atatürk	Early	Gestationa	Gestationa	N=250	Edinburgh	Cross-	Scale was	Women	Continuou	EPDS s	cores
	m	evaluate	itor given	City	group			(n-150) in	Postnatal	sectional	administer	who had	s variables	_13	were
	depression	postpartu		Hospital	(COVID-	of age	of age	each	Depressio	sectional	ed face-to-	recently	evaluated	<u>>15</u> significantly	were
	among	m		Turkey	19	previous	previous	group)	n Scale		face to	given birth	using t_{-}	associated	y with
	mother of	depression		Turkey	restrictions	loss not	loss not	women	(Turkish		nostpartu	but	tests or	previous hi	istory
	infants	and related			in place:	given	given	whose	(Turkish version)		m women	declined to	Mann-	of	story
	hospitalise	factors in			n = 125):	given	given	newborns	version)		hetween	narticipate	Whitney U	abortion/sti	llbirt
	d in the	mothers of			II=125). Median(IO			were in the			14 30 days	participate	winney 0	abortion/sti	nd/or
	u ili ilic	infants			P)			NICU			the early	, nau mental	Catagorica	neonatal a	death
	intonsivo	hospitalisa			K)			from Nov			- the early	rotordation	L veriebles	(OP-1 641)	Jean
		d in NICU			$111aternal}$			2021 to			group	hed o	1 variables	(OK = 1.041)	,
	during the	d III NICO			age=20(23)			2021 10 Juna 2022			the survey	, nau a	evaluated	95%CI I	.009-
		during two			(540), (540)			Julie 2022			hetween	mistory of	using cili-	2.009, p=.04	+)
	10				(04%)			Comple			Nevember	substance	square or		
	19	10			nunparou			Sample			November	abuse, nau	FISHER'S		
	pandenne	19 nondomio			(40.5%)			strategy			2021 - Eabraiana	twics, or	exact test		
		pandemic			(40.5%)			not clear			February	nad	EDDC		
		periods			maternal						2022	children	EPDS cut		
		and			secondary						during the	with	$\underline{011} \ge 13$		
		examine			nign						winter	severe	Deemonia		
		ally			school						COVID	ihi -	Pearson's		
											10. the lete	Ischennic	correlation		
		the			(99.50/)						19; the late	encephaio	s used to		
33		uie non domio			(00.5%)						group	parity were	define relationshi		
202		pandemic on the			incomo						this	excluded	relationshi		
ii, ,		ule mental			status						between		FPDS with		
pz		health of			status						March and		EFDS		
0		neatur or			Loto group						June 2022		scores		
		posipartu m women			(fower						Julie 2022		Odda		
		in women			COVID						when there		ratios of		
					10 cases:						cases		multiple		
					n = 125):						deaths and		risk factors		
					II=123). Median(IO						restrictions		TISK TACIOIS		
					P)						on		evaluated		
					K) maternal						visitation		by		
					nac=28(24)						visitation		by multiple		
					age=20(24)								logistio		
					(60%)								regression		
					(09%)								regression		
					s, 49										
					(39%)										
					maternal										
					primary										
					school										
					to4										
					104										
					(85.5%)										
					inadie										
					atotuo										
					status										

	Comparise	To soo if	Not given	Tortion	Woman	Woman	Castations	Not alaar	Edinburgh	Casa	Domogram	Already	Unnaired	EDDS soore of
	n of EPDS	To see II	Not given	Tertiary	women with good	women with good		not clear -	Edinburgh Bostnatal	Case	bio details	diagnosod	t tosts for	EPDS score of
	II OI EPDS	specific of		bospital	with good	with good	r age of	in the	Doprossio	control	nic details	ulagnosed	t-tests for	significantly
	scores	groups of		India	outcomos	outcomas	loss	hospital	Depressio	study	gaaniereu	with some	voriables	higher in
	women	would		muta	(n-80):	Mean(SD)	riven	nospitai	II Scale		medical	illness	and	women with
	with good	bonofit			(11-60). Moon(SD)	mean(SD)	given	N = 160 (80)			racorda	or	aliu abi squara	advarsa naonatal
	neonatal	from			age=26.56	gestational		n=100 (80			and the	delivered	for	
	outcomes	selective			(6.12) 31	1 23		group)			EPDS was	outside or	discrete	(n - 0.188)
	and	screening			(3875%)	1.23)		group)			administer	those who	variables	(p=.0400)
	adverse	screening			higher	Women		Adverse			ed to	needed	variables	
	neonatal				education	with		neonatal			women	ICU care		
	outcomes				44 (55%)	adverse		outcomes			when they	during the		
	outcomes				nrimigravi	neonatal		defined as			came for	perinatal		
					da	outcomes:		women			ther their	period		
					Mean(SD)			who			post	were		
					gestational	Mean(SD)		experience			delivery	excluded		
)23					age)=37.6(gestational		d stillbirth			follow-up			
, 5(1.23)	age=		or neonatal			or in the			
al.					,	35.3(2.54		mortality			postnatal			
et					Women			or neonate			ward (2-3			
sad					with			needing			weeks			
Pra					adverse			NICU care			after			
					neonatal						delivery)			
					outcomes									
					(n=80):									
					Mean(SD)									
					age=25.96									
					(5.98), 19									
					(23.75%)									
					higher									
					education,									
					38 (47.5%)									
					primigravi									
					da,									
					Mean(SD)									
					gestational									
					age =									
					35.3(2.54)									

	Impact of	То	1 How	England	Held the	Held the	Held the	All women	Psychologi	Secondary	Participant	None	Multiple	After adjusting
	holding	aomnara	1. HOW	Lingiand,	hoby	hoby:	hebu:	who had a	asl	analysis of	a filled in	given	logistio	for multiple
	the	compare montol	many	UK	(N-204)	172	172	who had a	cai wallhaing	analysis of	s fifted fif	given	rogistic	
			women		(1N=394):	1/3	1/5	registered	wendering	a postal	the survey		regression	pregnancy,
	Daby	nealth	saw or		202	(88.7%)	(88.7%)		reported	population	and		used to	ethnicity, and
	following	and well-	held their		(81.1%)	3/+ weeks	37+ weeks	England	through a	survey	some data		adjust for	Tertility
	stillbirth	being	baby after		aged 30-	D .1	5.1	between	symptom		was given		differences	treatment:
	on	outcomes	stillbirth?		39, 351	Did not	Did not	January-	checklist		by the		between	3 months after
	maternal	at 3 and 9	2. Who		(85.6%)	hold the	hold the	March	based on		ONS		the two	birth there were
	mental	months	held their		white, 357	baby:	baby:	2012 or	national				groups	no statistically
	health and	after the	baby after		(84.4%)	22 (11.3%)	22 (11.3%)	June-	surveys -					significant
	well-	stillbirth	stillbirth?		married or	37+ weeks	37+ weeks	August	asked if				Bivariate	associations
	being:	among	Did		with			2012 were	they had				analyses	with mental and
	findings	women	demograp		partner			identified	experience				using χ^2	physical health
	from a	who held	hic,					by the	d any of				described	9 months after
	national	or did not	clinical or		Did not			ONS and	the				outcomes	birth, only
	survey	hold their	care		hold the			sent a	symptoms				individuall	anxiety
	2	baby	characteris		baby			study pack	following				y for those	(OR=2.12,
		5	tics differ		(N=74):			between 6-	3 months				who held	95%CI 1.11-
			between		47 (18.9%)			9 months	after birth				and saw	4.04, p<.05) and
			women		aged 30-			after the	and in the				the baby.	relationship
			who held		39. 16			stillbirth	last few				only saw	difficulties with
			and did not		(21.8%)				days				the baby	family
16			hold their		black 66				aujo				and neither	(OR=5.33)
20			haby?		(15.6%)								held or	95%CI 126-
лI.,			3 Did		married or								saw the	22.53 p< 05)
et s			mental		with								haby	were statistically
M			health and		nartner								buby	significant
sha			well being		partiter								Logistic	significant
eds			outcomes										regression	After adjusting
R			diffor										regression	for multiple
			between										s, adjusting	noi munipie
			those who										for	othnicity,
			hold or did										101	fortility, and
													contounde	tertifity
			not noid										rs,	treatment:
			their baby?										compared	Holding the
			were										noiding	baby was
			differences										and seeing	significantly
			significant										- separate	associated with
			after										subgroup	anxiety 3
			adjustment										analyses	months after
			for										conducted	birth (OR=3.80,
			demograp										on current	95% CI 1.55-
			hic,										pregnancy	9.35, p<.01) and
			clinical										status,	9 months after
			and care										time	birth (OR=4.29,
			characteris										between	95% CI 1.49-
			tics?										antepartu	12.39, p<.01)
			4. What										m death	and relationship
			was the										and the	difficulties with
			unique										birth,	family 3 months
			impact of										gestation	after birth

 										1
		holding							at	(OR=3.52, 95%
		the baby							stillbirth,	CI 1.05-11.75,
		on mental							congenital	p<.05)
		health and							abnormalit	1 /
		well-being							v	Seeing the haby
		outcomes							5	was
		in contrast								significantly
		to that								associated with
		ottributabl								associated with
										all xiety 5
		e to only								high (OD 0.10
		seeing the								birth ($OR=0.19$,
		baby?								95% CI 0.06 to
		5. Was the								0.60, p < .01) and
		impact of								9 months after
		contact								birth (OR=0.27,
		with the								95% CI 0.07 -
		stillborn								0.98)
		baby								
		different								
		according								
		to current								
		pregnancy								
		status, or								
		the								
		condition								
		of the baby								
		(captured								
		(captured								
		from								
		IIOIII								
		antepartu								
		m death to								
		birth,								
		stillbirth								
		gestation,								
		presence								
		of								
		congenital								
		abnormalit								
		y)?								
				1						

	Previous	То	Not given	One	917(30%)	Not given	Gestationa	Sample	Anviety	Longitudin	Data on	Exclusion	Anviety	The number of
	T IC VIOUS	10	Not given	aliniaal)17 (57/0)	Not given		strategy	magging	al ashort	matamal	eritorio	and	mariana liva
	pregnancy	ineasure		chincai	aged 50-		i age oi	strategy	measured	al conort	maternar			previous rive
	outcomes	the		centre,	34,		previous	unclear	using the	study	demograp	included	depression	term births was
	and	association		Quebec,	860 (36%)		loss not		Pregnancy		hic	current	measures	significantly
	subsequent	S		Canada	had 0		given		Related		characteris	intravenou	and	associated with
	pregnancy	between			previous				Anxiety		tics and	s drug use,	response	lower pregnancy
	anxiety in	five past			pregnancie				Scale		pregnancy	severe	rates	anxiety in all
	a Quebec	pregnancy			s, 1017				(Dunkel-		history for	illness or	across	three trimesters
	prospectiv	outcomes			(45%)				Schetter)		each	life	different	(first, r=12,
	e cohort	(live			annual						known	threatenin	strata of	p<.01; second,
		preterm			household				Measure		previous	g	the sample	r=-0.10, p<.01:
		birth live			income				not named		pregnancy	conditions	using	third $r=-0.09$
		term birth			50.000-				used to		(including	and	univariate	p < 01) Prior
		miscarrian			99,000				measure		those 20	multiple		stillbirth (first
		a at 20			011(20%)				disordors		uiose (20	astation	ANOVA	r=0.08 $p<01$
		$e_{al} < 20$			911 (39%)						weeks)	gestation	Ear	1-0.06, p<.01,
		weeks,			university						were	pregnancie	FOI	second, $1=0.09$,
		stillbirth at			degree,				phobias,		collected	s	multigravi	p<.01; third.
		<u>>20</u>			1636				GAD,		retrospecti		d women	r=0.09, p<.001)
		weeks, and			(69%)				obsessions		vely via		only,	and elective
		elective			white,				,		interviewe		Pearson's	abortion (first,
		abortion)			2232				compulsio		r-		correlation	r=0.11, p<.01;
					(95%)				ns and		administer		s between	second, r=0.11,
17					married or				PTSD		ed		previous	p<.01, third,
20					living with						questionna		pregnancy	r=0.08, p<.05)
I.,					a partner				10- and 4-		ires at		outcome	were associated
et a									item		study entry		and	with higher
90.									version of				subsequent	nregnancy
iiq									the Center		Pregnancy		depression	anviety in all
sha									for		anviety for		and	three trimesters
01									Enidomial		the		and	Drior
									Epidemioi		(me		anxiety	
									ogical		(subseque		measures	
									Studies		nt) index		at each of	(r=0.09, p<.01)
									Depressio		pregnancy		the three	and prior PIB
									n Scale		and		trimesters	(r=0.06, p<.05)
									(CESD) to		depressive		- those that	were
									measure		symptoms		were	significantly
									depressive		were		significant	associated with
									symptoms		measured		were	pregnancy
									-		by self-		tested	anxiety in the
											administer		using	first trimester
											ed		linear	
											questionna		regression	After adjusting
											ire at each		s Adjusted	for all variables
											of the three		models	prior stillbirth (
											propetal		woro	
											prenatal		were	p=0.50,
											visits (8–		included	95%CI=-0.10-
											14 weeks,		all five	0.70), p=0.13)
											20-24		previous	was not
											weeks, 32–		pregnancy	significantly
											35 weeks)		outcomes	associated with
														pregnancy

					The anxiety disorders screening instrument was administer ed only once at the second- trimester assessment	Sensitivity analysis predicting pregnancy anxiety whilst controlling for depression and anxiety screening score	anxiety in the first trimester, or the second trimester (β =0.24, 95%CI=-0.08-0.57), p=0.14), but was in the third trimester (β =0.40, 95%CI=0.05-0.74, p=0.025)

	Counselin	To explore	Not given	Not clear	Neonate	Mean(SD)	Not given	n=28	Open	Cross-	Participant	Not given	Continuou	36% of parents
	g for	the			characteris	gestational		neonates	ended text	sectional	s were sent		s variables	received
	personal	personal			tics	age=28.6(Identified	boxes	survey	a		were	counselling
nly	care	care			(n=28):	6.8)		through			contact		analysed	during the same
6 O	options at	options			Mean(SD)			medical			letter to		by t-test or	visit or
tiv	neonatal	offered to			gestational			records			complete		Wilcoxon	hospitalisation
lita	end of life:	parents as			age=28.6(and			the survey			in which they
an	а	well as			6.8),			contacted			either		Categorica	learned about
nb)	quantitativ	parental			62.5%			for			online,		1 data were	their infant's
15	e and	perception			male, 24			recruitmen			paper, or		analysed	diagnosis or
20	qualitative	s of the			(86%)			t via a			telephone -		using chi-	prognosis - 23%
	parent	counsellin			singleton,			letter			other		square	received this
st a	survey	g they			12 (43%)						demograp			during the initial
tz e		received			diagnosed						hic and			visit and at later
iwi		regarding			with						clinical			visits - 27% of
Ikc		these			prematurit						data was			parents stated
she		options at			у						obtained			that they
01		their									via chart			received no
		infant's									review			counselling
		end of life												

	TT1	T	NT / 1	D 1	C' 1 /	тс	NT / '	D (C	C 1	T '/ 1'	E '1'	N	T	A
	The	10	Not given	Royal	Singletons	Infants	Not given	Part of a	General	Longitudin	Families	None	10	At two years,
	influence	examine		Women's	(n=129):	born at		broader	Health	al	completed	given	examine	there was no
	of	the		Hospital,	85 (66%)	<30 weeks'		longitudin	Questionn	observatio	questionna		whether	significant
	multiple	influence		Melbourne	primipara,	gestation		al study	aire	nal study	ires at		multiple	difference
	birth and	of multiple		, Australia	64%	or with a			(GHQ;		two and		birth and	between mental
	bereaveme	birth			secondary	birthweigh		N=162	two years)		seven		bereaveme	health, parenting
	nt on	(twins or			education	t <1250g		mothers	- score of		years		nt were	stress, or family
	maternal	triplets) on			at two,				24 or more		corrected		associated	functioning
	and family	mental			52%				indicates		age		with	
	outcomes	health,			secondary				clinically				maternal	At seven years,
	2 and 7	parenting			education				significant				mental	bereaved
	years after	stress, and			at seven,				symptoms				health and	mothers repoted
	verv	family			34%				of mental				family	more anxiety
	preterm	functionin			profession				health				functionin	symptoms after
	birth	g at two			al				problems				g. separate	controlling for
	onui	and seven			occupation				problems				linear and	social risk
		vears			at two				Hospital				logistic	B(95%
		corrected			3/1%				Anviety				regression	CD = 2.60 0.25
		age			unskilled				and				models	4.95 $p=03$
		age			occupation				Depressio				were fitted	They were more
		То			occupation				Depressio				to anoh	likely to report
		10			at two,				II Scale				to each	intery to report
9		investigate			85% intact				(HADS;				continuous	elevated
20		whether			Tanniy				seven					symptoms of
		bereaveme			structure at				years) -				categorical	anxiety
st a		nt within			two, 74%				scores in				outcome	(UK(95%) CD 4.12 1.17
qe		the context			intact				the 11-21				(multiple	CI)=4.12, 1.17-
vau		of very			Tamily				range				vs	14.48, p=.03)
eyı		preterm			structure at				classified				singleton;	and depression
Ţ		birth			seven				as				no	(OR(95%
		influenced							clinically				bereaveme	CI)=4.6/, 1.29-
		maternal			Multiples				significant				nt vs	16.93) after
		mental			(n=33):								bereaveme	controlling for
		health,			34 (75%)				Parenting				nt)	concurrent
		parenting			primipara,				Stress					social risk
		stress, and			45%				Index				То	
		family			tertiary				(PSI)				examine	
		functionin			education								whether	
		g			at two,								multiple	
					57%								birth and	
					tertiary								bereaveme	
					education								nt were	
					at seven,								associated	
					58%								with	
					profession								greater	
					al								parenting	
1					occupation							1	stress,	
1					at two.							1	linear	
1					57%							1	regression	
1					profession							1	models	
1					al							1	were fitted	
					occupation								at the child	

		at seven,				level using	
		97% intact				Generalise	
		family				d	
		structure at				Estimating	
		two, 80%				Equations(
		intact				GEEs)	
		family					
		structure at					
		seven					

Author and Year	Study Title	Study Aim	Researc h Questio n	Study Setting	Populati on Demogr aphics	Gestatio nal Age	Age at which the baby died	Sample Strategy /Size	Psycho metric Measur e Used (if applica ble)	Study Design	Method of Data Collecti on	Ethical Issues	Method of Analysis	Summa ry of Experie nces	Theoret ical Framew ork	Theme(s) Identifie d	Method ological Comme nts
Burkhammer et al., 2003	Grief, anxiety, stillbirth , and perinatal problem s: healing with kangaro o care	Not clear	Not given	Not explicitl y stated	Maternal age= 23	27 weeks	28 weeks (antepart um stillbirth)	Case study (n=1)	N/A	Case study	Method not explicitl y stated but mother was visited by research ers	Not given	Not given	"Kim" was a 23-year- old, single mother who experien ced pregnan cy- specific anxiety during her first pregnan cy that ended with a stillbirth at 28 weeks.	Not given	None (was a case study with results presente d narrative ly)	None

							-	1	
							Four		
							months		
							later, she		
							became		
							became		
							pregnant		
							again		
							and		
							experien		
							ced		
							faalinga		
							reenings		
							OI		
							anxiety,		
							attachme		
							nt. and		
							hypervig		
							ilanaa		
							nance		
							mixed		
							with		
							grief.		
							Her		
							newborn		
							newborn		
							son was		
							placed		
							skin to		
							skin on		
							her chest		
							for the		
							first time		
							inst time		
							and Kim		
							was		
							overcom		
							e with		
							memorie		
							s of		
							s UI		
							notaing		
							her		
							stillborn		
							son,		
							which		
							caused		
							the		
							ule 1		
							research		
							team to		
							interven		
							e. As she		
							continue		
							d ekin		
							to skin-		
							breastfee		
							ding, the		
							stories		

								of her		
								stillborn		
								son		
								continue		
								d, and		
								she		
								reported		
								an		
								improve		
								ment in		
								breastfee		
								ding		
								ease and		
								а		
								stronger		
								bond		
								with her		
1								baby		

	Recurre	То	Not	Explicit	Maternal	Experien	Experien	n=1	N/A	Case	Two	Intervie	Framew	Results	Lazarus	Causal	None
	nt	examine	given	location	age=30.	ced	ced	(case		study	open	ws were	ork	demonst	and	antecede	
	nerinatal	the	8	not	experien	three	three	(tudy)			ended	limited	focused	rated	Folkman	nts	
	lossi	impost		givon	and three	norinotal	norinotal	study)			intorvio	to two	on	that the	'o	modiatin	
	loss: a	impact		given	ced unee	permatar	permatar	D			Intervie		011	that the	8	mediatin	
	case	OI			perinatai	losses	losses	Part of a			ws were	nours	Lazarus	prior	theory of	g	
	study	recurrent			losses	(18	(18	larger			conducte	and	and	perinatal	stress	processe	
		perinatal			(18	weeks,	weeks,	phenom			d in the	collected	Folkman	losses	and	s,	
		loss on a			weeks,	26	26	enologic			mother's	over at	's	were not	coping	immedia	
		low			26	weeks	weeks	al study			home	least two	theory of	critical		te effects	
		income			weeks	where	where	5			between	intervie	stress	compon			
		A frican-			where	preterm	preterm				seven	w	and	ents of			
		Amorico			protorm	labour	labour				and nine	sossions	aoning	the wey			
		America				laboui	laboui					sessions	coping -	the way			
		n parent			labour	was .	was .				weeks		data was	the			
					was	experien	experien				after the		coded	mother			
					experien	ced, 12	ced, 12				most		accordin	responde			
					ced, 12	weeks	weeks				recent		g to	d to her			
					weeks	gestation	gestation				loss		three	most			
					gestation) - fifth) - fifth						categori	recent			
) - fifth	pregnan	pregnan						es from	loss			
6					pregnan	cy was	cv was						the	Percenti			
66					pregnan	cy was	cy was						fromorio	or of the			
.,1					cy was	lourth	lourth						Iramewo	on of the			
log					fourth	loss (25	loss (25						rk	care she			
arts					loss (25	weeks	weeks						(antecen	received			
be					weeks	gestation	gestation						dents,	from			
Rı					gestation	with	with						mediatin	healthca			
&					with	preterm	preterm						g	re			
gh					preterm	labour)	labour)						processe	provider			
an					labour)								s	s and			
'an					iuoour)								immedia	how this			
av													ta	now uns			
X														related			
													effects)	to ner			
														experien			
														ces with			
														her one			
														living			
														child			
														who was			
														horn at			
														the serve			
														the same			
														gestation			
														al age			
														was an			
														importan			
														t			
														determin			
														ant in the			
														response			
														to the			
														to the			
		1	1	1	1			1		1	1		1	IOSS		1	

	Counseli ng for	To explore	Not given	Not clear	Neonate characte	Mean(S D)	Not given	n=28 neonates	Open ended	Cross- sectional	Participa nts were	Not given	Content analysis	Participa nts	Not given	Guidanc e by	None
	personal	the	C		ristics	gestation	C	Identifie	text	survey	sent a	0		preferre	Ŭ	healthca	
	care	personal			(n=28):	al		d	boxes		contact			d lots of		re	
	options	care			Mean(S	age= 28 .		through			letter to			options		provider	
	at neonatal	offered			D) gestation	6(6.8)		records			complet e the			when their		S: Importa	
	end of	to			al			and			survey -			infant		nce of	
	life: a	parents			age= 28 .			contacte			other			was		receivin	
	quantitat	as well			6(6.8),			d for			demogra			coming		g	
	ive and	as			62.5%			recruitm			phic and			to the		informat	
	qualitati	parental			male, 24			ent via a			clinical			end of		ion to	
	ve	percepti			(86%)			letter			data was			their life		assist	
	survey	the			n = 12						via chart					decision	
	survey	counselli			(43%)						review					making	
		ng they			diagnose											by being	
		received			d with											presente	
(y)		regardin			prematur											d with	
on		g these			ity											choices	
ive		options														and	
litat		infant's														options	
lual		end of														Making	
5 (6		life														memorie	
201																s:	
ц., ;																Parents	
et s																apprecia	
itz																memorie	
KOW																s to take	
hell																away	
S																with	
																them as	
																that was	
																had -	
																these	
																included	
																memorie	
																s boxes,	
																handprin	
																ts, footprint	
																s, photos	
																., F	
																Feeling	
																cared for	
																and	
						1									l	d.	
			1	4												4 44.	

							r	
								Importa
								nce of
								facting
								leening
								cared for
								during a
								difficult
								time
								time
								Regrets/
								wishes:
								Describe
								d
								leenings
								of regret
								over
								what
								they
								wished
								1 1
								would
								have
								happene
								d e.g.
								spending
								spending
								more
								time
								with the
								baby
								-

Suj	pplementary	Material (1	Table 4): Cr	itical appra	isal for case	e control stu	dies.					
			Section A: A	re the results of th	ne study valid?			Section	B: What are the	results?	Section C: Will loca	the results help lly?
	1. Did the study address a clearly focussed issue? HINT: An issue can be 'focused' in terms of the population studied, whether the study tried to detect a beneficial or harmful effect, the risk factors studied	2. Did the authors use an appropriate method to answer their question? HINT: Consider is a case control study an appropriate way of answering the question under the circumstance s, did it address the study question	3. Were the cases recruited in an acceptable way? HINT: We are looking for selection bias which might compromise validity of the findings, are the cases defined precisely, were the cases representativ e of a defined population (geographical ly and/or temporally), was there an established reliable system for selecting all the cases, are they incident or prevalent, is there something special about the cases, is the time frame of the study relevant to disease/expos ure, was there a sufficient number of cases selected, was	4. Were the controls selected in an acceptable way? HINT: We are looking for selection bias which might compromise the generalisabili ty of the findings, were the controls representativ e of the defined population (geographical ly and/or temporally), was there something special about the controls, was the non- response high, could non- respondents be different in any way, are they matched, population based or randomly selected, was there a sufficient number of	5. Was the exposure accurately measured to minimise bias? HINT: We are looking for measurement , recall or classification bias, was the exposure clearly defined and accurately measured, did the authors use subjective or objective measurement s, do the measures truly reflect what they are supposed to measure (have they been validated), were the measurent methods similar in the cases and controls, did the study incorporate blinding where feasible, is the temporal relation	6. (a) Aside from the experimental intervention, were the groups treated equally? HINT: List the ones you think might be important, that the author may have missed, genetic, environment al, socio- economic	6. (b) Have the authors take account of the potential confounding factors in the design and/or in their analysis? HINT: Look for restriction in design, and techniques e.g., modelling, stratified-, regression-, or sensitivity analysis to correct, control or adjust for confounding factors	7. How large was the treatment effect? HINT: Consider what are the bottom line results, is the analysis appropriate to the design, how strong is the association between exposure and outcome (look at the odds ratio), are the results adjusted for confounding still explain the association, has adjustment made a big difference to the OR	8. How precise was the estimate of the treatment effect? HINT: Consider size of the p- value, size of the confidence intervals, have the authors considered all important variables, how was the effect of subjects refusing to participate evaluated	9. Do you believe the results? HINT: Consider big effect is hard to ignore! Can it be due to chance, bias, or confounding, are the design and methods of this study sufficiently flawed to make the results unreliable, consider Bradford- Hills criteria (e.g., time sequence, dose- response gradient, strength, biological plausibility)	10. Can the results be applied to the local population? HINT: Consider whether the subjects covered in the study could be significantly different from your population to cause concern, your local setting is likely to differ much from that of the study, can you quantify the local benefits and harms	11. Do the results of this study fit in with other available evidence? HINT: Consider all the available evidence from RCT's, Systematic Reviews, Cohort Studies, and Case Control Studies as well, for consistency

			there a power calculation	controls selected	correct (does the exposure of interest precede the outcome)							
Arach et al.,	Y	Y	Y Power calculation was conducted	Y	Y	Y	Y	Analysis was appropriate, controlled for confounders	Confidence intervals were small	Yes	Y	Y
Armstrong & Hutti, 1998	Y	Y	Y Power calculation was not conducted	Y	Y	Y	N No consideration of confounders	Results not adjusted for confounding - just assessed whether there was a significant difference between the groups	Can't tell (only p-values reported)	Partially - confounders were not considered	Y	Y
Couto et al., 2009	Y	Y	Y Power calculation conducted	Y	Y	Y	N	Results not adjusted for confounding – just assessed whether there was a significant difference between the groups	Can't tell (only p-values reported)	Partially – recruitment and design were robust but confounders were not considered	Y	Y
Janssen et al., 1996	Y	Y	Y Power calculation was not conducted	Y	Y	Y	Y Only considered reproductive history	Results only considered reproductive history - just assessed whether there was a significant difference between the groups	Confidence intervals not reported for these analyses	Yes	Y	Y

	Y	Y	Y	Y	Y	Y	Y	Analysis was	Important	Yes - authors	Y	Y
								appropriate	variables	controlled for		
			No power	Completed the		Questionnaire	Yes, but how	to the design,	appear to be	a wide range	Yes, but	
			calculation	same		s completed in	variables were	but adjusting	considered,	of	most	
			was conducted	measures at		the same	decided to be	for the	although	confounders,	participants	
)23				the same		gestational	included is not	confounders	ethnicity was	cases and	were	
2(gestational		week	clear	did not make	not reported	controls	married/cohab	
al.,				week in the				a big	or controlled	were selected	iting and at	
et				same settings				difference to	for	appropriately	least high	
ilat				– only the				the	Size of		school	
lair				experience of				regression	confidence		educated, with	
N				the loss was				coefficients -	intervals are		a	
				different				confounding	moderate		good/medium	
								may go some			economic	
								way to			situation	
								explaining				
	X/	N7	V	X7	N7	X7	N	the results	Q 14 4 11	D (* 11	X7	N/
	Ŷ	Ŷ	Ŷ	Ŷ	Ŷ	Ŷ	N	Results not	Can't tell	Partially -	Ŷ	Ŷ
~			Down					adjusted for	(only p-values	contounders		
023			Power					inst	reported)	were not		
, 5			calculation					- Just		and only n		
al			conducted					whether		values were		
l et								there was a		reported not		
sac								significant		the full		
Pra								difference		statistics		
								between the		statistics		
								groups				
N/R	V=Ves. N=No. C	T=Can't Tell_C	omments are inclu	ded in the same	hox where annlic	able					1	

Supp	olementary	[,] Material	(Table 5):	Critical a	appraisal	for cohort	t studies.							
			Section	A: Are the res	ults of the stud	lv valid?			Section	B: What are th	e results?	Section C: V	Vill the results	help locally?
	1. Did the study address a clearly focussed issue? HINT: A question can be 'focused' in terms of the population studied, the risk factors studied, is it clear whether the study tried to detect a beneficial or harmful effect, the outcomes considered	2. Was the cohort recruited in an acceptable way? HINT: Look for selection bias which might compromis e the generalisa bility of the findings, was the cohort representa tive of a defined population , was there something special about the cohort, was everybody included who should have been	Section 3. Was the exposure accurately measured to minimise bias? HINT: Look for measurem ent or classificati on bias, did they use subjective or objective measurem ents, do the measurem ents truly reflect what you want them to (have they been validated), were all the subjects classified into exposure groups using the same procedure	A: Are the res 4. Was the outcome accurately measured to minimise bias? HINT: Look for measurem ent or classificati on bias, did they use subjective or objective measurem ents, do the measurem ents truly reflect what you want them to (have they been validated), has a reliable system been established for detecting all the cases (for measurem ent measurem ent subjective been or objective been established for detecting all the cases (for measurem ent measurem ent measurem ent been established for measurem ent measurem ent been established for measurem ent measurem ent measurem ent measurem measurem ent measurem ent measurem ent measurem ent measurem ent measurem ent measurem ent measurem ent measurem ent measurem ent measurem ent measurem ent measurem ent measurem ent measurem ent measurem ent measurem ent measurem ent	ults of the stud 5. (a) Have the authors identified all important confoundin g factors? HINT: list the ones you think might be important, and ones the author missed	y valid? 5. (b) Have they taken account of the confoundin g factors in the design and/or analysis? HINT: Look for restriction in design, and techniques e.g., modelling, stratified-, regression-, or sensitivity analysis to correct, confoundi ng factors	6. (a) Was the follow up of subjects complete enough? HINT: Consider the good or bad effects should have to be long enough to reveal themselves , the persons that are lost to follow-up may have different outcomes than those available for assessment , in an open or dynamic cohort was there anything special about the outcome of the people leaving, or the exposure of the people entering	6. (b) Was the follow up of subjects long enough?	Section 7. What are the results of this study? HINT: Consider what are the bottom line results, have they reported the rate or the proportio n between the exposed/u nexposed, the ratio/rate difference, how strong is the associatio n between exposure and outcome (RR), what is the absolute risk reduction (ARR)	B: What are th 8. How precise are the results? HINT: Look for the range of the confidence intervals, if given	e results? 9. Do you believe the results? HINT: Consider big effect is hard to ignore, can it be due to bias, chance, or confoundin g, are the design and methods of this study sufficiently flawed to make the results unreliable, Bradford Hills criteria (e.g., time sequence, dose- response gradient, biological plausibility, consistency)	Section C: V 10. Can the results be applied to the local population ? HINT: Consider whether a cohort study was the appropria te methods to answer this question, the subjects covered in this study could be sufficientl y different from your populatio n to cause concern, your local setting is likely to differ much from that of the study, you can quantify the local benefits and harms	Vill the results 11. Do the results of this study fit with other available evidence?	help locally? 12. What are the implication s of this study for practice? HINT: Consider one observatio nal study rarely provides sufficiently robust evidence to recommen d changes to clinical practice or within health policy decision making, for certain questions, observatio nal studies provide the only evidence, recommen dations from observatio nal studies are always stronger when supported by other evidence
				the			the cohort							

				different groups, were the subjects and/or the outcome assessor blinded to the exposure (does this matter)										
Côté-Arsenault, 2007	Y	Y	Y	Y	N None identified	N None were controlled for in the hierarchical regression analyses	Y Those lost to follow up were not reported	Y	Pregnancy subsequent to loss is perceived as a threat, and this strongly predicted pregnancy anxiety. Pregnancy anxiety decreased over time, but threat appraisal and coping remained stable	CIs not necessary to report for these analyses	Can't tell - small sample size, no control for confounders	Y	Y	Y Anxiety should be addressed at each prenatal visit, but most notably in the first trimester when it is likely to be highest
Côté-Arsenault & Dombeck, 2001	Y	Y	Y	Y	N No confounder s identified or controlled for	N No confounder s identified or controlled for			Assignmen t of personhoo d was significantl y related to pregnancy anxiety and to the gestational age of the first loss but not to state anxiety	CIs not applicable to this analysis	Partially - small sample size but no control for confounders in the analysis so would need to be repeated	Y	Y	Y

	Y	Y	Y	Y	Y	Y	Y	Y	After	Moderate	Yes - wide	Y	Y	Y
									adjusting	range of	range of			
		Community		Used		Wide range			for	confidence	confounders			Monitor
		health		validated		of			covariates,	intervals	controlled			women
		survey		measures of		confounder			bereaved		for, large			during
14				anxiety,		s adjusted			mothers		sample size,			subsequent
20				social		for			had higher		inclusion of			pregnancies
al.,				phobia and					odds of		a control			and
et				OCD					moderate-		group			consider
old									severe					targeted
ŭ									GAD and					interventio
									social					ns
									phobia, but					
									not panic					
									disorder or					
									OCD					

-														
	Y	Y	Y	Y	Y	Y	Y	Y	Women	Moderate-	Yes - large	Y	Y	Y
									pregnant	to high	sample size,			
						They			after	range in	robust			
						differed for			stillbirth	CIe	analyses			
						unicica ioi			had a	C15	anaryses			
						each			nad a		controlling			
						analysis			higher		for			
									prevalence		confounders			
									of anxiety					
									(22.5%)					
									and					
									domnassion					
									depression					
									(19.7%)					
									compared					
									with					
									women					
									with a					
									with a					
									previous					
									live birth					
									and					
									previously					
									nulliparous					
~									women					
01:									Gastational					
, 5									Gestational					
al.									age at					
et									stillbirth (>					
en									30 weeks)					
stee									and inter-					
sue									pregnancy					
avi									interval <					
5									12 months					
-									12 monuts					
									were not					
									associated					
									with					
									depression					
									and/or					
									anxiety					
									Anviety					
									and					
									depression					
									decreased					
									six to 18					
									months					
									after the					
									birth of a					
									live horm					
									haba 1					
									baby, but					
									increased					
									again 36					
									months					
									postpartum					
									1					
			1	1	1	1						1 · · · · · · · · · · · · · · · · · · ·		

				Relationshi			
				р			
				satisfaction			
				did not			
				differ			
				between			
				groups.			

Y Y	-									DEGD	CT .	D	••		
Storeward symptoms reported for small analyses analyses analyses analyses analyses analyses analyses bereventer bereventer bereventer analyse bereventer <td></td> <td>Y</td> <td>Y</td> <td>Y</td> <td>Y</td> <td>N</td> <td>N</td> <td>Y</td> <td>Y</td> <td>PISD</td> <td>CIs not</td> <td>Partially –</td> <td>Y</td> <td>Y</td> <td>Y</td>		Y	Y	Y	Y	N	N	Y	Y	PISD	CIs not	Partially –	Y	Y	Y
Point Image: set of the se										symptoms	reported for	small			
Signature Image: set of the set										decreased	these	sample size,			
TO C										between 3	analyses	no control			
Year Image: Control of the second secon										and 6	unuryses	for			
S0 Critical Construction Image: Construction of the construc										and 0		101			
SCC - bestive - bestive - bestive VE - bestive <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>months.</td> <td></td> <td>contounders</td> <td></td> <td></td> <td></td>										months.		contounders			
SQ 1 Image: second										Positive		, but robust			
SP p between and and concurrent frequency of PTSD Work- Work- View related n View related positively and Self- Bianed Biane										relationshi		analysis			
Sign 2 Imminiation and and and concurrent respensely of TTSD symptoms. Negative Self-View and an Nearber Work-Weited Work-Weited Work-Weited Work-Weited Positively and Self-Blame related negatively to the concurrent mamber of PTSD Symptoms. Sign 2000 Positively and Self-Blame and Self-Blam										p between		-			
Signal Image: Signal Signa										rumination					
YOT TO THE ADDRESS AND										and					
YOUTING Concurrent Incurrent Wegative World Provide Self-View and Negative World Provide Provide Provide										anu					
YOC, 'T and 'T A Construction's and 'T A Constr										concurrent					
S0 of PTSD Symptoms. Negative and Negative World- World- World- World- Weiew related and Self- Blame related and Self- Blame related Blame related and Self- Blame related and Self- Blame related										frequency					
STOT Transmitter STOT Self-View Negative Self-View Negative Self-View Negative Self-View World- View View Positive's Blame Blame related negatively to to Occurrent number of PTSD Suppression Suppression and Distractional Distractional an increase an increase an increase an increase Baged Baged PTSD PTSD Suppression an increase an increase an increase an increase an increase Baged PTSD Symptoms. Risk Risk Risk Risk Risk Risk PTSD Symptoms Symptoms										of PTSD					
Statistics Negative Self-View and Negative World- World- Pelated Prelated Blame related negatively occurrent mumber of PTSD Suppression and Distraction predicted a decrease a and Numbing predicted a increase an increase in increase an increase in increase an increase in increase an increase PTSD PTSD PTSD										symptoms.					
SOC "THE DEPARTMENT Solf View mad Negative Works Negative Works View related relatively and Self- Blame related and Self- Blame related 1 Dispersion and Self- Blame related and Self- Blame related 2 Dispersion and decrease and and Numbing predicted an increase and number of PTSD 3 Dispersion and Blaged and Numbing predicted an increase and Numbing predicted an increase and number of PTSD										Negative					
Status add Negative World- View View Polated positively add Self- Biame Biame related negatively ococurrent ococurrent number of PTSD Suppressio add Numbing pression nand Distraction pression add Numbing pression nime- lagged namber of PTSD Symptoms suppression nand Numbing pression add Numbing PTSD Symptoms Symptoms Symptoms Symptoms PTSD Symptoms Numbing PTSD Symptoms Symptoms PTSD Symptoms Symptoms Symptoms PTSD Symptoms										Salf View					
SOCT and World- View Neegaive World- View Pailed related positively and Self- Blane Bane related negaively to concurrent negaively to concurrent number of PTSD PTSD symptoms, Suppression and decrease and Numbing predicted a laged and and strators for PTSD symptoms, Kisk Risk Risk Risk symptoms, Symptoms, Symptoms, Risk Risk symptoms, Symptoms, Symptoms, Risk										Sell-view					
SOC Title SUBJECT Biame related positively and Self Biame related related negatively 0 concurrent number of PTSD PTSD symptoms. symptoms. and and mumber of predicted a decrease and and Numbing predicted a decrease and number of PTSD predicted a decrease and and number of PTSD symptoms. symptoms. Kisk Symptoms. Symptoms. Symptoms.										and					
Story of the second sec										Negative					
SQ Tister View Tister Positively And Positively Blame related Blame related Regatively 0 Concurrent number of Provide Symptoms. Symptoms. an and Blame an and related negatively Concurrent number of Provide Positively Blame Blame Concurrent number of Provide Blame Blame Blame Blame Blame Concurrent number of Provide Blame Blame Blame										World-					
SOC related positively and Self- Blame related related negatively related negatively related negatively related negatively related negatively related number of PTSD PTSD Suppressio name Distraction predicted and and and Number of PTSD suppressio name nime-of predicted and and nime-of PTSD suppressio name and Distraction predicted and and number of PTSD suppressio name and Numbing predicted and and Numbing predicted number of PTSD Symptoms. Risk Risk Risk Risk Risk Risk Risk Risk PTSD										View					
SC TT										related					
OC	2									positively					
rigged number of structure and solve later related negatively oto concurrent number of PTSD Symptoms. Suppressio n and Distraction predicted a decrease and Numbing predicted a in ime- lagged number of PTSD PTSD PTSD	01									and Solf					
rig Bame related negatively to concurrent number of PTSD PTSD symptoms. Suppressio n and Distraction predicted a decrease an increase in time-of PTSD Suppressio symptoms. Suppressio symptoms. Suppressio nad Distracted a decrease decrease an increase in time- lagged number of PTSD Symptoms. Risk factors for PTSD Symptoms symptoms										allu Sell-					
To related negatively to to concurrent number of PTSD Symptoms. Suppressio n and Distraction predicted a decrease and Numbing predicted an increase in increase in increase in time- lagged number of PTSD symptoms. Risk ifactors for PTSD symptoms symptoms	al.									Blame					
1 1	et									related					
P 0 0 Output 0 0 PTSD PTSD Suppression Numbing 0 0 PTSD 0 0 Suppression 0 0 Numbing 0 0 PTSD 0 0 Suppression 0 0 Image: Comparison of the second of the	ch									negatively					
Image: Construct in the second sec	OLS									to					
number of PTSD Swptpms. Suppressio n and Distraction predicted a decrease and Numbing predicted a decrease in time- lagged number of PTSD symptoms. Risk factors for PTSD Symptoms	Ĕ									concurrent					
PTSD symptoms. Suppression n and Distraction predicted a decrease and Numbing decrease in time- lagged number of PTSD symptoms. Risk factors for PTSD symptoms.										number of					
Image: Construction of the symptoms of the symptom symptoms of the symptom symptom symptom symptom symptoms of the symptom symp										DTSD					
Symptoms. Suppressio n and Distraction predicted a decrease and Numbing predicted an increase in time- lagged number of PTSD Symptoms. Risk factors for PTSD Symptoms										TISD					
Supressio n and Distraction predicted a decrease and Numbing predicted an increase in time										symptoms.					
Image: state of the state										Suppress10					
Distraction predicted a decrease and Numbing predicted an increase in time- lagged number of PTSD symptoms. Risk factors for PTSD symptoms.										n and					
Image: state of the state										Distraction					
decrease and Numbing predicted an increase in time- lagged number of PTSD symptoms. Risk factors for PTSD symptoms										predicted a					
and Numbing predicted an increase in time- lagged number of PTSD symptoms. Risk factors for PTSD symptoms										decrease					
and Numbing predicted an increase in time- lagged number of PTSD symptoms. Risk factors for PTSD PTSD Symptoms.										and					
Number predicted an increase in time- lagged number of PTSD symptoms. Risk factors for PTSD Symptoms Risk factors for PTSD Symptoms Symptoms Symptoms symptoms symptoms symptoms										Mumbie -					
Image: specific definition of the spe										Numbing					
an increase in time- lagged number of PTSD Symptoms Risk Risk Risk PTSD Symptoms										predicted					
in time- lagged number of PTSD symptoms. Risk factors for PTSD symptoms symptoms										an increase					
Image: Image of the symplement										in time-					
number of PTSD symptoms. Risk factors for PTSD symptoms										lagged					
PTSD symptoms. Risk factors for PTSD symptoms										number of					
symptoms. PTSD Symptoms symptoms										PTSD					
Symptoms. Risk factors for PTSD symptoms										aumetores					
Risk factors for PTSD symptoms										symptoms.					
factors for PTSD symptoms										R1Sk					
PTSD symptoms										factors for					
symptoms										PTSD					
										symptoms					
were										were					

									younger age, lower income, fewer previous pregnancie s, and poorer perceived social support					
Lewkowitz et al., 2019	Y	Y Cohort was limited to Florida, but the cohort was clearly defined and reasons for exclusion were given	Y Coded using ICD criteria	Y Unclear if the outcome assessor was blinded to the exposure	Y Psychiatric disorders during pregnancy were excluded from the study	Y Potential confounds controlled for and sensitivity analysis conducted	Y	Y 12 months	Women who have experience d stillbirth are more than twice as likely to have psychiatric morbidity compared to women who give birth to a live infant. They also are at increased risk of inpatient psychiatric care or Emergency Departmen t admission - results suggest the highest risk interval for psychiatric illness is within the first 4 months after stillbirth	Range of confidence intervals is generally quite small, but were larger for the hazard ratios analysis	Yes - the analysis controlled for a wide range of confounding variables, data were from a hospital and state database, also conducted a sensitivity analysis	Y Yes but was conducted in a high income country, participant s were predomina ntly of low SES	Y	Y Recommen ds to screen all women for depression and anxiety after delivery, but to provide individualis ed care within the first 3 months

	Y	Y	Y	Y	N	N			EPDS	CIs are	Partially -	Y	Y	Y
									scores	very large	moderate			
3					No	No			significantl		sample size			Suggests
502					confounder	confounder			y higher in		but no			screening
:					s identified	s identified			women		control for			for
t al					or	or			with a		confounders			depression
le					controlled	controlled			history of		in the			whilst in
zdi					for	for			perinatal		analysis so			NICU
0									loss		would need			
											to be			
											repeated			
	Y	Y	Y	Ν	N	Y	Y	Y	Women	Confidence	Can't tell -	Y	Y	
									who held	intervals	needs to be			
		Efforts		Although	Only three				their	are large -	a wider			Y
		were made		questions	confounder				stillborn	the authors	control for			
		to		about	s				baby had	suggest this	confounders			Highlights
		diversify		psychologi	were				higher	is	, no power			the need for
		the sample		cal	controlled				rates of	because a	calculation			more
		(i.e., survey		wellbeing	for, and it				mental	very low	was			research on
		offered in		were based	was unclear				health and	number of	conducted			longer-term
016		18 different		on other	how these				relationshi	women saw	for the			outcomes
20		languages)		national	were				р	(and did	sample size,			
al.,		000		surveys, the	identified				difficulties	not hold)	small			
et				questions	to be					their baby	proportion			
aw				were not	included in						of women			
sha				clear, and it	the analysis						saw (but did			
ked				was unclear							not hold) the			
ц				if the							baby			
				questionnai							5			
				res had										
				been										
				validated or										
				were										
				appropriate										
				for the										
				population										

	Y	CT	Y	Y	Y	Y	CT	Y	Prior live	CIs	Yes - large	Y	Y	Y
									term birth	moderate in	sample size,			
		Exact		Yes -	Controls		Those lost		was	regression	controls for			Suggests
		recruitment		although	for a wide		to follow		associated	analyses	a wide range			further
		strategy		some	range of		up were not		with lower		of			research on
		unclear		measures	confounder		reported		pregnancy		confounders			guilt
				were not	s		_		anxiety in		but			-
				explicitly					all three		recruitment			
				named just					trimesters,		strategy			
				described					whereas		could be			
									prior		described			
									miscarriag		more			
~									e was					
01									significantl					
:									у					
t al									associated					
0 6									with higher					
pir									pregnancy					
ha									anxiety in					
01									the first					
									trimester					
									Prior					
									stillbirth					
									was					
									associated					
									with					
									greater					
									pregnancy					
									anxiety in					
									the third					
									trimester					

	Y	Y	Y	Y	Ν	Y	Y	Y	Compared	Confidence	Can't tell –	Y	Y	Y
									with	intervals	needs to be			
				Used	Only social	Only social	Those lost		mothers	are very	a wider			Highlights
				validated	risk was	risk was	to follow		who had	large	control for			the need to
				scales for	controlled	controlled	up		not		confounders			be offered
				anxiety and	for - it was	for - it was	were not		experience					longer-term
				depression	not clear	not clear	reported -		d					support as
16					how this	how this	just that		bereaveme					initial
20					was	was	there was		nt, mothers					assessment
					decided or	decided or	some		who had					s may not
et a					if other	if other	missing		were more					reveal any
pi d					potential	potential	data but not		likely to					difficulties
vaı					confounds	confounds	clear if this		report					
ey					were	were	was due to		elevated					
Ē					controlled	controlled	loss from		anxiety					
					for in the	for in the	follow up		and					
					analysis	analysis			depression					
									symptoms					
									at seven					
									years (but					
									not two					
									years)					
<i>N/B.</i> Y	N/B. Y=Yes, N=No, CT=Can't tell. Comments are included in the same box where applicable. 6a & 6b greyed out where studies are cross-sectional.													

		Section A: Are t	Section	Section C: Will the results help locally?					
1. Was there a clear statement of the aims of the research? HINT: What was the goal of the research? Why it was thought important? Its relevance	2. Is a qualitative methodology (or quasi- experimental or mixed methods) appropriate? HINT: Consider if the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants. Is qualitative research the right methodology for addressing the research goal?	3. Was the research design appropriate to address the aims of the research? HINT: Consider if the researcher has justified the research design e.g., have they discussed how they decided which method to use	4. Was the recruitment strategy appropriate to the aims of the research? HINT: Consider if the researcher has explained how the participants were selected, if they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought after by the study, if there are any discussions around recruitment (e.g., why some people chose not to take part)	5. Was the data collected in a way that addressed the research issue? HINT: Consider if the setting for the data collection was justified, if it is clear how data were collected (e.g., focus group, semi- structured interview, etc.), if the researcher has justified the methods chosen, if the researcher has made the methods explicit (e.g., for interview method, is there an indication of how interviews are conducted, or did they use a topic guide), if methods were modified during the study if so has the researcher explained how and why, if the form of data is clear (e.g., tape recordings, video material, notes etc.), if the researcher has	6. Has the relationship between researcher and participants been adequately considered? HINT: Consider if the researcher has critically examined their own role, potential bias and influence during (a) formulation of the research questions (b) data collection, including sample recruitment and choice of location. How has the researcher responded to events during the study and whether they considered the implications of any changes in the research design	7. Have ethical issues been taken into consideration? HINT: Consider if there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained, if the researcher has discussed issues raised by the study (e.g., issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study, if approval has been sought from the ethics committee	8. Was the data analysis sufficiently rigorous? HINT: Consider if there is an in- depth description of the analysis process, if thematic analysis is used if so is it clear how the categories/them es were derived from the data, whether the researcher explains how the data presented were selected from the data presented were selected from the original sample to demonstrate the analysis process, if sufficient data are presented to support the findings, to what extent contradictory data are taken into account, whether the research critically examined their own role, potential bias and influence during analysis	9. Is there a clear statement of findings? HINT: Consider whether if the findings are explicit, if there is adequate discussion of the evidence both for and against the research arguments, if the researcher has discussed the credibility of their findings (e.g., triangulation, respondent validation, more than one analyst), if the findings are discussed in relation to the original research question	10. How valuable is the research? HINT: Consider if the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g., do they consider the findings in relation to current practice or policy, or relevant research-based literature, if they identify new areas where research is necessary, if the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used

					saturation of data			data for presentation		
Burkhammer et al., 2004	N	Y	Y	СТ	СТ	CT Not mentioned	СТ	CT	Y	Not discussed in detail
Kavanaugh & Robertson, 1999	Y	Y	Y	Y	Y	CT Not mentioned	Y	СТ	Y	Not discussed in detail
Shelkowitz et al., 2015	Y	Y Quantitative was just descriptives of personal care options	CT Method was not justified or discussed but is appropriate for the aims of the research	Y	Y	CT Not mentioned	Y	СТ	Y	Not discussed in detail