



Review Article

Hope as a therapeutic resource in pregnancy after loss: operationalising woman-centred support in midwifery care

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ARTICLE INFO

Keywords:

Hope theory

Pregnancy after loss

Midwifery

Trauma-informed care

Perinatal grief

Woman-centred care

ABSTRACT

Background: Pregnancy after loss constitutes a particularly vulnerable period characterised by the paradoxical coexistence of fear and hope. Despite growing recognition of this phenomenon, significant gaps remain in understanding how hope can be operationalised as a structured therapeutic resource in midwifery practice.

Aim: This paper argues that hope can and should be operationalised as a structured, evidence-informed therapeutic intervention in midwifery practice, particularly in the care of women experiencing pregnancy after loss.

Discussion: Drawing on contemporary theories of hope as a cognitive-motivational process and trauma-informed care principles and illustrated through a single practice-based clinical vignette, this paper advances a theoretically informed conceptual model for operationalising hope in pregnancy after loss. The discussion explores how woman-centred interventions can support the coexistence of fear and hope, foster adaptive meaning-making, and facilitate emotional engagement with the ongoing pregnancy, while maintaining clinical coherence and transferability across maternity care settings.

Implications for Practice: This paper proposes that structured, evidence-informed interventions may meaningfully support women's emotional well-being during pregnancy after loss. The model challenges common practices of premature reassurance and suggests that fear and hope are not mutually exclusive. Midwives and maternity care providers can use hope-centred approaches to support women in reconstructing their parental project whilst honouring the memory of previous losses.

Conclusion: Hope is not a passive emotional state but an active therapeutic resource that may be intentionally cultivated through structured midwifery interventions, advanced communication skills, and the capacity to tolerate uncertainty.

Statement of significance

Problem or Issue	Standard antenatal care is inadequate for pregnancy after loss (PAL), characterised by persistent anxiety and the coexistence of grief and hope. Premature reassurance, the most consistently documented invalidating clinical response, increases women's sense of isolation and complicates psychological integration.
What is Already Known	Hope is recognised as a protective resource in PAL, yet no published model operationalises it as a structured, evidence-informed clinical intervention integrating hope theory with trauma-informed care.
What this Paper Adds	A five-component hope-facilitation model mapping Snyder's Hope Theory onto trauma-informed care principles; a three-

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dimensional conceptualisation of hope (informed, validated, integrated); a theory-to-practice mapping table; and the Herth Hope Index as a candidate outcome measure for future empirical validation.

Introduction

Pregnancy loss affects approximately 10-20% of recognised pregnancies, with miscarriage alone accounting for the majority of cases ([Practice Committee of the American Society for Reproductive](#)

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Medicine, 2020). For women who subsequently conceive, the resulting pregnancy, commonly described as a 'pregnancy after loss' (PAL), is characterised by heightened psychological vulnerability, including pervasive anxiety, the coexistence of fear and hope, and complex grief responses that coexist with the anticipation of a new life (Blackmore et al., 2011; Robinson et al., 2023). Recent qualitative evidence confirms that women in PAL pregnancies describe this experience as navigating a threshold state, simultaneously grieving a prior loss and guarding against premature emotional investment in the current pregnancy (Fernández-Basanta et al., 2023; Gower et al., 2023).

Theoretically, this threshold state has been conceptualised through the lens of liminality, the transitional, in-between space women occupy between the experience of loss and the uncertain future of a new pregnancy (Fernández-Basanta et al., 2023). Liminality captures the temporal suspension, identity ambiguity, and social disenfranchisement that characterise the PAL experience, illuminating why standard antenatal care, designed for uncomplicated pregnancies, is often experienced as inadequate or even harmful by this population (Robinson et al., 2023; Gower et al., 2023). Women in PAL pregnancies report that invalidating clinical responses, including premature reassurance and the minimisation of grief, exacerbate their sense of isolation and complicate psychological integration (Gower et al., 2023; Cacciatore et al., 2009).

Despite the recognised importance of hope as a protective psychological resource in PAL (Côté-Arsenault & Donato, 2007), hope remains rarely operationalised as a structured, evidence-informed clinical intervention in midwifery practice. Existing literature acknowledges the presence of hope in PAL but provides limited guidance on how midwives can intentionally cultivate it within the constraints of routine antenatal care. This gap is compounded by the absence of an integrated framework that connects hope theory with the principles of trauma-informed maternity care, a framework that has substantially developed since 2015 and is directly relevant to this population (Endres & Maurer, 2024; White et al., 2022).

This paper presents a theoretically informed conceptual discussion, illustrated through a single practice-based clinical vignette drawn from midwifery practice in Portugal. The vignette is used to make the theoretical argument practically tangible; it does not constitute empirical evidence of effectiveness, and no causal claims are made based on a single case. Drawing on Snyder's (2002) Hope Theory, extended through recent developments in hope research (Raphi et al., 2021; Piri et al., 2025; Solano et al., 2016), and integrated with trauma-informed care principles (Endres & Maurer, 2024; White et al., 2022; Cull et al., 2025), the discussion advances a five-component model for operationalising hope in PAL care. While this paper focuses on midwifery practice, the model's theoretical foundations make it transferable to obstetric and multidisciplinary maternity care settings.

Theoretical framework

Snyder's Hope Theory: goals, pathways, and agency

Snyder's (2002) Hope Theory conceptualises hope as a cognitive-motivational process comprising three interrelated components: goal-directed thinking, pathways thinking (the capacity to identify routes to achieve goals), and agency thinking (the motivation and perceived capability to pursue those pathways). Unlike affective models of hope, Snyder's framework emphasises hope as an active, learnable cognitive process amenable to clinical facilitation. This makes it particularly well-suited to the PAL context, where women's capacity for goal-directed thinking and perceived agency is systematically undermined by grief, anxiety, and prior traumatic experience.

Subsequent scholarship has extended and critiqued Snyder's model. Raphi et al. (2021) demonstrated in a randomised controlled trial with women following pregnancy loss that counselling based on Snyder's hope therapy significantly improved psychological well-being and quality of life compared to standard care, supporting the potential

applicability of hope-facilitation approaches in perinatal contexts; it should be noted, however, that this trial included women following induced abortion, and caution is warranted in extrapolating directly to the PAL (subsequent pregnancy) context, given differences in grief trajectories across types of loss. Piri et al. (2025) further showed that hope-based counselling reduced perceived stress and improved quality of life in pregnant women, supporting the translational potential of Snyder's framework in obstetric settings. Solano et al. (2016) further confirmed the utility of hope measurement instruments, particularly the Herth Hope Index, in chronic and uncertain illness contexts, supporting their applicability in PAL care. Critically, more recent conceptualisations foreground the relational dimension of hope: rather than residing solely in the individual, hope is co-constructed through therapeutic relationships and clinician behaviour, a dimension that Snyder's original model underemphasises.

Trauma-informed care principles in pregnancy after loss

The most relevant contemporary framework for PAL care is trauma-informed care (TIC), which has substantially developed since 2015 and is directly applicable to this paper's argument. TIC is grounded in six core principles: safety, trustworthiness and transparency, peer support, collaboration and mutuality, empowerment and choice, and cultural sensitivity (Endres & Maurer, 2024; White et al., 2022). In maternity settings, TIC has been operationalised through frameworks such as REVIVE (Endres & Maurer, 2024), which provides evidence-based nursing actions, safety, compassion, collaboration, communication, autonomy, and empowerment, for universal application in maternity care. The EMPATHY framework (Cull et al., 2025) provides evidence-based guidance for implementing trauma-sensitive conversations in maternity care, developed through participatory action research with over 1,600 women and 286 healthcare professionals, offering a structured yet flexible approach applicable to women affected by prior trauma, including pregnancy loss.

The integration of TIC with hope theory is conceptually coherent and clinically necessary. Premature reassurance, the most commonly reported invalidating clinical response in PAL (Gower et al., 2023; Cacciatore et al., 2009), violates the TIC principles of trustworthiness and empowerment by denying the reality of risk and foreclosing emotional processing. By contrast, the hope-facilitation model proposed in this paper operationalises TIC principles through hope-focused communication, explicitly moving away from reassurance-based approaches towards uncertainty-tolerant, validated care.

Hope as a three-dimensional construct in pregnancy after loss

Building on the theoretical foundations above, this paper proposes that hope in the PAL context is best understood as a three-dimensional construct, each dimension reflecting a distinct therapeutic function:

Epistemic dimension - Informed Hope: Hope anchored in realistic assessment, acknowledging uncertainty and risk rather than denying it. Informed hope focuses on process and agency rather than guaranteed outcomes. It operationalises Snyder's pathways and agency thinking by equipping women with a realistic but forward-oriented cognitive framework.

Relational dimension - Validated Hope: Hope that emerges from therapeutic relationships in which fear is acknowledged, loss is honoured, and emotional experience is legitimised. Validated hope operationalises TIC principles of safety and trustworthiness and challenges the clinical norm of premature reassurance.

Integrative dimension - Integrated Hope: Hope that does not require the denial of grief but incorporates loss into a broader narrative of resilience and meaning-making. Integrated hope operationalises Snyder's goal-directed thinking by enabling women to hold the memory of prior loss alongside investment in the current

pregnancy, experiencing this as integration rather than contradiction.

These three dimensions are not sequential stages but overlapping therapeutic orientations that midwives can cultivate simultaneously, depending on the woman's clinical presentation and emotional readiness. They are used consistently throughout this paper and explicitly mapped to each component of the practice model in Section 3.

A five-component model for hope-facilitation in pregnancy after loss

The following five-component model operationalises the three-dimensional hope construct described above within midwifery practice. Each component is explicitly mapped to Snyder's Hope Theory constructs and to trauma-informed care principles. The model is illustrated through a single clinical vignette (Section 4), which serves an illustrative rather than an evidential purpose. The language used throughout reflects the exploratory and conceptual nature of this paper: observations from the vignette are described as suggesting or illustrating potential rather than demonstrating effectiveness.

Component 1. Emotional Validation as Foundation

Snyder construct : Agency thinking | TIC principles
 : Safety, Trustworthiness | Hope dimension
 : Epistemic + Relational hope (Informed + Validated)

Hope can only be authentically cultivated after fear and grief have been acknowledged. This component challenges the clinical norm of premature reassurance, a response that, while well-intentioned, has been identified in recent qualitative evidence as a key source of invalidation for women in PAL pregnancies (Gower et al., 2023; Robinson et al., 2023), increasing their sense of isolation and complicating psychological integration. Validation interventions begin with explicit acknowledgement of the woman's emotional experience: "I hear how frightened you are. That fear makes complete sense given what you have been through." This establishes therapeutic safety, the foundational TIC principle, and activates agency thinking by communicating that the woman's emotional experience is legitimate and that the clinician can tolerate uncertainty alongside her.

Component 2. Normalising Fear–Hope Coexistence

Snyder construct : Pathways thinking | TIC principles
 : Empowerment, Choice | Hope dimension
 : Epistemic + Relational hope (Informed + Validated)

Women in PAL pregnancies frequently report guilt about their fear-hope coexistence, perceiving fear as a betrayal of the current baby, or hope as a betrayal of prior losses (Côté-Arsenault & Donato, 2007; Fernández-Basanta et al., 2023). This component operationalises pathways thinking by providing women with a cognitive framework in which fear and hope are not contradictory but complementary: "It is possible to be afraid and, at the same time, to hold hope. These two feelings do not cancel each other out." This reframing may reduce guilt and support emotional integration, empowering women to engage with both emotional realities simultaneously.

Component 3. Systematic Reinforcement of Progress

Snyder constructs : Goals + Pathways thinking | TIC principles
 : Empowerment, Collaboration | Hope dimension
 : Epistemic hope (Informed)

Hope is sustained by concrete evidence of progress towards meaningful goals. In PAL, where women may experience profound powerlessness, identifying and reinforcing small, measurable achievements may restore a sense of agency and forward momentum. Interventions include daily acknowledgement of completing another day of pregnancy, reframing each day as a concrete achievement, and structured journaling of 'reasons for hope'. The journaling practice draws on evidence from expressive writing research demonstrating that structured reflection and emotional disclosure reduce anxiety and support psychological well-being in clinical contexts (Baikie & Wilhelm, 2005). This component operationalises both goals thinking (identifying the pregnancy as a meaningful goal) and pathways thinking (identifying daily progress as evidence of movement towards that goal).

Component 4. Facilitating Grief–Hope Coexistence

Snyder construct : Goals thinking | TIC principles
 : Peer support, Cultural sensitivity | Hope dimension
 : Integrative hope (Integrated)

A central challenge in PAL care is supporting women to honour the memory of previous losses while simultaneously investing emotionally in the current pregnancy. This component operationalises integrated hope by reframing the relationship between grief and hope from mutually exclusive to potentially complementary: "Loving this baby does not mean forgetting the baby you lost. You can hold both." Women are explicitly invited to speak about previous losses within the antenatal encounter, facilitating narrative integration. This approach aligns with TIC principles of cultural sensitivity and peer support by acknowledging that grief for prior losses is legitimate, ongoing, and compatible with hope for the current pregnancy. This reframing may support the development of integrated hope, hope that does not require the erasure of loss.

Component 5. Promoting Agency and Perceived Control

Snyder construct : Agency thinking | TIC principles
 : Empowerment, Choice | Hope dimension
 : Epistemic + Integrative hope (Informed + Integrated)

Perceived control is a critical determinant of psychological well-being in high-risk pregnancy (Farren et al., 2016). This component operationalises agency thinking by helping women identify areas where they have genuine agency, distinguishing between controllable and uncontrollable aspects of the situation. Interventions include collaborative identification of actions within the woman's control (e.g., clinic attendance, self-care, communication with her support network) and reframing fear into adaptive action: "What can you do today that feels like caring for this baby?" This approach enacts TIC principles of empowerment and choice by positioning the woman as an active participant in her own care rather than a passive recipient of clinical monitoring. [Table 1](#)

Clinical vignette: illustrative application

The following vignette is drawn from midwifery practice in a tertiary maternity unit in southern Portugal and is presented with the woman's written informed consent; all identifying details have been removed. This vignette serves as a practice-based illustration of the theoretical model described above. It is not presented as evidence of effectiveness, and no causal inferences should be drawn from a single case. The clinical context reflects the Portuguese healthcare system, in which the [Roper-Logan-Tierney model \(2001, Portuguese edition\)](#) provides the nursing framework; care models and systems vary across settings, and

Table 1

Five-component hope-facilitation model

Table 1. Five-component hope-facilitation model for pregnancy after loss midwifery care, showing theoretical basis, clinical communication examples, expected outcome indicators, and suggested measurement tools. HHI = Herth Hope Index; STAI = State-Trait Anxiety Inventory; TIC = Trauma-Informed Care.

Component	Theoretical Basis (Snyder + TIC)	Clinical Behaviour / Communication Example	Expected Outcome Indicator	Suggested Measurement Tool
1. Emotional Validation as Foundation	Agency thinking (Snyder); Safety & Trustworthiness (TIC)	"I hear how frightened you are. That fear makes complete sense given what you have been through."	Reduction in perceived isolation; increased therapeutic alliance	Herth Hope Index (HHI); Working Alliance Inventory
2. Normalising Fear-Hope Coexistence	Pathways thinking (Snyder); Empowerment (TIC)	"It is possible to be afraid and, at the same time, to hold hope. These two feelings do not cancel each other out."	Decreased guilt about fear; increased emotional integration	HHI subscale (temporality & future); Perinatal Grief Scale HHI;
3. Systematic Reinforcement of Progress	Goals + Pathways thinking (Snyder); Empowerment & Collaboration (TIC)	Daily acknowledgement: "You completed another day of this pregnancy. That is real progress." Structured journaling: one reason for hope per day.	Increased goal-directed thinking; reduced catastrophising	State-Trait Anxiety Inventory (STAI)
4. Facilitating Grief-Hope Coexistence	Goals thinking (Snyder); Peer support & Cultural sensitivity (TIC)	"Loving this baby does not mean forgetting the baby you lost. You can hold both."	Narrative integration of loss and hope; reduced disenfranchised grief	Perinatal Grief Scale; HHI
5. Promoting Agency and Perceived Control	Agency thinking (Snyder); Empowerment & Choice (TIC)	Collaborative identification of controllable actions (e.g., attendance, self-care). Reframing: "What can you do today that feels like caring for this baby?"	Increased perceived self-efficacy; reduced helplessness	HHI (agency subscale); General Self-Efficacy Scale

Note. Theoretical basis draws on [Snyder \(2002\)](#) for Hope Theory constructs and [Endres & Maurer \(2024\)](#) and [White et al. \(2022\)](#) for TIC principles. Measurement tool suggestions are indicative; formal validation in PAL samples is recommended as a priority for future empirical research.

adaptation may be required in other national contexts.

Ana (pseudonym) is a 29-year-old woman admitted to the antenatal ward at 22 weeks of gestation for premature rupture of membranes and threatened preterm labour. Her obstetric history includes four prior spontaneous early pregnancy losses, two twin pregnancies at 14 and 18 weeks, one at 20 weeks, and one at 5 weeks, and a diagnosis of cervico-isthmus incompetence for which cerclage was performed at 16 weeks of the current pregnancy. She presents with significant anxiety, sleep disturbance, and emotional withdrawal. She states, "I am afraid to hope. Every time I hope, something goes wrong."

Application of the five-component model

Component 1 - Emotional Validation: The midwife explicitly validates Ana's fear: "What you are feeling makes complete sense. You have been through real losses, and your fear is a natural response to that experience." This establishes therapeutic safety and communicates that her emotional reality will not be minimised.

Component 2 - Normalising Fear-Hope Coexistence: The midwife introduces the concept of fear-hope coexistence: "Many women in your situation feel exactly this way, afraid and hopeful at the same time. Those feelings can exist together." This reframing may reduce Ana's guilt about the coexistence of fear and hope, and support emotional integration.

Component 3 - Systematic Reinforcement of Progress: Daily acknowledgement of completing another day of pregnancy is introduced, alongside a structured journaling practice: each evening, Ana writes one reason for hope from that day. This practice draws on evidence supporting expressive writing and emotional disclosure in anxiety reduction ([Baikie & Wilhelm, 2005](#)) and operationalises pathways thinking by making progress visible and concrete.

Component 4 - Facilitating Grief-Hope Coexistence: The midwife invites Ana to speak about her previous pregnancies: "Tell me about the babies you lost. They are part of your story, and we can hold them alongside this pregnancy." This may support the development of integrated hope by positioning grief and hope as compatible rather than contradictory.

Component 5 - Promoting Agency and Perceived Control: The midwife collaboratively identifies what Ana can control: clinic attendance, self-care practices, and communication with her partner.

Fear is reframed as adaptive: "Your vigilance is a form of caring for this baby." This may support the restoration of agency thinking and reduce the sense of helplessness that characterises PAL anxiety.

Observed responses

The following observations are anecdotal, self-reported, and uncontrolled; they are presented as hypothesis-generating illustrations only, and no causal inferences should be drawn. After three nights, Ana reported subjective changes in sleep quality, with a reduction in nocturnal awakenings and greater ease falling asleep, attributing this to the journaling practice: "the most important thing that helped me rest my head." Regarding distress, Ana reported a self-rated reduction on a subjective visual analogue scale from 8/10 to 4/10, and demonstrated increasing capacity to identify and name her emotional experiences rather than somatise them, stating: "For the first time, someone did not tell me not to think about the losses, but helped me to think about them differently." She also articulated a shift in her understanding of the coexistence of fear and hope: "Before, I thought that having hope was denying fear. Now I realise that I can have both, and that hope is not naivety, it is courage." Ana was discharged at 24 weeks with close outpatient surveillance. The pregnancy progressed to 36 weeks and resulted in a spontaneous vaginal birth of a healthy newborn. These self-reported observations are illustrative only; they indicate the model's potential clinical plausibility and warrant formal empirical investigation using validated instruments and controlled designs.

Outcome measurement in this vignette was limited to clinical observation and self-report. Future empirical studies should employ validated instruments to assess hope in PAL contexts. The Herth Hope Index (HHI; [Herth, 1992](#)) is the most widely validated hope measurement instrument across clinical populations, demonstrating strong internal consistency and cross-cultural validity across multiple populations and languages ([Nayeri et al., 2020](#); [Solano et al., 2016](#)). Although the HHI has not yet been formally validated in PAL-specific samples, its psychometric properties and theoretical alignment with Snyder's three-component model make it the most appropriate candidate for future outcome measurement in this context.

Discussion

This paper has argued that hope in PAL is not a passive emotional state but an active therapeutic resource that can be intentionally cultivated through structured, theoretically grounded midwifery interventions. The proposed five-component model integrates Snyder's (2002) Hope Theory with trauma-informed care principles (Endres & Maurer, 2024; White et al., 2022), providing a clinically replicable framework that addresses the specific psychological vulnerabilities of women in PAL pregnancies.

The model's central contribution is its explicit rejection of premature reassurance as a clinical default. Recent qualitative evidence confirms that invalidating responses, including minimisation of grief and unrealistic optimism, are experienced by PAL women as profoundly isolating and clinically harmful (Gower et al., 2023; Robinson et al., 2023). The five-component model offers an alternative: validated, uncertainty-tolerant care that honours both grief and hope as legitimate, coexisting emotional realities.

The integration of the liminality concept (Fernández-Basanta et al., 2023) strengthens the theoretical foundation by naming the threshold state that PAL women inhabit, suspended between past loss and uncertain future, and illuminating why standard antenatal care frameworks are frequently experienced as inadequate. Liminality provides a conceptual bridge between the psychological literature on PAL and the clinical literature on TIC, suggesting that what PAL women need is not more monitoring but more meaning-making.

Although the illustrative vignette is drawn from midwifery practice in Portugal, the model's grounding in trauma-informed care principles and Snyder's Hope Theory ensures its applicability to obstetricians, perinatal mental health specialists, and other maternity care providers. Future implementation research should explore adaptation across disciplines, care settings, and cultural contexts.

Future directions

The conceptual model proposed in this paper requires empirical validation before effectiveness claims can be made. The following research priorities are identified:

Feasibility and pilot studies: Randomised or quasi-experimental pilot studies testing the five-component model as a structured midwifery intervention in PAL antenatal clinics, with primary outcomes including hope (measured by the Herth Hope Index), anxiety (State-Trait Anxiety Inventory), and perinatal grief (Perinatal Grief Scale).

Longitudinal outcome research: Studies tracking hope, anxiety, and attachment across the PAL pregnancy trajectory (first trimester through postpartum), examining whether hope-facilitation interventions mediate anxiety reduction and support prenatal attachment.

Implementation and fidelity research: Studies examining how the model can be integrated into routine antenatal care without requiring specialist referral, including training requirements for midwives and fidelity assessment frameworks.

Cross-cultural adaptation: Adaptation and validation studies in non-Portuguese contexts, given that care models, grief norms, and the social meaning of pregnancy loss vary significantly across cultural settings.

Multidisciplinary extension: Studies examining the model's applicability in obstetric and perinatal mental health settings, including adaptation for use by obstetricians, psychologists, and perinatal mental health nurses.

Limitations

This paper has several important limitations that must be explicitly

acknowledged. First, and most fundamentally, the entire argument rests on a single illustrative clinical vignette. The vignette was not designed as a research instrument: it involves no control condition, no standardised outcome measurement, and no systematic data collection. Accordingly, no claims of effectiveness, causality, or generalisability can be derived from it. The positive observations reported in the vignette suggest the model's clinical plausibility and warrant formal empirical investigation; they do not constitute evidence of efficacy.

Second, the vignette is drawn from a specific clinical context, a Portuguese hospital setting, and reflects the care norms, professional frameworks (including the Roper-Logan-Tierney model, Portuguese edition), and cultural meanings of pregnancy loss in that context. The model has not been tested in other national or cultural settings, and adaptation may be required to ensure cultural appropriateness and contextual validity.

Third, the paper's theoretical framework draws primarily on Snyder's (2002) Hope Theory and recent TIC literature. Alternative theoretical frameworks, including attachment theory, acceptance and commitment therapy, and meaning-centred approaches, are not systematically engaged with, which may limit the comprehensiveness of the theoretical foundation.

Fourth, the paper does not address the training requirements for midwives implementing the model, the institutional conditions necessary for its adoption, or the potential for differential effectiveness across PAL presentations (e.g., recurrent miscarriage versus stillbirth). These are important considerations for future implementation research. Finally, no longitudinal follow-up data are available from the vignette case, meaning that the durability of any observed effects cannot be assessed.

Conclusion

Hope is not a passive emotional state but an active therapeutic resource that may be intentionally cultivated through structured midwifery interventions, advanced communication skills, and the capacity to tolerate uncertainty. This paper has proposed a five-component model for hope-facilitation in pregnancy after loss that integrates Snyder's Hope Theory with trauma-informed care principles, may provide a structured theory-to-practice mapping, and identifies the Herth Hope Index as a candidate outcome measure for future empirical validation.

The model challenges the prevalent clinical default of premature reassurance and proposes to midwives and maternity care providers a theoretically grounded, clinically transferable framework for supporting women through one of the most emotionally complex experiences in reproductive health. Empirical validation of the model is the essential next step towards establishing hope-facilitation as a standard component of pregnancy after loss care.

Declaration of generative AI and AI-assisted technologies in the manuscript preparation process

During the preparation of this manuscript, the authors used Claude (Anthropic) to assist with language editing and clarity. The authors reviewed and edited all AI-generated output and take full responsibility for the final content of the manuscript.

Funding

This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

Ethical considerations

Written informed consent was obtained for the use of anonymised clinical information. Formal research ethics committee review was not

required for this work on the following grounds: this paper is a theoretical conceptual discussion and not a primary empirical study; the clinical vignette relies exclusively on fully anonymised information; no systematic collection or analysis of identifiable personal data was undertaken; and the woman whose experience is described provided explicit written informed consent for its use for educational and publication purposes. This determination is consistent with standard institutional guidance governing conceptual scholarly work in health sciences.

CRedit authorship contribution statement

Andreia Filipa da Palma Correia: Writing – review & editing, Writing – original draft, Validation, Methodology, Conceptualization.
Mónica Sofia do Couto Antunes: Writing – review & editing, Writing – original draft, Validation, Supervision, Methodology.

Declaration of competing interest

The authors declare no competing interests.

Acknowledgements

The authors wish to thank the woman who generously shared her experience and consented to its use for educational and publication purposes. The authors also acknowledge the midwifery team involved in her care for their commitment to woman-centred practice.

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