End

In: J. Raphael-Leff (Ed). 'Spilt Milk' perinatal Loss & Breakdown (2000) Institute of Psycho-Analysis

4

Emanuel Lewis
& Stanford Bourne

Pregnancy after stillbirth or neonatal death: psychological risks and management[1]

After a perinatal death everyone hopes the next pregnancy will set things right. In reality, neurotic, phobic, depressive or hypochondriacal reactions may continue from the first stillbirth or may be reactivated after an apparent recovery (Cullberg 1972). The marriage (Meyer & Lewis 1979) or any member of the family may bear the brunt. Sequelae are often carried into the next generation, activated decades later by anniversaries or life-events (Guyotat 1980).

Human pain fades, but mourning of stillbirth and genuine recovery are difficult and require time. If mourning is achieved, another pregnancy will offer consolation and fulfilment. Unfortunately, the new pregnancy very often cuts short the mourning process, predisposing to mental disturbance. Serious and bizarre reactions occur unexpectedly, after the birth of a healthy subsequent baby (Lewis & Page 1978). Puerperal psychosis requiring admission to a psychiatric unit is uncommon: our clinical impression is that it is more likely to follow the next live birth than the stillbirth itself.

We refer, throughout, to stillbirth but the paper is applicable to neonatal death, which, in comparison, is mitigated by the experience of having a live baby – and a little more time to think.

Theoretical considerations

Normal mourning and its difficulties

Normal recovery from a loss involves taking in what has happened, and sorting out mixed feelings and lost hopes so that memories of the dead recede to a healthy perspective (Parkes 1972; Bowlby 1980). At first the inner world is occupied with conscious and unconscious images of the body and mind and illness of the dead, which contributes to the malaise, heaviness, and deadness as well as hypochondria and psychosomatic illness (Freud 1917; Abraham 1979). In failed or interrupted mourning, symptoms may become chronic;

and in some individuals who make an apparent recovery, there is a latent vulnerability to subsequent traumas (Guyotat 1980).

In a loss such as stillbirth the events and feelings are inherently confusing, but difficulties also stem from bad feelings around the dead person or the surrounding events. One feature that family and professionals find bewildering in an adult is the re-emergence of long-forgotten infantile reactions to loss (Klein 1959; Meyer & Lewis 1979).

Special mourning difficulties after stillbirth

Beyond ordinary pain and disappointment, stillbirth is complicated by extraordinary sensations of confusion and unreality, as birth and death have been fused (Bourne 1968, 1983). After months of expectation and growing fullness, there is sudden emptiness with nothing to show, a stupefying non-event. (Even after a live birth, women have a sense of emptiness and sadness mingled with their joy.) Women complain that, after a stillbirth, people expect them to go on as if nothing had happened. The mother feels the stigmata of disease, although she usually has no illness. She feels ashamed, inferior, and guilty without reason. If the baby's body is whisked away to an unknown grave, the reality may be yet harder to grasp.

After a stillbirth, the range of unmanageable feelings (Bourne 1979) involves conflict of love and hate and other complex emotions about the dead baby, about other women, and about childbirth; and there may also be grievances about the obstetric care. Bad feelings about what has been lost have to be disentangled from good ones to avoid idealisation and chronic, unresolved grievances.

Mourning during pregnancy

For normal mourning it is necessary to hold images of the dead person internalised in the mind's inner world until, eventually, there is resolution, relinquishment. In mourning, the dual processes of 'taking in' the loss and eventually freeing oneself from clinging to the past, 'letting go', could both interfere with the vaguely similar yet vitally different state of mind (Winnicott 1956) required during pregnancy to cherish the idea of the new baby, actually inside the mother's body. The baby will seem to be endangered by bad feelings and frightening ideas, inevitable in the mourning process.

During pregnancy after a stillbirth, it is particularly difficult for a woman to think through mixed feelings towards the dead baby still pictured inside herself whilst at the same time trying to grapple with her thoughts and feelings about the new baby, whose safety is her immediate chief concern (Lewis 1979a). The new pregnancy deprives the mother of time and space for mourning. It is therefore misguided to hurry people into another pregnancy after a stillbirth.

Management

There are techniques to facilitate mourning of a stillbirth (Giles 1970; Bourne 1979; Lewis 1979b; Forrest *et al* 1981; Klaus & Kennell 1982), but how do we know when mourning is taking an unhealthy course?

The danger signals are intensity or rigidity of symptoms rather than any specific features. If, in either parent, there are persistent immoderate grievances, persistent psychiatric disability, or an unrealistic idealisation of the dead baby or of the cure a new one will bring, then it is probably too soon for another pregnancy. We are, however, reassured if there is sadness and thoughtfulness of more ordinary proportions and also if there is the capacity to recognise some irrational ideas, where they exist, and to speak of them sensibly rather than becoming possessed by them. We urge special alertness where the reaction to the stillbirth seems to have been slight and the next pregnancy supervenes in a few months. The rush to the next pregnancy is hard to resist, especially for older women.

Reassurance and antenatal care

In a pregnancy that follows stillbirth, good obstetric care is reassuring but the anxieties of the mother and her family should not be smothered. Rather, they should be helped to express their specific anxieties. Questions persistently repeated despite comprehensive answers should suggest that other anxieties, or grievances, lie behind the questions and are being missed.

Obstetricians always take the patient's history but the wider family obstetric history gets meagre attention. This may collude with trends in precisely those inauspicious families where trouble gets ignored and old hidden traumas then await reactivation. Children grow up with a confusing mixture of half-knowledge in families where there has been a perinatal death in their own sibship or in their parents' sibship (Guyotat 1980; Lewis 1983). The girl whose mother had a bad obstetric history may be vulnerable to extra psychological disturbance if she has obstetric troubles herself when she grows up.

Reactions may be lessened by awareness of this legacy. Discussion may help a woman to differentiate herself from her mother and to free the events in this generation from those of the preceding one.

Congenital abnormalities and genetic counselling

Congenital abnormalities involve parents in exceptional conflict of revulsion and attachment towards the dead baby, towards themselves and each other. Spooky feelings about heredity and the power of bad thoughts are intensified and some daylight will help.

Issues related to genetic counselling provide opportunity to bring such difficult feelings and irrational fears into the open in addition to the contraceptive or obstetric issues that prompt such discussions or investigations.

The replacement child

Children born after any bereavement are at risk of becoming 'replacement children' (Poznanski 1972). Infancy and childhood are affected by the parents' anxiety and depression, together with their confused wishes and expectations carried over from unresolved mourning. Later troubles may involve confused identity, gender uncertainty, and sexual difficulties; disturbances of ambition and achieve-

ment; and, sometimes, a lifelong sense of nameless guilt as if living in someone else's shoes. All this has a worse twist after a stillbirth than after other deaths. 'Survivor guilt' and all these problems may be worst of all for the survivor of twins where one dies at birth.

We believe it something of a disaster for the next baby to be saddled with the name formerly intended for the one who died, adding to the danger that the new baby is only precariously differentiated from the dead one in the mind of the mother and her family. Also, ideas of reincarnation inflame other problems for the replacement child, adding to expectations that the new baby should make up for the old one. Doctors and midwives are in a good position to pick up these dangers early and should use their influence to stop the name being reused.

It is not at all rare for babies to be born on (or near) anniversaries of other births and deaths in the family. Whether or not these coincidences are predetermined by unconscious parental wishes, fantasies of reincarnation, or other magical thinking, they can certainly become charged with significance in the parents' minds and this, in our experience, is pathogenetic. The identity of one birthday with another, or with a death day, reinforces the confusion of the new baby with someone else. Those in charge of antenatal care should look out for these coincidences, either in prospect or in retrospect, so as to bring underlying ideas into the open. Parents should be especially warned against starting a new pregnancy 3 months after a stillbirth. It would usually be too soon, anyway; and it would lead to term around the first anniversary.

Continuity of care

These patients need a kind of mothering and fathering themselves during pregnancy, which can nourish their sense of having good parents within themselves, a basis for healthy self-confidence and optimism and for becoming good parents. They should be aware that someone is ready to share the pain, anxieties, and hopes. The ideal mixture will make the patient feel supported by concerned doctors and nurses and yet not feel infantilised and disabled.

Apart from providing attentive encouragement, the obstetric team should clearly specify its availability – especially for urgent contact. Continuity of care is important, and although one person should be in charge it is prudent to ensure that the mother is familiar with several central people in the team. The necessary integration of support is hard to sustain. In cases of stillbirth, 'teamwork' commonly becomes shared uncare. Flaws in the system, and lacunae in attentive concern, resonate dangerously with these patients' anxieties about nothingness and empty spaces.

The obstetric team: discussion forum

Unless precautions are built into the team structure the stress on staff can affect the care of these patients. Perinatal death is too uncommon for junior staff to acquire enough clinical experience of it. Staff dysfunction is manifested in the fragmentation of care and responsibility, and the professional deafness, blindness, and amnesia that tend to mark the stillbirth case (Bourne 1968). Units need a regular forum where each perinatal death is discussed, so that information and awareness are concerted (a safety-net for patients); and where sharing of experiences promotes the welfare and clinical knowledge of doctors and nurses (a safety-net for staff).

Psychotherapy and counselling

During pregnancy, especially after a perinatal death, women are difficult to engage in formal psychotherapy, even when they seem to be clamouring for help and presenting the kind of psychological difficulties that would normally justify referral for psychotherapy. The relationship with the obstetric team is of prime importance and cannot be bypassed by referral for counselling. Whilst psychotherapists may have skill in interpretation, we urge caution. The limited aims of sharing and support are more likely to be successful; forcing the pace in the pursuit of insight leads to hardening of resistance, panic, and breaking off of treatment. Interpretations are easily misconstrued as punishment and as a danger to the new baby. Help in differentiating the new baby from the dead baby is a central task where possible.

When anxieties about the pregnancy are discussed, involvement of both parents and any other children enlarges the information and promotes mutual trust. Siblings need help to sort out their misconceptions. Guilt and other anxieties may appear as exaggerated concern for the fetus or the mother during the next pregnancy. However, a blank lack of anxiety, as with grown-ups, is a danger sign too. Talking about these matters helps children to understand and share their distress; they should not always be excluded or forgotten. Yet it is often a question of working with whoever will come – and this may well be the father rather than the mother. Clinicians inexperienced in seeing families together may feel too awkward for such work.

The puerperium

After a stillbirth, feeding and rearing of the next baby are often difficult and pleasure can be spoiled. Mothering difficulties can be quite severe and either parent may reject the new child. We also think there is some increased risk of child abuse (Lewis 1979c). The parents should therefore be warned during pregnancy that they may expect to be puzzled by some of their reactions to their new live baby. They expect to be a bit overanxious but they need warning of sadness despite their joy; painful memories of the dead baby will be reawakened. They need to realise that they may at times confuse the live baby with memories of the dead baby. Preparation helps parents to be less frightened by their muddled thoughts and feelings. And it sometimes helps if they feel there is 'permission' to be confused and afraid.

When mourning is interrupted by pregnancy, anticipation of later difficulty will prepare for unfinished grieving, postponed until

the baby is safely in existence. Effective mourning may then be possible, when psychotherapy may also be timely.

General anaesthesia and caesarean section

Bewilderment and unreality – prime pathogenetic elements – will have been particularly intense if the previous stillbirth occurred during general anaesthesia. Caesarean section will have aggravated bad feelings about the dead baby, and the next one, and the whole experience. The dead baby and the obstetrician are both the subjects of irrational resentment over the fruitless wound; and this will exacerbate any unresolved mourning problems now reactivated in the next pregnancy. After a stillbirth, the irrational anxiety and stigma of being ill or diseased are intensified by the operation. Surgery turns a bereaved mother into 'a patient', in her own eyes and in the eyes of medical staff; and although this licence to be ill may be temporarily comforting, it can become disabling if it persists.

It is doubly important to anticipate these specific risks if another caesarean delivery is likely. The previous experience should be clarified and reclarified during pregnancy; such matters are not disposed of by a few questions and answers; anxieties and memories change focus. If intervention is needed, general anaesthesia is best avoided, especially if there is much likelihood of the next baby dying.

Another stillbirth?

Doctors may collude in unrealistic expectations and in avoiding prognostication. It may seem easier to avoid anxious areas, but this can lead to greater trouble later. If the worst happens again, much has been written (Lewis 1976, 1983; Kirkley-Best & Kellner 1982; Peppers & Knapp 1980) on overcoming the abhorrence of stillbirth: parents seeing and holding the dead baby; registering a proper name; keeping photographs; a funeral and a decent marked grave. Careful management helps to preserve the dignity and poignancy of the experience and to initiate the difficult mourning process. Thus, the way may be prepared for recovery in due time.

Acknowledgements

We thank Mrs Hazelanne Lewis, Dr David Morris, Miss Melinda Schneider, and Mrs Antonia Shooter for ideas and criticism, and our secretary, Miss Fay Reeves, for unstinting support.

Notes

1 A presentation on this topic took place on 2 November 1985 at a day of public lectures at the Institute of Psycho-Analysis, London.

References

ABRAHAM, K (1979) *Selected Papers on Psychoanalysis*, Vol. 4, Maresfield Reprints, pp.418–80

BOURNE, S (1968) 'The psychological effects of stillbirth on women and their doctors', *Journal of the Royal College of General Practitioners*, 16, p.103-112

— (1979) 'Coping with perinatal death: management problems and strategies', *Midwife, Health Visitor and Community Nurse*, 15, pp.89–92

— (1983) 'Psychological impact of stillbirth', *Practitioner*, 227, pp.53–60

BOWLBY, J (1980) *Attachment and Loss*, Vol. 3, Loss: sadness and depression, Hogarth Press

CULLBERG, J (1972) 'Mental reactions of women to perinatal death' in N Morris (ed.) *Psychosomatic Medicine in Obstetrics and Gynaecology*, Basel: Karger, p.326

FORREST, G C, Claridge, R S & Baum J D (1981) 'Practical management of perinatal death', *British Medical Journal*, 282, p.31–32

FREUD, S (1917) 'Mourning and melancholia', S. E. 14

GILES, P F H (1970) 'Reactions of women to perinatal death', *Australia and New Zealand Journal of Obstetrics and Gynaecology*, 10, p.207–210

GUTOYAT, J (1980) *Mort/naissance et Filiation: études de psychopathologie sur le lien de filiation*, Paris: Masson

KIRKLEY-BEST, F & KELLNER, K R (1982) 'The forgotten grief: a review of the psychology of stillbirth', *American Journal of Orthopsychiatry*, 52, pp.420–9

KLAUS, M H & KENNELL, J (1982) 'Caring for the parents of a stillborn or an infant who dies', *Parent–Infant Bonding*, St Louis: Mosby, pp.259

KLEIN, M (1959) 'Our adult world and its roots in infancy' in *Envy and Gratitude and Other Works, 1946–1963*, Hogarth Press and the Institute of Psycho-Analysis, 1980, pp.247–63

LEWIS, E (1976) 'The Management of stillbirth: coping with an unreality', *Lancet*, 2 (7986) (Sept.), pp.619–20

—— (1979a) 'Inhibition of mourning by pregnancy: psychopathology and management', *British Medical Journal*, 2 (6181), pp.27–28

—— (1979b) 'Mourning by the family after a stillbirth or neonatal death', *Archives of Diseases of Childhood*, 54, pp.303

—— (1979c) 'Two hidden predisposing factors in child abuse', *International Journal of Child Abuse*, 3, pp.327–330

—— (1983) 'Stillbirth: psychological consequences and strategies of management' in A Milunsky (ed.) *Advances in Perinatal Medicine*, Vol. 3, New York: Plenum

—— & Page, A (1978) 'Failure to mourn a stillbirth: an overlooked catastrophe', *British Journal of Medical Psychology*, 51, pp.237–241

MEYER, R & LEWIS, E (1979) 'The impact of stillbirth on marriage', *Journal of Family Therapy*, i, pp.361–369

PARKES, C M (1972) *Bereavement: studies of grief in adult life*, Tavistock

PEPPERS, L G & KNAPP, R J (1980) *Motherhood and Mourning*, New York, Praeger

POZNANSKI, E O (1972) 'The "replacement child": a saga of unresolved parental grief', *Journal of Pediatrics*, 81, pp.1190–1193

WINNICOTT, D W (1956) 'Primary maternal preoccupation' in *Through Paediatrics to Psycho-Analysis*, Tavistock, 1958