Parents Who Lost Their Baby: Guiding the Mourning Process in Stillbirths and Pregnancy Terminations

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6.1 Introduction and Aims

"Perinatal loss" refers to the psychosocial consequences of a pregnancy or birth ending in the death of the fetus or newborn. This loss is a devastating experience for parents, families, and, often, healthcare staff as well. The aim of this chapter is to provide both information and guidelines for clinical management of the psychosocial issues involved.

6.2 Definition in Lay Terms

Perinatal loss is a term used to bridge the gap between the biomedical aspects of the subject, on the one hand and, on the other, the psychosocial issues involved when pregnancy or birth ends with the death of the fetus/newborn. This event is always a devastating experience.

6.3 Didactic Goals

After reading this chapter you are expected to be able to:

1. Acknowledge the risks involved in unresolved grief after perinatal loss
2. Become sensitive to parents' emotional needs as it concerns healthcare
3. Distinguish between normal and abnormal psychosocial consequences of perinatal loss

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4. Know how long normal mourning lasts
5. Manage and use relevant information concerning the clinical features expected in this type of mourning process
6. Have a clear concept of the underlying foundation for the guidelines for clinical management presented
7. Manage clinical obstetric interventions during pregnancy, labor, delivery, and postpartum, taking into account and handling adequately the psychosocial issues involved
8. Recognize in yourself and other colleagues the emotional aftermath involved in clinical management of perinatal loss, developing protective measures for yourself and others

Case History

Maria Maroon, 32 years old, is a nurse, happily married, and mother of two preschool female children. Pregnant for the third time and highly expectant of a baby boy, she stops feeling fetal movements at week 22. Though her family insists that she consults the emergency department, she stays at home for several long days, absent-minded and singing nursery rhymes while she caresses and speaks to her unreactive fetus. Finally taken to the hospital after several days, she is delivered from the stillborn. The delivery is complicated by severe postpartum hemorrhage, losing 4 l of blood. Therefore, she is admitted to the intensive care ward, remains hospitalized in a severe physical condition for several days, and finally recovers. Later on, she recalls her experience of being unable to accept reality and the need to deny the loss of this child, so highly wished for and expected, even at the cost of her own health. For weeks, she remains distant from her children's care, and it is only after what she recalls as "endless hours" of conversation with her husband that she manages to overcome the loss. An essential component in their adaptation process is the acknowledgment of the baby boy as a lost "child," as valuable and precious as their other two children. This recognition of her lost son as a true person is in sheer contrast to the reactions of the hospital staff. They spoke about her son as a "product" to be expelled from her body and gave her medication to suppress her grief. Even some family members and colleagues tried to distract her from her sorrow by disregarding the lost fetus as a person, as her son. A couple of years later, she volunteered to help women undergoing stillbirth and, finally, gave birth to a healthy child.

6.4 Facts and Figures: Definitions, Classification, and Prevalence

6.4.1 Definitions

Perinatal loss is the term used to refer to the emotional and psychosocial consequences for the mother, her family, and relations of the loss of a child in the second or third trimester of pregnancy or in the first week after birth. These have been

termed as "perinatal bereavement" and generate multiple risks for the woman's mental health as well as for that of her subsequent child(ren).

Perinatal mortality is defined by the World Health Organization (WHO) as "the number of stillbirths and deaths in the first week of life" [1]. Although other definitions also are used, WHO defines the perinatal period as commencing at 22 completed weeks of gestation (154 days) and after seven completed days after birth.

Due to the varying definitions and the extreme variations among countries (and even within them, according to financial and socio-sanitary status), the WHO has not produced an estimated prevalence figure, though perinatal mortality is considered a key criterion to assess healthcare status and, furthermore, the degree of global development of a given country.

6.4.2 Historic Overview

Clinical management of perinatal loss has changed in the last decades in most Western countries, especially in those with adequate healthcare standards and in those where psychosocial issues are normally included in standard perinatal care. From the 1980s onwards, more and more attention was paid to the deleterious effects of perinatal loss, especially when followed by inadequate healthcare management [2–7]. Appleby, for instance, showed an increase of 600 % in suicide rates after perinatal loss [8], and Condon pointed out a significant increase in psychiatric hospitalization and consequences for children born after the loss [9]. At that time, in many countries, standard care involved cesarean section with general anesthesia and lack of any information about the dead child (including gender, weight, physical conditions, or estimated/assessed cause of death).

Furthermore, normal grief reactions were treated as pathological side effects; clinicians tended to provide antidepressants and sedatives to suppress desperation, pain, and mourning, also "prescribing" an immediate substitute pregnancy and a recommendation to forget this "unimportant event." Fathers were obviously not expected to undergo significant mourning for an unborn or very small child. Parents were advised to give the next child the same name as they had chosen for the lost child [10]. "Deny and forget what happened, look at the future" was the motto that added insult to injury. The iatrogenic effect of this motto manifested itself not only to the parents but also to the children yet to come, as shows in terms as the "replacement child syndrome" [3, 5] or the "vulnerable child syndrome" [4], which often appeared after neonatal death or when only one of a twin survived [11]. Other authors referred to the psychological consequences in terms of "black hole" or a "conspiracy of silence" [12], a "nonevent" [13], and "an overlooked catastrophe" [2].

What all these pioneering papers had in common was their alarming function, which caused a major change in the way hospital staff managed perinatal deaths. Both in the Northern Hemisphere as in Latin America, organizations such as the WHO or World Association of Infant Mental Health (WAIMH) produced the first guidelines for clinical management of perinatal death [14, 15].

At present, most hospital and community services use this kind of guidelines, which are also in line with state-of-the-art theoretical, clinical, and empirical developments on the importance of early attachment between parents and infant on the one hand and the need to emphasize prevention in mental healthcare, such as favoring normal grief processes, on the other.

It has even been stated that it is no longer ethical to do research on clinical management, which is so obviously in line with overwhelming evidence about the relevance of attachment and healthy grief processes by having, for example, parents randomly assigned to viewing their dead infant or not viewing it [15]. This lack of randomized clinical trials (a measure taken to protect parents) has, on the other hand, unfortunately led clinicians and researchers to revise management or develop guidelines based upon inconclusive evidence, such as Hughes et al.'s 2002 paper [16], which provided statistically nonsignificant data about posttraumatic stress disorder (PTSD) after viewing the dead child, an aftermath that was also disconfirmed in a later paper by the same research group [17].

In recent years, some clinical developments, such as the concept of "complicated grief," initially put forward by Boelen and van den Bout in 2008 [18], have been applied to perinatal loss [19], thus giving more sound ground to clinical observations about the unique character of the mourning process after perinatal death. This is especially important in order to prevent confusion with a concept that became quite popular in that decennium: the posttraumatic stress syndrome (PTSS), and therefore avoid clinical management which, upon inaccurate assessment of PTSD, may hinder the development of this very special type of mourning process.

Attention has been also called on the risk of what has been termed as "absence of mourning," especially after the loss of an "absent child," as it happens in stillbirth [15].

6.5 Etiology and Pathogenesis

In order to manage the consequences of perinatal loss, one has to understand the basic psychological principles of mourning. Mourning is a normal psychological reaction to the death of a beloved one, which always involves to some extent being deprived of something personal, which is carried away by whomever is lost. This process—which is the equivalent of a mental level of digestion—implies working through the loss, i.e.:

1. Accepting the reality of the loss, admitting that something terrible has happened, which is irreversible, on a cognitive level
2. Experiencing the pain of the loss on an emotional level
3. Adapting to the new situation and (slowly) returning to daily life on a behavioral level

If done successfully, some fundamental aspects of the loss become part of the person's inner world or strengthen the self by integrating parts of what is lost. The

person recognizes thoughts and feelings about the lost person as normal and valuable but is no longer overwhelmed by them. This process takes time (estimated at 6–12 months in normal conditions) and is characterized by reactions that may take place one after the other or overlap at different moments of the process. This pathway leads, finally, to acceptance and reorganization. However, it is essential to understand that, unlike depression, the whole process means not only pain and sorrow but also a struggle: against reality of the loss, against guilty feelings, against collapsing into depression, and "dying" alongside the lost person.

Mourning itself is often preceded by shock, which may last minutes, hours, or, sometimes, even days. The person is not able to react in any way and a sort of "blackout" appears, where no voluntary actions (let alone decisions) may be undertaken. In many countries, informed consent or even signed documents under such a state are not considered legally valid. In medical practice, this reaction may mislead attending personnel either into thinking that the person is mentally disabled or, the opposite, that he/she has overcome totally and wisely the traumatic situation in a few minutes. Asking parents to make decisions under such conditions about themselves (e.g., sterilization) or their infant (e.g., autopsy), even if legally valid, is neither wise nor sensible, as parents may regret for years decisions that often cannot be reversed later.

After shock has been overcome, the human mind still needs time to come to terms with painful facts, and therefore denial and dissociation delay real, deep perception of the loss. Denial implies not fully accepting the reality of the loss, even if it may seem to be so, since there is a cognitive acknowledgment of reality. This lack of emotional reactions may induce staff to believe either that the parents do not care about their child or that the loss has been readily accepted and overcome.

Dissociation, though normal under extreme circumstances, leads the person to pragmatic reactions totally devoid of affection, which may induce observers to think of emotional detachment and lack of involvement in the loss or, alternatively, that the traumatic situation has generated an abnormal reaction, equaled to psychiatric pathology.

In normal mourning, both denial and dissociation fade away progressively, giving way to full perception of the loss. This induces parents, their relatives, and staff to believe that, as time passes, the process becomes worse, since increasing awareness leads to increasing pain and depressive ideas and feelings, with the phantom of suicide always hovering over the scene.

Since mourning is also a struggle to survive the loss and its saga, hostile reactions often appear, which is especially relevant in this case, since it may lead to legal action against medical staff. This reaction is midway between denial ("I will win the struggle with death if I win the trial"), on the one hand, and depression, with its saga of guilty feelings, on the other ("He is to blame, not me"). The more guilty the person feels, the stronger the need to blame others.

Finally, reality wins; the loss no longer can be denied, and adaptation finally comes after this long period (months), in which the person "travels" to an inner world filled with memories and an inner presence that helps forget the absence of the loved one in the real world. Anniversaries and meaningful dates provide not only

memories but also the risk of relapse into the early signs of mourning, with the added risk of solitude and misunderstanding, since people around may not remember dates. This brings along increased risk of suicide, biological fragility, and, last but not least, the start of unnecessary psychiatric follow-up (in the wrong belief that time passes and things go not for the better but for the worse, often confusing complicated grief processes with PTSD).

6.5.1 Mourning After Perinatal Loss

All the aforesaid becomes especially intense, dramatic—and dangerous—when the loss involved is that of an infant, furthermore a newborn, furthermore an unborn child. This gradient of drama and risk is due to the fact that the early loss of a child stirs symbiotic feelings. The lack of a personal "social" history of the child makes it hard for parents to build his/her identity and memories upon this [20–23].

Mourning becomes extremely difficult when there is no clear distinction between the person who suffers the loss and the one who dies, be it due to symbiotic feelings or biological features. In stillbirth, both factors coincide. Normal psychological processes preparing for bonding and attachment during pregnancy make the mother feel all at one with her fetus who, at the same time, is still a part of its mother's body [24, 25].

Besides, the postpartum period is a time of extreme sensitivity in order to prepare the mother to protect and fully attach to the newborn child, conforming to what Winnicott described as primary maternal preoccupation [26]. This inevitably leads to extreme vulnerability, and, when the infant dies, the mother remains at extreme risk of psychological collapse, which may in turn lead to a psychiatric breakdown or even suicide, which has been proved to increase after the loss of a child [9, 27–30]. In the author's experience, religion may play an important role here in the prevention of suicide. Because in many religions suicide is punished with hell, all hope of reunion with the lost child in heaven is lost, so many parents feel obliged to carry on despite their enormous burden.

6.5.2 Complicated Grief

Perinatal loss often brings along complicated mourning. Not only the real person—the unborn or very young child—is mourned; many other losses are involved: the imaginary child created by the parent's minds [31], the child-to-be in parents' plans and dreams for the future, pregnancy itself as a state, and the mother's self-esteem, especially in stillbirth, where her body has been the scenario of her infant's death [14].

Therefore, the expected time of 6–12 months is too short, and the evolution of mourning gets entangled with biosocial conditions of the puerperium. The first month, which overlaps with primary maternal preoccupation, is marked by intolerable feelings of perplexity, bodily loss (similar to those felt in mutilation), and

emptiness. In a time meant to be devoted to nesting, caring, and sharing, mothers feel disoriented, while they often also carry the burden of their body producing blood and milk and frequently also wounded by scars of surgery or episiotomy. The urging need to hold and care for a child may lead parents to try to get pregnant again shortly after the loss or promptly adopt another child, be it legally or illegally.

The following months may be filled with nostalgia, rage, impotence, and loss of meaning. Meaningful dates (such as the expected due date or Christmas) arouse the same maddening sensation of the first days, accompanied by solitude, lack of understanding, and even pressure and criticism from the surrounding others, who underestimate the dimension of the loss and the magnitude of pain and desperation. If we do not take into account that perinatal loss, with its enormous emotional and psychosocial consequences for all involved, is a major life event that requires perinatal bereavement, we can wrongly define any disturbance of this adaptive process as pathological. The fact that an unborn, a newborn, or a very young infant is the object of mourning makes this adaptation process especially intense, dramatic, and thereby extremely vulnerable for "pathological" disturbances. This fits well with the description of complicated grief, which is characterized by searching and yearning, preoccupation with thoughts about the deceased, crying, disbelief about the loss, being stunned by the death, lack of acceptance of the loss, and impairment of global functioning, mood, sleep, and self-esteem [19, 32].

The following pregnancy is a time of heightened anxiety and medical risks as well as demand for support from attending staff [33–38]. Though research shows that parents do not wish to be given advice (just information) about the adequate time for the next pregnancy [39], clinically it is clear that some time is needed for parents to go through the loss before undergoing a new pregnancy, which should never be "prescribed" to calm down anxiety, replace the lost child, or subdue emotional involvement with the loss.

Some psychosocial risk factors have been identified for complicated grief after perinatal loss: lack of social support, preexisting relationship difficulties, the absence of surviving children, ambivalent attitudes, or heightened perception of the reality of pregnancy [19]. Some medical conditions have been shown to lead to a high prevalence of both complicated grief and psychiatric symptoms, such as pregnancy termination due to fetal malformation, intense ambivalence or attempted abortion, and previous psychopathology in the mother [19, 40–43].

Consequences of perinatal loss on the following child have been extensively researched [10, 44]. Risk factors for replacement child syndrome in the child born after the loss are specially relevant in the situations in which parents (especially the mother) do not get to view and give a name to their stillborn or dead newborn child and getting pregnant before a minimum time of 6 months after the loss [3, 5]. Having lost a twin sibling or being born after the previous child underwent severe pathology, often with neonatal intensive care unit (NICU) hospitalization, makes the following child prone to undergo what has been termed the vulnerable child syndrome [4], which often induces parents to perform excessive medical consultations, in which medical staff may take wrong clinical decisions following parents' distorted report of the child's condition.

Mothers and fathers do not take the same time to mourn or follow the same path, which brings added fear of loss by separation, as fathers often lack empathy for the time mothers need to mourn their multiple losses or misunderstand the way they mourn, often considering it masochistic or risky for their mental health. Unequal or incongruent grief between father and mother has been shown to increase both the risk of complicated grief as that of couple separation [19, 45]. On the other hand, deleterious consequences for other members of the family have been described especially after unresolved perinatal bereavement [46].

A father's mourning is often suffocated initially due to external (and internal) pressure to protect his wife, while he may flee into overwork in order to forget/avoid depressive feelings, which tend to appear later when the wife is able to offer some support [14, 45]. According to the author's clinical experience in the field, sexual life is often affected, both from depressive feelings in the mother and genitalia being associated with the painful situation surrounding birth instead of pleasure and enjoyment.

6.5.3 Grief in Perinatal Loss of One (or More) Twins

An issue of special concern is the perinatal loss of a twin [47]. This is often what today could be called "an overlooked catastrophe," since staff working in neonatal intensive care units often forget the lost child and only care for the surviving (and often at-risk) child. Besides that, relatives and friends tend to underestimate parents' feelings, believing that if one child is alive this will suffice to compensate the loss. In fact, parents face almost impossible simultaneous tasks: attaching and detaching, welcoming and letting go, and receiving congratulations and condolences. Frequently, parents split these processes and one attaches to the living child, while the other mourns the lost one. Hopefully, they will take turns in each role; otherwise, pathological grief may take over [11].

Assisted reproductive techniques have increased dramatically the amount of losses in multiple pregnancies, being the misnamed "embryo reduction" (feticide, in fact), a practice that is usually not addressed by researchers and clinicians as to its devastating consequences for parents. Though literature on the subject is scant, it describes panic attacks, and it is clinically sound to believe it has deleterious effects for the surviving children as well [48].

6.5.4 Grief in Late Pregnancy Termination

In perinatal loss due to late pregnancy termination, complicated grief or the development of psychiatric symptoms is more frequent than in perinatal loss due to natural death of the child [19, 42]. Guilty feelings involved may become intolerable, and research [49] has shown that decisions taken without proper reflection and agreement between the parents, as well as lack of pity for the unborn child (which may be considered as a nuisance in parents' lives), are the main risk factors for

complicated grief, couple discord, and breakup, as well as psychiatric pathology in parents, especially mothers.

6.6 Specific Diagnostic Aspects

6.6.1 Assessment of Stillbirth

Stillbirth is usually assessed by ultrasound scanning. This may be during a routine scan or after a period in which lack of fetal movements has been experienced by the pregnant woman.

It is advisable to scan another time, leaving some hours or a day between one and the other scanning. This may give time for the woman and her partner to go back home, talk to her other children and/or relatives and friends, set home and childcare issues, pick up adequate clothing for herself, etc. All these issues are relevant not only on practical grounds but help to diminish the feeling of chaos (and therefore risk of dissociation) generated by this unexpected and generally abrupt ending of pregnancy. Furthermore, this double scanning gives her subjective time to minimally "come to terms" with the news, leaving room to normal shock and denial/dissociation mechanisms after traumatic events and, therefore, helping adaptive mechanisms to emerge and be put into action during the intense days to come during labor, delivery, and the puerperal period. Furthermore, this time allows for other members of the family and/or the child's father to be present at the second confirmatory ultrasound session and support the mother through delivery and the subsequent days, providing also practical help for hospitalization.

6.6.2 Neonatal Death

In neonatal death, there are often difficulties stemming from a combination of parents' vulnerability and healthcare staff difficulties in handling emotional issues involved. This sometimes leads staff to stimulate what has been called "anticipatory grief" asserting that the infant will die. This may have devastating effects. If the child in fact dies, it may complicate mourning when parents feel guilty later for having given up caring for the child while it was still alive, something which parents often do in order to avoid intolerable sorrow. If the child finally survives, it has been found [50] that having undergone this anticipatory grief affects the quality of attachment with the infant. Furthermore, the fact that parents may give up participating in its care and providing it with emotional support may, in fact, increase the risk of death for that given newborn.

Delivering information to parents concerning either stillbirth or the severe condition and later death of their newborn child is a difficult process whose traumatic effect will be remembered for years by parents and has been shown to increase health risks for medical staff [13, 14]. Adequate care involves providing information in a private setting, giving parents adequate sitting time, and providing time and

privacy for primary reactions both in the interview as well as after the news has been delivered. Showing respect for the dying or dead child as a person, however ill, malformed, or premature it may have been, is considered paramount by parents.

6.6.3 Extreme Prematurity

A special reference should be made to newborns who die due to their extreme prematurity. Parents are often asked for informed consent on the decision of whether to provide invasive care or not in the worst moment: immediately after birth, if the decision is urgent. This may lead to one parent answering, either because the mother may not be in a physical condition to do so or simply because one of them is more introverted or needs a longer time to make these hard decisions. Depending on later events (e.g., a severely disabled child or its death), this may put at stake the stability of the family in the years to come, which may be filled with discord and reproaches over the quick decision. Parents must be given time to make a joint decision privately, whenever possible, before the birth of an extremely premature infant. Even a short period of time to discuss this may protect the couple and family's continuity over time.

6.6.4 Prenatal Detection of Malformations

In the case of prenatal detection of malformations that may or will eventually lead to pregnancy termination, providing repeated consultation (which may happen at different moments of the same day in families living far from healthcare centers) is essential to provide parents time to discuss termination between them and with other members of the family or close friends, as well as with professionals they trust. The fact that it is a consensus decision is paramount to the parents' relationship in the years to come. Therefore, healthcare staff should be careful about the way the clinical interview is conducted, giving clear messages that the opinion of both parents is essential. This should be expressed both in verbal and in nonverbal communication. Healthcare professionals need to pay attention to nonverbal details, such as putting the right number of chairs in the meeting room (also a chair for the partner) or which partner is addressed at by gestures during delivery of information concerning the assessment of malformation and decisions to be made.

6.7 Specific Therapeutic Aspects

In stillbirth, clinical management must fulfill the essential aim of granting the foundations for normal grief. This means that the parents must be provided with perceptual evidence of the child's separation from the mother's body and the fact that it is no longer alive. Therefore, the preferable way of delivery is a vaginal delivery instead of a cesarean section. Some studies based upon small samples and providing

inconclusive evidence have questioned the long-term beneficial effects of viewing the stillborn child [16]. However, clinical experience in the author's maternity hospital for more than 30 years with several thousands of mothers as well as the conclusions of experts (e.g., Zeanah [15] and Klaus and Kennel [6]) makes it clear to us that delivery of a stillborn must be treated naturally and without interfering with the mother's (and father's) spontaneous reaction to see (or not see) their dead infant. We believe that the mere fact of asking introduces a distortion, subtly suggesting that there might be something that they should better not see. On the other hand, evidence seems to become conclusive regarding holding the dead infant, which has been significantly associated with PTSD and marital discord [51].

Some neonatal deaths occur immediately after delivery, which makes it unclear for parents whether the child was stillborn or died during or very shortly after delivery. In our experience, the staff will often tell them that their child was stillborn. This may be done out of goodwill and following the belief that this will relieve parents' sorrow. The staff should be very careful not to do that. On the one hand, it does not alleviate psychological pain, since mothers usually feel more guilty when their child dies inside their bodies. On the other, this may increase risk for future pregnancies, since it may deviate research into other causes of the death, which was wrongly described as a stillbirth.

Be it by stillbirth or early neonatal death, when parents lose a child, some clinical management issues that may seem irrelevant for the staff may be essential for parents: keeping a memento (such as a picture of the baby, hand- and footprints, a picture of an ultrasound scan, etc.), giving the child a name, performing religious rituals, etc., may soothe desperation and emptiness. When the child dies after birth, sharing the last moments, being able to hold the child, and have contact with it both before and after death not only provide memories but also the chance to offer the child some of the affection and care that was in waiting. In all cases, perceiving a respectful and warm attitude from the staff toward the child—no matter how small, no matter how severely malformed—is repeatedly pointed out by parents as what could be called "essential spiritual care" [52, 53].

In all cases, providing at least approximate or estimate information about likely causes of death may relieve the mother from believing that it has been merely her fault. In this respect, wording such as "neonatal depression" or "fetal distress" are to be carefully avoided, since they increase mothers' feelings of guilt and the intolerable sensation that their child was not able to enjoy life even prenatally.

6.7.1 Funeral Rituals and Burial

The issue of funeral rituals and burial is controversial. Although they undoubtedly constitute part of parents' rights, they may turn out to be overwhelming, and many mothers have reported feeling awkward in crowded funerals with their breasts full of milk and pain they cannot speak about. Other mothers have described leaving their longed-for child in a cemetery far from their living place in a cold, impersonal burial place as almost equally traumatic as the loss. Lately, many parents

choose to keep their child's ashes at home, which provide some consolation for their wish to provide warmth and care as they had dreamed of. It is important that parents get the possibility to choose the rituals that suit best with their background and needs.

6.7.2 Information to the Parents

6.7.2.1 How Long Does Mourning Last? Is Formal Psychotherapy Needed for All Cases of Perinatal Loss?

An essential task for staff is informing mothers, fathers, and other relatives about the expected time for the mourning processes to evolve, as well as reactions expected in anniversaries or other special dates. It is essential to include a clear reference to the different features, paces, and length of mothers' versus fathers' mourning processes.

6.7.3 Information to Siblings

It is also necessary to confirm that older children have been informed about the death, since it has been repeatedly informed that risk for their mental health does not lie so much in the loss of a sibling they have had no relation with but in the total lack of information about the death. They may be filled with fear at children "vanishing" in the family, confused (and often guilty) at their parents' sorrow and tears, and burdened by fantasies that fill them with anguish, such as suffering the same disease that caused their sibling's death.

In some countries, older siblings are allowed in NICUs. In this way, they might have met their sibling already before it had died, supporting the reaction after the death. Also grandparents may be offered to meet their newborn grandchild.

Only in cases of complicated mourning or lack of evidence of normal grief processes, as in the case of parents with previous psychopathology, formal psychotherapy should be prescribed. Both research and clinical practice [54] show that normal grief first of all needs company, not treatment. Mostly, in parents undergoing losses, support in some special times, such as around expected date of birth and anniversaries, is sufficient [55]. Psychotropic medication should be used in a generous way to protect sleep, especially in the first weeks and, eventually, for some special anxiety-ridden moments but not to hinder normal sorrow and anxiety.

6.8 Critical Reflection and Conclusive Remarks

After first being detected as an "overlooked catastrophe," perinatal loss today has received proper, empathic care in most healthcare settings. Its relevance has been well stated, research has been conclusive and clear, and therefore, guidelines protect

both parents and staff from the strain of one of the most—if not the most—stressing outcomes in perinatology.

What remains to be highlighted and studied further are some still overlooked dramas, such as the aftermath of termination due to fetal anomaly, second and third trimester voluntary termination of pregnancy, and the loss of one or more twins (especially due to feticide).

Tips and Tricks

Guidelines for Clinical Management of Perinatal Loss

Concerning medical management:

1. Repeat confirmatory scanning of stillbirth.
2. Do not manage stillbirth as an urgency; give parents time to settle private/family affairs, and put some order in their lives before delivery.
3. Before birth of an extremely premature infant, give parents time and privacy to discuss and take decisions together as to management of their child's health situation.
4. In stillbirth, avoid unnecessary cesarean section or sterilization, while using all necessary analgesia to protect mother from unnecessary labor pain.
5. In neonatal death occurring immediately after birth, do not register it in clinical records or report it to parents as stillbirth, to avoid misleading research into causes of death.
6. Consider that all informed consent immediately after disclosure/death may not reflect parents' real needs or rights, since they will be under shock and unable to make decisions.
7. Stimulate parents to have an autopsy performed.
8. Provide psychotropic medication, even without being asked for it, to protect sleep, especially in first days.
9. Manage hospitalization of mother in order both to protect privacy and not disqualify her identity as a mother (e.g., placing her in another area of the hospital).
10. In stillbirth, discuss with parents the length of stay of the mother in the hospital after delivery.
11. Avoid suppressing normal grief by not providing antidepressants; prescribe, if necessary, tranquilizers only to be used in moments of extreme anguish.
12. Make sure routine puerperium medical follow-up of the mother is performed (preferably in a setting different from that of her child's death).
13. Make sure parents are offered the opportunity to take over the proceedings of burial and other death rites, but remember this may be extra stressful for them. Do ensure the child's body is respectfully dealt with and parents know its burial place. For parents living in distant places, favor a burial place they can visit often.
14. If parents wish to keep the ashes at home, do not consider this complicated or pathological grief but a consequence of their mental preparation to take care of their child.

Concerning mourning:

1. Favor and control evolution of normal mourning processes by follow-up at key moments: first week, first month, third month, and special dates (expected date of birth, anniversaries, etc.).
2. Pay special attention to the timing of parents' reactions according to time elapsed since death.
3. In high-risk pregnancies and neonatal death, avoid stimulating anticipated mourning, even in extremely severe cases, by mentioning likelihood, not certainty, of a fatal outcome.
4. Pay special attention to subdued mourning reactions, especially in fathers.
5. Validate normal aspects of grief, such as guilty feelings, as proofs of concern about the child and not something they should not feel.
6. Make sure older children have been informed about their sibling's loss.

Concerning parents' subjective experience of the loss:

1. Pay special attention to respecting parents' (or mother's) wish to view their dead infant, even if not openly expressed, by dealing with it respectfully and naturally (in neonatal death, also while it is alive).
2. If parents or other relatives have been unable to see the dead child, build mental representations of it by providing information that is both realistic and soothing.
3. In order to make a decision as whether or not to recommend parents to view a malformed stillborn child, remember that some medical conditions (such as cardiopathy, kidney agenesia, hydrops fetalis, macrosomia, PEG, or some conjoined twins) are not visually traumatic to parents, while less severe conditions (such as cleft palate or gastroschisis) may shock them.
4. In severely malformed newborn infants who are likely to die, consider possibility of parents viewing them in a protected way (e.g., covering exposed organs in gastroschisis).
5. Favor giving the dead child a name to avoid replacement child syndrome.
6. If possible, offer religious assistance for death rites.
7. Shortly after disclosure and/or death, provide general information as to likeliness of medical cause of death to avoid mothers' blaming themselves.
8. Discuss with parents and other relatives their beliefs about cause of death, emphasizing the lack of reliability of most circulating information about maternal stress affecting fetal welfare.
9. Prevent complicated grief and disavowal of the child's existence/death by providing perceptual confirmation of the reality of the infant and its death (viewing, photographs, mementos, etc.).
10. Avoid terms such as "fetal stress" or "neonatal depression" that induce guilt and confusion in parents.

11. In cases of perinatal loss of a twin, do not disqualify parent's complicated feelings, and provide evidence of memory and respect for the lost child, granting mental health control for the surviving child(ren).
12. In so-called embryo reduction, do not disregard risk for mental health for parents and surviving child(ren); if all fetuses/infants die, consider it a mental healthcare priority.

Concerning subsequent pregnancy/infant:

1. Discourage immediate next pregnancy, to avoid increased obstetrical risk and replacement child syndrome (6 months' time being a reasonable minimum).
2. After stillbirth, emphasize differences between this pregnancy and the previous one.
3. After second or third trimester stillbirth, be careful about mother generating conditions for a premature birth (e.g., not complying with bed-rest) in the belief she will avoid repetition of stillbirth, especially taking into account that many persons believe the eighth month to be of greater risk than the seventh.
4. After neonatal death (especially of a twin), make sure this information is included in the next/twin child's clinical information, and stimulate the parents to have one family pediatrician to prevent vulnerable child syndrome.
5. Specially avoid fetal sex assessment (or emphasize its lack of accuracy), since errors may induce another mourning process (for the imaginary child, in this case) and reactivate the previous mourning, putting at stake both mother's mental health and bonding processes.

Test Your Knowledge and Comprehension

1. Initial reaction to perinatal loss is sadness produced by the immediate full perception of the loss and its relevance.
   (a) True
   (b) False
2. Posttraumatic stress disorder is the most frequent pathological consequence of perinatal loss.
   (a) True
   (b) False
3. Viewing the dead infant as well as keeping mementos of its existence helps to set the foundations for normal grief, making both the infant and the loss more real, as well as contributing to help the mother realize it is no longer part of her.
   (a) True
   (b) False
4. Parents should be advised to be pregnant again as soon as possible after perinatal loss.
   (a) True
   (b) False

5. Mourning over perinatal loss should be processed as in any other loss, since there is no reason to expect a high rate of so-called complicated grief.
   (a) True
   (b) False
6. How long can mourning over perinatal loss last within the limits of a normal reaction?
   (a) 3 months
   (b) 6 months
   (c) 1 year
   (d) 1 year, with some elements still expanding into the second year
7. In stillbirth, delivery should be considered as
   (a) An emergency to be performed promptly after assessment of intrauterine death
   (b) A medical act devoid of all consideration for psychosocial issues involved, which are to be dealt with later by mental health staff
   (c) A capital moment in the lives of the parents and the family as a whole, which requires that also medical staff take emotional issues into account both in making decisions and to the clinical management
   (d) A traumatic event, which is very likely to result in posttraumatic stress syndrome, therefore a cesarean section is indicated
8. The use of psychotropic medication after perinatal loss should take into account the following issues:
   (a) Antidepressants should be provided routinely in order to avoid grief and mourning.
   (b) Sleep should be protected, especially in the first days after the loss, and some kind of sedatives can be used at given moments.
   (c) No medication at all should be prescribed in all cases, since mourning is a healthy process.
   (d) Sedatives should be prescribed to all mothers in the 6 months after the loss.
9. Which are aspects that are important in viewing and touching the dead infant?
   (a) Parents should be advised not to do any of these actions since evidence is conclusive about its harmful effect.
   (b) Parents should not be allowed to touch or see their dead infant.
   (c) Delivery should be handled so that the dead infant is treated with respect and parents may feel free to act about it as they naturally feel.
   (d) Parents must be shown the dead infant, whether they want or not to view it, since this is essential for normal mourning.
10. Which mourning reactions can be expected after perinatal loss?
   (a) Parents may be in shock after confirmation of their child's death, so they should not be asked to make any kind of decision at that moment.
   (b) Parents who do not react immediately to the news of death may have cognitive problems or psychiatric pathology.
   (c) Parents may act in an unemotional way after confirmation of death, which is proof of their lack of interest in the child or its loss.
   (d) If parents wish to have another child immediately after the loss, this means they have overcome this loss.

Answers

1. False
2. False
3. True
4. False
5. False
6. d
7. c
8. b
9. c
10. a

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