Introduction

In the UK, perinatal loss occurs in 8.1 per 1000 births (stillbirth after 24 weeks gestation and neonatal death in the first 7 days) [1] and in the US, it occurs in 9.5 of 1000 births (stillbirth after 20 weeks gestation and neonatal death in the first 7 days) in the US [2]. The incidence in both countries is related to social group.

Here we review the expected psychological effects on parents and other children in the family, and focus in particular on the psychosocial management of perinatal loss.

Psychological distress after perinatal loss

Following this serious loss, parents almost inevitably suffer a period of grief. Depressed mood, anxiety and irritability, sleeping and eating disturbance and preoccupation with the lost baby are part of the normal reaction to severe loss [3,4,5]. Fathers experience less intense depression and anxiety than mothers, but are more vulnerable to using alcohol to cope with their distress [6]. The severity of disabling symptoms diminishes over the first year [3,7,8], though around a fifth of women have symptoms at case level 12 months from loss [7], which compares to about 10% of adult women in the general population. One study suggests it is two to three years until parents feel ‘almost fully recovered’ [9]. In addition to a grief response, one
study reported 20% of women to have post traumatic stress disorder (PTSD) in the subsequent pregnancy (compared to 0.4-4.6% in the general population), although only 4% were symptomatic at case level a year after the next birth [10]. PTSD has not been evaluated in a non-pregnant group following perinatal loss. There is a slight increase in post partum psychosis after perinatal loss [11]. Factors associated with more intense and prolonged grief include poor support from a partner and lack of other social support [3,13,14,15,16,17] (NB lose 12), history of mental health problems [7,13,18] and more ‘neurotic’ pre-loss personality [7,19]. Some but not all studies found greater distress in childless women [7,13,16], while no association has been found with difficulty conceiving [3,13], greater maternal age [15,16], sex of the baby [20], socioeconomic status [7,13], nor religious observance [7,13,15,21].

The literature on 'pathological grief' is a patchwork of idiosyncratic definition and opinion. The failure to arrive at an agreed definition of what constitutes normal mourning has been a major problem. A summary of clinical opinion is that pathological grief differs from normal grief by its duration and the degree to which day to day behaviour and emotional state are affected [22]. Although various subtypes have been suggested [23], most descriptions fall into two broad categories, prolonged and absent grief. Grief is said to be prolonged if there is no improvement by 6 months after the loss. By this time the loss should not be centre stage in a person’s life, and though there will still be sadness, the parent might expect to be more or less able to carry out normal family or work responsibilities [24]. In contrast, a minority of parents experience a relatively low level of distress after loss, and perceive themselves as coping fairly well [25]. Although it has been suggested that ‘absent’ grief may predispose to subsequent psychological problems [26], this theory has not stood up to systematic study which has shown that people who suppress grief do not usually experience relapse or other symptoms, and many recover with relatively few difficulties [27,28,29,30].

**Treatment of grieving parents**

While we should strive not to pathologise a normal response to painful loss, prolonged depression or PTSD are unpleasant and debilitating for the parent, and may
affect other members of the family, including children. For most people grief is self limiting, but those who suffer prolonged sleep disturbance in the months immediately following loss may benefit from either a sedative antidepressant or short term treatment with a hypnotic. Counselling is often offered routinely to parents. It is appreciated by those who use it [31], but a recent Cochrane review found no randomised control trials to demonstrate its usefulness [32]. Clinicians have to judge whether the process of recovery is proceeding as expected, or whether the parent is suffering excessively and may benefit from therapeutic intervention. For those whose depression continues unabated for 6 months or more, antidepressant medication has a place for biological symptoms, and psychological treatment may be offered to address factors which might inhibit recovery. Common issues for parents in psychotherapy or counselling are damage to self esteem by the failure to parent a live child, a sense of guilt, continuing anger towards staff (justified or unjustified), or unacknowledged anger towards the partner or the lost child [33]. There is evidence that those who cannot accept the finality of loss and who continue to try to relate to the dead infant as though it were sentient are more likely to have a disorganised attachment relationship with the subsequent child [34,35]. These parents are aware of their loss, but behave as though the child has continuing needs: ‘I hope he doesn’t mind that we’re having another baby’; ‘I’ve told her we’re getting married on her birthday’. Intervention that helps parents accept the finality of the child’s death may therefore benefit a subsequent child. Though there is evidence for the effectiveness of antidepressant medication and psychotherapy in the treatment of depression [36], neither has been systematically evaluated after perinatal loss.

**The effect of perinatal loss on other children in the family**

There are no systematic studies of the effect of stillbirth on existing children. Data are based on case studies which describe an initial reaction of puzzlement and confusion. If parents do not provide explanation, children may fantasise active destruction or abandonment of the expected baby and may blame the parents or themselves [37]. Older children may suffer a severe sense of loss [38], and parents may be so preoccupied with their own grief that their children’s needs are overlooked [39].
Early case reports suggested the next born may be treated with particular anxiety, and coined the terms 'vulnerable child syndrome' [40], and 'replacement child' [41,42]. Recent empirical work has supported these clinical impressions. An epidemiological study found association between anxiety disorder in adolescents and maternal experience of stillbirth [43], and two groups showed that infants born after perinatal loss had increased risk of disorganisation of attachment to their mothers [34,44].

The psycho-social management of stillbirth

Psychosocial management after perinatal loss is fashioned by cultural forces as well as by the wish of health professionals to help parents recover from the loss. Practices whose effect has been evaluated include the time between diagnosis of intrauterine death and induction, the encouragement for parents to see and hold the body of their dead infant, and the timing of the subsequent pregnancy. Recent work found a number of associations:

1. A large retrospective study of a population where virtually all parents saw their stillborn infant’s body found no association between the length of time spent with the dead infant’s body and anxiety 3 years later. However, mothers who said that they would have liked more time with the body reported higher current anxiety symptoms [45,46].

2. The same study reported that delay of 24 hours or more between diagnosis and delivery was associated with increase in anxiety 3 years after stillbirth [45,46].

3. Contrary to assertions that contact with the body of the dead infant facilitates mourning and the relationship with the next-born child [26] a recent study found higher symptoms of depression, anxiety and post traumatic stress symptoms in the subsequent pregnancy in mothers who had seen their dead infant, compared with those who had chosen not to. In addition, disorganisation of attachment behaviour was greater in next-born infants of mothers who had seen the dead child compared to those who had not [34,47]. Though it may be argued that personality factors may have determined both the choice to see the infant and psychological morbidity, the association was dose related, with those having most contact also having the highest symptoms, suggesting that contact itself could be traumatising.
[47]. No work has been published on outcome after neonatal loss in relation to parental contact with a dead or dying infant.

4. Conception within 12 months after stillbirth was found to be associated with greater symptoms of depression, anxiety and PTSD in the subsequent pregnancy. As this may impact not only on the mother but also on the developing foetus, there may be benefit in delaying pregnancy for a year [10,48].

**Cultural and considerations in psychosocial management**

Although the claim that contact with the infant’s body is a healing experience does not have empirical evidence to support it, the publication of evidence that challenged this position [Hughes et al., 2002] stimulated a vigorous response from parent support groups, whose members believe the social value of parents having contact with the body far outweigh evidence of increase in psychological symptoms [Lancet letters]. Perhaps physicians can have more sympathy with this position if they are able to recognise that the ‘medical’ model is not the only way of framing the meaning of the practice. While a cultural model demands recognition of the importance of the loss of a child at birth, and emphasises the meaning of ritual designed to mark and dignify the experience, the medical model frames the contact as an intervention, which may have measurable health outcome. The cultural model can be better understood if we place it within the culture from which it sprang.

**Historical background to present psychosocial management**

Until the middle of the twentieth century pregnancy was a hazardous business both for mother and child, with the main causes of mortality being sepsis and haemorrhage in childbirth. Effective blood transfusion became available in the 1930s, sulphonamides and penicillin were introduced in the 1940s, and drugs to control blood pressure in pregnancy in the 1950s and 60s. There was a steady drop in maternal and infant mortality, partly because of the new medical treatments, and partly because as children, women giving birth had been better nourished, and thus less liable to structural damage such as rickets that made pregnancy hazardous (Oakley, 1986; Carter and Dunitz, 1984). Hospital births became the norm, rising in the UK from 15% in 1927 to 95% in 1974. Medical intervention became more active
in other respects, and by the 1970s, over a third of UK births were induced, most mothers had an episiotomy, and Caesarian sections were rising (though never to the levels reached in the US). [59,60]. Thus over about 40 years childbirth, previously managed at home by midwives, became a technically monitored, hospital based experience.

However, by the 1970s, medical authority was being questioned, and articulate women complained they were being treated as component parts in a mechanical process, rather than as individuals having one of the most emotionally important experiences of their lives. This protest was encouraged by the feminist movement, which demanded that women be allowed control of their own bodies, and by the beliefs and rhetoric of the counterculture movement of the 1960s. A full discussion is outside the scope of this paper, but the counterculture movement’s celebration of self awareness and emphasis on recognising and not suppressing one’s emotions is of particular relevance. This was the background against which changes in the psycho-social management of stillbirth were proposed and vigorously championed by increasing numbers of midwives, doctors and parents in the late 1970s.

Prior to the late 1970s, parents were told if the foetus had died, and labour was awaited or induced. Parents were discouraged from seeing the body, which was often cremated by the hospital or buried in an unmarked grave. The attitude was to put the loss behind you and look to the future. Parents were not clamouring for change. A paper that reported parental attitudes to contact with the body of a dead infant found that most bereaved parents thought contact would be harmful for the parent [61]. The move for change began in the 1970s with papers by Kennell and Klaus in North America [62], and by Lewis in the UK. These clinicians asked for acknowledgement of the severity of parents’ loss, and for sensitive handling after the trauma. Lewis also claimed that lack of contact with the infant’s body would inhibit mourning, and that adverse effects might impact on a subsequent child [63]. Despite the absence of systematic evidence, the ideas were quickly picked up and promoted. Parents began to be encouraged to see and hold the child’s body, to wash and dress it as though it were a live infant, and to bring other children in the family to share the ritual.
There is evidence that most parents who see the body are afterwards glad they did so [64,18]. This observation is important, but is affected by cultural expectation. To an extent contact determines outcome. It is likely that physical contact and fondling increases attachment to the dead child, so that the parent will want to retain and perhaps celebrate memories of the experience. At the same time, the contact and increased attachment may leave the parent struggling to accept the separation and the finality of death, with consequences for both maternal mental state and the development of the next child. The demand that it is important to show respect for the infant’s body is incontestable. However, present management could be modified: if parents are adversely affected by increased contact, another family member might take responsibility for ensuring the body is disposed of in a respectful way.

**Parental autonomy**

The psychosocial management of perinatal loss raises issues of parental autonomy and beneficence. Most professionals, bereaved parents and others agree that parents ought to make the decision about whether or not to see their child’s body, and agree that professionals have a responsibility to offer parents such evidence as is available about the likely outcome of doing so. However, offering evidence to parents in this circumstance is peculiarly difficult: routine discussion of perinatal loss is unlikely to be welcome in antenatal classes, and in the highly charged moments following the death or birth, dispassionate discussion of the evidence base may be insensitive. When it comes to practice, the literature reveals some confusion about the nature of evidence used to assess outcome. While a health professional may argue from his or her own experience that parents are glad they have seen and held their child’s body, they are not justified in going beyond this to claim that doing so will protect the parents or family from later adverse effects. Available evidence indicates that some professionals will try to persuade parents to have contact believing that their conviction of the benefit outweighs parental inclination [65,66]. Thus, in the past, a policy of beneficence was used to justify removal of the dead infant, and precisely the same stance is now taken to justify encouraging reluctant parents to see and hold the body of their child after a stillbirth [65,66].
**Conclusion**

Parents who suffer perinatal loss are likely to experience grief lasting up to 2 years, although most should expect to feel improvement in mood by 6 months from loss. Many centres routinely offer counselling to bereaved parents, and although those who use the service feel it is worthwhile, there is not yet empirical evidence to demonstrate its value. If a parent continues to suffer grief symptoms unabated for more than 6 months, further psychological assessment is indicated.

The practice of encouraging parents to see and hold the body of the dead infant is controversial. There is evidence that parents who chose to do this treasure the memory. However, claims that it helps the mourning process are not supported by empirical evidence, and recent work suggests that parents who elect not to see the body have lower subsequent psychological symptoms, and their next-born infants are less likely to show disorganisation of attachment behaviour at one year. Health care staff who encourage reluctant parents to see or hold the infant’s body may invoke the principle of beneficence, but it is doubtful that this can be justified on existing evidence.

**References**


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