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Personal practice

Mourning by the family after a stillbirth or neonatal death

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SUMMARY Failure of the parents to mourn after the sorrow of a stillbirth or neonatal death can result in dire consequences for the well-being of the family. Doctors and nurses should learn how to facilitate mourning and should accept the strange and sometimes bizarre forms this may take. When mourning is facilitated, the family is likely to adjust better to its bereavement.

Stillbirth is a common tragedy occurring in about one in 100 deliveries. Yet after a stillbirth everyone tends to behave as if it had not happened. In hospital bereaved women are usually isolated and avoided and then discharged as soon as possible. Although this is meant kindly, to protect the mothers from the painful awareness of live babies, it also means that the hospital staff do not have to face their own anxiety about stillbirth. Back at home, the family, friends, and professionals continue to avoid talking to the bereaved mother, depriving her of the talk that would help her mourn. There is silence. Statistical evidence shows that family doctors are astonishingly reluctant to know or remember anything about the patient who has a stillbirth (Bourne, 1968). This avoidance by the helping professionals extends into neglect of the study of the effect of stillbirth on the mother and the family. There is a conspiracy of silence. We seem unwilling to come to terms with the fact that it is a tragedy which can seriously affect the mental health of a bereaved mother and her family. After the failure to mourn a stillbirth, mothers can have psychotic breakdowns or there can be severe marital difficulties. Children born before or after a stillbirth where there has been a failure to mourn the stillbirth, can have severe emotional difficulties. Many mothers have mothering difficulties with the child born subsequently (Lewis and Page, 1978). The surviving twin of a stillbirth faces profound difficulties in life.

The psychoanalytical view of mourning is of an ongoing process during which the conscious and unconscious mind works on coming to an understanding of the memories, thoughts, and feelings about the dead person. The dead person is unconsciously imagined as being taken inside our mind and our body. The dead can be felt as dead inside us. We identify with the dead person. Doctors meet this phenomenon when a bereaved person develops imaginary symptoms related to the illness of the dead person. During the work of mourning we digest our memories and feelings about the dead and free ourselves from the identification. With incomplete or failed mourning the identification can persist and result, for instance, in a depressive illness with somatic symptoms. Or a failure to come to terms with our inevitably mixed feelings for the dead can lead to a denial of negative feelings and an overemphasis of positive feelings. A potentially dangerous idealisation of the dead person can result. When a mother idealises her dead child there can be dire consequences for the mothering of her subsequent children.

It is the nature of stillbirth that leads us all to avoid the subject. Bourne (1968) described stillbirth as a nonevent in which there is guilt and shame with no tangible person to mourn. A stillborn is someone who did not exist, a nonperson, often with no name. It is an empty tragedy and a painful emptiness is difficult to talk about. After a stillbirth there is a double sense of loss for the bereaved mother who now has a void where there was so evidently a fullness. Even with a live birth the mother feels a sense of loss but the consolation of a surviving 'outside baby' helps the mother to overcome her puzzling and

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bewildering sadness at losing her 'inside baby' (Lewis, 1976a). With a stillbirth, the mother has to cope with an outer as well as an inner void. There is an even more puzzling sense of nothingness for a mother who is anaesthetised at delivery—for example with a caesarean section.

Memory facilitates the normal mourning processes essential for recovery. With other bereavements there is much to remember. These memories can be shared and cried over with family and friends. Not so with stillbirth—there is no one to talk about and no one to talk to about it. The bereaved mother may herself avoid contact with people because of unconscious feelings of shame and guilt. Her shame is associated with the sense of having failed as a woman. She may feel that there is something wrong with her womb. Her guilt has to do with fantasies that her thoughts or actions have caused the death—for example, by having considered a termination of pregnancy or by having sexual intercourse late in pregnancy. If we allow mothers to isolate themselves we may seem to be confirming that their shame and guilt are justified. Many bereaved mothers keep their distress to themselves, not only to avoid too intense an awareness of their loss, but to protect others from distress. By so protecting others they deprive themselves of the talk which would aid mourning. And of course husbands and children also have their guilt about a stillbirth because of their mixed feelings about the pregnancy. This impedes their mourning.

To facilitate mourning I recommend that a stillbirth be managed by making the most of what is available and can be remembered. The aim is to fill the emptiness that impedes mourning (Lewis, 1976b). Bereaved parents should be encouraged to help lay out their dead baby. A post-mortem photograph, examination, and *x*-ray will assist genetic counselling. Parents should also be persuaded to take an active part in the certification of stillbirth, to name the baby, and to make the funeral memorable. The practice of burial in a common and nameless grave should be avoided. The family should be encouraged to attend the funeral or cremation and to know of a marked place or grave. Other children in the family find the idea of a stillbirth incomprehensible and frightening. Yet it is they, in particular, who tend to be left in the dark about the stillbirth, left without help with their grief.

It is my impression that if a stillbirth has been a real experience for the family in the ways that I have described, mourning will have been facilitated. This leads to fewer psychological problems for the mother and her family. When a stillbirth is managed in the way that I have suggested I believe that it is a helpful experience for staff and patients. However there is a need to be prepared for some upsetting and crazy experiences. The management of stillbirth causes considerable anxiety, particularly if the child is macerated as a result of intrauterine death or is malformed (Lewis, 1978). For this reason it is helpful if those managing such a painful happening as a stillbirth can have discussions with staff who have had experience of it. The reaction of parents and staff themselves to stillbirth and neonatal death can be disconcerting. The normal reactions to bereavement *are* disconcerting. Freud (1957) said of normal mourning that it would seem like an illness were we not aware of the bereavement. Most people know little of the natural history of the normal reactions of parents handling their dead babies.

With stillbirth or neonatal death, it is partly the loss of what might have been, the loss of experience in the future, which makes them such heart-rending and deeply frustrating experiences.

A baby of 27 weeks' gestation was resuscitated several times in the 10 days it survived. The mother had seen the baby collapse and thought it dead, but it was resuscitated to live a short time. With difficulty, the ward sister was able to arrange a funeral and cremation for this baby, even though it was under 28 weeks' gestation. The baby was laid out in the incubator. The mother was encouraged first to touch and then to hold him. She became frenzied, clutching her baby, and then stripping the clothes off. She kissed his navel and his penis. She forcibly opened his mouth and said, 'That's where his teeth would have been'. Then she 'walked' her baby on the floor. Soon the mother calmed down and gave the baby back to the sister. The sister was distressed but when later the parents came to see her, her impression was that this mother was coping better than many bereaved mothers.

The detailed study of the natural history of bereavement has shown that many seemingly crazy ideas and actions are within the normal range of responses to loss (Parkes, 1972). Although this mother's behaviour appears mad, if we examine it more closely we can see the sense in her behaviour. She was attempting to come to terms with the baby's lost future. In her mind she maintained the continuity of the cycle of life. By kissing the umbilicus she was remembering her creative link with the baby *in utero*; kissing the mouth may be linked to the kiss of life, to the resuscitation. The mother longed for her son to grow teeth and learn to walk, and kissing his penis could be considered a wish to restore her dead son's potential capacity to create life. Creating memories about her baby in this way facilitated mourning.

A nurse, a senior sister, suggested that the parents of a dying, severely brain-damaged 'prem' look at

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and touch their baby. Knowing that the mother had wanted to breast feed her baby, the nurse suggested that the mother might take off her blouse and hold her baby close to her skin. This suggestion by the nurse seems to ignore the critical state of the infant, and may have been provoked by her wish that this virtually dead baby might live. To the nurse's consternation the mother put the dying 'prem' to her breast, expressed milk into the infant's mouth, and then moved its mouth to encourage swallowing. When the baby died the parents washed and dressed him in the baby clothes that the nurse had suggested they bring with them. In her next pregnancy this mother's memory of her dead baby was of cradling him in her arms. So far, although at times tearful when remembering her dead child, she is making a good job of the mothering of her new baby. While the nurse went further than I would have advised out of my concern for the physical management of the admittedly moribund baby, nevertheless she may have helped the mother when the baby was beyond medical help.

A 28-week premature baby died at 3 days. The mother telephoned the nurse who suggested that the parents come to see their dead baby son. The mother asked if she could bring baby clothes and the nurse agreed. The nurse took the parents to the viewing room by the mortuary. They dressed their baby and told the nurse the baby's name. After this sort of experience with their dead baby many parents, because they find it helpful, keep in touch with the staff. The mother later visited the unit and asked the nurse whether she considered blue a morbid colour to paint their living room. She also said that she was learning to crochet. It seems to me that this mother was thinking about the blues, and perhaps associating blue with boys, and her dead son. She may also have been asking permission to go on living, to improve her living room, which unconsciously was probably symbolic of her womb, just as learning to crochet may have been symbolic of her making a new baby. She seemed to be asking the nurse if she could be considered the sort of woman who could be trusted with another baby. Unconscious destructive feelings to a lesser or greater extent are always present as part of the normal mixed feelings that a mother has about her pregnancies. After the baby died this mother feared that her unconscious destructive feelings were a reason for the child's death. Because of this she seemed to need the nurse's reassurance about her baby-making ability versus her destructiveness.

I am loath for parents to rush into pregnancy after a stillbirth until they feel that they have adequately mourned their dead baby. They need time to think through and come to terms with the stillbirth, and to understand how to avoid the idealisation of a dead baby that so often bedevils the life of subsequent children.

A premature baby died. The father gave away the baby clothes etc. The mother went home, took out a small bundle of baby clothes that she had hidden away, guessing that her husband might give the baby things away, and cried over the clothes.

The wife of a medical student studying anatomy had a stillbirth. He remarked to a fellow student that he wanted to get hold of his stillbirth to dissect it. His colleague was amazed, but now understands the father's need to have some tangible experience of his stillborn child, so as to facilitate mourning. This story seems upsetting but is an example of how bereaved parents will seek of themselves to get an experience of their stillborn, sensing that this will help them to mourn. Obviously this father would have benefited from other help.

Similarly many mothers seem to know that it would be helpful to look at their dead baby, although they are usually put off when they ask hospital staff whether they should do so. One mother in trying to get an experience of her stillborn child made the most of what she had seen—a cot and a wisp of black hair on the top of his head. This is now a dear memory for her.

A photograph of a dead baby can help parents who have been unable to see their stillborn child. Or other eyes that have seen can tell the parents. A husband carefully described to his wife how his stillborn daughter had looked, described her face and hair, her delicate normal body and limbs, and also the dark-stained blotches on one side.

A woman house surgeon did something like this for the parents of an anencephalic baby which her consultant had refused to allow her to show the parents. She described to the mother and father the normal body, the normal delicate hands and fingers, legs, feet, and toes of the anencephalic baby. The doctor also encouraged the father who had wanted to protect his wife by leaving her out of the funeral, to take her along. The doctor said it was also the mother's baby and so the father did take his wife to the funeral.

It is necessary to make recommendations about the management of stillbirth in hospital. I believe that parents left to themselves, and this is particularly so with domiciliary delivery, would do things better. You may feel that my suggestions about the management of stillbirth and neonatal death are silly. But I suggest that the normal 'rugby pass' management of stillbirth in hospital is rather more bizarre. I refer to the catching of a stillbirth after delivery, the quick accurate back-pass through the labour room door to someone who catches the baby

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and rapidly covers it and hides it from the parents and everyone. Our hospital culture tends to impede the normal healing process of mourning. We do this even by asking the mother whether she wishes to see her dead baby. Really what could be more natural? It heartens me when I hear of a father describing the baby in detail to his wife, of the mother who hid the baby clothes to cry over, or of the father who wished to dissect his baby, or of the mother who kissed and walked her dead baby. Sometimes people know how to help themselves. It is difficult in hospital. A senior midwife was encouraged by the obstetrician to show a stillbirth to the parents. She took the macerated stillbirth out of the labour room saying, with the irony of the unconscious, that 'to show them the baby would put them off stillbirth for life'. Fortunately this midwife recovered, brought the baby back to the parents and, with great sensitivity, showed them the normal limbs, fingers, and toes, and asked them the name of the baby.

In the Far East there is a cactus with white fragrant flowers that blooms briefly only every few years. Each bud opens and dies visibly in front of one's eyes within a few hours. A family may sit together and watch the birth and death of the flower, for it brings good luck. A Far Eastern couple buried their stillborn in a little grave with a small headstone inscribed with the name of this cactus given to their child. An act of creative poetic self-healing.

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