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Psychosocial Care for Women After Perinatal Loss in the Czech Republic

Opieka psychospołeczna dla kobiet po stracie okołoporodowej w Republice Czeskiej

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Abstract

This article presents selected aspects of psychosocial care for women after perinatal loss in the Czech Republic. The mourning process after stillbirth and after an early neonatal loss is defined and the management of psychosocial care for women is described. We foremost address ourselves to the usage of interventions that lead to getting to know the baby, to parting with the dead baby and to obtaining mementos of the infant's existence. According to the most recent research, new procedures for nurses or midwives are recommended (Piel. Zdr. Publ. 2014, 4, 1, 53–58).

Key words: psychosocial care, perinatal loss, stillbirth, early neonatal death.

Streszczenie

W artykule przedstawiono wybrane aspekty opieki psychospołecznej dla kobiet po stracie okołoporodowej w Czechach. Zdefiniowano proces żałoby po urodzeniu martwego dziecka oraz po wczesnej stracie noworodka i opisano zarządzanie opieką psychospołeczną dla kobiet. Obecnie wykorzystuje się interwencje, które prowadzą do poznania dziecka, do rozstania z martwym dzieckiem oraz do uzyskania pamiątki jego istnienia. Zgodnie z najnowszymi badaniami zaleca się nowe procedury dla pielęgniarek i położnych (Piel. Zdr. Publ. 2014, 4, 1, 53–58).

Słowa kluczowe: interwencje psychospołeczne, strata okołoporodowa, urodzenie martwego dziecka, wczesna śmierć noworodka.

The Czech Republic is one of the countries with the lowest perinatal mortality in the world. According to the Czech statistic office's data, the fetal death rate reached only 2.49 per 1,000 births, and the early neonatal death rate 1.02 per 1,000 births in 2010 [1]. However, 400 women and their families experience perinatal loss every year there. The term perinatal loss means death of a fetus or a newborn in the perinatal period (between the 24th week of gravidity and 7 days after the birth). The loss is mostly accompanied with feelings of sadness, helplessness, grief of varying intensity, and thoughts about the lost baby. These feelings are a natural reaction that accompanies the loss of loved ones and that is described as the grieving process.

Determinants of Grief After Perinatal Loss

Grief and mourning are natural states that follow the loss of somebody/something that was highly valuable for the affected person [2]. Grief is a multidimensional phenomenon which includes physical, behavioral, and spiritual components, and which is characterized by a complex combination of cognitive, emotional, and social changes, that accompany the loss of a loved one.

One part of mourning is acute grief, which is manifested by deep sorrow, nervousness, anxiety, irritability, insomnia, dysorexia or overeating, lack of concentration, and intrusive thoughts. Acute grief usually lasts from weeks to months, and it is an individual experience (with various intensity, various duration and various ways to express the sor-

row) [3]. Dolorous feelings gradually recede, and thoughts about the deceased one cease to dominate in the survivor's mind. Bonnano and Kaltman [4] mention that a certain resilience starts being developed within 6 months after the loss. Stroebe et al. [5] discovered that the majority of survivors coped with their grief well, and they found new, constructive ways of dealing with life changes.

The way the parents handle the situation of perinatal loss and how they adequately cope with the demands put on them depends on numerous factors. Among the significant determinants of perinatal grief, we count individual characteristics, the obstetric context, and social environment.

Individual Characteristics

In most of the studies conducted, no correlation between the age of women and the intensity of their grief after perinatal loss has been discovered [6]. Only some studies [7] have suggested that the younger the women are, the greater the intensity of their grief. It is possible that elder women have more resources to handle the situation and that they often already have elder children in their family. In the research of Cacciatore et al. [8], younger mothers and mothers who had experienced recent loss had more anxiety symptoms. Most experts agree that an important predictor of mourning intensity is the psychological health of women before the loss [6, 7].

Friedman and Gath [6] have in their study confirmed a connection between psychiatric history, neuroticism, and psychiatric morbidity (especially depression) after perinatal loss. Likewise, a correlation has been discovered between women's grief intensity and a positive psychiatric anamnesis before perinatal loss in the prospective longitudinal research by Janssen et al. [9]. Women who had more psychiatric symptoms before the loss reacted more intensely than others in the initial phase of the mourning process. The differences, however, equalized over time.

Obstetric Context

The prospective and longitudinal study of Janssen et al. [9] has concluded that late loss and absence of any living offspring in the family are significant risk factors for more intense grief response to perinatal loss. This was also concluded in previous studies [7, 9].

In the research of Cacciatore et al. [8], there were third trimester losses (vs. second trimester losses), low parity at the time of loss (vs. higher parity), and having experienced births after loss (vs. not having experienced births) associated with few-

er symptoms of anxiety. In addition, previous live births (vs. none), low parity at the time of loss (vs. higher parity), and having experienced births after loss (vs. not having experienced births) were associated with lower levels of depressive symptoms.

Social Environment

Matrimony and social support are important predictors of the health of grieving parents, both individually and as a couple [10]. Bad quality of the marital relationship relates to a higher level of grief and to the poor overall psychological condition of women as well [7]. The risk group, regarding the mourning process, is considered to include women whose communication with their partners had already been difficult before the loss, women without a partner, and women who consider their social environment to be insufficiently supportive [6]. When women perceived support from their friends and family, the degree of their sorrow was lower [7]. Being married (vs. unmarried or divorced/widowed), in the research of Cacciatore et al. [8], was associated with fewer symptoms of anxiety and with lower levels of depressive symptoms.

Parental grief is also related to external situation and circumstances. During the research of the grieving of parents who had lost their infant, a connection was discovered between grief intensity and the age of the infant, the situation, unexpectedness of the death, and the number of other progenies. The grief intensity was lower with parents who had experienced perinatal loss than with parents who had lost their offspring under the age of 17 years. Parents who lost their children unexpectedly suffered from a higher level of grief than parents whose offspring had passed away after an illness. Parents mourned less and depression occurred in fewer cases when they had other children in their family [11].

Grieving After Perinatal Loss

When awaiting a birth, parents gradually change their lifestyle, their home, their life. The child represents hopes for the future, hopes for a better life and hopes for bigger opportunities. The child may represent the potential of fulfilling the parents' dreams, a way to start again and a possible change in their life course. Perinatal loss is therefore the loss of anticipation and of the future. The child represents a part of the parents' identity. Parents, therefore, lose a part of themselves, lose their parental competence, their hopes. The lost baby is also a person who will always be missed

and whose loss will last despite the fact that their parents will have other children. After perinatal loss, most parents experience grief, distraction, feelings of guilt, or somatic problems. Women after perinatal loss often feel failure in maternity and the woman's role, feelings that "I am a bad mother", and fear of losing their partner. They feel excluded from society, of which children are an integral part. The research also shows a disruption of the relationship with the partner and with the family [12, 13].

Parents after perinatal loss go through the grieving process, in which we can distinguish certain phases [14]:

1. Shock. Emotions are cut off. It is a phase of a certain "numbness". This phase mostly lasts from a few hours to a few days. The shock phase accompanies the announcement of the death and it can be associated with an inability to believe and accept the information about the loss. "It is impossible. It can't have happened".

2. Disorganisation. The inability to perform even simple tasks. Meaningless activities are typical, together with a "Why me?" question.

3. Denial. Searching for possibilities that the loss didn't happen. "The baby may start to cry after the birth."

4. Depression, sorrow, feelings of emptiness, crying, sadness, anxiety. The feeling of physical emptiness after the birth corresponds with emotional emptiness. Parents may intensely think, dream, or daydream about their lost infant. This phase can be accompanied with dysorexia and somniphobia.

5. Guilt. "Could I have done anything differently? Whose fault is it?" Mothers frequently blame themselves.

6. Anxiety. Loss of control of the future, fear of the future. "Could the thing that happened have any meaning? Can it happen to me again?"

7. Aggression. It can be projected onto anybody, such as friends, family, God or, of course, doctors and midwives.

8. Decision. Acceptance of life and the fact that positive things will happen again. "We are getting over it."

9. Reintegration. Practical acceptance of the decision, building a new life. A regression of sorrow and despair occurs on the baby's birth/death anniversary, during a new pregnancy etc. "We will never forget."

It is important to realize that the phasic models of grieving are only a guide to the care of survivors and that it is necessary to always apply them in an individual context, with consideration of interindividual, intersexual, and intercultural differences.

Psychosocial Care Management After Perinatal Loss

Midwives or nurses manage and plan care for women after perinatal loss. A specific case of perinatal loss has a significant name – stillbirth. Not only does the baby not announce its arrival by crying, but the death of the fetus is also invisible in its way. The mother felt the infant's movements, she may have called the baby by its name and dreamed about its appearance. However, she lacks any other memories: she lacks concrete evidence of her baby's existence. The loss therefore becomes ambiguous. Doctors and the public frequently call this situation the loss of a pregnancy, not loss of a baby. The ambiguity of the loss can be manifested by denial, uncertainty on what approach to the loss to take, tireless searching for information, helplessness, and lower social support from the environment. In psychosocial care management, we emphasize the interventions that can help the mother know the infant (see it, hold it), to part with it and also to gain mementos of the baby's existence (such as a photograph, a handprint or footprint, a lock of hair, etc.). Knowing the infant and parting with it can take the form of a ritual. Ritual behavior at the time of a loss of a close person is based on deep human need and the urge for meaning, for social support, and for meeting the supernatural. Rituals performed in society aren't invariant, they change, they evolve. The rituals always need to be based on the needs and wishes of the parents in the case of perinatal loss. Midwives should always take interest in these needs and wishes, offer the options, provide the conditions, support and take part in the rituals chosen by the mother/parents [15, 16]. The term ritual is commonly used in foreign publications to describe the interventions, procedures, or habits that occur when caring for the mourning parents. The rituals which are used to support parents stricken by perinatal loss should function in a protective and supportive manner, provide a sense of control over the situation, a sense of reality of the baby and of its loss, and help to start the mourning process this way [15].

In the Czech Republic, we learn about the rituals that can be used by parents after a stillbirth, primarily from foreign literature and research conducted in western countries. The basic rituals that are offered to the parents after perinatal loss are: to see the baby and part with it, hold it and be alone with it. Contact with the baby is, in western countries, enhanced by bathing and dressing the infant and taking it home. Professionals caring for such parents in western countries have started to

be uncritically convinced about the benefits of all the rituals. However, in 2001, certain concerns that the interventions might have a negative impact on mourning parents in some cases started to occur. Most discussions among the professionals have been held about the physical contact with the dead baby (seeing the baby, holding it, bathing it). These discussions were started mainly by the publication of a cohort study by Huges and Turton [17] from Great Britain. The authors reported that the respondents of their study who had seen or held their stillborn baby had been more anxious, depressive, and had suffered from post-traumatic stress disorder in the following pregnancy more often than women who hadn't seen their stillborn baby. Women who had held their stillborn baby were more depressed than those who only saw the infant, while those who did not see the infant were least likely to be depressed. Women who had seen their stillborn infant had greater anxiety and higher symptoms of post traumatic-stress disorder than those who had not and their next-born infants were more likely to show disorganized attachment behavior. Having a funeral and keeping mementos were not associated with further adverse outcomes. [17] Hughes therefore recommends that women should not be forced to see or hold the infant after the birth, or that they should not be encouraged to do it by saying that the mourning process will be more complicated if they don't do so. Badenhorst [18] points out a certain chance that physical contact with a dead baby may be connected with a worse psychological impact, development of post-traumatic stress disorder in both parents and a higher probability of mother-infant relationship disturbance in a following pregnancy. Cockburn [14] reports that women who had seen or held their stillborn infant had a disturbed relationship with the fetus in 42% of cases in a following pregnancy, compared to 8% in the case of women who had never seen their lost baby.

In 2004–2005, an extensive study [8] was conducted. 2,292 women from the USA, Australia, and Canada that had had the experience of miscarriage/stillbirth (after the 20th week of gravidity), and from whom 286 had been pregnant again, were questioned. This research confirmed the negative influence of interventions on women's psyche during the pregnancy following perinatal loss. The research, however, also showed a positive influence of interventions in the long-term perspective. Among women who weren't pregnant during the research, the intervention "seeing the baby" was connected with a lower level of anxiety and depression. Cacciato et al. [8] therefore recommend psychological support in the following pregnancy instead of discouraging women from contact with the baby.

Experts generally agree that it is impossible to take a backwards step and prohibit the mothers from seeing or holding their babies. If the parents themselves wish to see and cuddle their stillborn, the midwife should inform them about what the parents would see and feel during the physical contact. It is necessary to keep an open and individual attitude, to respect the woman's desires, and instruct them about the possible impacts on any following pregnancy. It is also necessary not to rush the women who are uncertain of their decision. Parents are mostly still in the shock phase and it is very difficult for them to make a decision. Each pair is unique and has unique strategies for dealing with the difficult life situation. Therefore, it is impossible to recommend one universal approach. It is most convenient to have a dialogue with the clients, answer their questions, suggest the alternatives (e.g. if parents don't want to see their infant, they might want the midwife to describe how the infant looked, or they can come back for a photograph), give the stricken parents enough time to make a decision, and then respect and support their decision.

Mementos of the baby are considered very important for the grieving process. Lasker and Toedler [8] discovered that parents who had a photograph or other memento of their baby were significantly more satisfied than parents who did not have any particular memento.

Another observation study showed that owning mementos of an infant decreases the amount of anxiousness of mothers in a long-term perspective. Many parents are shocked and stressed at the time of loss, especially when the loss is sudden and unexpected. At that moment, they are not able to think about making mementos, and they are later grateful to the staff who helped them capture and preserve the mementos. Depending on the type and time of the loss, sonograms, cardiotocograms, hospital bracelets (name labels), photographs, or clothing of the baby are usually gathered into a memento package by the hospital staff in western countries. Also, in the Czech Republic, some hospitals already offer a birth certificate with condolences, or a handprint/footprint as a memento of the lost baby [19, 20]. It is very important to manufacture the memento package (card, brochure) really carefully and neatly so that parents have something they can keep forever.

The aspect of time is also important. Parents need enough time to ponder what they want, and what they don't. The decisions can vary throughout time. It is not unusual that parents start to miss the mementos after returning home. Some hospitals therefore always take photos of the baby and archive them. Parents can always come back for the photographs later.

Equally important for parting with the dead baby is creation of a dignified environment. A birthing room separated from the delivery room, or a room dedicated to parting with the infant, which can be equipped with candles or religious attributes, is convenient. It is also helpful to inform the staff that there are mourning parents in the room so that no painful and disturbing questions and comments are spoken. The door to the room might, for example, be marked with a black ribbon or flower. Sometimes a candle that burned during the birth can be included in the memento package. If parents decide for physical contact with their infant, they should be given enough time for the parting (as much as the parents wish). Also, the other family members (grandparents, siblings, etc.) should be given time and space to part if the parents so desire.

Conclusions

In the Czech Republic, physical contact of mother and infant after perinatal loss is held in approximately one third of the cases [21]. It is a small amount in comparison to western countries (see Table 1). We consider it a problematic issue that the intervention is mostly not offered to women, and that they only have a little time to make a decision whether or not to see their baby. 53% of women mentioned that they weren't offered the option to see the baby at all, and that this option didn't come to their mind at the moment of loss. 70% of these women now regret it. [21] This attitude indicates the uncertainty of the health professionals in their approach to women after perinatal loss and, from this uncertainty, their resulting paternalistic communication style. The dominant position of medical professionals allows them to decide what to tell the parents and what is the "best" for them.

To integrate the experience in their personal history, women after perinatal loss need to rediscover meaning in spirituality, motherhood, womanhood, and sexuality. Searching for the meaning and welfare requires a safe space for receiving the information, for pain, fear, and sorrow relief, and

for expressions of craving for the lost beloved person. If such a space is not provided, and women keep being socially persuaded about what "normal" is, the rediscovery process is spoiled. Women are kept in disintegration, and integrity is substituted with feelings of inadequacy. [22] It is therefore necessary to maintain an individual and open approach to women after perinatal loss. A sufficient amount of information about all the options that the parents can utilize to handle the difficult situation after stillbirth or neonatal loss should be unexceptional. It is important to leave the competence of the decision, whether or not to utilize their options, to the mother or parents. It is also important not to hurry parents who are not sure about their decision.

Every couple is unique and has unique strategies of dealing with a painful situation, and it is therefore impossible to apply one universal approach. It is more convenient to openly communicate with the clients, answer their questions, suggest alternatives (e.g. if the parents don't want to see their dead baby, they may want the description from the midwife, they may come back for the photograph of their infant, they might symbolically part with them, arrange the funeral, etc.), leave the parents enough time for a decision, and respect and support the decision thereafter. True care of mourning parents is very psychologically demanding. The medical staff involved directly encounter human suffering, despair and helplessness. When being confronted with perinatal loss, medical professionals may also experience a high level of anxiety and emotional fatigue, and some studies also mention indirect traumatization, which manifests itself with depression, anger, helplessness, intrusive thoughts, and/or nightmares [8]. Also Slezińska and Krzyżanowski [23] mention that for nurses, the experience of a patient's death causes a lot of emotions – especially negative. It influences not only aspects of the professional work, but also the private life, psyche, mood or value system of nurses. Medical and nursing staff therefore need quality education in the field of caring for mourning people [24]. They also require certain support and space where they can process their feelings and experience, for example by supervision.

Table 1. Interventions in the Czech Republic compared to western countries

Tabela 1. Interwencje – porównanie Republiki Czeskiej z tzw. krajami zachodnimi

Stillbirths	Mothers who did see and hold the baby [%]	Mothers who only saw the baby [%]	Mothers who did not see the baby [%]
Czech Republic [21]	22	11	67
United States, United Kingdom, Australia and Canada [8]	90	5	5
Sweden [25]	81	10	9

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Conflict of interest: None declared

Received: 14.10.2013

Revised: 5.03.2014

Accepted: 27.03.2014

Praca wpłynęła do Redakcji: 14.10.2013 r.

Po recenzji: 5.03.2014 r.

Zaakceptowano do druku: 27.03.2014 r.