Review

Gestational, Perinatal and Neonatal Loss: Emotional and Psychological Consequences on Mothers, Fathers and Healthcare Professionals

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ABSTRACT
The current article contains compilation of significant contributions done by theorists over the years about the phenomenon of perinatal loss. The objective of this paper is to provide information about important emotional and psychological consequences on parents who suffer stillbirth. This article addresses identity issues of the mother, father, and their relationship as a couple. It also provides information on the psychological, emotional, and legal aftermath of healthcare professionals who assist during the process of loss.

Keywords
Patient-child; Healthcare professionals; Child death.

INTRODUCTION
The death of a loved one can extraordinarily affect those who suffer the loss, with negative consequence on the psyche. Some psychologists have indicated that the psychological trauma of loss is analogous to the traumatic experience of being severely burned or wounded. The loss of a loved one is, in itself, a painful event. Beyond being a painful event, it is categorized by one of the most complex and stressful experiences a parent can suffer, and could be considered a devastating event. This type of loss is especially intense when the loss of an unborn child is involved. It is peculiar different from other types of losses; due to the unnatural process that negates the creative biological cycle for which parents-to-be are not prepared. Also, this type of loss is not acknowledged by society, which may influence a mother to remain silent about her suffering, increasing mental and emotional distress. This matter is not recent; over the years, authors have made significant contributions to our understanding of the subject, suggesting the need for specialized attention.

de Madinabeitia refers to the first article about the suffering of stillborn parents published in 1959. The article reviewed the difficulties that an obstetrician had when facing fetal death before, during, and after childbirth. It demonstrated that the doctors’ suggestion that as soon as the mother woke up from anesthesia, she would be told about the birth process but avoid mentioning seeing or holding the baby. The doctor would suggest that the mother have another baby as quickly as possible, giving her happiness and self-confidence.

In 1968, Bourne drafted an article on the psychological effects of the deceased baby in the women and their doctors. He suggests that the deceased could become a type of “blind spot” for the professionals (professional blind spot) that go through the experience, pretending that it had not occurred at all. The medical professionals kept absolute silence about the occurrence and would sedate the mother in the stillbirth with the intention of “avoiding the pain” of seeing the baby lifeless. When the mother woke up, the body had already been taken out of sight. As previously mentioned, the most common recommendation for these cases was to suggest a new pregnancy for parents to forget the passing.
Further, Kennell et al. published about the grief of neonates. The paper highlighted distinctive elements such as sadness, poor appetite, difficulty sleeping, and concern with the lost child, and the inability to return to the activity of daily life. Benfield et al. studied the responses of grief in first-borns of neonates in vital risk, and in that same year, work on the specific management of stillbirth was published.

Peppers et al. proposed other elements of grief: difficulty concentrating, anger, guilt, refusal to accept reality, temporary confusion, exhaustion, lack of energy, depression, and repetitive dreams with the deceased baby. After this contribution, the interest in attending the perinatal loss according to its particularities began.

Callahan et al. stated that the perinatal loss is different from others because of the “refusal to talk about what happened because the cause of the death is often unknown and because of the intense guilt it generates.” Addressing this issue, as described, was called the unrecognized bereavement. That same year, Kirkley-Best et al. pointed out “without proper study, professionals are destined to follow the fashions of popular books about grief, without meeting the specific needs of the parents of stillbirths.” To facilitate the elaboration of grief and reduce the guilt it generates in the parents, they recommended the birthright to see and hold their baby. In addition, they proposed to develop support groups for those affected.

Leppert et al. documented that women experience intense grieving reactions during the first six weeks after the loss. The results reflected that guilt seems to be the predominant feature in the sample’s grieving response, with manifestations regarding the cause of the death is often unknown and because of the intense guilt it generates.” The paper highlighted distinctive elements such as sadness, changes in appetite, alteration of sleep patterns and inability to perform the functions of daily living. Moreover, Benfield et al. studied the responses of grief in the firstborn of the neonates. Another author that provides more information on the topic was Rando. Rando proposed six phases in the bereavement process: (1) recognize the loss, (2) react to separation by remembering, re-experience the deceased, (3) remember and experience pain, feel, identify, accept and find ways of expression for psychological reactions to loss, (4) give up the attachment with the deceased and previous vision of the world, (5) readjusting to the new world adaptively without forgetting the above and developing a new relationship with the absent as well as new ways of being in the world, (6) reinvest energy in the present and look to the future. This author also pointed out the importance of losses that lack social recognition, such as perinatal loss. Finally, Niemeyer proposed a new vision of grief. Defined grief by reconstructing the meaning of the loss, and highlighting the active process. Also, he indicated that the grieving process is determined not only by the emotions, but by the relational context and the meanings the grieving person gives to the grief and to the restructuring after the loss. The author established the following steps in the process: (a) avoidance, (b) assimilation, and (c) accommodation. The contributions made by experts on the subject revives some of the consequences that the loss can cause to those involved. In addition to the aforementioned sequels, such losses can disrupt other related areas such as motherhood, fatherhood, and couples’ relationship.

**MATURE AND LOSS**

Women who suffer the loss of their baby may experience a variety of symptoms such as shame, guilt, and a sense of failure. Of all these symptoms, guilt is the most common because they feel they could have done something to prevent the death of their. This feeling of guilt can come from the social perception in which parents are expected to be the ones who take care of their children and provide them with protection. In addition to the feeling of guilt, both the mother and the father may experience feeling, shame, desire to die, and suffer the stigma because of their feel they.

The intensity of the symptoms that each person experiences can be varied; individuals who are predisposed to feel shame and guilt often experience symptoms with higher intensity. Dur-
ing pregnancy, if a woman suffers the loss of a child, her identity can be disrupted. An explanation for this is that the mother feels that her baby is part of her body and cannot differentiate it from herself. This process is known as “the embodied nature” of the loss. She understand that if the creature is within her body, it is part of herself; therefore, it will present difficulty in seeing the creature as an individual being. In advanced gestation stages, the mother experiences physiological changes that help her see her child as an independent and differentiated being from herself. These changes contribute to the adoption of a protective role. When a woman suffers a loss in the advanced stages of her pregnancy, she may feel that she failed to care for and protect her child. When this happens, she may experience feelings of guilt. Also, during pregnancy, because the maternal attachment has been strengthened, the woman may experience other sequelae in the future, such as attachment problems. This type of sequelae could be seen reflected in relationships with other children, partners, and social interactions.

According to Smith, when a woman manages to get pregnant, due to her physical changes, she perceives that she already “ascended to being a mother.” In addition, interpretation of the physiological changes in pregnancy concern women since pregnancy assume their new maternal role. For women who face difficulty that may prevent them from fulfilling this role, such as the loss of a baby, will result in significant psychological distress. The degree of commitment that women to with their maternal identity will influence her psychological distress. Besides in confronting an interruption in the gestational process, women will be exposed to losing the social status that would entail being a mother. It could be influenced by the socio-cultural values woman holds.

From the intrapsychic perspective of Freud, the psychological impact that the mother goes through is due to the “lost object” to which mourning should be kept. He described this stage as one of great importance due to the loss of psychic energy stemming from the “lost object.” Also, the mourning process could be more complex and difficult without the presence of the baby’s body.

When a woman becomes pregnant after having suffered a loss, she may face emotional and psychological sequelae. A study conducted by Gaudet, Rivera with 96 pregnant women who experienced perinatal losses, revealed the presence of high-levels of anxiety in comparison with the control group. The study identified four factors of risk that could provoke a woman to experience anxious symptomatology and prenatal grief in the period after a loss, such as (1) pregnancy after a stillbirth, (2) finding herself in the same stage of pregnancy where previous stillborn was lost (3) that the loss of the baby has occurred in the last stages of gestation, and (4) the number of losses experienced.

Women expecting a first child can manifest feelings of fear related to the pregnancy. For example, in a study with first-time mothers, it was found that they show greater worry and attachment with their baby compared with a group of mothers with experiences of pregnancy.

### PATERNITY AND LOSS

When a baby dies, generally, it is perceived that the mother suffers the loss in a way more severe and intense than the father. However, this loss can affect the father as well. The impact on the father can be related to the level of involvement that he has had during the gestational and perinatal process.

The participation of men in the process of the pregnancy, childbirth, and puerperium, has changed over the years. A few years ago, fathers faced paternity when their first child was born, or sometimes, when the child had already grown up. Men used to practice a traditional paternity, which involved the responsibility of being family’s economic provider. This type of paternity excludes fathers from involvement in the care and early development of their children, awarding women such tasks. This social construction has led to the avoidance of affective involvement with the pregnancy, and suppression of feelings in front of others. However, through the years, a “new sense of paternity” in which a man no longer is considered only as provider of the family but also is involved in tasks related to domestic works and the care and development of his children. Several researchers have indicated that men, especially the younger generations, have increased their participation in terms to the caring of children. Through the years, it has become common to see generations of young men participating in prenatal care activities, preparation childbirth, and involvement in the immediate puerperium. A father has been able to be present at labor and at times, has been able to cut the umbilical cord and even witness the expulsion of the placenta. Studies indicate that a father who witnesses his child’s birth has the opportunity to obtain a more intimate relationship with his child that those who “do not witness it.” These authors explained that this breaks the cultural expectations that minimize the importance of men in a woman’s gestational process due to ignorance about the emotional and cognitive aspects of fatherhood.

Like women, men also face critical psychological processes during the gestational process of their partners. Maldonado-Duran et al indicate that parents accomplish some psychological tasks during the pregnancy. These are the following: (1) resolve each other’s ambivalence towards pregnancy and the future child, (2) establish an attachment with the fetus, (3) redefine the identity of the man becoming a father, (4) achieve internal conviction that
he can take care of the fetus first and then the baby, (5) give sup-
port to his partner and prepare a psychological and real “nest” for
the child and (6) assume the new responsibilities as a father.

Regarding the emotional aspect, investigations\(^{54,56}\) indicate
that men may experience fears related to the behavior that
their partners will exhibit during childbirth, their ability to play the
new role, and their relationship as a couple. This tends to happen
when a man assumes this role for the first time in his life.

The fear parents face may increase when they receive the
news that the child they expect has low probability to live or does
not have vital signs. This news can have an emotional impact on
men, especially Latin men. Osores\(^{57}\) has mentioned that for a Latin
man, the paternity is motivated by the desire to perpetuate his fam-
ily and kin through their descendants. When a man experiences the
loss of his child, it involves the loss of his transcendence and his
future. Besides, the lack of social recognition of the loss makes it
more challenging due to the lack of social support that can prolong
the mourning process.

Palaces et al\(^{58}\) indicate that men that confront the death
of their child will go through the following phases: (1) paralysis,
(2) longing, (3) disorganization, and (4) reorganization. The first
phase refers to when a man feels distant from others. He usually
has thoughts of disbelief, thinking “this cannot be happening” or “this
cannot be true.” Also, he can suffer changes in sleep, appetite, or
experience difficulty concentrating. The second phase is about the
need and the desire to become a father. Some of them who get
exposed to friends who have children and do activities with them
can feel excluded. The third phase is the longest one and is char-
acterized by lack of control, anxiety, and hopelessness. The fourth
and last phase is about acceptance and personal repurposing of
one’s life. It is assumed that this phase can take a couple of years.
It is essential to point out that these phases are not universal. Also,
if these manifestations occur, they do not necessarily happen in a
particular order because each loss is an individual phenomenon.
Therefore, they can only be utilized as a reference point for educa-
tional purposes and bring perspective to the process of loss.

When a father experiences a loss and faces the grie-
ing process in terms of its the impact on the “self,” it could be
less difficult than what the mother experiences.\(^{60}\) Fathers, unlike
mothers find themselves excluded from the differentiation process.
Nonetheless, when fatherhood is valued by the father he also expe-
riences a sense of frustration and feelings of failure in protecting
his child when the loss occurs.

Lang et al\(^{61}\) indicate that men who experience mourning
can manifest aggressiveness, anxiety, somatic and psychic symp-
toms. Other than these behaviors, suppression of feelings tend to
occur to conform to social expectations and to show themselves as
“emotionally strong.”

A study done with 3,503 fathers of a stillborn baby,
showed that half suppressed their feelings because they believed
society wanted them to forget their baby and move on to another
pregnancy as soon as possible.\(^{61}\) When fathers suppress their feel-
ings, stress begins to mount and can create maladaptive behaviors
that prolong the natural grieving process of a loss. These respons-
es can prevent the father from seeking help. At times, men find
themselves immersed in supporting their partners while feeling
alone and fearful and avoid asking for support. Literature suggests
that man’s natural suppression of feelings works as a defense to
conform to society’s expectations. It could cause risky behavior
that may even lead to legal problems. Conway et al\(^{62}\) suggests that
some of these legal issues tend to be the use and abuse of alcohol
and other narcotics. Additionally, men may worry about the behav-
ior of the mother during childbirth and their capacity to perform
as a father and partner.\(^{54,56}\)

THE COUPLE’S RELATIONSHIP AFTER THE LOSS

The death of a child can influence the relationship between the
couple. Literature shows that stillbirth is a risk factor in the rupture
of a relationship.\(^{63}\) A study conducted by Gold et al,\(^{64}\) Koopmans
et al\(^{65}\) revealed that stillbirth increases the probability of a divorce
by 40%. In another study conducted by Shreffler et al,\(^{66}\) it was
found that relationships are four times more likely to dissolve after
a stillbirth than relationships that do not suffer perinatal loss.\(^{67}\) It
should be noted that these studies do not consider other factors in
the relationship.

However, couples that face emotional and psychological
challenges of a stillbirth can develop a stronger relationship.\(^{68}\) This
may be due to the different elements that support the relationship
such as communication, trust and emotional closeness. Perinatal
loss creates vulnerability in the couple, and with the right mix of
the elements mentioned above can evolve a better bond within
the relationship. Also, couples that rely on each other during the
grieving process tend to report fewer intense grief reactions, and a
higher level of satisfaction in the relationship.\(^{69,70}\)

Barr\(^{71}\) indicated that fathers have fewer symptoms of
anxiety than mothers. This outcome does not mean that the loss is
less significant to them; it could mean that they may have different
ways of grieving. Fathers also tend to have a delayed response to the
event of a stillbirth. They usually carry out funeral arrange-
ments and handle the final processes. In the aftermath, they tend to
submerge themselves in work to provide for the family. They also
tend to fabricate a false sense of “strength” to try to support their
significant other.\(^{71}\) This creates in fathers a sense of responsibility
for the emotional stability of the relationship.\(^{72}\) Nevertheless, due
to the fact the men and women mourn in different ways, a sense of
loneliness overcomes the process because each of them may not
quite comprehend what the other is feeling.

A study by Cacciatore\(^{28}\) and Campbell et al,\(^{73}\) revealed a
relationship between self-condemnation, shame, guilt, and parental
mental health. The study was done online with 2,232 women who
suffered a stillbirth and were followed over three years. It revealed
that 24.6% of women reported self-condemnation and a signifi-
cant increase in depression and anxiety.\(^{74}\) Barr\(^{72}\) conducted a study
with couples who suffered perinatal loss, and it showed that par-
ents felt guilty for surviving their children. This sense of guilt will
eventually is reflected in the grieving process.
Parents who suffer a stillbirth also manifest frustration with the lack of understanding and support of healthcare professionals who assist in the process, as well as with the lack of support from society. This can affect later pregnancies creating a fragile emotional state and feelings of isolation and/or can influence negatively the development and behavior of the child.

Around 50% of couples that suffer stillbirths give birth within a year. When a couple gives birth after one or several perinatal losses it is expected that the couple would be overcome with happiness. However, literature shows that feelings of anxiety, depression, and postpartum stress arise in comparison to couples that have never experienced a perinatal loss. This may be due to the uncertainty about their protective role. Besides, some parents may still be dealing with the effects of previous stillbirths and the grief related to perinatal losses. In some cases, the crisis resolution turns out to be maladaptive and individuals can meet the criteria for persistent complex bereavement disorder. Couples who meet the criteria for this type of diagnosis will experience greater psychological vulnerability. This process requires specialized attention addressing parents’ psycho-emotional status to ensure their well-being as much as the well-being of the expected new child. They also would require a safe space to overcome and process their grief.

Grieving process tends to mitigate the negative impact of the loss. Any individual that goes through a significant loss will face this process. From the psychoanalytic perspective established by Freud, grief is not a product of a pathological condition; therefore, with the passing of time it should improve. Due to some unique conditions of perinatal loss, first-time parents could suffer serious repercussions that could profoundly affect their well-being to the point of needing clinical intervention depending on the symptoms the individual has.

**CLINICAL SEQUELAE**

According to the Diagnostic and Statistical Manual of Mental Disorders, uncomplicated bereavement (V62.82) is defined as a normal reaction to the death of a loved one, in which some individual afflictions range in symptoms of major depression episode with feelings of deep sorrow, significant weight loss/gain, insomnia or hypersomnia, psychomotor retardation or agitation, and recurrent thoughts of death. Other definitions from prominent expert authors in bereavement define bereavement as the reaction to the loss of a loved one, as well as to the loss of something material, or symbolic, depending on the attachment to the object. Authors agree that bereavement should be considered as a life-altering experience, but should also be considered as a common or expected process in the circle of life in the sense that most individuals will face bereavement in their lifetimes. According to the DSM-5, there are some similarities and differences between uncomplicated bereavement and clinical depression. Both conditions deal with feelings of guilt. During uncomplicated bereavement, feelings of guilt may persist as well as a sense of emptiness. These feelings are associated to the deceased and tend to improve with the passing of time (e.g., days or weeks), but they come back occasionally. Different from clinical depression, where sadness and negative thoughts persist, during uncomplicated bereavement at times, the individual has positive and even joyful feelings. During the clinical depression there is the inability of experiencing happiness or pleasure. Through this episode, the depressed mood an individual is experiencing is not associated with thoughts or specific worries, contrary to uncomplicated bereavement.

The guilt is the common denominator between uncomplicated bereavement and clinical depression. Regardless of the culpability experienced in both diagnoses, it can be differentiated through the content of thought. During uncomplicated bereavement, guilt is associated with surviving a lost child while in clinical depression, it is associated with thoughts of low self-worth and pessimistic rumination. Generally, the self-esteem of an individual in clinical depression is highly affected due to an overwhelming feeling of poor self-concept and self-deprecation. Usually, in uncomplicated bereavement, individual's self-esteem is not impacted. Nevertheless, some mother's self-esteem can be impacted during the grieving process.

Another element that differentiates both diagnoses is the perception of death experienced by the individual. In both diagnoses, there are thoughts about death or dying. However, in clinical depression it is usually centered on ending one's life due to a sense of helplessness, unworthiness, or the inability to handle the pain caused by the depression. Meanwhile, in uncomplicated bereavement, feelings of death are focused around dying to reunite the deceased loved one. When the process of grief is mishandled, the individual's capacity to find a sense of life and the ability to make future plans, is diminished; this, characterizes the persistent complex bereavement disorder.

According to the DSM-5, the persistent complex bereavement disorder specifies criteria A through E. Criterion A requires that the individual has experienced the death of a loved one; criterion B requires the presence of one of four symptoms related to yearning, longing, and sorrow; criterion C requires six of 12 symptoms demonstrating reactive distress or functional impairment, and; criterion E requires that distress or impairment is outside of socio-cultural norms. Persistent complex bereavement disorder requires that symptoms be present for at least twelve months and that they are not better accounted for by major depressive disorder, generalized anxiety disorder, or post-traumatic stress disorder (PTSD).

Some individuals could manifest symptoms that belong to post-traumatic stress disorder. Generally, an individual that is grieving may not experience PTSD. However, individuals with pre-existing medical conditions could suffer PTSD, and might have a higher risk of experiencing persistent complex bereavement disorder.

The attention given by a healthcare professional to women during pregnancy, birth, and postpartum, has direct and indirect consequences. From the moment the parents receive the news that their child does not have vital signs or has low probability of life, parents start feeling the distress caused by loss. According to the literature, the healthcare professional's delivery of the diagnos-
tic has a bearing on the parents’ emotional and psychological state. Healthcare professionals who do not receive specialized training or guidelines to properly manage perinatal loss can aggravate the anguish of loss. Even as the years go by, parents will remember who gives them the news, and even specific phrases such as “there is no heartbeat; the child is not compatible with life, among others.” When professionals do not use the appropriate expressions and bedside manners recommended by scientific literature, parents might develop a wrong perception about healthcare professionals.

In Puerto Rico, a newspaper article, presented an interview with mothers who suffered perinatal/postnatal loss. The article mentioned the dissatisfaction and discontent mothers and family members had with healthcare providers after suffering a loss. The mothers described the assistance received from professionals that worked in the hospital as “cold and inhuman.” Mothers mentioned that the behaviors of the professionals caused additional distress to them and their families. The publication references Project 2560, known as Law 184, which demands proper procedures in a perinatal loss in every hospital and healthcare center in Puerto Rico. The Law establishes that mothers and their families must receive professional assistance according to their needs and should participate in the decision-making process of the loss.

There are countries that have examined mothers’ perspective towards the healthcare provider’s assistance. A study conducted in Sweden by Höglund et al. looked at the answers that mothers received to their questions from the healthcare professionals after the stillbirth. The results showed the following: 48.6% did not receive any explanations on cause of deaths, 23.6% received a specific reason and 27.8%, received vague or generic explanations. Participants described the service received from healthcare professionals as poor and their attitude as arrogant and evasive. Beyond the stillbirth process, it was found that these attitudes where also common during pregnancy.

**LITIGATION AND PSYCHO-EMOTIONAL ASPECTS OF HEALTHCARE PROVIDERS**

When the results of a medical procedure are negative, what is known as “bad outcome,” and whether or not there is medical malpractice, it could end up in he courts. This may affect directly the medical personnel involved. A questionnaire study Gold et al. revealed that 75% of obstetricians who suffered a loss indicated that they felt a heavy burden, and 10% considered abandoning their practice. In cases where malpractice occurs, professionals might experience psychological and somatic distress.

Some of the initial emotions the medical community feels after litigation are guilt and shame. These responses reduce the sense of self-value. Professionals become afraid of being exposed publicly and getting rejected or diminished by their peers, commonly accompanied by feelings of guilt, anxiety, and depression. Receiving unexpected news about being sued could create a traumatic experience, “shock,” emotional detachment, tension and insomnia, among others. In these cases, lawyers recommend the professionals not make any statements about the subject. When a professional follows this recommendation and does not talk about the event, they tend to suffer more significant distress because they cannot express their feelings about what happened. This could lead the professional to isolation, which tends to increase levels of stress and dysfunctional behavior.

**CONCLUSION**

Perinatal loss is a complex process and can influence the woman’s cognitive and emotional functioning. Healthcare professionals need to follow proper guidelines to assist the woman, her partner, and their family in an effective way. Important aspects of cultural values, paternal and maternal identities, self-esteem and the different ways the couple could deal with grief, help minimize the effects of this experience. It is equally important to understand the symptoms associated with the loss, such as uncomplicated bereavement and clinical depression, to provide better management toward the healing process. The literature suggests that interventions should be aligned with the needs of the parents to avoid negative psycho-emotional sequelae for mothers and their families. Management based on scientific evidence can benefit healthcare professionals to effectively assist during perinatal loss. Healthcare professionals must acquire strategies that also benefit their own psychological and emotional well-being. For future investigations, it is recommended that the perception of healthcare professionals that assist women and their families in a stillbirth be explored more deeply. It is crucial to identify possible barriers that may influence women and their partner’s participation about the decision-making process in the short time-frame surrounding birth. It is also recommended to explore different approaches that can benefit the emotional and psychological health of the women, their partners and the health professionals who assist them.

**CONFLICTS OF INTEREST**

The authors declare that they have no conflicts of interest.

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