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ORIGINAL ARTICLE

Psychosocial Implications of Stillborn Babies on Mother and Family: A Review from Tertiary Care Infirmary in India

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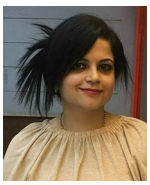

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Abstract

Background When a mother loses a baby after the period of viability, there is no way to fathom her grief, neither any words, nor an explanation. It is an unexpected event. Stillbirth presents a situation where the early activation of the grief process primarily in mother is exacerbated by the circumstances surrounding the loss. It thus becomes imperative for the healthcare providers to evaluate the significance of parent's perception on the loss and the factors contributing to it before the initiation of therapy.

Objective To evaluate the psychosocial impact of stillbirth among mothers and its contributing factors.

Materials and Methods A WHO-funded prospective study was conducted in VMMC and Safdarjung Hospital from September 2015 to August 2016 on all women who gave birth to a stillborn baby, using a questionnaire based on EPDS, after taking their written informed consent. Data were entered on the predesigned proforma and analyzed after applying Chi-square test, keeping a null hypothesis value of 15% for all the variables.

Results Out of the 709 women who delivered stillborn babies, 645 respondents, who willingly consented to participate, were included in the study. There was a significant

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relationship between psychosocial impact after perinatal loss and support from caregiver and family.
Conclusion Mothers with stillborn fetuses should be screened for psychosocial impact and offered support when needed. Appropriate counseling by healthcare providers and continued psychosocial and emotional support by family members must be provided.

Keywords Stillbirth · Consequences · Psychological effects · Social impact

Introduction

Stillbirth is defined as a baby born with no signs of life after 22 weeks of gestation. There were around 2.7 million stillbirths worldwide in 2015 [1]. Besides, being an unfortunate event for the family, it is a source of subjugated grief for the couple [2]. This initiates many complex emotional responses having psychological sequelae [3, 4]. Also, there is a perceived loss of parental identity [5, 6]. It is associated with loss of hopes and potential for fulfilling dreams related to childbearing.

The bereaved couple constitute a high-risk group for complicated grief with up to 25% suffering severe symptoms years after the death of their baby [7]. Studies have proven it to be one of the major stress-inducing phenomena associated with post-traumatic stress disorder (PTSD), and these parents are more likely to develop prolonged psychological problems if professional support is not given [7, 8].

The bereavement period is characterized by feelings of denial, emptiness and sense of failure for the mother. Besides, they are more prone to anxiety, depression, self-blame, guilt toward the loss and feel isolated socially [9].

These parents might have future pregnancy apprehensions due to either external or internal pressures. Some are pressed to prove their reproductive capabilities as soon as possible, and as such the desire to have a newborn to nurture could be overwhelming [10]. Few want to delay next pregnancy due to fear of recurrence of stillbirth.

Stillbirth can also have intergenerational consequences such as an adverse impact on siblings and complicate attachment for parents, in case of a surviving twin and subsequent children including next child-replacement child syndrome, vulnerable child syndrome [8, 9].

Critically, the provision of care for families when a child is stillborn is immensely significant to avert short- and long-term deleterious aftermaths. Also there is a paucity of literature focusing on needs and perception of women with stillborn babies. Most of the conclusions come from smaller studies in the west [1–10].

Till date, there is no Indian study exploring the impact of this condition depriving a woman from the joy of motherhood. Though not finding much place in the literature, these issues may actually influence couple's coping mechanisms to grief and the meaning they attribute to their loss [11]. Also, it remains an area in which most obstetricians and midwives receive little or no training or inadequate training.

With the above viewpoint in focus, the present study was planned to evaluate the psychosocial impact among mothers and families with stillborn fetuses. Also it was proposed to assess the contributing factors to the same.

Materials and Methods

This was a prospective study conducted in the Department of Obstetrics and Gynecology of Vardhman Mahavir Medical College and Safdarjung Hospital, New Delhi, India, for a period of 12 months from September 1, 2015 to August 31, 2016. All patients delivering a stillborn fetus in the hospital during this period were enrolled in the study. Patients who consented to be part of the study were included. After a mother delivered a stillborn baby, a detailed discussion was ensued by the investigator along with a psychologist as per a questionnaire based on Edinburgh Postnatal Depression Scale [12]. Mothers' feelings surrounding the event, its impact on relationships and family were assessed after developing an emotional rapport with her, besides ensuring her privacy. Also the mothers' attendants particularly the husband was interviewed to express concerns and feelings. Follow-up was done at 6 weeks telephonically. All comments were noted verbatim and later on entered in the predesigned preformat. Data were analyzed using SPSS 21 version for windows, considering null hypothesis value of 15% for all variables under study. p value of < 0.05 was considered significant.

Results

A total of 26,213 deliveries took place in the hospital during the study period, out of which 709 (2.7%) patients delivered a stillborn baby. Among these 64 patients who did not wish to discuss about stillbirth were excluded from the study.

Mean age of patients was 25.5 years (ranging from 19 to 38 years). Majority of cases hailed from rural areas (94.88%) belonging to lower socioeconomic status (17.05%-Class V, 42.79%-Class IV, 40.46%-Class III). Most women were illiterate (64.34%) and housewives (93.33%). Higher parity was seen in 6.36% patients; earlier miscarriages and bad obstetric history were seen in 29% of them ($p < 0.0001$).

Hindu women were a majority (89.92%). Proportionately, a large number mothers who lost their babies did not

have a peri-conceptional care ($p < 0.0001$). There was a definite history of domestic violence in the family in some form in 34.42% of cases during the antenatal period. This was in the form of physical bashing by partner and verbal abuse as per history given by 33 cases, whereas some women reported partners not taking them to health facility on scheduled visits. However, further details of physical abuse could not be extracted as they were reluctant in sharing the same considering it to be a personal matter (Table 1).

The main causes that led to stillbirth are tabulated in Table 2. Abruptio placentae topped the list, followed only by fetal growth restriction. The associated conditions were hypertensive disorders of pregnancy, diabetes, maternal anemia, heart disease. There were 359 unexplained cases in which no cause was found.

There were 360 patients who delivered a macerated baby. There was a male preponderance among all stillbirths (55.8%, $p < 0.01$). Most of these pregnancies failed to reach term gestation in 445 patients, 495 patients went into spontaneous labor and 568 patients delivered vaginally. These were statistically significant findings. Notably, in 88.02% cases, a plausible cause leading to stillbirth could be identified ($p < 0.0001$) (Table 3).

Approximately 57.67% mothers had prior knowledge about baby's demise on admission (p value < 0.0001). Five hundred eighty two couples were informed and counseled about the loss by the obstetrician, and 386 were explained about the cause (p value < 0.0001). However, only 37.21% couples seemed satisfied about the information (Table 4).

On assessing the parents reaction to the loss, with respect to confusion, parental grief, emotional response and tearfulness, anger or guilt, varied types of grief reaction were seen in 616 women. Some mothers were confused as they did not know how to react to the situation. When the news of a dead baby was broken, some cried and laughed successively and showed signs of stress, while others refused to eat the meals or drink water, after hearing the news. Approximately 19% and 11% of women reported spousal abuse and rejection by extended family, respectively. Around 5% women remained indifferent to the news emotionally (p value < 0.03). Around 5% women showed no effect following the fetal loss (Table 5).

When enquired about having seen/wishing to see their dead babies, a large number of women (295) saw their stillborn fetus; some even held the baby for some time, either themselves or after being encouraged by the obstetricians, and most of these women reported to experience calmness after holding the baby ($p < 0.0001$) (Table 6).

Almost all couples said that they received voluminous emotional support by the care providers following the loss of their baby, followed by family support in the grief

Table 1 Baseline demographic and maternal characteristics of mothers with stillbirths

Baseline demographic and maternal characteristics	Patients *n* (%)	Percentage	*p* value
Age (years)			
< 20	61	9.46	< 0.0001
21–25	292	45.27	
26–30	238	36.90	
> 30	54	8.37	
Parity			
PGR	210	32.56	< 0.0001
G2–G4	394	61.09	
> G5	41	6.36	
Obstetric history in multigravidas (n = 435)			
Previous one abortion	77	17.70	< 0.0001
≥ Previous two abortions	32	7.35	
Previous no live issue	33	7.58	
BOH	123	28.27	
Previous live babies	170	39.08	
Socioeconomic status			
I	0	0	< 0.0001
II	1	0.16	
III	273	42.33	
IV	261	40.47	
V	110	17.05	
Religion			
Hindu	580	89.92	< 0.0001
Muslim	64	9.92	
Sikh	0	0	
Christian	1	0.16	
Others	0	0	
Residence			
Urban	33	5.12	< 0.0001
Rural	612	94.88	
Education			
Illiterate	415	64.34	< 0.0001
Primary	148	22.95	
Middle	68	10.54	
Secondary	12	1.86	
Senior secondary	0	0	
Graduate	2	0.31	
Postgraduate	0	0	
Occupation			
Housewife	602	93.33	< 0.0001
Working	43	6.67	
Semiskilled	39	6.05	
Skilled	4	0.62	
Professional	0	0	
History of present pregnancy			
Preconceptional care			< 0.0001
Yes	30	4.65	
No	615	95.35	
Antenatal care			< 0.0001
Yes	130	20.16	
No	515	79.84	

Table 1 continued

Baseline demographic and maternal characteristics	Patients *n* (%)	Percentage	*p* value
If required higher level of antenatal care			< 0.0001
Yes	33	5.12	
No	612	94.88	
History of domestic violence			< 0.0001
Yes	222	34.42	
No	423	65.58	

Table 2 Main causes attributable to stillbirths

Main causes	Number	Percent
Abruptio placentae	75	10.5
Fetal growth restriction	64	4.94
Cord prolapse	40	5.6
Fetal distress	38	0.7
Birth defects	35	5.3
Maternal fever	32	1.6
Rupture uterus	25	9.03
Placenta previa	16	4.5
Obstructed labor	12	3.5
Postdatism	8	1.1
IHCP	5	2.2
Unexplained	359	50.6

Table 3 Birth details of stillborn baby

Birth details	Patients *n* (%)	Percentage	*p* value
Type of still birth			
MSB[a]	360	55.8	0.003
FSB[b]	285	44.2	
Sex of the baby			
Male	355	55.0	0.010
Female	290	45.0	
Period of gestation			
Preterm	445	69.0	< 0.0001
Term	200	31.0	
Type of delivery			
Spontaneous	495	76.7	< 0.0001
Induced	150	23.3	
Mode of delivery			
Normal vaginal delivery	568	90.85	< 0.0001
Operative vaginal delivery	4	0.62	
Operative abdominal delivery	73	11.32	
Identifiable cause of stillbirth			
Yes	586	90.9	< 0.0001
No	59	9.1	

[a]Macerated Stillbirth

[b]Fresh stillbirth

(53.8%) ($p < 0.0001$). This was mostly in the form of sympathy and encouragement (94.42%).

Table 4 Events related to stillbirth

Events related to stillbirth	Patients *n* (%)	Percentage	*p* value
Knowledge of baby's demise			
Before delivery			< 0.0001
Yes	489	57.67	
No	156	18.45	
Given by			< 0.0001
Obstetrician at present facility/outside	491	76.12	
Family member	154	23.88	
Role of obstetrician			
Information education and counseling			< 0.0001
Yes	582	90.23	
No	63	9.77	
Explanation about the cause of stillbirth			< 0.0001
Yes	386	59.84	
No	259	40.16	
Patient satisfaction about the way information was passed by doctor			< 0.0001
Satisfied	240	37.21	
Unsatisfied	405	62.79	

Table 5 Psychosocial effects on parents after stillbirth

Psychosocial effects on parents after stillbirth	Patients (*n*)	Percentage	*p* value
Confusion	445	68.99	< 0.0001
Parental grief	616	95.50	< 0.0001
Grief reaction			
Emotional response and tearfulness	486	75.35	< 0.0001
Sadness	481	74.57	< 0.0001
Remorse	465	72.09	< 0.0001
Mental trauma	437	67.75	< 0.0001
Anxiety	333	51.63	< 0.0001
Depression	314	48.68	< 0.0001
Self-blame	238	36.90	< 0.0001
Anger	214	33.18	< 0.0001
Guilt	120	18.60	0.010
Fear of bad events	109	16.90	0.1766
Challenge to faith	103	15.97	0.490
Stress			
Low	66	10.23	< 0.0001
Intermediate	523	81.09	
High	56	8.68	
Effect on relationships			
Stigmatization	492	76.28	< 0.0001
Rejection by family	160	24.81	< 0.0001
Spousal abuse	124	19.22	0.003
Effect on siblings	70	10.85	0.003
Disturbed relationship with extended family	65	10.08	0.0005
No effect	33	5.12	< 0.0001

Seventy seven percent couples were found to be in a dilemma following the loss 6 weeks later (p value < 0.0001), whereas 203 had accepted the same and moved on. Few others were still reliving the

Table 6 Mothers' experience of stillbirth

Mothers experience with stillbirth	Patients *n* (%)	Percentage	*p* value
Woman's contact with baby			
Seen the baby	295	45.74	0.030
Didn't see baby	350	54.26	
Wish to see	170	48.17	0.6305
No such wish	180	51.42	
Baby holding (n = 295)			
Yes	192	65.08	< 0.0001
No	103	34.91	
If held the baby (n = 192)			
Picked herself	73	38.02	0.094
Held the baby on being asked	69	35.93	
Encouraged by obstetrician	50	26.04	
Time spent with baby (n = 192)			
< 6 h	147	76.56	< 0.0001
6–12 h	42	21.87	
> 12 h	3	1.56	
Experience of holding the baby (n = 192)			
Unpleasant	70	36.45	<0.0001
Upsetting	90	46.87	<0.0001
Sad	117	60.93	<0.0001
Calming	23	11.98	0.2412

circumstances related to the stillbirth and thinking about the triggers.

When questioned about their thoughts on future pregnancy, 50% of the bereaved couples were thinking to conceive again, though 358 of them were uncertain of the outcome, while a few were fearful in expecting the worst to happen again.

Discussion

In the present study, the ratio of stillbirths was 27/1000 live births, which was similar to the rate across the world [1–4]. The patients belonged to the younger age-group as compared to their counterparts seen in American and European studies [1–11].

In contrast to western literature, most of the study participants were illiterate, hailing from rural background and belonged to lower socioeconomic strata, engaged in household work and were majorly following Hindu religion [1–11, 13, 14]. Illiteracy leading to lack of awareness about antenatal care and deficient counseling probably made them vulnerable to suffer from the wide range of emotions ranging from sadness, fear, anger, denial, guilt and worthlessness. Cultural sensitivities in the region often disempower young female population by getting them marry at a relatively younger age than their counterparts in developed nations, thus embarking on pregnancy also at an early age.

On further scrutiny and unlike previous reports, it was remarkable that majority of the patients were un-booked with neither a preconception nor an antenatal supervision, in the extant pregnancy [1–11, 13, 14]. In under-resourced settings like India, there is a need to segregate un-booked cases coming to hospital from those having a fetal demise in the hospital, as the preponderance of the former indicates a lack of basic infrastructural health facilities pertaining to essential and emergency obstetric care. This further calls for equipping the primary health centers with necessary infrastructure and good number of healthcare providers to offer optimal prenatal and antenatal care to expectant and high-risk mothers and referring them to higher centers in light of identification of any complication at the earliest. Many investigators in Indian studies [14, 15] mention this particular need.

A novel finding observed in the present study was getting a definite history of domestic violence during this pregnancy inflicted on the expectant mother in a large number of participants. Such behavior is entrenched in gender inequality, which is unfortunately still persistent in our country, arguably throughout all societies. These observations support the notion of previous researchers studying the disclosures on domestic violence during pregnancy [16]. A simple assessment to identify abusive behavior during pregnancy by the attending obstetrician, coupled with the timely referral to a secondary agency, whenever needed, may effectively thwart and prevent recurrences of domestic violence and consequently go a long way in averting the fetal morbidity and mortality in such women. Most of the stillborn babies were male in the present study.

More than 60% of women had prior knowledge about baby's demise. Role of obstetrician has been found to be very significant as a primary counselor regarding sensitization of a couple toward the factors leading to and the cause of stillbirth [8].

Varied types of grief reactions became apparent during the study period ranging from sadness and tearfulness particularly at the sight of attending doctor contemplating discussion about the dead baby, anger, guilt and a challenge to their faith in God, particularly in the primipara. Most of the respondents mentioned that accepting the loss was the foremost difficulty they encountered. They did not know what to enquire for further explanation. However, 5.12% women showed no effect following the fetal loss. This was a startling and an unfamiliar observation when compared to previous researches on the subject [4–10]. A further detailed evaluation unearthed the fact that this was exhibited by those women (4.8%) who were multigravidas with living children and demise of one baby, even though accepted as an invincible loss, did not seem to have much effect to the psychology. Spousal abuse and rejection by

extended family were reported in around 20% of women, majorly due to the social stigma associated with giving birth to stillborn baby and discordant relations in these families. The 'incongruent grief' of mothers and fathers led to frequent disputes and doubts about fidelity on the part of the partner were seen in a small number of cases, while some even reported physical violence and strained sexual relationships after the stillbirth. They reported guilt and seeing of troubling images, thoughts and feelings that hindered establishing such relations. Women were frequently held accountable for the death of their babies.

On follow-up, most of these women communicated the noteworthy change they observed in relationships with partner and their families. A well-balanced wholesome counseling of the entire family regarding the stillbirth, its exacting causes and prevention would help them change their perception and attitude toward the grieving lady and would go a long way in helping the latter cope up with this tragedy which was quoted in various studies [17–19]. The obstetricians and the psychology support groups while offering them the much-needed care at the institute must therefore adopt these facts.

Some parents stated feeling ripped between dealing with their own anguish of losing a baby and nurturing other children. Few couples sent the children to close relatives who could take good care of them while they mourned the loss. Many parents reported feeling emotionally guarded about their children dreading losing them and going through repeated grief. These were quite similar to the findings in two studies [20, 21].

Holding the stillborn baby had been reported to produce positive memories and to assist the grieving process. In our study, 45% of mothers mustered the courage of seeing their stillborn fetus, and around 192 held the baby. According to the best practice guidelines, all parents should be offered a choice and be supported in their decision making to have a contact with the baby, which was done in our study [5, 6, 21–25].

It has been widely reported that support from doctors, staff and particularly family members is associated with lower levels of anxiety and depression in mothers following a stillbirth [26–37]. The support was acknowledged as voluminous by the care providers in the hospital by majority of them, though the role of family could not be ignored. Some studies advocated allowing of memorabilia related to baby to be given to the grieving parents, which may have a soothing effect [36–41].

On follow-up, 77% of couples were found ambivalent to the loss 6 weeks later, whereas a quarter of the patients had accepted the same and moved on. Fifty percent of couples were hopeful enough to plan for another pregnancy, though fear of recurrence hovered in nearly half of them; this finding was similar to other studies [38–42]. Others felt that they could not contemplate 'replacing' that baby and chose to wait for some time. Half of those who were eager to conceive stated external pressures were being imposed on them with the belief of filling the emotional void loss with another baby soon. These observations were similar to the observations made by past few studies [38–42].

Limitations

The data provided in the tables are based on a self-designed questionnaire based on Edinburgh Postnatal Depression Scale. It is not validated as no such scale is available in India to cater to the local Hindi-speaking population of the region. This is one of the limitations of this study.

Conclusion

Loss due to stillbirth has profound long-term detrimental psychological, physical and social impact. Though a cause could be assigned to most of the stillbirths, there were many unexplained stillbirths in the study for whom counseling the parents was a task. Relatives were easily satisfied where a cause was found and explained to them, mostly associated with maternal comorbid conditions and babies with birth defects. Such mothers should be screened for psychosocial effects and offered voluminous support when needed.

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Compliance with Ethical Standards

Conflict of interest The authors declare that they have no conflict of interest.

Ethical Approval All procedures followed were in accordance with the ethical standards of the responsible committee on human experimentation (institutional and national) and with the Helsinki Declaration of 1975, as revised in 2008. Ethical clearance was taken for the study by the then chairman of institute ethics committee, bearing no. IEC/SJH/VMMC/Project/September-14/3/323.

Informed Consent It was taken from each participant enrolled in the study.

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