

MONIKA GUZEWICZ
KATARZYNA SZYMONA-PAŁKOWSKA

PSYCHOLOGICAL, FAMILY, AND SOCIAL ASPECTS OF LOSING A BABY BEFORE BIRTH

A b s t r a c t. The situation of women who lost their baby through miscarriage, premature delivery or perinatal death is a distressing experience, posing an emotional burden on the life of both such women and their close family. Often, the medical staff is emotionally affected by a prenatal death, yet they are likely to treat the patient and her baby like objects. The presented article is a review of available literature concerning psychological, social, family, and religious consequences of losing a baby before birth.

Key words: stillbirth, miscarriage, loss of procreation.

INTRODUCTION

Most women who wait for their baby to be born hope that it will be healthy and full term. Procreation failures are taken as a sign of being an incompetent parent. Expecting mothers experience a deep symbiosis with their baby by endowing it with life. They provide their baby with a chance of physiological and emotional growth. A threatened pregnancy and altered date of the delivery takes the mother and her family by surprise – it is an unforeseen event and difficult to prepare for. With a threatened pregnancy, the

MONIKA GUZEWICZ – assistant in Chair of Adult Clinical Psychology, Institute of Psychology, John Paul II Catholic University of Lublin; address for correspondence: Al. Raławickie 14, 20-950 Lublin, e-mail: monika.guzewicz@gmail.com

Dr. KATARZYNA SZYMONA-PAŁKA – assistant profesor in Chair of Adult Clinical Psychology, Institute of Psychology; John Paul II Catholic University of Lublin; address for correspondence: Al. Raławickie 14, 20-950 Lublin.

perception of risk is mitigated by hope, which according to Łuczak-Wawrzyniak¹ allows the impact of the situation and potential future negative outcomes to be committed to a less conscious sphere.

If a pregnancy has a negative outcome, be it miscarriage, foetal death, stillbirth, or neonatal death, the expectations of the parents are ruthlessly shattered. Parents who feel responsible for their baby start feeling angry that this should have happened to them, and they demonstrate a sense of guilt regarding the death of their baby². A woman who suffers such a loss enters a period of grief, but she should be able to pass the stage of shock and denial to accept the fact of her baby's death, which is especially difficult since most women would rather sacrifice their own life to give their baby life.

Mothers whose baby dies prenatally have to struggle with numerous psychological consequences. Each woman in a state of physiological pregnancy is getting ready to accommodate a new family member into her life. Regardless of her attitude to the condition of the pregnancy, be it positive or negative, she undergoes significant emotional changes. If a miscarriage occurs, she often blames her body for letting her down in some way. Reactions to baby loss are typically very intense, combined with such emotional experiences as helplessness, anger, aggression, guilt, shame, as well as a disturbed identity³. Also, the way the family members and friends react to the tragic news vary. Many are likely to play down the significance of the miscarriage since the loss occurred in an early stage of the pregnancy.

1. SOCIOLOGICAL AND SOCIAL DIMENSIONS

The sociological and social dimensions of losing a baby before birth is closely connected with cultural and historic changes. For example, prior to the 18th century conceived children were not attributed any worth. Only a newly born baby was perceived as a "little adult". It was later that children were granted the dignity of a human being, and consequently children's own

¹ J. Ł u c z a k - W a w r z y n i a k, *Matka wcześniaka – sytuacja psychologiczna i społeczna w trakcie pobytu w szpitalu i po opuszczeniu oddziału noworodkowego*, "Ginekologia Praktyczna" 17(2009), No 1, pp. 7-8.

² C. M. S a n d e r s, *Jak przeżyć stratę dziecka?*, Gdańsk: GWP 2001.

³ B. P r a ż m o w s k a, G. P u t o, E. K o w a l, & B. G i e r a t, *Niespełnione macierzyństwo*, "Ginekologia Praktyczna" 17(2009), No 4, pp. 53-56.

specific nature and needs came to be recognised. The general perception of marriage changed over time, with a shift towards love as the chief motivation and women's role as primarily that of mothers. The death of a child already constituted a social and emotional issue, in the opinion of Szczepska-Pustkowska⁴. It was the mother's failure and was associated with family grief and painful memories. Societies tried to reduce the rates of infant and foetal death. In the 20th century, a conceived baby came to be seen as foetus, embryo, or a fertilised egg. Debates began on the moment when a conceived baby can be referred to as a human. Concern for better support and greater social awareness towards parents affected by baby loss became marginal⁵.

From the social point of view, the death of a conceived baby is nowadays marred by a similar degree of indifference as in the past times. McFarlane⁶ ventures to say that the suffering of mothers who has lost their unborn baby is disregarded, the patients who lose a baby are treated like things, the experience of such a loss is totally dehumanised, and the loss and the associated problem are openly denied. A conception of a child might seem like a personal issue for a mother and her partner. However, a child is born in a certain social group, first in a family, then neighbourhood, school community, and finally in a country. The mother's affiliation with various social groups is altered or even suspended during the post-partum period. The rarely mentioned issue of losing a conceived baby has a practical dimension. If a baby dies before birth, especially early, it is hard for a third party to comprehend the tragedy of the parents and give them enough support. Other people often attribute very little value to a baby lost in this way; they want to divert the bereaved parents' attention from their grief, trying to focus their attention on next children to come.

Parents who suffered the loss of a baby expect mainly support from others and that their lost baby be fondly remembered. It appears that the main reason for weakened relations between grieving parents and other people is the inability to talk about a baby who died. All possible topics for conversations are raised, but not the one concerning the central issue for the mother – all

⁴ M. S z c z e p s k a - P u s t k o w s k a, *Kategoria dzieciństwa – od Ellen Key do współczesności*, „Edukacja i Dialog” 7(1997).

⁵ I. B a r t o n - S m o c z y Ń s k a, *O dziecku, które odwróciło się na pięcie*, Łomianki: NAF 2006, pp. 11-15.

⁶ A. M c F a r l a n e, *Traumatic Stress in the 21st century*, “Australian and New Zealand Journal of Psychiatry” 34(2000), pp. 896-902.

to support her. Despite her overwhelming grief, she is anxious to speak out and be heard; they long for tenderness. They do not want to circumvent the problem but they want to communicate it, expecting others to join them in their grief. In society, there is fear of information concerning baby loss, and people react defensively with denial⁷.

2. A RELIGIOUS DIMENSION

In our culture, funeral is a natural consequence of a person's death, and the last respects are supposed to be paid to every person who dies. When this happens to a baby before birth, the decision on the burial lies mainly within the parents' discretion, but the law must be obeyed. The parents, in accordance with their worldview, can but do not have to bury their dead baby. Yet it turns out that parents who desire to say goodbye to their dead baby in a manner that is consistent with their religion will not always have such a chance. This is associated with legal and church regulations described below.

The Code of Canon Law⁸ expressly provides in Canon 1183, §2 that "The local ordinary can permit children whom the parents intended to baptize but who died before baptism to be given ecclesiastical funerals". The Church uses a special form exists regarding a memorial service of an unbaptized baby. Therefore, parents who find it essential to bury their baby are fully entitled to do so, however this is not so easy to achieve. Parents are often refused such a possibility as they run into problems at the very beginning when, for example, requesting the death certificate or obtaining consent for the body to leave the hospital. Often, priests themselves are not familiar with the provisions of the Code. All legal regulation relies on a certificate of death in which it is written "deceased" ("Polish Journal of Laws", No. 219, Item 2230); however after the amendments relating to the issuance of birth and death documents of 2 February 2005, a distinction into miscarriage, pre-term delivery, etc. is introduced, hence the difference between two documents: a certificate of death and birth certificate with a "deceased" entry. This statement does not apply to babies who were born before the 22nd week of pregnancy or with a birth weight less than 500 g. In such a case a birth/death

⁷ Ibid., pp. 896-902.

⁸ *Kodeks Prawa Kanonicznego*, Poznań: Pallottinum 1984.

certificate cannot be issued. Consequently, a baby weighing 480 g who died before birth will not be issued such a certificate, and its body will not be handed over to the parents or buried. Hospital staff use various excuses, referring to those law regulations that mention social benefits (e.g. a right to maternity leave) or regulations of the Main Statistical Office on the duty to maintain statistics of births and deaths. Barton-Smoczyńska⁹ says that parents are often ignorant of their rights, so they remain powerless in the face of procedures.

From the psychological point of view, a refusal to be handed over the body of their baby and inability to arrange for a proper funeral is detrimental to the process of grief. Such parents are not well understood; they are treated *ex officio*, which strengthens their conviction that the death of their baby is unlike other deaths. Given the circumstances, they demand respect for their pain. New regulations on the burial of babies who die prenatally are being drafted. According to them parents would have a chance to bury their baby regardless of either the age of the pregnancy or the weight of the dead baby. Consequently, any parent whose baby died before birth or in the perinatal period would be entitled to bury his or her baby.

Parents who were refused such a possibility often decide to have their own a ritual in a close circle of friends and other family members. They talk about their experience, unfulfilled hopes, and pain. They address the baby personally, taking opportunity to say goodbye to him or her. This demonstrates how important funeral rituals are for parents who need to enter the next phase of their grieving process.

3. PSYCHOLOGICAL CONSEQUENCES OF LOSING A BABY BEFORE BIRTH

Losing a baby is very painful to the family. It affects both the mother and father, as well as the other family members – each in a different degree. Moreover, not all women are affected in the same way. Most couples joyfully await the arrival of their offspring. From the very beginning, they are often happy to attribute a personal dimension to the budding life, searching for a suitable name or collecting necessary objects as the delivery is drawing

⁹ Barton-Smoczyńska, *O dziecku, które odwróciło się na pięcie.*

near. As Lachelin¹⁰ puts it, “the more advanced the pregnancy is the more relatives and friends know about it and more preparations are taking place: fitting the bedroom, buying things and toys.” The loss of a baby at a later stage is a harder experience, though if the baby is long-awaited, the loss occurring at any stage can have an equally powerful impact¹¹.

Initial reactions accompanying the loss of a baby are often somatic (a lump in the throat, choking, shorter breath, need for deeper breathing, empty stomach sensation, lack of muscle strength), as well as those related to guilt, anger towards others, or disturbed behaviour¹².

The loss of a baby at the prenatal stage is a hard experience since the cause of its death is often unknown. Of the possible causes of stillbirths and miscarriages, 13.4% are mentioned by ICD-10 as the so-called “other” causes (O31-O88), while 26.6% constitute unspecified causes of foetal death (P95), hence this category will also include possible psychological causes, apart from undeterminable medical ones¹³.

It is assumed that about 10-15% of pregnancies end in spontaneous failure¹⁴. Bręborowicz provides some statistics to demonstrate that as many as 25% of all women who had become pregnant lost one or several pregnancies. In Poland, in the years 1981-2001, this figure did not change significantly, fluctuating between 9.8% and 11.1%. However, recently a downward trend has been observed in the number of prenatal deaths (Guzewicz, 2014). This is associated with improved accessibility of prenatal care, higher quality of medical care in general, and an overall drop in birth rates.

At a later stage, losing a baby brings about various emotions that surface at various times¹⁵: fear of miscarriage itself, concern about the future, huge disappointment, grief, anger, regret, sense of maladjustment, envy at others

¹⁰ C.G. L a c h e l i n, *Poronienia*, Warszawa: Prószyński i S-ka 1998.

¹¹ R. R a i & L. R e g a n, *Recurrent Miscarriage*, “Lancet” 368(2006), pp. 601-611.

¹² E. L i n d e m a n n, *Symptomatology and Management of Acute Grief*, “American Journal of Psychiatry” 101(1949), pp. 141-148.

¹³ H. R o w e, *Spontaneous Pregnancy Loss. Mental Health Aspects of Women’s Reproductive Health. A Global Review of Literature*, Geneva, Switzerland: World Health Organization 2009, pp. 67-78; M. T r o s z y ń s k i, T. M a c i e j e w s k i, A. W i l c z y ń s k a, B. & B a n a c h, *Przyczyny martwych urodzeń i zgonów noworodków w Polsce w latach 2007-2009*, “Ginekologia Polska” 82(2011), pp. 598-601.

¹⁴ J. S k r z y p c z a k, *Poronienie*, in T. P i s a r s k i (Ed.), *Położnictwo i ginekologia. Podręcznik dla studentów*, Warszawa: Wydawnictwo PZWL 2002, s. 334.

¹⁵ R. K o c y ł o w s k i, *Trudny czas po poronieniu*, „Dobra Mama” 15(2012), No 4, pp. 44-45; L a c h e l i n, *Poronienia*.

having children, or overwhelming sadness that can turn into depression. All these feelings and emotions can persist for a very long period of time and intensify in certain circumstances, for example when seeing another couple with a child, watching a programme for parents, or under the influence of unintended words of others. This can also happen on such occasions as the anniversary of the child's death, the original due date of the baby's birth, family celebrations, etc.

The scale of experienced emotions and their type depend upon many factors, for instance the current situation of the woman and her earlier experiences. Even if a woman miscarries an unwanted pregnancy, she may experience a sense of guilt since – in the emotional sphere – she assumes the responsibility for the miscarriage.

Overall, by losing a long-awaited baby the parents lose the possibility of raising it. The loss induces biological changes and affects the psychological and spiritual functioning. If the baby was happily expected, the mother develops feelings of sorrow, guilt, and a sense of incompetence as a woman. Mothers, in general, seek the causes of their baby's death in their own body, behaviour, and possible mistakes in taking care of it¹⁶. Having lost a baby, a woman exhibits intense fear associated with this trauma, which makes her associate subsequent pregnancies with a risk of another loss and this in turn further deteriorates her already poor emotional state. This fear is often mitigated by medical staff, who are open for conversation and ready to provide their patients with information on numerous aspects of procreation.

The bond between a mother and her child is the strongest of all interpersonal relations; no other relation relies on such a natural and profound symbiosis¹⁷. While establishing such a bond the mother assigns the unborn baby the qualities of an autonomous being, interacting with the baby prenatally. According to some authors¹⁸ this interaction is synonymous to an emotional bond. It can be variously manifested, for example by thinking of the baby, talking to it, touching one's belly, singing songs and lullabies, calming or exciting the baby's motor activity¹⁹. It is thought that attempted contacts

¹⁶ B. P i l e c k a, *Kryzys psychologiczny. Wybrane zagadnienia*, Kraków: Wydawnictwo Uniwersytetu Jagiellońskiego 2004.

¹⁷ A. K ę p i ń s k i, *Lęk*, Kraków: Wydawnictwo Literackie 2003.

¹⁸ E. B i e l a w s k a - B a t o r o w i c z, *Determinanty spostrzegania dziecka przez rodziców w okresie poporodowym*, Łódź: Wydawnictwo Uniwersytetu Łódzkiego 1995, pp. 14-15.

¹⁹ Ź. G o l a ń s k a, *Interakcja matki z dzieckiem w okresie prenatalnym*, "Annales

with a baby before birth foster parental attitudes of both parents and facilitate the assumption of the future roles as parents²⁰. Typically, feelings shown during pregnancy are positive. Sporadically, however, a period of indifference or negative disposition towards the baby occurs. In women, negative emotions are accompanied by low self-esteem, little trust in oneself and one's body²¹. These emotions may surface as fear of giving birth to a baby with a disease or disability, or may be associated with a concern for one's health or life. Emotions during pregnancy are not stable; they can evolve and turn into positive attitudes²².

The major consequence of losing a baby during pregnancy is that another pregnancy will be threatened. While potential medical threats can be minimised, the psychological impact is difficult to mitigate. Barton-Smoczyńska²³ believes that "a high-risk pregnancy is a condition that poses chronic and intense stress for a woman and her partner". This idea is taken up by Steuden and Szymona²⁴, who speak of mental fatigue and tendency to shift responsibility onto others in a situation of a high-risk pregnancy. The research conducted by Magdalena Chrzan-Dętkoś²⁵ indicates that the death of a baby occurring in the perinatal period produces long-lasting, psychological consequences both for the mother and her family. One in five women who have lost their babies during pregnancy is diagnosed with chronic depression.

A woman who loses her unborn child can later have psychological difficulty getting pregnant, especially if planning on it less than a year after the loss. Barton-Smoczyńska²⁶ states that such attempts are influenced by the woman's history, hence each woman who has suffered baby loss should be treated individually. Her personality, her history of various losses, as well as

Academiae Medicae Silesiensis" 65(1989).

²⁰ D. K o r n a s - B i e l a, *Wokół początku życia ludzkiego*, Warszawa: Nasza Księgarnia 1993, pp. 50-58.

²¹ B i e l a w s k a - B a t o r o w i c z, *Determinanty spostrzegania dziecka przez rodziców w okresie poporodowym*, p. 15.

²² *Ibid.*, pp. 16-17.

²³ B a r t o n - S m o c z y ń s k a, *O dziecku, które odwróciło się na pięcie*, p. 26.

²⁴ S. S t e u d e n, K. S z y m o n a, *Psychologiczne aspekty macierzyństwa i ojcostwa w sytuacji ciąży wysokiego ryzyka*, in J. M e d e r (Ed.), *Problemy zdrowia psychicznego kobiet*, Kraków: Biblioteka Psychiatrii Polskiej, Komitet Redakcyjno-Wydawniczy Polskiego Towarzystwa Psychiatrycznego 2003, pp. 109-120.

²⁵ M. C h r z a n - D e ń k o ś, *Utrata dziecka w okresie okołoporodowym – dobre praktyki szpitalne w opiece nad matką*, "Ginekologia Praktyczna" 18(2010), No 2, pp. 27-30.

²⁶ B a r t o n - S m o c z y ń s k a, *O dziecku, które odwróciło się na pięcie*.

the sources of emotional support need to be examined. Women who lose a baby but rely on emotional support of the loved ones and professional approach of the medical staff find it easier to adjust after the experience of baby loss. This is key for subsequent procreation attempts. Regular co-operation with a psychologist is vital since it models behaviours and emotions accompanying next pregnancies. The procreation capability involves not only the physical or hormonal aspect of the body but also the emotional and spiritual condition of both parents-to-be.

4. GRIEVING PROCESS IN PARENTS WHO LOSE A CHILD

Tucholska²⁷ says that, psychologically, the grieving process “is a complex process involving the whole person (the somatic, psychological, and social spheres), a response to loss and its consequences.” Not being a disease, grief fulfils nearly all criteria of it – it is a natural response to loss. A bereaved person feels bad, her social and physical functioning deteriorates²⁸.

Many authors have studied various stages of the grieving process. However, there is a clear agreement as to the presence of two: the initial (opening) and final (closing) stage. At the outset, a person undergoes what some authors refer to as a shock phase²⁹. This occurs at the news of death. The bereaved person may at first exhibit dissociative symptoms, i.e. emotional or sometimes physical numbing³⁰. Disbelief and denial set in it is a means of natural defence against such news. Sanders³¹ calls it “psychological distancing”, which implies emotional evasion of engagement in a loss which is too painful to cope with. The second stage of the grieving process involves an acknowledgement of the death both in emotional and cognitive terms. Being the most intense, this phase is characterised with high ambivalence and variability of feelings. According to Nolen-Hoeksema and Larson³², this time

²⁷ S. T u c h o l s k a, *Psychologiczna analiza procesu żałoby*, in S. S t e u d e n & S. T u c h o l s k a (Eds.), *Psychologiczne aspekty doświadczania żałoby*, Lublin: Wydawnictwo KUL 2009, pp. 11-33.

²⁸ W. B a d u r a - M a d e j, *Psychologiczne aspekty śmierci, umierania i żałoby*, Kraków: Ośrodek Interwencji Kryzysowej 1993, p. 11.

²⁹ C. S a n d e r s, *Powrót nadziei*, Gdańsk: GWP 1996.

³⁰ A. G r e t k o w s k i, *Ból i cierpienie*, Płock: Wydawnictwo Naukowe Novum 2004.

³¹ S a n d e r s, *Powrót nadziei*.

³² T u c h o l s k a, *Psychologiczna analiza procesu żałoby*, pp. 11-33.

brings the greatest risk of a person developing an array of full-scale depressive symptoms which can be indicative of a depressive episode or a major depressive disorder (judging by the clinical presentation in accordance with the criteria of diagnostic manuals), such as: loss of interest in life, sleep disorders, lack of appetite, inability to take decisions, feelings of hopelessness, or even suicidal thoughts. In this period, a person will often withdraw from social contact and not infrequently from everyday duties. It is a time when grief, even if experienced for a long period, will gradually give way to new tasks and reconstruction of one's life. The last stage involves a readjustment to normal and full functioning – fulfilment of life roles and one's work. The intensity of the grieving process and its course is influenced by many factors, such as predispositions and traits of the bereaved person, the suddenness of the loss, the position of the deceased in the family, the possibility of substituting him or her with another close person, and support received from others³³. Below are presented major and most frequently presented stages of the grieving process as viewed by different authors (see Table 1).

Table 1. Grieving process stages according to different authors

E. Kübler-Ross (1969)	J. Bowlby (1980)	C. Sanders (1996)	S. Nolen-Hoeksema, J. Larson (1999)
denial	protest	shock	initial stage
anger	despair	unawareness of loss	middle stage
bargaining depression acceptance	detachment	protecting oneself and recovery	transformation stage

Losing a baby during pregnancy makes it difficult to work one's way through the grieving period, which may lead to pathological grief³⁴. It can have the form of two irregularities, one being a delayed reaction and the other a distorted reaction. The former occurs when the expression of emotions is suppressed, leading to significant tension and dissipation of psychic energy. On the other hand, distorted grief reactions can have manifold forms,

³³ Ibid., pp. 11-33.

³⁴ J. M a k s e l o n, *Typologia i dynamika żałoby*, in B. L. B l o c k & W. O t r ę b s k i (Eds.), *Człowiek nieuleczalnie chory*, Lublin: WNS KUL 1997, pp. 111-119.

such as: excessive activity (accompanied by lack of perception of the person's absence), hostility towards relatives and friends, hostility towards those who had contact with the child, inability to perform work as a form of punishing oneself (accompanied by lack of perception of one's guilt)³⁵.

The process of parents coming to terms with the death of their child is affected by numerous factors. Kornas-Biela³⁶ enumerates the following: time elapsed since the death, the cause of the death, the parents' feelings about their ability to have prevented the death, the suddenness of this event, possible child's disability, earlier procreative failures, the importance of the baby to the parents and family, the economic, professional or family circumstances of the parents, and the kind of received support from the close ones.

According to Pilecka³⁷, the grieving process calls for an explicit expression of love for a dead person, while internalised anger and incomprehension block this expression. In the case of mothers who lost their baby during pregnancy the situation complicated by the fact that they had no natural contact with their baby (hugging, stroking, feeding) or this intimate relationship based on a baby's dependence on the mother for survival outside her body. Therefore, the purpose of grief is to sever the bonds with the deceased baby so as to obliterate those memories and hopes that always bring pain and suffering. This is achieved under huge emotional strain; however, when the grieving period is over, grief and the blame that is placed on others fade away, the sense of guilt becomes reduced, and the lost child is often perceived by the parents and family as an "angel" or intercessor for the family in Heaven. In this way the baby becomes someone who lends spiritual help to the family. Such a role of a lost child is extremely important to the parents, especially if they are believers. Parents establish a balanced and healthy relationship with their child on a spiritual level by talking to him or her, sharing their experiences and asking for support for the family. Such parents often cherish the hope of meeting their child in the life beyond death. Notably, women differ from men in their perception of their child's death. Ove-

³⁵ T u c h o l s k a, *Psychologiczna analiza procesu żałoby*, pp. 11-33.

³⁶ D. K o r n a s - B i e l a, *Potrzeby rodziców po stracie dziecka w okresie okołoporodowym*, in E. B i e l a w s k a - B a t o r o w i c z, D. K o r n a s - B i e l a (Eds.), *Z zagadnień psychologii prokreacyjnej*, Lublin: Redakcja Wydawnictw KUL 1992, pp. 61-75.

³⁷ P i l e c k a, *Kryzys psychologiczny*.

rall, women are more sensitive and more affected than fathers as the death of a family member has a much more painful impact on them³⁸.

5. SUPPORTING MOTHERS WHO LOSE A BABY DURING PREGNANCY

The psychological aftermath of such a traumatic experience as a loss of a baby before it is born is an experience which often requires intervention of a psychologist. The form of this assistance is extremely important. It is vital that the medical staff know as much as possible about the emotional state of the parents since the former are in close contact with parents who have suffered a loss. Equally important is the possibility of receiving psychological help in the long run. Research done by a Swedish team³⁹ demonstrates a lower percentage of psychosocial complications in mothers who were helped by medical staff after they had lost their baby compared to a group of women who did not. Studies of Singaporean nurses and midwives in 2007 who provided assistance to parents who suffered a loss indicate that helping such parents is a very demanding task, often difficult and causing the medical staff to feel remorse. The study indicates that those nurses who declared themselves as believers fared better providing help and were better equipped to cope with the strains of their work. Also, adequate training which they had been given, and the presence of a psychologist available both to the parents and the medical workers were very of great importance⁴⁰. Conry and Prinsloo⁴¹ observed that support provided to grieving mothers as early as in the hospital was conducive to a well-managed grieving period and their correct readjustment for life.

³⁸ M. C l a i r e n, R. D i e k s t r a, J. M. F. K e r k h o f & I. V a n W a l, *Mode of Death and Kinship in Bereavement. Focusing on "Who" Rather than "How"*, "Crisis" 1(1994), pp. 22-36.

³⁹ C h r z a n - D e t k o ś, *Utrata dziecka w okresie okołoporodowym – dobre praktyki szpitalne w opiece nad matką*, pp. 27-30.

⁴⁰ M. F. C h a n & D. G. A r t h u r, *Nurses' Attitudes Towards Perinatal Bereavement Care*, "Journal of Advanced Nursing" 65(2009), No 12, pp. 2531-2541.

⁴¹ J. C o n r y & C. P r i n s l o o, *Mothers' Access to Supportive Hospital Services after the Loss of a Baby through Stillbirth or Neonatal Death*, "Health SA Gesondheid" 13(2008), No 2, pp. 14-24.

Parents who lose their baby do not need to use tranquilisers in exchange for a possibility to externalise their feelings, hold back their tears and sadness, cover up the fact that the baby had lived, repressing their experiences by saying “it was but a little baby, you did not have a chance to become attached to it”, or rationalising: “it is better for the baby to have died, otherwise it would have suffered”, or consoling: “you will have another baby”⁴². Such parents need to be lent an empathetic ear, encouraged to express their feelings and thoughts; they need to get their guilt off their chests, strengthen family bonds, or someone to affirm their baby’s dignity or suggest that they name the baby.

Support provided to women who lose a baby and to their families should respect their grief and make it possible for them to express their feelings. From the observations of Chrzan-Dętkoś⁴³ in a obstetric ward it appears that the emotional state of the patients who do not manifest their emotions is likely to be disregarded. Psychological help is typically provided to these mothers who outwardly suffer their loss, and not to those who appear calm or even deny their grief. Stresses that regaining balance after a trauma (such as losing a baby during pregnancy) consists in learning to live with an awareness of what happened, not in being able to brush it aside.

Säflund, Sjörgen, Wredling⁴⁴ (2004) carried out some research into the best ways of helping mothers who lose their babies before their birth. The Swedish study envisaged a retrospective appraisal of assistance offered to them in the moment of loss – assistance which would support them and teach how to adjust to a new reality. The helping behaviours, valuable in that particular situation, included: help provided in a moment of shock and chaos, possibility to see and say goodbye to the baby, supporting the parents in their grief, explanations of the cause of death, and sympathetic attitude towards them. These observations provide obvious indications for medical staff with regard to the psychological needs of grieving parents and continuity of medical and psychological help, provided by the same team. When it comes to the interaction between a parent and a medical worker, the hardest moment ar-

⁴² K o r n a s - B i e l a, *Potrzeby rodziców po stracie dziecka w okresie okołoporodowym*, pp. 65-66.

⁴³ C h r z a n - D e t k o ś, *Utrata dziecka w okresie okołoporodowym – dobre praktyki szpitalne w opiece nad matką*, pp. 27-30.

⁴⁴ K. S ä f l u n d, B. S j ö g r e n, R. W r e d l i n g, *The Role of Caregivers after a Stillbirth: Views and Experiences of Parents*, “Birth” 31(2004), No 2, pp. 132-137.

rives when the parent has to be told the bad news. This moment releases tremendous shock and stress; it is now that the parents are in desperate need of information what comes next. A medical worker must select content of their message as appropriate for this difficult time, displaying sensitivity and gentleness in conveying this information.

Some hospitals still do not envisage the possibility of parents saying goodbye to their baby, seeing or touching it. The results of the Swedish researchers emphasise the value of the experience of the parents who were granted a chance to interact with their dead baby while at hospital. The supporting openness of the medical staff and letting the parents have a private moment allowed them to say goodbye to their baby. Both mothers and fathers were fully spontaneous in showing their feelings towards their baby, who was dressed up and nestled for as long as several hours. The parents themselves left the room calmer, while those who were prevented from seeing their baby (not to mention touching it) did not. It is essential to suggest, not force, that parents have physical contact with their dead baby. The latter is common practice in England, where such physical contact is an element of procedures aiming to support mothers. An individual approach and the presence of a psychologist when a decision on contact with the baby is being taken permits the best option to be chosen to benefit the mother and other family members.

When rehabilitating a mother who has suffered a baby loss it is essential to help her have another baby. Women with such failures constitute the largest group of patients visiting pre-conception consultancy units. Attempts to locate the cause of miscarrying or foetal defects usually prove unsuccessful. However, physicians try to diagnose the aetiology of earlier procreation failures in order to minimise the risks and complications of a next pregnancy. As Chazan⁴⁵ explains, about 5% of recurring miscarriages are caused by genetic diseases, while anatomical abnormalities of the reproductive organs account for 15-30% and the mother's diseases for 20-50%. In 30-40% of cases no cause can be found.

Following the loss of a baby, the needs of parents can be said to follow from several premises. This would be the unsatisfied biopsychic desire to have a baby, which, given the circumstances, may give rise to thoughts of being inadequate and disturb a positive image of oneself. Another factor

⁴⁵ B. C h a z a n, *Medycznie chronione macierzyństwo: profilaktyka niepowodzeń macierzyńskich*, in D. K o r n a s - B i e l a (Ed.), *Oblicza macierzyństwa*, Lublin: Redakcja Wydawnictw KUL 1999, pp. 163-177.

would be the perpetual separation of the mother from her unborn child – the longer it lived the more harrowing is the loss⁴⁶. The sense of unreality of the baby's death is associated with the sense of unreality of its life. According to Kornas-Biela⁴⁷, this is due to the fact that the parents were unable to *see* the baby die, *see* it after the delivery, and the fact that it never physically entered the family, as well as the absence of memories connected with a living baby – all in the circumstances of a hospital stay.

6. FAMILY ASPECT OF LOSING A BABY BEFORE BIRTH

In the situation of a baby loss, the experience of the mother's partner or husband is crucial. By participating in the pregnancy, the latter provides immediate support to the mother. By being involved in her pregnancy, he observes her reactions and experiences, looking forward to the birth of his descendant. May⁴⁸ distinguishes three phases of a man's involvement in the course of a pregnancy, emphasising their similarity to those of a pregnant woman as well as differences. The first, called *announcement*, starts when the first guesses appear and lasts until the good news is confirmed. During this time, the man's task is to support his partner in making decisions about the reception of the baby, and to help her introduce necessary changes in her lifestyle. The second phase, called *moratorium* and lasting from the 12th to the 25th week of the pregnancy, is a period during which men hardly ever notice any significant physical changes in their partner, expecting her emotional state to stabilise. The last phase, called *focusing*, concentrates on getting ready for the birth. Men increasingly see themselves as fathers during this period, which is connected with new duties and tasks. Some men display fear of the forthcoming delivery due to concerns about the baby's condition and intense pain felt by the mother. Bullinger⁴⁹ speaks of contradictory feelings exhibited by men. On the one hand, there is joyful expectation and

⁴⁶ K o r n a s - B i e l a, *Potrzeby rodziców po stracie dziecka w okresie okołoporodowym*, p. 61.

⁴⁷ *Ibid.*, pp. 61-63.

⁴⁸ B i e l a w s k a - B a t o r o w i c z, *Determinanty spostrzegania dziecka przez rodziców w okresie poporodowym*, pp. 123-124.

⁴⁹ *Ibid.*, p. 125.

planning life together, but on the other there is fear of taking up a new role and losing the privileged status in the family.

When the pregnancy is qualified as high risk, the stress experienced by both parents increases, and the mother projects her emotions upon her husband/partner. Studies by Steuden & Szymona⁵⁰ demonstrate that men appear tolerant of the ailments and experiences of their partners. The relation between the two parents is affected by such factors as the degree of mutual understanding, the strength of their bond, the quality of their two-way communication, as well how advanced the pregnancy is. The father of the baby is the person the mother strongly depends on for emotional support.

The siblings of the baby who died before birth may feel disappointed as well as responsible for the situation. This is connected with feelings of jealousy and fear of a new family member appearing. Older children are afraid of being rejected and losing the love of their parents after another baby is born in the family; they do not admit any siblings beg that they are not born. If the baby dies before birth, its brothers or sisters may blame themselves for that. Fearing that a manifestation of their true feelings will evoke anger and rejection in their parents, they frequently suppress these emotions and keep them to themselves. It is important to devote enough time for the siblings of the deceased baby, to explain the real cause of its death, which would remove the weight they have imposed upon themselves⁵¹.

CONCLUSIONS

For parents, losing a baby prenatally constitutes a situation that has psychological consequences, potentially for all of the family members. The psychological impact of a prenatal death varies depending on the sex of the parents, the age of the pregnancy, obstetrical history, number of children, support received after the death, and the social status of the parents.

Social acceptance for a woman grieving her baby's death differs from that experienced by a father. Although we recently notice a growing social aware-

⁵⁰ S. S t e u d e n & K. S z y m o n a, *Doświadczenia macierzyństwa i ojcostwa przez rodziców w sytuacji ciąży wysokiego ryzyka*, in J. J a n i c k a, T. R o s t o w s k a (Eds.), *Psychologia w służbie rodziny*, Łódź: Wydawnictwo Uniwersytetu Łódzkiego 2003, pp. 228-244.

⁵¹ B a r t o n - S m o c z y ń s k a, *O dziecku, które odwróciło się na pięcie*, pp. 144-152.

ness in this respect (owing to improved prevention), it seems still insufficient. Not adequate as it may seem, women obtain some support from medical staff; however it is still uncommon to sympathise with a man (father) when a miscarriage occurs. Very often, no one even knows that such a situation has taken place. On the contrary, a man is expected to lend support to his wife in this hard time. As research suggests, the best support for the woman is supplied by her own partner. This assistance has the greatest impact on the whole grieving process and the time when she regains her balance and consciously comes to grips with the loss. Living through the period of mourning in accordance with one's own personal convictions is an important factor.

Frequently, the friends and family of the grieving parents do not know how to help them, therefore they prefer not to raise the topic; even if they do, trying to help, they do it incompetently, downplaying the significance of the difficult situation. This often leads to misunderstanding. The best possible support in these circumstances is to acknowledge the parents' needs, lend a sympathetic ear, and enable them to pay a last tribute to their baby in the way as they both see fit.

Losing a baby prenatally affects all family members, including the children, who sense the parents' emotions and try to grasp the situation in their own way. Anxiety, guilt, confusion and the feeling of being misunderstood appear. They expect an adequate degree of attention and they need to be relieved of the burden of the loss. The psychological and somatic consequences should be treated on a par with the medical aspects. The more comprehensive help is offered to parents who have lost their baby, the better results intervention, therapy, and rehabilitation will produce.

BIBLIOGRAPHY

- B a d u r a - M a d e j W.: Psychologiczne aspekty śmierci, umierania i żałoby, Kraków: Ośrodek Interwencji Kryzysowej 1993.
- B a r t o n - S m o c z y ń s k a I.: O dziecku, które odwróciło się na pięcie, Łomianki: NAF 2006.
- B i e l a w s k a - B a t o r o w i c z E.: Determinanty spostrzegania dziecka przez rodziców w okresie poporodowym, Łódź: Wydawnictwo Uniwersytetu Łódzkiego 1995.

- B r ę b o r o w i c z G.H.: Cięża wysokiego ryzyka, Poznań: Ośrodek Wydawnictw Naukowych 2010.
- C h a n M.F. & A r t h u r D.G.: Nurses' Attitudes Towards Perinatal Bereavement Care, "Journal of Advanced Nursing" 65(2009), No 12, pp. 2531-2541.
- C h a z a n B.: Medycznie chronione macierzyństwo: profilaktyka niepowodzeń macierzyńskich, in D. K o r n a s - B i e l a (Ed.), *Oblicza macierzyństwa*, Lublin: Redakcja Wydawnictw KUL 1999, pp. 163-177.
- C h r z a n - D ę t k o ś M.: Utrata dziecka w okresie okołoporodowym – dobre praktyki szpitalne w opiece nad matką, „Ginekologia Praktyczna” 18(2010), No 2, pp. 27-30.
- C l a i r e n M., D i e k s t r a R., K e r k h o f J. M. F. & V a n W a l I.: Mode of Death and Kinship in Bereavement. Focusing on “Who” Rather than “How”, “Crisis” 1(1994), pp. 22-36.
- C o n r y J. & P r i n s l o o C.: Mothers' Access to Supportive Hospital Services after the Loss of a Baby through Stillbirth or Neonatal Death, “Health SA Gesondheid” 13(2008), No 2, pp. 14-24.
- G o l a ń s k a Ż.: Interakcja matki z dzieckiem w okresie prenatalnym, „Annales Academiae Medicae Silesiensis” Katowice: ŚAM 1989.
- G r e t k o w s k i A.: Ból i cierpienie, Płock: Wydawnictwo Naukowe Novum 2004.
- G u z e w i c z M.: Sociological and Psychological Situation of Stillbirths in Population of Poland, “Economics & Sociology” 7(2014), No 1, pp. 174-182.
- K ę p i ń s k i A.: Lęk, Kraków: Wydawnictwo Literackie 2003.
- K o c y ł o w s k i R.: Trudny czas po poronieniu, “Dobra Mama” 15(2012), No 4, pp. 44-45.
- Kodeks Prawa Kanonicznego (1984), Poznań: Pallottinum.
- K o r n a s - B i e l a D.: Potrzeby rodziców po stracie dziecka w okresie okołoporodowym, in E. B i e l a w s k a - B a t o r o w i c z & D. K o r n a s - B i e l a (Eds.), *Z zagadnień psychologii prokreacyjnej*, Lublin: Redakcja Wydawnictw KUL 1992, pp. 61-75.
- K o r n a s - B i e l a D.: Wokół początku życia ludzkiego, Warszawa: Nasza Księgarnia 1993.
- L a c h e l i n C. G.: Poronienia, Warszawa: Prószyński i S-ka 1998.
- L i n d e m a n n E.: Symptomatology and Management of Acute Grief, “American Journal of Psychiatry” 101(1949), pp. 141-148.
- Ł u c z a k - W a w r z y n i a k J.: Matka wcześniaka – sytuacja psychologiczna i społeczna w trakcie pobytu w szpitalu i po opuszczeniu oddziału noworodkowego, „Ginekologia Praktyczna” 17(2009), No 1, pp. 7-8.
- M a k s e l o n J.: Typologia i dynamika żałoby, in B.L. B l o c k & W. O t r ę b s k i (Eds.), *Człowiek nieuleczalnie chory*, Lublin: WNS KUL 1997, pp. 111-119.
- M c F a r l a n e A.: Traumatic Stress in the 21st Century?, “Australian and New Zealand Journal of Psychiatry” 34(2000), pp. 896-902.
- P i l e c k a B.: Kryzys psychologiczny. Wybrane zagadnienia, Kraków: Wydawnictwo Uniwersytetu Jagiellońskiego 2004.
- P r a ż m o w s k a B., P u t o G., K o w a l E., G i e r a t B.: Niespełnione macierzyństwo, „Ginekologia Praktyczna” 17(2009), No 4, pp. 53-56.

- R a i R. & R e g a n L.: Recurrent Miscarriage, "Lancet" 368(2006), pp. 601-611.
- R o w e H.: Spontaneous Pregnancy Loss, in *Mental Health Aspects of Women's Reproductive Health: A Global Review of Literature*, Geneva, Switzerland: World Health Organization 2009, pp. 67-78.
- S a n d e r s C.: Powrót nadziei, Gdańsk: GWP 1996.
- S a n d e r s C.: Jak przeżyć stratę dziecka, Gdańsk: GWP 2001.
- S ä f l u n d K., S j ö g r e n B. & W r e d l i n g R.: The Role of Caregivers after a Stillbirth: Views and Experiences of Parents, "Birth" 31(2004), No 2, pp. 132-137.
- S k r z y p c z a k J.: Poronienie, in T. P i s a r s k i (Ed.), *Położnictwo i ginekologia. Podręcznik dla studentów*, Warszawa: Wydawnictwo PZWL 2002, pp. 334-346.
- S t e u d e n S. & S z y m o n a K.: Doświadczenia macierzyństwa i ojcostwa przez rodziców w sytuacji ciąży wysokiego ryzyka, in J. J a n i c k a & T. R o s t o w s k a (Eds.), *Psychologia w służbie rodziny*, Łódź: Wydawnictwo Uniwersytetu Łódzkiego 2003, pp. 228-244.
- S t e u d e n S. & S z y m o n a K.: Psychologiczne aspekty macierzyństwa i ojcostwa w sytuacji ciąży wysokiego ryzyka, in J. M e d e r (Ed.), *Problemy zdrowia psychicznego kobiet*, Kraków: Biblioteka Psychiatrii Polskiej, Komitet Redakcyjno-Wydawniczy Polskiego Towarzystwa Psychiatrycznego 2003, pp. 109-120.
- S z c z e p s k a - P u s t k o w s k a M.: Kategoria dzieciństwa – od Ellen Key do współczesności, "Edukacja i Dialog" 7(1997).
- T r o s z y ń s k i M., M a c i e j e w s k i T., W i l c z y ń s k a A. & B a n a c h B.: Przyczyny martwych urodzeń i zgonów noworodków w Polsce w latach 2007-2009, "Ginekologia Polska" 82(2011), pp. 598-601.
- T u c h o l s k a S.: Psychologiczna analiza procesu żałoby, in S. S t e u d e n & S. T u c h o l s k a (Eds.), *Psychologiczne aspekty doświadczania żałoby*, Lublin: Wydawnictwo KUL 2009, pp. 11-33.

PSYCHOLOGICZNE, RODZINNE I SPOŁECZNE ASPEKTY UTRATY DZIECKA PRZED NARODZENIEM

S t r e s z c z e n i e

Utrata dziecka w wyniku poronienia, przedwczesnego porodu lub śmierci okołoporodowej jest bardzo trudnym doświadczeniem, będącym obciążeniem emocjonalnym dla tych kobiet, które takiej utraty doświadczyły, jak i dla ich najbliższej rodziny. Często również personel medyczny emocjonalnie przeżywa śmierć dziecka w okresie prenatalnym, choć niestety istnieje też ryzyko przedmiotowego traktowania pacjentki i jej dziecka. Prezentowany artykuł stanowi przegląd literatury w aspekcie psychologicznych, społecznych, rodzinnych oraz religijnych następstw wiążących się z utratą dziecka w okresie prenatalnym.

Słowa kluczowe: utrata dziecka, poronienie, strata prokreacyjna.