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Pregnancy after stillbirth or neonatal death: psychological risks and management

After a perinatal death everyone hopes the next pregnancy will set things right. In reality, neurotic, phobic, depressive or hypochondriacal reactions may continue from the first stillbirth or may be reactivated after an apparent recovery (Cullberg 1972). The marriage (Meyer & Lewis 1979) or any member of the family may bear the brunt. Sequelae are often carried into the next generation, activated decades later by anniversaries or life-events (Guyotat 1980).

Human pain fades, but mourning of stillbirth and genuine recovery are difficult and require time. If mourning is achieved, another pregnancy will offer consolation and fulfilment. Unfortunately, the new pregnancy very often cuts short the mourning process, predisposing to mental disturbance. Serious and bizarre reactions occur unexpectedly, after the birth of a healthy subsequent baby (Lewis & Page 1978). Puerperal psychosis requiring admission to a psychiatric unit is uncommon: our clinical impression is that it is more likely to follow the nextlive birth than the stillbirth itself.

We refer, throughout, to stillbirth but the paper is applicable to neonatal death, which, in comparison, is mitigated by the experience of having a live baby – and a little more time to think.

Theoretical considerations
Normal mourning and its difficulties
Normal recovery from a loss involves taking in what has happened, and sorting out mixed feelings and lost hopes so that memories of the dead recede to a healthy perspective (Parkes 1972; Bowby 1980). At first the inner world is occupied with conscious and unconscious images of the body and mind and illness of the dead, which contributes to the malaise, heaviness, and deadness as well as hypochondria and psychosomatic illness (Freud 1917; Abraham 1979). In failed or interrupted mourning, symptoms may become chronic;
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The experience of grief and the psychological impact of the loss of a child can be profound. Mothers and fathers may experience a range of emotions, including shock, anger, guilt, and confusion. The process of mourning and recovery can be slow and complex, and it is important for healthcare providers to be sensitive to the needs of families during this time.

Risks to women and infants include:

- Postpartum depression
- Insomnia
- Anxiety
- Low self-esteem
- Physical neglect
- Substance abuse

Counselling and support can help to address these issues and promote a healthy recovery for mothers and their families.

PSYCHOANALYTIC IDEAS

Special mourning and deploration might be observed in some individuals who have experienced a significant loss.
The paradigm of pregnancy after stillbirth or near-miss death presents unique challenges and opportunities for women, families, and healthcare providers. This paradigm shifts the focus from a transactional to a relational approach, emphasizing the importance of understanding the patient's experience and providing holistic care. The paradigm highlights the need for integrated care, collaboration among healthcare professionals, and support for families throughout the pregnancy journey. 

The paradigm also underscores the importance of addressing the emotional and psychological needs of women and families, including grief, loss, and post-traumatic stress. It promotes the use of evidence-based practices and community-based support systems to enhance the effectiveness of care. The paradigm encourages the development of guidelines and protocols that are specifically tailored to the needs of this population, aiming to improve outcomes and provide a more personalized approach to care.

In conclusion, the paradigm of pregnancy after stillbirth or near-miss death offers a framework for understanding the complex and multifaceted needs of women and families. By adopting this paradigm, healthcare providers can work collaboratively to create a more supportive and effective approach to care, ultimately leading to improved health outcomes and quality of life for women and families.
References


