

**THE PSYCHOLOGICAL EFFECTS OF
STILLBIRTHS ON WOMEN AND
THEIR DOCTORS**

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THIS is the account of a series of 100 cases of stillbirth, compared with 100 livebirths, from observations supplied by their family doctors. The primary aim of the study was to discover the psychological effects of stillbirth on the mother and her family, following clinical experience that disabling mental complications had followed stillbirths in some women who appeared previously to be normal; but, the actual results of the investigation force attention upon the disturbed doctor-patient relationship ensuing in these cases, characterized by a strong reluctance of doctors to know, notice or remember anything about the patient who has had a stillbirth.

Method

Two series, consisting of 100 cases of stillbirth (SB) and 100 cases of livebirth (LB), were obtained from the register of statutory notifications. To provide comparable random series, each of the ten area health offices in the County of Middlesex supplied details of the first cases of SB and LB notified in each of ten months in one year (1962).

In 1964, a questionnaire was sent to each mother's general practitioner to provide the information set out in this paper. The questionnaires and covering letters for the two series were matched as far as possible so that useful comparisons could be made. The doctors were told that this was an attempt to gather information regarding the psychological sequelae of having either a live baby or a stillbirth, according to whichever type of case they had. Elaborate reports were not expected, many of the questions were designed for Yes/No answers but it was emphasized that all additional impressions and comments, however uncertain or brief, would be appreciated and that all questionnaires should be returned in any case. Stamped addressed envelopes were supplied. A second questionnaire was sent to those doctors who had not replied after a month.

Results

I. Comparison of the doctors

Since the response of the doctors was so different in the two series it is necessary to clarify this first. There is a consistent tendency for the doctors with stillbirths not to answer, not to notice and not to remember.

TABLE I
SB DOCTORS RETURN FEWER FORMS THAN LB DOCTORS

	<i>SB (100 forms)</i>	<i>LB (100 forms)</i>	
Forms returned	77	88	$\chi^2=4.19$
Forms not returned ..	23	12	$p < 0.05$

Of 100 cases in each series, forms were eventually returned for 77 SB's and 88 LB's. This is a significant difference ($\chi^2 = 4.19$; $p < 0.05$).

Three doctors took the trouble to write letters refusing to participate in the investigation. Two of these doctors had SB cases. The third doctor had two SB's and one LB. All complained of insufficient time for their own needs.

The 27 doctors with more than one form were not responsible for any preponderance of unreturned forms in either series. They had, between them, 27 SB's (13 returned) and 30 LB's (20 returned).

TABLE II
SB DOCTORS RETURN MORE BLANK FORMS THAN LB DOCTORS

	<i>SB (77 forms)</i>	<i>LB (88 forms)</i>	
Forms returned blank ..	16	12	$\chi^2=1.02$
Forms with any usable information	61	76	$p > 0.05$

Of the forms returned, a higher proportion of SB forms were totally blank (16/61 SB's compared with 12/76 LB's). This difference is not statistically significant.

SB doctors record more 'don't know' answers than LB doctors

Doctors were asked about: (1) the patients' responses during the puerperium; (2) later reactions and progress; (3) previous and subsequent obstetric history; (4) previous medical and psychological history.

There were 61 SB and 76 LB forms containing any usable information (i.e. not totally blank) and, at almost every point, the SB doctors

record a higher proportion of 'don't knows'.

TABLE III
DISTRIBUTION OF 'DON'T KNOW' ANSWERS REGARDING THE PUERPERIUM

		SB (61 usable forms)		LB (76 usable forms)		Significant difference
<i>All cases:</i>						
Some answer	..	30	(50)	61	(80)	$\chi^2 = 13.09$ $p < 0.001$
Don't know	..	31	(50)	15	(20)	
<i>Home deliveries:</i>						
Some answer	..	7	(70)	29	(100)	$\chi^2 = 4.48$ $p < 0.05$
Don't know	..	3	(30)	Nil	(Nil)	
<i>Hospital deliveries:</i>						
Some answer	..	23	(45)	32	(68)	$\chi^2 = 4.36$ $p < 0.05$
Don't know	..	28	(55)	15	(32)	

(1) *Puerperium*. Rather more SB's (51/61 * = 84 per cent) than LB's (47/76 ** = 61 per cent) were born in hospital, and their doctors would have observed less of the early responses at first hand. However, the 'don't know' answers are far more discrepant for this period, viz 31/61 (50 per cent) for SB's to 15/76 (20 per cent) for LB's (significant difference: $\chi^2 = 13.09$, $p < 0.001$). Moreover, those patients delivered at home and where doctors might be expected to remember most, present an even more striking contrast. Amongst 29 LB's born at home there were no 'don't knows' referring to the lying-in period: every LB doctor felt able to remember *something* of his patient. At the other extreme, among the ten SB's born at home there were three 'don't knows'. Of the hospital cases, doctors were able to record some answer for 32 out of 47 LB's (68 per cent) but only 23 out of 51 SB's (45 per cent). These smaller figures for the home and hospital deliveries considered separately are still significantly different between the two series ($p < 0.05$).

(2) *Later reactions and progress*. Under this heading, the different trends continue with no 'don't knows' in the 76 LB's and four 'don't knows' in 61 SB cases.

(3) *Previous and subsequent pregnancies*. In the LB series there were 24 'don't knows' (in 76 usable questionnaires) concerning the incidence of any previous or subsequent pregnancies. In the SB series there were 32 'don't knows' (in 61 usable questionnaires). This difference is significant: $\chi^2 = 5.27$, $p < 0.05$.

There were 15 women in the LB series noted to be pregnant again

*See table II—61 is total of usable questionnaires for SB's.

**See table II—76 is total of usable questionnaires for LB's.

and the doctors were able to report upon all of them. There were 29 women in the SB series who became pregnant again but in two of these cases the doctors did not know anything about the course of the pregnancy or its outcome (table VI).

TABLE IV
DISTRIBUTION OF 'DON'T KNOWS' FOR INCIDENCE OF PREVIOUS AND SUBSEQUENT PREGNANCIES

	<i>SB</i> (61 usable forms)	<i>LB</i> (76 usable forms)	Significant difference
Some answer	29	52	$\chi^2 = 5.27$
Don't know	32	24	$p < 0.05$

It was emphasized on the form that this question about the course of later pregnancies was of particular importance to answer if at all possible and the doctors gave some indication, however cursory, of the psychological response *explicitly* for 11 (73 per cent) of the 15 LB women; by contrast, explicit reference to the psychological reactions was made in only 11 (41 per cent) of the 27 SB women reported upon (table VI).

Moreover, in all four LB cases where there was abnormal labour in a later pregnancy, there was an explicit report of the mental response; on the other hand, of nine SB cases of abnormal labour in a later pregnancy, five (including one abortion) received no comment on the mental response. The number of cases is too few for these figures to reach statistical significance (table VI).

(4) *Previous illnesses, psychological disorders, marital or sexual difficulties.* The reported incidence is the same—only a few cases in both series but the extent of other miscellaneous observations volunteered by the doctors does appear to be impoverished in the SB group with only 11 cases receiving further remark in 61 SB's (18 per cent) compared with 23 remarked in 76 LB's (30 per cent).

II. Comparison of the patients

TABLE V
CONDITION IN PUERPERIUM (EXCLUDING CASES WHERE DOCTOR PUT 'DON'T KNOW')

	<i>SB</i>	<i>LB</i>	
Psychologically disturbed	21	5	$\chi^2 = 34.64$
Not psychologically disturbed	9	56	$p < 0.001$

Condition in puerperium. There were 61 LB's and 30 SB's for whom answers of any sort were given. Of these, patients were

described as calm, 'NAD' etc., in 51/61 LB's but in only 9/30 SB's (and one of these mothers had a live surviving twin). This is a highly significant difference ($p < 0.001$). As would be expected, most mothers of healthy babies are reasonably 'normal' during the puerperium and the great majority of mothers of stillbirths are visibly distressed. Beyond this, the reports are not adequate to provide a reliable detailed picture.

Two-year follow-up (table VI). There were 76 LB's and 57 SB's for whom some answer was given. Those reported as having lasting psychological symptoms of any type at all total 20/76 (26 per cent) of LB's and 19/57 (33 per cent) of SB's. Of these, nine LB's and five SB's had the same symptoms before the pregnancy. Thus, the totals for *new* symptoms during the follow-up are 11/76 (14 per cent) LB's and 14/57 (24 per cent) SB's—quite a considerable proportion for both groups. The numbers here are small and the difference between the two groups is not statistically significant. Anger and recrimination is reported in 5/61 SB's and in none of 76 LB's.

Change of doctor. During the two-year follow-up 21/77 (27 per cent) SB patients and 14/88 (16 per cent) LB patients had changed their family doctor. This difference is not statistically significant. (Change of doctor accounts for forms returned blank for nine SB's and eight LB's).

Subsequent pregnancies (table VI). Within two years of a stillbirth 29/61 (49 per cent) of patients had become pregnant again. In the LB series 15/76 (20 per cent) of patients had become pregnant again within two years. (This is a highly significant difference: $\chi^2 = 10.75$, $p < 0.001$). The reported courses of these pregnancies do not differ in the two series but only large differences would be exposed in these small numbers. The doctors mention anxiety during pregnancy as a symptom in 2/15 LB's and 4/29 SB's, i.e. about one in seven patients for both groups. Post-partum psychological symptoms are reported in 2/15 LB's and 1/29 SB's.

Previous pregnancies

There were 53 LB's and 33 SB's for whom answers of any sort were given. Of these there were 36/53 (70 per cent) LB's and 16/33 (50 per cent) SB's with one or more previous pregnancies. There was insufficient information to form any reliable impression about the morbidity in either group. Previous abortions, stillbirths and neonatal deaths were reported in six LB's and three SB's—roughly the same incidence in both groups it would seem, rather surprisingly.

Other previous history

The two series do not differ. Recorded symptoms of any sort

(physical, psychological, sexual, marital) are only a few per cent each in both groups.

TABLE VI
SUBSEQUENT PREGNANCIES

	<i>SB (61 forms)</i>	<i>LB (76 forms)</i>	
Total pregnant within two years	29 women (30 pregnancies)	15 women (19 pregnancies)	$\chi^2=10.75$ $p < 0.001$ Very significant
Cases with no explicit mention of psychological response	16 (59)	4 (27)	$\chi^2= 2.90$ p between 0.1 and 0.05
Cases for whom doctor could not report at all	2	Nil	No significant difference
Anxiety during pregnancy reported	4	2	
Postpartum psychological symptoms reported ..	1	2	
Abortions	2	1	
Abnormal labour ..	9	4	
Abnormal labour with no psychological report ..	5	Nil	

Discussion

The SB doctors know less, remember less, and appear to be able to think less about their patients than the LB doctors. This affects the doctors' memory for all aspects of the case, not only the question of psychological symptoms. The SB doctors return fewer questionnaires (table I) and two wrote especially to refuse to participate. Of the questionnaires returned, fewer SB's contained any usable information (table II). Of those returning usable questionnaires, the SB doctors tend repeatedly 'not to know', they confine themselves more to Yes/No answers and their replies are impoverished in comparison with the LB doctors who manage to provide more spontaneous comment. For example, all 29 doctors with LB patients delivered at home are able to say something about the puerperium whereas three out of ten doctors with stillbirths delivered at home 'don't know' (table III). Of 76 LB doctors whose forms are usable, 75 answer something about the question on subsequent

pregnancy and all 15 women pregnant again in the LB group are described (if only in monosyllables): by contrast, four of 61 SB doctors 'don't know' if there were subsequent pregnancies and another two doctors 'don't know' anything about two of the 29 women reported to have become pregnant again in the SB group. For these subsequent pregnancies the proportion of LB doctors making explicit comment upon the psychological reactions is nearly twice as high (11 out of 15 LB doctors) as it is in the SB's (12 out of 29 SB doctors), (tables IV and VI).

Some sequelae distinguish the SB patients but the study provides only a rough indication of how women with stillbirths fare afterwards, owing to the extensive omissions and distortions of reporting in the SB series. More SB patients changed doctors; this itself may be a symptom of something wrong but many of these (possibly crucial) patients were lost to the study. During the puerperium a highly significant proportion of the SB women were noticeably disturbed, as would, of course, be expected. Some psychological morbidity in the SB series is suggested; new mental symptoms in the next two years are reported in 24 per cent of the SB women against 14 per cent in the LB's but this trend is not statistically significant. No cases of psychotic breakdown are reported but, since the average incidence of puerperal psychosis in other series seems to be around one in 600 pregnancies, none could reasonably have been expected; an increase of even ten times the average incidence of puerperal psychosis could very easily have been missed altogether in this study. Half the SB women are again pregnant within two years—a highly significant ($p < 0.001$) increase over the LB women (table VI). It is understandable that mothers with young babies might defer the next pregnancy and that, by contrast, patients having a stillbirth would want another baby soon. The reported course and outcome of these subsequent pregnancies do not differ in the two series but only large differences would be exposed in these small numbers and there are ample reasons for suspecting some masking of events in the SB series. It is hard, for example, to believe that the extent of anxiety during later pregnancies was the same in both groups yet this is what the doctors seem to recall.

The differences between the responses of the two sets of doctors are far more striking than the reported differences between the two sets of patients. This is the central problem raised by this investigation and it almost certainly reflects a deterioration in the doctor-patient relationship in SB cases, whatever additional explanations are invoked. It is conceivable that a doctor's current amnesia may indicate repression of a distasteful experience and may not necessarily reflect neglect of his patient at the time; but it certainly does mean that he cannot now be fully alive to his patient's needs and that his relation-

ship with her has suffered.

It is also possible that doctors are reluctant to communicate with colleagues owing to feelings of anxiety or inadequacy aroused by a stillbirth so that, for example, hospital obstetricians' reports to the general practitioners on stillbirths may have been attenuated in the same way as the general practitioners' own reports in this investigation. Conceivably then, the doctor-patient relationship may remain rather better than that suggested in a context of poor communication between medical colleagues.

Mothers of stillbirths drift away from their doctors. Five out of 61 SB mothers are reported as angry or recriminating, compared with none of the LB's. Only two of these five actually changed doctors. More (but not quite statistically significant) SB women are known to have changed doctors and it is likely that the non-replies (23 per cent SB's, 12 per cent LB's) include many women who had moved, in both series. Moreover, it is probable that some women in the LB series changed doctors owing to a changed address, necessary with the advent of the baby, i.e. their reasons for changing doctors may be less closely linked with dissatisfaction and distress than in the SB series.

The problems, rewards and hopes associated with new babies must bring some LB doctors closer to their patients so that the alienation of medical interest from women with stillbirths appears worse by contrast. On the other hand it is serious to find that a group of patients in difficulty do not come in for *their* share of enhanced medical attention. For many of these women with stillbirths, the relationship with the doctor has suffered a critical blow at precisely the time when all possible help might be desirable.

Doctors have to evolve skills and judgment to distance themselves optimally in relation to their patients. Training and modern therapeutics combine to equip them for handling physical illness, but family doctors are also at home, even if uncomfortable and largely self-taught, with emotional problems. Yet a stillbirth is hard for both doctor and patient to place, a 'non-event' whose nature is hard to fit with conceptions of illness. There are the bodily anxieties, miseries and shame of disease but (usually) no physical illness to treat or learn to live with: there is bereavement but no tangible experience of a lost human being to mourn. At depth, an abortion may be similar but the sheer physical experience makes stillbirth something of another order, rendering favourite psychological defences inapplicable. An abortion may be more successfully denied: the gestation is short, investment and disappointment less, the product is tiny and unrecognizable (especially if you choose not to look) and the experience is mainly private. By contrast, a stillbirth is inescapably a dead baby and it is public: the pregnancy has

been obvious for some months, names may have been chosen and clothes prepared, the foetus has to be delivered and disposed of by somebody else and it is notifiable to the authorities. An abortion is commonplace (perhaps one in four to six pregnancies) but stillbirth is relatively rare (one in 66 livebirths).

General practitioners do not generally shirk unpleasantness and often find fresh resource and purpose when work is demanding. Nevertheless, doctors may find it hardest to tolerate the case where there is intense pain but where usual medical activity feels irrelevant, where common psychological defence mechanisms are undermined and where 'being a good listener' is not enough to hold a patient who is withdrawing in shame and anger and who may have little inclination to talk.

It is tempting to urge the next pregnancy as the ultimate cure. Another baby may indeed be essential for a woman to get over a stillbirth but it may also not be enough. The reports obtained from this enquiry do not bear out previous clinical experience which suggested that a variety of severe psychological disturbances may ensue from a stillbirth. The writer had encountered cases where, for example, frigidity, severe phobias and inability to continue work have occurred and also cases when all seemed well until the next pregnancy, a livebirth, ushered in various severe symptoms and even psychotic breakdown. It remains possible that a more extensive and thorough survey might show, nonetheless, that such sequelae are equally common with normal pregnancies but even in this study there were clear signs that the incidence of any trouble is obscured in the SB doctors' reports. For example, the incidence of anxiety during subsequent pregnancy is reported to be the same in both groups of patients, which is surely inconceivable. In any case, some women remain unable to have another baby, for whatever reason; half the 61 SB women for whom data were ascertained were, after all, not pregnant within two years and the disappearance of 39 per cent from the study is not reassuring.

There is virtually no medical literature touching the mental sequelae of stillbirths. Isolated references must presumably exist but it has been possible to search some hundreds of papers on the psychology of pregnancy and abortion, puerperal psychosis and related disorders, without meeting a single mention of the topic. It seems there is a professional blindspot.

Summary

In order to examine the extent of psychological illness in women following stillbirth, a questionnaire was sent to family doctors concerning 100 cases of stillbirth and compared with a very similar questionnaire to family doctors for 100 livebirths.

Although the replies provided some evidence of psychological morbidity in the stillbirth group, the most striking differences between the two series seem to indicate changes in the doctors and the doctor-patient relationship.

In the stillbirth series fewer doctors replied; two wrote letters of explicit refusal to participate; more returned totally blank forms; those who did reply showed a marked tendency not to know and not to remember at nearly every point; answers tended to be confined to the Yes/No type; spontaneous thought and comment were impoverished in comparison with the livebirth doctors, even on non-psychological aspects of the cases.

It seems that, in addition to her own sadness and anxieties, a woman experiencing a stillbirth is liable to be bereft of medical help owing to the unconscious alienation of her doctor's interest from her and her family or because the doctor-patient relationship breaks down. Some of the reasons for this are discussed.

This professional blindspot is probably connected with the dearth of medical literature on the subject.

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Mass screening for cancer of the breast. S. BARNES, M.B., W. H. C. BERRY, M.B., M. J. WILLIAMS, S.R.N., S.C.M., M. BAUM, M.B., F.R.C.S., W. D. MACKAY, M.B., F.R.C.S., F.R.C.S.E., D.Obst., C. T. HOWE, B.M., F.R.C.S. and J. G. MURRAY, M.Ch., F.R.C.S., F.R.C.S.E. *Lancet* 1968, **1**, 1417.

Two general practitioners, a London borough health department, and a university department of surgery co-operated in a survey to detect cancer of the breast in a London practice. Women over the age of 25 were 'screened' by clinical examination of the breasts. Sixteen abnormal breast lumps were found in 654 women examined (1,721 had been invited to attend). Five of these were cancers, of which four were early (i.e. in pathological stage 1). The survey took nine months to complete. (Author's summary).