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## Grief in Multifetal Death

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**Abstract.** The grief process is examined within the framework of multifetal pregnancy in a variety of demise situations. The case studies examined were obtained from approximately 120 letters and interviews with families predominantly of higher order multiple births, who have experienced either partial or total loss in their pregnancy or afterwards. Objective and subjective factors were addressed. Results indicate the steps of the grief response are worked through in the same order as a singleton demise, but differ in intensity, duration, and frequency, depending on the individual circumstances, type of loss, gestational age, and the parents' backgrounds, expectations and beliefs. A unique feature discovered is that the entire grieving process, from shock through acceptance, appears to be completely experienced twice, with a large percentage of parents experiencing all of the stages three or more times. The general conclusion of the study is that the grieving pattern in multifetal death indeed follows a cycle and pattern of its own and requires special considerations.

**Key words:** Grief, Child loss, Multiple pregnancy

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The number of higher order multiple births has risen appreciably with the increased use of fertility-inducing agents such as clomiphene citrate, menotrophin and invitro fertilization. Whereas the birth of triplets, quadruplets, or quintuplets was a cause for great concern twenty or thirty years ago, such events are now commonplace. Currently much effort is being directed towards solving the unique problems of prenatal obstetrical care in multiple birth pregnancies and the special needs of these often premature infants.

In the past, the unique aspects of grieving associated with multifetal loss have been poorly recognized. In this paper, some of the differences between a fetal and/or infant demise in a singleton pregnancy and the same loss in a multifetal

situation will be discussed and suggestions will be offered to assist in the resolution of this process. All of the concepts presented here are based upon personal experience of the author in grief counseling and written and verbal communication with over 100 mothers who have experienced a loss related to multifetal pregnancy. Additional information was obtained by interviews with obstetricians, social workers and the personal experience of my own quadruplet pregnancy with the post delivery death of my son.

## THE PROBLEM

In contrast to single pregnancies, two situations associated with fetal death are totally unique to multiple pregnancies: the first occurs when three, four, or more children die, either during the pregnancy itself or as neonates. The second is when some of the children die and others survive. Both events entail special concerns and needs.

The first condition is when all of the fetuses or neonates succumb. This possibility is not at all uncommon in higher order multiple births. Whereas 27.6% of singleton pregnancies end in miscarriage or fetal loss, total pregnancy loss is significantly increased in higher order multiple births. Little consideration is given to the mother of quadruplets who loses all of her children in a spontaneous abortion at 24 weeks of gestation, or to the parents whose 500 g infants die one by one in their first month of life. Unlike their singleton counterparts, parents of these children, in particular the mother who has been so intimately linked with her pregnancy, may experience an intense cycle of grief compounded by grief for not one, but two, three, four or more children simultaneously.

Whereas the grieving cycle after a singleton miscarriage lasts approximately one year (in agreement with other types of death experiences), the grieving cycle after a multiple death may be increased significantly, depending on the individual circumstances. Although parents who experience total multifetal loss appear to go through all the typical stages of grief, including anger, denial, guilt, depression, and acceptance, each of these stages may differ in frequency, intensity, and duration. In general, the mother experiences a lengthened and more intense grief experience the further along the pregnancy has progressed and the more bonding that has taken place with the unborn infants.

An important factor to consider in total losses is that the mother already may have significant feelings of low self-esteem as a result of her inability to conceive naturally. Of the 450 multifetal woman surveyed in the past year by the Triplet Connection, 60% had used some type of fertility drug or procedure to achieve pregnancy. Women who finally achieve the positive reinforcement of pregnancy and then have this totally destroyed may experience further damage to their self-esteem and regard this loss as an additional personal failure.

After a total miscarriage loss, obsessive desire to soon become pregnant again, or an unreasonable fear of future pregnancy, may be used as coping mechanisms to

deny or suppress grief and/or feelings of inadequacy. While a subsequent pregnancy may help ease the pain, it cannot undo what has happened, nor will it replace the prior loss. The demise must be acknowledged and faced just as any other demise must be addressed. Some patients who experience total fetal miscarriage or neonatal death deserve special recognition of their intensified grief experience as it may be two, three, four, or more times as powerful and generally at least six months longer in duration than that of a singleton loss. These mothers also require bolstering of their self-esteem, particularly in those cases where fertility has been an issue.

The second and more complex circumstance is when some of the newborns survive and some do not. Consider, for example, a quadruplet birth in which two children live and two die, or one child lives and three die. Such circumstances initiate conflicting emotions which are unique to a multifetal mother. To simultaneously experience such intense and opposing emotions related to life and death creates internal conflict in an already stressed woman. The ambivalence related to this conflict tends not to be as powerful when the losses are diagnosed early, because this delay may allow some grieving prior to the birth of the surviving infants. In spite of this, many mothers are surprised to find a resurgence of their grief or to experience a second cycle of grief at the time of birth. The duration of the second grief cycle is usually shorter because the mother has had prior opportunity to partially grieve her loss.

When the fetal or neonatal loss occurs at birth or postpartum, a simultaneous birth death experience occurs which is also unique in its conflicting effects and its ability to lead to feelings of guilt about experiencing the grieving process. Well intentioned comments such as, "Two out of three isn't bad", or "You are lucky to have three healthy babies", only serve to reinforce this guilt. The mother may begin to feel that she should overlook her loss and only be grateful for the children that survived. Perhaps more importantly, she may feel that she is being pressured to act in a way that is not compatible with her true feelings. Comments such as those quoted minimize the opportunity to address and acknowledge the pregnancy loss, a step which is necessary before the mother can progress toward the step of acceptance. Stated another way, a mother who has dreamed joy bringing home four healthy newborn infants will believe that three out of four is bad.

A further factor complicating partial losses is the decreased opportunity for grieving because of the overwhelming responsibility for the care of the surviving infants. A mother who has two, three, or more surviving babies may want and need to grieve, only to quickly awaken to the reality of the other children who need and deserve her love and personal care. When responsibility for the living children overcomes the mother's need to grieve, the result is postponement of addressing the loss.

These circumstances tend to be reinforced by the medical community which often urges the mother to bond with and care for her other children. Unfortunately, when the grief is delayed, denied or repressed, it may be experienced more intensely and for a longer duration at a later date. Some mothers report the most intense feelings of loss and depression more than three years after the death occurs.

Nearly all mothers with partial loss report ambivalent feelings of how to label their surviving children. The majority feel such conflict initially and most never reach a point where they can hear their multiples labeled by the number of survivors alone without feeling some discomfort.

Almost all mothers report they are unable to initially understand and discuss their feelings with anyone, including family and medical personnel. At this time, contact with another mother who has experienced a multifetal loss can serve to help identify and meet needs as well as to provide hope through a positive role model. The mother needs to be educated as to the uniqueness of her situation and, at the same time, recognize that the grieving process is natural, healthy, and indeed necessary.

On the average, three to five years are required before mothers can totally incorporate their loss without significant periods of sadness or depression. This is in contrast with an average one-year period following a singleton demise.

A final factor unique to remember is that the mother and father will always have living reminders of their missing child or children. As the survivors pass through their developmental stages, parents often report repetitions of grief or sadness. In addition to the commonplace reminders such as birthdays, holidays, seeing an item intended for the lost child, or hearing the lost child's name, the mother and father of the deceased multiples have a reminder of their loss whenever their quintuplets are called quadruplets or their quadruplets are called triplets. A statement such as "Oh, what beautiful triplets you have!", might be intended to express a positive outlook to new parents, but if the triplets are really three surviving quadruplets, such a remark may only stimulate a painful reminder of their loss.

## **PATHWAYS TO A SOLUTION**

As health care professionals, we can be instrumental in helping multifetal parents adjust to their unique situation of loss. The following are some specific suggestions to facilitate the grieving process and ease the sadness of multiple losses.

### **Mixed Fetal Loss and Survival**

1. Allow bonding opportunities. Whether a fetus is stillborn or dies in the neonatal period, allow the parents to hold and bond with the child to the total exclusion, during those moments, of the surviving babies. The parents will have ample opportunity to bond with the survivors, but will never have another chance with their newly lost child or children.
2. Emphasize the need and legitimacy to grieve and to take special time out for this. If possible, assist in providing quiet, uninterrupted time, away from the other newborns, to begin the bonding and grieving process.

3. Label the surviving children accurately. Surviving triplets are not twins. In a year or two, if the parents choose, they may become such, but in the immediate period both babies are triplets. You may feel more comfortable addressing the surviving babies as “the children” or “the babies”.
4. Avoid judgmental statements such as: “Well three out of four isn’t bad”. At that moment, it is bad!! Respect the real and actual death of the patient’s child, exclusive of her “gain”.
5. Educate the parents about the recurring cycles of grief often triggered by the living reminders of her loss.
6. Assist the patient in contacting an appropriate grief support network.
7. If at all possible, suggest contact with another multifetal loss mother.

### **Total Multifetal or Neonatal Demise**

1. Allow bonding.
2. Emphasize the need and legitimacy to grieve the pregnancy and the infants.
3. Reinforce self-esteem, particularly in cases where fertility has been an issue.
4. Avoid making judgmental statements.
5. Strongly urge the patient to contact appropriate grief support.

As health care professionals, our place is to assist the parents in the facilitation of their grief by appropriately applying the measures discussed. In order to be effective, we must remember to withhold our own expectations and values and to allow the parents the opportunity to express grief within the framework of their own value system.

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