Stillbirth – psychological impact on fathers

Although there is a lot of information on the psychological impact of stillbirth on mothers, data on the effect on fathers is very rare. We often fail to acknowledge that fathers can have a difficult time after a stillbirth in separating their own grief from that of the mother. Their role in supporting the mother through this ordeal cannot be overemphasised and the recent article by Turton *et al* (2006) is important because it describes the psychological stress and needs of fathers during subsequent pregnancy and the puerperium. However, I would like to raise a few points which need further discussion.

Social support from family or partner following such a life event can have a substantial impact on subsequent mental and physical well-being, which may also determine the subsequent level of coping. Turton *et al* measured support from partner and family as a dichotomous (yes/no) variable, which does not seem entirely appropriate. Social support is a multidimensional construct and should have been analysed in terms of quantity and quality. Various questionnaires such as the Norbeck Social Support Questionnaire; http://nurseweb.ucsf.edu/www/NSSQ-Instrument.pdf are available to evaluate social support in a holistic and objective manner. Second, Turton *et al*, relaxed the inclusion criteria by including four couples after the safe arrival of their babies. This might have skewed the final result.

Interestingly, the fact that fathers often refused to take part in the interview could have led to underestimation of the psychological impact of stillbirth and the underlying psychiatric morbidity. It would have been informative if the authors had identified the reasons for their refusal. This is particularly important since it is well accepted that fathers generally tend to minimise their problems, put on a 'brave face' and refuse to speak out. There is no mention of the reliability or validity of the scale used for the assessment of marital satisfaction. Moreover, exclusion of Black participants and those from minority ethnic groups limits the application of the results to a wider general population.

However, I think this is a relevant and significant study which may prove to be beneficial for a wider understanding of this poorly recognised problem. It highlights the importance of actively encouraging fathers to be more forthcoming about their problems and also helps health professionals to focus on high-risk couples.

Turton, P., Badenhorst, W., Hughes, P., *et al* (2006) Psychological impact of stillbirth on fathers in the subsequent pregnancy and puerperium. *British Journal of Psychiatry*, **188**, 165–172.

N. Kader Park Lodge Hospital, Orphan Drive, Liverpool L6 7UN, UK. Email: nishakeem@gmail.com
doi: 10.1192/bjp.189.2.188

Authors' reply: We would like to expand on the points raised relating to sampling and assessment tools. We accept the criticism that relaxing the inclusion criteria might have skewed the final results, but have already explained our rationale for this decision. Unfortunately it is not possible to make any inference about the psychological morbidity of non-participants. Non-responding fathers fell into two groups: those who were persistently unavailable and those who declined to take part. Only one father gave a reason for his refusal: rejection of what he perceived as a false assumption that it was possible for a parent to 'recover' from a stillbirth. Although we were active in seeking fathers' participation, ethical considerations did not permit us to persist in questioning fathers who declined to take part. Black couples and those from minority ethnic groups were not excluded from the study; rather they were underrepresented as a result of higher non-participation rates.

Two factors contributed to our use of a single dichotomous variable for the presence or absence of appropriate social support. First, social support at the time of loss was not a primary focus of the study and we felt it appropriate to limit the number of questionnaires that participants had to complete. Second, research in this field has relied on a range of assessment tools (e.g. Zeanah *et al*, 1995; Lin & Lasker, 1996). The use of multiple complex tools limits the comparison of data across studies. However, we accept the view that elaborating on the quality of support would deepen the findings. The Golombok Rust Inventory of Marital State, which was used to assess marital satisfaction, is a short and easy-to-administer assessment which has high face and content validity and good reliability (Rust *et al*, 1988).

We hope that continuing research in this field will lead to greater awareness of the needs of parents experiencing stillbirth.

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P. Turton Division of Mental Health, St George's University of London, London SW17 0RE, UK. Email: pturton@sgul.ac.uk

W. Badenhorst, P. Hughes, S. Riches Division of Mental Health, St George's University of London, London, UK
doi: 10.1192/bjp.189.2.188a

Promotion of psychiatric drugs

Dr Moncrieff (2006) attacks the pharmaceutical industry for promoting the idea that depression is 'caused by imbalances in brain chemicals' and berates it for the fact that people are taking more prescription drugs than ever before. She implies that because the biochemical basis of depression is not known, the promotion of antidepressants is a plot to encourage profiteering.

The history of medicine teaches us that many crucial and life-saving drugs were and still are used despite a lack of knowledge of their scientific action (e.g. the use of steroids in asthma). In fact, there are very few instances where the scientific basis of action of crucial medicines is fully understood. The history of psychiatry teaches us that before antidepressant medication there was no treatment for depression except waiting for natural recovery: frequently a long and painful process during which the patient often starved to death or ended life by suicide.

One can easily take, like Moncrieff, an extreme view of the pharmaceutical industry, emphasising how it controls research and uses advertising to influence clinicians, and I note that the current issue of the *Journal* has no fewer than 12 full-page colour advertisements promoting psychotropic medication. The alternative view, however, would be that the industry has helped us to move out of the dark ages when all we could offer was asylum and