Grief, Bereavement, and Mental Health After Stillbirth

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KEYWORDS

• Stillbirth • Grief • Bereavement care • Perinatal loss • Perinatal trauma

KEY POINTS

- After stillbirth, traumatic stress is common, and grief is lasting and profound.
- Grief and mental health conditions like depression share many characteristics but are ultimately different processes. Clinicians must learn to differentiate these processes and to abstain from pathologizing grief.
- Emotional support and optimal bereavement care can help the grief process, ease loneliness, and decrease risk of mental health conditions.
- Significant social stigma persists surrounding stillbirth and contributes to poor psychosocial outcomes for parents.

INTRODUCTION

Stillbirth is a devastating event. The emotional, psychological, and existential repercussions persist for years, often resulting in intense and enduring grief responses, posttraumatic stress, and other adverse psychobiological outcomes.[1,2] Compounded by societal stigma, bereaved parents frequently report feelings of isolation, guilt, and invalidation.[3,4] In the following article, we will highlight grief as the primary response to stillbirth, contrast it with mental health conditions, and propose forms of support and therapy for bereaved parents.

Grief

The emotional impact of stillbirth is vast. For many bereaved parents, the death of their baby is transformative, reshaping identity, perspectives, and relationships. Despite

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Abbreviation
PTSD posttraumatic stress disorder

more extensive research on bereavement generally, grief specific to stillbirth is understudied. Colin Parkes' theoretic contributions to bereavement research delineate the psychosocial transitions associated with grief, especially in the context of traumatic and unexpected losses such as perinatal death. We will describe how Parkes' theory applies to stillbirth. Grief is shaped by a complex interplay of psychological, relational, and situational variables that modulate an individual's response to loss.[5,6] Parkes draws from Bowlby's attachment theory[7] to understand intense yearning for the person who died. The impulse to search for the deceased, despite conscious awareness of its futility, manifests as separation distress or pining.[5,8] This yearning is frequently accompanied by a withdrawal from other activities and a singular, repetitive focus on the child who died, illustrating the profound psychological disruption caused by such untimely loss.

In his model of mourning, Parkes identifies 3 recurring behavioral patterns: (1) preoccupation with thoughts of the deceased, conceptualized as attachment-seeking behaviors; (2) mental repetition of the loss experience, cognitive efforts to affirm and integrate the reality of the loss; and (3) the eventual search for meaning, wherein the bereaved construct an explanatory narrative that renders the death meaningful or even tolerable.[5,9] These patterns are especially salient in the case of perinatal loss, where the death may lack conventional cultural rituals or public acknowledgment, compounding the bereaved parent's sense of ambiguity and disenfranchisement.[1,10] See **Table 1** for examples of these behavioral patterns in stillbirth.

Furthermore, Parkes offers a framework for understanding the determinants of grief responses, dividing influential factors into *antecedent, concurrent*, and *subsequent* categories. Antecedent factors encompass personal history and prior vulnerabilities, including early childhood trauma, the nature and strength of the attachment to the deceased, preexisting psychological distress or mental health conditions, and the timeliness of the death.[5,6] In the context of perinatal death, deep feelings of attachment are present throughout pregnancy for many parents, and the death is both unexpected and untimely, rendering the loss especially debilitating.[5,11] Concurrent factors include current circumstances such as socioeconomic status, family dynamics, and religious

Table 1
Examples of Parkes' behavioral patterns of mourning as applied to stillbirth

Attachment Seeking Behaviors	Mental Repetition of Loss	Search for Meaning
Looking at ultrasound photos	Telling story of loss to friends and family	Creating an organization to help other stillbirth parents
Using baby's name in conversation	Consulting with clinicians to review facts of loss and explanation	Advocacy work at the level of the hospital, community, state, country, and world
Creating memorials and/or displaying photos and mementos at home	Social media posts about stillbirth/baby who died	Participating in and/or leading research efforts
Parenting behaviors at time of loss	Packing up items intended for baby (nursery, clothes)	Participating in stillbirth memorial events and walk/runs

practices. These factors can exacerbate or buffer capacity to cope with traumatic grief. Parents with fewer social, educational, and financial resources often experience more enduring and intense grief trajectories after perinatal death.[2,5] Finally, subsequent factors include the quality of provider care, social support, the emergence of new stressors or life transitions, and changes within the family system.

The interaction of these domains shapes the bereaved individual's adjustment process, making the grief response highly individualized. This framework is unique in the context of perinatal bereavement, where the parent's attachment to the baby is often invisible to others, the death often marked by societal devaluation, and meaning-making frequently complicated by cultural silence around stillbirth.[12] Thus, many bereaved parents ultimately experience disenfranchised grief.[13]

Mental Health Conditions

Grief is a relational, culturally situated response to loss. While some bereaved individuals also experience mental health conditions that warrant care, clinicians must resist pathologizing situationally appropriate and culturally sanctioned expressions of mourning. While individuals with serious mental health conditions warrant therapeutic intervention, clinicians must exercise discernment to avoid over diagnosing and mislabeling grief as a disease.

In the first-year post loss, stillbirth parents experience intense trauma and stress. They have a dramatically higher risk of being diagnosed with mental health conditions compared to individuals who experienced live birth. There is 7 times greater odds for posttraumatic stress disorder (PTSD), 4 times the odds for depression,[14] twice the risk for anxiety,[15] 5 times the odds for suicide,[16] and significantly greater use of tobacco, alcohol, and other substances.[17–19] Interestingly, large studies evaluating long-term outcomes have not consistently shown long-term increased risk of depression or anxiety post stillbirth suggesting that integration of the loss can occur over time.[20,21]

Certain demographic and social factors confer increased risk for mental health conditions after stillbirth. Having a prior history of depression or post-traumatic stress disorder (PTSD) triples the odds of screening positive for depression or PTSD in the first year post loss.[14] Intimate partner violence doubles the odds of mental health symptoms.[22] Past psychiatric disorders also predicted anxiety and OCD among perinatally-bereaved mothers.[15] A history of infertility, being unmarried, and having lower social support predicted depression in some studies with higher social support being protective.[14,23–25]

Identifying mental health disorders after loss is important for future pregnancies as well. Untreated prenatal PTSD is associated with preterm birth and low birth weight.[26,27] Untreated maternal depression impacts numerous fetal and infant neuroendocrine markers[28] and is associated with almost 50% higher risk for preterm birth and 90% higher risk for low birth weight.[29] Addressing postloss mental health may also reduce the risk of stillbirth in subsequent pregnancies.[30–32]

Clinical Presentation

Grief does not have a uniform progression. One study showed that bereaved parents experience intense and enduring symptoms of grief lasting more than 4 years post loss.[33] Despite this, many grieving parents learn to function while experiencing ongoing longing and grief for their baby. Even years later, there may be intense grief exacerbations during memorial dates such as the baby's due date or birthday or other events associated with parenting. Clinicians can validate these emotional fluctuations. Periodic intensifications are consistent with normative grief and do not indicate maladaptation.

There is significant overlap between presentation of normal, albeit painful, grief and symptoms of depression or anxiety (Fig. 1). Where distress remains refractory over long periods of time, despite access to strong, culturally congruent supports—a collaborative, trauma-informed assessment may be warranted. Persistent, overwhelming hopelessness, active suicidality, or escalating use of substances should prompt a safety assessment that involves patient input. Symptoms that become functionally disabling for long periods of time—that is when they consistently disrupt sleep, self-care, work, or relationships—as defined by the person and their community may be cause for concern as well. Many bereaved parents report persistent nightmares, intrusive thoughts, or debilitating flashbacks that signal a posttraumatic stress response and warrant consented, trauma-informed care—offered without coercion and without pathologizing grief. Patients with lived expertise should be centered in codesigning their care.

It is worth commenting on subsequent pregnancies after a stillbirth. These pregnancies often confer substantial anxiety, and it may be extremely difficult to reassure families when they have experienced the death of their baby. Many have lived the reality that a seemingly *normal* pregnancy can result in death, so normal findings carry less weight and may not provide reassurance. Clinicians should offer more frequent visits, particularly around the time of significant dates such as the anniversary of previous baby's death. They should provide increased antenatal surveillance and a clear delivery plan that provides parental agency. Throughout, clinicians must be sensitive to parental psychological needs.[34,35] It is helpful to reassure families that fear is a normal and adaptive response in subsequent pregnancies and usually improves dramatically after the delivery of a healthy baby. If the anxiety is disabling and extending to aspects of life well beyond the pregnancy, social support and good clinical care may help pregnant individuals cope.

Mental Health Care

For bereaved parents who are struggling to cope, therapy with a counselor who is also experienced with trauma and grief may be beneficial.[36] Some mental health providers

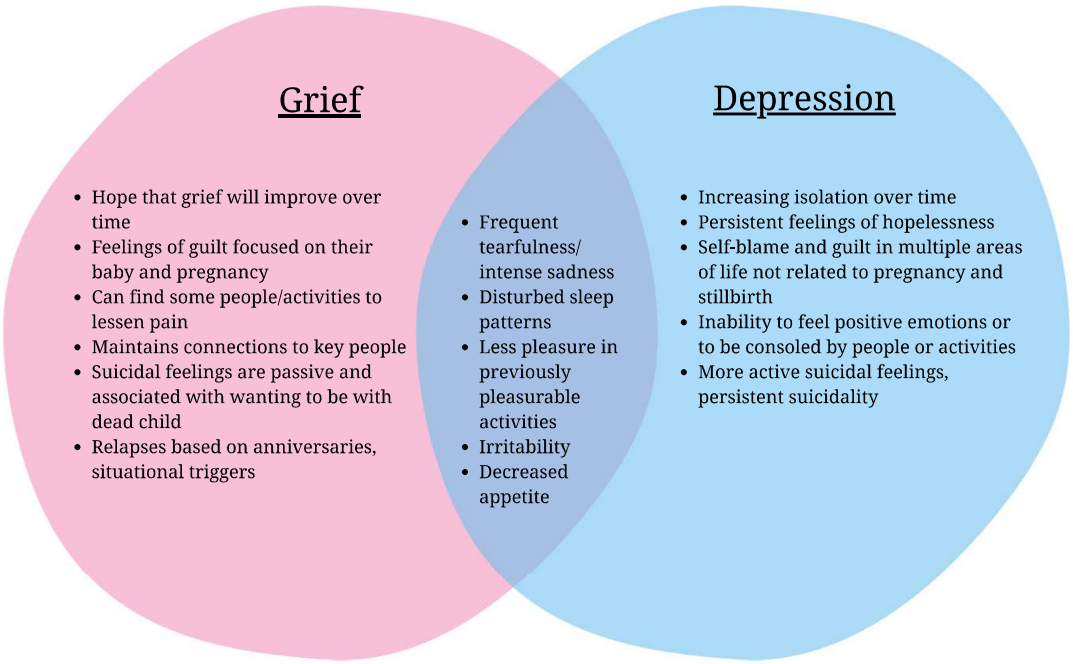

Fig. 1. Behaviors that align more with grief versus depression and the overlap between the 2.

specialize in perinatal trauma and loss, although these can be challenging to find. One resource is the Perinatal Mental Health Provider Directory.[37] A few studies have evaluated specific interventions for depression, anxiety, and PTSD post stillbirth, but most are small pilot studies. Modalities have included yoga,[38] interpersonal therapy,[39] mindfulness,[40] and internet therapies[41] (Gold KJ. Mental health sequelae after stillbirth: the Michigan Mother's Study [Unpublished data]. 2012.).[42] Pharmacotherapy for bereaved parents after stillbirth should not be reflexively pursued or treated as a default. Clinicians should prioritize a careful, culturally grounded, differential assessment—attending to the family's community-defined mourning practices, history, safety, and functional needs—before considering medication. When significant psychiatric syndromes persist, pharmacotherapy can be offered after shared decision-making along with community and peer support.

While parents of different races experience similar rates of depression, anxiety, and PTSD, non-Hispanic Black mothers receive far less mental health care after stillbirth or infant death compared to non-Hispanic white mothers.[14] In the United States, Black women, including those who are postpartum, have a lower likelihood of accessing conventional mental health resources.[43–46] While clinicians must remain vigilant against labeling cultural mourning practices as pathology, we must also ensure that care and support are provided equitably.

Partners and Family

Stillbirth impacts the entire family, particularly coparents and partners of the birthing person. Partners scored higher on depression indices, distress scales,[47] and PTSD scales[48,49] after stillbirth than after live birth, although not as high as the birthing parent.[50] Compared to fathers with a live born infant, fathers with stillbirth but no prior psychiatric treatment were much more likely to initiate nonpharmacologic psychiatric care or take hypnotics.[51] However, fathers overall appear to have less psychological distress compared with mothers over time, although it is unclear the role that gendered expectations of emotional expression plays in this assessment.[49,52] There is limited information on partner experiences in same sex relationships and transgender or nonbinary individuals.

Stillbirth is also a risk factor for partnership breakdown. At 6 to 8 years after stillbirth, 36.5% of couples had separated, compared to 11.8% after a live birth (odds ratio [OR] 4.3, 95% CI 1.6–12.0).[53] Factors associated with higher odds of partnership breakdown include younger age, shorter relationship preceding stillbirth, baseline social disadvantage, PTSD diagnosis, and poor perceived partner support. These risk factors mirror those associated with adverse mental health outcomes for the birthing parent. It is possible that providing adequate support for bereaved parents could reduce risk of both mental health issues and partnership breakdown.

Other family members, such as siblings and grandparents are also impacted by a stillbirth in the family, although this is an understudied area. Siblings, both those born before and after their stillborn sibling, feel the effects of stillbirth. Parents report challenges in completing day to day parenting tasks while in the middle of acute grief, while they also try to engage their living children in recognizing their stillborn sibling.[54] For living siblings, this may be their first experience with death. Although there are no clinical trials to inform interventions to support siblings, we have advice from parents. A survey of 411 parents regarding how to support siblings of stillborn babies, found themes clustered around making the stillborn baby and loss real for siblings and responding to siblings needs.[55] Advice to support these goals included meeting the baby, demonstrating but not transferring your own sadness, having siblings participate in memorial and bereavement practices, talking about the baby, and reading books about death and

baby loss. Similarly, while it is acknowledged that grandparents feel the loss of their stillborn grandchild, the impact has not been measured, and no clear beneficial interventions have been identified.

Bereavement Care and Social Support

The stillbirth of a baby represents a profound disruption to the psychological, biological, existential/spiritual, economic, and social fabric of parenthood. The psychological risks associated with traumatic grief after perinatal death necessitate the provision of high-quality, evidence-based bereavement care as a core component of perinatal health care.

Best practices in bereavement care emphasize individualized, multidimensional approaches that extend beyond hospital discharge.[56–61] Effective communication is crucial, such as directly acknowledging the baby by name and validating parental grief. Creating opportunities for memory-making—such as holding the baby, taking photographs, and collecting mementos—has been shown to promote psychological integration and continuing bonds.[62,63] These practices, however, must be culturally sensitive, never coerced, and aligned with parental wishes.[64]

Sustained emotional and social support significantly shapes bereaved parents' capacity to adapt following perinatal loss. Perceived support from providers, family members, and peers can buffer against adverse outcomes such as PTSD and adverse psychological outcomes.[23,65,66] Conversely, invalidating experiences or abrupt clinical disengagement may exacerbate trauma and later grief. Institutions should implement bereavement care programs that ensure follow-up care and access to interdisciplinary acute and long-term support.[67,68] Additionally, clinicians should receive specialized training in traumatic grief.[69,70]

Social support after loss is key to integrative healing. A qualitative investigation into bereaved individuals' perceptions of social support following traumatic loss found that emotional support—defined by nonjudgmental presence, empathic listening, and the validation of grief—emerged as the most meaningful form of care.[71] Participants consistently rated their relationships with animals as one of the most satisfactory forms of grief support, with 89% describing these relationships as *mostly* or *extremely* helpful. In contrast, many respondents expressed dissatisfaction with the emotional and communicative responsiveness of health care professionals, therapists, religious leaders, family, friends, and broader community members. Common shortcomings included a lack of follow-up, avoidance of the topic of death, and failure to acknowledge the ongoing nature of grief. These findings suggest that while formal systems may be limited in their capacity to offer sustained emotional presence, alternative and nontraditional sources of companionship—such as animals—may fulfill unmet emotional needs in grief support.

Ritualization, narrative expression, and community-based support promote meaning-making while also affirming the dignity of the baby who died.[72–74] Supportive behaviors such as allowing plenty of time for families to see and hold the baby, offering options for ritual, providing safe spaces for extended family to meet the baby, and maintaining consistent communication and a compassionate presence are frequently cited as helpful. Examples of emotional support and memory making that can be supported during the delivery hospitalization and postpartum care are presented in **Fig. 2**. There is tremendous value in emotionally responsive care that is culturally sensitive, and grounded in a nonpathologizing framework, particularly in the context of traumatic bereavement. Additional resources for patient support and health professional education on stillbirth support are available in **Box 1**.

Fig. 2. Examples of emotional support and bereavement care at stillbirth hospitalization and postpartum.

Stigma and Stillbirth

Stillbirth remains subject to notable stigma, which acts as a barrier to healing and identity integration.[13,75] Stigma is a collection of attitudes around an identity or experience that result in shame, isolation, and loss of status. Stillbirth violates the natural course; children are not supposed to die before their parents. When this violation occurs, many cultures blame the parents, especially the birthing parent, either explicitly or through avoidance. This combination of blame and avoidance perpetuates the stigma.

In 1 survey of 817 parents, 38% reported experiences of stigma, including identity challenges, discrimination, and separation.[76] The recently created Stillbirth Stigma

Box 1
Resources after perinatal loss

International Stillbirth Alliance: International group working to prevent stillbirth and newborn death and to improve care. Primarily a resource for advocacy and research.

https://www.stillbirthalliance.org/

Return to Zero: HOPE: Provides resources, virtual support groups, and in person retreats for bereaved parents, family, and friends. Founder Kiley Hanish's first son was stillborn.

https://rtzhope.org/

Star Legacy Foundation: Virtual support groups, resources, family support, health professional guidance surrounding stillbirth and baby loss. Founding members experienced stillbirth.

https://starlegacyfoundation.org/

MEND Mommies Enduring Neonatal Death: Miscarriage, Stillbirth, and Infant Loss Support: Collection of support groups across the United States. Also has virtual support options and resources for parents and health care providers.

https://www.mend.org/

Share Pregnancy and Infant Loss Support: Grief and bereavement support for families including state by state resources; educational webinars and workshops for health professionals and interested community members. Provides peer support and memento making training.

https://nationalshare.org/

Propublica Stillbirth series: Propublica has published a series of articles on stillbirth, including a *What You Need to Know About Stillbirths* piece that is useful for families. They also have an online stillbirth memorial and have created a documentary on stillbirth.

https://www.propublica.org/series/stillbirths

Scale includes 20 items across the areas of perceived devaluation, discrimination, self-stigma, and disclosure. When applied to 889 bereaved mothers from an international sample, 54% were subject to stillbirth.[77] 80% experienced self-stigma, or feelings of shame and self-blame. Importantly, higher scores were associated with poorer mental health outcomes and more intense grief, although the direction of causality is not clear.

Social isolation or loneliness in bereaved parents is extremely common and often one of the first experiences of stigma. At the time of the baby's birth, parents report feeling abandoned by clinicians on the labor and delivery unit.[78] While some clinicians may avoid parents experiencing stillbirth due to a desire to give them space, many do so due to their own personal discomfort, failing to meet their patients' emotional support needs. In some countries, bereaved parents are explicitly avoided due to taboos surrounding stillbirth. Even when these taboos are absent, stillbirth leads to social isolation. Many people, including friends and family members, wish to avoid discussing death, particularly a death that they cannot make sense of like stillbirth. Others simply fear that bringing up the baby who died will upset the parents. This avoidance leads to withdrawal, social isolation, and compounding stigma.

Cultural expectations presume that grief over a stillborn baby should be less intense than grief for a liveborn child, and that it should attenuate over time. Stillbirth is not treated the same as the death of a child but rather the loss of something less.[78] Along with this, bereaved parents are not routinely treated as parents if they do not have any living children.[79] Many are often excluded from parenthood recognitions such as Mother's and Father's Day.[80] If they give birth to a live baby after their stillborn baby, medical providers, friends, and families often refer to that baby as their first child, erasing the parenthood that already existed with their stillborn child. While many parents and parent advocates work to uplift bereaved parent identities and increase open memorialization, these efforts require significant personal emotional energy and vulnerability.

Lack of communication about stillbirth contributes to stigma. Because discussions of stillbirth risk are not a routine part of prenatal care, parents often report feeling that they are an extreme outlier and thus must have done something wrong. This lack of information also means that parents who do not experience stillbirth have no point of reference or understanding to relate to bereaved parents. The mystification of stillbirth is yet another obstacle to open communication regarding bereaved parent experiences and memories of their babies. A central task of grief is talking about the person who has died. Bereaved parents are often denied this social permission by friends and family, therefore turning instead to peer communities for solace and belonging. This silencing both reflects and reinforces stigma.

Coping Mechanisms

Parents leverage multiple coping strategies after loss. Coping strategies are behaviors used to handle stress and seemingly unbearable emotions. While we hesitate to moralize coping mechanisms as *healthy* or *unhealthy*, some are associated with more adaptive, health promoting outcomes than others. Data on coping mechanisms after stillbirth are modest in scope and predominantly self-reported.

For example, substance use is common after stillbirth. The Stillbirth Collaborative Research Network, the largest multisite, prospective cohort study of stillbirth in the United States, conducted follow-up of participants at 6 to 36 months post delivery. This follow-up cohort included 691 people with living children, 285 with stillbirth, and 49 with neonatal deaths. There was an increase in tobacco use or drinking alcohol to cope in the first 2 months postpartum in those with perinatal loss, 16.1% versus

5.4% (aOR 3.3, 95% CI 1.6–7.1, adjusted for prepregnancy tobacco or alcohol use and age). Moreover, use of tobacco or alcohol to cope increased odds of an EPDS score greater than 12 at follow-up (aOR 6.4, 95% CI 2.5–16.4).[81] However, the direction of causality is not clear, as experiencing symptoms of depression may lead to a desire to use substances to escape those symptoms. Another study of births in Florida found that within 1 year after stillbirth, 1.4% experienced an emergency department encounter or hospital admission for substance use disorder, more than twice the rate seen after live birth.[82]

About 334 bereaved parents were asked about which coping methods they would recommend to others for managing grief.[81] The number 1 recommended strategy was communicating about their baby and emotions surrounding their loss (n = 94), followed closely by memorializing their baby (n = 65). People also prioritized physical contact with their baby as important for the grief process (n = 57). In general, parents recommended peer support more often than professional support, with 50 recommending support groups and 29 mentioning formal mental health support. It is unclear whether this is due to access or preference. Few mental health providers receive adequate training in grief or perinatal loss. There is also strength in peer shared experiences that cannot be replicated in individual formal mental health support. Other methods mentioned included relying on internal strength (n = 44), the passage of time (n = 41), turning to spirituality (n = 30), connecting with clinical providers (n = 14), and seeking additional information (n = 11). Only 1 mentioned medication.

There were some differences in recommendations by race and ethnicity. Non-Hispanic White people were more likely to recommend memorializing activities, while non-Hispanic Black and Hispanic people were more likely to recommend spiritual coping mechanisms. Support groups were also referenced more frequently by white parents (19.4%) compared to Black (9.8%), and Hispanic (11.5%) parents. This may reflect the current racial makeup of many existing formal support groups for bereaved parents, which is not always a safe and welcoming space for all. Given longstanding systemic racism within health care, groups sponsored by hospital systems are less likely to be appealing to Black parents as well. In 1 survey of 91 Black parents of stillborn babies, higher perceived social support was linked to lower symptoms of depression, anxiety, and posttraumatic stress.[83] This underscores the importance of access to equitable, culturally safe, and community defined supportive care for all bereaved parents, with particular attention to Black and indigenous families who bear a disproportionate burden of stillbirth.

SUMMARY

Stillbirth leaves a long-lasting emotional and psychological imprint on parents; while grief, sometimes enduring and intense, is the predominant and nonpathological response, a subset of parents experience more serious mental health struggles. In both instances, clinicians should cocreate care plans that are trauma-informed, while considering contextual and systemic factors such as racism, lapses in compassionate obstetric care, and economic precarity. Culturally concordant emotional support is the most effective intervention to aid healing. Health professionals require training to ensure that we adequately provide this support at time of stillbirth diagnosis, delivery, postpartum, and in all future health care.

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