Contemporary Themes

Inhibition of mourning by pregnancy: psychopathology and management

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Summary and conclusions

A bereavement during pregnancy is difficult to mourn: a pregnant woman is so increasingly preoccupied with the new life that mourning is interrupted and often impossible to resume later. This may lead to idealisation of the child as a reincarnation of the dead person or child abuse. A bereaved woman should be helped to mourn at the time of death and to keep alive the expectation of future mourning once her baby is thriving.

Introduction

It is well known that pregnancy can be a way of avoiding mourning; and also that a bereavement may impair a mother's ability to care for her family. It is not widely realised, however, that a bereavement in pregnancy is unlikely to be successfully mourned¹ and dire consequences may result.

A pregnant woman becomes increasingly preoccupied with thoughts and feelings about the baby. Eventually, around the puerperium, there may be little mental space left for anyone else. Winnicott² identified this intense concern as the basis for maternal bonding, and called it "primary maternal preoccupation." Mourning entails a comparable intense concern with the dead in order eventually to become free from the loss.

A bereaved pregnant woman has conflicting and paradoxical needs to think and feel intensely both about the new life and the dead. She opts for her live baby and mourning is interrupted, it is too difficult while she nurtures her new baby, and is often impossible to resume later. Unresolved mourning may be reactivated in pathological forms by later events.

Unresolved mourning in pregnancy

With incomplete mourning there may be a persistent identification with the personality and diseased body of the dead resulting, for instance, in prolonged depression, hypochondriasis, or somatic conversion symptoms. Strong feelings about the loss may be suppressed, leading to a sense of being emotionally cut off; and this may impair the tie to the new baby. Unexpectedly severe depression may occur, as if postponed, with a

subsequent loss. Failure to mourn becomes more likely with certain personality defects; when there are excessive mixed feelings about the dead; or where the absence of a body allows the reality of the death to be doubted—for example, "missing believed killed" or "drowned at sea."

Reasons why pregnancy inhibits mourning are complex. Normal parenthood entails mixed feelings even for the most wanted baby. There are comparable mixed feelings for the dead person, however beloved, that mourning helps. During mourning the dead person is unconsciously imagined as being taken inside our minds and our bodies. The dazed mourner will say, "I can't take it in yet." The dead can be unconsciously felt as dead yet active inside us; imagined variously as alive and supporting or as damaged, burdensome, or persecuting. The dead person and the live fetus both inhabit the mother's body and mind. Because a pregnant mother's idea of her fetus is inevitably imaginary and poorly defined she can easily confuse her unconscious mixed feelings for the fetus with those for the dead. It protects her fetus from the dangerous summation of her confused mixed feelings if she blocks the process of mourning. Additionally, a loss in pregnancy can cause a pathological idealisation of the dead person to avoid the stressful conflict of mixed feelings. A pregnant woman can then unconsciously equate her loved but unknown fetus with the idealised dead person; she avoids mourning.

Case histories

REINCARNATION

Denial of loss may be associated with the unconscious idea of reincarnation in the baby. A woman lost her father during her second pregnancy. Unable to mourn she imagined the baby to be the reincarnation of her father. Thereafter she idealised this second son to his discomfort; and neglected her elder son and her husband so that the son was depressed and her marriage spoilt.

CHILD ABUSE

Failed mourning associated with a bereavement in pregnancy predisposes to child abuse.³ A woman's husband died suddenly during her third pregnancy. When the baby was 8 months old the depressed woman strangled her eldest daughter, aged 5, and then tried to hang herself. She said that her two younger sons would not miss her, but that her daughter would. She was in a prison for the criminally insane for three years; but on release she was able to marry again and lead a normal, though emotionally restricted, life. She went to her GP at the age of 69, after the death of her second husband, for help with mourning. The death of her first husband had seemed unreal, and she could not resume her mourning after its inhibition during pregnancy. The murdered child who had so evidently missed her father had provoked her mother to murder by reminding her of the loss of her husband whom she was herself unable to mourn. The child had been like a reflection of her own hurt self that she wanted to destroy.

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PATHOLOGICAL MOURNING IN A WOMAN REFLECTED IN HER SON

A pregnant woman's father died a few days before her baby was born. Usually a complaining man, he had tried to hide the severity of his illness to shield her pregnancy. Her mother and her husband both told her not to cry or attend the funeral as they feared for her baby. Only after her 5-year-old elder son had repeatedly asked to visit his grandfather was he told of his death. His mother remained unable to talk or let her son talk about it. He became enuretic, refused to sit on his depressed mother's lap, and like her could not cry for several months. Now aged 11 he is underachieving, isolated, and accident prone. He may be carrying the brunt of his mother's failure to get over the loss of her father; a problem of incomplete mourning, pathologically prolonged, for which they are both receiving psychotherapy.

Management of perinatal bereavement

Firstly, the syndrome itself requires recognition. Powerful natural forces have hitherto led to its neglect. A perinatal bereavement presents a family and their doctors with the bewildering predicament of needing to think and feel about a new life and a new death at the same time. The bereaved woman may be helped if we enable her to keep alive the expectation of future mourning once her baby is thriving. She should participate in those activities that help to differentiate between the fetus and the dead and cannot be left until later. It may be more important and valuable for her than for anyone else to look at and touch the corpse, and she should attend the funeral. Death at home and former prevalent ceremonies—the wake, the closing of the coffin—all used to facilitate contact that now has to be

reconstructed artificially. Others should not sort out and dispose of the personal effects of the dead person; this should be left for the bereaved woman to do when she feels ready. Letters and photographs should be preserved.

The name of the dead should not be given to the newborn. False ideas that the new baby "looks so like" the dead person should be resisted and recognised as danger signals—the "replacement child" syndrome⁴; the fantasy of reincarnation; and the associated tendency to idealise the dead. These risks to siblings are increased considerably when a child has died.

A bereavement during pregnancy may sometimes be actively circumvented, as when an oncologist agreed to further treatment for a child dying of leukaemia as his mother was pregnant. This gave some fraught time to work with the mother in the puerperium.

The psychotherapeutic focus, both before and after the birth, should be to help the mother achieve a clear psychic separation between her baby and the dead, particularly necessary if a child has died. When the new baby is securely in existence the memories of the dead can be revived to help make the death real. This helps reactivate the normal mourning process inhibited by pregnancy.

References

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Personal Paper

Sexual dysfunction

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The treatment of sexual dysfunction presents a persistent difficulty for we do not really know what "normal," "healthy," "adequate," or "inadequate" sexual behaviour really is, and we have, therefore, adopted a patient-centred definition of the problem. So a sexual problem exists when an individual expresses a complaint about one or more cognitive, affective, or behavioural elements of sexual functioning or sexual relations. In addition, behaviour that produces demonstrably harmful consequences for the perpetrator or for others is also defined by society as a problem, even if the patient does not complain of it. Being effective, as a doctor, in making suitable therapeutic interventions in sexual medicine can be a rather complex procedure, and treatment may be considered under three head-

ings: (a) anxiety dispersal, (b) restructuring behaviour, and (c) restructuring people.

A slightly different way of stating this is to suggest that therapeutic strategies may be based on three options.

(1) If anxiety is causing the dysfunction it must be reduced or avoided.

(2) If sexual attitudes and behaviour are unrewarding or damaging they may be restructured by means of psychosomatic or pharmacotropic treatments.

(3) If a dysfunction is maintained by ineffectual interpersonal communication this must be modified in an attempt to reverse the dysfunction—for example, by counselling.

Anxiety dispersal

Unfortunately the classic treatment strategies that have evolved in the world of sexual medicine have been, generally speaking, credo orientated rather than patient orientated. This has led to conflicting and often self-defeating "schools" of treatment developing. The Masters and Johnson credo is an instance of this, and if we examine this in a little detail we can see how slavish application of such a credo can lead to dis-

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