

# A Mother's Account About Lactation in the Context of Perinatal Death

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## **Abstract**

**Objective:** To discuss the importance of listening and having a humanized intervention in regard to the donation of breastmilk in the context of perinatal death.

**Methodology:** Content analysis of an interview with a mother in mourning that went through a traumatic lactation following a perinatal death. This case study is one of qualitative, longitudinal research, realized over two partially-structured interviews with parents who had lost their babies with less than 22 weeks of gestation at a public hospital, in Belo Horizonte, Brazil, from February to October 2019.

**Results:** The interviews in the case of “Eva” (hypothetical name) presented significant suffering from lactation following the death of her child and her mourning process, which caught the authors’ attention about the importance of this topic.

**Conclusions:** Women who have lost their babies before, during, or after birth should be offered the option of donating their breastmilk, to allow them to choose what to do with it, and then to counsel them during the mourning process.

**Keywords:** Mourning, Professional Training, Neonatal Death, Human Milk Banks, Disenfranchised Grief.

## 1. Introduction

The Brazilian Human Milk Bank Network (BHMBN) is available in every state of Brazil and takes part of the Brazilian healthcare system (referred to as ‘SUS’), it is a technical reference for many countries in consultation and assistance in breastfeeding and human milk donation. In 2007, the Ibero-American Program of Human Milk Banks was founded, consisting of the countries from South America, Central America and some countries from Europe. In 2008, it also incorporated the Lusophone African countries of Angola, Cape Verde, and Mozambique. The latter program, which collaborates with the BHMBN, assists the participating countries to achieve the goals of ODS/2030, whose emphasis is the reduction of infant mortality. All countries are to follow donation norms according to Statute RDC 171.1 (Ortiz, 2012; Global Network of Human Milk, 2019).

Some mothers opt to donate milk following the loss of a child, as a way of alleviating their suffering, to honor the memory of their child, or to help other mothers in need of breastmilk. These mothers in mourning often find support in human milk banks (HMB) which has the means available to support donations and counseling. It is important that healthcare professionals that work with mourning mothers to share this information, so that these mothers understand the options available to them in such circumstances (Human Milk Banking Association of North America, 2020).

It is important to understand the physiology of how breastmilk is produced: Phase I of lactation occurs during gestation; Phase II occurs when the placenta is expelled after birth. Therefore, when the death of a baby occurs during the second trimester of gestation (after 20 weeks), breastmilk production and breastfeeding can occur: that is, breastfeeding is not solely dependent on sucking stimulation from the baby. Following a fetal or neonatal loss, the common practice in maternity wards is to prescribe drugs and to have women wrap their breasts with bandages or restrictive bras to suppress lactation (Cole, 2012). Medical professionals should be attentive and prepared for the question of mothers in mourning in order to counsel them on possible steps they can take in such situations (Cole, 2012). Some professionals raise the question: wouldn’t donating breastmilk further complicate the mourning process?

Regarding the mourning of mothers who have lost a child, the social denial in assisting women who suffer this form of loss is unquestionable. There is a general practice of encouraging women to deny what happened to them in these circumstances, rather than embracing their loss and suffering. In fact, some practices involve minimizing and “objectifying” the loss and suffering, counseling the mother that she need not suffer, that she can have another child. Not to mention that there are practices that aim at medicalizing emotional pain. In this way, we, somewhat, have framed practices that have created the impossibility of listening to these mothers in such moments of despair (Cole, 2012). This style of interaction with this type of suffering is harmful for the mourning process, and points out that it should be considered “unusual” to behave in ways that socially dehumanize these situations (Lang et al., 2011). To deny the suffering of a mother is a contradiction of the loss she had and creates an obstacle for making sense of the reality. This type of denial can compromise the mourning process, which is an elaborative one, and instead frames it as a type of disconnected mourning (Attig 2004). Indeed, there may be some “confusing language” with a mother who loses a child, and with people who have never gone through such an event generally – or have done so and no

longer recognize it anymore. In a sense, their backgrounds have made them immune to comprehending this type of traumatic reality, and they therefore relegate it to a level of disbelief, of impossibility, or of indifference. According to Doka (1989), a society possesses norms and rules for the act of mourning, which outline who, when, where, for whom mourning may take place; and whereby those who are not in mourning may not make their feelings known, and are therefore condemned to silence.

It is, therefore, possible to think about how this issue touches something rather primitive in humans: the fear of helplessness, of facing loss, and one's powerlessness in the face of such an event. In this sense, it is necessary to underscore that there is nothing that scars the human psyche more profoundly than the feeling of helplessness. It is the first pain that settles in. It is the first trauma, the first part of mourning. Hence, it must be emphasized the importance of having a space to recognize and to receive this type of suffering – a place to receive the unspeakable suffering of now, which brings all past losses to light, as well as a place to receive the initial pain of loss.

Healthcare professionals can be facilitators (or not) in the way mothers cope with such loss, and can help with questions regarding what to do with breastmilk following a baby's death. Given the professional shortcomings regarding mothers in mourning, and all the difficulties they face in dealing with the loss of a child, the objective of this article is to discuss the importance of listening and having a humanized intervention in regard to the decisions involved with breastmilk donations in the context of perinatal death. It attempts to enrich the possibilities of reflection on this topic through the analysis of interview excerpts with a mother in mourning that went through a traumatizing lactational experience following the loss of her child.

## **2. Methodological Preliminaries**

This case study is one of a qualitative, longitudinal methodology, based on two partially-structured interviews conducted with parents who lost babies with less than 22 weeks of gestation in the high-risk maternity ward, of Odete Valadares Maternity of the Hospital Foundation of Minas Gerais State, reference for high obstetric risk in Belo Horizonte - Minas Gerais, Brazil, during the months of February to October 2019. The conducted interviews examine specifically the case of "Eva" (hypothetical name), who went through considerable suffering from her lactation following the death of her baby and her subsequent mourning, which caught the attention of the authors about this subject.

The first interview was realized during Eva's admission into the maternity ward during the first 24 hours after her loss, whereby her demographic data were collected, which serve to support the analysis.

The second interview was conducted one month following her loss, in Eva's home – a place selected by her. In this interview, guided questions were used to verify her perceptions of that moment, her perceptions about her adaptation to daily life following her loss, and her perceptions about mourning and the quality of her professional activities. The interview was recorded and transcribed in its totality, and includes the following additional elements: interruptions, laughter, crying, pauses, changes of topic, etc., for content analysis in accordance with Waitzkin (1991). A partially structured interview is utilized for the sake of facilitating questioning, as it does not restrict the researcher to a format of succinct data collection. It, instead, provides more extensive and more detailed information to be divulged, which, in turn, leads to a better comprehension of the point of view of the other – an objective of this case study. A partially structured interview is one which, by using basic questions supported by hypotheses and theories, expands opportunities for other fields of questioning.

The material obtained was submitted for content analysis and later for thematic analysis of the data. The thematic analysis allows the discovery of nuclei of meaning, which are the basis of communication, and whose presence or frequency signify meaningful utterances. These categorized thematic nuclei of the obtained data are centered on words or meanings expressed in the speech of the interviewees (Minayo, 2018).

### 3. Results and Discussion

Eva is 34 years-old, married, unfinished middle school, day laborer, no labor documentation, whose obstetric history consists of three pregnancies, with one previous delivery and two abortions. Eva has a living daughter of eight years old. She had two prenatal consultations and was admitted to the hospital during her gestation for sepsis. She was diagnosed with amniorrhexis (i.e. rupture of the amniotic membrane), acute oligohydramnios (i.e. deficiency of amniotic fluid), which eventually resulted in intrauterine fetal death. During the first interview, she was accompanied by her husband. During her second interview, one can note Eva's suffering while in mourning:

"It's like this, I cannot focus on anything else. Every hour, I keep thinking about this for practically 24 hours. I sleep, I have nightmares, in the beginning I had horrible nightmares. I couldn't get to sleep at bedtime, I got, like, in a panic, I didn't want to and my husband went back to work."

"I lost 5 kg because I just couldn't eat. You know when you try to eat and you just can't. I only ate after the third day when I got home. I drank [beet juice], my mother made beet juice to help me get stronger. I didn't have any strength at first after what happened, I had a bad hemorrhage, due to what happened, I arrived home the color of my refrigerator, white."

From the excerpt above, it is possible to infer that Eva did not solely address her physical pain: that is, even though it appears that she could not find the words to properly describe her feelings, she did address her psychological suffering and about the pain of losing her child. What we have here, therefore, is an incursion into narcissism. As Freud (1974) notes, this is a retraction of the libido in direction of the ego, which is notable during the mourning process, complicated or not, and ceases to be linked to objects. This is, hence, best defined by the concept of "death drive" (i.e. Freud's concept of "*Todestrieb*"), in the sense that there is unbound psychic energy, manifesting itself in a devaluing way. Here, Eva seems to seek in the interviewer someone to help her symbolize and validate the pain she feels.

A mother's loss of a child, at least in the circumstances in which there is a disruptive state via psychic distress, will always be traumatic in our view. However, if there is no process of contradiction, no negation of the loss, this trauma can result in a painful process of reliving the loss, of reallocating libidinous investments, and hence turning it into a complicated mourning process. In cases in which there is need of another person and the need goes unfulfilled – that is, the response to the need of another is one of absence or negation –, a destructive slope of trauma can become validated, and the mourning process will encounter significant impediments over its course.

Maternal love possesses particularities in which there is an apex along the identity of femininity in becoming a mother: that is, motherhood has something related to feminine identity. Thus, in the realization of the mother's narcissism (as it is reborn), as well as its manifestations of the "ideal me" or "ideal of me," culminate during the maternal experience – motherly care and connection thereof, which maintains a strong persistence in the motherly psyche. Maternity brings the possibility of a woman to experience or to care for her connections, which run rather deep. It is from these deep-rooted experiences – that is, reliving the trademarks of one's own lineage –, that a woman seems to guide her views toward her new relationship with her child, to project onto her child repressed ideals of her own psyche.

In this study, it is worth emphasizing that the mourning process will also be influenced by the personal history of each woman. When a woman loses a child, usually – adjusted, of course, by the personal history of each woman/mother –, everything seems to come undone. The mourning process, in this form, will be compromised according to the situation in which the loss has occurred: that is, according to the traumatic episode in which the loss of a child is contextualized. With this in mind, we need to talk about the mourning process as it intersects with traumatic experiences. In the event of an unexpected loss, everything that a mother has constructed and lived through up until that moment collapses, and the mourning process may become compromised according to the disruptive nature of the loss. Wounded narcissism becomes present. Personal histories of each woman act upon how the mourning process will be undertaken. Sympathetic listening to these personal aspects can be of enormous help,

so that a woman may comprehend what she is going through and can aid in decision-making – such as what to do with her breastmilk in accordance with her desires and feelings, which may aid in the mourning process.

Following Freudian theories, one can argue that some women will go through the mourning process in terms of a gradual disconnection from the libido invested in the object. Other mothers, however, according to their melancholic structures, will enter into a complicated mourning process, whereby, as we have seen, the object's shadow falls upon the ego in a way that includes the denial of the loss, demonstrating that the chosen object was made according to a narcissistic basis: that is, faced with loss, there is an identification with a regressive substitute for the lost object. According to Hudson et al. (2012), complicated mourning is one which is characterized by people who experience a long period of disorientation, which impedes them to return to their normal activities prior to their loss. Worden (2013) also details manifestations that may be present during a complicated mourning: expression of intense feelings that persist for a long time after the loss; frequent somatizations; radical changes in lifestyle that steer toward isolation; depression, low self-esteem, and impulsive self-harm.

We contend that it is important to listen to mothers' feelings that they attribute to their babies, they loss they suffered, and, of course, ask: what does lactation represent for them? If the question is poised to a mother about what to do with her breastmilk, the answer will depend on each mother, depending on her feelings, expectations, idealizations in relation to her baby, the place of the mother, and the type of loss. In Eva's case, such a practice was not adopted by the maternity personnel, leaving her with no counseling about lactation, which further complicated her mourning process: that is, the pain of her loss was further exacerbated by a sense of "wasting" her breastmilk.

"I didn't know I would have breastmilk. My breastmilk came and it made me sadder, (cries) because I say that, oh my God, I really wanted to breastfeed, what I wanted, and then I was even planning to donate my breastmilk if there was any left, to give to children who needed it. I wanted to breastfeed so much, and then my breastmilk came and I had to stop it, it was more painful."

It's worth underscoring that proper counseling for Eva about her loss, lactation, and donation options for breastmilk would have been helpful to her during her mourning process.

"Oh, that hurt a lot, I was crying a lot and asking God for forgiveness, my God how much I wanted [to breastfeed], now I have to bandage my breasts to stop my breastmilk (cries). Then I had to take medicine, which was also painful, because I believe that everything is in God's nature and then you have to drink [sic] something to stop it. But I couldn't do anything about it."

"Any mother that loses her child, she feels pain, but my pregnancy was aborted. There is nothing worse than this, a mother having to choose because she... The doctors, 'Eva your life is at risk, you have a bacterial infection, and you don't have fluids, and there is nothing we can do.' Since I was in the beginning of gestation, there was nothing I could do, because the baby needed milk, milk and not amniotic fluid. I didn't have any more fluids."

Asking for God's forgiveness, as well as saying that her baby needed milk instead of fluids, seem to suggest her feeling of guilt, her insufficiency to deliver a healthy baby. The realization of her sensation of "lack of fluids" at her diagnosis also possibly reemerged now she began producing breastmilk. Her "fluids" were there, but without a baby to feed. There was also a feeling of guilt and regret in Eva, which she seemed to also experience when she was "wasting" her breastmilk, in the same way that she felt when she lost her baby: that is, she somehow believed she had "chosen" to abort the pregnancy. The interviewer and doctor, however, made clear that Eva's baby had no chance of survival, there was no "option" at all involved, and that she was assigning these words as a way to give new meaning to her loss and to the beginning of her mourning process.

This analysis was made from one interview and, therefore, it cannot be regarded as a singular truth for all cases. However, this case and its possible analyses offer knowledge on how to engage in better listening skills and the counseling of mothers going through this type of suffering, which can then result in directing them to outside

services to assist them with their pain and suffering. Breastmilk donation or suppression should be the personal choice of each mother.

Regarding the possibilities for mothers in mourning, breastmilk can be donated to HMB, which contributes to the nutritional needs of babies admitted to hospitals. Some women share that, through their breastmilk donations, they feel that they are offering a personal and meaningful contribution for the survival of babies who they feel could be their own. In short, it is fundamental to humanize the counseling of such women, individualizing options according to each one's needs. Special attention should be given according to women who have had babies that were born and survived for some time in neonatal intensive care, since, in these cases, their breastmilk was pumped several times a day.

To counsel women about lactation is fundamental, as some can opt to donate their breastmilk gradually. But, in instances where women choose to donate their breastmilk, medical assistance is necessary to detect any health problems like mastitis, as well as to monitor their mental health. An informed choice on whether or not to keep breastmilk requires counseling on the possible risks and benefits, on the mourning process, on the individual needs, and on the available professional support systems.

In cases where breastfeeding ceases to be possible (and also the learning of personal hygiene) (Australian Breastfeeding Association, 2020), this may put a woman in an identity crisis that can overwhelm her psyche (Figley, Bride & Mazza, 1997). A healthcare professional with a sympathetic ear to a mother in mourning will be able to counsel about services available to her, which can aid her in her mental recovery. Specifically, in the case of lactation, counseling a mother about the possibilities she has can create a sense of support, assurance, and possible paths to help her make sense of her pain, both emotional and physical. How healthcare professionals approach the topic of mourning, the possible options for what to do with breastmilk, with counseling grounded in sympathy, can undoubtedly reduce anguish and aid in the mourning process.

#### 4. Conclusions

The objective of this article is to argue that common healthcare measures of imposing feelings and practices upon mothers who have lost children during pregnancy or following birth is not helpful for the mourning process. For a mother in mourning, it is necessary to understand that gestation, birth, breastfeeding, and mourning extrapolate a variety of natural human aspects: these include feelings, emotions, and expectations. Women who have lost their babies before, during, or after birth should be offered the option of donating their breastmilk, to allow them to choose what to do with it, and then to counsel them during the mourning process. The practice outlined herein, evidently absent in the case of Eva, can make a difference in a mother's mourning process. Allowing women to cry and feel pain will aid them on their road to recovery from such trauma.

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#### Disclosure of interest

The authors report no conflict of interest.

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