Parenting paradox: Parenting after infant loss

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ABSTRACT

Objective: to gain an in-depth understanding of the parenting experiences of bereaved parents in the years following an infant death.
Design: an exploratory qualitative study.
Setting: semi-structured interview in the participants’ homes. Data were collected over a five-month period in 2008 and analysed using thematic analysis.
Participants: a purposive sample of 13 bereaved parents (10 mothers and three fathers) was used. Parents who had accessed the support services offered by two bereavement support agencies were recruited. Participants were asked to describe their experiences of raising their subsequent child. Interviews were conducted when the next born child was at least three years of age.
Findings: the parents described a ‘paradoxical’ parenting style where they were trying to parent using two diametrically opposed unsustainable options. For example, they described trying to hold their subsequent child emotionally close but aloof at the same time.

Key conclusions and implications for practice: the results from this study indicate that the impact of a loss of an infant has far-reaching consequences on subsequent parenting. Support and early intervention at the time of the stillbirth and subsequent pregnancy are likely to be useful. However, further research is required to determine the extent to which early intervention can alter the tendency towards bereaved parents adopting a paradoxical parenting style. The impact of this style on mental health and the emotional health and well-being of the next born child/ren after perinatal loss should also be further examined.

Introduction

It is commonly reported that bereaved parents, in the pregnancy after the death of an infant, may delay emotional attachment to their coming baby for fear of another loss (Lewis, 1979; Armstrong and Hutti, 1998; Cote–Arsenault and Marshall, 2000; Lamb, 2002; O’Leary, 2004). Literature in this area also discusses the subsequent child in terms of being a ‘replacement’ (Cain and Cain, 1964; Anisfeld and Richards, 2000), ‘vulnerable’ (Green and Solnit, 1964; Sabbadini, 1988; Grout and Romanoff, 2000) and ‘penumbra’ (shadow) (Reid, 2003; Kempson et al., 2008), who may be subject to increased risk of psychopathology (Anisfeld and Richards, 2000) including attachment disorders (Sabbadini, 1988; Powell, 1995; Reid, 2007; O’Leary and Thorwick, 2008).

Furthermore, literature acknowledges that parents may be anxious when pregnant again (Armstrong and Hutti, 1998; Robertson and Kavanaugh, 1998; Warland, 2000) and in the postpartum period (Warland, 2000; O’Leary et al., 2006). This apprehension can extend into parenting subsequent infants (Theut et al., 1992; Lamb, 2002). This anxiety may have far-reaching consequences for both the bereaved parent and/or the subsequent child (Cote–Arsenault and Marshall, 2000), especially if parents become overprotective (Parker, 1983). Whilst there is considerable literature concerning parents’ experiences of loss of an infant at or around birth as well as during the subsequent pregnancy, the literature is almost silent on parents’ experiences of parenting after loss or the longer-term effect that the loss may have on parenting style. Such literature as exists on this topic is reviewed here.

Literature review

Parental overprotection and anxiety

It is normal for all adults to protect their young from danger; however, bereaved parents have been described as more likely to be extra vigilant, with a rapid response to any sign of trouble or danger (Rosenblatt, 2000). Overprotection, defined as ‘behaviours...
beyond what most parents would do in similar circumstances’ (Thomassagard and Metz, 1993, p. 67), is also something to which bereaved parents can be more prone. For example, Pantke and Slade (2006) asked adolescents to recall their parents’ parenting style and found differences in young adults’ psychological well-being between those children raised in a family who had experienced peri or postnatal loss and those who had not. They found that young adults remembered their parents being more protective of and anxious about them if they were born after a loss, and this group scored lower in the overall mental health scores than adolescents who were not born after a loss. Although bereaved parent overprotection and anxiety has not been specifically examined in the literature, these have been associated with a range of negative psychological sequelae in children, including externalising problems (Holmbeck et al., 2002), anorexia nervosa (Shoebbridge and Gowers, 2000), as well as anxiety and depression (Mullins et al., 2004; Yahav, 2006; DiBartolo and Helt, 2007; Herbert and Dahlquist, 2008).

Subsequent parenting

Only one reported study has specifically examined the effect of perinatal loss on subsequent parenting soon (16 months) after the loss. Theut et al. (1992) compared 25 mothers who had experienced perinatal loss with 30 women who had not, to determine maternal concern regarding the health of their toddlers. They found that women who had experienced perinatal loss had more difficulty with concerns about their children’s health than mothers who had not. They concluded that the effects of a perinatal loss are not short lived but endure for at least 16 months after the birth of the subsequent child. No published study has examined how long these concerns may impact on parenting in the longer term.

Long-term emotional sequelae for families following perinatal loss

Three studies have reported on the longer-term emotional impact of a perinatal death on all members of the family. O’Leary et al. (2006) found that adults who were the child born after a loss reported feeling invisible in their family of origin, some giving vivid examples of their mothers not believing they were going to stay.

Price (2008) used data from a large (n=10,688) population-based cohort study to compare parenting capacity and depressive symptoms between those parents with a history of pregnancy loss with those without. She found no significant differences between groups either in depressive state of the women or parenting outcomes with the child enrolled in the study. Her findings indicate a ‘picture of resilience and recovery that produces very few negative, detrimental effects to women’s long term mental health and future parenting’ (p. 115). However, the type of data used in this study meant that Price was unable to distinguish between early and late pregnancy loss and the time since the child’s death. These are all well-known risk factors for ‘complicated grief response’ (Franche and Bulow, 1999). This means that questions remain as to the impact of late pregnancy loss on parenting style, as well as maternal and infant/child health.

A recently reported study (Fanos et al., 2009) suggested that this was the case when they identified a number of long-term emotional consequences for children raised in bereaved families. They interviewed 14 adults who had experienced the death of a sibling when they were young, and reported that they felt their parents had not resolved their grief. Furthermore, many of these participants reported heightened anxiety associated with their own pregnancies and children.

Subjects and methods

A qualitative approach was chosen as the most appropriate method of exploring families’ experiences of raising their subsequent child (Flick, 2009). Semi-structured interviews were used to enable the conversations to be purposively steered in the direction of the topic (Flick, 2009, p. 185).

Community organisations that offer support to the target population such as SANDS (Stillbirth And Neonatal Death Support) and ‘SIDS & Kids’ (Sudden Infant Death Support) were approached and agreed to advertise the study in their newsletters. The participants enrolled in this study via self-referral. Their infant’s death could have been through stillbirth, neonatal death, SIDS or accidental death in infancy (under two years of age). Participants needed to have had another baby since the death, and the subsequent child should have reached at least three years of age. This age requirement was to enable the parents to narrate experiences of raising the next born child as distinct from grieving for the infant who had died. This step was also taken to ensure that a number of years had passed since the infant’s death, to make it less likely that these parents would be retraumatised by telling their stories. At the time of the interview, the child who had been born immediately following the loss was between three and 15 years of age (see Table 1), with most families also having other younger children.

Data collection

Data were collected through conversational style interviews conducted from February to June 2008. In order to elicit information about raising a subsequent child, the following question was asked: ‘Can you tell me about your experiences of raising your subsequent child?’ The information was then allowed to flow in a conversational, rather than a directed, manner, with the participant being encouraged to control the direction of the interview. Participants were listened to and given non-directive prompts when the flow of narrative waned, such as ‘Can you tell me a little more about that?’ or ‘What happened next?’ Interventions were completed when no new material concerning the participant’s experiences of raising their subsequent child was forthcoming. Each interview lasted between 45 and 90 minutes.

Analysis

Interviews were audio-taped and transcribed verbatim by a professional transcription service. Transcripts were then thematically analysed using a six-step process, described by Braun and Clarke (2006).

In the first of these steps, all researchers familiarised themselves with the data, separately and then together, by reading and rereading the transcripts. The second step consisted of generating initial codes of interesting features, noted to be in keeping with an ‘unit of meaning’ (Shkedi, 2005). These initial codes were then broadly collated into two potential sub-themes that were mainly centred on participants’ parenting behaviours towards and thoughts about their subsequent child. Once we achieved data saturation (Guest et al., 2006), no further interviews were conducted. Then our focus moved to reviewing the initial sub-themes to check if they ‘worked’ across the data set. After that, each sub-theme was compared and connections were drawn between them in order to refine the specifics of each main theme. As a final step, we related the themes back to the research question by way of the discussion section in this paper.
Rigour

With respect to ensuring rigour, we separately read and reread the transcripts and singly coded them. We individually arrived at the same or very similar codes and sub-themes. However, where differences occurred, these were discussed and consensus was achieved. We consider we have provided an accurate account of the experience of raising a subsequent child by identifying a set of participant quotations which exemplify each sub-theme. Moreover, to ensure we had captured the essence of the experience, a summary of main themes was sent to each participant with all respondents agreeing with the statement ‘Do you feel these themes have captured your experiences of raising a subsequent child?’

Ethical considerations

Ethics approval was granted for this study by a university human research ethics committee. Prior to their interview, participants read an information sheet outlining the study’s aims and objectives, as well as the usual information about participant confidentiality and the voluntary nature of participation. They then completed consent forms and a demographic profile. In the event that it was required, all participants had access to free counselling following the interview; however, no participant availed themselves of this service.

Findings

Sample

Thirteen bereaved parents (10 female and three male) participated in 11 interviews. There were eight mothers alone, two couples together and one father alone. Although only three fathers are included in this sample, it was felt important not to discount their comments, especially as there is a lack of research on fathering and we wanted to describe experiences of parents. The participants were bereaved through stillbirth, neonatal death, SIDS or sudden death in infancy. They were all recruited through their previous association with bereavement support agencies. The time since their loss ranged from three years nine months to 18 years, with a median time since loss of six years. All participants were Caucasian, other demographics including the participants’ age group, age of the participants’ subsequent child/ren at the time of the interview, numbers of living children and whether or not the child was the couple’s first born are listed in Table 1. Throughout this paper, we have used ‘baby’ when referring to the new pregnancy, ‘infant’ to refer to the baby who died and ‘child’ when referring to the subsequent child.

Identified themes

One main theme with four sub-themes emerged from this study. The main theme was a parenting style which we have named ‘paradoxical’ because all participants described their parenting using two diametrically opposed and unsustainable options. Whilst there were many indicators of this paradoxical style, four consistently recurring sub-themes within this main theme were identified:

- Holding close/holding at arm’s length
- In control/out of control
- Loss of perspective/sense of empowerment
- Checking/pragmatic

Each sub-theme was reported by all participants at least once, and will be described in more detail below.

Holding close/holding at arm’s length

Participants expressed the need to hold their subsequent child close because they were so very grateful for their child’s life, whilst holding the child at an emotional arm’s length, fearing their child might die. One mother expressed this...
best saying:

you do that bonding thing but you keep it at a certain level... like an air bag cushioning everything... It’s like don’t let too much out because it hurts too much. [Jill]

Mary pointed out the reason she wanted to hold her child close by being ‘with him all of the time’ was to ensure that nothing would happen to him. She then went on to say she was aware of emotionally ‘holding aloof’ because she was afraid to invest in her subsequent child least he die. She ‘never wanted to go through that [pain] again’.

It may be that the fear of another child dying is driving this parental behaviour, with some parents admitting during interview that they were ‘holding close’ out of a sense of obligation to their child whilst consciously withholding their emotional attachment through fear of another loss:

I am not saying I didn’t love my kids, but I was scared to invest everything in them and I could see that I would sometimes force myself to play with Sarah because I knew I was supposed to do that. I think you try and protect yourself. [Jill]

In control/out of control

In order to attempt to protect themselves from a repeat loss, these parents also said they took control of things they felt they could control. Annie summarised this sub-theme by saying:

You do your best to keep it in your control but there are still some factors that happen that you can’t control... there is that safety aspect which is a fear factor maybe for people like us more so. I wish I could prepare.

Attempting to take control was often established in or even before the subsequent pregnancy, with parents choosing to change maternity care providers, or in Heather’s case, her smoking behaviour:

I was determined not to conceive until I was a non-smoker. So I went to the ‘quit’ team at my work to make sure that happened…. I think that it was a control thing as well as a risk reduction. I thought I could have some control.

Once established, this need to be in control extended well into parenting and was expressed by the participants ensuring that immunisations were up-to-date and things like dental appointments were made and kept. Whilst this may be considered quite normal for all parents, these bereaved parents seemed particularly careful to do things properly, for example:

She can’t have shoes until she has walked properly for 8 weeks; they all go to the dentist when they need to go; they all get their shots at exactly the right time. I am very mindful that I have to do it properly. [Izzy]

Parents also tried to take control of the environment; for example, Izzy took control of her child’s sleeping environment. The cot had only a bottom sheet, he slept uncovered, there was a bare floor, because ‘carpet attracts dust mites and dust mites might cause SIDS’ and there were no soft toys for the same reason.

She also took control of the parenting, excluding all others from relieving her, even her partner (the child’s father):

My husband [Angus] didn’t look after him at all. I was his primary carer and he just didn’t get a look in... I thought if I left him with Angus, if something happened to Christopher our marriage wouldn’t be fine anymore. I could distance myself but I couldn’t forgive Angus.... I still don’t think I could. So that’s why I didn’t let Angus look after him. [Izzy]

This need to control was also reported by fathers; for example, Colin talked about playing with his child in a rough and ready manner, provided he felt he was in a safe environment where he felt in control:

in a controlled environment, that is the time you can push limits. You know you can’t do that in an uncontrolled environment, but you can in a controlled one...

In spite of taking control of things they considered they were able to control, the participants also acknowledged times when they felt very much out of control. This was particularly true for the mothers. All mothers shared stories of feeling out of control, especially when faced with ‘normal’ or ‘common’ childhood events, such as tussilitis, middle ear infection or being stung by a bee. These events were enough to cause them to feel hysteria and intense fear they were about to lose another child.

These stories were sometimes told with a degree of humour, acknowledging that the level of hysteria was probably unfounded. For example, when her subsequent child was undergoing a routine tonsillectomy, Izzy said:

He was going to have an anaesthetic and I didn’t like that. When they knocked him out, I was hysterical. As the doctor walked me out of the theatre, he said ‘He’ll be ok’. He’s supposed to be in there taking his tonsils out and he’s outside with me holding my hand!

Loss of perspective/sense of empowerment

The parenting paradox was also evident when participants talked about making parenting decisions. They shared a loss of confidence in the ability to make parenting decisions as a result of their infant’s death, alongside stories where they said they had felt empowered to make decisions because their infant had died.

When discussing their loss of perspective, parents talked about their difficulties determining which parenting decisions and judgment calls they could make unassisted, against the things that required expert assistance. These ranged from deciding if and when to seek medical advice and what schooling to choose:

You feel pretty exposed and there are a million things that could come out now with the kids that would just knock me off my chair, never heard of it, can’t cope with it and they die from it. [Bob]

I lost my confidence in being a parent. I really question my ability as a mother and second guess my judgement all the time. [Jill]

Paradoxically, parents felt empowered to make decisions and judgement calls because of their infant’s death:

I always want to know options so I can go okay I can either do this or that. I don’t like to be surprised anymore. [Faye]

I am never going to second guess myself again with my children. I am going to make a decision strongly about how I feel about something and just stick with it. [Gayle]

During the pregnancy, we asked a lot more questions and were a lot more aware generally of the things that could go wrong... I am a lot more challenging of doctors now... I know it’s not a good attitude [questioning doctors] but it’s left me with that. [Bob]
Checking/pragmatic

The parenting paradox was also expressed through participants being concerned about checking and protecting their child, and paradoxically leaving their child unchecked. These parents described checking on their subsequent children while they were sleeping, often in the middle of the night. Checking was not confined to their own children but also involved other people's children sleeping over in the house or in one case, grandchildren.

Every night I go in before I go to bed and check that they are covered up and still breathing. [Debbie]

I check the boys [grandchildren], I still check them. I might just have a look at them when I am putting the washing away or something while they are asleep and I think 'oh okay'. It does make you feel more comfortable. [Kelly]

A father shared a story that not only described how he tried to protect his children but also how he had received a blow to his 'assumptive world' as described by Janoff-Bulman (1992), leading him to think about the unlikely as likely. He made changes to his parenting in order to try to control and prepare for the possibility that the unthinkable just might happen again:

Out in the yard supervising, they just don't get out of my eyesight. It is just so easy for them to scoot around from the back of the car. I understand exactly how that can happen now. Those worst-case scenarios, the things that when you haven't had a tragedy you think, it will never happen to me or my family. All of a sudden you have the other approach. It's just the bloody thing that is likely to happen to mine. I am just likely to back out of the driveway and knock one of my kids over, so what do we need to do then to make sure that doesn't happen? [Bob]

These checking and protecting stories were also often told with a sense of humour:

He's not allowed to go swimming with anyone except us… and that's even my good friend whose child died too and that's how we are friends. She rang up, not this summer but last summer, and said 'I'm going to my mum's for a swim, do you want me to come and get Christopher?' and I said 'no thanks' and she said 'I'm not going to let him drown you know!' cos she knows… and I said 'I know but he still can't come. [Izzy]

Along with checking and protecting behaviour, participants had paradoxically also used a pragmatic attitude towards protecting their children from harm, saying things like:

if it happens it happens… if something happened to them I wouldn't deal with that very well, but at the same time if their time is up it's up… [Heather]

Colin put a positive spin on this by saying he was happy enough to let his children just go and play unsupervised because 'the odds are everything will be okay'.

Discussion

The results of this study both confirm and support previous research findings, and suggest several new paths for future exploration.

The only other published study which has examined parenting after perinatal loss reported mothers needing constant reassurance regarding the physical health of their subsequent child, and fearing failure to notice a medical problem might mean the child would die (Theut et al., 1992, p. 164). Our findings suggest that these fears and anxieties not only occur when the next born child is young, but also many years into parenting the older subsequent child.

These findings also suggest that bereaved parents do not always trust their own decision-making abilities. This lack of trust noted to occur during pregnancy seems to continue into parenting, particularly when the child is having medical problems. Parents seek to be assured that their child is healthy and will remain alive, even many years after the loss of their infant. This has implications for health professionals to begin educational intervention during pregnancy along the lines suggested by O'Leary et al. (2006) and O'Leary and Thorwick (2008), so expectant couples can begin learning trust in the world again in order to embrace the new baby.

Previous research on bereaved parents' relationships with subsequent children has focused, quite understandably, on attachment theory (Bowlby, 1980), in particular the impact of heightened anxiety in the subsequent pregnancy (Theut et al., 1988) as well as mothers deliberately delaying attachment in the subsequent pregnancy (Uren and Wastell, 2002) and early infancy (Lamb, 2002). Additionally, participants in our study described continuing to deliberately hold aloof from their child well into that child's childhood. We suggest that this finding means there may be disruption of affectional bonds between bereaved parents and their subsequent child, which extends far into the parenting of that child. This may explain why the subsequent child describes feeling invisible (O'Leary et al., 2006), and could place them at increased risk of all the negative sequelae associated with disorganised/ambivalent attachment, including depression and anxiety disorders (Main and Solomon, 1986).

It is known that the development of internalising problems in adolescence, such as depression and anxiety, may be more related to the presence of psychological control than to the absence of psychological autonomy granting (Silk et al., 2003). Therefore, we anticipate that bereaved parents who want to control and plan every aspect of their child's care may later have more difficulty in granting their adolescent autonomy to make choices about activities and behaviour, thereby discouraging the development of independence (Morris et al., 2001). The extent to which this is a problem for bereaved families also requires further and more detailed inquiry.

Some of the parental behaviours reported by our participants, particularly protective parenting, controlling and checking, raises concerns regarding the emotional well-being of the child born into a family after infant death. For example, if teenaged subsequent children are aware of their parents checking on them in the middle of the night, they could perceive this as overprotective parenting. Pantke and Slade (2006) suggest that these children do remember their parents being more protective of them, and those who held this perception scored worse on self-esteem and mental health scales than those who did not. Fanos et al. (2009) also suggest that adults who suffered bereavement when they were children may be more vulnerable to anxiety, especially when it comes to their own pregnancies and child-rearing. Shoebridge and Gowers’ (2000) anorexia study found the more high concern factors present (such as history of late pregnancy loss, significant puerperal worries about losing the pregnancy, near-exclusive maternal care in the first five years and high maternal trait anxiety), the more significant the risk of anorexia in subsequently born daughters. Many of these factors were contained in the stories parents told in our study, suggesting that adolescents who are subsequent children are likely to be at an increased risk of a range of poor mental health problems. Further study should be aimed at identifying those children at risk.
and employing early intervention strategies before any onset of these disorders. Lin and Lasker (1996) studied levels of grief in a group of bereaved parents for a period of two years. They found that whilst a subsequent birth may help assuage grief, a continuing low level of grief persisted for the length of their study. It is not known if such a level of grief persists for longer than this two-year period, and if it does, how this might impact on the paradoxical parenting style these parents seem to adopt. Whilst it cannot be said that this persistent low level of grief is in any way pathological or even unusual, it is something that health professionals who come into contact with bereaved parents, need to be aware of, especially if and when the subsequent child is in any way unwell.

**Study limitations**

Whilst this study does not claim to be transferable to all bereaved parents who are parenting subsequent children, it should be understood that the participants in this study told their stories from a place where they were currently identifying as a bereaved parent. Further, they were recruited because they had, at some stage in the past, used bereavement support. It should be noted that none were currently accessing counselling support. The experiences of other parents, who had lost contact with or who had never had this kind of support, were not heard and it is acknowledged that their stories may have been considerably different from those of these participants. Further, the fathers that participated were too few to enable any kind of gender comparison (similarities or differences), and are included to enrich the stories the parents gave and speak to the need for more research in this area.

**Conclusions**

The results from this study indicate that loss of an infant has far-reaching consequences on subsequent parenting. This research shows that bereaved parents can adopt a paradoxical parenting style when parenting after a perinatal or early infant loss. There is a need for research into the effect of this on not only the emotional development of the subsequent child, but also other children already in the family, and the mental health status of the bereaved parents. Further research is required to support specific education during the subsequent pregnancy and postpartum period. This education should aim at early intervention with anxiety and attachment issues, and alert parents that their infant’s loss impacts future parenting.

**Conflict of interest statement**

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