



Long-term outcomes for mothers who have or have not held their stillborn baby

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Abstract

Objectives: to investigate long-term outcomes of mothers who have or have not held their stillborn baby, and predictors of having held the baby.

Design: postal questionnaires.

Setting: a nation-wide cohort study of mothers who gave birth to a singleton stillborn baby in Sweden in 1991.

Participants: 314 out of 380 women answered the questionnaire and 309 reported whether or not they had held their baby.

Measurements: scales measuring anxiety, depression and well-being.

Findings: 126 (68%) mothers of 185 babies stillborn after 37 gestational weeks had held their baby and 82 (68%) mothers of 120 babies stillborn at gestational weeks 28–37 had also done so. Compared with mothers who agreed completely with the statement that staff gave enough support to hold the baby, mothers who did not agree were less likely to have held their baby [relative risk (RR) 4.1; 95% confidence interval (CI) 2.7–6.1], and mothers with a low level of education were less likely to have held their baby than mothers with a higher level of education (RR 2.2; 95% CI 1.3–3.8). Mothers who had not held their babies born after 37 gestational weeks had an increased risk of headache (RR 4.3; 95% CI 1.1–16.5), and they were less satisfied with their sleep (RR 2.7; 95% CI 1.5–5.0). The increased risk of long-term outcomes associated with not holding, compared with holding, a stillborn baby were less pronounced for women who gave birth at gestational week 28–37 compared with women who gave birth after 37 gestational weeks.

Key conclusions: in this cohort, we found an overall beneficial effect of having held a stillborn baby born after 37 gestational weeks, whereas findings for having held a stillborn baby born at gestational weeks 28–37 are uncertain. The attitude of staff influenced whether or not the mother held her stillborn baby.

Implications for practice: if the mother is guided by staff in a sensitive way to hold her stillborn term baby, the experience will possibly be beneficial for her in the long term.

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Introduction

When a baby dies before birth, the mother's expectations and happiness with her baby are brutally replaced by a need to say farewell and mourn her loss. Care after a stillbirth influences whether the mother will cope with this abrupt change and recover psychologically, or if the stillbirth will result in mental health complications. In general, seeing the stillborn baby has a beneficial effect on the mother (Forrest et al., 1982; Rådestad et al., 1996a). Whether or not doing more than just seeing the baby will improve the mother's well-being after a stillbirth is unclear.

Holding the stillborn baby could possibly enhance the attachment some mothers need for a healthy mourning process, whereas others might find holding the baby a traumatic experience, especially if they are persuaded by staff rather than acting on their own initiative. Hughes et al. (2002) interviewed 65 mothers of stillborn babies, 18 gestational weeks and older, and concluded that holding the baby may be harmful for some mothers. We studied 314 mothers who gave birth to a stillborn baby after 28 gestational weeks, using a questionnaire that allowed us to distinguish mothers of stillborn babies born at 28–37 gestational weeks from mothers of stillborn babies born after 37 gestational weeks. We investigated the long-term outcome after having held or not having held a stillborn baby, and predictors of having held the baby.

Methods

We used the Swedish population-based Medical Birth Register to identify all women who had had a stillborn baby in Sweden in 1991; that year 124,201 children were born in Sweden, of whom 464 (3.7 per 1,000) were stillborn. Current Swedish legislation defines a stillborn as a 'baby' when the baby is born after 28 gestational weeks. Three hundred and eighty women fulfilled the criteria of giving birth to a singleton stillborn baby in Sweden in 1991, speaking Swedish and having an identified permanent address in Swedish at the time of the study.

We developed a study-specific questionnaire on the basis of clinical experience, a literature search, our own and others' experience from clinical work and interviews with mothers of stillborn babies. The questionnaire was tested for face-to-face validity; an investigator accompanied 15 women as they completed the questionnaire, ensuring that they understood the questions correctly. In a pilot study, we evaluated our means for data collection, participation rate and rate of missing answers. We refined the questionnaire during the face validation and after the pilot study (Rådestad et al., 1996b).

Questions about the care and support received after the birth were formulated for the present investigation. We asked: 'did you hold your baby?' The answer categories were 'yes' and 'no'. Concerning support from staff about holding the baby, we asked: 'how well does the following statement agree with how you feel? I received enough support from the staff for seeing and holding my baby.' The response categories were as follows: 'agree completely', 'agree to a large part', 'agree somewhat' and 'do not agree at all'. For the gestational age of the stillborn baby, the questionnaire had the following categories: 'gestational age 28–37 weeks', 'gestational age 38–42 weeks' and 'gestational age >42 weeks'.

We assessed anxiety-related symptoms using Spielberger's State (STAI-S) and Trait (STAI-T) Anxiety Inventory (Spielberger et al., 1983), and depression-related symptoms using the Center for Epidemiological Studies Depression Scale (CES-D) (Radloff, 1994).

On a separate matrix, we asked questions about eight complaints resulting from physical or psychological problems. At the head of the column, we asked: 'have you been bothered by any of the symptoms specified below after you lost your baby in 1991?' The categories were 'backache', 'stomach complaints', 'headache', 'episodes of tachycardia', 'chest pressure', 'panic attacks', 'nausea or fainting' and 'weakness or tiring easily'. In the other column headings, the category choices were 'no, not at all', 'yes, somewhat', 'yes, to a large part' and 'yes, very much'.

To assess self-reported psychological status and social situation, we included a modified version of a

quality-of-life scale, developed for a Swedish population (Wiklund et al., 1990). Respondents marked with an X, the extent to which they were satisfied with different aspects of their situation, for each category. Domains were 'situation at home and in the family', 'dwelling', 'situation at work', 'health', 'economy', 'leisure time', 'physical fitness', 'appetite', 'temper', 'energy', 'patience', 'self-confidence', 'sleep', 'being important and appreciated outside of the home' and 'being important and appreciated at home'. Available response categories were defined as 'no, not at all satisfied', 'yes, somewhat satisfied,' 'yes, to a large part satisfied' or 'yes, entirely satisfied'.

The medical superintendent at each of the 60 Swedish clinics where women had given birth was asked to sign a letter of introduction and to approve our request to approach the women for the study. The women who gave their consent to participate were sent a postal questionnaire. Complete anonymity of the investigation was secured by letting the women return the questionnaire separately from a second form in which they stated they had replied. The questionnaires were primarily collected 3 years after the stillbirth.

Data were analysed using SAS version 9.2 (Carey, NC, USA). All outcome variables were dichotomised. To calculate an average score, the summary score for the scales comprising anxiety-related and depression-related symptoms (STAI-S, STAI-T, CES-D) were divided by the number of answers given for each scale; we used a previously chosen cut-off point for the dichotomisation (the 90th percentile). A woman who did not respond to three or more items in a scale was regarded as 'missing' for that scale. We estimated ratios of proportions with 95% confidence limits (95% CI) using the variance formula suggested by Mantel and Haenszel (Rothman, 2002). Adjustment of the relative risks (RRs) was done in Proc Genmod using the log link. We calculated two-sided p values by means of Fisher's exact test and considered a value below 0.05 as indicating a statistically significant association. The study was approved by the Regional Ethics Committee at the Karolinska Institutet in Stockholm.

Findings

Among the 380 eligible mothers who had given birth to a stillborn baby, 314 (83%) answered the questionnaire. Reasons for not answering were as follows: 'no contact established' (2%), 'refusal' (10%) and 'other' (5%), mostly referring to lack of time.

We found that 99 (32%) mothers had not held their baby and 210 (68%) had done so. One hundred and twenty-six (68%) mothers of the 185 babies born after 37 gestational weeks had held their baby, and 82 (68%) mothers of the 120 babies born at 28–37 gestational weeks had also done so. Mothers having held or not having held their stillborn baby had a similar age distribution, and did not essentially differ with respect to other maternal, birth or baby characteristics. Compared with mothers with a university education, mothers with an elementary school education were more likely not to have held their baby (adjusted RR 2.2; 95% CI 1.3–3.8) (Table 1). Other maternal, birth and baby characteristics included in Table 1 did not influence the probability of not having held their baby (data available on request).

The ways in which attitudes of staff influenced the frequency of holding the stillborn baby are presented in Table 2. Compared with mothers who agreed completely that they had received enough support from staff to hold their baby, women who disagreed or only slightly agreed faced a four-fold increase in probability of not holding their baby in the adjusted analysis. Other variables were not statistically associated with whether or not the mother held the baby after adjusting for 'staff gave enough support'.

Long-term outcomes in mothers are presented in Tables 3 and 4, distinguishing between holding stillborn babies born at 28–37 gestational weeks and babies stillborn after 37 gestational weeks. Among mothers who did not hold their stillborn baby (>37 weeks), an RR above 1.0 was obtained for 21 (81%) of 26 measured outcomes, indicating harm. Statistically significant associations were found for headache (RR 4.3, 95% CI 1.1–16.5, $p = 0.022$) and for dissatisfaction with sleep (RR 2.8, 95% CI 1.5–5.0, $p = 0.001$). For mothers who did not hold their stillborn babies (28–37 weeks), 12 (46%) of 26 RRs were above 1.0, and the risk for stomach complaints was significantly increased (RR 8.9, 95% CI 1.0–76.7, $p = 0.015$). The RR for anxiety was 0.6 (95% CI 0.1–2.8, $p = 0.717$) and for depression 0.0 (CI not calculated, $p = 0.056$) for mothers who did not hold their stillborn babies born at 28–37 gestational weeks compared with mothers who held their stillborn babies born at 28–37 gestational weeks.

Discussion

We found an overall beneficial effect of holding a stillborn baby born after 37 gestational weeks. Statistically significant increased risks were found

Table 1 Characteristics of the mother and stillborn baby according to whether the mother had or had not held her baby.

	Not held baby (n = 99)		Held baby (n = 210)	
	n	%	n	%
Mother ≤ 22 years	9	9	15	7
Mother 23–35 years	77	78	166	79
Mother > 35 years	12	12	29	14
Missing	1	1	0	0
Elementary school education	31	31	39	19
College education	51	52	113	54
University education	14	14	56	27
Missing	3	3	2	1
Married/co-habiting	93	94	206	98
Single	5	5	4	2
Missing	1	1	0	0
First baby	48	48	90	43
Second baby	28	28	64	30
Third baby	14	14	36	17
Fourth baby or later	9	9	19	9
Missing	0	0	1	0
The baby was a girl	49	49	111	53
The baby was a boy	50	51	99	47
Baby's gestational age 28–37 weeks	38	38	82	39
Baby's gestational age 38–42 weeks	44	44	110	52
Baby's gestational age > 42 weeks	15	15	16	8
Missing	2	2	2	1
Mother knew the baby was dead before birth	81	82	165	79
Mother did not know the baby was dead before birth	18	18	45	21
Vaginal birth	92	93	192	91
Caesarean section	5	5	16	8
Missing	2	2	2	1
The baby was not malformed	90	91	189	90
The baby was malformed	7	7	20	10
Missing	2	2	1	0
The baby was not at all macerated	53	54	103	49
The baby was somewhat macerated	28	28	79	38
The baby was to a large part or severely macerated	8	8	23	11
The mother did not know if the baby was macerated	10	10	3	1
Missing	0	0	2	1

for headache and sleep disorders among mothers who did not hold their stillborn baby born after 37 gestational weeks. Concerning mothers of stillborn babies born at 28–37 gestational weeks, possible benefits or adverse effects of holding the baby were uncertain. From our data, it is not possible to distinguish the effect of holding the baby in itself from the circumstances in which it was carried out. Staff support influenced whether or not the mother held her stillborn baby, as did the mother's level of education.

In this cohort, holding a stillborn baby born after 37 gestational weeks implied an overall beneficial effect. It is possible that holding the stillborn baby

enhances the mother's attachment to her baby; holding makes the baby real and facilitates a healthy mourning process. Active management to make the baby seem real was introduced into maternity health care after stillbirth in a randomised trial published in 1982 (Forrest et al., 1982). Forrest et al. (1982) randomised 50 women to active management (including support to see and hold the stillborn baby) and routine care. 'Psychological complications' after 6 months were observed in two out of 16 women who had been followed-up, who had received active management compared with 10 out of 19 women who had received routine care. Attrition was high, and no

Table 2 Relative risk of not having held the stillborn baby according to the mother's experience of the staff's actions and attitudes.*

Variable indicating staff's actions or attitudes	Percentage not having held the baby n/total % n	Relative risk not having held	95% CI of relative risk	Relative risk adjusted for staff's support	95% CI
Staff showed respect to the baby					
Agree completely	59/217 27	1.0	Reference	1.0	Reference
Agree to a large part	22/54 41	1.5	1.0–2.2	1.0	0.8–1.4
Agree somewhat	8/19 42	1.5	0.9–2.7	0.8	0.5–1.3
Do not agree at all	4/7 57	2.1	1.1–4.1	1.1	0.6–2.0
Staff showed tenderness to the baby					
Agree completely	46/167 28	1.0	Reference	1.0	Reference
Agree to a large part	15/61 25	0.9	0.5–1.5	0.8	0.5–1.3
Agree somewhat	19/46 41	1.5	1.0–2.3	0.9	0.6–1.2
Do not agree at all	8/16 50	1.8	1.0–3.1	0.9	0.5–1.4
Staff seemed to be afraid of the baby					
Do not agree at all	78/263 30	1.0	Reference	1.0	Reference
Agree somewhat	10/22 45	1.5	0.9–2.5	1.0	0.6–1.5
Agree to a large part	0/3 0	0.0	Not done	0.0	Not done
Agree completely	3/5 60	2.0	1.0–4.2	1.0	0.5–2.0
Staff dissociated themselves from the baby					
Do not agree at all	83/273 30	1.0	Reference	1.0	Reference
Agree somewhat	5/13 38	1.3	0.6–2.6	0.7	0.1–3.0
Agree to a large part	1/3 33	1.1	0.2–5.5	0.6	0.1–2.9
Agree completely	1/3 33	1.1	0.2–5.5	1.0	0.6–1.9
Staff gave enough support to see and hold the baby					
Agree completely	30/177 17	1.0	Reference	Not appropriate	
Agree to a large part	18/61 30	1.7	1.0–2.9		
Agree somewhat	27/38 71	4.2	2.9–6.2		
Do not agree at all	20/29 69	4.1	2.7–6.1		
Staff had adequate routines for support					
Agree completely	14/72 19	1.0	Reference	1.0	Reference
Agree to a large part	43/132 33	1.7	1.0–2.8	1.0	0.6–1.9
Agree somewhat	21/58 36	1.9	1.0–3.3	0.8	0.4–1.6
Do not agree at all	16/38 42	2.2	1.2–3.9	0.8	0.4–1.6

*Relative risk is the percentage of mothers not having held their babies in one category of the variable indicating staff's actions or attitudes divided by the percentage of women not having held their babies in the reference category of the variable indicating staff's actions or attitudes. 95% CI denotes 95 per cent confidence interval. Figures in the two columns to the right are adjusted for 'Staff gave enough support to see and hold the baby'.

statistically significant differences were obtained at 14 months follow-up. Another way to make the stillborn baby seem real is to collect tokens of remembrance, such as photographs, a lock of hair or hand- and footprints. In an observational study, long-term anxiety was lower among women having tokens of remembrance from their baby than

among women without these tokens (Rådestad et al., 1996a).

Among women who gave birth to stillborn babies in gestational weeks 28–37, the possible influence of holding or not holding the baby was uncertain. For example, none of the women who had not held a baby born before 37 completed gestational weeks

Table 3 Relative risk (RR) of certain outcomes comparing mothers who did not hold their stillborn baby born after 37 gestational weeks and stillborn babies born at gestational weeks 28–37 with mothers who did hold their stillborn baby.

Outcome	Not held baby > 37 weeks			Held baby > 37 weeks			RR > 37 95% CI			Not held baby 28–37 weeks			Held baby 28–37 weeks			RR 28–37 95% CI		
	n/total	%	n/total	%	n/total	%	n/total	%	n/total	%	n/total	%	n/total	%	n/total	%	n/total	%
STAI-S above 90th percentile	10/56	18	16/121	13	1.4	0.7–2.8	2/37	5	7/79	9	0.6	0.1–2.8						
STAI-T above 90th percentile	8/56	14	10/125	8	1.8	0.7–4.3	4/37	11	7/81	9	1.3	0.4–4.0						
CES-D above 90th percentile	9/54	17	11/120	9	1.8	0.8–4.1	0/37	0	9/81	11	0.0	$p = 0.055^*$						
Backache, very much/not at all—to a large extent	2/59	3	6/125	5	0.7	0.1–3.4	3/35	9	8/81	10	0.9	0.2–3.1						
Stomach complaints, very much/not at all—to a large extent	6/59	10	4/122	3	3.1	0.9–10.6	4/36	11	1/80	1	8.9	1.0–76.7						
Headache, very much/not at all—to a large extent	6/58	10	3/124	2	4.3	1.1–16.5	5/36	14	4/82	5	2.8	0.8–10.0						
Tachycardia, very much/not at all—to a large extent	1/59	2	2/124	2	1.1	0.1–11.4	1/36	3	1/81	1	2.3	0.1–35.0						
Chest pressure, very much/not at all—to a large extent	1/59	2	4/125	3	0.5	0.1–4.6	1/36	3	1/81	1	2.3	0.1–35.0						
Attacks of panic, very much/not at all—to a large extent	3/59	5	6/125	5	1.1	0.3–4.1	1/36	3	1/80	1	2.2	0.1–34.5						
Nausea or fainting, very much/not at all—to a large extent	3/59	5	3/123	2	2.1	0.4–10.0	1/36	3	0/79	0	∞	$p = 0.313^*$						
Weakness, very much/not at all—to a large extent	5/59	8	8/125	6	1.3	0.5–3.9	0/36	0	4/81	5	0.0	$p = 0.310^*$						

*A confidence interval was not calculated, we give the p value for Fisher's exact test.

STAI-S, Spielberger State-Trait Anxiety Inventory; STAI-T, Spielberger State-Trait Anxiety Inventory-Trait; CES-D, Center for Epidemiological Studies Depression Scale; 95% CI, 95 per cent confidence interval.

had depression-related symptoms above the 90th percentile, whereas the corresponding rate among women who had not held their stillborn baby (> 37 weeks) was 17%. One may speculate that a mother's instinct to hold and to bond with her stillborn baby is less if the baby is born preterm. Consequently, for very preterm stillborn babies, actions (such as holding) intended to enhance attachment may not be fruitful for some women. We did not study stillborn babies born before 28 gestational weeks, and could not further disentangle the effects within the 28–37 gestational week group owing to limited precision. During this period, the baby grows rapidly and the mother feels her baby's movements every day.

Hughes et al. (2002) concluded that, for some women, holding a stillborn baby implies a risk of additional and unnecessary psychological trauma. Owing to small numbers, their findings are uncertain, and selective non-participation of a few women may, for example, have heavily influenced the findings. Their findings may also be influenced by unmeasured confounders, such as the attitude of staff and insensitive behaviour, which may produce major stressors for the mothers. Nevertheless, our data are uncertain for babies born at gestational weeks 28–37. Hughes et al. (2002) studied mothers of stillborn babies born at 18 gestational weeks or older; we have no data for babies born at 18–27 gestational weeks. Thus, presently, we have a dearth of data concerning the effects of holding a preterm stillborn baby, particularly very small babies.

We found that mothers were more likely to hold their stillborn baby if they perceived encouragement from staff by showing respect to their baby, or formally discussed holding their baby with staff. Most women who have had a stillbirth are confronted with death for the first time. Some wonder if the baby is cold, stiff or contagious (Trulsson and Rådestad, 2004). Messages conveyed by staff through speech, body language and other behaviour may influence what the mother perceives to be a normal reaction. During this state of shock, and because of the emotional turbulence caused by learning that the baby is dead, some mothers do not have the capacity to take initiatives on their own.

In our cohort, 14 (4%) of 314 women did not see the baby compared with 17 (26%) out of 65 women that Hughes et al. (2002) interviewed after the stillbirth. The difference may reflect variations in practice between Sweden and England as well as differences over time; we observed stillbirths in 1991, and Hughes et al. (2002) studied stillbirths during the 1980s and 1990s (the follow-up was

Table 4 Relative risk (RR) of not being satisfied at all with self-assessed psychological status and social situation among mothers who did not hold their stillborn baby compared with mothers who did hold their stillborn baby.

Psychological status or social situation	Not held baby > 37 weeks		Held baby > 37 weeks		RR > 37 weeks		95% CI		Not held baby 28–37 weeks		Held baby 28–37 weeks		RR 28–37 weeks		95% CI	
	n/total	%	n/total	%	n/total	%	n/total	%	n/total	%	n/total	%	n/total	%	n/total	%
Situation at home and in the family	10/58	17	16/124	13	1.3	0.6–2.8	3/37	8	9/82	11	0.7	0.2–2.6				
Dwelling	10/59	17	24/126	19	0.9	0.5–1.7	3/37	8	17/82	21	0.4	0.1–1.3				
Situation at work	22/59	37	40/120	33	1.1	0.7–1.7	10/34	29	32/80	40	0.7	0.4–1.3				
Economy	28/59	47	58/126	46	1.0	0.7–1.4	15/37	41	28/82	34	1.2	0.7–1.9				
Health	16/59	27	20/126	16	1.7	1.0–3.1	5/37	14	16/82	20	0.7	0.3–1.7				
Leisure time	14/58	24	37/124	30	0.8	0.5–1.4	8/37	22	28/82	34	0.6	0.3–1.3				
Physical fitness	44/59	75	77/125	62	1.2	1.0–1.5	22/37	59	46/82	56	1.1	0.8–1.5				
Appetite	18/59	31	23/125	18	1.7	1.0–2.8	5/37	14	13/82	16	0.9	0.3–2.2				
Temper	25/59	42	40/126	32	1.3	0.9–2.0	9/37	24	24/82	29	0.8	0.4–1.6				
Energy	30/59	51	51/124	41	1.2	0.9–1.7	11/37	30	33/81	41	0.7	0.4–1.3				
Patience	28/59	47	47/126	37	1.3	0.9–1.8	15/37	41	29/82	35	1.1	0.7–1.9				
Self-confidence	24/59	41	47/126	37	1.1	0.7–1.6	12/37	32	25/82	30	1.1	0.6–1.9				
Sleep	19/58	33	15/125	12	2.7	1.5–5.0	10/37	27	20/81	25	1.1	0.6–2.1				
Being important and appreciated outside of the home	23/59	39	34/125	27	1.4	0.9–2.2	10/37	27	21/81	26	1.0	0.5–2.0				
Being important and appreciated at home	11/58	19	21/125	17	1.1	0.6–2.2	5/36	14	9/80	11	1.2	0.4–3.4				

95% CI, 95 per cent confidence interval.

during and after a subsequent pregnancy 1–15 years after the stillbirth). The varying percentages (4% vs. 26%) probably mean that in the cohort examined by Hughes et al. (2002), co-workers' attitudes and behaviours of staff differed more frequently from a live birth than in our cohort. This difference may influence the long-term outcome in the respective populations.

In our cohort, mothers with a high level of education were more likely than others to hold their baby. Perhaps doctors and midwives are better able to communicate with well-educated mothers about what to expect after the birth. Qualitative data from Trulsson and Rådestad (2004) suggest that some mothers used the time from diagnosis of the intrauterine death to induction of labour to learn from the staff that the stillborn baby will be warm, soft and not contagious. We speculate that mothers with a high level of education may have obtained this information before the birth more frequently than other women. Moreover, a mother with a higher level of education might be more empowered to act on her own initiative, even if the staff directly or indirectly tell her not to hold her baby.

Our population-based setting and high participation rate minimises problems resulting from selection; however, we cannot exclude the possibility that non-participating women have been affected differently by holding the baby than those who did participate. Our use of anonymous self-administered questionnaires prevents interviewer-related bias. To avoid investigator-dependent selection, we reported all documented outcomes. If showing the stillborn baby respect encourages staff to support the mother to hold her baby, adjustment may be inappropriate. Thus, one interpretation of our data, using the unadjusted RR, is that showing the baby respect predicts whether or not the mother holds her baby. We were interested in the long-term psychological outcome after a stillbirth, not the expression of grief, explaining why we followed-up the women 3 years after a stillbirth.

The questions about whether or not it is beneficial to hold the baby were raised by Patricia Hughes et al., first in a paper in *The Lancet* (Hughes et al., 2002), and thereafter in an international meeting (Hughes, 2005). We therefore went back to this previously collected material, aware that no other study had data solving the question; this explains the duration between the original data collection and the preparation of this manuscript. Generalisability to other populations and calendar years may be compromised by culture-specific attitudes and reactions among mothers whose babies die before birth.

A mother needs to be guided through the process of meeting and saying farewell to her stillborn baby. The challenge for developing clinical skill in this field, as well as for obtaining scientific knowledge, is to define the boundary between beneficial guidance and harmful persuasion. If the mother is guided sensitively by staff to hold her term stillborn baby, the holding will possibly be beneficial for her in the long term.

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