# Support for Bereaved Families of Multiple Births

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**Full Text:** Headnote ABSTRACT: The loss experienced by parents following the perinatal death of a twin is often underestimated by other people and the particular problems are rarely appreciated. A Bereavement Clinic for multiple birth families provides the opportunity to discuss concerns such as incomplete information, lack of a memorial, anger, the fantasy twin, the response to the surviving child and zygosity determination. An informal lunch allows families to meet and share their experiences with other bereaved families. INTRODUCTION Since the Twins and Multiple Births Association (TAMBA) was established in 1978 we have become increasingly aware of the very particular problems faced by parents who lose a twin in the perinatal period. Their loss is often underestimated by both the professionals caring for them and by their friends. When one twin survives and the other dies, not only the bereaved but also those who care for them are faced with contradictory psychological processes. The celebration of the birth of the live baby and the increasing emotional commitment of the mother contrast with the opposing processes of sorrowful relinquishing and of coming to terms with the painful emptiness of having a dead baby (Bryan 1986, Lewis &Bryan 1988). The dead baby may seem a fantasy, particularly if no tangible memories remain. As a mother's full commitment is necessary for effective nurturing of her newborn live baby, the mourning processes may understandably be postponed for many months, even years; if not resumed later they may give rise to the various syndromes of failed mourning. On the other hand, the mother may grieve compulsively for the dead baby and be unable to devote herself to the care of the live baby. Excessive polarisation of feelings about the live baby and the dead baby may occur if she starts idealising the dead baby (her "angel baby"), especially if the surviving twin is difficult or demanding. The pride of being an expectant mother of twins is enormous and the failure to become one is therefore all the greater. The bereaved mother usually continues to think of herself as a mother of twins or triplets (Bryan 1986). Many mothers who had a higher order birth deeply resent the labelling of their surviving children as, say, triplets when they were born as members of a quadruplet set. Some like to keep close contact with their local Twins Club, not least because the members may be alone in appreciating their loss. Others find the contact with twin children too painful. THE CLINIC In order to try to improve the support given to bereaved parents of multiple births a three monthly Bereavement Clinic was established in 1988 at Queen Charlotte's and Chelsea Hospital in London. The clinic continues all day and three individual appointments of an hours duration are held in the morning and three in the afternoon. The most important part of the day is the lunchtime meeting which often continues until late in the afternoon. Families attending the clinic include those who have had miscarriages, stillbirths, neonatal deaths, sudden infant deaths and later childhood deaths. In approximately 25% of the families both babies have died. The lunchtime meeting is run by the coordinators of the three Bereavement groups, one for the loss of a newborn twin, one for the loss by sudden infant death and the third for the loss of both twins including miscarriages. A buffet lunch is provided for parents and children. All the parents have chosen to introduce themselves, their dead child and sometimes also their surviving child to the group. A short talk is sometimes given by a visitor, either a representative from a bereavement organization or a bereavement counsellor. Books and general information are available. During the first year 25 parents have had individual appointments to discuss unresolved questions or worries. Some of the particular problems that they voiced included: 1. incomplete information-for example about aspects of twinning such as the foetofoetal transfusion syndrome. 2. the need to create a memorial-several couples were sad that they had no memorial of their twins, particularly those that were miscarried. One mother, a writer, never saw her 22 week gestation twin daughters. Three years

later she was still unable to work because of her unresolved grief. A memorial service was arranged and the babies were baptised 'by intent'. A month later she had resumed her writing. 3. anger-several mothers still felt angry with their doctors. One mother, four years after the intrauterine death of one twin, was still bitterly angry with her obstetrician. With help she wrote to him listing her complaints which were mainly related to his insensitivity to her feelings after the baby's death. She received no reply but seemed greatly relieved to have expressed her anger and was comforted by the thought that he might at least be more sensitive to other mothers in the future. 4. substantiation of a fantasy twin-one mother was unable to distinguish in her mind the dead baby from the live and was doubting its very existence. Unfortunately it was not possible to find a photograph of the ultrasound scan to show the two foetuses. For others a photograph of the two babies together is important. If one baby is stillborn and the other survives a photograph of the two together may not be desirable but there are a number of artists who are prepared to make a sketch of the two babies together from two separate photographs. 5. zygosity determination-one couple was very anxious to know whether their twins had been identical. Details of the placenta were available giving conclusive evidence of monozygosity but these had not been given to the parents. 6. consideration of a selective reduction in a quadruplet pregnancy-a couple had been offered a reduction of the pregnancy to twins which meant the killing of two 12-week healthy fetuses. Sometimes is is helpful for a couple to have a third person to discuss the many arguments for and against this procedure particularly if they are each seeing it from a different viewpoint. 7. the response of the surviving child-several parents wanted to discuss how they should tell the surviving twin about his brother or sister. Some parents welcomed help with actually explaining to the child what had happened. Families are only allowed an individual appointment on one occasion. Those who need more should be receiving more regular help from someone nearer their own home. But all families are welcome and encouraged to regularly attend the lunchtime meetings where they continue to receive support from other parents. The pediatrician is always present to respond to any specific questions. For many parents this is their only opportunity to meet others who share their experiences and really understand the intensity and complexity of their grief. SUMMARY Parents who lose a twin face particular problems. A bereavement clinic with a mutual support component has been established to try to provide the necessary support. References REFERENCES Bryan, E.M. (1986) The death of a newborn twin: how can support for parents be improved? Acta Geneticae Medicae Gemellologiae (Rome). 5, 115-118. Lewis E. &Bryan, E.M. (1988). Management of perinatal loss of a twin. British Medical Journal 297, 1321-1323. AuthorAffiliation Elizabeth Bryan, M.D. FRCP, DCH AuthorAffiliation Elizabeth Bryan is a consultant pediatrician and the Medical Director of the Multiple Births Foundation. She was a cofounder of the Twins and Multiple Births Association and established the first Twins Clinics in the U.K. She has written two books The Nature and Nurture of Twins (Bailliere Tindall 1983) and Twins in the Family (Constable 1984). She may be reached at the Multiple Births Foundation, Queen Charlotte's and Chelsea Hospital, Goldhawk Road, London W6 OX G, England.

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