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The Challenges of Expecting, Delivering and Rearing Triplets

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Abstract. Twenty-one couples with complete sets of triplets aged between four and six years were interviewed about their experiences of being "triplet parents". The diagnosis of triplets had been a shock for most. All triplets were born prematurely, the mean birth weight being 2,000 g. The first time at home was chaotic for most of the parents. They spent more time organizing and arranging their day and less time on emotional care than did parents of single infants. Growing up as a triplet, with constant competition for attention, stimulation and love from the mother (parents), differed a great deal from the situation for singletons and twins.

The early relationship between mothers and triplets must be managed differently from that between mothers of singletons and twins. The study shows how important it is for obstetricians, paediatricians and other professionals to understand the specific needs of these families.

Key words: Triplets, Triplet Pregnancy, Parental reaction, Mother-infant relationship, Siblings

INTRODUCTION

The incidence of triplet births has increased in Sweden [10] and in other countries, mostly due to an increased use of ovulation induction and/or assisted conception procedures [2, 7, 8]. Triplet pregnancies are associated with several complications, particularly premature delivery. Although the chances of a successful outcome have increased as a result of early diagnosis, good obstetric management and neonatal care [8, 12], triplets still run the risk of physical and psychological problems [1, 11].

In a previous study, we reported on the physical and mental development of a group

of triplets [1]. This paper aims to give deeper insight into the overall living conditions of triplet families, with special emphasis on what the parents see as the most challenging problems.

MATERIAL AND METHODS

Twenty-one families with complete sets of triplets born between 1986 and 1989 were invited to participate in the study. (We excluded families in which any of the triplets had died). For practical reasons, we chose families who lived less than 200 km from Stockholm. Four families declined to participate. (They did not differ from the study group with regard to perinatal outcome). Thus, the study group included 17 families, all apparently in good socio-economic conditions. Ten of the pregnancies were spontaneous and seven resulted from various types of assisted conception. The triplets' average age at the time of the study was 4 years and 5 months (range 3 years and 9 months – 6 years and 2 months).

After completing the neurological and psychological assessments of the children, a semi-structured interview, usually with both parents, was performed. The interview included questions about the pregnancy, how and when the diagnosis had been made and about their recollection of the delivery. We then asked about the time at home soon after the infants' birth and life afterwards, up to the present time. In many cases the triplets and their siblings participated and gave their views about being triplets and siblings of triplets. The interviews were audiotaped.

RESULTS

Diagnosis

All of the families had planned to have one child, perhaps two, but none had wished or expected to have three. In pregnancies where the conception had been spontaneous, diagnosis of the triplets was entirely unexpected. On the contrary, all parents who underwent assisted conception knew the risk of having more than one baby, but none of them had taken in this information emotionally. Some of them felt that they had not received enough information regarding the risks involved in the hormone treatment.

Thirteen of the women were informed about the diagnosis of triplets before the 18th gestational week. One woman received the information in the 28th week and three at the time of delivery. Of these three women, two were expecting to have twins.

Two of the women were told about it in the absence of their husbands. All the parents felt it came as a shock. Several of them thought that the information was given without empathy (at the time of the ultrasound examination).

Pregnancy and delivery

The pregnancy had been physically and mentally very stressful for all the women. In most cases (n = 14), the nausea associated with the pregnancy was more severe than they had expected and spoiled much of the joy of being pregnant. The multiparous women

(n = 10) experienced the nausea as being greater than during their earlier pregnancies. Three women suffered from severe oedema and one had hepatosis. Early contractions of the uterus were frequent as also was physical fatigue. The increase in weight, difficulties in lying down and the enlarged uterus made many of the women feel that their situation was unbearable during the last months. Only three women had a relatively uncomplicated pregnancy.

The deliveries took place at 11 hospitals. Gestational age at delivery varied between 33 and 36 weeks, with a mean of 34.7 weeks. The birth weights varied from 1,290 to 2,670 g (mean 2,003 g). Three women delivered vaginally and thirteen by caesarean section (CS). One woman was delivered of the first child vaginally and of the other two by CS. Five women required an emergency CS, all of whom felt cheated by the delivery procedure. Some of the women delivered by elective CS were also unprepared for the procedure. The most frustrating experience was that the delivery seemed to be more of an event for the hospital staff than for themselves. The number of doctors, nurses, midwives, photographers and others who invaded the delivery room was estimated to be between 15 and 20. Two couples had observed a clergyman outside the delivery room, a very frightening experience. They had not been told why he was there, and therefore thought there was a risk that their babies would die. However in these hospitals it was a routine procedure for a clergyman to be present at multiple births.

Care of the newborns

Immediately after delivery, the newborns were taken to a neonatal care unit. Often it became the father's task to accompany the babies to this unit. Some mothers were not well enough to visit their children until one day later. Many of the mothers experienced the contractions of the uterus after the delivery as extremely painful. Most of the triplets had to stay a long time in the neonatal care unit (median 4 weeks, range 2-8 weeks). With a few exceptions, all the triplets were fed through a tube during the first days. During this period, half of the mothers received advice and encouragement concerning breast-feeding. The others were told that breast-feeding would be too troublesome, and should be avoided. Consequently, eight mothers did not breast-feed at all, six nursed their triplets for a short period (one to eight weeks) and only three mothers nursed their infants (partially) for up to five months. Some of the mothers pumped their breasts and bottle-fed their babies for a short period, but they all soon gave this up. Feeding, generally, was very stressful.

The first phase at home was chaotic for most of the triplet families. Feeding and diaper-changing occupied their time day and night. They had very little time for rest. All the families concluded that the only way to manage feeding and diaper-changing was to do it at regular hours:

> *"If one of the babies woke up at night, we woke the other two up as well, so that we could feed them at the same time."*
>
> *"The baby who cried loudest was allowed to start. That was the one who took what he needed and wanted from the start."*
>
> *"We never let the children decide and they were always nursed by the clock - we continued the routines that started at the hospital."*

How to live with triplets

A triplet parent in Sweden is entitled to 540 days of paid sick leave and an additional 270 days with an allowance of 8 dollars a day. The parents' first time at home was busy, organizing and structuring life in every respect. Most of the fathers tried to stay at home as much as possible. Three of them ran their own businesses and found it difficult to be at home. In those cases the grandparents were able to help.

Support from the local community varied greatly between the families. Several parents felt that they had to plead for the support they needed. A great problem was that home-helpers often were unqualified, and many of them had no experience of children. Some families had several helpers. Those families frequently felt the support to be more a burden than a help. Only two of the families felt that they had received sufficient information in advance about the possibilities of getting financial assistance and help from the local community.

The noise level was very high in most of the families. One mother said that the children disturbed one another and that the relationship between them affected their individual development. They could never find peace and quiet. At the same time, the children seemed to be very much afraid of being "left out". In one of the families the children always told a parent when they were going to the toilet. In another family one could constantly hear sounds from the toilet, as if the children wanted the parents always to hear where they were.

When the children grew older, the strong feeling of, "having one another", never being alone and always having a playmate, became apparent. Even if they often quarrelled and fought, no outsiders were allowed to interfere.

During interviews with the parents, both the triplets and their siblings took part in the discussion. At the time of the study, ten of the families had older children, one family had a younger child and two of the mothers were pregnant again. These last mothers wanted to have a single child just to have the feeling of giving that child undivided attention. All the parents were aware of the difficult situation for the siblings. The child who had previously received all the attention suddenly not only lost the attention of the mother, but also of many of their friends. As it was always very messy at home, they avoided taking their friends there. They were never left in peace because of the triplets. When adult friends came to visit the families, the triplets received all the attention, while the siblings felt very "left out".

DISCUSSION

Triplet births are rare and documented experiences of becoming a triplet parent are few [4, 9]. Only families with all triplets alive were included intentionally since we wanted to focus on the parents' and children's (including siblings) experience of living in a complete triplet family. When a triplet has died it may have been due to medical complications which might have affected even the surviving children. Bereavement also affects parents and children directly in the sensitive, early bonding period.

Children in this study were examined by a paediatric neurologist and no major physical disabilities were found [1]. The Griffiths Mental Development Scales (GMDS)

showed a trend towards lower quotients for triplets with a birth weight less than 2,000 g. Unlike what is usually found in singletons and twins, there were no differences in mental development between the triplet boys and girls. Thus, physical and mental development did not differ much from findings in twins and singletons of the same age and with the same birth weight. These factors placed our families in a better psychosocial situation than many other parents expecting triplets.

In cases diagnosed early, the shock and reaction phase was usually described as short, lasting hours rather than days. The reorientation phase rapidly focused on the safe continuation of the pregnancy. At the same time, no family reported worry at the thought that their children would run a greater risk of being born with a disability. Their concern centred on practical matters, such as getting enough housingspace and money. The short course of this crisis reaction notably is related to the selection of families having complete and healthy sets of triplets.

Although sick leave and hospitalization were used in the hope of carrying the pregnancies towards term, it is a fact that all triplets will be born prematurely. The problems about "bonding" to a premature child are well known [4], but all the families said that they felt inadequately informed about these aspects by the paediatrician. Despite this, most seemed to have been able to cope. As is the rule in Sweden, all were actively involved in the early postnatal care of their infants. Obviously parents-to-be endlessly need continuous information during the pregnancy, about what may happen to them, the risks, how a triplet delivery is managed, what a CS means and how to cope with three babies at the same time. Winnicot talks about "primary maternal occupation" [13], meaning that pregnancy is a preparation for empathy and identification with the child.

After birth, other problems arise – if the mother is "good", she will be able to offer a breast which is for the child's "being and not doing". Guntrip [5, 6] describes the good mother as one who understands the child's emotional needs and is able to let children feed and enjoy feeding at their own pace and fall asleep quietly at the breast. They simply let the child rest peacefully and quietly in their arms. In contrast, the busy, organizing, dominating mother is always in a hurry, her attitude is that the child should be fed according to a set schedule made up by herself. In the first case, the infant will have an experience of simply being – safely and quietly. Bryan points out [3], since few mothers produce enough milk to satisfy three babies, they may become frustrated. Triplet mothers therefore must be given expert advice about nursing.

For practical reasons it was impossible to meet the individual child's need for a certain rhythm. All the parents knew this and expressed their sense of short-comings in this respect. This became most noticeable when the husband was at work and the domestic helper had left the home. When this occurred (mostly in the afternoon), all three babies cried and all wanted to be near the mother. Fear of inadequacy preoccupied most parents. This corroborates findings by Goshen-Gottstein [4] and Robin [9].

Although Sweden has generous rules for parents' allowances and parental leave for both parents, the standard support is not sufficient. Triplet clubs exist, but most parents lack time for such activities during the first few weeks after delivery. For this reason help from the community becomes very important. Since each family has its own social network, it is essential that early contact is routinely established between parents, child welfare staff and social authorities. Thus the details of help can be agreed on before the

triplets are born. However the needs may differ. One family may benefit from the help of a trained paediatric nurse, another may only need domestic help.

We had the distinct impression that the triplet fathers were competent, close to their children, and very much involved in their daily care. We ascribe this to the fact that these fathers were obviously necessary and irreplaceable during the early life of their children.

The older sibling constitutes a special problem [3]. After having previously enjoyed the individual attention of his parents, he suddenly finds them wholly preoccupied with the new arrivals. He loses not only much of his parents' time and attention, but that of his friends, too. At home it is noisy, and the smaller children don't leave him alone. He gets the feeling that the triplets are favoured by visitors, and the triplets get most of the attention in the surroundings. This makes him feel isolated. Stewart summarizes that higher order births may have a profound effect on the emotional development of the children and their siblings [11].

As there is a need for the triplets to separate and to form personal, external relationships, we intend to continue our study by making new assessments of the children at school age.

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REFERENCE

1. Alin Åkerman B, Hovmöller M, Rådestad A, Thomassen P (1995): Physical and mental development in four-to six-year-old triplets. Acta Pœdiat 84: 661-6.
2. Botting BJ, MacFarlane AJ, Price FV (1990): Three, Four and More: A study of Triplets and Higher Order Births. London: HMSO.
3. Bryan E (1992): Twins and higher multiple births. London: Edward Arnold.
4. Goshen-Gottstein ER (1980): The mothering of twins, triplets and quadruplets. Psychiatry 43: 189-204.
5. Guntrip JS (1968): Schizoid phenomena, object relations and the self. London: The Hogarth Press.
6. Guntrip JS (1971): Psychoanalytic theory, therapy and the self. New York: Basic Books.
7. Levene M, Wild J (1992): Higher multiple births and the modern management of infertility in Britain. Br J Obstet Gynœcol 99: 607-13.
8. Lipitz S, Reichman B, Paret G, Modan M, Shalev J, Serr DM, Mashiach S, Frenkel Y (1989): The improving outcome of triplet pregnancies. Am J Obstet Gynecol 161: 1279-84.
9. Robin M, Bydlowski, Cahen F, Josse D (1991): Maternal reactions to the birth of triplets. Acta Genet Med Gemellol 40: 41-51
10. Rådestad A (1991): Trilling-och fyrlingfödslar i Sverige (Triplet and quadruplet births in Sweden). Nordisk Medicin 106: 297-8.
11. Stewart A (1991): The long-term outcome. In: Harvey, D. & Bryan, E. (Eds) The stress of multiple births. London: Multiple Birth Foundation. Queen Charlotte and Chelsea Hospital.
12. Weissman A, Yoffe N, Jakobi P, Brandes J, Paldi E, Blazer S (1991): Management of triplet pregnancies in the 1980s – are we doing better? Am J Perinatol 8: 333-37.
13. Winnicot, DW (1971): Playing and Reality. London: Tavistock Publication.

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