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# Pregnancy loss

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Women who lose desired pregnancies by miscarriage, stillbirth, or genetic termination are at risk of suffering from grief, anxiety, guilt and self-blame that may even present in subsequent pregnancies. It is important to find effective means of helping women deal with these losses. The approach to stillbirth has shifted from immediately removing the child from the mother to encouraging the parents to view and hold the baby. This approach has been questioned as possibly causing persistent anxiety and post-traumatic stress disorder. Women who miscarry are currently encouraged to find ways to memorialise the lost fetus. Couples who decide to terminate a pregnancy after discovering a defect may deal not only with sadness but also guilt. Immediate crisis intervention and follow-up care should be available, recognising that individual women may experience different reactions and their specific post-loss needs must be assessed.



## Introduction

The loss of a desired pregnancy by miscarriage, stillbirth or termination for genetic indications can result in grief, guilt, self-doubt, anxiety and post-traumatic stress disorder (PTSD). These losses may result in immediate and long-term psychological consequences. Caregivers need to identify the best practices for managing women and their partners who have experienced such losses. Recent research has raised questions about the efficacy of practices that have become the standard of care in many settings.

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## Miscarriage

Miscarriage or spontaneous abortion is defined as an unintended termination of pregnancy resulting in fetal death before 20 weeks of gestation. The overall incidence is 15–20%; 27% in women between aged between 25 and 29 years and 75% in women aged over 45 years [1]. About three-quarters of losses occur before week 12. Although the causes of these losses are numerous, in the case of a first or second miscarriage, causes are seldom investigated and often remain unknown.

Early symptoms of miscarriage generally include vaginal bleeding and pain. An ultrasound can confirm the pregnancy is no longer viable. If the fetus has not been expelled, there are three types of management. In expectant management, the miscarriage is left to proceed of its own accord. Surgical intervention involves the removal, often under general anaesthetic of retained products of conception. In the medical approach, medication induces uterine contractions to expel the tissues. As Neilson [2] found that women are equally comfortable with all of these methods, women should be allowed to make their own choice.

### *Psychological effect*

Early in miscarriage, as women begin to develop cramps or bleeding, they may experience anxiety, fear, helplessness and feelings of loss of control [3]. The actual incidence of grief after miscarriage is unknown. Beutel et al. [4] found that 48% of the 125 women they studied had no change in their emotional reactions; however, most studies agree that many women experience sad feelings or grief in the first days after the loss. This grief may be intense and similar to that experienced after any other significant loss [5]. The distinctive quality about miscarriage grief is that the focus is on the anticipated future and what might have been rather than on memories [5]. It also commonly includes feelings of guilt or self-blame. Most studies show a gradual decline in grief over the first 6 months after loss [4].

A number of studies have reported an increase in depressive symptoms after miscarriage. Neugebauer et al. [6] found that, in the early weeks after a loss, 36% of women had moderate to severe depressive symptoms that gradually decreased but still were elevated by 6 months. Robinson et al. [7] found levels of depressive symptoms at 6 months that were lower than reported just after the miscarriage but still elevated (10.9% *v* 4.3% for controls) and remained high at one year. It was not clear whether the elevated levels at 1 year represented a sustained level of distress or an anniversary reaction. Some women experience an actual major depressive disorder. Neugebauer et al. [8] reported that 10.9% of his miscarrying group experienced a major depression in the first 6 months after loss, a relative risk of 2.5 compared with a comparable community group.

Women at highest risk of having depressive symptoms are those who have a history of major depression [9]; are childless [10]; are highly invested in the pregnancy [11]; or are concerned about being infertile. Women who were already pregnant at follow up were less depressed than those who were not [12]. No relationship has been established between intensity of grief and maternal age, social class, or previous therapeutic abortion [8]. Reports of the relationships between symptom intensity and length of gestation [5], partner support, marital or family problems, and history of previous miscarriages are inconsistent [11].

Anxiety can also be a major reaction to miscarriage. A significant number of women report elevated levels of anxiety up to 6 months after miscarriage, and may also be at increased risk for obsessive–compulsive and PTSD [13]. Nikcevic et al. [14] found the anxiety is largely focused on concerns about the cause of the miscarriage and risks in future pregnancies. Robinson et al. [7] found that the anxiety experienced often seemed worse than the depression. A total of 41.2% of the women who had miscarried felt the loss was partly their fault, and 22.6% felt others blamed them; 85.3% felt stressed; 77.6% found the miscarriage was as great as any previously experienced stressor. Many felt dissatisfied and angry with the care they had received from medical personnel.

Many women have little support for dealing with the results of a miscarriage. Health professionals may fail to acknowledge the effect of the loss, treating it as a medical event only and minimising the psychological effect. Lack of investigation into the cause of the miscarriage may leave women feeling insecure and anxious about a subsequent pregnancy.