

Pregnancy loss: a major life event affecting emotional health and well-being

Comprehensive management of pregnancy loss is enhanced by psychological support and follow-up counselling

IT IS GENERALLY ACCEPTED that 12%–15% of confirmed pregnancies do not progress to term, with the risk of pregnancy loss increasing with maternal age. In particular, early pregnancy loss (< 20 weeks' gestation) is experienced by one in four women. In about half these women, a medical explanation can be found,¹ although, in clinical practice, investigations to identify the cause are rarely pursued. Most women go on to have successful subsequent pregnancies, although there is a slightly increased risk of a second miscarriage that increases incrementally with each subsequent loss.¹

Although early-pregnancy loss is relatively straightforward medically, the psychological outcome is more problematic and the grieving process is complicated.² First, there is no tangible life or memory to grieve. Instead, the woman has to come to terms with grieving for a *potential* life with all its hopes and aspirations. Second, the grieving is often complicated by feelings of self-blame, particularly when there is no medical explanation for the loss or the woman has engaged in potentially hazardous behaviour (eg, alcohol consumption or smoking). Her partner may also harbour feelings of responsibility for the loss.

Other factors which may influence the grieving process and the emotional outcome include miscarrying later in gestation (especially if the woman has felt the fetus move and formed an emotional attachment to it);^{2,3} the importance and meaning of the pregnancy (eg, a first, wanted pregnancy lost near the end of the reproductive lifespan); and the difficulty experienced in conceiving the pregnancy (eg, an assisted conception). Finally, psychosocial factors, such as a woman's support network (especially her intimate relationship) and her personality style and culture, will affect how she appraises her loss and her level of distress.

The psychological sequelae after a late pregnancy loss and stillbirth are well described;³ those after an early pregnancy loss are similar but may not be as severe.

■ There can be high levels of psychological distress characterised by anxiety, depression and somatisation, which can persist for at least six months⁴ and are only partly accounted for by grieving for the loss of a potential child.

■ There is an increased risk of developing a depressive or anxiety disorder in the six months after a pregnancy loss, and any pre-existing psychotic disorders can be precipitated.

The risk of developing depression is high, with studies reporting rates between 10%⁵ and 48%,⁶ depending on the study methods.⁷ One of the more rigorous controlled studies⁵ reported that 10.9% of women developed major depression after a miscarriage, compared with 4.3% of women (controls) from the same community who had not been pregnant in the previous year. Depression is more likely in women with a history of depression or past psychopathol-

ogy, and in women who have had a previous pregnancy loss or have no other children. Other factors precipitating depression, such as poor social support or having a vulnerable personality style, are well recognised. The rates of anxiety disorder are lower than those for depression. Recently, exacerbation of obsessive-compulsive disorder after miscarriage has been reported.⁸ Finally, if the pregnancy loss has been traumatic (eg, an ectopic pregnancy or the woman's life was at risk), post-traumatic stress disorder can arise.⁹

The comprehensive management of pregnancy loss will be enhanced by psychological support and follow-up counselling.^{7,10} This can be provided by the woman's obstetrician, general practitioner or another health professional involved in her care, who can address medical as well as psychological issues.¹¹ The purpose is to allow open discussion about the loss, monitor progress and counsel the woman about future pregnancies. In the initial stages, she will benefit from the opportunity to talk about her loss and have her grieving acknowledged. Providing information about the normal grief process may help a woman who is masking her grief or does not believe it is legitimate. The grief process will be facilitated by the opportunity to talk about feelings of guilt and self-blame, particularly when there is no medical explanation.^{12,13} In our opinion, there should also be an opportunity to discuss dissatisfaction with medical care, as the woman may feel angry and blame her medical practitioner for the loss. An open discussion about this will help her, and may reduce the possibility of litigation.

Medical practitioners, particularly when the issue is pregnancy loss or stillbirth, are often reluctant to use the phrase "I'm sorry" because of fears that this equates with an acknowledgement of guilt and may have legal implications. Bereaved parents are often highly aware of this omission, angered by it, and may actually retaliate through litigation. Both obstetricians and insurance companies need to seriously look at the distinction between empathic expression of "sorrow" *for the distress experienced* as opposed to an apology for negligent action.

Regular follow-up is recommended for the first six months. Distinguishing between feelings of grief (which may require grief counselling) and the onset of a depressive illness (which may require specific treatment) can be difficult. Depression is suggested by persistence of depressed mood, lack of enjoyment in pleasurable activities, low self-esteem or excessive guilt, and sleep or appetite disturbance or fatigue.^{14,15} A pathological grief reaction, characterised by excessive distress, guilt feelings or a preoccupation with the loss, may require more specific counselling. Sometimes a woman may have her depressed feelings dismissed as

“grieving” and miss out on appropriate and effective treatment for a depressive disorder.

Other family members may also need psychological support. The woman’s partner may experience similar feelings of loss.¹⁶ In such situations, the father is often neglected (“men aren’t expected to talk about their feelings”). He will also benefit from an opportunity to talk about his feelings of loss, as will other children in the family, especially as they may feel responsible if they had feelings of jealousy about the new sibling.

The sense of loss may dissipate when the woman becomes pregnant again, and some studies suggest that the shorter the time between a pregnancy loss and a subsequent pregnancy the better the outcome for the woman.¹³ Such women usually feel anxious during the stage of pregnancy at which the previous loss occurred. Finally, women may benefit from the opportunity to talk to other women who have experienced a pregnancy loss through support groups such as SANDS <<http://www.sands.org.au/>>.

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Bioterrorism in Australia

How real is the threat, and how prepared are we?

THE WORLD CHANGED on September 11, 2001, and again on October 4, when the first case of inhalational anthrax in the United States raised worldwide fears of bioterrorism. Although the threat of bioterrorism in Australia has been assessed as low,¹ defence and civil authorities had upgraded preparations before the 2000 Olympics.² Those plans, coordinated by Emergency Management Australia, provided a basis for responses by state emergency services, health services and postal services to the numerous false alarms, “white powder” incidents and hoaxes that followed the US events. No anthrax spores or human anthrax cases associated with these incidents have been detected in Australia, but understandably they have caused considerable public anxiety. In retrospect, it now appears that the anthrax-containing letters in the US were probably of domestic origin, with no targets outside that country.³

After the US incidents, health departments were swamped with calls from the public asking what had been done to protect them. They wanted to know how to protect themselves, and whether they needed antibiotics, vaccines

for anthrax or smallpox, or gas masks. Health authorities emphasised communication to reassure those who were worried, as well as to provide authoritative information and planning advice about anthrax and other conceivable threats. Should a biological incident ever occur in Australia, communication would be even more important, not only in managing the emergency, but also in minimising community alarm, which could cause more damage than the biological agent itself. In any incident, healthcare agencies would play a key role in recognising resulting illnesses and managing the health consequences.

The anthrax threat has highlighted the importance of multidisciplinary approaches to biological emergencies. Security intelligence must be wedded to health intelligence, and the lessons learned from past disaster management appropriately applied. As an editorial in the *Lancet* recently said, “Appropriate reaction to such deliberate attacks, but also to any other emerging epidemic, by a well-organised and well-functioning public health system requires preparedness at all times on all levels”.⁴ Australia’s federal system