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Chapter 30

Prebirth loss and pregnancy complications

30.1 MISCARRIAGE

'Three times then/ Seeping loss/ And with each seeping/ A child becoming nothing/ An empty hollow pain/ A flushing away – / Then grief.' . . . (Miscarriage, Penny's Poem, in *Hidden loss – miscarriage and ectopic pregnancy*)

30.1.1 Spontaneous abortion

About one in six confirmed pregnancies end in miscarriage, 75% of these occurring during the first trimester and some 60% of these showing evidence of chromosomal disorders. Thus, the crisis of miscarriage often begins at home. During early pregnancy, spotting, cramps or pain may be disregarded until considerable bleeding or expulsion raise the alarm. This denial could be due to emotional ambivalence about the pregnancy, ignorance or a hope that if she ignores it 'it will go away'. With threatened abortion or gradual and prolonged miscarriage, the hopeful woman reaches an emotional watershed, after which she hopes the fetus will be miscarried as she cannot believe it would be born healthy after all the pain and profuse loss of blood.

These days of anxious uncertainty are particularly difficult for busy women and mothers who try to take bedrest in the hope of preventing the miscarriage, monitor the colour and clots in their bleeding, and blame themselves and silently question what they might have done to bring on the miscarriage, while being emotionally available to answer and appease mystified children. Nevertheless, the longer period of adjustment gives them time to 'deflate' the hopes and aspirations of pregnancy in a way that abrupt spontaneous abortion does not. After the latter, women often feel dazed and bewildered by the sudden unexplained change in their fertile status, and may be as disbelieving of the miscarriage as they were of the unseen conception.

A late miscarriage, heralded by bleeding or leakage, catches by surprise the woman who has begun to take her pregnancy for granted. The

wide circle of concerned relatives and acquaintances who know of the pregnancy will enhance her precarious sense of being at the mercy of erratic fate, and although their support can be a comfort during the long helpless days of waiting for a threatened miscarriage to settle, if she does abort, she may feel she has let them all down. If miscarriage occurs in hospital, the aborted fetus may be unceremoniously removed, usually in a bedpan, and women are not generally asked whether they would like to see the baby. Bodies may be disposed of in the hospital incinerator or macerated and, according to some reports, flushed down the 'foul drain'. Staff may feel they are protecting the mother from the sight of a monstrosity. However, their attitude of dismissal and disposal is hurtful to the shamed mother, and implies that her baby is 'an object unfit to be seen, unfit to be loved, unfit to live and not worthy of mourning' [1]. The woman too may be unceremoniously 'removed', discharged from the ward, having become an embarrassment in a place that is dedicated to producing life not death. Questions about what happened to her aborted baby may continue to persecute her in waking thoughts and dreams.

Most women feel they would like information about the cause of the miscarriage, both to reduce the sense of guilt, mystery, confusion and unfinished business about this pregnancy and to ensure that this miscarriage does not preclude another full-term pregnancy. If it occurred at home, they arrive at the clinic clutching what remains of the 'products of conception', the expelled contents of their body which they have painstakingly collected, often having had to overcome squeamishness and trepidation to do so. In most cases a woman who has miscarried is simply given a check-up or D & C but no tests are conducted on the expelled fetus (which might not even be accepted from her) and she is blandly told that 'each pregnancy is unconnected to the one before' or to 'go home, wait three months and try again'. Justification for lack of routine examinations is expense and since over 50% of spontaneously aborted fetuses are abnormal, prevention of miscarriage without commensurate prenatal screening would lead to an enormous increase in the numbers of handicapped babies born. To the woman seeking information why her baby died and whether it will happen again, it matters greatly whether this was a 'blighted' pregnancy, a hormonal insufficiency or genetic abnormality. Above all she needs to differentiate a random event from one with a cause that can be cured; she wants to know how future pregnancies may fare and whether she herself is to blame in any way. A miscarriage, like a still-birth, is a non-event. However, unlike the latter, she may be granted little recognition of her emotional condition or entitlement to any legitimate grief by relatives or professional staff. Indeed, if she has not begun disclosing it, many people may not even realize she has been pregnant. She tries desperately to make sense of her tragedy.

('I feel like a cork bobbing at the mercy of dark forces of inevitability. There is no arbitrariness to Fate. When I lost the baby, in my mind it was clearly a punishment for the abortion I'd had when I was 19. You can't get away from what you've done. It catches you up in the end.') In reality, less than 4% of miscarriages are due to previous abortions.

('With the miscarriage it was as if my parents whisked me back to the past, breaking the illusion of freedom I'd had all these past years since leaving home. I'd been so lively and happy in my pregnancy but when I came to visit them, they felt I was flaunting it defiantly and the next thing I knew I was bleeding. They killed the life in me. This miscarriage was murder, a vindictive act, their revenge on me for wanting my own independent life.') Miscarriage can follow emotional stress.

Even early miscarriage means that on some level, a bereaved woman is burying her hopes for a baby, losing trust in her body's reliability and her special connection to her partner's genetic being. In a society in which 'people tend to stigmatize the bereaved as if their loss and suffering is catching', the depth of feeling and duration of grief are often denied yet the woman who has experienced a prebirth loss needs to be granted the right to mourn, not as a 'self-indulgence or weakness', but as a 'psychological necessity' [2]. The ensuing process of grieving follows the stages of all mourning – shock, pangs of grief and search for the baby, painful acceptance of the loss and gradual recuperation. Nevertheless, miscarriage is not regarded as a 'proper' bereavement ('not like losing a real baby is it?'), although as one woman who has had seven miscarriages writes years later: 'the lost babies never let go, I can remember exactly when each one was due' [3].

30.1.2 Missed 'abortion'

The bizarre situation when pregnancy technically ends and the fetus dies *in utero* but is not expelled for some weeks, is emotionally harrowing for the mother. She may disbelieve the diagnosis, experiencing hope with every movement of her guts. Denial may alternate with grief-stricken terror at carrying a corpse inside her. She may oscillate between acceptance that she no longer feels pregnant, impatience to abort yet a morbid desire to hold onto her baby a little longer. Gradually, she begins to feel her body has become her baby's grave. Nightmarishly, unbeknown to others, she walks around with a dead 'thing' inside her, awaiting a birth that is not life-giving. She herself has not been able to sustain life. Unlike a spontaneous miscarriage, it does not seem that the baby has chosen' to reject or leave her, but that she has failed her dead child and her mate who entrusted the baby to her. Stimulation of labour may not immediately succeed, and an exceedingly painful birth results in a macerated 'non-baby' after which she is shunted off to a side ward or 'dismissed' from hospital. She has become a 'non-mother', returning with empty arms to her home with its painful reminders of joyful anticipation.

30.1.3 Resorption

This experience raises strange fantasies in the mother: she may feel she has selfishly 'digested' her baby for her own growth, or that the loved fetus has now become an integral part of her, always to remain with her. She may also have the harrowing feeling that her live body is shot through with contaminating dead matter. Where ultrasound reveals one twin having been reabsorbed, the surviving unborn twin may be unconsciously regarded as having demolished the other, eaten him/her up or greedily taken the twin's share of nourishment. This fantasy can create a prejudicial 'set' long before the surviving baby is born, labelling him/her as a 'survivor' or a 'selfish go getter', a preconceived internal image of the fetus which may persist after the birth.

30.1.4 Reactions of the partner

The male partner (or female in the case of a lesbian couple) may find miscarriage very difficult. Not receiving physical or emotional attention like the woman who has aborted, yet often suffering a similar disappointment, he is left without social acknowledgement of his plight and usually lacks opportunities among his male friends to express his grief. In addition he has not had the physical sensations that make her loss a tangible emptiness. The partner has the frustrated sense of his baby being at the mercy of his wife's body, while he, the father, is unable to ensure that she sustains the pregnancy, keeps the baby in, or even conceives again. Communication may be impaired as each partner deals alone with their complex feelings. Unconscious blame may fester in their relationship alongside unanswered questions about whose 'fault' it is, whether miscarriage was triggered by sexual intercourse or if she may be responsible for having broken some antenatal taboo or whether it occurred because of a previous abortion or is a 'blighted pregnancy' which comes from his or her 'side of the family'. Bodily disillusionment often follows miscarriage, with subsequent pregnancies being treated by both members of the couple rather gingerly and tentatively. The following pregnancy no longer can be the robust natural process of the pre-miscarriage pregnancy, and sometimes reactivates an uncompleted mourning process for the miscarried baby. Other couples may not have the courage to start another pregnancy.

It is estimated that over 6000 women or couples in the UK lose a baby through miscarriage every year according to the Health Education Council. Some of these may benefit from outpatient counselling from

their obstetrician or GP. Others might wish to join or create a self-help group and women who have experienced a traumatic or repeat miscarriage may benefit from contacting a support group such as the Miscarriage Association to attain a better understanding of the problems associated with their miscarriage. Psychotherapy might be requested by women whose complex feelings preclude considering a further pregnancy until this interrupted one is resolved [4].

KEY POINTS

*Miscarriage, particularly in late pregnancy, can constitute a major life event for a woman and her family. Information about the cause of loss reduces the generalized sense of guilt and confusion and facilitates healing, so that the next pregnancy is not hampered by unresolved painful issues from this abortive one.

*'Missed abortions' involving a long wait for the dead baby to be expelled are harrowing for the bereaved mother who needs help to tide her over this period of carrying death and undergoing a fruitless birth.

*Similarly a life-threatening event, such as an ectopic pregnancy, confronts the couple with dangerous aspects of creativity, with the need to evaluate whether to take the risk of another attempt to have a baby, and indeed, the possibility that reproductive capacity has been technically impaired. During the long interim period of waiting for the all important 'verdict' on their fertility the woman, and her partner too, may need therapy to come to terms with the shock of emergency and drastic shifts in their identities.

*After a miscarriage, the interrupted psychological process of pregnancy is replaced by a new process of accommodating to loss, not only loss of the baby and all the hopes and expectations invested in it, but loss of the pregnancy and disruption of the fertile aspects of the woman and her sense of femininity.

*The social and professional 'conspiracy of silence' and discomfort about death before birth, often prevent the bereaved woman/couple from expressing grief once initial numbness has passed. Yet mourning for what is gone is necessary to make place for future creativity. Grieving the gap created by the absense of a baby never encountered is difficult, and may be helped by making the loss more tangible – through ritual, by seeing and/or naming the baby, writing fantasies about him/her, talking about the sensations of pregnancy as well as the events of the miscarriage – thus constructing memories of a precious experience rather than a 'non-event'.

*Despite yearning for a baby, unresolved self-blame and marital conflicts may lead to sexual difficulties and fear of becoming pregnant again, as do underlying guilt about having 'failed' the baby or partner and resentment about being singled out by fate or 'rejected' by the baby.

*Pregnancies following miscarriage are inevitably accompanied by a loss of trust in the body's natural capacity to function unmonitored, and a high level of tension and vigilance are to be expected. Partners, too, may need help in resolving issues of frustration, blame and anxiety.

30.1.5 Ectopic pregnancy

When implantation has developed outside the uterine cavity, the woman, experiencing symptoms of nausea or breast enlargement, suspects conception yet may receive a negative pregnancy test result. In such cases, the crisis of ectopic pregnancy poses a double disillusionment – the life-threatening shock side by side with the belated discovery of pregnancy now obsolete. Once the immediate surgery and risk are over, the patient, particularly one who has had difficulty conceiving, may feel emotionally cheated of her brief pregnancy which she did not even experience as such. She may have irrational feelings of anger towards her lover who 'put the baby in the wrong place' or guilt about her own lack of provision of a roomy and safe place for the pregnancy to grow. Nightmares and fantasies about the cramped doomed baby are part of a process of coming to terms with her own strangled hopes and a pregnancy that was but was not ('the ectopic pregnancy just confirmed what I always felt – that I had bad insides. It's left me with a great void of loneliness and guilt. As if I was careless with a treasure I didn't even know I had'). Although young (40% of cases occur between 20 and 29 years), her prognosis for a future normal pregnancy is fraught with risk, and the woman may feel doomed to fail. If she was aware of the pregnancy, her reaction will be similar to that following miscarriage yet coupled with the existential shock of having been so close to a brush with Death. Her partner, too, stunned by the threat of losing his woman, may weigh up the desire to have a baby with the danger of another ectopic pregnancy. On the positive side, there is a greater chance of being accepted for IVF because the ectopic pregnancy is proof of fertility despite damage to tubes.

30.2 HIGH-RISK PREGNANCIES AND MEDICAL COMPLICATIONS

30.2.1 Living with latent emergency

Chronic anxiety often accompanies conditions requiring special medical attention, bed rest or hospitalization during pregnancy, whether for threatened abortion, coexisting medical conditions or pregnancy complicated by hypertensive syndromes, threatened premature labour or placenta praevia. Not only is the pregnant woman removed from her ordinary daily routine but must be continuously vigilant for warning

signs of impending crisis. The latent emergency of a high-risk pregnancy and potential high-risk infant poses a real psychological threat as physical disequilibrium tends to create additional stress, heightening the woman's anxiety and fear [5]. She feels responsible for the two lives in her body, living a restricted and cautious life yet helplessly unable to influence her physical condition. If she has other children at home, she is acutely aware that hospitalization with this baby restricts her availability to her other children as she dwells on the effects of separation and maternal deprivation. In planning nursing management, her physical needs must be weighed against the emotional needs of the entire family necessitating careful evaluation of the possibility of maintaining home-based bed-rest with appropriate medical care and domestic help.

Women suffering from pre-existing conditions such as heart disease or one exacerbated by pregnancy such as diabetes, not only have to contend with all the complex processes of pregnancy but also with monitoring and management of a serious, possibly life-threatening disorder. The patient and her family naturally become extremely dependent on professional help for informative communication, guidance about management and decision-making. The adaptive processes in this critical situation have been found to follow the usual sequential pattern of coping mechanisms, beginning with rationalization and denial of the crisis, followed by depression, disorganization and finally acceptance [6]. While she 'rests' in bed, the woman's mind is not at rest but plays out the internal scenario in a series of fantasies related to what she imagines is happening within:

a. Hypertension may be interpreted as an internal emotional conflict with the fetus raising her blood pressure.
b. Toxaemia may be unconsciously regarded as her being poisoned by the baby or vice versa and thus playing on the fantasy tandem of good mother–bad baby or bad mother–good baby contamination.
c. Placental insufficiency may be imagined as the greedy baby outstripping the placental supply or the stingy mother withholding what the baby needs for growth.
d. Anaemia may be guiltily experienced as a result of her own iron-impoverished diet or blamed onto the demanding fetus who has depleted her iron stores.

Once again, a sense of failure and inadequacy usually accompanies these syndromes, as the mother feels she is letting down her baby and partner by being unable 'simply' to be pregnant and have a baby like everyone else. As she fearfully awaits the birth, she tries to prolong this very uncomfortable and anxious time, rationalizing that every additional day in the womb brings the fetus closer to maturity and survival, yet paradoxically, she feels that their ongoing close proximity keeps them both in danger.

30.2.2 Threat to fetal health

Where a mother is incapacitated with infections such as rubella, she has the additional guilt of having introduced an extraneous factor into the pregnancy, not only endangering her own health but possibly threatening the fetus and having a long-term deleterious effect on the baby's development. The additional worry about whether the drugs that cure the mother harm the baby, highlights their symbiotic inter-dependence while the threat of abortion emphasizes the nature of their separateness. Venereal infections carry the added burden of stigma and risk of punitive professional disapproval when seeking help. The woman herself guiltily feels she is transferring the fruits of her dangerous sexuality to the innocent victim of her creative sexuality. AIDS is a particular case in point where an HIV positive woman unwittingly may transmit the illness to her fetus. Less dangerous but also guilt-arousing threats are mothers who cannot control their substance intake of drugs nicotine or alcohol yet know that their behaviour is potentially damaging the fetus. In some mothers' minds, the baby is being put to the test and exposed to the worst she can offer to see whether the baby is 'strong enough' to resist her destructiveness. Far from being complacent, each drink or fix may be experienced as a battle between the 'forces of darkness and light' with the fetus often playing the part of innocence being corrupted or Good that will survive the onslaught of Evil. A woman who makes a suicide attempt during pregnancy will continue to experience guilt and fears of having damaged her baby (especially if she overdosed), long after the depression has lifted. Attempts at self-induced abortion or distress due to physical assaults on the fetus by the father have been documented [7]. All these factors are discussed in greater detail in Chapter 33.

30.3 ACCESS TO THERAPY

Many women suffering from chronic anxiety during pregnancy would welcome the opportunity to talk about their tumultuous feelings and stress-related concerns with a trained professional therapist. The pregnant woman at risk needs someone to 'keep vigil' with her during the long wait until the 'moment of truth' when the birth will reveal whether the baby has been affected by the mother's condition. She would benefit from having help to ease her difficult 'journey' by working on psychological factors influencing the physical condition or resulting from it [8]. Following a miscarriage or ectopic pregnancy, women or couples may need therapeutic intervention, especially if fertility may have been impaired. Similarly, women suffering from infectious diseases, chronic medical conditions or addictive disturbances may need help. Such

intervention can be very rewarding. Since, as noted previously, in her state of heightened awareness and greater accessibility to unconscious material, the pregnant woman is amenable to psychotherapy and is usually highly motivated to 'sort herself out' before the birth [9].

30.2.4 Multiple pregnancies

A woman expecting two or more babies is having to meet greater physiological demands on her body during pregnancy. Discomfort is greater and the risk of premature labour, lower birth weight and perinatal mortality are increased; at times, these are combatted by hospitalization and bed rest during weeks 32–36. Psychologically, the mother-to-be has the complicated task of accepting a dual or multiple pregnancy. Routine ultrasound screening, repeated following first trimester bleeding, reveals that five times as many twins are conceived as are born. Physical resorption of one twin means that a mother who has been expecting two babies, has also psychically to resorb the vanished twin and adjust to one rather than two babies.

Where diagnosis is complicated, a mother may only receive news or confirmation of multiple pregnancy as late as the sixth month and suddenly finds that the baby she has been anticipating is not unique but has 'split' into two. Prenatal bonding with two or more unknown babies is more difficult unless the mother projects quite different fantasies 'into' each of her babies, articulating and heightening perceived or imagined differences between them. Sex differences revealed by ultrasound or amniocentesis may foster gender stereotyped fantasies. If the mother herself is one of twins, she may select one of her babies to represent herself. However, lacking differentiating 'tags', the mother may continue to relate to both babies as 'the same', two 'peas' inside her 'pod'-like uterus. At times she herself feels 'left out' by the twins who provide each other with company inside her, taking the nourishment they need from her but having fun without her [10]. Like her partner, she may feel excluded from immediate contact with the babies who have such intimate close physical contact with each other. Thus, a division between generations may be set up already at this point, with the parents forming one unit and the babies another, rather than the mother-baby as a unit, or a triangle of asymmetrical relationships (including the father) such as might occur in single births.

KEY POINTS

*Pregnancies following miscarriage are accompanied by a loss of trust in the body's natural capacity to function unmonitored. Partners, too, may need help in resolving issues of 'blame' and 'guilt'.

*The medical term 'abortion' offends miscarrying women.
*High-risk pregnancies entail living in a chronic state of high tension and anxiety about a possible emergency developing. Relaxation technique and biofeedback may be useful in offering the woman more control over a prolonged uncertain situation and to stall premature labour.
*Nursing management and hospitalization plans must weigh up the physical needs of the woman against the emotional needs of her family, particularly if she has young children. Home-based bed-rest should be considered where appropriate help can be made available.
*On an emotional level, conflicts and guilt about retaining their potentially dangerous mutuality affect the mother's prenatal bonding to her baby. Fears about exacerbation of her own condition as a result of the pregnancy, and/or dread of possible miscarriage or fetal abnormality add to her already considerable endurance test. These anxieties can be helped and contained by counselling or psychotherapy.
*Conditions of psychological vulnerability, depression, excessive anxiety and frank disturbance benefit from prompt treatment during pregnancy.
*Ultrasound diagnosis of multiple pregnancies allows the couple time to adjust to the idea, and discriminatory prenatal bonding may be facilitated by naming the fetuses and identifying them as separate on the screen and in movements.