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Unexpecting: mental health after pregnancy loss (miscarriage, trauma, and how healthcare providers contribute to disenfranchised grief)

Abstract

Miscarriage affects millions of women annually. The frequency of which miscarriage occurs, and the *ease* associated with the medical management of miscarriage has meant that a miscarriage is now considered a common pregnancy complication.[1] Due to the perceived simplicity in medical management during a miscarriage, providers often neglect the mental healthcare of the mother during such a traumatic loss.[2] Healthcare should be all-encompassing,efficient, effective, and humanistic, guiding patients through their treatment with physical and mental care. The medicalized view of miscarriage does not consider the physiological and psychological trauma, grief, and distress experienced by women following a miscarriage.[1,2] Thisarticle will show that depression and post-traumatic stress disorders (PTSD) are common after a miscarriage, particularly in a late miscarriage when a woman feels in the "safe" zone of her pregnancy journey and yet suddenly becomes *unexpecting*. This article will also highlight that during a miscarriage, regardless of gestational age, healthcare providers are adding to the traumaalready experienced during the loss due to the lack of empathy and lack of supportive care provided.[3] Additionally, this article explores what studies have concluded, that women going through a miscarriage believe that healthcare providers often lack acknowledgment of what theexpecting mother is going through and healthcare providers fail to help with managing the distress and ongoing care needed following a miscarriage, contributing to disenfranchising the grief that occurs with pregnancy loss.[4]

Keywords: miscarriage, spontaneous abortion, pregnancy loss, mental health, depression, post-traumatic stress disorder, provider medical negligence, dignity, disenfranchisedgrief

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Introduction

Miscarriage is when a pregnancy ends before 20 weeks gestation, also known as *spontaneous abortion*.[1] A miscarriage before 12 weeks is often chromosomal, a defect in development that could not sustain life. Later miscarriages, those after 12 weeks, are often related to other issues, including physical trauma, infection, incompetent cervix, and other possible genetic anomalies. Unfortunately, sometimes the reasons why a pregnancy ends beforeterm are never known.[1]

Criteria dictate medical treatment during miscarriage, and first-line care is expectant management, allowing the body to expel and pass the fetal tissue.[1] This process can take hours toweeks, and research shows this to be debilitating for the grieving mother due to the overall lack of physical and emotional support.[2,3] However, with further interventions and treatments, healthcare providers can lessen the physical and emotional pain a grieving mother will undoubtedly feel during a miscarriage.[3,4] Based on the research, implementing further interventions is often neglected, and the reasons are multifaceted.[5] The lack of oversight in maternal mental health and wellness, when it comes to miscarriage and pregnancy loss, is astonishing. Mental healthcare is crucial in providing optimal healthcare, regardless of specialty. If a healthcare provider is not addressing the patient's mental health, they are not providing the full mandate of providing ethical medicine. In *women's health, obstetrics, and gynecology*, mental health has an even larger umbrella since these providers are helping women through theirmost vulnerable time in life, pregnancy.[3–5] The changes that a woman goes through during pregnancy, both physically and mentally, need to be continually addressed, and it should not stop here. Continuity in care needs to overlap in those patients who went from expecting to unexpecting.[2–5]

Miscarriage, also known as *spontaneous abortion*, has several distinct types. These include threatened, inevitable, incomplete, complete, missed, and septic abortions.[1] Medical professionals use these terms to classify and diagnose the patient going through a miscarriage based on symptoms and what interventions might be applicable and appropriate.[1,6] Threatenedmiscarriage is the only one where the fetus can survive to a viable gestational age. The other types of miscarriage result in fetal demise – death. The loss of the pregnancy is inevitable.[1,5,6]

Healthcare providers need to understand the terminology used, but they also need to impart empathic care to the mother during this time. No provider should use the above terms when confronting a mother going through a miscarriage.[3] Lack of proper wording and empathy when delivering the words can lead to long-term mental health consequences.[3,6,7] Acknowledgment by healthcare providers that the mother is birthing a baby that she will not bebringing home, a pregnancy that was full of hope and joy only moments before, is now gone. Ahealthcare provider that cannot empathize and care for the mother and her *lost* baby will affect this mother, and her mental health, for the rest of her life.[2–4,6,7]

Review of literature

Disenfranchised grief is grief experienced after a loss where the loss is not socially or publicly mourned or acknowledged.[4] Miscarriage often falls into this category of grief due to societal norms surrounding the bereavement of a mother post-miscarriage and the lack of recognizing the loss of the pregnancy as a loss of life.[4] Despite the rates of miscarriages and howcommonly it occurs, miscarriage is often taboo to discuss in terms of bereavement and grief.

Recent literature shows that a mother faces stigma, shame, and guilt during a miscarriage. The inability to grieve appropriately and recognize the loss as a loss of life further increases the trauma.[3,4] Statistics show that 85% of miscarriages happen before a woman even announces they are expecting, so when they experience a loss, they feel obligated to experience the loss and grieve in secret.[4] Even if a pregnancy is made public and others are aware when a loss occurs, asin the case of women who experience a second trimester, or late pregnancy loss, the inability of others to mourn with the mother or acknowledge the loss often leads to this disenfranchised sense of grief for the mother.[4] Mourning in silence or feeling forced to negotiate their emotional experience against the social expectation to carry on post-loss is unbearable for many mothers.[2–4] We intensify this fear so much that most mothers never speak of their loss due to theworry that it makes others uncomfortable. Restrictions on grief are arbitrarily defined, and pregnancy loss is an example of an area where societal norms restrict what is expected or allowed in terms of who, what, and how a mother can grieve.[2–4] The medicalization of miscarriage, the death of an unborn child, and the inability to mourn appropriately due to the sanitation set forth by the medical profession carry a significant emotional burden for the bereaved mother. [2–4,6,7]

Healthcare providers who work in maternal health will care for women going through miscarriages, and they need to be aware of their impact on the overall experience of a miscarriage.[5–7] Research shows that how a healthcare provider oversees the medical management of a miscarriage can alter the grieving process the mother experiences tremendously.[6] Public recognition of pregnancy loss and heightened sensitivity by medical providers on how they medically manage a miscarriage can vastly change a mother's grief response and ability to cope with the loss.[6] Providers in the setting of miscarriage need adequate training to allow for open discussion, acknowledge the suffering from the loss, and empathize with the mothers as they navigate the loss.[6–8]

Based on the data, significant barriers to providing proper care in the medical management of miscarriage remain, notably patient care in the emergency department (ED).[3,5]Overwhelmingly, women report negative experiences in their ED care during miscarriage. Negligent emotional support, the inability of the provider to acknowledge what is occurring, lack of provider knowledge of miscarriage, and the inadequate ability to communicate with the bereaved mother are just some reasons for the negative experiences of these mothers.[3–5] These experiences and emotions are made worse by the lack of provider follow-up post-miscarriage, which ties the whole experience back to this *disenfranchised grief*.[4] No one in our society, not even medical professionals, wants to acknowledge that a miscarriage is a valid and traumatic lossfor the mother that requires ongoing care.[6–9]

Recent research in reproductive rights and care highlights the lack of medical training surrounding the management and patient care of women who present to the ED during a miscarriage.[3–5] Miscarriage-related ED care accounts for approximately 900,000 emergency room visits each year. During a presumed miscarriage, recommendations are that an expecting mother go to the ED for care, yet emergency medicine providers lack adequate training in managing miscarriages.[3,5,6] Current estimates are that 15% of known pregnancies end in a miscarriage, again a loss before 20 weeks gestation, and a large majority of those women will present to the ED for their initial care, only to find that they are left alone to labor and deliver thelost baby in isolation and without support, this is expectant management of a miscarriage in an ED.[3–5]

Research has shown that clinical guidelines are in place for the medical management ofmiscarriage, yet healthcare professionals often overlook the psychological morbidity associatedwith the loss.[3–6] There are minimal resources educating providers on how to support grieving mothers as a part of routine care during a miscarriage. Even more striking is that post- miscarriage, women are rarely ever followed up by their healthcare providers on the miscarriage,the physical healing process, and their long-term mental health.[3–8]

Miscarriage is medically common, but the lifelong impact on those that experience a miscarriage is vastly underappreciated. Miscarriage is a traumatic loss. Miscarriage is a multifaceted loss.[2,3] Not only is it the loss of life, but the loss of dreams and a future for that life and family. For the bereaved mother, it is the loss of her reproductive ability and the belief in herbody to nurture a life.[2–4] A mother loses her sense of self during a miscarriage. Miscarriage is a loss traditionally held as private, not often talked about. This isolation in grief surrounding one of life's most traumatic events leaves women who experience a miscarriage at risk for mental health conditions following the loss.[2,4] Studies show clinically significant depression and anxiety occur in approximately 15% of women following a miscarriage.[8,9] Regardless of gestational age,researchers have found that grief from a pregnancy loss can be just as intense for the mother at 11 weeks versus 20 weeks gestation, and it is not up to the medically experienced provider to define grief during a miscarriage.[9] As healthcare providers, we need to label miscarriage as a *traumatic loss* to validate the experiences of these mothers.[4,7] Medical definitions of early versus late pregnancy loss should not dictate empathetic care provided during a miscarriage. Studies show that often medical providers cannot empathize and acknowledge the depth of the loss that a mother is going through during a miscarriage.[3–5,7] Traditionally, the fetus is viewed asa specimen and treated as such during the expectant management of the miscarriage.[3,5] This narrow view of miscarriage sets the stage for emotional turmoil and intense trauma for the mother, especially when the healthcare providers show unempathetic and unsympathetic care during the labor and birthing process of a miscarriage.[3–5,9] It is vital to understand the experiences of women and their psychological distress during miscarriage to make recommendations for future healthcare practices that can positively affect this already traumaticevent experienced by so many women during their reproductive years.[8,10]

The process of miscarriage and expectant management of miscarriage is not one size fits all intervention. Gestational age, comorbidities, and other variables dictate the medical care of a miscarriage.[6] Early pregnancy loss may be physically much less traumatic for the mother in terms of passing the fetus and physical pain levels, but because medically it is defined as a simpler process does not mean that emotionally and psychologically, we discount the depth of the sadness or grief the mother is experiencing.[6,7] A woman experiencing a late pregnancy loss, amiscarriage in the 2nd trimester, will likely require much more medical attention and intervention due to the size of the fetus and the underlying cause of the miscarriage, often relating to trauma or infection. Medical management in these patients is much more intense if these patients are appropriately evaluated and cared for. These later losses often result in the labor and delivery of a non-viable fetus, which is physically and emotionally painful to the mother.[6,7] During these miscarriages, medical management occurs in the ED, and inadequately trained medical providers intensify the physical and emotional distress of the grieving mother.[3,5] Providers in this setting often are not trained in labor and delivery and do not view the miscarriage as a valid labor and delivery process.[3,5] Providers in the ED do not have the time to devote to the patient physically or emotionally, often leaving the laboring mother alone in a room

to experience this traumatic journey alone.[3,5] Healthcare providers unable to provide supportive care to the mother and the non-viable fetus during labor and delivery during expectant management of a miscarriage add significant distress to an already traumatic life event.[3,5,7]

In the context of grief due to the loss of life, we must take a step back and evaluate the loss of pregnancy when a fetus is not viable outside the mother's womb. Societal rules and accepted norms surrounding miscarriage do not recognize the loss as legitimate and do not allow the bereaved mother to speak about the death of their baby.[4] This restriction on grief in the context of pregnancy loss sets the stage for a host of mental health complications for the bereaved mother.[2,4] Healthcare providers must assess how caring for the mother's physical pain and emotional distress affects their long-term health. They must also acknowledge that how they care for the fetus during these miscarried births will impact the mother's mental health for her lifetime.[6,7] No bereaved mother should labor and give birth to their baby to see it treated like a specimen, called such in front of them, put into a labeled plastic bag, then sent off to pathology. No mother should give birth to their baby alone, feel the baby fall out, knowing it only has seconds on this earth, but be unable to reach for the baby due to the intense pain of labor they are still experiencing. No mother should ever see a medical provider scoop up their lost baby like a piece of trash, wadded in a pile of bloody towels, and put at eye level beside their bed.[3–5] Dignity in patient care for the mother and the lost fetus, the baby, is applicable in the context of miscarriage.[6,7] The baby should be treated with respect and with all the dignity of life, as a person, even in the face of death. Undignified care should not be the experience of so many women in the ED during the medical management of miscarriage, but the stories are endless and all too similar.[3,4,5] Studies show that these experiences due to medical neglect, the inability of the provider to relate to the loss and empathize, and the lack of provider acknowledgment that the baby, a life worthy of protection and dignity even in the face of fetal demise, deserves respect and proper care, end up leading to long-lasting mental health problems for the mother.[2–5,8,9]

Post-traumatic stress disorder (PTSD) develops more often in women who report a lack of proper medical care surrounding the events and management of the miscarriage.[9] The medical management of miscarriage involves the healthcare for the mother but needs to include how we care for the baby, even in the face of death. Women who experience severe depression, anxiety, and PTSD surrounding the experiences of miscarriage, report that it is due to the medical management of the miscarriage that they carry these added mental health problems post- pregnancy loss.[2,5,9] The trauma of miscarriage can cause distress and lasting grief, compounded with medical neglect in miscarriage care, and the mother's ability to accept and navigate the stages of grief is affected.[3,7–9] Further, mental health problems are routinely not recognized or treated promptly when they do occur.[9] When heightened trauma and medical mismanagement of the miscarriage are part of the experience by a mother during miscarriage, complicated perinatal grief is likely to occur and can often manifest as PTSD. PTSD is debilitating and often overlooked in the context of miscarriage and pregnancy loss due to the lack of the providers' and societal ability to acknowledge miscarriage as a valid loss.[4,9] These medically defined terms surrounding miscarriage and proper patient care during miscarriage set the stage for all the trauma experienced during a miscarriage to be discounted and overlooked as valid for the mother who just experienced it.[9] Recent studies show that medical providers who care for women during a miscarriage need training as advocates for these women, able to support them during their time of need and counsel them throughout and following the loss.[8–10]

Conclusion

There is no wrong in grieving for a lost pregnancy and all that it encompasses. Data gathered detected that up to 50% of all pregnancies, known or unknown, result in miscarriage.[1,4] With a loss that is so common, the question is still, why can we not openly talk about the loss and grieve as necessary? In retrospect, looking at those who respond first to the pregnancy loss may reveal our answer.[4,5] Healthcare providers' ability to provide empathetic care, those who relay the news of a miscarriage to the mother, are instrumental in understanding how women cope with the loss.[6,7,10] The comments, actions, and interventions made by these first responders in the ED during a miscarriage can alter and shape the emotional impact felt by women for an extended time, well beyond the period of normal grief. Women grieving their loss are trivialized and left unable to express their feelings and this needs to change.[4] Miscarriage is minimized by healthcare providers and viewed as a single reproductive event without repercussions or the need for continuity of care.[7,8,10] Disenfranchised grief pervades pregnancy loss, and it is time that we open the dialogue, especially in healthcare, to fill the void for grieving mothers and parents.[4] Healthcare providers with a graduated understanding of what women experience during a miscarriage can use this knowledge to provide support that implements preventative interventions to reduce the burden of illness long term.[10] Progress in the medical management of miscarriage is overdue, and healthcare providers' focus on promoting the healthy adjustment of the grieving mother is paramount in optimal patient care following a miscarriage, a truly traumatic loss.[2–4,10]

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Conflicts of interest

None to disclose.

References

1. Alves C, Rapp A. Spontaneous abortion. Treasure Island (FL): StatPearls Publishing; 2023.
2. Davoudian Teni, Gibbins Karen, Cirino Nicole H. Perinatal loss: The impact on maternal mental health. *Obstetrical & Gynecological Survey*. 2021;76(4):223.
3. Plews Angie. How we contribute to disenfranchising the grief of pregnancy loss. *Peri- natal Mental Health*. 2018.
4. Benson L, Magnusson S, Gray K, et al. Early pregnancy loss in the emergency department. *Australian and New Zealand Journal of Obstetrics and Gynecology*. 2021;2(6):e12549.
5. Bellhouse C, Temple-Smith M, Watson S, et al. The loss was traumatic… some healthcare providers added to that": Women's experiences of miscarriage. *Women and Birth*. 2019;137-146.
6. Emond T, Guillaumie L, de Montigny F. Using a logic model to develop an intervention for improving miscarriage care in the emergency department. *Eval Program Plann*. 2021;85:101910.
7. Lee L, Ma W, Davies S, et al. Toward optimal emotional care during the experience of miscarriage: An integrative review of the perspectives of women, partners, and health care providers. *J Midwifery Womens Health*. 2023;68(1):52–61.

8. Hiefner A. R, Villareal A. A Multidisciplinary, Family-oriented approach to caring for parents aftermiscarriage: The integrated behavioral health model of care. *Frontiers in Public Health*. 2021.

9. Fernández-Ordoñez E, González-Cano-Caballero M, Guerra-Marmolejo C,et al. Perinatal grief, and post-traumatic stress disorder in pregnancy after perinatal loss: A longitudinal study protocol. *Int J Environ Res Public Health*. 2021;18(6):2874.

10. Miscarriage: worldwide reform of care is needed. *The Lancet*. 2021.

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