# Wijnland
# Miscarriage Clinic

Having a miscarriage (especially in your first pregnancy), can be a traumatic experience if the underlying anatomy and physiology is not fully understood. Every pregnancy carries an approximate risk of 1/7 to end in a miscarriage.

The main reason is that some abnormality has occurred. This might include chromosomal abnormalities (eg. Down syndrome, Turner syndrome etc.), anatomical abnormalities in the fetus (eg. Heart abnormalities etc.), anatomical abnormalities of the uterus (eg. Septum etc.) and many others. Having a first miscarriage is thus considered to be nature's way of "protecting" us against abnormal babies. However having 2 or more miscarriages cannot automatically be accepted as being "normal". On the medical side a thorough Gynaecological and Obstetrical history and examination (including a specialized ultrasound) are indicated and some specialized blood tests might be needed. After 3 miscarriages, a full miscarriage screening is indicated. The psychological impact of losing a pregnancy can also not be ignored and at Wijnland, dealing with this trauma, is part of our ethos.

We have therefore created a special space and service for patients who have experienced 2 or more miscarriages. If you make an appointment to make use of this service, remember to state these facts so we can allocate you to the correct avenue in our clinic.

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## Psychological And Emotion Impact

**Psychological Effects Of Miscarriage And Stillbirth**

Patients who miscarried or suffered stillbirth may experience adverse psychological effects. [5] As the incidence of miscarriage in clinically recognised pregnancies is estimated to be approximately 15%-20%, this subject has been well studied in terms of psychological impact. [4]

While the physical effects of miscarriage and stillbirth are associated with a varying amount of bleeding, cramping, backache and abdominal pain, the psychological and social effects may be considerably more severe and longer lasting. [4]

The psychological impact of a miscarriage can be devastating and can last for a long time, esp. in patients with increased risk factors such as pre-existing anxiety or insufficient social support. [4] There are a number of risk factors that predispose women to feeling psychological distress after a miscarriage, e.g. a history of psychiatric illness, childlessness, lack of partner support or other social support, and previous miscarriage. These factors increase the chances of severe psychological distress after miscarrying. [4] At-risk patients may experience longer lasting psychological complications. [5] An older patient who has her first pregnancy at age 40 and miscarries may experience significantly more psychological distress than a younger woman who suffered a miscarriage.

Patients who miscarry (or suffer stillbirth) also experience distressing physical symptoms if medical intervention was used to remove the foetus or baby, and continued heavy bleeding occurs. [4]

There is no evidence that different methods used to remove the foetus following the loss of the pregnancy result in different psychological reactions [4] i.e. – whether the patient has a missed or retained miscarriage, incomplete miscarriage and a complete miscarriage does not impact on the grieving process and in all cases would be similar. These are all experieced as a “loss”. A miscarriage (or a stillbirth) represents the loss of an opportunity to give birth to a live baby, to be a parent and to raise a child. [4]

The psychological impact of stillbirth (loss after 22 weeks of pregnancy) and perinatal death is more severe in terms of grief intensity and of longer duration. [4] Patients do normally experience this as a bereavement and post-traumatic stress. Here the option of a burial is often relevant and a death certificate is normally issued.

Studies have shown that reactions of women immediately after miscarriage may vary. [5] Some may experience no psychological symptoms, others may experience grief, or depression, or both grief and depression. [4,5]. Other studies have shown that some women may suffer from anxiety and that the majority of women who miscarried may experience elevated levels of depression after the loss. [5]

The psychological effects may include increased anxiety, grief and depression lasting up to 4 months after the event. Symptoms of grief, sadness and depression include loss of appetite, weight loss, guilt, insomnia and morbid thoughts.

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This may strain a couple's relationship. A number of disorders have also been described in the context of the loss of a pregnancy, including post-traumatic stress disorder, obsessive-compulsive disorders and panic disorders that require treatment. [4]

Patients with pre-existing anxiety and increased risk for depression, may endure psychological symptomology for 7 to 12 months after the loss of the pregnancy.

The grieving and coping processes following a loss starts immediately after a loss. Men and women grieve differently and culture also plays a major role. In some cultures the loss of a pregnancy still carry stigmatisation, and a woman may suppress her emotional needs for fear of social consequences. [4]

A first miscarriage should be distiguished from a recurrent miscarriage as the recurrent miscarriage has more severe psychological consequences. [4] Women who miscarried before are also at an increased risk of developing psychiatric illness during a subsequent pregnancy. [4] Stress and anxiety experienced during a later pregnancy can have an adverse effect on the foetus. [4]

**Treatment And Duration Thereof**

Internationally, studies have shown that psychological interventions after miscarriage improved patients' well-being. [5]

As anxiety, depressive symptoms, post traumatic stress disorder and other psychological symptoms can last for several months, psychological support and care should start immediately after the loss of the pregnancy. The psychological treatment should continue weekly in 50-minute sessions for at least a 4 month period. In the case of recurrent miscarriage, individual assessment is critical as counselling and support may be needed weekly for up to 7 months. At-risk and older patients may also require psychological support for up to 7 months.

Patients who suffer from severe post-traumatic stress disorder following miscarriage or stillbirth should receive weekly cognitive behavioural therapy for a period of 4-6 months. An alternative approach would be to allow for daily 50-minute sessions over a period of two weeks – i.e. 10 sessions in total.

Psychologists specialising in women's health may be able to assist women who suffered miscarriage. [4]

Patients who lost a pregnancy and who are at higher risk for developing more severe psychological problems, e.g. due to their pre-existing anxiety disorder or other psychological illness, or multiple miscarriages, should have psychiatric evaluation. Such patients may benefit from psychiatric treatment in the early stages following the loss, and prescribed medical treatment/medication should be initiated as indicated.

Men/partners experience the grieving process differently and weekly support counselling for up to 6 weeks is sufficient.

Counselling programmes for couples who experienced stillbirth or neonatal death may also be effective. [4]

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In all cases a once-off psychological assessment follow up after one year is indicated. Here the need for individual longer term treatment/support will be evaluated.

## Longer Term Medical Treatment

**Direct Medical Treatment**
Women who miscarried or suffered stillbirth as a result of contracting LM will normally not require further medical treatment if the process described in par 8 above goes uncomplicated. If managed correctly, no further direct treatment should be needed.

**Indirect Treatment**
If a pregnancy was enabled with fertility treatment and the patient lost the pregnancy, she may require further fertility treatment in future in order to conceive again. This will be individualised by taking into consideration the pregnancy/fertility facts.

The patient age is important as it is well known that older women (>35 years) would generally have greater difficulty to conceive and also have a higher chance of miscarriage. The “preciousness” of the pregnancy lost should also impact. If the pregnancy was with the help of fertility treatment (IUI (Intra Uterine Insemination) or IVF (In Vitro Fertilisation)) then the future treatment will include these options.

In terms of the fertility issues, these should be addressed along with the psychological issues and attended to as soon as possible to reflect the age-related fertility wishes of the patient.

## Bibliography


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