Introduction

Death is the most powerful stressor in everyday life, causing both somatic and emotional distress in virtually everyone closely tied with the person who has died.\(^1\)

Working in a tertiary military hospital serving a large population, we have had many pregnant women in all trimesters who have lost their husbands. Pregnant women are brought to our clinic for a pregnancy check up either before or right after the notification of the death of their husbands, with the fear of an adverse outcome due to the bad news. As unexpected death is a bitter experience for all family members, our obstetric team had to deal with shocked and bereaving pregnant wives, as well as grieving family members.

We searched for a model for death notification to pregnant women, but couldn’t find a specific model.

Since the situation does not allow for a clinical trial application by its nature, we decided to gather information and derive a model from the existing models, and to modify it for pregnant women, along with our clinical experience.

Grief is considered to be a healthy emotional experience or an active psychological response by which an individual adapts to changes caused by bereavement. There is much evidence that unanticipated or unnatural death leads to a more severe reaction. Deaths due to suicide, accidents and acute illnesses have significantly higher grief measurement scores.\(^2\)

Loss of a close relationship often causes profound suffering and can have important effects on health status.\(^3\)

While the vast majority of bereaved individuals (80 to 90 percent) cope with their losses without requiring professional intervention,\(^4\) pregnant women in most cultures are accepted and treated as more vulnerable individuals, and some strongly believe that the sudden emotional changes may influence the course of the pregnancy. This cultural belief also has scientific support, as will be mentioned later in the text.

The fear of adverse outcome of pregnancy is more important when there is unexpected loss of the husband, since husband-usually-is the closest and the most supportive individual during pregnancy.
The statistics on how often pregnant women must be informed of the death of their spouses are not generally tracked.

However, the sudden loss of the husband, may it be due to a car accident, crime, terrorism, gunfight or suicide, starts a very painful process for pregnant woman, associated with denial, sadness, anger and despair because she had to live this experience, and fear of being left alone through the pregnancy, labor and during the raising of the child.

Telling the pregnant woman about the death of the spouse is a difficult task.

In many cultures, the fear of a possible damage to the pregnancy after hearing “the bad news” renders the people around the pregnant woman helpless, and many try to avoid the situation rather than helping the woman to cope with it.

We have seen relatives avoiding to give the news, avoiding to be with the pregnant women at the moment of delivering the news, giving the women the wrong information- usually telling her that the husband is in heavy condition, but alive.

In a military hospital setting, and especially if the pregnant woman knows her husband is in a military mission, she is always very sensitive to the - unusual - behavior of the people around her.

We have pregnant women brought to our clinic for “a routine pregnancy check up” by her relatives or neighbours, before being told about the death of their husbands. The pregnant woman almost always suspects something is wrong, but she does not want to believe, or accept the situation.

Giving the bad news

Although the verbal component of actually giving bad news is important, other skills are also needed. These include responding to a patient’s family members, and moving members of the patient’s family toward a sense of hope for the future.

The task of giving bad news can be improved by understanding the process involved and approaching it as a step-wise procedure, applying well-established principles of communication and counseling.

The experiences of chaplains and the social workers reveal that most people want to be told about the death of a loved one, rather than having the truth hidden.- In addition people have a right to know the truth.

Although the intention to withhold news of a loved one’s death is most often due to compassion for a patient, the patient’s grief and suffering will not be diminished by withholding the news. And if the patient finds out later that family members withheld the information, relationships could be unnecessarily strained at a time when family members should be comforting one another.5

Jurkovich et al conducted a survey to identify the most important characteristics and methods of delivering the bad news of death. Their study revealed that the most comforting and helpful behaviors were described as: A caring attitude of a well-informed, sympathetic caregiver who gives a clear message and is able to answer questions. A suitable news giver person should be (ideally) someone who can spend whatever time is needed with the family, and provide adequate information about the loved one’s death.6

Unfortunately, as the close relatives tend to avoid to be the news giver in case of pregnant women, this may be left to the person who is “in charge of the pregnancy”, the obstetrician.

Sudden death is totally abrupt, giving no time for preparation or to say goodbye which can be extremely difficult for those left behind. The sudden death of a loved one has the capacity to leave people damaged or to result in a prolonged and painful grieving process that is made worse by the lack of time or preparation for the death, leading to a “double grief,” - for what is lost and for what might have been.7

**Stress of bereavement and pregnancy**

In a study of the stress of bereavement on the endocrine and immune systems of bereaved widows, mortality and physical illness increased during the first 2 years of bereavement. Of note, the changes in the endocrine and immune parameters were significantly marked in the early weeks of bereavement and were still present in some widows even 6 months after the death of their spouse. Sometimes what is not being said or talked about can also add stress and anxiety, and the delay in telling the news may be adversely affecting the patient.5

This is of importance in case of an ongoing pregnancy. In their excellent review, Hobel et al.8 pointed out to the issue of psychosocial stress. They pointed out to 2 factors which are consistently emerge as particularly relevant to the risk of preterm birth: 1) the timing of the stressor, and 2) the woman’s perception of it. As women evidently become less responsive to stressful stimuli as the pregnancy advances, of course with some exceptions, studies show that life events stressors tend to affect birth outcomes most when they occur in the first trimester. The results of various studies which evaluate the effects of psychosocial stress on pregnancy outcome have been summarized on the Table 1.

Immediate adverse outcome to a pregnancy after hearing the bad news has not been mentioned on the literature to the best of our knowledge. Thus there seems to be no scientific evidence of doing a pregnancy check up on a normally progressing pregnancy before giving the bad news, as well as no acute measures to be taken to avoid an adverse outcome. The rationale behind this behavior is to involve the obstetrician on the bad news process.
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What may be recommended for giving the bad news to a pregnant woman?

There are some models for informing about the death of a loved one, such as PEWTER, SPIKES and the Eberwein’s mental health clinician’s guide to death notifications. These models have both similarities and small differences from each other. Eberwein model permits the viewing of the body of the deceased, as part of a acceptance and closure processes. This model may not be an option if the body is severely disfigured due to trauma, burns or explosions.

We modified a table for breaking the bad news for pregnant women, from the common aspects of these models and indicated where in our practice we might have to interfere with the situation as obstetricians.

Although none of the mentioned models is initially intended for pregnant women, a suggestion for how to approach a pregnant women can be derived from these models. This has been pointed out in the Table 2.

Table 1: Psychosocial Stress and Pregnancy outcome, derived from Hobel et al.

<table>
<thead>
<tr>
<th>Obstetric Outcome</th>
<th>AUTHOR</th>
<th>Timing of the stress and the clinical outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1st Trimester</td>
</tr>
<tr>
<td>Preterm Birth</td>
<td>Glynn et al</td>
<td>Women have shorter gestational age at delivery</td>
</tr>
<tr>
<td></td>
<td>Lederman et al</td>
<td>Shorter average length of gestation</td>
</tr>
<tr>
<td></td>
<td>Levi et al</td>
<td>No risk of preterm delivery found to be associated with psychological stress</td>
</tr>
<tr>
<td></td>
<td>Hedegaard et al</td>
<td>N/A</td>
</tr>
<tr>
<td>Low Birth weight</td>
<td>Wadhwa</td>
<td>Each unit of life event stress was associated with a 55 gram reduction in birth weight, and an odds ratio of 1.32 for Low Birth Weight.</td>
</tr>
<tr>
<td></td>
<td>Hoffman and Hatch</td>
<td>Stressors may contribute to poor outcomes through their negative association with negative health behaviours.</td>
</tr>
<tr>
<td></td>
<td>Hobel et al</td>
<td>Chronic stress and prolonged exposure to catecholamines could contribute to reduced fetal growth</td>
</tr>
</tbody>
</table>

Table 2: Models for communicating bad news during pregnancy, suggestion for the obstetrician’s position. Based on Watson, Nardi and Keefe-Coooperman, Eberwein and Baile et al.

<table>
<thead>
<tr>
<th>STEPS</th>
<th>PREGNANCY MODEL FOR BAD NEWS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Assessment of the situation</td>
</tr>
<tr>
<td></td>
<td>When the pregnant women is alert, and willing to participate.</td>
</tr>
<tr>
<td></td>
<td>Evaluate general well being (mother and fetus)(OB)</td>
</tr>
<tr>
<td></td>
<td>Evaluate the baseline risk for preterm delivery,(OB)</td>
</tr>
<tr>
<td>2</td>
<td>Gathering Information before the bad news To control the situation:</td>
</tr>
<tr>
<td></td>
<td>1) Gather detailed information about the circumstances of the death of the loved one,</td>
</tr>
<tr>
<td></td>
<td>2) Know where the body is at the moment,</td>
</tr>
<tr>
<td></td>
<td>3) Determine if the pregnant woman will be / should be able to see the deceased</td>
</tr>
<tr>
<td></td>
<td>4) Have the possible funeral plans</td>
</tr>
<tr>
<td>3</td>
<td>Preparation of the setting</td>
</tr>
<tr>
<td></td>
<td>Determine</td>
</tr>
<tr>
<td></td>
<td>1) who will be the discussion leader,*</td>
</tr>
<tr>
<td></td>
<td>2) who will be present at the room,*</td>
</tr>
<tr>
<td></td>
<td>3) Provide suitable environment, privacy, timing, and alternative plans*</td>
</tr>
<tr>
<td></td>
<td>Have only close relatives nearby</td>
</tr>
<tr>
<td></td>
<td>Have psychiatrist to support</td>
</tr>
<tr>
<td></td>
<td>Have obstetrician to support - if not the newsgiver.*</td>
</tr>
</tbody>
</table>
We propose that the following steps may be considered - on minimum - when giving the bad news to the pregnant women.

1) Assessment of the situation

The preferred time for breaking the bad news is when the pregnant woman is alert, able and willing to participate in the conversation. From our past experience with sudden deaths in military families we have seen that the pregnant women are brought to obstetrics departments with the fear of a damage to the baby during the bad news.

Normally neuro-endocrine systems respond to acute stress, psychosocial or otherwise, allowing an individual to adapt and react to changes in the environment. When stress is chronic or excessive, however these adaptive mechanisms may fail and the stress response may even cause disease. It is hypothesized that when the fetal placental unit is exposed to excessive stressors during pregnancy, this neuro-endocrine response may be triggered, resulting in maternal endocrine changes, accelerated fetal maturation, preterm birth and low birth weight.8

However, none of these outcomes are acute outcomes.

Most of the time, when there is no underlying risk factors for adverse pregnancy outcome, (such as previous preterm delivery, multiple pregnancy, cervical incompetency, first trimester bleeding, pregnancy complicated by maternal pathologies etc.), routine pregnancy check up and evaluation seems not to be crucial, but still, it gives a sense of security to pregnant women, and we believe it should not be avoided.

2) Gathering Information before the bad news

Sudden loss of the loved one is very painful situation when the pregnant woman may ask questions that are hard to answer, especially in a military or police setting. 1) Gathering detailed information about the circumstances of the death of the loved one, 2) where the body is at the moment, 3) if the pregnant woman will be (or should be) able to see the deceased, and 4) the possible funeral plans help the informer to have control of the situation. If a member of the obstetric team has to give the bad news, this person should be informed about as many of these details as possible.

3) Preparation of the setting

Important for both the pregnant woman and the news giver person, this step involves determining 1) who will be the discussion leader, 2) who will be present at the room, and providing 3) suitable environment, privacy, timing, and alternative plans in case the patient learns about the death inadvertently.

4) Discussion of the situation with the pregnant woman

When the delicate moment comes, If the pregnant woman is not familiar with everybody in the setting, everybody should be introduced first. Strangers and unnecessary bystanders should be avoided at all times.

It is usually better if only one person leads the discussion when breaking the bad news. The close relatives are usually in the middle of their own grieving and may be unable to provide an objective approach to discuss, to assess and to manage the emotional needs of the pregnant woman during the discussion. The situation is even harder, and more complicated, when a few relatives are trying to to give the bad news at the same moment.

The obstetrician may have to be the person to give the bad news, if there are no other professional helpers, such as a...
The main antidepressant choices should be SSRI's and tricyclic antidepressants. Fluoxetine has been widely used in the past two decades for the treatment of depression during pregnancy. SSRI's have the advantages of achieving full therapeu-

tic dose in the first day in contrast to tricyclic antidepressants, and being associated with mild maternal side effects.\textsuperscript{12}

Recent data on most SSRI’s used during pregnancy over 15 years did not find any significant increase in major or minor fetal malformations, but there was a significant increase in the risk of miscarriage, and a suggested increased risk of preterm delivery, low birth weight, fetal death, and fetal seizure.\textsuperscript{13}

Also an association between SSRI use in late pregnancy and primary pulmonary hypertension in the newborn has been suggested but yet has to be confirmed.\textsuperscript{14}

A point to be kept in mind is that, if the loss of the loved one has been as a result of a suicide, this puts the pregnant woman under increased risk for suicide, as Agerbo stated, bereavement due to spousal suicide might increase the suicide risk more than bereavement after other modes of death. And spousal loss by suicide increased the suicide risk more in both genders, than spousal loss after other modes of death.\textsuperscript{15}

\section*{Conclusion}

From our clinical experience, close relatives from the families usually lack control of their own feelings because of the acute situation. It may be hard to find somebody in the close relatives to calm the pregnant woman. In previously mentioned models, a chaplain, a social worker or a trained nurse is suggested for the immediate consultation, but they are not always available, and neither of these models deal with pregnant women. So the obstetrician or a member of the obstetric team may have to cope with the stressful situation.

In the busy daily routines of obstetrics, an obstetrician may not have too much time to help the pregnant women who have lost their husbands unexpectedly although the numbers of such patients are not very much. But when it happens, one should have a plan at hand as the leader of the obstetric team. The families and close relatives feel comfortable to have an obstetrician around, when giving the bad news with the fear of a damage to the pregnancy.

While there is no direct scientific reports to suggest acute effects of bad news - and the psychosocial stress associated with it - to pregnancy, the long term effects are reported in the literature, and well known. Since the obstetrician has to deal with the whole pregnancy period, it is not very strange to have one in the scene when giving the bad news, to emphasize to the pregnant woman, that she has to cope with the situation for the good of her baby, later in her pregnancy.

As we have observed in our clinical practice, when told about the possible adverse consequences of the psychosocial stress in the pregnancy, many women better try to cope with the pain and the bereavement associated with it.

As well as the obstetricians and the residents, the other
members of the team -psychologists, nurses, midwives, and social workers - in the maternity hospitals and tertiary centers should have a knowledge of possible approach model mentioned above.

Gebelikte Eşin Ölümü Aci Haberin Verilmesi ve Yaklaşım

Gebelek kötü haber almak için hassas bir zamandır. Ölüm her an olabilir ve bazı kadınlar gebeliklerinde bunu yaşamaklardır. Pratijimizde gebe kadınların, çocuğun beklenmedik ölümü karşısında çaresizliklerine şahit olmuşuzdur.

Kültürlerin çoğunda gebe kadınlar daha kırılgan olarak kabul edilir ve kendilerine bu şekilde davranılır.

Bazıları ani duygusal değişikliklerin gebeliğin seyri üzerinde kötü etki yaptığına inanırlar. Literatürde kötü bir haberin duyulmasından hemen sonra gebeliklerin kötü sonuçlanmasından bahsedilmemektedir. Normal devam eden bir gebelikte, kötü bir haberin verilmesinden önce bir gebe muayenesinin yapılmasını kötü sonuçların önlenmesine yardımcı olduğuna da alınabilecek akut önlemlerin varlığına dair bilimsel bir kanıt da yokt.

Bizler, sevilen kişinin hamilelikte beklenmedik kaybı konusunu derleyerek, kötü haberin verilmesini, sonrasında gebelerin ihtiyacı ve beklentilerini, ve acının azaltılması için mümkün olan profesyonel yardım yollarını göstermeyi amaçladık.

Anahtar Kelimeler: Obstetric, Yas, Antidepresif ajanlar, Ölümü karşı duruş, Matem, Matem tedavisi

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