Experimental
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Clinical Article

Death of the Spouse During Pregnancy Giving the Bad News and the Management

Emre KARAŞAHİN, İbrahim ALANBAY, Mutlu ERCAN, İskender BAŞER

Ankara, Turkey

Pregnancy is a vulnerable time for receiving bad news. Death may occur anytime,and some women will experience this during their pregnancy. In our practice we have seen the dispair of the pregnant women after the unexpected death of the spouse. The pregnant women in most cultures are accepted and treated as more vulnerable individuals. Some believe that the sudden emotional changes may influence the course of the pregnancy. Immediate adverse outcome to a pregnancy after hearing the bad news has not been mentioned on the literature. 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. We reviewed the unexpected death of the loved one during pregnancy, giving the bad news, understanding the needs and expectations of the pregnant women, and about the ways of professional help to ease the pain

Key Words: Obstetrics; Grief; Antidepressive Agents; Attitude to Death; Bereavement; Hospice Care

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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 griefing 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.

Selcuk University Meram Faculty of Medicine, Department of Obstetrics and Gynecology, Konya,

Address of Correspondence: *Emre Karasahin*
Gülhane Askeri Tıp Akademisi
Kadın hastalıkları ve Doğum kliniği
Etlik, Ankara
dremrekarasahin@hotmail.com

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Partially with the fear of harming the pregnancy with the bad news, and partially it is traditionally hard and disliked to be the one to give the bad news, we, as obstetricians who are primarily in charge of the pregnant women, have been put in a position to give the bad news, or to support them right after.

Subjects:

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 illnessess 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]

Since death may occur anytime, unfortunately some women will have to experience this during their pregnancy.

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 stepwise 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 withold 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 behaviour is to involve the obstetrician on the bad news process.

Table 1: Psychosocial Stress and Pregnancy outcome, derived from Hobel et al.[8]

PSYCHOSOCIAL STRESS AND PREGNANCY OUTCOME				
Obstetric Outcome	AUTHOR	Timing of the stress and the clinical outcomes		
		1st Trimester	2nd Trimester	3rd Trimester
Preterm Birth	Glynn et al	Women have shorter Gestational age at delivery	Women at these gestational periods are less stressed with the same stressor	
	Lederman et al	Shorter average length of gestation	Found no effect of stress on gestation	N/A
	Levi et al	No risk of preterm delivery found to be associated with psychological stress		
	Hedegaard et al	N/A	No association with preterm delivery	Psychologic stress around 30 weeks is associated with preterm delivery
Low Birth weight	Wadhwa	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.		
	Hoffman and Hatch	Stressors may contribute to poor outcomes through their negative association with negative health behaviours.		
	Hobel et al	Chronic stress and prolonged exposure to catecholamines could contribute to reduced fetal growth		

What may be recommended for giving the bad news to a pregnant women?

There are some models for informing about the death of a loved one, such as PEWTER[9], SPIKES[10] and the Eberwein's mental health clinician's guide to death notifications.[11] 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[5] 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 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.

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

4	iscussion of the situation with the pregnant woman	İntroduce everybody at the setting. (OB),* Only one person leads the discussion* The obstetrician may have to be the newsgiver. Bad news is given. Observe the reaction-emotional response* Ask if she wants to see the body- don't force* Attending funeral –as an acception and closure processes.
5	Support for the woman during the pregnancy	Check her reactions and response to stress during obstetric visits. (OB) Reassure for the support Attend the funeral as part of an acceptance and closure process. Continue support by family members Social security and insurance processes, financial support. Companion during obstetric visits
6	Resources for continuing support after the delivery	Continuing support by close relatives, also after the delivery. Make her feel she is not alone Social security and insurance processes, financial support. Observe for suicide risk postpartum (OB)

*(OB) :obstetrician, * : presence of obstetrician may be helpful / welcomed or required by the relatives or by the patient.*

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 by standers 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

chaplain, a religious person or a social worker present.

Usually a brief introductory speech, clarifying the actual events and confirming the facts, is helpful. Obstetrician at this moment, may very shortly mention that the ongoing pregnancy is fine, and continue by the bad news.Usually at this point the patient guesses the coming news. Then the bad news is given.

Attending a funeral is considered a part of the acception and closure processes, and also culturally very important in some cultures

5) Reassuring Continuous Support for the woman during the pregnancy

The pregnant woman has to go through a complicated process after loosing her husband. art of a complete acceptance and closure process. ıt is also culturally important in some cultures. If she can or if she should attend the funeral may be discussed with obstetrician.

As her primary physician during the pregnancy,ck her reactions and her response to psychological stress associate with her loss and the consequences and can be the one that she may feel more comfortable sharing her feelings with. Her doctor's reassurance for the continuous support is very valuable. The obstetrician may also mention to the relatives about the increased demand for attention during pregnancy. Since the husband is gone, having a close relative during the obstetric visits to share the moment can be helpful for the patient.

6) Resources for continuing support after the delivery

The postpartum period itself is a predisposing factor for depression. The loss of the loved one, necessitates the continuing support in this period also. If the close relatives are available and willing to continue their support, the patient copes with the stressful situation much better. The obstetrician is still the primary physician of the patient at this period, and the signs of impeding depression and the risk for suicide - if the husband has committed suicide- can be diagnosed by the obstetrician, earlier than others.

The medical treatment of depression is not the primary topic of this article, but in some cases, the drug therapy may be necessary for the depression following the loss of the loved one.

We strongly suggest that psychiatry consultation should be obtained before making a decision to start antidepressants, especially during pregnancy. A medical council decision would also prevent medico-legal complications that a single physician may face, if adverse affects are encountered.

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 therapeutic dose in the first day in contrast to tricyclic antidepressants, and being associated with mild maternal side effects.[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.[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.[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.[15]

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

Gebelik kötü haberler almak için hassas bir zamandır. Ölüm her an olabilir ve bazı kadınlar gebeliklerinde bunu yaşayacaklardır. Pratiğimizde gebe kadınların, eşin beklenmedik ölümü karşısındaki 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 gebeliğin kötü sonuçlanmasından bahsedilmemektedir. Normal devam eden bir gebelikte, kötü bir haberin verilmesinden önce bir gebe muayenesinin yapılmasının kötü sonuçların önlenmesine yardımcı olduğuna yada alınabilecek akut önlemlerin varlığına dair bilimsel bir kanıt da yoktur.

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

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

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