

Psychosocial aspects of complicated pregnancy

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Objectives

- Recognize psychosocial issues unique to the patient whose pregnancy is complicated by high-risk issues or prolonged hospitalization
- Identify important interventions to consider in addition to the medical interventions for these patients

Case example

Maria, after seeking pregnancy for 4 years, was admitted to our Obstetric ward with a diagnosis of spontaneous periviable premature rupture of membranes (PPROM) at 23 weeks of pregnancy. She had an admission of 46 days. In these long 6 weeks medical protocol for PPRM was followed: she was on bed rest, with regular frequent blood tests and antepartum assessment to assess maternal and fetal well-being. In week 29, she suddenly started with very heavy bleeding, and a placental abruption was diagnosed requiring an emergency caesarean section. A 1250 grams live male was born. He was admitted to NICU. Maria had a satisfactory recovery and she was discharged at 4th day after cesarean section. However, on the 9th day of life the newborn unexpectedly died due to a complication with parenteral nutrition.

Considerations during hospitalization

1. During admission

Clinical management entails a complex balance between two therapeutic strategies



Experience of Vital Exclusion

Maternal Health

- Infection
- Treat. complications

Optimization

Fetal Health

- Avoid infection
- Prematurity
- Sequelae (RD, IVH, NE, PL...)



1. During admission

..., but also...

She desires:

- To end the pregnancy as soon as possible
- To go back to normal life

Ambivalent feelings

She desires:

- To avoid the birth of a preterm infant
- To avoid possible infant's sequelae



1. During admission

10 Key-points to manage pregnancy complications and high obstetric risk women

**A decalogue to help women in obstetric uncertain scenarios from
day 1**

Decalogue

1. The pregnant woman must be at the center of the entire process during admission. All medical cares should be focused on her and her future child

Avoid distortions & pressures from

- Health Care System
- Obstetric team

Decalogue

2. Educate. Let her know **gestational age** as a continuum for intrauterine development:

- A single day is important
- Fetal maturation is a gradual process

3. Try not to set mid or long-term goals

- Our goal: "one single day to add without incidences"

4. Ego-Reinforcing messages

- Admiring the sacrifice of following treatments in the benefit of her child
- Making sense of the change that has taken place in her life
- Detect and eliminate irrational cognitions and catastrophic thoughts

Decalogue

5. "Anchoring Messages":

- **Conveying the team's interest in ensuring the success**
- **The team is doing all what medically must be done**

6. Let her know if the clinical situation is stable

- **If short-term complications might be expected**
- **The obstetric team is ready to act if needed**
- **Detect & eliminate irrational beliefs**

7. Convey local experience in handling situations like her own:

- **Provide hard data on:**
 - **Prevalence of her problem**
 - **Local outcomes**
- **Let her know what can and cannot be expected**

Decalogue

8. Explicitly show interest in her mood state, sleep pattern and psychological health

- Direct questions about her feelings, emotions and needs

9. Identify her main accompanying person:

- Get an idea of social-familial support
- Learn about her needs of company

10. Accompany her in the situations in which crucial decisions need to be made:

- Convey the wish to accompany in all the possible scenarios.
- Never abandon her
- Always accept her criterion

Considerations following delivery

2. Interview after neonatal death

Factors to be considered as emotional risk factors

- Long admission
- Uncertainty about
 - the duration of pregnancy
 - the type of delivery
 - the neonatal outcome
- Life threatening end: Emergency / emergency situation
- New team of professionals present for delivery without personal familiarity with patient
- Premature birth
- Neonatal Complication: Legal responsibility?

2. Appointment to deliver the necropsy report

10 Key-points to prepare the interview after neonatal death

A decalogue to prepare the interview

Strategy to prepare the interview

- 1. Be familiar with patient's history, her clinical evolution during admission and as many details of the case as possible**
- 2. Provide appropriate time and space**
- 3. Disposition to let her (and her partner) talk from the beginning, by the means of empathic listening and allowing emotions to surface**
- 4. Efforts to analyze the conversation in order to detect**
 - Knowledge gaps
 - False beliefs

Strategy to prepare the interview

5. Identify figures to whom negative feelings are directed

- Others (staff)
- the system,
- herself

6. Evaluation of the intensity of emotions

- Anxiety
- Depression
- Guilt
- Anger

Strategy to prepare the interview

- 7. Request woman's permission to start an objective narration of clinical events prior to neonatal death,
- Limits should be set at the beginning**
- 8. Avoid refuting arguments. It is better to confront reality**
- 9. Actively search for remaining unsolved questions**
- 10. Plan medical and/or psychological support**

Looking forward: Counseling in
future pregnancy

3. First medical visit in a new pregnancy

- Possible Post-Traumatic Stress Disorder and/or any kind dysfunctional grief
- Uncertainty about a possible recurrence of
 - previable PPROM,
 - placental detachment,
 - preterm birth
 - neonatal death
- Fears of the complications of her previous pregnancy

3. First medical visit in a new pregnancy

10 Key-points to help women during a pregnancy following a perinatal death

A decalogue to guide physicians

A decalogue to guide obstetricians attending women after a perinatal loss

1. Evaluate whether and how patient has overcome the previous traumatic situation
2. Assess general maternal mental health, specifically depression and anxiety at least in first visit
3. Evaluate general maternal health

A decalogue to guide obstetricians attending women after a perinatal loss

4. Consider other risk factors for perinatal mood disorders
5. Provide the best evidence based clinical support and treatment to avoid complications
6. Provide or refer to specific perinatal mental health units for psychological treatment in case of mood disorder

- Pharmacological (SSRI)

- Non-Pharmacological interventions (support groups, Cognitive-Behavioural-Therapy)

A decalogue to guide obstetricians attending women after a perinatal loss

7. Screen for anxiety, depression or sleep disorder at least once in each trimester
8. Explicitly convey regularly your efforts and interests to succeed
9. Let her know all small milestones reached during the pregnancy
10. Share with potential care providers the risk of emotional break down

Conclusions

- Complicated pregnancies may result in severe emotional trauma
 - Ambivalence during hospitalization
 - Complicated grief following adverse outcome
 - Post-traumatic stress disorder complicating subsequent pregnancy
- Obstetric providers must anticipate emotional reactions and provide appropriate counseling, support and referral