



MISCARRIAGE: THE HIDDEN LOSS

RESOLVE: The National Infertility Association, through a generous private donation, has developed this publication to provide a comprehensive understanding of the emotional and medical components of miscarriage.

Common Causes of Miscarriage	Page 2
Terminology	Page 6
Symptoms of a Miscarriage	Page 6
The Miscarriage	Page 7
Recurrent Pregnancy Loss	Page 7
Questions to Ask if You Have Had Several Miscarriages	Page 8
Questions to Ask About Immunologic Therapy for Miscarriage	Page 9
The Emotional Aspects of Miscarriage	Page 11
Coping With Pregnancy Loss	Page 13
Resources	Page 15
Suggested Readings	Page 15

Miscarriage, the loss of a pregnancy before 20 weeks, is a devastating event with both physical and emotional components. (A loss of a pregnancy after 20 weeks is considered a stillbirth.) Often women are unaware of the possibility of having a miscarriage and are caught off guard if one occurs. In fact, miscarriage is not uncommon; one in six pregnancies end in miscarriage before 12 weeks.

First trimester pregnancy loss can be categorized as biochemical, anembryonic or embryonic. Biochemical pregnancy loss is characterized by a positive result on the blood pregnancy test (hCG test) but hCG levels rise slightly rather than double every few days as they should, and there is no gestational sac (small sac which holds the developing embryo) visible by ultrasound. Anembryonic loss, often referred to as a blighted ovum, is characterized by an empty gestational sac in the uterus, which is visible by ultrasound. Embryonic loss, also known as clinical pregnancy loss, occurs after a gestational sac with a developing fetus has been documented on ultrasound.

COMMON CAUSES OF MISCARRIAGE

Genetic Error

Genetic problems in the embryo account for approximately 70% of pregnancy losses, some of them so early that they go unrecognized. A genetic abnormality may be passed from one of the parents; however it is more likely to arise at fertilization, when the genetic material from the male and female combine in an abnormal manner. For most women this is usually a one-time event but the rate of this type of pregnancy loss dramatically increases in women over the age of 40, reaching as high as 40%–60%.

Determining if genetic issues are the cause of pregnancy loss is difficult. If pregnancy tissue is passed spontaneously, it is often difficult to obtain enough tissue for genetic analysis. If a dilation and curettage (D&C) procedure is performed, tissue is often obtained for analysis. However, maternal uterine lining cells (endometrium) may be mixed with the pregnancy tissue, and hard to distinguish, making chromosome analysis difficult.

Some doctors believe that miscarriages result from a genetic similarity between the two parents, preventing the woman's immune system from adequately protecting the pregnancy from immune attack. With treatment known as paternal leukocyte immunization (PLI), the man's immune cells are removed from a sample of his blood and used to immunize the woman. Studies have shown that this treatment has led to only minor improvements in pregnancy outcome. In addition, most patients will have a significant allergic reaction at the injection site. Some women who do not respond to the treatment use white blood cells from a donor. This treatment carries a small risk of viral infection. Many doctors currently do not recommend PLI to their patients.

Abnormal Hormone Levels

Progesterone, the hormone that triggers the development of the uterine lining, is produced in the luteal (after ovulation) phase of the menstrual cycle and in early pregnancy. If mid-luteal phase measurements of progesterone levels are low (below 10 ng/ml) the uterine lining may not adequately develop to implant and nourish the fertilized egg, and miscarriage may occur.

Women with thyroid and adrenal gland problems may be at a higher risk for miscarriage due to hormonal imbalances. If hypothyroidism (underactive thyroid gland), which can increase the chance of pregnancy loss, is diagnosed during pre-pregnancy evaluation, thyroid hormone replacement can be given. Levels of thyroid hormone normally change during pregnancy, and sometimes a woman may need an adjustment of thyroid medication. In addition, an elevated prolactin level (prolactin is a hormone normally produced when a woman is breastfeeding) can disrupt normal uterine lining development.

In addition, sometimes the use of the oral medication Clomid may improve ovulation, enhance progesterone production and increase the chances of embryo implantation. This is especially important if a woman has irregular cycles or poor ovulation. However, Clomid may eventually thin the endometrial lining of the uterus and should not be used for more than four to six cycles.

Polycystic Ovarian Syndrome

Patients who are significantly overweight due to polycystic ovarian syndrome (PCOS) may have an increased miscarriage risk, particularly if they have insulin resistance, an inability to metabolize sugars. As a result, these women make extra insulin to compensate for the problem, which may lead to obesity, overproduction of male hormones, heart disease and type 2 diabetes. This condition can improve through weight loss and exercise. However, some women will require the use of insulin sensitizing drugs, such as metformin or rosiglitazone. Patients taking these drugs may have a lower risk of miscarriage.

Structural Problems

Structural problems of the uterus may cause miscarriage by interfering with the implantation of the fertilized egg. Fibroids, also known as uterine myomas, are non-cancerous growths in the uterine wall, which may not allow the embryo to implant well.

Another factor that can affect implantation is a uterine septum. This is an abnormal structure that partially or totally divides the uterine cavity. Implantation is unlikely if the fertilized egg tries to implant on the septum, due to the poor circulation and lining development on the septum.

Women whose mothers were given the drug DES (diethylstilbestrol) during their pregnancies have an unusually high number of uterine abnormalities, including small or odd shaped uterine cavities

Asherman's syndrome, characterized by scar tissue inside the uterus resulting from an overly vigorous D & C or an infection following an abortion, can also prevent implantation of the fertilized egg. Women with Asherman's usually notice very light or absent menstrual periods.

In most cases, these structural problems can be diagnosed by a hysterosalpingogram (x-ray using dye) or by sonohistogram (ultrasound using saline). In some cases a hysteroscopy (inspection of the uterine cavity with a tiny microscope inserted vaginally through the uterus) will be performed,

Another structural cause of miscarriage is an incompetent cervix, meaning the cervical muscle is weak and cannot remain closed as fetus develops and puts pressure on the cervical opening. Miscarriage resulting from this problem occurs in the second trimester and is usually rapid and

painless. To treat a woman with an incompetent cervix, stitches are placed in the cervical muscle to tighten the opening 13-17 weeks into the pregnancy; the stitches are removed when labor begins.

Many women wonder if a retroverted uterus, one that is tilted backwards, can be the cause of a miscarriage. About 30% of all women have a retroverted uterus and only a few will have problems as a result. If the uterus is bound down by adhesions (scar tissue) and is not freely moveable it can be a problem when a pregnancy is 12 weeks and beyond. The doctor may have the pregnant woman sleep on her stomach or do gentle exercises up to 18 weeks to allow the uterus to move forward. Occasionally a pessary, a soft plastic tube, is inserted into the vaginal canal; this will allow the uterus to gradually move to the correct position.

Infections

Infections such as German measles (rubella), herpes simplex, ureaplasma, cytomegalovirus and chlamydia can affect fetal development and in some cases, result in miscarriage.

- **German Measles.** If you are not sure if you are immune to German measles, you should have a blood test. Contracting measles during a pregnancy is dangerous to the fetus, therefore if you are not immune, you should be vaccinated and postpone trying to get pregnant for three months. If you were vaccinated against measles after 1959, ask your doctor if there is any need to be re-vaccinated, especially if you have regular contact with children.
- **Herpes Simplex.** This virus if in its active stage with open sores can cause miscarriage or problems to a newborn baby.
- **Ureaplasma.** This condition, a cross between a virus and bacteria, may cause early miscarriage. Because the test for this infection is expensive and requires sophisticated lab equipment, following a miscarriage many doctors treat couples with an antibiotic such as tetracycline or doxycycline just in case the infection is present.
- **Cytomegalovirus (CMV).** This virus which is spread by urine, saliva, semen, cervical mucus and infected blood can cause miscarriage, still birth or newborn death
- **Chlamydia-**This sexually transmitted infection can cause late term pregnancy loss.

The role of toxoplasmosis and listeriosis in miscarriage and fetal development is also being studied. Toxoplasmosis is transmitted through cat feces; if you are pregnant, you should avoid emptying or cleaning cat litter boxes. Listeriosis is an infection caused by eating food contaminated with the bacteria *Listeria*. Pregnant women are advised not to eat certain deli meats, cheeses and other foods. (For complete information visit <http://www.foodsafety.gov/~fsg/f02liste.html>)

For more information on infections and infertility, see the resource list on page 15.

Environmental Factors

Toxins in the air can also lead to fetal damage or miscarriage, especially if you experience regular exposure after 20 weeks of pregnancy. Chemicals such as solvents, insecticides, lead products, benzene and mercury all seem to increase the chance of miscarriage. Tell your doctor if you had any contact with these substances during your pregnancy.

For more information on environmental factors and infertility, see the resource list on page 16.

Blood Incompatibility

Blood incompatibility between a mother who has an Rh-negative factor in her blood and a fetus that has an Rh-positive factor can result in miscarriage after 20 weeks. Fortunately, a drug called RhoGam can be given to counteract this.

Age

As a woman ages miscarriage rates increase. The miscarriage rate is about 13% for a woman in her 20's; rises to 20-25% for a woman in her late 30's; and is more than 50% after age 42. These higher rates of miscarriage are the result of aging of the egg which causes aneuploidy, the gain or loss of one or more chromosomes in the egg.

Immunologic Causes

Blood clotting disorders have also been associated with pregnancy loss. Some disorders, such as the Factor V Leiden gene mutation or the Prothrombin 20210 mutation may cause small blood clots to form within placenta tissue. There are more common clotting disorders that are immune in origin, such as lupus anticoagulant factor and anticardiolipin factors. The current treatment is baby aspirin and injectable heparin, a blood thinner, or anticoagulants. There is a risk of bleeding or bone loss with long-term use of heparin, so all patients must be monitored closely while on this drug. Baby aspirin taken alone is not effective.¹

Another cause of miscarriage is an abnormal immune response which prevents the body's normal protective response to the embryo. The tests used to evaluate this factor include the human leukocyte antigen, maternal antipaternal lymphocytotoxic antibodies, the assessment of natural killer cells and the embryotoxic factor. Treatments include immunizing the woman with her partner's white blood cells, special suppositories containing seminal plasma, and immunotherapy using intravenous immunoglobulin. The first two treatments are rarely done and the latter is under evaluation awaiting information from large controlled research studies.

Some physicians test for an array of obscure immune markers to diagnose other immune problems leading to miscarriage. The levels of these markers in the bloodstream may not be entirely reflective of what is happening locally at the uterus and placenta. Experimental treatments for some immune problems include intravenous infusion of immune globulins, a mixture of immune proteins purified from human blood products. At present, there is no convincing data to justify the use of immune globulins. In addition it is very expensive, usually not covered by insurance and is not risk-free. The risks include possible allergic reaction and viral infection. This medication is often in short supply and is needed by critically ill patients with failing immune systems.

Embryo toxic factor (ETF) is a "cytokine" produced by the immune system in response to pregnancy tissue. Measurement of ETF is complicated because it involves culturing the woman's cells with mouse embryo cells. ETF testing is considered experimental. If the test is positive, progesterone suppositories are prescribed.

¹ (Pattison NS, et al. Am J Obstet Gynecol 2000; Rai R. et al. Human Reprod 2000)

Progesterone given as a vaginal suppository or gel cap in doses of 100–200 mg two-to-three times daily may be a worthwhile natural immunosuppressive drug. Vaginal progesterone is directly absorbed through the vaginal tissues and acts on the uterus, where it is most needed; oral progesterone is not absorbed as well. Progesterone in oil injections are usually not suggested unless the woman is undergoing IVF and has used Lupron in that cycle. Supplementing with progesterone will not save every pregnancy destined for miscarriage, however it is unlikely to do harm.

TERMINOLOGY

Unfortunately, the medical term for a pregnancy loss before 20 weeks is “abortion,” which is painful to hear when you have planned and wanted your pregnancy. There are several more terms that medical staff might use when referring to a miscarriage:

- **Blighted ovum.** A pregnancy resulting from an abnormality in the sperm, the ovum or the fertilized egg. The products of conception are a mass of cells rather than fetal tissue.
- **Complete abortion.** All the products of conception are expelled from the uterus.
- **D & C.** (Dilation and curettage). A medical procedure, often after a miscarriage, involving a scraping of the uterine cavity.
- **Hydatiform Molar Pregnancy.** Also called trophoblastic disease or hydatiform mole, this unusual condition results in placental tissue growing rapidly and causing high beta-sub unit levels. The condition is diagnosed by 10 weeks when the ultrasound shows no fetus.
- **Incomplete abortion.** Tissue from the pregnancy remains in the uterus and must be removed with a D&C.
- **Inevitable miscarriage** - Characterized by increased bleeding (usually bright red), cramping and a dilated cervix.
- **Missed abortion.** The fetus dies in the uterus and is not expelled.
- **Spontaneous abortion.** A pregnancy loss that takes place without any medication or medical interventions
- **Threatened miscarriage.** Prior to a miscarriage the opening to the uterus (the cervix) is still closed, but there is vaginal staining or bleeding.

SYMPTOMS OF A MISCARRIAGE

Some women experience signs and symptoms before a miscarriage occurs; others do not. The onset of symptoms may be referred to as “threatened miscarriage” because there is a chance you could lose the pregnancy. Some of the signs that a miscarriage may be about to start are: vaginal staining, usually dark brown and changing to pink or red; a decrease in breast tenderness or fullness; and

absence of fetal movement or heart sounds. Cramping and vaginal bleeding are signs that a miscarriage is occurring. It is very important to call your doctor and to keep track of the amount of bleeding that occurs. If tissue is passed, try to save it. Many doctors will want it for laboratory evaluation to help determine the cause of the miscarriage.

If a miscarriage is threatening, doctors often measure and monitor progesterone and Beta-sub unit (HCG) levels. The HCG levels normally double every two days until the eighth week of pregnancy. If there is a drop in either of these levels, it may mean that the pregnancy is no longer progressing normally. When the HCG levels are 6,000 or the pregnancy is 6-8 weeks along, ultrasound is used to monitor the size of the fetal sac and to detect heart movement.

THE MISCARRIAGE

Emotionally, a threatened miscarriage is very difficult: everything is in limbo; there is usually no specific treatment. Some doctors suggest bed rest or at least limited physical activity. Sexual intercourse and the use of tampons are discouraged during because the risk of infection is higher when there is a possibility that the cervix is opened. The tampon can bring bacteria into contact with the cervix. It is also possible that any object in the vagina could trigger uterine contractions. When HCG levels drop or fetal heart sounds are no longer heard, a D & C is often done to remove all tissue from your uterus. This usually involves being in the hospital for 12-24 hours. If the doctor determines all the tissue has been expelled you would not need this procedure. In either case, you should have your HCG levels tested to be sure they are back to zero because in some cases, an ectopic or tubal pregnancy can continue after a D & C.

Your body may take time to return to normal following a miscarriage. The signs of pregnancy such as tender, full breasts and an enlarged abdomen may continue for several weeks. Vaginal spotting can persist. If this discharge increases significantly, changes to bright red, or has a foul odor, notify your doctor. A temperature or a tender abdomen may be signs of possible infection and your doctor should do an examination at once.

Recent research indicates that there is up to a 60% probability of having a successful pregnancy following one or two miscarriages. After three losses, the chance of having a successful pregnancy is approximately 40%. When you are feeling better, meet with your doctor to discuss his or her views on your chances of a future pregnancy. Ask your doctor about any tests or treatments that should be started (i.e., genetic studies, hormonal evaluation or immune testing).

RECURRENT PREGNANCY LOSS

Recurrent pregnancy loss is usually defined as three or more consecutive miscarriages; some researchers also define it as two consecutive pregnancy losses. These pregnancy losses usually follow a pattern, such as occurring at the same time in the first trimester or early in the second trimester.

If you have had recurrent pregnancy loss, it is important for your doctor to do a thorough evaluation, including any relevant hormonal and genetic blood tests, tests for common immune conditions, x-ray or saline sonogram of the uterus, evaluation of the uterine lining by endometrial

biopsy and evaluation for infection. Couples should have blood tests for “karotyping” to assess their genetic patterns and look for any evidence of a chromosomal problem in both partners which would indicate a miscarriage rate of almost 100%. In approximately 50%–60% of women with recurrent pregnancy loss, no reason will be found.

In general, testing for sperm abnormalities is not needed. Some studies have shown that problems in the Y chromosome may affect pregnancy loss, but more research is needed to clarify this.

Some couples may continue trying to get pregnant, even after several pregnancy losses. Others may decide to have their embryos screened for genetic abnormalities through the use of IVF with preimplantation genetic diagnosis (PGD). With PGD, only the genetically normal embryos are transferred back to the uterus.

For couples suffering from recurrent pregnancy losses, the chance of carrying a pregnancy to birth is still extremely promising, even if no treatment is given. Patience and persistence can be the keys to success. This is an extremely difficult experience to go through and you deserve, and should seek, support from your family, friends and doctor.

QUESTIONS TO ASK IF YOU HAVE HAD SEVERAL MISCARRIAGES

If you have had several early pregnancy losses, ask your doctor the following questions:

- ❑ **Will tests be done to evaluate your hormonal levels?** Hormone levels change as a pregnancy progresses. If prolactin and progesterone levels are abnormal, the uterine lining can be too thin. Additionally, low thyroid levels can contribute to miscarriage. Ask your doctor to check your prolactin, thyroid and progesterone levels not only before you try to get pregnant but during a pregnancy. If levels are abnormal and you are treated, make sure that your levels are retested.
- ❑ **Will tests be done to evaluate structural problems in your uterine cavity or cervix?** A hysterosalpingogram (x-ray using dye) or sonohistogram (ultrasound using saline) will evaluate the shape and size of your uterus and detect possible scarring in the uterus, polyps, fibroids or a septal wall, which could affect implantation. If there is concern about the uterine cavity, a hysteroscopy (examination done in combination with laparoscopy or as an in-office procedure) can be done. Some women’s cervical muscle is too loose causing pregnancy loss after the first trimester. A special exam is done when a woman is not pregnant to check for an incompetent cervix.
- ❑ **Will tests be done to evaluate the uterine lining?** An endometrial biopsy may be done on cycle day 21 or later and will document if your lining is getting thick enough for the fertilized egg to implant. If you have a lag of two or more days in the development of the lining, you will be treated with various hormones (Clomiphene, hCG, Progesterone). It is important to have the biopsy repeated after several cycles to make sure the treatment is helping. A vaginal ultrasound can be used to measure the uterine lining. According to most reports, it is best if the lining measures 10 millimeters or more at mid-cycle. Some centers also are using special Doppler techniques to measure the blood flow to the uterus. If you are being treated with medications to improve your lining and are on Progesterone, discuss the

various advantages of the oral, vaginal suppositories, tablets or injection routes with your doctor.

- ❑ **Will tests be done to evaluate the chromosomes?** Chromosomal tests can be done on tissue from a miscarriage but it is often difficult to preserve the tissue for adequate studies. Or, the tissue obtained has cells from the mother as well, making genetic assessment impossible. If chromosome testing is needed, you and your partner will have blood tests to make sure there is no translocation of genes (a condition in which the number of genes is the normal 46, but they are joined together abnormally). This condition can result in pregnancy loss.
- ❑ **Is an immunologic evaluation needed?** Blood tests to check for immunologic responses that can cause pregnancy loss include antithyroid antibodies (antibodies to thyroglobulin and thyroid peroxidase). Often the lupus anticoagulant factor and anticardiolipin antibodies tests are done as well. These appear to influence blood clotting mechanisms within the placenta as it develops. There are also blood tests that check for protective blocking factors. These are essential to protect the pregnancy from being rejected by the mother's body.
- ❑ **Will cervical cultures be done?** Cultures can be taken to check for the micro-organisms microplasma hominis and ureaplasma urealyticum which may cause pregnancy loss.
- ❑ **Ask your doctor how many cycles should you wait before trying again?** Some doctors feel that it can take the uterine lining up to three cycles to get back to normal.
- ❑ **If you have RH negative blood type and your partner is RH positive, ask if you will receive the drug Rhogam after every miscarriage to prevent the potentially harmful antibody from jeopardizing a future pregnancy.**

General considerations:

- ❑ **Thinking positively about the possibility of having a normal delivery after three or more miscarriages is difficult.** But, in reality, statistics show that 15-20% of all pregnancies end in miscarriage and that even after three consecutive losses you have only 40% risk of having another miscarriage; there is still a 60% chance for you to be successful.
- ❑ **The loss of a pregnancy and of a baby that has been planned for and dreamed about is devastating.** It is hard to trust again; it is hard to hope again. While there are not always answers as to why you have experienced pregnancy loss, there have been some new studies and developments in recent years. In the future there will be more solutions to the causes of multiple miscarriages and new ways to treat them.

QUESTIONS TO ASK ABOUT IMMUNOLOGIC THERAPY FOR MULTIPLE MISCARRIAGE

If you have had multiple pregnancy losses, talk with your doctor about the following issues:

Heparin or Aspirin Treatment:

- ❑ **Have you had a blood test to document whether you have high levels of one or more immunologic factors which may be associated with miscarriage, such as anticardiolipin and lupus anticoagulant factor?**
- ❑ **Should you have a repeat test before undergoing treatment?** Because some tests can give a false positive result, meaning they might come back positive when they are actually negative, a doctor may order another test before starting treatment.
- ❑ **Heparin affects blood clotting.** If you are going to take Heparin, tell your doctor if you have hypertension, prolonged bleeding, bruise easily, or have stomach ulcers or ulcerative colitis.
- ❑ **If you are taking Heparin, ask what type of blood tests will be done and how often your blood clotting time will be monitored.**
- ❑ **Aspirin can be irritating to your intestinal system so tell your doctor if you have a stomach ulcer, or ulcerative colitis.**
- ❑ **Will Heparin or aspirin be continued if you get pregnant? If so, for how long into the pregnancy?**
- ❑ **Ask an obstetrician whether you should continue to use Heparin or aspirin during the second or third trimester of pregnancy.**
- ❑ **Long term use of Heparin may cause osteoporosis.** Discuss this with your doctor and ask if you should be taking extra calcium.

IV Immunoglobulin Therapy:

- ❑ **Because IV immunoglobulin therapy uses blood products from many donors, discuss the possible health risks.**
- ❑ **Discuss possible long-term effects from IV immunoglobulin therapy on your immune system.**
- ❑ **If you have no history of pregnancy loss, discuss the doctor's reason for using IV immunoglobulin during an IVF cycle and the necessity of this additional cost.**
Immunologic therapy for infertility is not covered by insurance and at present is not standard infertility treatment although it is used in patients who are serious ill and immune compromised such as post organ transplant patients etc.
- ❑ **Discuss how many immunoglobulin treatments will be needed. Ask about the timing and cost of each treatment.**

Prednisone Therapy:

- ❑ **Keep in mind that Prednisone, a type of steroid, can cause changes in bone density, especially in the hip joint.**

- ❑ **If you are on this drug, you must tell your primary care doctor.** If you get an upper respiratory tract infection or any other illness, you must be watched carefully; steroids can mask the fact that you might have a significant infection and need antibiotics.

THE EMOTIONAL ASPECTS OF MISCARRIAGE

Often people are so overwhelmed by the physical aspects of miscarriage—symptoms, possible hospitalization or medical procedures—that the emotional aspects may become obscured. In many cases, family, friends and health care professionals are uncertain how to comfort and support a couple that has experienced a miscarriage. Whether you have had one pregnancy loss, or a series of losses, you will experience both physical *and emotional* distress.

Feelings During a Threatened Miscarriage

Unfortunately, there is little that can be done to prevent a threatened miscarriage. In order to cope during this uncertain time you may deny your fears and focus on hope, or you may feel angry that more is not offered to help save your precious pregnancy. The anxiety and helplessness of waiting and wondering are extremely difficult to deal with.

Feeling during a Miscarriage

Many pregnancies lost in the first months are usually discovered on a routine ultrasound. The shock and pain of receiving such news is tremendous.

A miscarriage that occurs after the pregnancy is well established can be frightening, and the vaginal bleeding and cramping can be significant. Some women have said they were afraid of hemorrhaging, and even of dying. You should know that miscarriage is rarely a life-threatening event.

Some people feel that the medical team fails to offer comfort and support during a miscarriage. Additionally, a couple may be separated in the hospital when they most need each other. The focus tends to be on what is happening to the woman medically--vital signs and blood loss become the focus of the medical team; the woman may be heavily medicated so she will physically feel more comfortable. The partner often feels frightened about his wife's health and may feel left out or in the way. Frequently husbands recall standing in the hall waiting as doctors and nurses hurried in and out of their wives' room. The woman's hospital room may be near the obstetrical unit; cries of newborns in the nursery and the general atmosphere of celebration associated with maternity wards intensify the couple's sense of loss.

Feelings During Recovery

After a miscarriage, many women describe a great sense of emptiness. Ultrasound pictures may be the only tangible evidence that you have to document that you “really were pregnant.” Because technology today allows women to know very early on when they are pregnant, the bonding process

starts early. Dreams and fantasizes begin as you imagine your life with a baby. Yet with a miscarriage, there is often nothing tangible to grieve. It is an invisible loss.

You may dream and fantasize about being pregnant for weeks after the loss. Anger and depression are common, and questions such as, "Why me?" may surface. It is common to want answers even though none may exist. Anger may be directed at the doctor, feeling that he or she could have done more or at least have been more concerned. Guilt is one of the most common post-miscarriage feelings. You may wonder if something you did caused the event. Many women ask, "Did I exercise too much?" or, "What did I eat that might have caused this?" In truth, such factors are rarely, if ever, the cause of a miscarriage. If there is a "secret" in your past or your partner's past (such as a previous abortion or pregnancy), you may interpret the miscarriage as a form of punishment. You may need to discuss this with a friend or therapist in order to put those feelings of guilt to rest.

When you have had a miscarriage you need to grieve several things: the baby, the pregnancy and your hopes and dreams about how this pregnancy would have changed your life. This is particularly hard to do when the loss occurs early in the pregnancy. There may have been few physical changes, and only a few family members or friends aware that you were pregnant. If the loss occurred later in a pregnancy, you may have something tangible to help you grieve, such as ultrasound pictures and celebration cards or you may have felt the baby move. After a late miscarriage and especially after a stillbirth, the grieving process may be facilitated if you had an opportunity to see the baby or if you have pictures of the baby, both of which make the loss very real. Many hospitals encourage parents to hold their baby and give them pictures and other memorabilia to help with the grief process.

Grief takes time; it peaks and fades. Certain events can trigger its intensity such as going back to work, getting your period, making love again, and anniversaries of the miscarriage and birth date. Often grief is triggered by holidays such as Mother's Day or Father's Day or when a friend gives birth. Grief has several stages. The initial feelings are usually shock and denial followed by the feelings of being out of control and very vulnerable, including thoughts about your own death and how short life is. Anger, irritability and mood swings are very normal. Sadness, loneliness and emptiness may be intense, and depression is not uncommon. Feelings about other losses may resurface. If these feelings impact your sleeping, eating, working and ability to cope everyday, seeing a therapist is important and helpful.

Men and woman often react differently to the trauma of a miscarriage. Many men feel they must be strong and protect their wives from their own feelings of loss and sadness. Others are more concerned about the medical and emotional health of their wife and spend much of their energy trying to "make it better." Society tends to reinforce this; often others only ask how the woman is doing, not the expectant father. In most cases it helps if a man can show his sadness to his partner. It will not make her feel worse and will lessen any sense of isolation or feelings that this was more important to her than to him. If a husband avoids the topic the wife may feel that he is emotionally abandoning her. Remember that you may each react in individual ways; one may be actively grieving while the other gives support and later the roles may reverse. Talk about what is the hardest part for each of you, and tell your partner what they can do to help you through this difficult

time. Grief is a lonely and individual experience, but you can support and not judge each other as you navigate the waves of sadness, anger and vulnerability of grief.

Talking about how to memorialize the loss of your baby and pregnancy can be helpful. Suggestions from other couples include: plant a shrub or tree; place a special stone in your garden; write a poem or share your written thoughts; buy a piece of jewelry with the baby's birthstone; or make a donation in acknowledgment of the loss.

Following a miscarriage, you may be surprised at how envious and jealous you are of woman who are pregnant or who are parenting. You may feel like a bad person when these feelings erupt but you need to understand that this is a common response following a pregnancy loss. You will not always feel this way, but for a time you may need to protect yourself from situations that increase your pain or envy.

Family and friends often will unknowingly say all the wrong things to a couple who has recently lost a pregnancy. Society has no rituals to address this kind of loss or to acknowledge the couple's grief. With an early miscarriage they may have been unaware that you were pregnant and may just focus on that. If you have another child at home they may say you are lucky to have at least one. Others may say it was nature's way of preventing a child with defects from being born. They may tell you were lucky to get pregnant and after a certain amount of time expect you to "get over it." None of these responses are comforting when you have lost a longed-for child. Often people are embarrassed and don't know how to address others' feelings of sadness. They may feel uncomfortable talking about intimate feelings or it may set off some personal feelings of loss. It is important you select people to talk with who will be supportive and understanding. If people say unhelpful things, be direct and say, "We lost a baby and we need you to understand how awful this is for us."

If you have other children, this can be a confusing and frightening time for them. If you were hospitalized it is important to reassure them that are better now, and if they see you emotional tell them that it is because you are sad. Young children need to be reassured that you love and treasure them. If they are old enough to know that you were pregnant, they need to be told that the baby will not be coming. Your explanations will be different depending on their ages, to meet their level of understanding

If you are a single woman experiencing a miscarriage, addition to the above-described grief, you may feel very alone. It may be harder to share your feelings with family and friends, because they may not have been as supportive as you had hoped about your pregnancy. Lack of support or compassion may make you pull back from others and try to cope alone.

Long-Term Effects of Miscarriage

Just as it took time to adjust to the idea of being pregnant, it may take time to adjust to the non-pregnant state. There is a tendency for people to feel that they must get on with life and not focus on sad events and feelings. But, in truth, grieving is a process and healing is a process; with them, emotions ebb and flow. On some days or weeks you may feel fine; on others, you may feel sad and depressed.

One long-term effect of having experienced a miscarriage is the dread and fear that it will happen again. If you have had several pregnancy losses this is particularly true. Never again does a positive pregnancy test mean that your worries are over; for many, the early months of a pregnancy are filled with anxiety. Thoughts and memories about the previous pregnancy and miscarriage become more prevalent. You may not really dare to be happy. If there has been a history of infertility leading up to the pregnancy, you may feel you are back to the beginning, to fertility drugs, and other treatments. This, combined with the fear that a miscarriage might happen again, may intensify the feeling of being out of control of your life.

COPING WITH PREGNANCY LOSS

Consider the following if you have suffered a pregnancy loss:

- ❑ Realize that many people do not understand how great a loss miscarriage is and that the sometimes hurtful things they say are often borne out of ignorance.
- ❑ Understand that many people have a difficult time facing painful feelings; they avoid and deny their own and, likewise may be uncomfortable with yours. Remember, this is their problem and not yours. The pain you are feeling is a normal reaction to the loss you have experienced.
- ❑ Educate the important people in your life about pregnancy loss. Suggest that they read a book on the subject.
- ❑ Those who have gone through a pregnancy loss are the true experts on the subject. Ask family and friends if they or anyone they know has had a miscarriage and arrange to speak to them. Joining a RESOLVE support group can be very helpful for the same reason.
- ❑ Women sometimes minimize the emotional impact of miscarriage and blame themselves for not getting over it quickly. Miscarriage is both physically and emotionally stressful. It is important to give yourself time to heal.
- ❑ Recognize that miscarriage causes both physical and emotional reactions. Both pregnancy and the post-miscarriage periods are characterized by rapid changes in hormone levels. Mood swings and/or depression may be caused by or intensified by these hormonal shifts.
- ❑ Others may pressure you to return to "life as usual." This is an expression of their need for you to be over the loss and is unrealistic.
- ❑ Friends and family may offer help but may not know what to do for you. While nothing will make the loss better, it can be helpful to decrease some of your usual responsibilities. Ask for specific kinds of help.
- ❑ Some women dread having to tell people that they have miscarried. If you feel too fragile to deal with other people's reactions or if you prefer not to talk about what has happened, ask a friend, relative or co-worker to tell others for you.

- ❑ Often women who have miscarried find it difficult or impossible to be with friends who are pregnant or with those who have small babies. Give yourself permission not to visit if it feels too painful. Tell them that this is a very hard time for you, that you value their friendship, but that it is too painful to see them right now.
- ❑ Think hard before accepting invitations to baby showers, baptisms or first birthday parties.
- ❑ Anniversaries may be difficult. Often the date the pregnancy was lost and the due date are particularly painful. Expect to feel sadder than usual at these times. You may want to take the day off, attend a religious service, or mark the date in some special way.
- ❑ Holidays are also often difficult. They are times of celebration, a time when the family gets together, and a time you may have looked forward to. You may not want to participate in the usual manner. Think about observing the holiday quietly at home, or of attending festivities briefly.
- ❑ Couples who have experienced multiple miscarriages need to think about how much loss they can bear. At some point it is important to think about whether you want to continue trying.
- ❑ When one door closes there may be another which can be opened. Many couples find that it is helpful to look into the possibility of adoption as another means of building a family.

RESOURCES

- **RESOLVE:** The National Infertility Association
www.resolve.org; HelpLine 888-623-0744; HelpLine counselors and local nationwide chapters offer support and information on miscarriage and fertility-related issues.
- **The Compassionate Friends, Inc. (National Office)**
www.compassionatefriends.org; 630-990-0010; Provides support and information to couples who have experienced pregnancy loss.
- **Pregnancy and Infant Loss Center**
612-473-9372; Provides support, resources, and education on miscarriage, stillbirth, and newborn death.
- **Pregnancy Environmental Hot Line**
800-322-5014 or 617-787-4957 (outside MA).
- **SHARE Pregnancy & Infant Loss support Inc.**
www.nationalshareoffice.com; 800-821-6819; Offers support after miscarriage, stillbirth or neonatal loss.

SUGGESTED READING

- *Coming to Term: Uncovering the Truth About Miscarriage.* Jon Cohen, Houghton Mifflin, 2005
- *Miscarriage After Infertility: A Woman's Guide to Coping.* [Margaret Comerford Freda, Carrie F. Semelsberger](#), Fairview Press, 2003
- *Empty Arms: Coping After Miscarriage, Stillbirth and Infant Death.* Sherokee Ilse, Wintergreen Press, 2000
- *The Impact of Environmental Factors, Body Weight & Exercise on Fertility.* www.resolve.org.
- *Miscarriage: A Shattered Dream.* Sherokee Ilse, Wintergreen Press, 1992
- *A Silent Sorrow: Pregnancy Loss – Guidance and Support for You and Your Family.* Ingrid Khon, MSW, Perry-Lynn Moffit, Isabelle A. Wilkins, Brunner-Routledge, 2nd edition, 2000
- *Surviving Pregnancy Loss.* Rochelle Freidman, Bonnie Gradstein, Carol Publishing, 1996.
- *Unspeakable Losses: Healing From, Miscarriage, Abortion and Other Pregnancy Loss.* Kim Kluger-Bell, Perennial Currents, 2000

The information contained in this document is in no way intended to substitute for individual medical or legal advice. Discuss your situation with a qualified medical or legal professional.