Do We Scare Because We Care?

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Rarely considered are the harms—if any—we and our obstetric and midwifery colleagues, as well as the media, may perpetrate on a pregnant woman's mental health. A gestating female's brain is well designed to attenuate hypothalamic-pituitary-adrenal (HPA) axis responses and lower corticotropin-releasing factor as the mother moves toward delivery. This evolutionary hardwiring ensures that mothers remain calm and capable of handling the stresses of postpartum, including forging a secure attachment.[1] However, a quick look at what forces assault every pregnant woman's senses in America offers quite a different picture.

A randomly chosen pregnancy magazine offers stress galore[2]:

"Twice I dreamed that I was drinking a glass of wine. . . . When I woke up I had to reassure myself it was just a dream."

"I was paranoid about everything I ate, chewed, or drank."

"Even more upsetting is discovering you've already ingested something taboo."

"I know I should sleep on my side—I go to bed that way—but I often wake up on my back. Am I hurting my baby?"

Also included are articles on "The Big-Deal Tests—5 Main (and optional) Screening Tests," "Help! What Can I Eat?" and "Food-Safety Cheat Sheets."[2]

Meanwhile, if women visit prenatal providers hoping for reassurance, they often find more to fear. Turley[3] notes tremendous anxiety among patients—and providers—in obstetrics today. Obstetricians and midwives are understandably anxious in our litigious climate. Yet they often compensate with ever more interventions and operative deliveries, creating less time to reassure and educate patients on the realities of pregnancy and, particularly, on what current technology can and cannot do. Women face an unending menu of interventions and decisions, as well as the covert message that they can ensure a healthy baby if only they "do everything right." It follows then, if anything does go wrong, it must be solely the mother's fault.

As technology and interventions increase and prenatal care schedules decrease, the prenatal visit becomes a time to inform women on what test or procedure they may need to succumb to next, versus a time to answer concerns or questions, or offer reassurance. In a Swedish study by Hildingsson and Radestad[4] of satisfaction with prenatal care, very few women complained that their provider ever offered "too much time." Women who were dissatisfied with care often saw more than 2 providers and/or did not feel their provider was "supportive." Inadequate time spent on supportive counseling, encouragement, and questions produced the greatest risk of patient dissatisfaction.

Labeling women as "high risk," or simply "advanced maternal age," also increases prenatal stress, regardless of actual risk status.[5] Morbidity statistics for women under or over age 35 in fact do not differ.[5] In a qualitative study by Carolan and Nelson,[5] in Australia, women over 35 felt confident until they were labeled "at risk," at which point they often felt something must be wrong with their baby. They hoped for reassurance and often chose more testing to find it, yet repeated testing tended to fuel, rather than alleviate, anxiety. Reassurance was not forthcoming from providers, a lack that often added to stress and anxiety. Mothers perceived this high-

risk categorization as a crisis that did not abate until fully 4 to 6 months postpartum. The authors conclude that a small increase in risk status causes an "inordinate emotional response."

Hoskovec et al[6] compared women with soft ultrasound findings or abnormal serum screens to women of "advanced maternal age." The first group experienced significantly higher state anxiety compared to the advanced maternal age group. However, there was no actual difference in true numerical risk between groups. Anxiety caused by even simple interventions (ultrasound or a false positive blood test) created stress far greater than was congruent with actual risk.

Do we scare because we care? It would appear so. As a group, we must educate obstetric colleagues and ourselves—as well as the external media—on how to cope with our own anxiety (for instance, on current evidence-based data on psychotropics during pregnancy). We must remind ourselves of the essential normalcy of pregnancy, sober—versus sensationalized—assessment of risks, and, ultimately, the well-informed woman's choice as to treatment. We have a collaborative responsibility to offer reassurance, information, and support—no matter how good or bad the news may be—to each and every pregnant woman who is in our care.

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