NATIONAL CURRICULUM IN REPRODUCTIVE PSYCHIATRY

Infertility and Loss

Progressive Case Conference

Psychological Aspects of Perinatal Loss

Trainee Guide

Contributors

Jessica L. Coker, MD
Soudabeh Givrad, MD
Premala Jones, PhD

Structure of Session

Sessions are typically designed to last 90 minutes but can be modified for a longer or shorter session by either presenting both or one of the cases. Prior to the session, the trainees should read the articles included in the pre-reading section of this module. During the session, the cases will be distributed to trainees and will be read along by a resident volunteer. The entire group will then discuss the case as well as formulate the diagnosis and treatment approach based on facilitator guided questions. This session can be run by a single facilitator who oversees the entire group.

Breakdown of Session:

1) Review overview (5 minutes)
2) Case Presentation Part 1a including reading of the case and discussion questions (30 minutes)
3) Case Presentation Part 1b (15 minutes)
4) Case Presentation Part 2a (30 minutes)
5) Case Presentation Part 2b (15 minutes)

Goals and Objectives

At the completion of this session, participants will be able to:

1) Define various kinds of perinatal loss (Case 1)
2) Define psychological reactions and psychiatric disorders associated with perinatal loss (Cases 1 and 2)
3) Learn how to differentiate a normal grief process vs complicated grief and other psychiatric disorders such as Depression, Anxiety and PTSD (Case 2)
4) Learn about some of the appropriate treatments and interventions (Cases 1 and 2)
5) Discuss interview techniques that are suggested when evaluating and treating women with perinatal loss (Case 1)

Resources Required

1. A faculty (or senior resident) facilitator
2. A white board can be helpful for writing notes during large group discussions
3. Facilitator and student guides

Pre-assessment Learning

Before you attend the classroom didactics on this module, please review some basic concepts regarding the psychological aspects of perinatal loss by reviewing the following resources:

1) Self-study guide for perinatal loss

2) Barnes D.L. (Ed.). (2014). *Women's Reproductive Mental Health Across the Lifespan.* Springer.
    a) The Reproductive Story: Dealing with Miscarriage, Stillbirth, or Other Perinatal Disease by Janet Jaffe
3) Bhat, A., & Byatt, N. (2016). Infertility and perinatal loss: when the bough breaks. *Current psychiatry reports*, *18*(3), 31.

Overview

It is thought that most individuals have a reproductive story or mental representation, which is a narrative by mothers and fathers as they imagine what their child will be like, and what they will be like as parents. This narrative includes the internalized images of parenthood, the dreams and hopes of parents for their children and factors such as their own background, history, culture, traumas, and experiences within their family of origin can affect it. For many women and men this reproductive story might not be fully conscious, until they face infertility or perinatal loss. (Jaffe, 2017) Infertility, perinatal loss, or other medical traumas can disrupt and change these mental representations and reproductive stories in fundamental and often traumatic ways with lasting psychological effects on parents, their relationship, and possibly on how they relate to their children.
Perinatal grief following a reproductive loss can often be disenfranchised by close family and friends or society at large. Both women and men receive a message that they should grieve a particular way and on a particular time line. They are encouraged to get past their grief quickly, or told they should not experience certain feelings. Reproductive loss, similar to other losses, impacts women and men differently. For example, though it does not apply to all women and men, it is not uncommon for women to grieve intuitively and to experience and express their grief soon after the loss. Men tend to grieve instrumentally and often escalate in their experience and expression of grief later, sometimes up to years, after the loss. (Doka & Martin, 2011)

This progressive case conference encourages learners to discuss and learn about the *psychosocial* aspects of perinatal loss as well as *refine diagnostic skills* when determining treatment options primarily for women who have experienced this loss.

Case Presentation Part 1a: Guided Case Presentation (Psychological aspects)

Emma is a 35-year-old African American woman, gravida 3 and parity 1, that is coming to see you for a preconception consultation for anxiety. She reports a 1-year history of increased anxiety, difficulty concentrating at work and feelings of not being fully present when spending time with her three-year-old daughter. She reports being in a good marriage, but admits to feeling more distant and struggling with sexual intimacy at times. Recently, Emma's husband has expressed his desire to try for another baby. While Emma agrees with expanding their family, she admits she is feeling anxious and ambivalent about trying again. She is uncertain of why she feels anxious. During the intake she reports also being anxious about taking psychotropic medication during pregnancy.

Reproductive History: She reports two previous perinatal losses. One was at 8 weeks of pregnancy when she was 27 y/o and most recently she had a loss at 21 weeks about a year ago. She had multiple episodes of bleeding throughout that pregnancy and was reassured by her OB team. When she was 21 weeks pregnant she went to see OB for another episode of bleeding. During the visit her exam and ultrasound were reassuring and so she was sent home. On her way back home she had more cramps and bleeding. She presented to the ED and on ultrasound the baby had no heartbeat. Patient delivered via an uncomplicated vaginal delivery following labor with loss of fetus.

Past Psychiatric History: Emma has had a history of generalized anxiety disorder, history of panic disorder, resolved, and one episode of depression in the past year.

Social History: She lives with her husband of eight years, and their 3 year old daughter. She works as a manager at a local bank. She completed her MBA when she was 29 years old. She denies use of tobacco, alcohol and drugs.

Guided Case Questions/Discussion

1. What are the types of perinatal loss presented in this case? What additional types of perinatal loss are possible and what are some examples?

2. What are the psychological responses or psychiatric conditions that are common following perinatal loss(es) such as Emma's?

3. What other interview questions would you ask to get more of her reproductive story?

4. What interview techniques would be important when discussing her anxiety?

Case Presentation Part 1b: Guided Case Presentation, continued

You acknowledge and validate the feelings Emma and her husband have experienced and ask them to elaborate more on these feelings and experiences. You inquire about Emma's reproductive story, any history of previous losses or reproductive traumas, her dreams and aspirations for her family and herself as a mother and the feelings she is experiencing due to grief.

In a whispering voice, Emma reveals a history of abortion as a teenager that she has rarely discussed with anyone and the feelings of self-blame, guilt and shame that have resurfaced after this recent perinatal loss. She further admits she has not shared this with her husband.

Guided Case Questions/Discussion

1.How do you understand the effects of the abortion she had as a teenager on her current grief?

Case Presentation 2a: Guided Case Presentation (Diagnosis and Management)

Elizabeth is a 33-year-old white woman, gravida 2 and parity 1, referred to you for depression following the loss of her infant daughter. She is currently one month postpartum. Her daughter was diagnosed with Trisomy 18 at 20 weeks gestation and passed away 3 days after birth. She reports having difficulty with excessive crying, guilt, poor energy, and frequent thoughts of death and dying. She reports being fearful that her or one of her family members may also pass away. She also describes insomnia, poor appetite, and thoughts of wanting to be with her daughter in heaven. She states that these symptoms have gotten worse since her delivery. She is anxious and tearful on exam. She reports that prior to delivery she was more optimistic and feels that she should be more thankful for the time that she spent with her daughter. She has joined a support group on social media regarding the loss of an infant. She is very hesitant to take medications stating "I don't want to box my grief up and pretend it doesn't exist".

Past Psychiatric History: She has been seeing a therapist for one year since the sudden death of her father and describes this as supportive. She reports taking escitalopram (Lexapro) one time in the past after her father's death but reported significant GI side effects and did not continue.

Social History: She lives with her husband and 3 year old son. She denies marital discord. She became a stay at home mother during her pregnancy. She did complete college. She has started a blog to help with her grief. She has supportive family and friends. She denies use of tobacco, alcohol and drugs.

Guided Case Questions/Discussion

1.What are the differences and similarities between Major Depressive Disorder and Complicated Grief?

2. What diagnosis do you think Elizabeth has?

3. What treatment options could be presented at this initial appointment?

Case Presentation Part 2b

Elizabeth left her first appointment and decided that she did not think medications were the right choice for her but continued to see you and her therapist. Over the next few sessions with the you, patient continued to endorse depressive symptoms most days over the past several weeks including: feeling depressed, anhedonia, feelings of guilt, perseverations on death and dying, poor appetite, isolating herself at home, poor concentration, and weight loss. Furthermore, she endorsed having difficulty spending time with her 3 year-old and difficulty being present with him.

1. Would you change your initial diagnosis of this patient? If so, why?

2. What treatment recommendations would you give at this point?

Case Presentation Part 2c

Elizabeth elected to start escitalopram and engage in cognitive behavioral therapy after this appointment. She had moderate improvement over the next several months. At a follow up medication management appointment when she was 10 months postpartum, she informs you that she is 8 weeks pregnant with her third pregnancy. She reports an increase in anxiety since finding out that she was pregnant and having conflicting feelings of both happiness and guilt. She also reports that her husband has been more distant since they found out about this pregnancy and this has put strain on their marriage.

1. What are some difficulties women experience in their subsequent pregnancies after having perinatal losses?

References and further readings:

1. Barnes D.L. (Ed.). (2014). *Women's Reproductive Mental Health Across the Lifespan.* Springer.
    a. The Reproductive Story: Dealing with Miscarriage, Stillbirth, or Other Perinatal Disease by Janet Jaffe
2. Bhat, A., & Byatt, N. (2016). *Infertility and perinatal loss: when the bough breaks*. Current psychiatry reports, 18(3), 31.
3. Doka, Kenneth J and Martin, Terry L. Grieving Styles: Gender and Grief [online].Grief Matters: The Australian Journal of Grief and Bereavement, Vol. 14, No. 2, Winter 2011: 42-45. Availability: <https://search.informit.com.au/documentSummary;dn=339916590087229;res=IELHEA>ISSN: 1440-6888. [cited 30 Mar 19].
4. Fredenburg, M. (2008). *Changed: Making sense of your own or a loved ones abortion experience*. San Diego, CA: Perspectives.
5. Kersting, A., & Wagner, B. (2012). *Complicated grief after perinatal loss.* Dialogues in clinical neuroscience, 14(2), 187.
6. Life Perspectives: http://www.abortionchangesyou.com/
7. Life Perspectives: https://www.miscarriagehurts.com/

8. Markin, R. D. (2018). *"Ghosts" in the womb: A mentalizing approach to understanding and treating prenatal attachment disturbances during pregnancies after loss.* Psychotherapy, 55(3), 275.
9. Jaffe, J. (2017). Reproductive trauma: Psychotherapy for pregnancy loss and infertility clients from a reproductive story perspective. *Psychotherapy,54*(4), 380-385. doi:10.1037/pst0000125
10. Jaffe, J., & Diamond, M. O. (2011). *Reproductive trauma: Psychotherapy with infertility and pregnancy loss clients*. American Psychological Association.
11. Stroebe, M., Schut, H., Boerner, K. (2017). *Cautioning Health-Care Professionals. Bereaved Persons Are Misguided Through the Stages of Grief.* Omega (Westport). 74(4): 455–473.
12. Kluger-Bell, Kim. *Unspeakable Losses: Healing from Miscarriages, Abortions, and Other Pregnancy Loss.* Harper, 2000
13. Worden, J. Williams. *Grief Counseling and Grief Therapy: A Handbook for the Mental Health Practioner.* Springer Publishing Company, 2009.
14. Return to Zero: H.O.P.E. http://rtzhope.org/