Perinatal Loss and Maternal Mental Health

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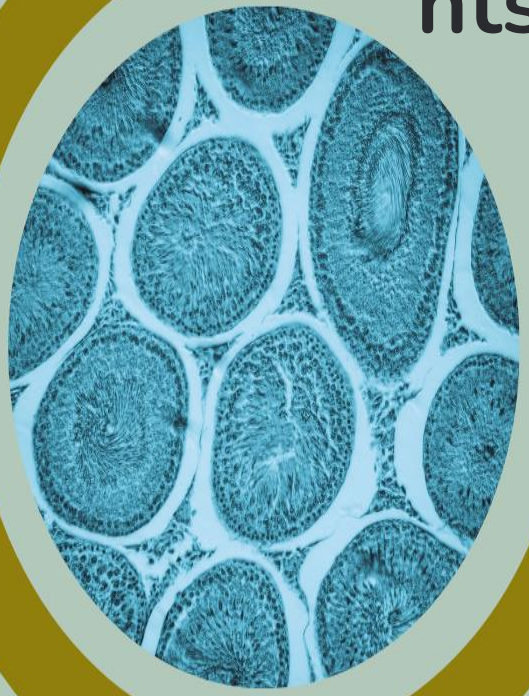
NATIONAL CURRICULUM IN REPRODUCTIVE PSYCHIATRY



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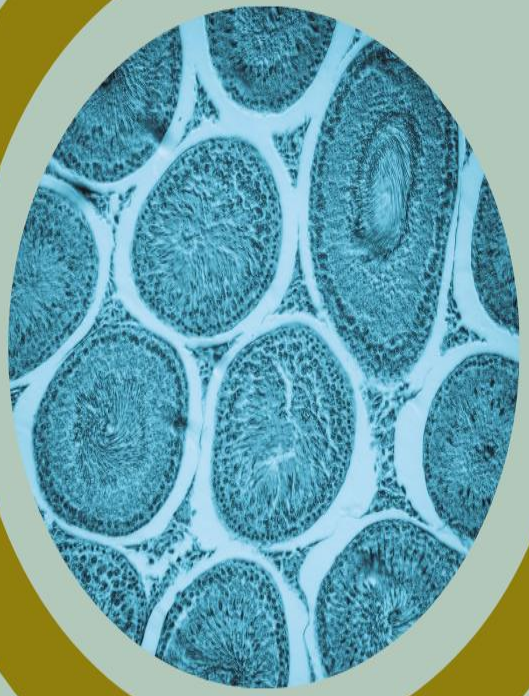
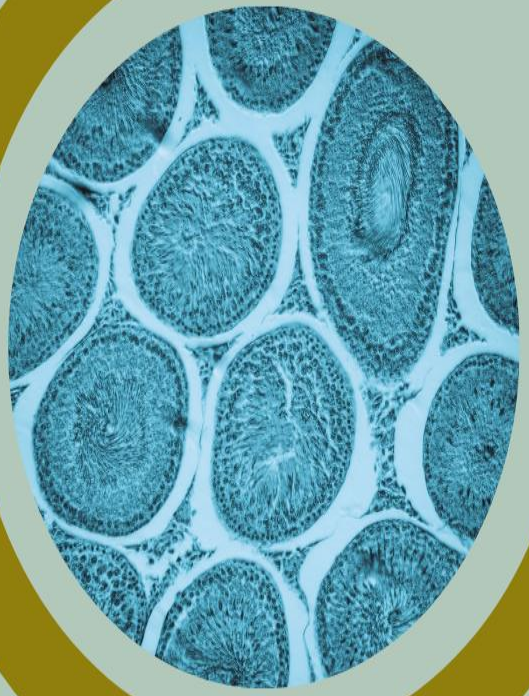


How to use this material

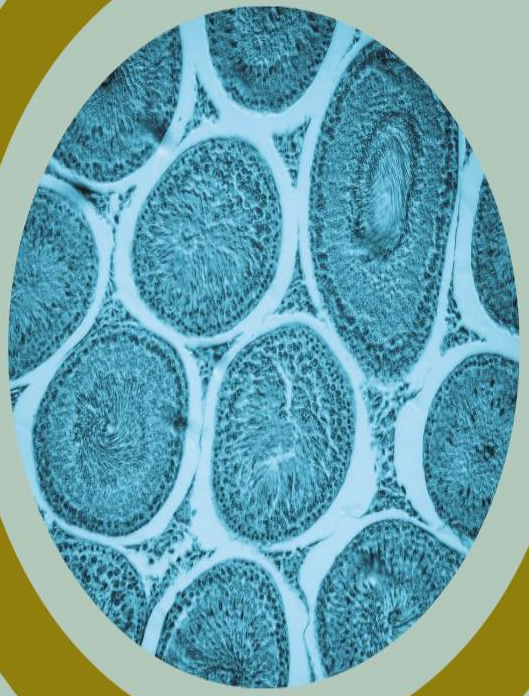
- Review slides individually or as a self study group.
- For questions, go to normal view and read the notes.



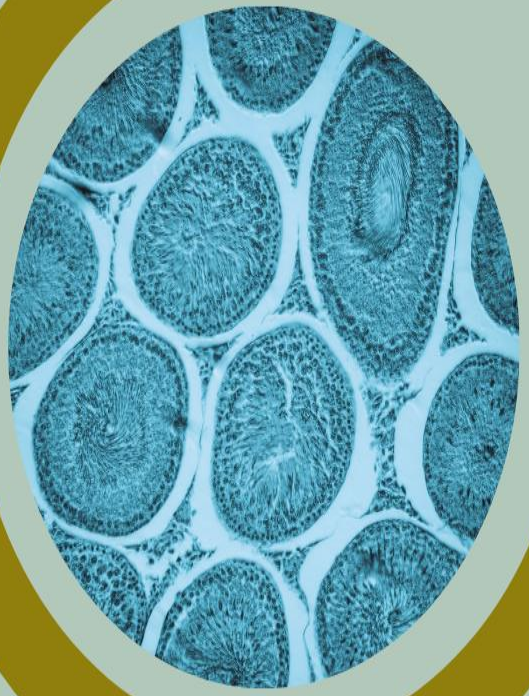
Learning Objectives:

- Develop an understanding of the mental health impact of perinatal loss
- Discuss the clinical approach to mental health impact of the patient with perinatal loss
- Appreciate unique factors in the management of perinatal loss as it relates to normal grief, anxiety, depression and other acute psychiatric presentations

Outline



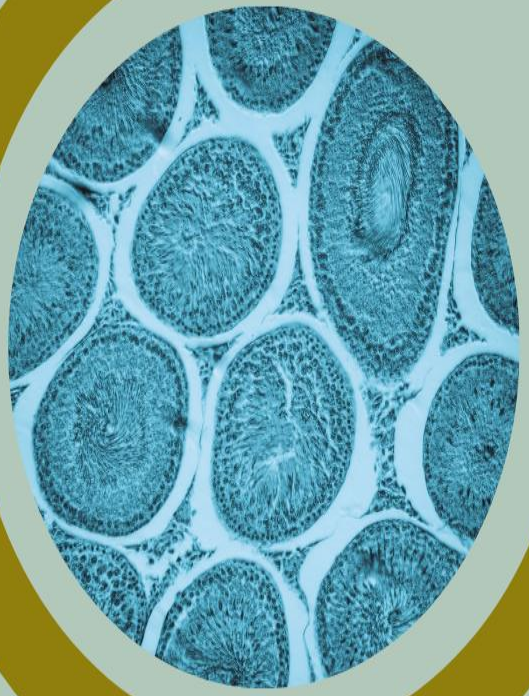
- Introduction/Overview
- Epidemiology
- Inpatient and Outpatient approaches
- Screening
- Diagnosis/Clinical Features
- Pathophysiology
- Treatment Considerations
- Key Clinical Points
- References
- Resources



Case

Marlee is a 36F, Black, non-Hispanic, G5P1122 at 24w gestation who presents to the hospital with chest pain and bilateral LE edema.

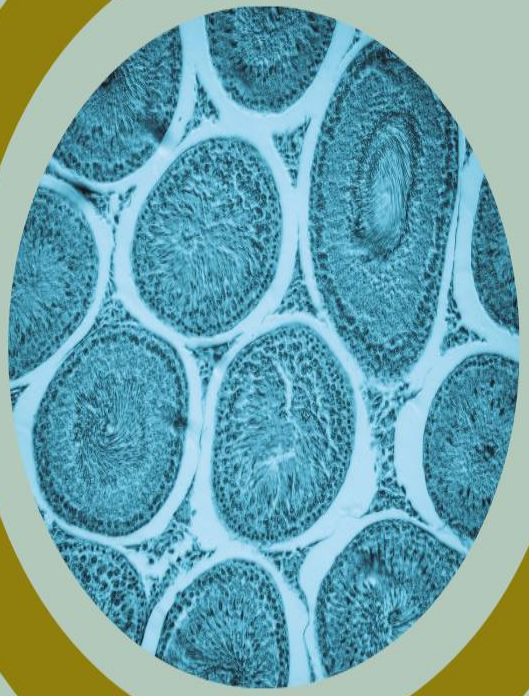
Social work notes she is married, works in a daycare, has two young children, and experienced pre-eclampsia in a prior pregnancy leading to preterm labor and NICU stay for newborn, ultimately discharged and now healthy and thriving. She also experienced a miscarriage and pursued D&E after genetic findings at 14 weeks. She has been in therapy on and off, never on medications.



Perinatal Loss: Definition: Not one thing

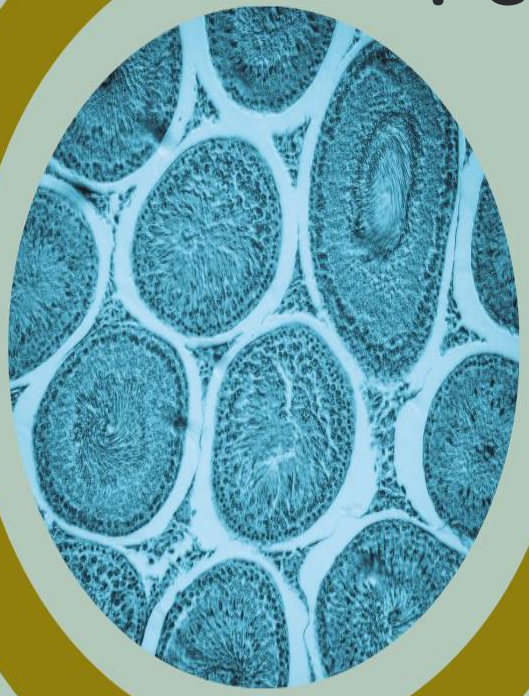
Either the non-voluntary end of pregnancy or death of the infant from conception until twenty-eight days postpartum, including:

- Miscarriage/Spontaneous abortion
- Ectopic pregnancy
- Stillbirth/Intrauterine Fetal Demise
- Neonatal death
- Termination for medical reasons
- Infertility (+ all the treatments)
- Recurrent Loss
- Fetal anomalies
- Maternal morbidity/mortality
- Abortion



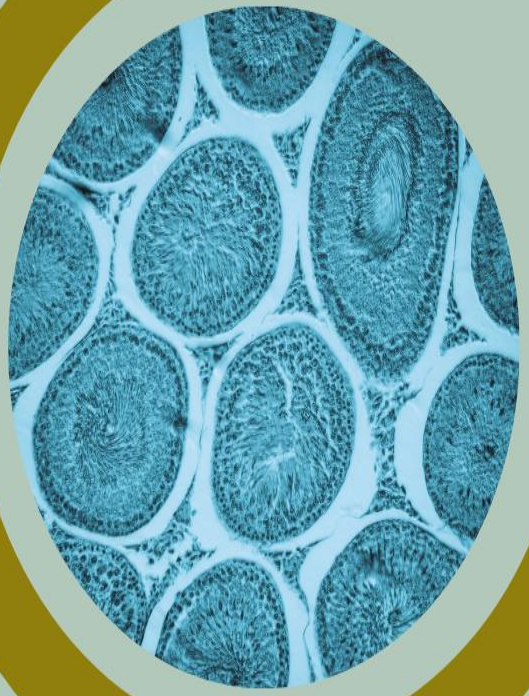
Perinatal Loss: Unique Factors to consider

- Causes are often unknown
- Stillbirth: higher rates in Black women & lower income women
- Non-Hispanic Black women more likely to experience miscarriage, IUFD and infant death
- In urgent situations (ie. pre-eclampsia), the patient's own medical literacy and history of trauma can dictate a lot of their experience of choice and agency



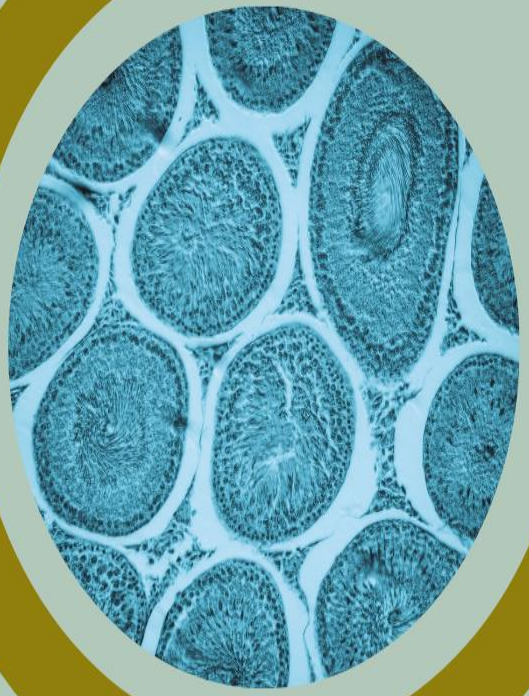
Perinatal Loss & Mental Health

- Experience of loss is common (25% of all pregnancies)
- Can be highly distressing
- Can be associated with significant psychiatric sequelae
- Not robustly studied or funded for mental health outcomes, though called upon often often as a priority for care (Lancet 2021 miscarrage series & Stillbirth paper series)
    - Retrospective
    - Single time-point
    - Self-reported
    - Scale based only, often a single scale
    - Not comprehensive.
    - Variable timing



Epidemiology: Perinatal Loss & Mental Health

- Perinatal loss increases the risk of depression (RR = 2.14) and anxiety disorders (RR = 1.27) when compared to controls
- Bereaved mothers are 7x more likely to develop symptoms consistent with PTSD than non-bereaved mothers
- Gestational age associated with increased rates of depression and anxiety.
- Miscarriage and ectopic pregnancy demonstrated cross-sectional rates of post-traumatic stress up to 29%, anxious symptoms up to 24%, and depressive symptoms up to 11%.
- Black women have double the risk of depression after perinatal loss compared to non-Black women



Epidemiology: Perinatal Loss & Mental Health

One comprehensive study from claims data in Florida following stillbirth (>23w) found significant increased risk of presentations to the hospital for psychiatric concerns.

- aOR for ED or Inpatient Psychiatric Admission within a year of loss between stillborn singletons versus liveborn singletons were as follows:
  - 3.16 for suicide attempt,
  - 2.75 of depression,
  - 2.29 for anxiety,
  - 2.27 for psychosis,
  - 4.36 PTSD,
  - 1.66 acute stress reaction,
  - 4.15 adjustment disorders,
  - 2.53 for drugs use/dependence,
  - 2.69 for alcohol use/dependence.

Take Home Messages from Lewkowitz Study, 2019

4% stillbirth
vs 1.6% live birth
have ED visit/Admission

2.5x
Increased risk of
ED/Admission for
psychiatric reason

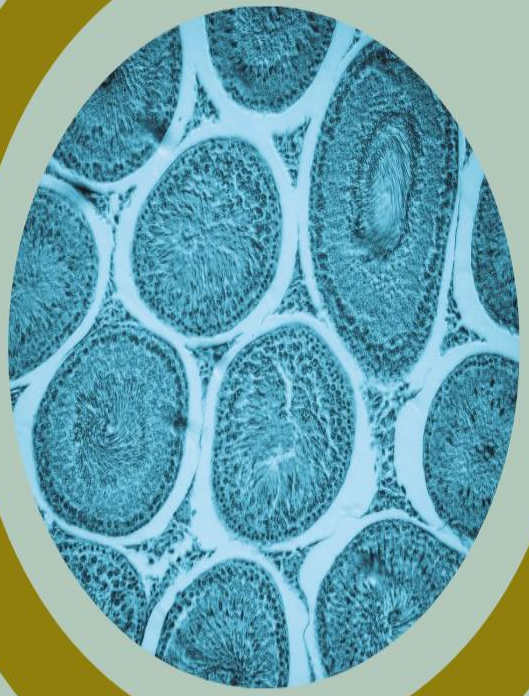
Nearly **3x**
increased risk for
hospital admission
after stillbirth

Depression and anxiety
were most common

Highest risk in **first four months** after stillbirth (aHR 3.26)

Risk remains elevated
in post-loss months
4-12 (aHR 2.42)

Supports prior study findings: 4x risk of depressive symptomatology and 7x risk of PTSD compared to live birth mothers (Gold 2016)

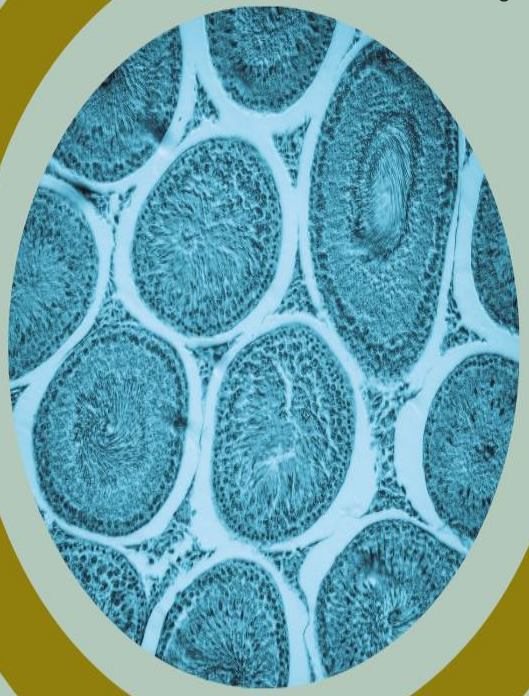


Case: Marlee is a 36F, Black, non-Hispanic, G5P1122 at 23w gestation w/ chest pain and bilateral LE edema.

Marlee is admitted to the hospital and initially observed for pre-eclampsia. Because she is in a state with more restrictive care laws, the team share with her that they are concerned about the progression of preE. Things escalate quickly and it is determined that her life is in danger without moving toward induction of labor.

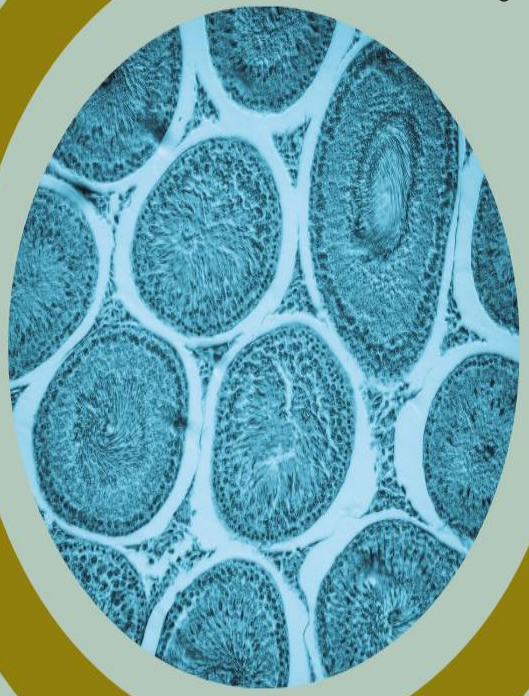
What are the best ways the team can mitigate trauma and potential distress at this point in care?

Inpatient/Immediate Care



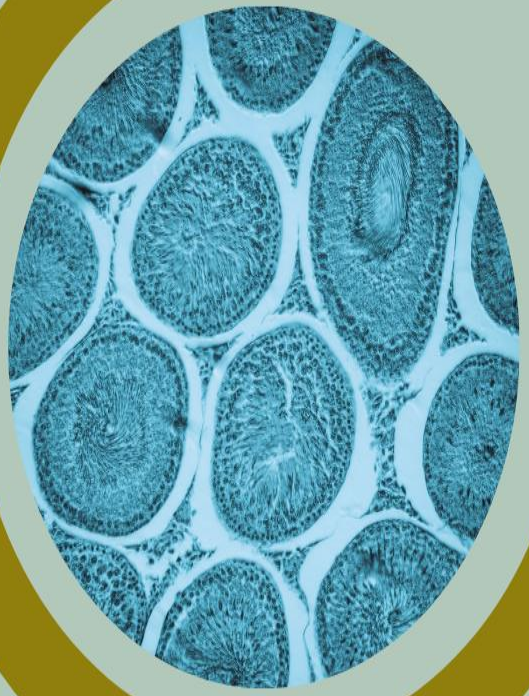
- The data remains mixed on how to discuss potential or confirmed fetal loss, though overall recommendations include patient-centered care to assist in shared decision making.
- The earliest phases of grief include shock and numbness, so many patient may not be able to formulate questions and request for needs.
- Early referral to local loss groups, online resources, and national maternal mental health hotlines are critical including:
  - **National Maternal Mental Health Hotline (1-833-852-6262)**
    - 24/7 support with reproductive mental health focus
  - **Postpartum Support International Warmline (1-800-944-4773)**
    - Assists patients with finding basic information, support and local resources
    - Business hours 8am-11pm EST; NOT a crisis hotline for emergencies

Inpatient/Immediate Care



Research in obstetrical journals focuses on:

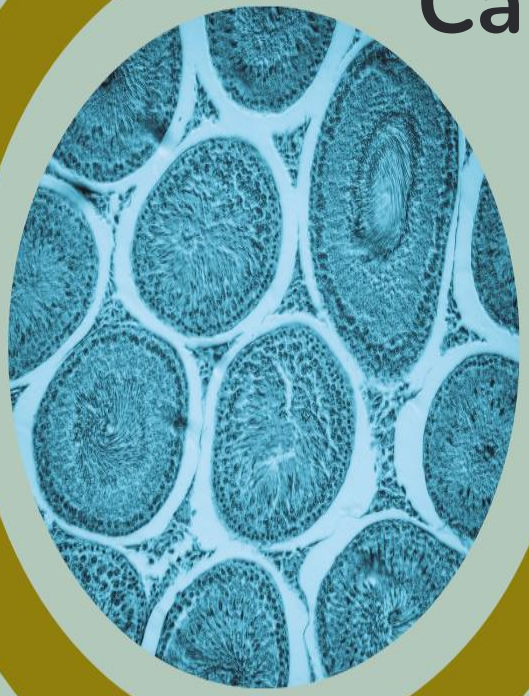
- Clear communication of results
- Recognition of parenthood
- Inquire from patient how they'd like to refer to the loss (ie. by naming the loss)
- Empowering parents in decision making
- If applicable, offer time with the stillborn/fetus/newborn (or not)
- Mementos
- Offering chaplain services
- If inpatient, try rooming patient outside of the postpartum area
- Make staff aware (ie. facilities staff)
- Providing resources
- Close obstetrical follow-up to discuss questions about the process
- Referral for psychological care
    - Maintain a resource guide!



Case

Marlee returns for her postpartum appointment 2 weeks. While she answers questions about her physical healing, she remains tearful and withdrawn during the rest of the appointment.

You are concerned. What are some ways to best handle this appointment and to consider next steps?

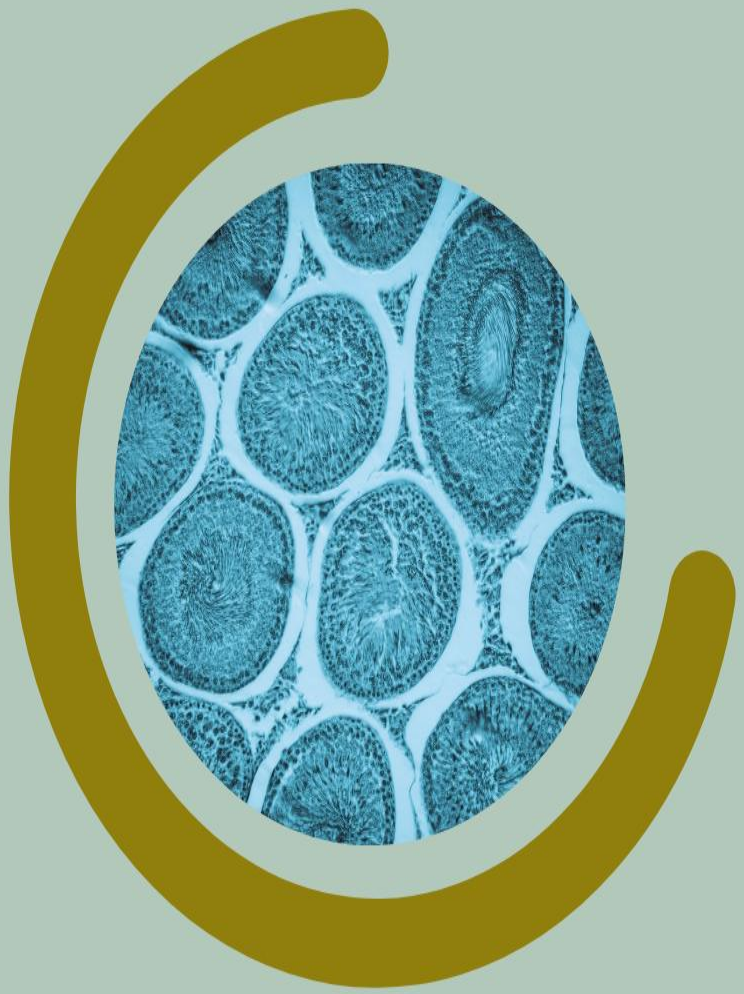


Fundamental Principles of Care following Loss

- When assessing for mental illness, it's not a question of Grief OR illness, it's Grief AND illness
  - While not wanting to pathologize normal grief, the skill is in assessing for comorbid mental illness that may impair progress through grief and functioning for patient
- Myriad responses – not always bad – some patients may find relief
- Using the language of the patient – if they name the pregnancy/baby, ask them and use that name

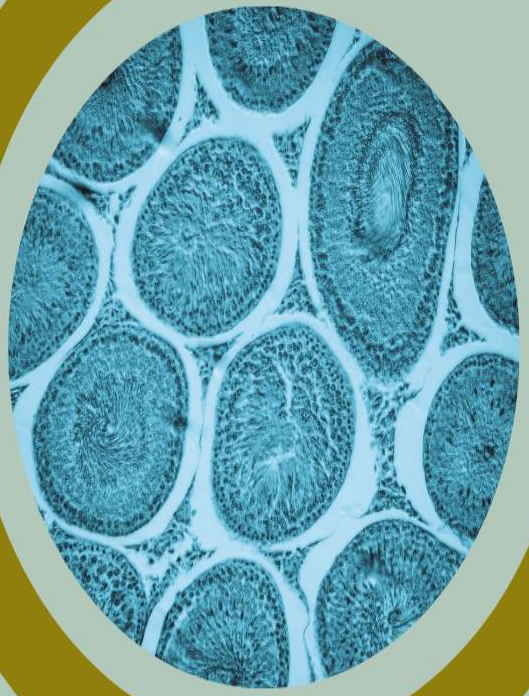
In Care: Building Rapport

Pearl/Pitfall	Description
Language related to the loss	Ask patient about preferred term for the loss; not mirroring language can be invalidating
Validate grief regardless of gestational age at time of loss	A common error is to minimize grief after early miscarriages; for some women, there was significant attachment in this time
Allow grief without the need for actionable items	Help patients understand grief without pathologizing it. Allowing patients to grieve openly can be the primary intervention.
Take a reproductive history and consider prior losses	Previous postpartum experiences may clarify post-loss risks; current loss may reignite grief from prior losses
Consider culture and/or religion	Familial, ethnic and religious culture can impact feelings of isolation, pressures to ignore grief, opportunities to find meaning
Do not focus on future pregnancies	Assuming grief will resolve with subsequent pregnancy is a common pitfall. Providing a space to focus on the recent loss is advised. Allow patients to dictate discussion about future attempts at conception.



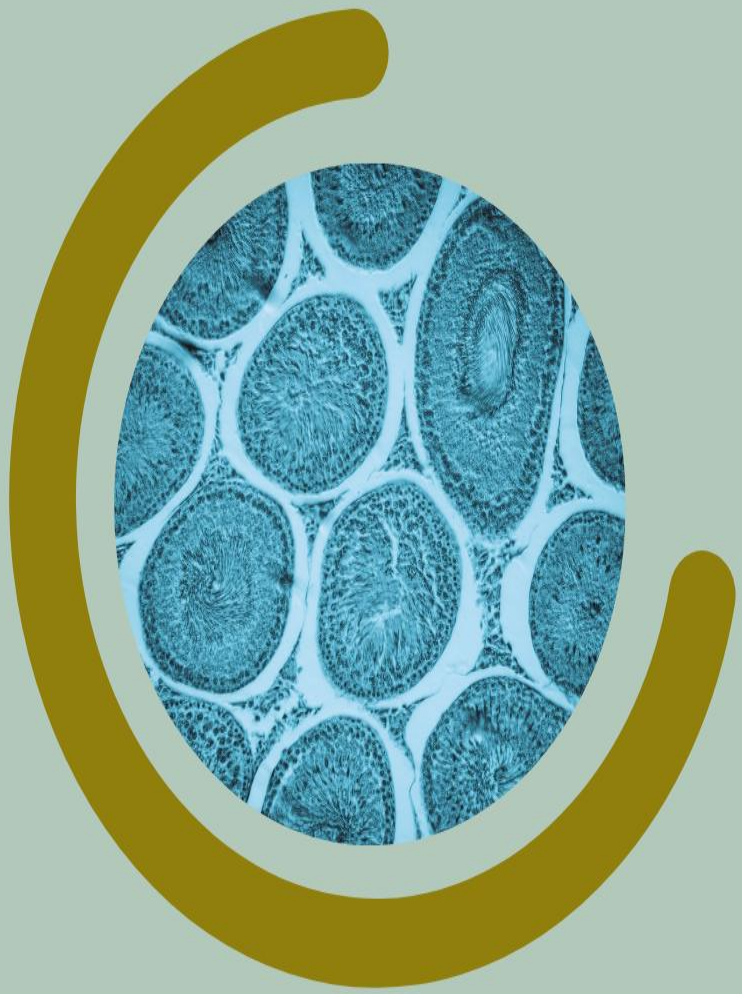
Screening

- Validated in perinatal loss population (but less accessible):
  - Perinatal Grief Scale
- Not validated in perinatal loss population but helpful:
  - Generalized Anxiety Disorder (GAD-7) scale
  - Posttraumatic Stress Disorder Checklist for DSM5 (PCL-5)
  - Quick Inventory of Depressive Symptomatology
  - Edinburgh Postnatal Depression Scale (EPDS)
    - See speaker notes on issue with the EPDS prompt
- Screen for use of alcohol and other substances
  - Alcohol Use Disorders Identification Test–Consumption (AUDIT-C)



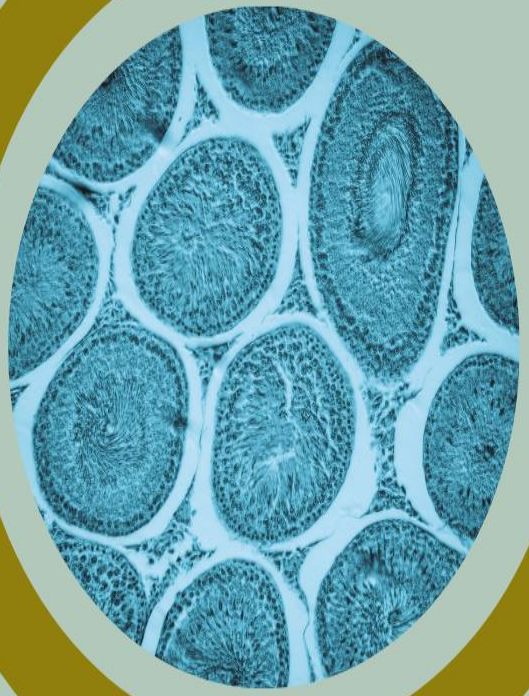
Common mental health conditions related to perinatal loss

- Grief/complicated grief
- Depressive disorders
- Anxiety disorders
- Acute stress disorder
- Post-traumatic stress disorder
- Suicidal thoughts
- Worsening of other underlying conditions



Assessment/Diagnosis: Risk Assessment

- Thoughts of suicide/self-harm
    - It is critical to ask about thoughts of self harm along with intent and plan
    - Women often describe “wishing it was me rather than the baby”
- Personal psychiatric history
    - Prior history of suicide attempts are the #1 predictor of future attempts
- Supports
    - Empower the patient to consider their support system
- Collateral
    - If there is a safety concern, reach out to collateral informants (spouse, parent, friend)
- Safety Plan
    - Consider having the patient complete a Stanley-Brown Safety Plan if there is a high concern



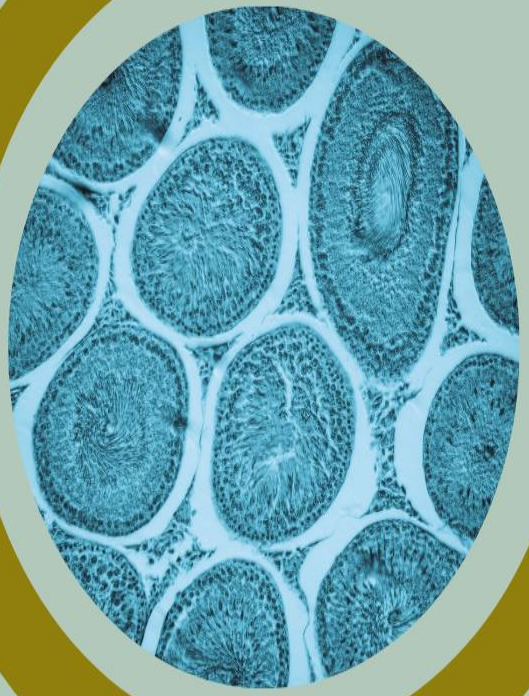
Pathophysiology: Risks and Protective Factors

RISK FACTORS

- **prior suicide attempts (largest risk factor)**
- prior suicidal ideation
- nonsuicidal self-harm
- history of physical or sexual abuse
- family history of psychiatric illness or suicide
- history of witnessing suicide

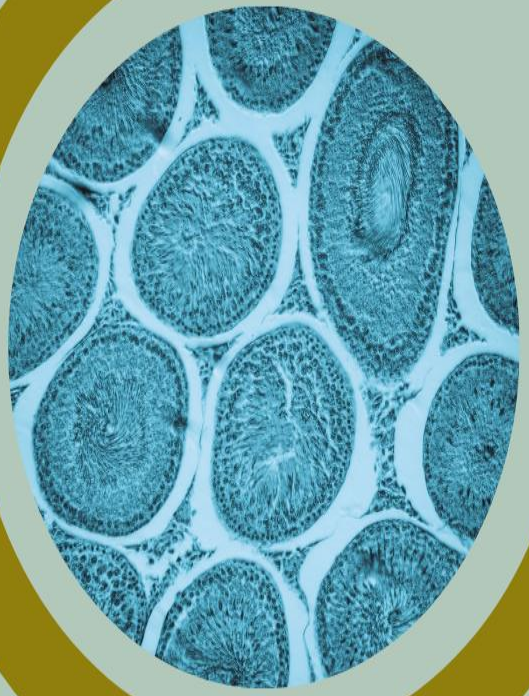
PROTECTIVE FACTORS

- responsibility for other children
- sense of support
- lack of prior suicide attempts



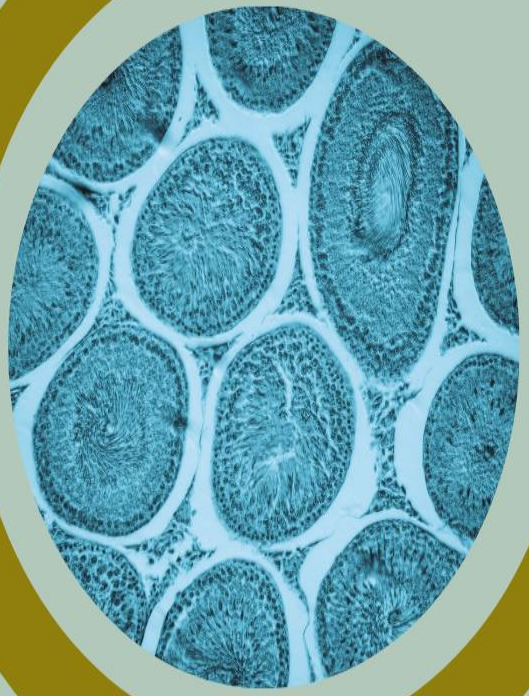
Treatment: Psychoeducation & Plan

- Discuss that grief is a normal and a “forever” process, though it does change with time
- Provide the structure of 6 months with caveat that this is not one-size fits all
- The goal is not to “forget” or “accept” per se – rather it is to integrate and accommodate
- Discuss how to monitor for developing a mental illness that may warrant medical treatment (because we can treat it!)
  - Goal: to allow grief
  - Refer early if concerned and (hopefully) find a medical provider that you like
- Ask the patient what they are hoping for
- Discuss a safety plan should suicidal thoughts develop



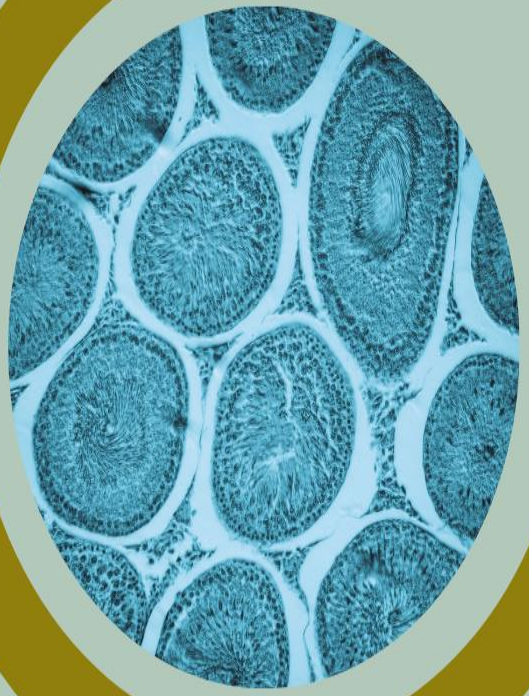
Grief

- Normal and very common
- Still very difficult
- Unknown trajectory
- Population data: 6 months with potential peak at 4 months
- Disenfranchised grief
- Associated with self-blame and guilt
- The unknown



Treatment

- No published psychopharmacology treatment studies of psychiatric conditions associated with perinatal loss
- However, it is common to be prescribed a medication--usually an antidepressant--in the year following perinatal or neonatal loss
- Until there are further studies on best practices, close monitoring and treating any underlying illness – depression, anxiety, OCD, PTSD – is the mainstay of treatment. This is considered separate (or in parallel) with the grieving process



Psychotherapy: general approach

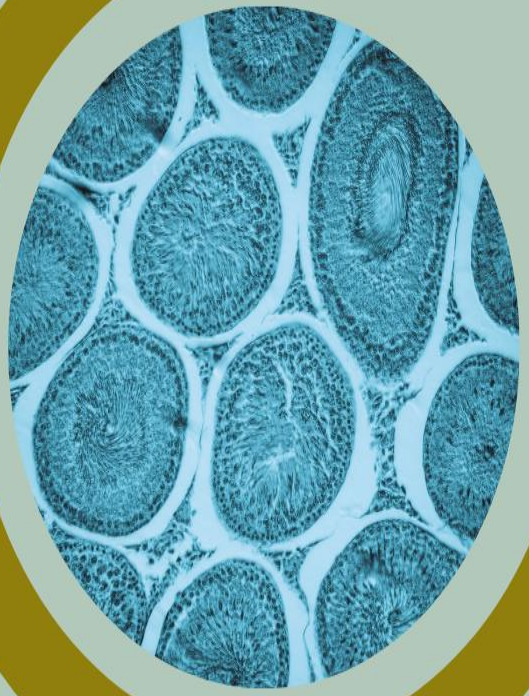
- Perinatal loss considered a highly personal; grieving patients often feel alone
- Perinatal loss has been called "disenfranchised grief," a grief that occurs when a loss is not generally recognized by society
- Many psychotherapy modalities studied and applied:
- Interpersonal Therapy (IPT)
- Acceptance and Compassion Therapy (ACT)
- Cognitive Behavioral Therapy (CBT)
- There are many virtual groups, but it is important to assess how a patient responds to groups (i.e.. some may not be vetted and thus can be potentially destabilizing)

Importance of Language

- I'm here to listen, *rather than* It will all be ok
- I wish I could take the pain away, *rather than* Things happen for a reason

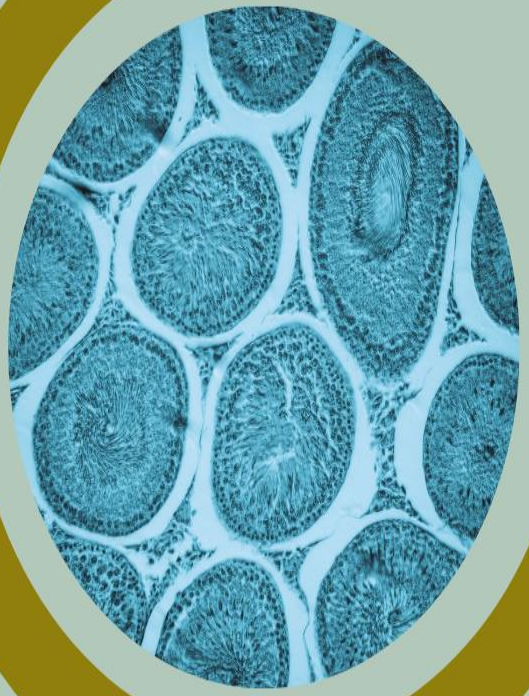
Other Considerations

- The family unit:
  - partner,
  - children,
  - grandparents
- Return to work parameters
- Care for yourself
  - Utilize debriefing or mental health service



Impact of perinatal loss on subsequent pregnancies

- Higher prevalence of anxiety (22%) and depression (20%) in patients with a history of stillbirth as compared to patients without it
- Symptoms can persist up to 6 -18 months after the birth of a live infant
- Perceived low levels of support can increase the risk of depression and anxiety in a subsequent pregnancy, as can pregnancy within the first year following the loss



Key Clinical Points

- Psychiatric illness can arise with grief after loss
- Screening and treatment can be difficult
- Refer for care – psychiatry and therapy – early (ie. if anomaly noted, if prior losses, high risk of PTL, prior/current psychiatric illness, etc)
- Consider language used with patient
- Care for yourself as much as possible as the secondary trauma of perinatal loss can uniquely impact OBGYNs

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Resources

- March of Dimes: Dedicated to dealing with grief and perinatal loss
- Return to Zero (HOPE): Engages with a global community of bereaved parents and their health care providers to improve mental health outcomes while also advancing pregnancy and infant loss awareness.
- Share Pregnancy and Infant Loss Support: Provides information for families and professionals about early pregnancy loss, stillbirths, and neonatal loss
- International Stillbirth Alliance: A coalition of stillbirth awareness groups and organizations that work to promote stillbirth research and awareness. The Alliance provides support resources for parents.
- The Miscarriage Association (UK): Support group that offers resources for families to cope with miscarraiage and spreads awareness of miscarriage. The Association has a ntwork of support volunteers and provides information to help people better understand miscarriage - including post-miscarriage tests and information on “trying again” after loss.

Resources

- The Compassionate Friends: Though not exclusively focused on pregnancy loss, the Friends provides support for families who are grieving the death of a child.
- Grief Out Loud: Offers online support for grieving families affected by pregnancy loss, stillbirth, or infant loss.
- Star Legacy Foundation: Supports research, education, and advocacy regarding pregnancy loss and neonatal death. The Foundation has counselors who are available 24/7.
- Faces of Loss, Faces of Hope: A place to share your story with others who understand.
- Black Mamas Matter Alliance: An advocacy organization focused on improving the health and well-being of Black women through research, policy, and cultural shifts.
- Grieving Dads - To the Brink and Back: A forum for dads to connect.