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COMMENTARY

Depression after miscarriage: Follow-up care is key

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A Washington Post article <https://www.washingtonpost.com/health/after-miscarriage-i-was-rocked-by-depression-like-many-other-women-i-didnt-get-follow-up-care-for-this-loss/2019/11/29/bd3dcff0-0729-11ea-8292-c46ee8cb3dce_story.html> on depression after miscarriage is a reminder that, although couples can suffer deeply from such a loss, there still are ways to provide them with meaningful support ("After miscarriage, I was rocked by depression. Like many other women, I didn't get follow-up care for this loss," by Katie C. Reilly, Nov 30, 2019).

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Psychiatrists who focus on reproductive psychiatry and collaborative care are trying to change the current therapeutic landscape and improve practitioner awareness and treatment. Ob.gyns. managing patients who have experienced reproductive loss, especially early-term loss, may not immediately refer couples to a therapist or psychiatrist, but we can change this. Practitioners who focus on reproductive health – both physical and mental – are trying to better understand such couples' experiences, increase their access to care, develop preventative care strategies, and improve provider education.

At the outset, providers who treat patients who have experienced a perinatal loss must recognize that not all individuals will feel that a loss is tragic. Instead, patient reactions occur along a spectrum, and there is no "correct" way to process a loss. A couple's reaction may depend on a variety of factors, including how late or early in pregnancy the loss occurs, whether the pregnancy is planned or unplanned, and what other psychosocial stressors, such as unstable housing, limited income, and few social supports, may exist. Not every patient experiencing grief, even profoundly, will shed tears; we need to be open to all potential reactions and be mindful when a person may need additional support.

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According to the Washington Post article, even though 50% of miscarriages are due to chromosomal abnormalities, women still feel ultimately responsible for the loss. As a society we are bombarded with "experts" in the media telling us the best way, the right way, the healthiest way to live. This barrage of advice distorts our views of what it really means to be a good parent and subtly conveys the idea that mothers are solely responsible for any bad pregnancy outcomes. I remember being fearful of causing unintentional harm to my unborn baby during my own pregnancy. What if I accidentally ate something that would affect her development? Is exposure to second-hand smoke as I walk down the street harming her? How bad would it be if I just had one cup of coffee? My doubts caused quite a bit of distress for me, which is a mild form of the distress I see when counseling couples after their miscarriages.

The article's author also expressed concern about the emotional sterility of the environment in which miscarriages usually occur: a hospital ED. EDs are designed to promote a level of detachment and to quell any stress for the clinicians so that they can calmly handle unexpected health crises. EDs are not primarily designed to provide patients with emotional support, nor should they be. However, we still can make some improvements to existing ED design to better address couples' emotional needs. For example, some EDs have placed mental health clinicians on staff, others call patients post discharge to address concerns, and some EDs even provide patients access to mental health trauma teams. Such services are not found in all EDs, and even those that exist may just scratch the surface of what is needed, but they are a step in the right direction. Providing this level of auxiliary care directly from the ED increases patients' ability to access mental health support in the place where miscarriages are most likely to be first diagnosed and managed.

The American College of Obstetricians and Gynecologists already is trying to fill in the missing pieces when it comes to identifying mood symptoms following miscarriage. One of the key recommendations from the May 2018 Committee Opinion on Redefining the Postpartum Visit

<https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Optimizing-Postpartum-Care?IsMobileSet=false> is that every woman who has experienced a miscarriage, stillbirth, or neonatal death should receive follow-up care. Mental health is a suggested component of the postpartum care plan. Some outpatient ob.gyn. practices and inpatient units are using screening tools to identify postpartum depression. For example, the Edinburgh Postnatal Depression Scale <http://perinatology.com/calculators/Edinburgh%20Depression%20Scale.htm> can be utilized following a miscarriage to help providers identify symptoms of depression and anxiety.

However, advancements in screening practices are only the tip of the iceberg of helping patients following miscarriage. A major question is how do we provide treatment? The trend in psychiatry over the past decade has been toward collaborative care, models that embed psychiatrists and other mental health clinicians in ob.gyn. practices to help guide the diagnosis and treatment of mental health problems. Some psychiatrists practice a co-located model in which they see patients alongside their ob.gyn. colleagues, whereas other psychiatrists treat a larger number of patients by using chart reviews for medication management while relying on behavioral health care managers for counseling and monitoring. Using this model of mental health care, more patients have access to services that are provided in a location familiar to them.

Another step in the right direction is the October 2019 launch of The National Curriculum in Reproductive Psychiatry (NCRP <http://ncrptraining.org/>), which provides free educational material for psychiatry faculty and residents to enhance education on topics related to reproductive psychiatry, including miscarriage, loss, and development of trauma disorders. NCRP aspires to develop educational materials for ob.gyn. residents.

In the past we may have missed the mark in recognizing and treating the trauma that prenatal loss can cause, but we are trying to improve our approaches. More and more couples are sharing their experiences and advocating for themselves and others, often creating change in medical practice, and doctors are starting to listen. As any clinician knows, changes to standards of care can take several years to disseminate into general practice, but this gap between knowledge and treatment is now in the forefront of our minds. I am hopeful that we will continue to make advances and provide better care to our patients who have endured the loss of a pregnancy.

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