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Depression and Anxiety Following Early Pregnancy Loss: Recommendations for Primary Care Providers

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ABSTRACT

Early pregnancy loss is a shocking and traumatic event for women and their families. Miscarriage usually induces an intense period of emotional distress. This reaction tends to improve over the following several months, but some residual psychological concerns remain. It is important to screen for depression and anxiety in patients following a miscarriage. Most women in this circumstance do become pregnant again, yet mood disturbances can still coexist. When women are having difficulties at conception, worries may be magnified. Most women and physicians see post-miscarriage intervention as desired, and it is important to provide appropriate treatment. Management of depressive and anxiety symptoms after pregnancy loss can benefit future patient well-being.

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Among the 6.5 million pregnancies in the United States in 2008, about 1.1 million ended in miscarriage.[1] Approximately 10%–25% of all pregnancies end in miscarriage, making it a common early pregnancy complication.[1] Pregnancy and birth are regarded as a joyful time, but early pregnancy loss is usually a shocking and traumatic event for women and their families. At the time of miscarriage, most women will experience a period of intense emotional distress. This reaction tends to improve by 6 weeks, with further resolution of symptoms after several months.[2] During the initial weeks following a loss, symptoms of grief may be impossible to distinguish from depression, and some women may continue to experience depressive symptoms for months.[2] Screening this population for depression and anxiety is difficult.

Contributing to the distress experienced after miscarriage is the fact that society may not recognize the significance of the loss to the parents. Traditionally when a death occurs, families are able to openly mourn their loss and receive support for many months. However, in miscarriage, the loss is sudden and often unexpected, and women may not have shared the fact that they were pregnant, leaving them to grieve alone, socially isolated.

The psychological impact of miscarriage is sometimes overlooked because miscarriage is so common and its management is medically straightforward. Although 90% of women desired specific follow-up care from their physician, only 30% of them received such attention.[3] Primary care providers, family physicians, obstetricians, and others

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CME Objective

After studying this article, you should be able to:

- Routinely screen patients after early pregnancy loss to identify those who need formal mental health evaluation and treatment

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Clinical Points

- Nearly 20% of women who experience a miscarriage become symptomatic for depression and/or anxiety; in a majority of those affected, symptoms persist for 1 to 3 years, impacting quality of life and subsequent pregnancies.
- Women at highest risk for psychiatric morbidity following miscarriage include those who are younger, Hispanic, or of lower socioeconomic status and those with loss of a planned pregnancy, a history of infertility or prior miscarriages, and poor social support or coping skills.
- Clinicians should screen women frequently for depressive symptoms beginning at 6 weeks following a miscarriage and may facilitate the assessment by utilizing the Patient Health Questionnaire-2; those experiencing clinically significant symptoms beyond 2 months after miscarriage should undergo formal mental health evaluation and treatment.

may lack comfort and training in assessing patients at risk for mental health problems following miscarriage. Some women are inadequately screened for depression or anxiety following early pregnancy loss, leaving them unidentified, untreated, and at increased risk of mental health sequelae.

PSYCHOLOGICAL DISTRESS

Women who experience the trauma of a miscarriage experience psychological distress, and the prevalence of clinically significant depressive symptoms is often underestimated. Subjects interviewed at 6 to 8 weeks following a miscarriage experienced substantially more depression than a matched cohort of nonpregnant women.[4] Further, 20% of them were considered overtly symptomatic for affective illness.[4] Six weeks after a miscarriage, approximately 11% of Chinese women suffered major depression and 1.4% were diagnosed with anxiety disorders; however, the incidence of major depression was lower than in studies conducted in Western cultures.[3] At 6 months following miscarriage, women are at a significantly increased risk for minor depressive episodes, and the majority developed symptoms within the first month after miscarrying.[5]

The uncertainties that women experience after a pregnancy loss contribute to a high level of anxiety, which may represent a greater psychological burden than depression. Concerns include waiting for the return of menstrual cycles, desire to conceive, risk of recurrent miscarriage, and fears about their reproductive abilities. At 12 weeks after miscarriage, anxiety was more frequent and intense than depression.[6] A 2007 investigation at 1, 6, and 13 months following miscarriage documented anxiety as more likely than depression at all 3 endpoints.[7]

Not only are anxiety and depression common following miscarriage, these symptoms tend to persist. While there is a gradual decrease in depression and anxiety over time, even at 30 months, some parents who experienced infant loss due to perinatal death or sudden infant death syndrome continued to show almost twice the level of psychological distress as controls.[8] A longitudinal study of over 13,000 women in the United Kingdom who had experienced previous prenatal losses revealed that some of them experience persistent depressive and anxiety symptoms after 33 months.[9] Depression following miscarriage persisted for up to 1 year.[10]

PSYCHIATRIC MORBIDITY AND SUBSEQUENT PREGNANCIES

Between 50% and 80% of women who experience miscarriage become pregnant again.[9] A subsequent pregnancy represents a time of intense and often conflicting emotions; couples balance being hopeful, while also worrying about the risk of a repeat loss. After miscarriage, 68% of women were still upset 2 years after the event, and 64% reported that it affected decisions about subsequent pregnancies.[6] Contrary to popular belief, becoming pregnant again is not a protective factor against depression or anxiety. Mood symptoms following a prenatal loss do not always resolve with the birth of a subsequent healthy child.[9]

A prior pregnancy loss is also a risk factor in developing depression and anxiety during future pregnancies. Research on over 20,000 pregnant Chinese women noted that those with a history of miscarriage had a greater risk of anxiety and depression during the first trimester than primigravid subjects.[11] Even conception less than 6 months after their loss did not reduce anxiety during the first trimester regardless of maternal age, education, body mass index, income, and residence.[11] Those with a history of miscarriage have higher levels of pregnancy-related fear during their first trimester, which correlates with complications including increased rates of vaginal bleeding, fatigue, hospitalization, and low APGAR (Appearance, Pulse, Grimace, Activity, and Respiration) scores in the neonate.[12] Although controversial, research suggests that the presence of anxiety or depression in a new pregnancy constitutes a risk factor for perinatal complications.[9–13]

Managing prenatal care in women with a history of miscarriage is challenging. Not only are these women at increased risk for psychiatric problems, they also may struggle with maladaptive coping skills that further complicate their situation. In parents studied, mothers tend to diminish the significance of previous loss in order to remain hopeful for the current pregnancy, while fathers experience frequent thoughts about the previous loss.[13]

HIGH-RISK POPULATIONS

Not everyone who experiences a miscarriage will develop clinically significant anxiety or depression, but several factors have been identified that can predict which women may experience greater emotional distress. These factors include loss of a planned pregnancy, history of infertility or long periods of trying to conceive, no warning signs of the loss, prior miscarriages, loss at a later gestational age, no living children, social isolation, relationship strain between partners, and prior history of poor coping skills.[2] Miscarriage exerts a greater depressive effect on women who are younger, Hispanic, and of lower socioeconomic status, and the level of depression rises with increased number of miscarriages.[4]

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Miscarriage management may also impact psychiatric symptoms. Surgical intervention after failed management exerts greater psychological distress.[14] Even though symptoms diminish during the early months after miscarriage, 25% of women experience clinical depression at 1 year.[15] Those who were depressed initially after miscarriage are more likely to remain depressed a year later.[15]

DISCUSSION AND RECOMMENDATIONS

There are discrepancies between patient needs and current medical practice. Women are responsible for seeking medical attention following miscarriage, and their perceptions of care following miscarriage indicate this approach is inadequate.[16] Among health care providers, 74% believe that routine psychological support should be provided following miscarriage, but only 11% feel that the level of care was adequate.[17]

Studies of patient satisfaction indicate the need for improvement in follow-up. After a miscarriage, many women want information about why their miscarriage occurred, implications for future pregnancies, and support from health care professionals.[18] Patient dissatisfaction often focuses on psychological issues.[17] Even though a follow-up appointment was desired by most women following miscarriage, there were no significant differences in levels of anxiety, depression, or grief between subjects who attended follow-up appointments and those who did not.[18] However, those not offered the opportunity to discuss their feelings during a follow-up visit reported more anxiety.[18] Health care professionals should address the psychological needs of patients who miscarry and assure them that mental health care is available.[17]

The timing of follow-up care plays a role in psychiatric symptoms. Because feelings of guilt experienced immediately following the loss can be particularly difficult, all women should be asked about self-blame. Since distress is most marked immediately after the loss, initial counseling should begin within 1 week of miscarriage.[2] Immediate counseling right after the miscarriage is diagnosed while patients are distressed is less helpful; it is better to reinforce this information at a later time. Telephone interviews conducted at 2 weeks after miscarriage were associated with significant reduction in depressive symptoms at 6 weeks and 6 months.[19] A 6-week post-miscarriage primary care office visit is the best time to screen patients.[5] Unfortunately, follow-up visits after medically managed miscarriages are rarely offered.

Extensive training is not needed to identify patients experiencing clinically significant symptoms. The Patient Health Questionnaire-2 instrument is sensitive and specific for detecting postpartum depression.[20] When significant distress or impaired functioning persists for more than 2 months after miscarriage, a formal mental health evaluation is indicated.[2] Untreated anxiety is associated with an increased risk of developing depression.[7] Primary care providers should counsel women with a history of miscarriage that they may experience an increase in emotional distress during a subsequent pregnancy. Clinicians should review the patient's obstetric history for past traumatic experiences that could increase the risk of depression and anxiety during subsequent pregnancies.[13] Providers should consistently be proactive in discussing previous losses, current emotional states, ongoing psychological distress, and plans for future pregnancies.

The World Health Organization recommends waiting 6 months following miscarriage before conceiving again to allow time for physical and mental recovery.[21] However, for women who have a desire to have a child quickly, delaying efforts to conceive may be an additional strain. Infertility is recognized as a source of psychiatric morbidity regardless of miscarriage history. Clinicians should counsel women on the warning signs of developing anxiety or depression and screen them for symptoms during each prenatal visit.

The American College of Obstetricians and Gynecologists[22] recognizes the increased incidence of depression during pregnancy and postpartum, yet, they do not recommend universal screening despite acknowledging the benefits of the practice. Miscarriage is a significant source of psychiatric morbidity, and the lack of screening increases the risk of psychiatric sequelae. Primary care providers should maintain a high index of suspicion and a low threshold to screen women for developing depressive symptoms following miscarriage. This is especially important for those with a history of prior miscarriage, those who are younger or Hispanic, those who have a history of infertility or lower socioeconomic status, and those with a history of depression, anxiety, or poor coping skills. Distress following a miscarriage falls along a continuum of symptoms and follows a waxing and waning course, and frequent screening is indicated.

Disclosure of off-label usage: The authors have determined that, to the best of their knowledge, no investigational information about pharmaceutical agents that is outside US Food and Drug Administration–approved labeling has been presented in this article.

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Posttest

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1. Up to 1 in 4 pregnancies end in miscarriage. Most women experience intense emotional distress after early pregnancy loss, and some develop clinically significant psychological symptoms. According to this review, clinicians should routinely screen patients for mental disorders beginning ___ after miscarriage.

a. 1 week

b. 2 weeks

c. 4 weeks

d. 6 weeks

2. Which of the following characteristics is a predictor for clinically significant anxiety or depression after miscarriage?

a. History of infertility

b. Lack of prior miscarriages

c. Higher economic status

d. Presence of living children

3. Ms A had a miscarriage 6 months ago and is now pregnant again. Her current pregnancy is a protective factor against anxiety and depressive symptoms related to the miscarriage.

a. True

b. False

4. You are seeing Ms B about 2 months after an early pregnancy loss. Which of the following steps should be *avoided*?

a. If screening indicates a possible mood or anxiety disorder, provide a formal mental health evaluation

b. Discuss plans for future pregnancies only if Ms B asks, because bringing up this topic could negatively affect her mood

c. Screen Ms B for mood and anxiety disorders at each office visit, because distress following miscarriage follows a waxing and waning course

d. Provide information and support, and address issues of self-blame

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