When the Bough Breaks: Psychological Management of Perinatal Loss

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Disclosure Statement

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Objectives

Review risk factors for development of psychiatric disorder after a perinatal loss.

Describes non-pharmacologic and pharmacologic management of grief symptoms.

List a step-wise approach in the management of a patient suffering from a perinatal loss and struggling with depressive symptoms.

Grief is a Natural Response to Loss

Primary loss	• Loved one or major life changes
Secondary loss	• Perceived or real loss: • freedom, companionship, support services, recreational, school and spiritual activities, family gatherings
Anticipatory loss	• Anticipation of the unknown future

Symptoms of Grief

EMOTIONAL/PSYCHOLOGICAL	PHYSICAL
Disbelief	Fatigue
Avoidance	Nausea
Trouble accepting the loss	Trouble breathing
Anger	Weight changes
Sadness	Difficulty falling or staying asleep
Fear	Restlessness
Social withdrawal	
Feelings of disconnectedness	

Risk Factors for Psychological Distress after Pregnancy Loss

Childlessness

Higher number of previous reproductive losses

Personal history of psychiatric illness

- >50% risk of MDD after perinatal loss

Surgical vs. medical management

Less support from partner/social network

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Surgical vs. medical management

Grief Post-Miscarriage

40% women suffer from grief symptoms

Symptoms include:

- Sadness, yearning, desire to talk about loss, search for meaningful explanation
- Guilt w/ underlying self-blame

Symptom resolvement varies: 3 months - 2 years

Pathological grief

- Despair
- Feelings of hopelessness/helplessness/worthlessness
- Difficulty in performing activities of daily living

Depression Post-Miscarriage

20-55% report elevated depressive symptoms

- 2-3 weeks post-miscarriage, 3.6x pregnant, 4.3x community w/o pregnancy loss

Incidence of clinical major depressive disorder

- 10-50% diagnosed 4 weeks-6 months post-loss
- Symptoms remain elevated after 6 months and may return to baseline after 1 year

Increased suicide rate

- 18.1/100,000 post-miscarriage
- 5.9/100,000 after live birth
- 11.3/100,000 reproductive age

Anxiety Post-Miscarriage

20-40% report elevated anxiety symptoms

- Focus on pregnancy-related issues, somatic/physical symptoms
- Concern of cause of miscarriage and risk of recurrence
- Up to 4-6 months post-loss with return to background levels by 1 year

Increased risk for anxiety d/o post-miscarriage

- Obsessive-compulsive disorder: 8.0 relative risk (significant)
- Substantial, but not significant increase in panic disorder
- Conflicting results re: PTSD

Pregnancy Subsequent to Miscarriage

50% who miscarry become pregnant within 1 year

Increased pregnancy-related anxiety

If conceive < 1 year post-miscarriage, higher rate of state anxiety during 3rd trimester and one year postpartum

However, if experienced grief/depression with miscarriage, subsequent pregnancy may provide healing

Psychological Management following Miscarriage

92% wanted follow-up care, 30% received any

- 40% dissatisfied w/ care received after miscarriage

GHQ-12 found to be satisfactory screening

Limited data on what psychological intervention is most useful, appropriate format, delivery

Late Pregnancy Loss

Psychological Effects of Perinatal Loss

Sadness, guilt, irritability, somatic symptoms

- Severity of symptoms decreases after 1 year
- 20% women w/ symptoms 1 year after loss
  - Prolonged symptoms associated with: poor social support, history of mental illness

20% experienced PTSD symptoms

- 4% w/ symptoms persisting after 1 year

Marital dissatisfaction

Psychological Management

Explanation of the stillbirth

Organization of their care

Support in time of chaos

Support in meeting with and separation from the baby

Support in bereavement

Understanding the nature of their grief

Delivery Decisions

Opportunity to decide on spontaneous vs. induction of labor (IOL)

- Spontaneous labor typically begins within 1-2 weeks of demise
- Waiting may decrease medical complication of IOL

Choice (in absence of maternal medical concerns) of hospital admission vs. going home

- Somewhat controversial: studies demonstrate increased anxiety in years after loss in women who were induced 24 hours after diagnosis vs. 6 hours

C-section should be reserved for unusual circumstances

Delivery Decisions, cond.

Parental CHOICE of how to form bond with baby
- Seeing/holding baby
  - Consider malformations or advanced maceration – swaddling?
- Giving child name: Staff should refer to child by name if one is given
- Taking photographs
- Having "keepsakes"
- Having a funeral or memorial service

Transfer to postpartum floor vs. general floor; identification on door if on L&D floor

Breast engorgement/milk production

Birth certificate not generated; a fetal death certificate may be issued instead

Autopsy discussion
- Gross examination of the fetus and placenta
  - If there is a clear finding, then this should be communicated.
- Otherwise, wait until all tests and examinations have been completed before speculating about the cause of death

Contact with Stillborn Infant

Developing a connection with the baby makes the death real, helps prevent emotional withdrawal from the loss

Prospective study over 12 years. Majority want contact, but different options and no single option was chosen by all parents

Systematic review. 21 of 23 studies suggest that viewing and holding the stillborn aids healthy grieving and mourning and reduces the risk of long-term psychological problems, there is some controversy.

- Some studies have reported that encouraging parents to view and hold the stillborn can cause psychological morbidity in the subsequent pregnancy and increases the risk of clinically significant posttraumatic stress, anxiety, and depression
- May be related to how well the parents were prepared for seeing and holding their baby, the support they received, and their sense of control of the decision.

Post-Discharge

Follow-up visit with care provider earlier than usual 6 week post-partum visit

Review emotional status, query depression and anxiety symptoms

Review autopsy and possible reason for death or have set timed intervals to check in with patient regarding results, as may take several weeks/months

Important to discuss possible causes and risk for recurrence and plan for another pregnancy

Conception planning

Management of Future Pregnancies

No data to suggest optimum interpregnancy interval

Reasonable to recommend delay of conception until psychological closure, often thought as 6-12 months

Consider anniversary dates as potential triggers

Management of Symptoms of Grief

Insomnia

Dissatisfaction with sleep quality or quantity:

- Difficulty falling asleep
- Difficulty staying asleep
- Inability to return to sleep after wakening

Disorder and a symptom

- Prominent with anxiety disorders and depression

Pre-existing condition can worsen during pregnancy

How quickly are you able to fall asleep? How long do you sleep for?

Are you waking yourself (ie need to urinate or discomfort) or is something waking you ?

How do you think your sleep is?

Are you (or does your partner tell you) snoring? Do you experience restless leg sensations?

How alert does she feel during the day? Do you feel rested in the morning?

Anxiety

Spectrum of anxiety symptoms and disorders
- GAD, PTSD, OCD, panic disorder

As common as depression

Anxiety may occur in conjunction with depressive symptoms
- Usually a more severe illness, and more difficult to treat or independently of mood disturbances

Symptoms that impact functioning!
- Persistent and excessive worries
- Inability to relax
- Physiological arousal
- Intrusive thoughts

Screen…but Interpret Cautiously

Generalized Anxiety Disorder-7 (GAD-7)	Patient Health Questionnaire – 9 (PHQ-9)
7 items <5 minutes to administer Using cut-off score of 10: Sensitivity 89% Specificity 82% Free to administer	9 items < 5 minutes to administer Using cut-off score of 10: Sensitivity 75% Specificity 90% Free to administer Assesses suicidality

Non-Pharmacologic Treatment Options

Treatment Options

Options with evidenced based use

- Psychotherapy
- Complementary Alternative Options
- Sleep hygiene
- Self-care

Emphasize Sleep Hygiene

Consistent bedtime and out of bed time

Bedroom is only for sleep/sex

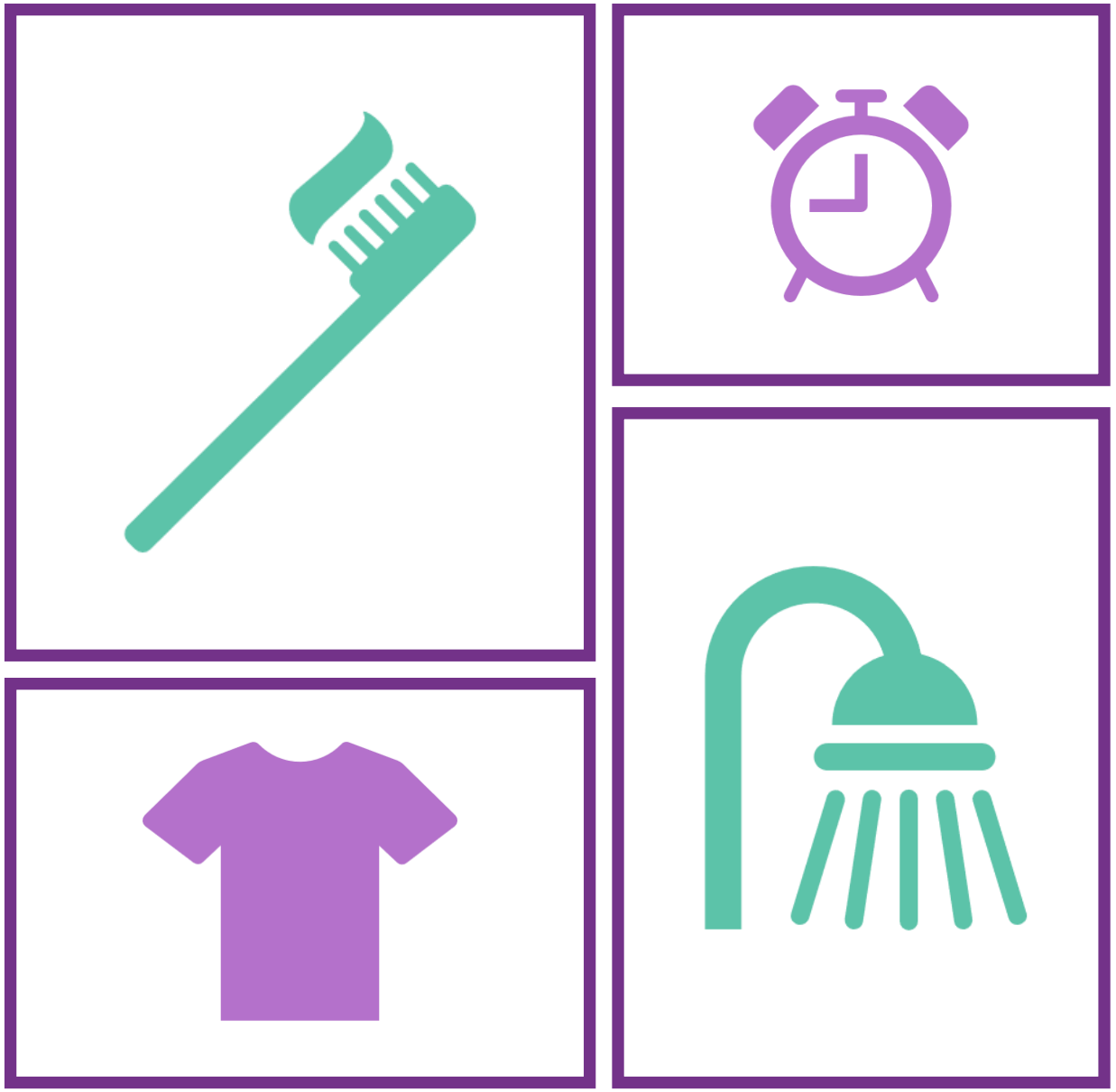
Move clocks/screens away from reach

If not asleep within 30 minutes (by perception), get out of bed and do something quiet (without a screen) until feel tired

“No More Sleepless Nights” by Peter Hauri

Apps to utilize:

- CBT-I Coach
- CALM
- Headspace



Good Self Care

Maintenance of routine
- Shower
- Brush teeth
- Change clothes

Sleep hygiene

Nutrition: schedule times to eat

Once cleared to exercise, attempt to do so daily

Get outside!

Avoid alcohol, tobacco and other drugs

Allow self to take time off work/other responsibilities

Say “YES!” to those with offers of help

Connect with friends/family

Encourage Patients to Ask for Help

Get creative to maintain social distancing!

Meal drop offs

Running errands

Take shifts with partner for child duty

Talk to doctor if symptoms do not improve

Things you can do!

Make direct eye contact with patients

Use supportive & clear verbal communication

Close follow-up appointment for both physical and MENTAL health

- If do not appear for appointment, reach out!

Screening tools to gauge depressive and anxiety symptoms

Pharmacological Treatment

Goal is to NOT medicate grief!

Do NOT prophylactically start antidepressant after loss

Appropriate to utilize PRN medications to aid with symptom relief

Primary issues with grief that can benefit from medications:

- Anxiety/panic symptoms
- Insomnia

Over the Counter Sleep Aids

Doxyalamine (Unisom)	Diphenhydramine (Benadryl)	Magnesium	Melatonin
• Anticholinergic	• Anticholinergic	• Best taken on nightly basis • Aids with anxiety • Can cause GI distress	• Best taken on nightly basis • Needs to be taken 2 hours prior to sleep to be effective

Prescription Sleep Aids

Zolpidem (Ambien)

- Typical onset with 20-30 minutes, lasts 4-6 hours
- Sleep walking/eating/doing activities without knowledge

Zalpelon (Sonata)

- Best for use of initial insomnia given short half-life (~90 minutes)

Trazodone

- Best for middle/terminal insomnia given longer half-life
- Worst offender of morning grogginess
- Has antidepressant properties
- Least concern for physiologic dependence/addiction concerns

Comparison of Sleep Aids

AS NEEDED UTILIZATION	CHRONIC, NIGHTLY USE
OTC sleep aids: doxylamine, diphenhydramine, melatonin	Magnesium supplementation
Low dose benzodiazepines	OTC sleep aids: doxylamine, diphenhydramine, melatonin
Zolpidem	Trazodone
Zaleplon	Zolpidem (short term)
	Zaleplon (short term)
	Mirtazapine

Comparison of Anxiolytic Medications

	Lorazepam	Hydroxyzine	Buspirone	Gabapentin
Mechanism	Enhances the inhibitory effects of GABA	Histamine blockade	Partial agonist of serotonin 5HT1a receptors	Modulates the action of the GABA synthetic enzyme
Dosing	0.5-1 mg PO BID PRN; goal < 3x/week	25-50 mg PO BID-TID PRN	5-10 mg PD BID-TID	300 mg PO TID
Side effects	Dizziness, poor memory/attention	Anticholinergic! Dry eyes, mouth, constipation	Dizziness, HA, GI upset	Edema, nystagmus
Considerations	Concern for patients with SUD		Most effective scheduled; dose escalation may be needed	Consider if would aid with pain control

And if an Antidepressant is Needed…

Return to utilization of previous effective antidepressant

- If patient not recently on antidepressant, will need to re-titrate

Monotherapy if possible

If no history of antidepressant use, SSRIs are first line management

UNLESS utilizing other classes for their side effect profile or other indications

SSRI: Serotonin Specific Reuptake Inhibitors

Represent over 60-70 % of new prescriptions for depression

Easy to use and dose

High therapeutic index

Common side effects:
- Headaches
- GI upset
- Weight gain dependent on anti-cholingeric activity
- Sexual dysfunction
- Withdrawal syndrome

Once at “baseline” mood/anxiety, would want to continue for minimum of 6-12 months after that time

Fluoxetine (Prozac)

Sertraline (Zoloft)

Paroxetine (Paxil)

Citalopram (Celexa)

Escitalopram (Lexapro)

Fluvoxamine (Luvox)

Bupropion (Wellbutrin)

MOA: enhances both noradrenergic and dopaminergic neurotransmission via reuptake inhibition of the norepinephrine transporter and the dopamine transporter

Indication: Major depressive disorder, Smoking cessation

Can be useful in management of mild ADHD symptoms and smoking cessation

Causes increased energy, motivation: good for “couch potato depression”

Side effects: insomnia, decreases seizure threshold, increased jitteriness, anxiety

Dosed in AM in order to minimize effect on sleep

Mirtazapine (Remeron)

MOA: noradrenergic and specific serotonergic antidepressant

Indication for major depressive disorder

Dosed at bedtime; starting dose of 15 mg

Side effect considerations:

- Nausea less likely than with SSRIs
- Weight gain – helpful if patient without appetite or losing weight
  - 40% patients have >7% increase in body weight in one year
- Sedation, therefore dosed at bedtime
  - Inverse relationship with dose and level of sedation

Tricyclic Antidepressants

Widely used in pregnancy prior to advent of SSRIs

MOA: block the reuptake of serotonin and norepinephrine in presynaptic terminals, which leads to increased concentration of these neurotransmitters in the synaptic cleft

Most are quite anticholinergic: dry eyes, dry mouth, constipation, sedation

Desipramine and nortriptyline preferred as least anticholinergic

Why utilize? Other indications: sleep, pain, migraine

Imipramine

Desipramine

Nortriptyline

Amitriptyline

Doxepin

Pre-conception Planning!

50% of pregnancies are unplanned in the US

Majority of women with perinatal loss pregnant within one year

ASK: “Would you like to become pregnant in the next year?”

- www.onekeyquestion.org

DOCUMENT about birth control and/or conception planning

Discussion of risks at time of administration of medications, rather than awaiting conception

- Especially important if starting antidepressant medication, as goal would be to keep on medication fpr 6-12 months after return to psychiatric baseline

Encouragement of women to contact mental health provider upon learning of their pregnancy prior to discontinuation of any medication

Periscope is Here to Support You

A **free resource** for health care providers caring for **perinatal women** who are struggling with **mental health** or **substance use disorders**

Providing health care professionals access to:

Real time provider-to-provider psychiatric teleconsultation

Educational presentations and tools

Community resource information

Perinatal Loss Specific Resources

Bo's Heavenly Clubhouse: Promotes positive grieving tools, provide books, journals, coloring books and utensils for free, Although they focus in Dodge and Washington counties, they do not have boarders for helping families. They are 'always open' moms and families can contact them when they need to speak to someone. www.bosheavenlyclubhouse.com

Grieve Out Loud: www.grieveoutloud.org

- Pen Pal Program
- Private Online Support Group available through Facebook
- Customizable Individual Support

Star Legacy Foundation Support Group: Provides live, interactive, online support groups for families who have experienced a perinatal loss and for individuals experiencing a pregnancy after a loss. Facilitated by trained mental health professionals. https://starlegacyfoundation.org/support-groups/

Faith's Lodge: In its North Woods setting, Faith's Lodge provides a peaceful escape for families to refresh their minds and spirits while spending time with others who understand what they are experiencing. https://faithslodge.org/about/

Questions? Thank you!

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