Ref: Ro Med J. 2021;68(4)
DOI: 10.37897/RMJ.2021.4.4

Pregnancy after miscarriage: Psychological implications and emotional care

Diana-Antonia Iordăchescu[1], Elena-Otilia Vladislav[1], Corina-Ioana Paica[1], Corina Gica[2,3], Anca Maria Panaitescu[2,3], Gheorghe Peltecu[2,3], Nicolae Gica[2,3]

[1] Faculty of Psychology and Educational Sciences, University of Bucharest
[2] "Carol Davila" University of Medicine and Pharmacy, Bucharest, Romania
[3] "Filantropia" Clinical Hospital, Bucharest, Romania

ABSTRACT

This article propose a review of the most important medical and psychological aspects regarding pregnancy after miscarriage. We highlighted the results of studies that reflect the importance of psychological implications and emotional care. This paper is a review based on information from the literature. The analysis was limited to articles and guides in English published between January 1, 2010 and June 1, 2021 on PubMed, ScienceDirect and Google Scholar using the following keywords: miscarriage, pregnancy after miscarriage, psychological counseling, psychological interventions.
In this review we discuss the medical and psychological characteristics of this research area. We focus on the emotional aspects involved, the emotional and mental states that appear and the ways to deal with this difficulty in life. Psychotherapy, psychological counseling and care practices influences the wellbeing of women and represents a real support in mental recovery after miscarriange.

Keywords: miscarriage, pregnancy after miscarriage, psychological counseling

INTRODUCTION

Abortion and emotional complications from this event can damage a woman's psychological health. Spontaneous abortion is one of the most common complications during pregnancy and leads to great suffering for both women and the couple. When repeated pregnancy loss (RPL), doctors say it is a clinical disorder that can have multiple causes.

Emotional symptoms that occur after a miscarriage include depression, anxiety and pain. The advanced age of the woman, the fact that she does not yet have a biological child, the reduced social support and the previous pregnancy losses can be triggering factors for depression and clinical anxiety.

Studies have highlighted the abortifacient risks of high stress on the hypothalamic-pituitary-adrenal axis, especially in early pregnancy [1]. Evidence of the psycho-neuro-immunological causes behind RPL suggests that emotional distress, guilt, and negative psychological states contribute to changes in cortisol, NK cell activity, CD3 +, CD8 +, CD56 +, T cells, Th1 and Th2 helper cells, and uterine receptivity. progesterone-induced blockade, thus diminishing the viability of pregnancy [2-4].

Social isolation after losing a pregnancy increases women's vulnerability to developing depression [5]. Depression is significantly associated with negative life changes, such as the deterioration of the couple's relationship due to poorly perceived mutual support [6] and can turn into a major depressive disorder [7]. To the same extent, women may develop anxiety disorders following the loss of a pregnancy [8].

Studies show that these emotional disorders have led to the use of medical services and the need to consult specialists more frequently in these women, compared to women without pregnancy loss [9].

Also, the loss of a pregnancy is accompanied by pain, extremely complex compared to the emotion-

Corresponding author:
Corina-Ioana Paica
E-mail: corina.paica@unibuc.ro

Article History:
Received: 12 December 2021
Accepted: 18 December 2021

al reaction that does not involve mourning. Persistence of pain for more than six months can lead to intense separation distress [10]. Patients who go through a miscarriage are recommended psychosocial interventions, which aim to optimize psychological and emotional well-being, biological functioning [11], but also the development of adaptive resources to cope with grief.

Women who lose pregnancy or recurrent pregnancies manifest the need for emotional support, psychological assistance in ventilation, pain and loss processing, to facilitate acceptance [12]. Studies [13], but also the ESHRE [14] recommendations emphasize the need for women, but also for the couple as a whole, for public health specialists to look at their loss with more sensitivity and empathy. Patients also want access to health care that takes a couple-centered approach and includes earlier access to testing and treatment, the provision of information and psychological and supportive care.

PREGNANCY AFTER MISCARRIAGE

Miscarriage is the most common adverse outcome of pregnancy, with approximately 17% of clinically recognized pregnancies ending in loss [15].

Women who experience a miscarriage want to know what to do to prevent a future miscarriage. Also, they seek the advice of health care providers on how long couples should wait before trying again to conceive.

The World Health Organization (WHO) [16] is the only advisory body that puts it formal notes, but note that their recommendation to wait at least six months is limited, as they are based on a single cross-sectional study that did not differentiate between induced and spontaneous abortions.

Many doctors recommend that you wait at least 3 months after a miscarriage to reduce the chances of another miscarriage.

As the age of first pregnancy increases in developed countries, recommendations for postponing future pregnancies should be balanced with the risk associated with increasing maternal age.

In many situations miscarriage is a one-time occurrence and women who miscarry go on to have healthy pregnancies after. After one miscarriage the average risk of a future miscarriage is 20% and after two consecutive miscarriages the risk increases to about 28%, and after three or more consecutive miscarriages the risk of another miscarriage is 43%.

Pregnancy after miscarriage can be very difficult because women are still feeling guilty.

PSYCHOTHERAPY IMPLICATIONS

Cognitive-behavioral therapy targets cognition, emotion, behavior and therapeutic relationship. It can be effective for women who have gone through the painful experience of miscarriage, as it proposes three intervention strategies: behavioral activation, cognitive restructuring, and acceptance. It is also important that this therapy takes into account the balance between the therapeutic relationship, the patient's emotional experience and the implementation of strategies for cognitive and behavioral change [17]. Even online, this type of therapy can be effective, with stable effects for women after pregnancy loss. Thus, the possibility of online therapy is helpful in the rapid implementation of an intervention program for women in a situation of loss [18,19].

Short-term supportive psychotherapy (BSP) involves a non-directive approach, in which the patient is helped to clarify their symptoms, difficulties, alleviate anxiety and facilitate resilience. Administration of the BSP session in the first 24 hours of hospitalization for women with miscarriage can be considered a reliable method of preventing symptoms of anxiety, symptoms of depression and perinatal pain, by psychological reassessment of women 4 months after the event [20].

Cognitive therapy based on mindfulness [21] helped create a sense of control, with patients managing to cope with the positive, predictable and negative aspects of unpredictable miscarriage. Mindfulness has also helped women to have realistic hopes, to find meaning, courage and optimism, improving their quality of life and emotional state.

Another study shows that a therapeutic support program for women experiencing high emotional symptoms is promising and deserves further investigation [22].

The results of a study that used art therapy by exposing the work of patients who suffered various traumas such as pregnancy loss, the birth of a deceased child or infertility, showed that sharing the difficulties they go through with other people, through art, supported the process. reintegration of trauma treatment. The psychotherapeutic benefits also appeared as a result of the feelings of emotional validation, the support felt and due to the meaning they gave through the exposure of the trauma [23].

Interpersonal therapy is a form of first-line psychotherapy in the treatment of major depressive disorder in general [24] and in perinatal disorders [25,26]. It addresses interpersonal challenges and increases social support. In short, interpersonal therapy focuses on an acute life event, helping the individual to optimize communication and build their social support network. All three areas in which treatment goals can be set (pain, role transition, interpersonal disputes) can be adapted to address perinatal loss. In a study in which the authors

used IPT, the results demonstrated the feasibility and acceptability of using therapy after perinatal loss [7]. Other strengths mentioned by the authors include faster recovery from the disorder, reduced depressive symptoms in treatment, and more improvement in the social support system, social functioning, and pain symptoms.

Psychosocial interventions are effective in improving psychological well-being among women who have suffered a miscarriage [27]. Experiential psychotherapy and unification therapy through physical and physical relaxation techniques can help to connect with one's body, to understand the pains in the body and to integrate them. Through various techniques, the woman can become aware of her reality and unlock her wounds so that she can heal.

CONCLUSIONS

Psychosocial care, provided by psychotherapists or clinical psychologists, helps to reduce clinical symptoms and focus on appropriate mechanisms of resilience with loss. Also, this article aims to draw doctors' attention to the psycho-emotional needs of women who have gone through a miscarriage, offering them recommendations from clinical practice or directing them to psychotherapy or supportive therapy. Psychological intervention along with medical counseling can be beneficial in reducing adverse emotional complications after pregnancy loss.

REFERENCES

1. Li W, Newell-Price J, Jones GL, Ledger WL, Li TC. Relationship between psychological stress and recurrent miscarriage. *Reprod Biomed Online.* 2012;25:180-9.
2. Practice Committee of the American Society for Reproductive Medicine. Evaluation and treatment of recurrent pregnancy loss: A committee opinion. *Fertil Steril.* 2012;98:1103-11.
3. Arck PC. Stress and pregnancy loss: Role of immune mediators, hormones and neurotransmitters. *Am J Reprod Immunol.* 2001;46:117-23.
4. Faust Z, Laskarin G, Rukavina D, Szekeres-Bartho J. Progesterone-induced blocking factor inhibits degranulation of natural killer cells. *Am J Reprod Immunol.* 1999;42:71-5.
5. Shaohua L, Shorey S. Psychosocial interventions on psychological outcomes of parents with perinatal loss: A systematic review and meta-analysis. *Int J Nurs Stud.* 2021;117:103871.
6. Gausia K, Moran AC, Ali M, Ryder D, Fisher C, Koblinsky M. Psychological and social consequences among mothers suffering from perinatal loss: perspective from a low income country. *BMC Public Health.* 2011;11:451.
7. Johnson JE, Price AB, Kao JC, et al. Interpersonal psychotherapy (IPT) for major depression following perinatal loss: a pilot randomized controlled trial. *Arch Womens Ment Health.* 2016;19(5):845-859.
8. Gold KJ, Boggs ME, Muzik M, Sen A. Anxiety disorders and obsessive compulsive disorder 9 months after perinatal loss. Gen Hosp Psychiatry. 2014;36(6):650-654.
9. Burden C, Bradley S, Storey C, et al. From grief, guilt pain and stigma to hope and pride - a systematic review and meta-analysis of mixed-method research of the psychosocial impact of stillbirth. *BMC Pregnancy Childbirth.* 2016;16:9.
10. Bhat A, Byatt N. Infertility and Perinatal Loss: When the Bough Breaks. Curr Psychiatry Rep. 2016;18(3):31.
11. Mackrill T, Sørensen KM. Implementing routine outcome measurement in psychosocial interventions - a systematic review. Eur. J. Soc. *Work.* 2020;23:790-808.
12. Koert E, Malling GMH, Sylvest R, et al. Recurrent pregnancy loss: couples' perspectives on their need for treatment, support and follow up. *Hum Reprod.* 2019;34(2):291-296.
13. van den Berg MMJ, Dancet EAF, Erlikh T, et al. Patient-centered early pregnancy care: a systematic review of quantitative and qualitative studies on the perspectives of women and their partners. *Hum Reprod Update* 2018;24:106-118.
14. European Society of Human Reproduction and Embryology (ESHRE). ESHRE guideline: recurrent pregnancy loss. *Hum Reprod Open* 2018:hoy004.
15. Sundermann AC, Hartmann KE, Jones SH, Torstenson ES, Velez Edwards DR. Interpregnancy Interval After Pregnancy Loss and Risk of Repeat Miscarriage. *Obstet Gynecol.* 2017;130(6):1312-1318.
16. WHO Recommendations on Antenatal Care for a Positive Pregnancy Experience. Geneva: World Health Organization; 2016.
17. Wenzel A. Cognitive behavioral therapy for pregnancy loss. *Psychotherapy* (Chic). 2017;54:400-405.
18. Kersting A, Kroker K, Schlicht S, et al. Efficacy of cognitive behavioral internet-based therapy in parents after the loss of a child during pregnancy: pilot data from a randomized controlled trial. *Arch Womens Ment Health.* 2011;14:465-477.
19. Gold KJ, Boggs ME, Kavanaugh KL. MOMSonLINE: Lessons Learned From a Feasibility RCT of Online Support for Mothers Bereaved by Perinatal Loss. *Omega* (Westport). 2019;30222819861558.
20. Barat S, Yazdani S, Faramarzi M, et al. The Effect of Brief Supportive Psychotherapy on Prevention of Psychiatric Morbidity in Women with Miscarriage: A Randomized Controlled Trial about the First 24-hours of Hospitalization. *Oman Med J.* 2020;35(3):e130.
21. Patel A, Dinesh N, Sharma PSVN, et al. Outcomes of Structured Psychotherapy for Emotional Adjustment in a Childless Couple diagnosed with Recurrent Pregnancy Loss: A Unique Investigation. *J Hum Reprod Sci.* 2018;11(2):202-207.
22. Kong GW, Chung TK, Lok IH. The impact of supportive counselling on women's psychological wellbeing after miscarriage-a randomised controlled trial. *BJOG.* 2014;121:1253-1262.
23. Andrus M. Exhibition and Film About Miscarriage, Infertility, and Stillbirth: Art Therapy Implications. *Art therapy.* 2020;37:169-176.
24. National Collaborating Centre for Mental Heath. Depression: The NICE guideline on the treatment and management of depression in adults, updated edition. 2010:Leicester, UK: British Psychological Society.
25. Pearlstein TB, Zlotnick C, Battle CL, et al. Patient choice of treatment for postpartum depression: a pilot study. *Arch Womens Ment Health.* 2006;9(6):303-308.
26. Koszycki D, Bisserbe JC, Blier P, et al. Interpersonal psychotherapy versus brief supportive therapy for depressed infertile women: first pilot randomized controlled trial. *Arch Womens Ment Health.* 2012;15(3):193-201.
27. San Lazaro Campillo I, Meaney S, McNamara K, O'Donoghue K. Psychological and support interventions to reduce levels of stress, anxiety or depression on women's subsequent pregnancy with a history of miscarriage: an empty systematic review. *BMJ Open.* 2017;7(9):e017802.