Follow-up for improving psychological well-being for women after a miscarriage

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1. INTRODUCTION

Miscarriage is defined by the World Health Organization (WHO) as the premature loss of a fetus up to 23 weeks of pregnancy and weighing up to 500 g (1). Overall, about 12–15% of clinically recognized pregnancies end in miscarriage (2), with the frequency increasing with rising maternal age.

Available studies suggest that after a miscarriage 30%–50% of women experience anxiety symptoms and 10%–15% experience depressive symptoms, which commonly persist up to four months (3). These symptoms have been conceptualized as a pattern of grief following the loss of a baby. Miscarriage is also viewed as a traumatic event, distressing all the affected women to a greater or lesser degree (3, 4). Unfortunately, hospital staff are often not sensitized to provide support for the emotional distress associated with a miscarriage.

While a lot of attention has been devoted to the physical management of miscarriage, the evidence for psychological management of miscarriage is less well developed. Follow-up of women who have experienced a miscarriage could help to identify at-risk women or those who have already developed psychological complications. It can allow health-care workers to undertake appropriate interventions, enhancing the overall psychological well-being of women or reducing the adverse effects of miscarriage on their personal relationships or employment. Strategies for follow-up used in various studies have differed and the evidence has remained equivocal. There is a need to review systematically the evidence on follow-up after miscarriage in order to assess the efficacy of various interventions.

This Cochrane review (5) was planned with the primary objective of ascertaining whether follow-up at any time affects the psychological well-being of women who have experienced a miscarriage. A secondary objective was to compare the effects of different types of intervention. It is to be noted that the review focused on spontaneous miscarriages only.

2. METHODS OF THE REVIEW

The authors considered only randomized controlled trials that had compared various methods of follow-up
after miscarriage: (i) psychological intervention versus no intervention; (ii) psychological intervention versus usual care; and (iii) one psychological intervention versus another psychological intervention. Trial participants included women of child-bearing age experiencing miscarriage as defined by WHO (1). Quasi-randomized trials were excluded.

The outcomes were pre-specified. Primary outcomes were psychological well-being and patient satisfaction, as defined by the trial authors. The secondary outcomes were adverse reaction to follow-up, referral to primary health-care services, admission to hospital and costs associated with follow-up.

The authors searched the Cochrane Pregnancy and Childbirth Group’s Trials Register, which maintains an updated list of trials identified from various scientific databases. No language restrictions were posed. The authors made an attempt to include unpublished data by screening the reference lists of retrieved papers and contacting professional/lay organizations for sharing information on ongoing trials or any unpublished data.

Data extraction and assessments were carried out by all the authors independently and risk of bias was appropriately assessed by all the authors. Overall, the methodology of the review was scientifically rigorous. A protocol was published ahead of time and there were no subsequent deviations.

3. RESULTS OF THE REVIEW

This review included six studies involving a total of 1001 women. The quality of studies was determined to be between moderate and good. Overall, the risk of bias was judged to be low. Interventions comprised of 1–3 counselling sessions based on recognized techniques, delivered between 1–11 weeks of miscarriage by nurses, midwives or psychologists. Psychological well-being was defined in the included studies by a number of different measures, including absence of depression, anxiety, grief and self-blame.

Three studies (236 women) comparing one counselling session versus no counselling at four months found no statistically significant difference in psychological well-being of the groups. One study (242 women) compared three counselling sessions versus no counselling. Out of a total of 22 scores, only three were significantly different at 4 months and only four at 12 months. Some of these favoured counselling, while others favoured no counselling. All significant results were found only in subscales of the complex instrument developed by the trial author. No significant results emerged in any of the standardized instruments used in the study.

Findings from the remaining two studies were described in narrative form as data were unavailable for meta-analysis. One study (280 women), which had compared two counselling session with no counselling, found no significant difference in psychological well-being between the two groups at 6 weeks, 3 and 6 months. Another study (341 women) had compared combined-caring, nurse-caring, self-caring and no treatment. The counselling techniques, videos and workbook were devised by the study authors. In this study, compared with no treatment, women in all three treatment groups showed a faster resolution of depression and grief. Further evidence favoured nurse-caring in accelerating resolution of depression (Bayesian odds ratio: 7.9, median 0.7, P = 0.89) and self-caring in hastening resolution of grief (Bayesian odds ratio: 3.2, median 0.2, P = 0.76).

None of the trials measured the other primary outcome (patient satisfaction) or any of the four secondary outcomes.

4. DISCUSSION

4.1 Applicability of the results

There is an insufficient evidence to demonstrate the superiority of psychological support over no intervention following miscarriage. Most of studies included in this review were not adequately powered.
Furthermore, there was marked heterogeneity in the methods of the included trials. In settings where some form of psychological support is being formally provided to women with miscarriage, there is no reason to change the current practice. The findings are equivocal and do not give a reason to alter the existing services in any way.

Most of research, including the trials included in this review, has come from resource-rich settings. Even if future studies show evidence in favour of psychological follow-ups, there will be a need to replicate their effectiveness in under-resourced settings. Cultural variations may exist in the methods of coping with a loss and may have implications for the choice of components or the methods of follow-up. Another important issue which need to be considered in low- and middle-income countries is that of resource constraints, since these countries are still struggling with adequate coverage of basic health-care services (e.g. safe delivery, safe abortions, etc.). This is not to say that the psychological services after a miscarriage are not needed for women residing in under-resourced settings. Rather, the appropriate issues for discussion in this context would be identification and prioritization of these services for at-risk women and development of low-cost, effective models for follow-up as well as integration of such services with existing primary care services in the country. Families continue to serve as a major source of support in developing countries such as India. The extended families often provide the necessary care and emotional support, perhaps compensating for the deficits in the formal care services to a certain extent.

4.2 Implementation of the intervention

There is no evidence to either recommend or refute the psychological follow-up of women after miscarriage.

4.3 Further research

There is a need to plan and conduct good-quality, adequately powered randomized controlled trials for the effectiveness of psychological follow-up for women following miscarriage. It is also important that standardized psychological assessments are employed in such trials in order to facilitate comparison across studies.

The outcome parameters in future studies could be expanded to include women’s satisfaction and impact of follow-up on relationships and day-to-day functioning. There is a need to study components that can make the psychological intervention more suitable and acceptable in a given cultural context. Another area of potential relevance for developing countries is to assess systematically the role of extended families in providing psychological support following miscarriage.

It is possible that the follow-up may be more effective in a subgroup of women following miscarriage. It will be useful to direct research efforts towards identifying the at-risk women and testing the effectiveness of psychological follow-up in this subgroup. The economic implications of such psychological follow-ups may be integrated into any future study. Low-cost culture-sensitive models, involving community health workers, may be explored in the low- and middle-income countries.

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References


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