Views of health professionals on the impact of early miscarriage on women’s mental health and the accessibility of services and support
Jessica Yang, Anthony Dowell, Sara Filoche

ABSTRACT

BACKGROUND: Miscarriages, the majority of which occur in the first trimester, can have a detrimental impact on women’s mental health.

AIM: To explore health professionals’ views on the impact of early miscarriage on mental health and accessibility of services and support available to women.

METHODS: Semi-structured interviews were conducted with 10 health professionals from an urban tertiary hospital and a community setting, followed by semi-inductive thematic analysis.

RESULTS: Three overarching themes were identified: (1) extent and nature of psychological impact, (2) barriers to accessing mental health support and (3) facilitators of change or improvement. Early miscarriage was regarded as a “loss” that affected not only the women but their partners and other family/whānau members. Establishing how women felt about the pregnancy was regarded as important in directing both the scope of the consultation and subsequent guide to support services. Inequitable access to services and support was identified. Cost of counselling, geographic location and fragmented care were cited as barriers to accessing support. Improved clinical pathways and channels for inter-professional communication, as well as more accessible counselling, were regarded as key areas for service improvement.

DISCUSSION: This study highlights that, although health professionals appropriately recognise early miscarriage as a significant loss, access to support is inequitable and fragmented. Early miscarriage care is an area of unmet need and, given the high incidence of early miscarriage and its impact on mental health, urgent action around service provision is needed.

A quarter of women experience miscarriage in their lifetime. The vast majority (99%) of miscarriages occur early, in the first trimester (12–14 weeks). International literature suggests that early pregnancy loss can have a lasting effect on mental health, from mental distress to symptoms or diagnoses of post-traumatic stress disorder and anxiety. The association with depression seems less clear; however, some evidence indicates a higher risk of suicide and self-harm. Some studies have explored women’s perspectives of miscarriage alone; others suggest there is a discrepancy between women’s and health professionals’ awareness of psychological morbidity after miscarriage.

In Aotearoa New Zealand, primary maternity care is provided by lead maternity carers (LMCs), who take responsibility for the care provided to women throughout pregnancy, during labour and birth and up to six weeks following birth. The majority of women (93.6% in 2015) are cared for by autonomous, self-employed midwives contracted to the state. Approximately
two-thirds of women register with an LMC in the first trimester (in 2017). There are approximately 25,000 miscarriages annually in Aotearoa, based on an incidence rate of around one or two in every 10 pregnancies. Health professionals can play a significant role in shaping women’s experiences of miscarriage, including their access to services and support. In order to inform service provision for women and whānau experiencing early miscarriage, this qualitative study explored the health professionals’ views on the impact of early miscarriage on women’s mental health and the accessibility of services and support.

Methods

Study development and design

Existing connections and a snowball methodology were used to recruit health professionals from an urban tertiary hospital and a community setting. The participants included, but were not limited to, health professionals working near the research location. Twelve participants from a variety of professional backgrounds with experience in both women’s health and mental health, including a mix of hospital employees and community-based professionals, were invited to participate.

The semi-structured interview guide was developed by the research team (JY, AD, SF) to explore: the extent and ways that early miscarriage (first-trimester loss) may impact on mental health; the different health and support services (including mental health services) that are available to these women, as well as the existing level of access to, and communication between, these services; and potential areas for improvement.

Ten interviews undertaken by one interviewer took place at various sites between November and December 2018. Nine interviews took place in person and one online using Zoom. All were audio-recorded and lasted between 22 and 48 minutes. No remuneration was given.

All interviews were manually transcribed by the interviewer, who removed verbal fillers and any material that could identify the participants. Transcripts were then emailed to key participants for review. Two participants elected to review their respective transcripts before analysis.

Data analysis

Thematic analysis was carried out using a semi-inductive approach. Two researchers independently coded each transcript and identified preliminary themes using QSR International’s NVivo 12 Software. Data were analysed until no new themes emerged. Discussion revealed similarity between the two independent codebooks, though intercoder reliability was not calculated. Consensus was reached through discussion.

Ethical Approval

Ethics approval was gained from the University of Otago Ethics Committee (D18/363), along with appropriate locality approval for the district health board.

Results

Ten health professionals from a range of backgrounds participated in this study (Table 1). Each professional was asked about their background for the purpose of context; all responses indicated experience in women’s health and mental health. No further demographic information, such as age, ethnicity or years of experience, was collected.

Three overarching themes were identified:

- Extent and nature of psychological impact
- Barriers to accessing mental health support
- Facilitators of change or improvement

Table 1: Health professionals’ area of work.

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<thead>
<tr>
<th>General practitioner 1</th>
<th>Clinical psychologist</th>
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<tr>
<td>General practitioner 2</td>
<td>Termination of pregnancy counsellor</td>
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<tr>
<td>Maternal fetal medicine specialist</td>
<td>Maternal fetal medicine midwife</td>
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<tr>
<td>Termination of pregnancy provider</td>
<td>Emergency department nurse</td>
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<td>Maternal mental health psychiatrist</td>
<td>Social worker</td>
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</table>
Extent and nature of psychological impact

Participants described wide-ranging impacts of miscarriage on mental health with sub-themes around who else was affected, how they were affected and how to identify those at risk. A consistent finding from all the health professionals was that miscarriage is a significant loss and that grief was the usual response. To ascertain the potential impact of miscarriage, it was considered important to understand whether, and to what degree, the pregnancy was “wanted” or “planned.” When the pregnancy was planned or wanted, the potential for significant impact was deemed greater than when it was unwanted or unplanned (Table 2). However, for some women, the end of the pregnancy may lessen an impact on mental health:

“It can be anything from bereavement and loss—depending on the stage of the miscarriage, or how much they wanted to be pregnant—through to some women [being] quite relieved, [or] struggling with adapting, [or] adjustment reaction and anything in between, [or] grief, guilt...” – Maternity mental health psychiatrist

Establishing how women felt about the miscarriage was an important step in directing women to relevant services and support. However, predicting the impact on mental health was more challenging (except for women with known mental health conditions and risk factors such as misuse of alcohol or illicit drugs) because there are so many different influencing factors:

“Red flags are often difficult because they’re usually not particularly red or being waved particularly kind of furiously. And I think there are different sorts of red flag...” – General practitioner 1

Some spoke about the psychological impact that women could carry through to future pregnancies after a miscarriage, which could be an enduring grief response:

“There’s some evidence that trying to have another pregnancy very quickly after a loss can [I] have the psychiatric problem that grieving for the loss is put off until the end of the next pregnancy, and then the woman is trying to bring up her new baby, and she’s grieving for the baby that she doesn’t have. And there is literature around that as well. So that’s why doctors and midwives try to suggest that women [and] partners grieve before they embark upon another pregnancy. Otherwise those people are at increased risk of depression subsequently.” – Maternal fetal medicine specialist

Participants described how women felt the miscarriage was their fault (“What did I do that made me miscarry?”) and how “their bodies have let them down.” This description of failure was more prominent when women had experienced multiple miscarriages or when a fetal anomaly was identified as being the cause of the miscarriage. The idea that pregnancy places certain expectations on women was viewed as a source of pressure:

“There’s this kind of view that pregnancy has to be perfect...you’ve got to exercise the right amount, you can’t eat this, you’ve got to eat that, you’ve got to do this, you can’t smoke, you can’t drink. So women often I think feel under a lot of pressure to notmiscarry.” – General practitioner 1

An early miscarriage was also a loss felt by people with close relationships to the woman:

“[Fetal loss] has collateral damage to relationships, children, parents—it affects families, not just the women.” – Maternal fetal medicine midwife

Although several participants noted that women’s partners were also affected, one did give an example to the contrary:

“So many women will say, ‘Oh yeah my husband or my partner, he kind of got it for the first day and then after I had the D&C he was kinda like, ‘Well just get on with it, you gotta go back to work now’ or ‘What do you mean you’re still sad?’” – Clinical psychologist

Barriers to accessing services and support

Several barriers to accessing support services were identified: cost, type of counselling, location/geography, limited
Table 2: Exemplar quotes on the extent and nature of impact on mental health.

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<tr>
<th>Topic</th>
<th>Quote</th>
<th>Source</th>
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<tr>
<td>Grief</td>
<td>“Miscarriage in particular, or especially if it's a long fought-for pregnancy—IVF, they've been on that emotional rollercoaster and then they've lost the pregnancy. That sense of failure can be huge, and that has a massive impact on their mental health.” – Social worker</td>
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<td>“There's no set pattern to an emotional response, it's a grief reaction often—so it's your normal grief reaction, but it's whether their behaviour or response sits outside of those normal reactions. For instance, I'm more interested in someone who has a blunted emotion, who shows no emotion, than one who does. Because if I told you your sister had just been in a car accident, you would have an emotional response, and that would be entirely appropriate. But if you sat there and nodded and grinned at me, we just carried on the conversation, my alerts would go up.” – Maternity fetal medicine midwife</td>
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<td>Attitude towards the pregnancy</td>
<td>“I think it depends on if it's a wanted pregnancy or not. So if it wasn't wanted, then the chances are that mental health issues are not such a big deal. Maybe age as well, when you start getting pregnant. If you're 40 and had some help with getting pregnant, and then you have a miscarriage, then it might be a bigger thing than if you're eighteen, twenty.” – Emergency department nurse</td>
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<td>“As soon as they become pregnant, women are thinking about that baby as a fully formed being, and they're projecting that child into the future. You know, growing up and—it's not just, 'Oh so I'm pregnant so I've got this cell that's been dividing inside of me and now it's the size of a...'-you know? I think women don't have that... I think it's more[...]'I'm gonna have a baby and it's gonna be this and it's gonna grow up to do this and it's gonna look like this'” – Clinical psychologist</td>
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<td>Women taking the blame</td>
<td>“People don't really talk about having miscarriages. And for a lot of women that have been healthy and well, that's the first time that they've felt that their body's [] let them down, or they're disappointed... I'm thinking of lots of women that I've spoken to. There's a lot of different [] thoughts for a lot of different people. Some women feel really like their body's let them down or that they're useless.” – Social Worker</td>
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<td>“I guess if [it] was a recurrent miscarriage and nothing had been found like the first time, then the second time part of the psychological thing would be doing that search for any underlying obvious medical reasons, but then talking through the psychological implications of that so, 'We are going to check that you weren't very anaemic, we don't think you were but it's worth doing that... we'll check a whole bunch of other stuff.' And part of that I guess is looking at it from a medical scientific point of view and not that it is the woman's fault that she miscarried, which I think sometimes women would be kind of carrying that around, you know, 'what did I do that made me miscarry?... could I have looked after myself better?'” – General practitioner 1</td>
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<td>Who's impacted</td>
<td>“It's multifaceted and it's very individualised, and really it's on case-by-case basis. You can't make assumptions about how someone is going to process information or what their reaction is going to be. But you can bet your bottom dollar that most of the situations that occur in fetal medicine affect every woman's mental health.” – Maternity fetal medicine midwife</td>
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<td>“I think the other of it of course is blokes tend to get left out—nobody talks about the blokes. And you do wonder if fathers grieve, and nobody ever asks the father, “How do you feel about a miscarriage?” [I've] probably never asked a father about that, except when it's in the moment, so that's pretty tough. So I think the other big conversation we're missing is the guys.” – General practitioner 2</td>
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<td>Risk factors</td>
<td>“Are you more at risk when you're 23 years old, if you have an early termination or if you have a miscarriage... There's so many factors to take into account.” – Clinical psychologist</td>
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availability of professionals and gaps in communication between and within services (Table 3). These barriers created inequitable and fragmented access:

“There are always people falling through—we know that. ‘Cause I know the demographics of who we treat, and then the research I’ve done has also shown the demographics of people who do have mental health problems in the community sample... For example, we’re missing young Māori, young Pacific Island women. They’re not coming through to our service, so there’s obviously some kind of barrier there. Our service is predominantly Pākehā, middle class, reasonably well-employed kind of people.” — Maternal mental health psychiatrist

Inaccessibility to the appropriate services was exacerbated by constraints on the system, which was “designed for the mother–baby diad” (Maternal mental health psychiatrist). Organisational factors also acted as a barrier to appropriate services and support, as early miscarriages were identified as not being a priority and women cared for by junior staff (Table 3).

“I think where we have difficulty is that women come in with the miscarriage [at any time of the day or night] and they often are not high priority in the hospital service... they often get seen by junior nursing and medical staff who’ve got limited experience both with the problem and they’ve got limited life experience, ‘cause they tend to be younger, and so they probably just don’t get that good a deal” (Maternal fetal medicine specialist.)

Gaps in communication between the different service professionals who women may have seen was viewed as contributing to barriers to accessing appropriate support. Some explained that communication exists but is limited to aspects of physical health, rather than including mental wellbeing:

“You get the letter back saying [the miscarriage] happened, in a timely way. So you know what physically has happened and when it’s happened. So there is communication. There’s not much communication about their mental health state. So it’s just physically what happened and this is what they did.” – General practitioner 2

Communication with women about their obstetric history in relation to their mental health was not routine in all healthcare settings:

“We don’t routinely ask women if they’re suicidal or their mental health is not very good. We don’t say, ‘Have you had a recent miscarriage or are you pregnant?’ We don’t really link that up very well.” – Emergency department nurse

One health professional also raised the scale of reproductive morbidity and an associated unmet need for services and support:

“The women with miscarriage, if they are depressed, they’re a silent voice. Their voice isn’t heard. 15% of all women who have an identified pregnancy will miscarry. So it’s not an insignificant number. We estimate that, if there’s 60,000 births in New Zealand each year, there’s 85,000 pregnancies. The rest don’t make it to 20 weeks, for a variety of reasons. So that gives you an idea of the size of the reproductive morbidity in New Zealand. So what is happening to those 20,000 odd women, who’s looking after them, how good is their care?” – Maternal fetal medicine specialist

Facilitators of change or improvement

Facilitators for improving access to support for women and their whānau included system-, organisational- and community-level solutions. System-level facilitators to improving access included having primary care clinical pathways that would improve the integration of seamless care and follow-up, and communication between professionals/services, particularly where more than one health professional has been involved in a woman’s care (Table 4). Organisational improvements to improve access included incorporating talking therapies into primary care. A consistent finding was a call for more accessible counselling for not only women, but partners and
Table 3: Exemplar quotes associated with barriers to accessing services and support.

| Cost                                                                 | “I think you’re probably aware that the mental health services in New Zealand would really probably only manage to take this on if it was an acute major depressive illness. They’re just not in a space at the moment to deal with psychological as opposed to psychiatric disorders. So the best the GP could do would be to get counselling… [either] psychological counselling or social work counselling. And psychological counselling in the community is not really available free. So there would be a charge, and you could be looking at in excess of $90 an hour.” — Maternal fetal medicine specialist |
| Location/geography                                                   | “Remembering some women drive in the car for seven hours to get to an appointment here…” — Maternal fetal medicine midwife |
| System and organisational factors                                   | “There is a lot of inequity, and those [who] are educated, well, probably white with good family support, are the ones that will probably be the squeaky wheels and get the most help, because they will describe how they’re feeling, they will front up, they will not DNA. People that are poor, haven’t got transport, haven’t got financial security, who can’t necessarily speak our language, who can’t necessarily understand medical jargon or hospital jargon or clinical jargon—this isn’t their place of comfort, is it? They don’t want to be here, this isn’t where they feel safe. So yeah, there is a lot of inequity.” – Maternal fetal medicine midwife |
| System and organisational factors                                   | “The new mental health review’s talking about increasing private professionals, or PHOs. My only comment on that—from being a mental health professional myself and also having experience in that area—is that it can become extremely fragmented. ‘Cause no one actually knows who knows who for what, and you pick up that and there’s not a lot of information sharing and it gets really messy. It’s like, ‘Oh yeah she’s known to us but we didn’t know anything about that, and mmm, okay.’ So it’s trying to streamline information that people want to share so that they don’t have to re-traumatise themselves. I don’t know. It’s messy. Mental health is [a] messy business.” – Maternal fetal medicine midwife |
| System and organisational factors                                   | “So if someone loses their baby, even if they do get depressed, we don’t get to see them. If they have a termination, we don’t get to see them. Ours is specifically designed for the mother–baby diad.” – Maternal mental health psychiatrist |
| System and organisational factors                                   | “There is an issue where, for many clinicians, certainly like me, we only do relatively part-time clinical work, so lots of GPs now are not working full-time, which means there’s always the risk and worry of women in this instance—the follow-up not following through because they can’t come at the times that I would be there as a clinician and so on. So I think there is potentially a real risk of that follow-up not happening, in a particularly coordinated way.” – General practitioner 1 |
anyone else affected by the loss too (Table 4). Suggestions to improve the accessibility of counselling included removing or reducing financial barriers and ensuring that counselling meets the needs of those seeking support (Table 4).

Knowing about community support and having community-based care were regarded as areas to improve access. Such supports had been in place but were withdrawn due to lack of funding (Table 4).

Discussion

The health professionals interviewed in this study clearly acknowledged that early pregnancy miscarriages have wide-ranging and long-lasting impacts on women’s and their families’ mental health and wellbeing. These findings are similar to those of other studies. However, the accessibility of services and support for women who have experienced an early miscarriage did not match the extent of these impacts.

Suicide has been the leading cause of maternal mortality in Aotearoa for many years. Its rate in New Zealand is seven-times the rate in the UK. Women who identify as Māori and their whānau experience the greatest burden of suicide. The Perinatal and Maternal Mortality Review Committee proposed a practice point regarding psychosocial health and maternal suicide, which includes identifying “a history of termination of pregnancy or miscarriage in the previous 12 months, and any past or present mental illness, including self-harm and previous suicide attempts.” In a recent study, New Zealand midwives were asked about their perceptions of maternal mental health antenatally, including screening. The findings from this study, drawn from the views of 27 midwives, indentified a chronic shortfall primary care mental health services, and that if “routine screening, such as is recommended, is implemented then more services will need to be available.” However, not all women who experience an early miscarriage are in the care of an LMC midwife. In Aotearoa New Zealand and elsewhere, women experiencing a miscarriage frequently seek medical care in emergency departments. International evidence has shown that some emergency-healthcare staff feel insufficiently equipped to manage miscarriages.

In an Australian-based study, women who experienced a miscarriage in an emergency department felt marginalised, silenced and that their loss was dismissed. Investigating how to support emergency staff in Aotearoa to support women/whānau experiencing miscarriage, and to enquire about mental health with presentations of self-harm and previous pregnancy loss, appears to be needed.

Participants described a range of ideas that they believed would prove access at both individual-support and system levels. These included locally relevant clinical pathways that are linked to local support groups and services, which would help facilitate coordinated care and follow-up. At the time of writing, an integrated, shared electronic health platform is gaining traction. Such a system would undeniably facilitate more seamless care and referral to services and support—if these services and support were available in the first place. Fragmented services and support have been reported in other countries, such as the UK, with one survey estimating that 237 of 300 women reported that they received no aftercare following a miscarriage and only 87 felt well cared for emotionally. Comparable qualitative studies from Canada and Australia also suggest that miscarriage has significant emotional impact and that access to support is limited by health professionals’ awareness as well as system-wide factors. In our study, more affordable (free) access to mental health services was cited by all the health professionals as being a significant service change that would improve support for women and their whānau. However, an international Cochrane review found insufficient evidence for the benefit of counselling—but none of these interventions were developed with women who had experienced miscarriage, and given the diverse needs of women and whānau who experience miscarriage, it is imperative that women contribute/lead any new initiatives for services and support design.

A strength of this study was the inclusion of a wide range of health professions. Open questions were used in the interviews to minimise research bias. The independent coding by two researchers also served to reinforce the thematic interpretations. While this was a small qualitative sample, analysis of the data was in keeping with
### Table 4 Exemplar quotes for facilitators and ideas to improve access.

| **System improvements** | “I think there’s the systems level. We should make sure that the clinical pathways are working well, and I mean I am a big believer in up-to-date and locally adapted clinical pathways, which we can log on to and you go, ‘miscarriage,’ ‘management,’ la de da. Locally this is what we do, locally these are the follow-up arrangements that we should’ve made, and then we stick to that clinical pathway.” – General practitioner 1  

“Sometimes those people don’t talk, you know—the GP’s not meeting with the mental health professional, who’s not meeting with the midwife—and my thought was, well if you have a woman who comes in and is pregnant and she’s got a community mental health worker and she has a midwife and she has a GP, then those people should have some communication along the way. And [] if there is any risk, there should already be a plan in place about how to manage this woman’s mental health.” – Clinical psychologist |
| **Organisational improvements** | “There would be access to psychological talking therapy from a general practice setting, we’ve got that within the practice, so that’s one route in which you can provide access to services, and depending on the social circumstances, it is likely that would be free. Or if not then there are other referral options.” – General practitioner 1  

“I think it’s so individual, that loss stuff, and the cultural component or the societal stuff is quite individual too. I think counselling and counsellors would hopefully be able to see what that need is for that person. And two people from the same whānau—it won’t be the same... there’ll be elements of support that will be good. I think there needs to be cheaper counselling for people full stop. I think that [partners] have the double-whammy of worrying about their partner and the concern that that stirs up for them, as well as their own grief and loss around what that means for them.” – Social worker |
| **Accessible counselling** | “There’s got to be a lot more money spent in looking after people in their homes, in their communities, where they live. Things happening, coffee groups, places to go, you know. The previous government wiped out [some services]—for instance, there was [a] drop-in centre for people that could go in and have coffee and meet and who just had no place to go, and no one to talk to… that place is no longer, it wasn’t funded, the funding was withdrawn. That’s cheap, you know, that costs nothing. But they’d rather, you know, maybe employ a psychiatrist somewhere and put them in a tertiary hospital. I don’t know what they want to do but they need to reorganise their priorities hugely and look at community and supporting people.” – Maternal fetal medicine midwife  

“I think us in general practice being more aware of community groups and [] support networks—there’s a lot of different ones, and there’s so many we forget them all... somehow [we need] a better interface between us in general practice and knowing what community groups there are. It’s quite hard, cause there’s so many different groups, and we need to know so much that we forget them all the time. So some sort of better way of interacting with community networks and support I think would be helpful.” – General practitioner 2 |
| **Community support** | “What we’ve tried to do is embed some of our workers from our team in the [] secondary care services (obstetric or antenatal care services) in the region. So we have what we call ‘the wellness clinic’ here at [the] hospital, so that’s in primary maternity care, where, if [a woman is] identified by the midwife or someone like that, [they] get seen by someone from our service, who then can make a judgment on whether they need to ramp it up and get them in or not.” – Maternal mental health psychiatrist |
| **Local solution** |  

|
overseas studies in terms of identified themes, and the data were re-analysed until no new themes were evident. Our recruitment process (using existing connections and a snowball method) may not have gathered a comprehensive representation of all professionals involved in miscarriage care. This study was based in a tertiary district health board, and we do not know whether care has been more fragmented because of the size of the population served, or whether more rural and remote areas of Aotearoa carry greater inequities in access. However, this seems somewhat of a moot point, as we know that miscarriage impacts mental health, and that there is a significant burden of maternal mental health and persistent failings in healthcare for Māori (Wai 2575 the Waitangi Tribunal Health Services and Outcomes Inquiry, and Wai 2700, Mana Wāhine Kuapapa Inquiry).

**Conclusions**

Our study's findings highlight health professionals’ experiences and perception that care is often fragmented for women who have experienced an early miscarriage, and that there are many barriers to receiving appropriate support. Changes to improve equity in access are urgently needed.
Competing interests:
Nil.

Acknowledgements:
The authors would like to thank all the health professionals who participated in this project for their time and insights.

Author information:
Jessica Yang: Department of Obstetrics, Gynaecology and Women's Health, University of Otago Wellington, Wellington, Aotearoa New Zealand.
Anthony Dowell: Department of Primary Health Care and General Practice, University of Otago Wellington, Wellington, Aotearoa New Zealand.
Sara Filoche: Department of Obstetrics, Gynaecology and Women's Health and Department of Pathology and Molecular Medicine, University of Otago Wellington, Wellington, Aotearoa New Zealand.

Corresponding author:
Sara Filoche, Department of Obstetrics, Gynaecology and Women's Health and Department of Pathology and Molecular Medicine, University of Otago Wellington, Wellington 6242 Aotearoa New Zealand; +64 4 918 6888
Sara.Filoche@otago.ac.nz

URL:

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