

# Psychosocial approach to pregnancy loss in primary health care

Abordagem psicossocial às perdas gestacionais na Atenção Primária à Saúde

*Abordaje psicossocial de las pérdidas gestacionales en Atención Primaria de Salud*

Fatima Elisa D'Ippolito Alcocer<sup>1</sup> , Karoline Baruque Bignotto<sup>2</sup> , Guilherme de Sousa Barbosa<sup>3</sup> 

<sup>1</sup>Meiga & Charruf Serviços Médicos e Associados S/S – São Paulo (SP), Brazil.

<sup>2</sup>Instituto Israelita de Responsabilidade Social Albert Einstein, Unidade Básica de Saúde Paraisópolis – São Paulo (SP), Brazil.

<sup>3</sup>Hospital Israelita Albert Einstein, Centro de Saúde Escola Samuel Barnsley Pessoa – São Paulo (SP), Brazil.

## ABSTRACT

**Introduction:** Pregnancy losses are common events in reproductive life. In view of the individual and professional difficulty of dealing with the mental suffering that they cause, we question the choice of technique, the regularity and the way of carrying out approaches that would be better suited to cope with this situation. Therefore, this clinical review aimed to assess the recent literature and seek the best scientific evidence about the psychosocial approach to these losses. **Methods:** Keywords determined by MeSH were used to select study titles in the databases PUBMED, ACCESSSS, BMJ, DYNAMED, EBM and LILACS. The inclusion criteria were: year of publication between 2010-2020; study type (meta-analysis, systematic review, randomized clinical trial, non-randomized clinical trial and cohort or control case); induced abortion not addressed; written in English, Portuguese or Spanish; and found in full text. **Results:** Twenty-eight articles were found and their abstracts were evaluated, where 14 were excluded and 14 were read in full. In the end, 9 studies were included in this review. It was observed that psychological symptoms are frequently presented after pregnancy losses, that there are several ways to access these data and that there is no consensus on the best intervention. In addition, in men and homosexual couples, there is a greater chance of making suffering invisible and a lesser mourning approach by health professionals. **Conclusion:** In the absence of consensus on which interventions have the best results, it is recommended to screen for mental suffering and share the decision with the parties involved.

**Keywords:** Stress, psychological; Abortion; Stillbirth; Primary health care.

### Corresponding author:

Karoline Baruque Bignotto

E-mail: karolbignotto@gmail.com

### Funding:

No external funding.

### Ethical approval:

not applicable.

### Provenance:

Not commissioned.

### Peer review:

external.

Received: 14/02/2021.

Approved: 18/01/2022

**How to cite:** Alcocer FEDI, Bignotto KB, Barbosa GS. Psychosocial approach to pregnancy loss in primary health care. Rev Bras Med Fam Comunidade. 2022;17(44):2927. [https://doi.org/10.5712/rbmfc17\(44\)2927](https://doi.org/10.5712/rbmfc17(44)2927).



## RESUMO

**Introdução:** Perdas gestacionais são eventos comuns na vida reprodutiva. Tendo em vista a dificuldade individual e profissional de lidar com o sofrimento mental que ocasionam, indaga-se sobre a escolha da técnica, a periodicidade e o modo de execução das abordagens que melhor se adequariam ao enfrentamento dessa situação. Sendo assim, esta revisão clínica tem como objetivo avaliar a literatura recente acerca do tema e buscar as melhores evidências científicas em relação à abordagem psicossocial a essas perdas. **Métodos:** Foram utilizadas palavras-chave determinadas pelo *Medical Subject Headings* (MeSH) para selecionar títulos de estudos nas bases de dados: PubMed, ACCESSSS, *British Medical Journal* (BMJ), DYNAMED, Literatura Latino-Americana e do Caribe em Ciências da Saúde (LILACS). Os critérios de inclusão foram: ano de publicação entre 2010 e 2020; tipo de estudo (metanálise, revisão sistemática, ensaio clínico randomizado, ensaio clínico não randomizado, coorte ou caso controle); não abordar abortamento induzido; estar em inglês, português ou espanhol; ser passível de ser encontrado na íntegra. **Resultados:** Foram encontrados 28 artigos, que tiveram seus resumos avaliados; 14 foram excluídos e 14 lidos na íntegra. No fim, nove estudos foram incluídos nesta revisão. Foi possível observar que sintomas psicológicos são frequentemente apresentados após perdas gestacionais, que há diversas maneiras de acessar esses dados e que não há consenso sobre qual a melhor intervenção a ser feita. Além disso, em homens e casais homossexuais, há maior chance de invisibilidade do sofrimento e menor abordagem de luto por profissionais de saúde. **Conclusão:** Na falta de consenso sobre quais intervenções apresentam melhores resultados, recomenda-se o rastreamento de sofrimento mental e o compartilhamento da decisão com as partes envolvidas.

**Palavras-chaves:** Estresse psicológico; Abortamento; natimorto; Atenção primária à saúde.

## RESUMEN

**Introducción:** Las pérdidas de embarazos son eventos comunes en la vida reproductiva. Ante la dificultad individual y profesional de afrontar el sufrimiento mental provocado, nos cuestionamos la técnica, la periodicidad y la forma de los mejores abordajes a afrontar esta situación. Por lo tanto, esta revisión clínica tiene como objetivo evaluar la literatura reciente y buscar la mejor evidencia científica sobre el abordaje psicossocial de estas pérdidas. **Métodos:** Se utilizaron palabras clave determinadas por MeSH para seleccionar los títulos de los estudios en las bases de datos: PUBMED, ACCESSSS, BMJ, DYNAMED, EBM, LILACS. Criterios de inclusión fueron: año de publicación entre 2010-2020; tipo de estudio (metaanálisis, revisión sistemática, ensayo clínico aleatorizado, ensayo clínico no aleatorizado, cohorte o caso de control); no abordar el aborto inducido; estar en inglés, portugués o español; posible encontrar en su totalidad. **Resultados:** Se encontraron 28 artículos, se evaluaron sus resúmenes, se excluyeron 14 y se leyeron 14 completamente. Al final, se incluyeron 9 estudios. Se pudo observar que los síntomas psicológicos se presentan con frecuencia después de las pérdidas del embarazo, que existen varias formas de acceder a estos datos y que no existe consenso sobre la mejor intervención. Además, en los hombres y las parejas homosexuales existe una mayor posibilidad de invisibilizar el sufrimiento y un menor enfoque de duelo por parte de los profesionales. **Conclusión:** En ausencia de consenso sobre qué intervenciones tienen los mejores resultados, se recomienda realizar un seguimiento del sufrimiento mental y compartir la decisión con las partes involucradas.

**Palabras clave:** Estrés psicológico; Aborto; mortinato; Atención primaria de salud.

## INTRODUCTION

Pregnancy losses are common events in reproductive life. There are estimates that 12% of all pregnancies will result in abortions and that 25% of women up to 39 years of age who have already been pregnant have already suffered at least one type of pregnancy loss during their life.<sup>1-3</sup>

These events can be classified as early or late, according to the gestational period in which they occurred. Early pregnancy loss is the presence of a confirmed empty gestational sac or with an embryo inside without a fetal heartbeat up to 12 weeks;<sup>1</sup> abortion is the premature expulsion of the fetus or embryo from the uterus, up to 23 weeks of gestation and weighing less than 500 g.<sup>1</sup> After this period, loss of a fetus weighing more than 500 g or of a child born without life, are considered fetal death or stillbirth.<sup>4-6</sup>

Since the beginning of the 20th century, scholars already observed the effect of pregnancy loss on women's psychological health and designed studies to evaluate it. However, the analyses carried out always focused on grief and did not assess the long-term effects.<sup>7</sup> From the 1990s onwards, with Neugebauer et al., Engelhard et al. and Cumming et al. (apud Farren et al.<sup>7</sup>), studies began to better evaluate these perspectives on the physical and psychological health of both individual parents and couples experiencing

this situation. These and other studies with the North American and British populations observed rates of 41% for anxiety, 36% for depression after one month of the loss, and 39% for post-traumatic stress disorder after three months of the loss.<sup>7</sup> There is also a considerable rate of alcohol and illicit drug abuse in the male population.<sup>8</sup>

Based on the aforementioned data, we wondered which group of people and what is the best way and time to address the psychological effects resulting from these losses. According to Rowlands et al.,<sup>9</sup> prenatal care would be the opportune time, as it would address the couple's expectations and fears, clarify doubts and prepare parents for the pregnancy that would develop or not, thus being able to screen and decrease stress levels related to loss.

With this in mind, family health strategy makes it possible to carry out this screening and follow-up, since its proposal is to provide comprehensive care to families, including pre- and postnatal/ puerperal care.

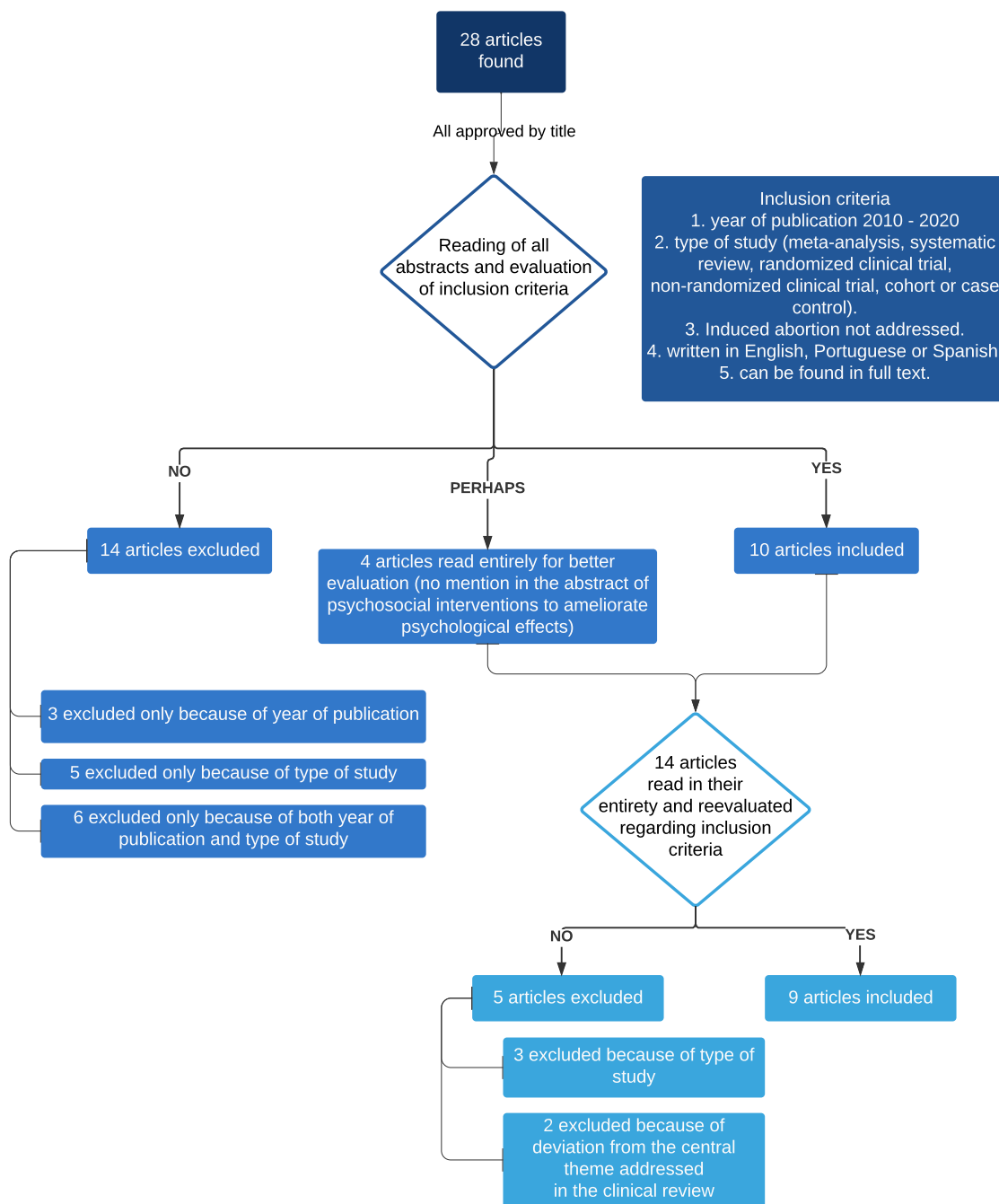
Therefore, the aim of this study was to conduct a clinical review of the recent literature on psychological distress triggered by pregnancy loss, in addition to evaluating the scientific evidence to better accommodate this situation, in an attempt to reduce related symptoms and improve the quality of life of the population affected.

## METHODS

The following keywords were used in the databanks, medical subject headings (MeSH): "*aborto espontâneo*", "*aborto espontáneo*", "*spontaneous abortion*", "*psychological stress*", "*primary care*" and "*pregnancy loss*". These words were entered alone or in combination in the following databases during the month of August 2020: PubMed, ACCESSSS, British Medical Journal (BMJ), DynaMed, Latin American and Caribbean Literature in Health Sciences (LILACS). The first step was approval by title, which should contain the cited keywords or synonyms, which led to the selection of 28 articles. Subsequently, the following inclusion criteria were used: year of publication between 2010 and 2020; type of study (meta-analysis, systematic review, randomized clinical trial, non-randomized clinical trial, cohort or case control); not addressing induced abortion; written in English, Portuguese or Spanish; found in full text. After filtering by these criteria, between September and December 2020, 14 articles were excluded and 14 remained. These articles were read in full by FEDA and KBB, dividing them equally and randomly, and had their outcomes summarized in a filing table, according to the individual understanding of each author. It is worth mentioning that, in this first moment, articles in Portuguese and Spanish were excluded because they did not comply with the established time range and because they focused primarily on the biomedical aspect of pregnancy loss, ignoring the subjectivities of care for individuals affected by it.

At the end of the full reading, a deviation from the inclusion criteria was noticed not previously apparent in the abstracts of five texts (for example, not addressing psychological distress in the article itself and not belonging to the types of study selected), so that the articles were excluded from analysis of the results and discussion. In case of doubt regarding the inclusion of a work in relation to the criteria listed above, the third author (GSB) also analyzed it and expressed its opinion, whether the article was included or not after three-way consensus.

Finally, nine texts had their outcomes analyzed by the authors; all were written in English. Figure 1 presents the article selection process.



**Figure 1.** Determination of articles included in the clinical review.

## RESULTS AND DISCUSSION

Among the articles included in this clinical review, it was possible to perceive a repetition in the pattern of topics addressed, so that the grouping of these subjects becomes relevant for a better discussion and for a deeper analysis, to complement the specialized clinical practice of family and community medicine (FCM). They are: screening for psychic suffering; delegitimization of mourning; pregnancy loss and the main diagnoses in mental health; proposed psychosocial approaches and interventions; and subsequent pregnancies.

The summary of the file produced by the authors after reading the nine articles included in the study can be found in Table 1.

## Screening for psychic suffering

Several studies propose strategies to detect and measure the mental suffering caused by pregnancy loss.

One of these strategies was the use of psychometric scales; in the systematic review by Due et al.<sup>8</sup>, the Beck Depression Inventory (BDI), State-Trait Anxiety Inventory (STAI), Perinatal Grief Scale (PGS) and Impact of Event Scale were used (IES) to assess the impact of pregnancy loss on the couple. Kong et al.<sup>10</sup> used the General Health Questionnaire (GHQ-12) and Dyadic Adjustment Scale (DAS) to assess women's psychological stress level immediately after pregnancy loss. Rowlands et al.<sup>9</sup> applied the 5-item Mental Health Subscale (MHI-5) scale to assess the adjustment of Australian women who self-reported previous pregnancy loss.

Another access strategy mentioned was that performed by health professionals, and only the BMJ 2020<sup>11</sup> database was more specific in determining which professional should do it: FCM, gynecology-obstetrics (GO) and/or nursing professionals. These should pay attention to the following risk factors: previous personality of the person, level of distress immediately after the loss, social context (high levels of external stressors and low education), homosexuality, history of living children and personal history of psychiatric morbidities (mainly anxiety and depression).<sup>9,11-13</sup>

There was no consensus on the exact time frame in which screening should take place,<sup>1</sup> but most texts suggested a short-term assessment (up to 12 weeks after loss).<sup>8,10,11</sup> If screening showed high levels on the scales or presence of risk factors, a follow-up proposal should be offered to reduce possible psychological sequelae or the development of more serious mental disorders.<sup>9-13</sup>

## Delegitimization of mourning

Delegitimizing is defined as the act of denying that something is validated, justified, recognized or legalized.<sup>14</sup> This situation is quite common with pregnancy or neonatal loss, since both health professionals and people who live with these parents have difficulties in recognizing the grief.<sup>15</sup>

Non-recognition makes it difficult for these individuals to talk about what they are feeling and to request or get support.<sup>8,11,15</sup> Due et al.<sup>8</sup> recognize that this phenomenon is even more intense in the homosexual and male population, which influences how these groups adapt to the loss, which can generate negative impacts in different areas of daily life — such as the couple's relationship, living with the family, returning to work (and consequently on productivity) and family income.<sup>15</sup>

One way to change this outcome is to recognize the loss and the possibility of suffering, with the inclusion of the partnership in this reception, regardless of the couple's arrangement, whether homosexual or heterosexual. In addition, it is suggested that the professional support this couple and encourage insight and social and spiritual support.<sup>9</sup>

Furthermore, it is important to point out that, during the discussion of this topic, difficulties were perceived in finding studies that evaluated the delegitimization of grief in single parents, regardless of gender. Future studies may address both individuals who did not form a couple from the beginning and those who broke up during pregnancy, analyzing the impacts of grief alone and in the combination of pregnancy loss with marital separation.

**Table 1.** Summary of article included in the clinical review.

Authors/ references	Title	Journal	Year of publication	Type of study	Country of origin	Summary
Murphy et al. <sup>1</sup>	Follow-up for improving psychological well-being for women after a miscarriage	Cochrane Database Syst Rev.	2012	Systematic review	United Kingdom	Assessed the impact of interventions on the well-being of women who had a pregnancy loss and compared the effect of existing intervention patterns. What varied was the frequency of sessions (zero to three sessions), the care modality (combined care — nursing + self-care, nursing care, self-care), care technique (recognized or unstructured), time of intervention after the pregnancy loss (1 week to 12 months). It assessed that, due to the variation in time of interventions, it was not known for sure how long it takes for the remission of psychological symptoms and showed that the scientific evidence obtained was insufficient to demonstrate the superiority of counseling versus no post-loss intervention, suggesting a shared decision between professional and pregnant woman.
DynaMed <sup>2</sup>	First trimester pregnancy loss	Ipswich (MA): EBSCO Information Services	1995	Databases	USA	Reviewed first trimester pregnancy loss and suggested avoiding terms such as “failure/faults” when referring to pregnancy loss to avoid confusion between induced and spontaneous abortion, as well as the negative effects these terms have (which could lead to negative psychological outcomes). It suggested that counseling is beneficial. It recommended as an initial approach the assurance that the loss was not caused by daily living activities and that an abortion episode will not affect future fertility. Some women may need additional psychological support due to psychological sequelae. Such a complication is common and defined as a sense of loss and grief. Not having children or a previous personal history of depression are risk factors for the development of sequelae. <sup>3</sup>
DynaMed <sup>4</sup>	Stillbirth	Ipswich (MA): EBSCO Information Services	1995	Databases	USA	Reviewed stillbirths, referring to the intrauterine dead fetus or the delivery of a lifeless child. It can be early (20–27 weeks) or late (over 28 weeks). Termination of pregnancy due to fatal fetal anomaly or premature rupture of the ovular membranes (PRMO) are not considered stillbirths. Counseling: recognition of psychological sequelae resulting from stillbirth/fetal death and promotion of support, follow-up and access to formal professional counseling, both for the pregnant woman and her partner (Royal College of Obstetricians and Gynecologists — RCOG Grade A), without randomized studies that have evaluated interventions to support families after perinatal death. <sup>5</sup> Referrals: sharing care with grief counseling staff, church leaders, peer support groups, and/or mental health professionals for grief and depression management (American College of Obstetricians and Gynecologists — ACOG level C); assessed the need for referral to a specialist in maternal-fetal genetics or medicine for discussion of parental chromosomal testing. Postpartum care: avoid persuading the parents to have contact with the stillborn child (RCOG Grade C), support any and all parental decisions to see or hold the child (RCOG Grade C), prior to the autopsy, should be given possibility of holding the child or carrying out cultural/religious activities; seeing and holding the stillborn child may be associated with positive paternal outcomes (DynaMed level 2 - Birth 2015 — systematic review that evaluated 23 studies, 21 reported positive benefits, 5 suggested potential harm). Complications: increased risk for depression and post-traumatic stress disorder; <sup>6</sup> multiple pregnancy losses are associated with increased severity of symptoms of depression and anxiety in subsequent pregnancies and the postpartum period; women who give birth 12 months after the stillbirth may be at increased risk of depression and anxiety in the current pregnancy.

Continue...

Table 1. Continuation.

Authors/ references	Title	Journal	Year of publication	Type of study	Country of origin	Summary
Due et al. <sup>8</sup>	The impact of pregnancy loss on men's health and wellbeing: a systematic review	BMC Pregnancy Childbirth	2017	Systematic review	Australia	Systematic review aimed at evaluating the impact of pregnancy loss on men, from the couple's perspective. Evaluated quantitative and qualitative articles. Quantitative — assessment performed at an average of eight weeks after the loss using psychometric scales such as the Beck Depression Inventory (BDI), State-Trait Anxiety Inventory (STAI), Perinatal Grief Scale (PGS) and Impact of Event Scale (IES). It was observed that anxious and/or depressive symptoms tend to last less in men than in women and that their way of dealing with grief assumes a character of greater avoidance or distraction with other tasks. Qualitative — evaluation made at an average of six weeks after loss, most of them with a phenomenological approach, finding the process of internalization/avoidance and also delegitimization of the man's grief by society.
Rowlands and Lee <sup>9</sup>	Adjustment after miscarriage: predicting positive mental health trajectories among young Australian women	Psychology Health and Medicine	2010	Cohort	Australia	Cohort study of young Australian women (18 to 23 years old) who responded positively to the question about previous abortions in The Australian Longitudinal Study on Women's Health (ALSWH) survey. A scale called the 5-item Mental Health Subscale (MHI-5) was used to assess the adjustment of this population. It recommends offering support in relation to the mental health of women with a previous history of mental suffering or with high levels of stress to guarantee their quality of life in the months after the loss and in a future pregnancy. It suggests prenatal stress screening and, if positive, indicates cognitive-behavioral intervention. It suggests qualification of the FCM professional in relation to stress management since the bond with this professional was considered a protective factor.
Kong et al. <sup>10</sup>	The impact of supportive counselling on women's psychological wellbeing after miscarriage--a randomised controlled trial	BJOG	2014	Randomized clinical trial	China	It compared structured psychological counseling versus standard care after pregnancy loss. The initial assessment includes accessing risk factors for psychological stress through psychometric scales such as the General Health Questionnaire (GHQ-12) and BDI and a 1-hour conversation with nurses trained in grief counseling and identification of common psychiatric disorders (with the aim of discussing concerns, feelings, and physical symptoms and discovering possible stressors). The second access point took place 15 days later, by telephone, lasting 30 minutes, reinforcing this same theme. Impact was assessed by completing the same psychometric scales 1.5, 3 and 6 months after the intervention. The result was a reduction in suffering time, with the greatest impact on the population of women with higher baseline psychological stress levels (GHQ-12 $\geq$ 4 and BDI > 12).
Muslim and Doraiswamy <sup>11</sup>	Miscarriage (Counseling and prognosis)	BMJ	2020	Databases	United Kingdom	It reviewed the main topics on pregnancy loss. Suggested counseling after all losses. Such counseling may be provided by an FCM, gynecologist or nursing professional to support and encourage insight and social and spiritual support. Helping tools can be used, such as videos, manuals and counseling sessions (e.g., Sands-Stillbirth and Neonatal Death Charity protocol), focusing on the couple. Such an approach should take place in the short term (up to one month after the loss). While long-term psychological disorders are not uncommon, not all women or couples will need psychotherapeutic or psychiatric care. The severity of symptoms depends on the person's previous personality, the level of distress immediately following the loss, and the social context in which they live. It is attentive to a less common and less studied situation, which is pregnancy loss in homosexual women, and suggests that health professionals should recognize and actively include the same-sex partnership, being sensitive to the high probability that this pregnancy was deeply planned. Addresses anniversary syndrome (depressive feelings close to the date of the loss).

Continue...

Table 1. Continuation.

Authors/ references	Title	Journal	Year of publication	Type of study	Country of origin	Summary
DynaMed <sup>12</sup>	Recurrent pregnancy loss	Ipswich (MA): EBSCO Information Services	1995	Databases	USA	Database that reviewed the main topics in recurrent pregnancy loss. It cites psychological sequelae as a complication and suggests psychological support and counseling as it also has an impact on the success of future pregnancies.
DynaMed <sup>13</sup>	Second trimester pregnancy loss	Ipswich (MA): EBSCO Information Services	1995	Databases	USA	Database reviewing second trimester pregnancy loss. Recognizes psychological sequelae after pregnancy loss and recommends the promotion of support, follow-up and access to professional counseling if necessary (information and psychological support, as well as counseling and support groups). Prognosis: overall maternal mortality of 0.7/100,000 abortions, increased risk of abortion/recurrence of abortions over three episodes.

Continue...

## Pregnancy loss and the main diagnoses in mental health

The most recent studies and databases bring some symptoms of specific mental disorders as something expected and common. The main disorders related to depression, anxiety, adaptation, use of alcohol and other substances and anniversary syndrome are listed as the main disorders.<sup>1,4,8,9,11</sup>

It is important to realize that there is an important differentiation between adjustment strategies (presentation of psychological symptoms) and the disorders themselves, with the latter specific criteria generally based on the duration of symptoms and their impact on functioning.<sup>15</sup>

Detailing each of these criteria is beyond the scope of this review, and we chose only to define the anniversary syndrome as it is more specific to this situation. Such a condition is described as the appearance of depressive feelings close to the date of the event (days and weeks before the date of the loss).<sup>11</sup>

As already discussed in the sub-item "Screening for psychic suffering", psychometric or risk factor assessment scales can help determine which population would be more predisposed to fit these diagnoses. In these populations, it is imperative to structure a follow-up plan, which will be better described in the sub-item below.

### *Proposed psychosocial approaches and interventions*

In eight of the nine articles read, some type of approach was advised, especially for those women or couples whose level of anguish or stress after the loss is high or in which there are risk factors.<sup>9-13</sup> We discuss psychosocial approach/intervention. because, although there is no consensus on the format of interventions (techniques, professional involved, means of application and frequency of access),<sup>1</sup> they all take into account psychological aspects and the social and cultural context of the individual/couple. Below is a brief summary of the outcomes found in each of the articles:



- Murphy et al.<sup>1</sup> found that the evidence was insufficient to demonstrate the superiority of psychological counseling (whether combined care — nursing + self-care, nursing care or self-care; with recognized technique or not; with regularity between one week and 12 months after the pregnancy loss) in relation to no post-loss intervention, suggesting a shared decision that takes into account the desire of the woman/couple involved.
- Due et al.<sup>8</sup> evaluated the impact of the phenomenological intervention in men, without specifying the professional who performed it and with an average access time of up to six weeks after the loss, reaching the conclusion that this group is mostly delegitimized in their feelings of loss and that more studies are needed for a better position on the subject.
- Rowlands et al.<sup>9</sup> suggested a prenatal screening of stressors, with the application of a cognitive-behavioral technical intervention after the pregnancy loss, to be performed by a trained FCM professional, since the pregnant woman-professional bond would be a protective factor.
- Kong et al.<sup>10</sup> demonstrated benefits in structured psychological counseling aimed at women at high risk of psychological and psychiatric disorders, carried out by nurses trained in grief counseling and identification of common psychiatric disorders. It proposes an access structure, initially, in a 1-hour face-to-face consultation immediately after the loss and, 15 days afterward, in a 30-minute telemedicine visit.
- The BMJ database, last updated in 2020,<sup>11</sup> suggests that there be counseling after all losses, which can be done by a FCM, GO or nursing professional, to support and stimulate insight and social and spiritual support. Helping tools can be used, such as videos, manuals and counseling sessions (for example, the Sands-Stillbirth and Neonatal Death Charity protocol), focusing on the couple and in the short term (up to one month after the loss).
- The DynaMed database, last updated in 2018,<sup>2,4,12,13</sup> divides its approach into early and late pregnancy losses. In early loss, it only suggests some forms of professional communication: terms such as “failure/faults” should be avoided because of the negative effects they can have, which can lead to negative psychological outcomes. It should also be reinforced that the loss was not caused by activities of daily living and ensured that an abortion episode will not affect future fertility. In late loss (fetal death), there should be support, follow-up and access to formal professional counseling for both the pregnant woman and her partner (Royal College of Obstetricians and Gynecologists — GRCOG Grade A). Recommended is referral to grief counseling staff, church leaders, peer support groups, and/or mental health professionals for grief and depression management (American College of Obstetricians and Gynecologists — ACOG level C), and it suggests that before fetal autopsy, there should be the possibility of holding the child or performing cultural/religious activities, considering these practices as associated with positive outcomes in the well-being of the couple.

## Subsequent pregnancies

After a pregnancy loss, it is usual for the woman or couple to seek rational or guilty explanations to alleviate their suffering, in addition to worrying about future pregnancies.<sup>9,11-13</sup> At this point, it is important to emphasize that there is no relationship between the loss and daily living activities, and that an abortion episode does not influence the couple’s fertility.<sup>2</sup>

Most pregnancy losses occur in the first trimester and are caused by fetal chromosomal disorders (50–85%), which makes the pregnancy unfeasible and does not indicate the need for investigations.<sup>2</sup> These are only necessary in the case of recurrent miscarriages ( $\geq$  two losses documented by ultrasound

or pathological examination, with no related gestational age, or  $\geq$  three losses in the first trimester of pregnancy) or those that occurred after the second trimester of pregnancy.<sup>12,13</sup>

Even so, the main cause of recurrent miscarriages is idiopathic (50–75%)<sup>13</sup> and about 50–60% of women become pregnant again without experiencing any losses (depending on parity and maternal age).<sup>12</sup> Therefore, there is no need for drug or surgical interventions and there is benefit of emotional support for having a positive impact on the evolution of future pregnancies,<sup>13</sup> reducing the severity of symptoms experienced in later pregnancies and in the puerperium.<sup>4</sup>

As previously described, it should be noted that the topics addressed are extremely relevant for the training of FCM professionals, since they value the principles of primary health care, such as integrality and longitudinality, and the specialty itself as a practice. influenced by the community and by the intensification of the doctor-patient relationship (bond).<sup>16-19</sup>

Integrality is when care transcends curative practice, contemplating these individuals at all levels of care and considering them in a social, family and cultural context. If the professional takes this principle into account, he will already be acting in a way that allows himself to be influenced by the community. Longitudinality, in turn, guarantees the follow-up of care over time and the assessment of how the impact of the loss will evolve in each of the parties involved. Longitudinal care promotes the intensification of the established bond.

## FINAL CONSIDERATIONS

According to the studies evaluated, there is a consensus regarding screening for risk factors for the development of mental disorders after pregnancy loss, both in individuals and in couples; however, there is no information regarding the best approach and coping techniques and when these interventions should be carried out and by which professionals, once mental suffering has been diagnosed. In addition, there is no statistically significant evidence indicating a better outcome in the groups that underwent psychosocial interventions versus those that did not. With this in mind, the attributes of FCM are shown as options for the discussion of the topic, individualizing the treatment according to the characteristics of those involved and taking into account the technical capacity of the professionals, the link established between the families and the health care services and desires and expectations about pregnancy. Thus, especially in Latin American countries, where the scarcity of articles evidences the neglect of the topic for more than 20 years, further studies are needed to guide clinical practice as well as the training of professionals and services for approaches on the topic, so as not to make protagonists invisible or neglect care.

## ACKNOWLEDGMENTS

We thank the patients for motivating us to seek the best evidence to better serve them, our families and partners for supporting us and Denize Ornelas S. P. de Oliveira for inspiring us to be family and community doctors par excellence and adequate resources for our population.

## CONFLICT OF INTERESTS

Nothing to declare.

## AUTHORS' CONTRIBUTIONS

FEDA: project management, formal analysis, conceptualization, data curation, writing – first draft, writing – review and editing, research, methodology, validation and visualization. KBB: project management, formal analysis, conceptualization, data curation, writing – first writing, writing – review and editing, research, methodology, validation, visualization. GSB: project management, formal analysis, conceptualization, data curation, writing – review and editing, research, methodology, supervision, validation, visualization.

## REFERENCES

- Murphy FA, Lipp A, Powles DL. Follow-up for improving psychological well being for women after a miscarriage. *Cochrane Database Syst Rev* 2012;3(3):CD008679. <http://doi.org/10.1002/14651858.cd008679.pub2>
- DynaMed [Internet]. First trimester pregnancy loss. Record No. T113658. Ipswich (MA): EBSCO Information Services; 1995. Available at: <https://www.dynamed.com/topics/dmp~AN~T113658>. Registration and login required.
- Neugebauer R, Kline J, Shrout P, Skodol A, O'Connor P, Geller PA, et al. Major depressive disorder in the 6 months after miscarriage. *JAMA* 1997;277(5):383-8. PMID: 9010170
- DynaMed [Internet]. Stillbirth. Record No. T115491. Ipswich (MA): EBSCO Information Services; 1995. Available at: <https://www.dynamed.com/topics/dmp~AN~T115491>. Registration and login required.
- Koopmans L, Wilson T, Cacciatore J, Flenady V. Support for mothers, fathers and families after perinatal death. *Cochrane Database Syst Rev* 2013;2013(6):CD000452. <http://doi.org/10.1002/14651858.CD000452.pub3>
- Giannandrea SAM, Cerulli C, Anson E, Chaudron LH. Increased risk for postpartum psychiatric disorders among women with past pregnancy loss. *J Womens Health (Larchmt)*. 2013;22(9):760-8. <http://doi.org/10.1089/jwh.2012.4011>
- Farren J, Mitchell-Jones N, Verbakel JY, Timmerman D, Jalmbraant M, Bourne T. The psychological impact of early pregnancy loss. *Hum Reprod Update* 2018;24(6):731-49. <http://doi.org/10.1093/humupd/dmy025>
- Due C, Chiarolli S, Riggs DW. The impact of pregnancy loss on men's health and wellbeing: a systematic review. *BMC Pregnancy Childbirth* 2017;17(1):380. <http://doi.org/10.1186/s12884-017-1560-9>
- Rowlands I, Lee C. Adjustment after miscarriage: predicting positive mental health trajectories among young Australian women. *Psychol Health Med* 2010;15(1):34-49. <http://doi.org/10.1080/13548500903440239>
- Kong GWS, Chung TKH, Lok IH. The impact of supportive counselling on women's psychological wellbeing after miscarriage - a randomised controlled trial. *BJOG* 2014;121(10):1253-62. <http://doi.org/10.1111/1471-0528.12908>
- Muslim I, Doraiswamy J. Aborto espontâneo. *BMJ* 2020;3-74. Available at: <https://bestpractice.bmj.com/topics/pt-br/666/pdf/666/Aborto%20espont%C3%A2neo.pdf>. Acesso em: 07 mar. 2022.
- DynaMed [Internet]. Recurrent pregnancy loss. Record No. T116364. Ipswich (MA): EBSCO Information Services; 1995. Available at: <https://www.dynamed.com/topics/dmp~AN~T116364>. Registration and login required.
- DynaMed [Internet]. Second trimester pregnancy loss. Record No. T904101. Ipswich (MA): EBSCO Information Services; 1995. Available at: <https://www.dynamed.com/topics/dmp~AN~T904101>. Registration and login required.
- Legítimar. *Dicionário Michaelis Online*. Available at: <https://michaelis.uol.com.br/moderno-portugues/busca/portugues-brasileiro/legitimar/>
- Heazell AEP, Siassakos D, Blencowe H, Burden C, Bhutta ZA, Cacciatore J, Stillbirths: economic and psychosocial consequences. *Lancet* 2016;387(10018):604-16. [https://doi.org/10.1016/S0140-6736\(15\)00836-3](https://doi.org/10.1016/S0140-6736(15)00836-3)
- Starfield B. Atenção primária: equilíbrio entre necessidades de saúde, serviços e tecnologia. Brasília: UNESCO, Ministério da Saúde; 2002.
- McWhinney IR, Freeman TR. *Manual de medicina de família e comunidade de McWhinney*. 4ª ed. Porto Alegre: Artmed; 2017.
- Stewart M, Brown JB, Weston WW, McWhinney IR, McWilliam CL, Freeman TR. *Medicina centrada na pessoa: transformando o método clínico*. 3ª ed. Porto Alegre: Artmed; 2017.
- Gusso G, Lopes JMC, Dias LC. *Tratado de medicina de família e comunidade: princípios, formação e prática*. Porto Alegre: Artmed; 2019.