Perinatal Loss:
Recognizing Health Risks & Supporting Recovery

Sofia Noori, MD MPH

January 15th, 2026

ACCESS
Mental Health
and Substance Use
for Moms

Disclosures

I run a trauma clinic called Nema Health

No other disclosures!

About Me

Sofia Noori, MD, MPH

Assistant Clinical Professor,
Yale Department of Psychiatry

Reproductive Psychiatrist,
ACCESS Hotline for Moms Connecticut

Co-founder & CEO,
Nema Health

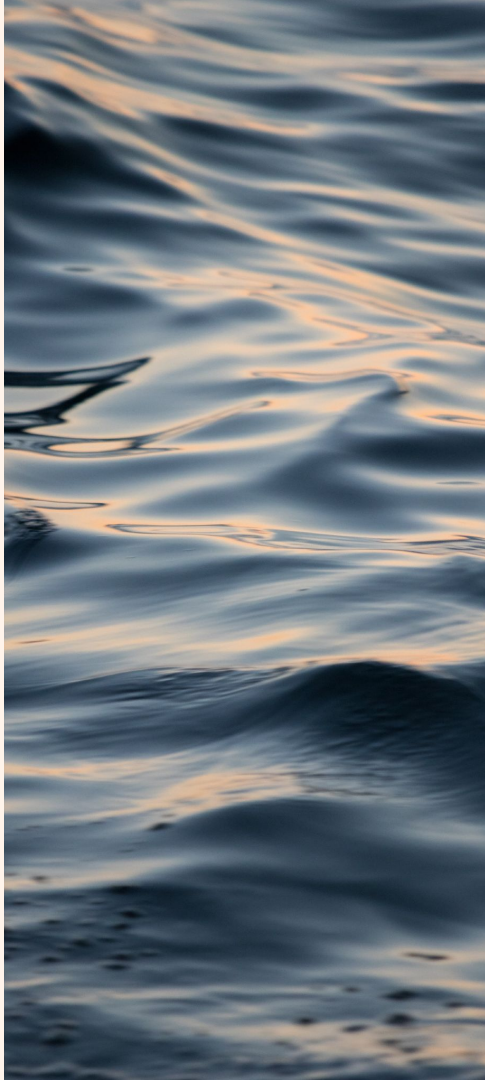
Founder,
the Women's Mental Health Conference at Yale

Education:
Yale Department of Psychiatry Residency
UCSF School of Medicine, MD
UC Berkeley School of Public Health, MPH

Objective of today's talk

After attending this session, participants will be able to:

- **Describe** how pregnancy loss and stillbirth can increase risk for postpartum mental health complications.
- **Recognize** key cues and symptoms to provide sensitive, trauma-informed engagement.
- **Outline** evidence-based treatment options and statewide resources—such as ACCESS Mental Health for Moms—to support affected patients and families.



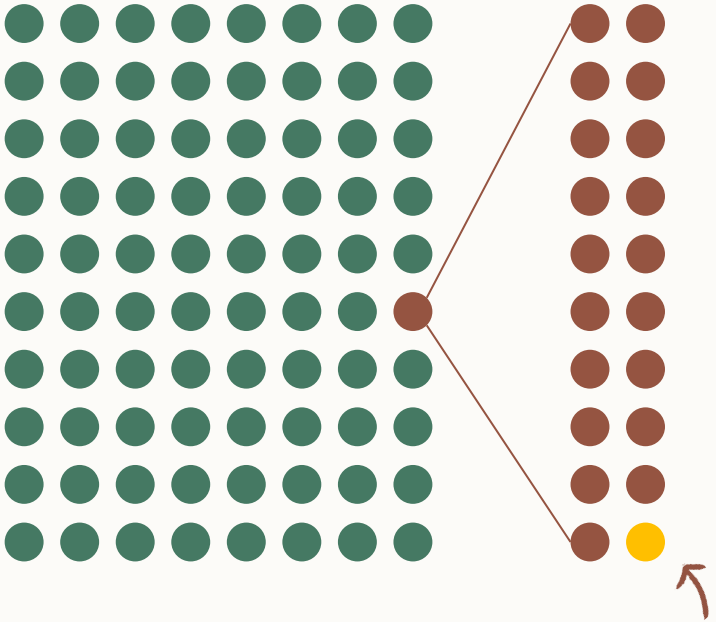
Agenda

1. Define common terms used to describe types of perinatal loss
2. Review myths and misconceptions regarding perinatal loss
3. Understand the course of normal grief
4. Identify risk and protective factors for developing mental health conditions after loss
5. Learn how to sensitively screen for mental health conditions
6. Get familiar with trauma-informed communication strategies with patients
7. Understand the evidence-based treatments for mental health conditions and how to refer to them
8. Identify local resources that can be of help for patients with birth loss

The Perinatal Period: A setting rife with vulnerabilities

Only 0.32% of research is done on pregnant patients

Of that, 0.6% is on perinatal trauma



High likelihood of stress or trauma

The perinatal period increases likelihood of exposure to trauma, including negative birth experience and life-threatening complications

Hormonal fluctuations affect people differently

Hormonal events are associated with increased distress. Low estrogen states are associated with higher vulnerability.

Little-to-no research to help drive care planning

Few studies on perinatal PTSD screening & interventions specifically. Low policy guidance

Most care not trauma-informed

Perinatal care is not always delivered using trauma-informed principles, and is often traumatogenic

Perinatal loss refers to many different types of losses across the perinatal period

Perinatal loss, reproductive loss, and birth loss are used interchangeably

Perinatal period - defined as pregnancy + the 12 months after

Includes a wide range of events:

Unsuccessful IVF
Loss of a desired pregnancy following assisted reproductive technology

Ectopic pregnancy
Implantation of a pregnancy outside of the uterus

Genetic termination
Elective termination due to fetal anomalies

Miscarriage
Further characterized into early (<20 weeks) vs late (still birth)

Neonatal death
Death of a live-born infant <28 days of age

Public perceptions about perinatal loss are often inaccurate

Most Americans believe miscarriage is rare:

thought it occurred <6% of the time

They believed that miscarriages are preventable:

though stress, heavy lifting, STDs, previous abortion history and undesired pregnancy were causes

And therefore pregnant people believe this too:

>80% of patients believe they could have prevented their perinatal loss

These myths contribute to shame and guilt for parents

Perinatal loss is very common:

Occurs in 10-35% of known pregnancies

Most causes are uncontrollable and unforeseeable:

Causes like genetic abnormalities, structural reproductive issues, and chronic autoimmune diseases are the most common causes of perinatal loss

Disclosures by public figures help:

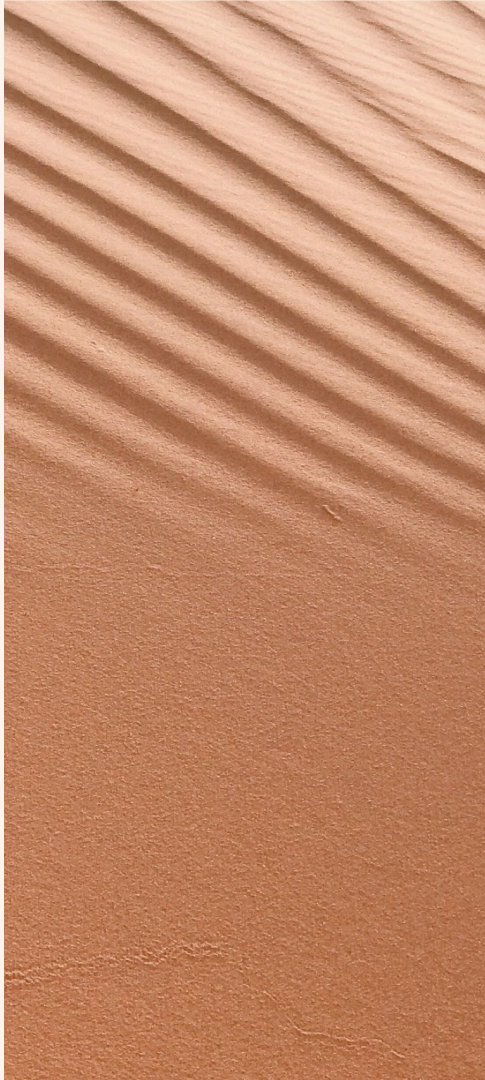
28% reported fewer feelings of isolation after hearing a story from a public figure

After a perinatal loss, there is no one “right” way to feel

- Grief is an expected, normative experience to loss
- Is generally temporary, and results in disrupted functioning
- Does NOT correlate to gestational length
- Peaks at 6 months following the loss, and then generally improves by 12 months (although this can vary)
- Reproductive grief has unique traits
- Limited social acknowledgement results in fewer cultural rituals to aid in grief
- Much more isolative
- Grief at multiple losses - loss of bodily faith, of a planned future, in modern medicine

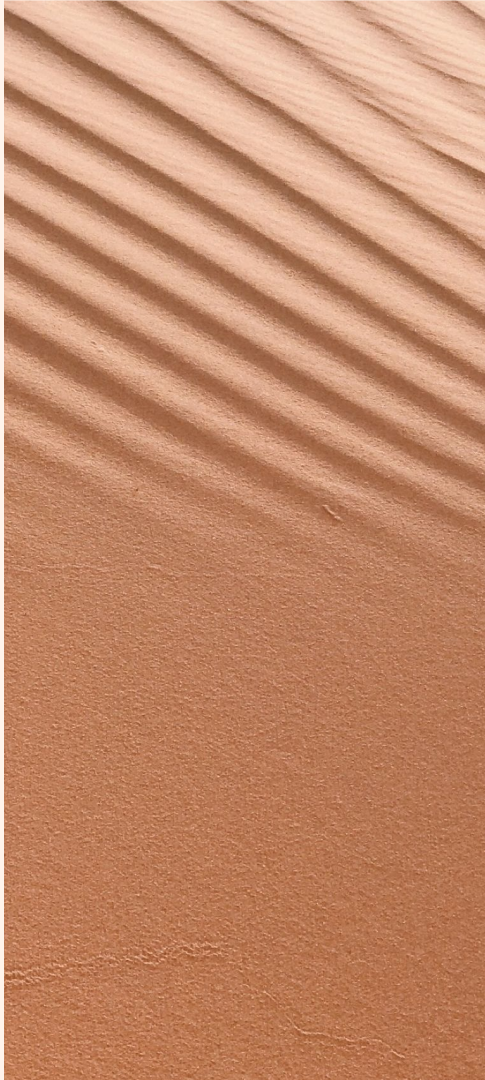
Perinatal loss is a risk factor for mental health conditions

- Patients most commonly develop major depressive disorder, generalized anxiety disorder and post-traumatic stress disorder (PTSD)
- PTSD is particularly under-recognized, and occurs in 23-49% of patients
- MDD and GAD occur in about 25-28% of patients
- Grief fades, mental illness persists
- Mental health conditions generally persist and become increasingly disruptive over time



Perinatal loss is a risk factor for mental health conditions

- Risk factors for developing a mental health condition include:
  - History of mental illness
  - Childlessness
  - Relational issues with significant other
  - Young age
  - Lower socioeconomic status
  - Low health literacy
  - Note: Little research into diverse populations here
- Protective factors include:
  - Spirituality
  - Social support
  - Marital stability
  - Life goals outside of parenting

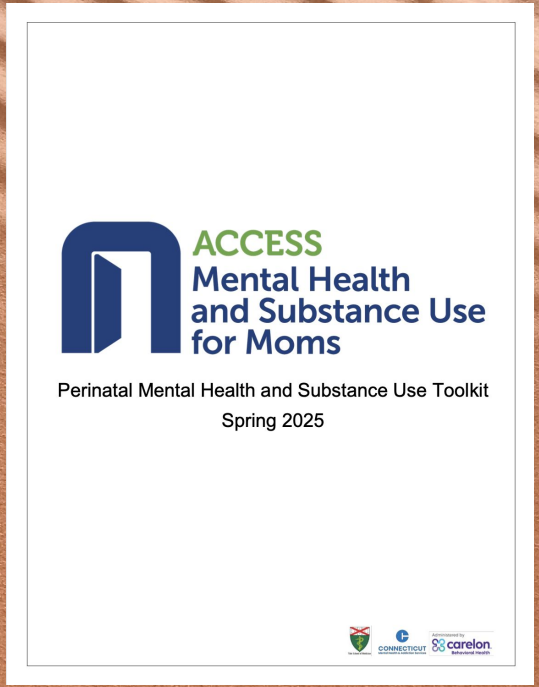


Overview of the most common mental health conditions

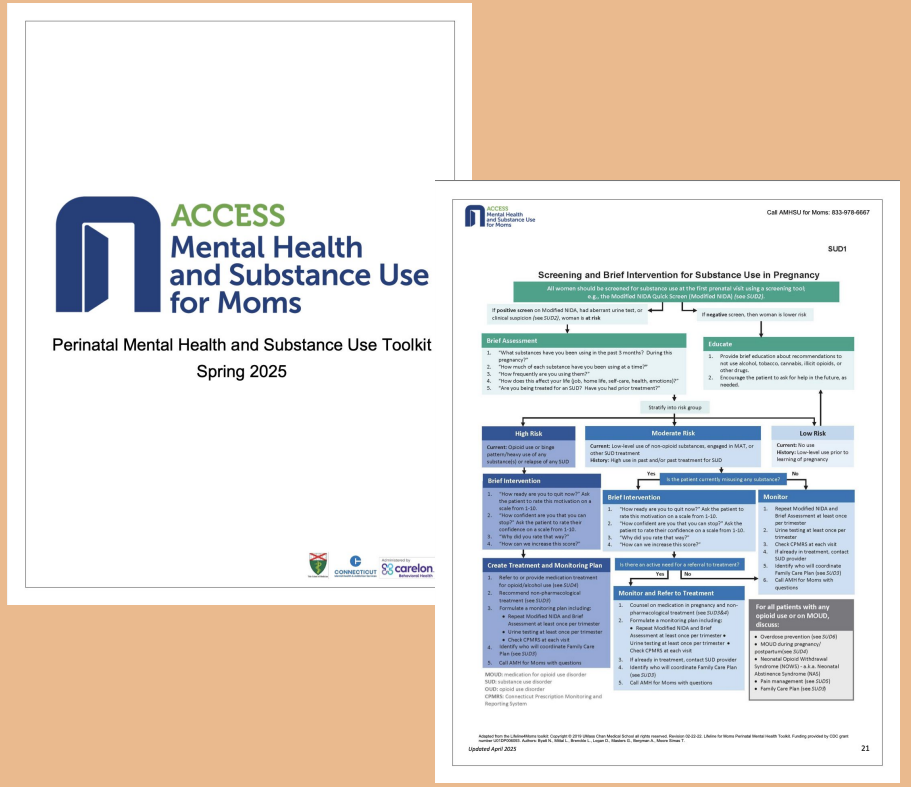
Feature	Core Trigger	Primary Mood/Emotion	Key Symptoms	Duration	Functional Impairment	Course	Differentiating Points	Specifiers/Subtypes
MDD	No specific external trigger required; may follow stress but not necessary	Persistent depressed mood and/or loss of interest/pleasure	≥5 of: depressed mood, anhedonia, appetite/weight change, sleep disturbance, psychomotor changes, fatigue, worthlessness/guilt, poor concentration, suicidality	≥2 weeks	Required	Can be single episode or recurrent	Prominent anhedonia, feelings of worthlessness/guilt, suicidality common	With anxious distress, melancholic, atypical, psychotic features, etc.
GAD	No specific trigger; chronic excessive worry about multiple domains	Excessive anxiety and uncontrollable worry	Excessive worry ≥6 mo, difficult to control, with ≥3 of: restlessness, fatigue, poor concentration, irritability, muscle tension, sleep disturbance	≥6 months	Required	Chronic, often waxing/waning	Worry is generalized (not event-specific), muscle tension prominent	None in DSM-5, but can be comorbid
PTSD	Exposure to actual or threatened death, serious injury, or sexual violence (direct, witnessed, or indirect)	Fear, horror, guilt, anger; re-experiencing traumatic emotions	Four clusters: (1) Intrusion (flashbacks, nightmares), (2) Avoidance of reminders, (3) Negative mood/cognitions (guilt, detachment, blame), (4) Hyperarousal (hypervigilance, startle, irritability, sleep disturbance)	Symptoms ≥1 month after trauma	Required	Onset within months of trauma (can be delayed); may be chronic	Trauma exposure mandatory; re-experiencing and avoidance are core; trauma-linked nightmares/flashbacks	With dissociative symptoms (depersonalization/derealization), delayed expression

How to best assess for mental health conditions

1. Access mental health has an entire toolkit to help you with this!
2. Share screenshot from the toolkit
3. Overview of perinatal mental health conditions



Practical guide to treatment for mental health conditions



PTSD: Common & Undertreated in Moms with Perinatal Loss

1. **Criterion A traumatic event**
   Exposure to life threatening injury or illness, or witnessing it happen to someone else

2. **Intrusion symptoms *(1 required)***

   → "I keep thinking about this over and over…" "I can't fall asleep."

3. **Avoidance symptoms *(1 required)***

   → I'm not leaving the house. I'm afraid to talk about it."

4. **Arousal symptoms *(2 required)***

   → "Even when the baby is safe in her crib, I can't relax."

5. **Negative alterations in cognition and mood *(2 required)***

   → "I blame myself for the miscarriage… I can't help but think I caused it."

nema

DSM-5 Criteria for PTSD

Criterion A *(1 required)*

The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, in the following way(s):

- Direct exposure
- Witnessing the trauma
- Learning that the trauma happened to a close relative or close friend
- Indirect exposure to aversive details of the trauma, usually in the course of professional duties (e.g., first responders, medics)

Criterion B *(1 required)*

The traumatic event is persistently re-experienced, in the following way(s):

- Unwanted upsetting memories
- Nightmares
- Flashbacks
- Emotional distress after exposure to traumatic reminders
- Physical reactivity after exposure to traumatic reminders

Criterion C *(1 required)*

Avoidance of trauma-related stimuli after the trauma, in the following way(s):

- Trauma-related thoughts or feelings
- Trauma-related reminders

DSM-5 Criteria for PTSD

Criterion D *(2 required)*

Negative thoughts or feelings that began or worsened after the trauma, in the following way(s):

- Inability to recall key features of the trauma
- Overly negative thoughts and assumptions about oneself or the world
- Exaggerated blame of self or others for causing the trauma
- Negative affect
- Decreased interest in activities
- Feeling isolated
- Difficulty experiencing positive affect

Criterion E *(2 required)*

Trauma-related arousal and reactivity that began or worsened after the trauma, in the following way(s):

- Irritability or aggression
- Risky or destructive behavior
- Hypervigilance
- Heightened startle reaction
- Difficulty concentrating
- Difficulty sleeping

Criterion F *(1 required)*

Symptoms last for more than 1 month.

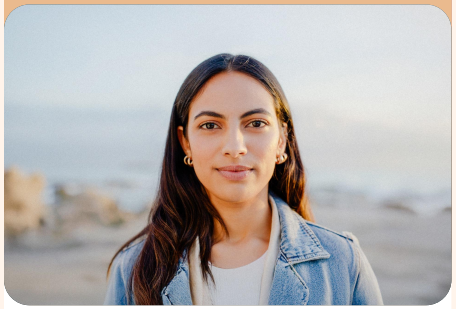
Criterion H *(1 required)*

Symptoms create distress or functional impairment (e.g., social, occupational).

Criterion G *(1 required)*

Symptoms are not due to medication, substance use or other illness.

Trauma-Focused Psychotherapy is Gold Standard



Trauma therapies treat the underlying cause of a mom's mental health condition.

So they improve not just PTSD, but associated depressive, anxiety or other symptoms too.

Cognitive Processing Therapy (CPT)

Reframes your thinking by challenging unhelpful beliefs after a trauma to help you see yourself and the world differently

- ✓ Most effective treatment according to the largest body of research
- ✓ Effective virtually
- ✓ Does not require re-exposure or discussing trauma

Prolonged Exposure (PE)

Involves controlled and repeated exposure to thoughts, feelings, and situations related to the trauma to gradually reduce the fear and avoidance associated with it.

- ✓ Research shows it is effective in reducing symptoms and improving overall functioning
- ✓ Considered first-line treatment by the APA and VA

Eye Movement Desensitization & Reprocessing (EMDR)*

Uses bilateral stimulation and eye movements to reprocess your trauma while recalling difficult experiences

- ✓ Successful for those who finish the course of treatment
- ✓ Has significant mainstream awareness

Second-Line Treatments for PTSD

Pharmacotherapy

Antidepressants with proven efficacy in PTSD such as Sertraline, Paroxetine, and Venlafaxine

Note: BZAs and cannabis are **contraindicated**

Note: Internal Family Systems, Brainspotting, EFT (tapping) are not considered EBTs nor are they recommended alternatives to EBTs

Non-Trauma Focused Manualized Therapies

Including:
Present-Centered Therapy (PCT)
Stress Inoculation Training (SIT)
Interpersonal Psychotherapy (IPT)

What does compassionate, trauma-informed care look like?

Empathy

"I'm so very sorry for your loss."

Providing resources in multiple media

"It can be hard to remember everything we talked about after news like this. I'm sending you written information as well."

Reminding patients they aren't at fault

"Sometimes people blame themselves for this, but please know it is not your fault."

Inviting supports into discussions

"Please feel free to bring your partner to future appointments."

Normalizing diverse reactions

"There's no right or wrong way to feel about this."

Referring to mental health services

"Some of our patients find it helpful to meet with a therapist after events like this. Would that be helpful for you?"

Listening over talking

"Would you like a moment? I'm here to listen."

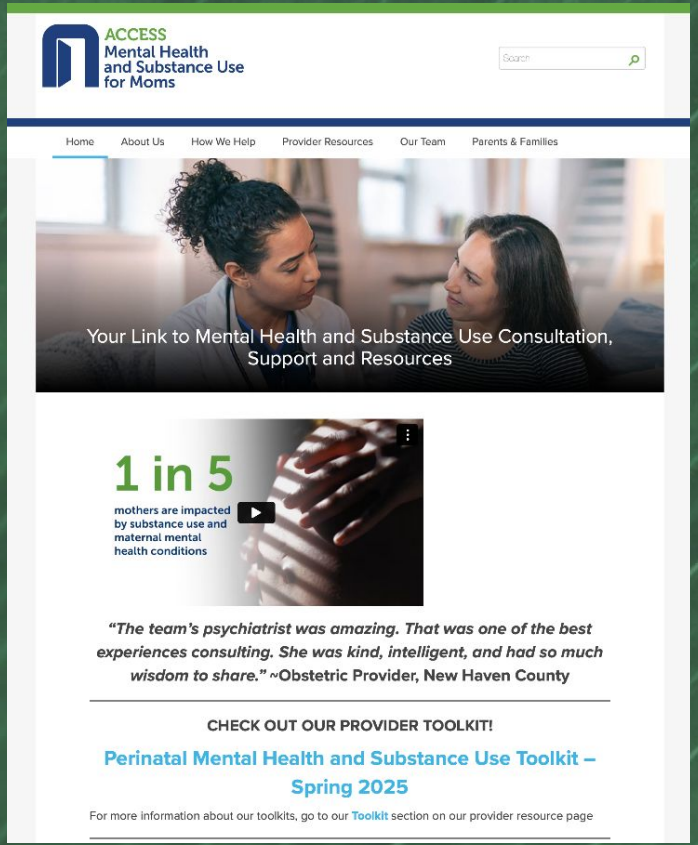
Use the terms the patient uses, and document them so others do, too

"I see that you experienced a "fetal/pregnancy" loss, how have you been feeling since then?"

What resources exist in Connecticut for my patients?

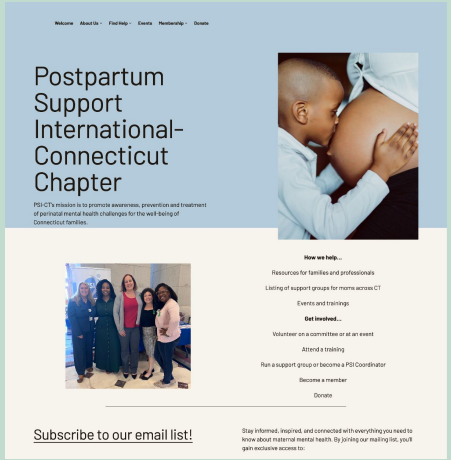
The Access mental health for moms hotline!

- Free case management and connection to perinatal resources
- Free consultation with a reproductive psychiatrist
- Call 1-833-978-6667, Monday-Friday, 9am-5pm



What resources exist in Connecticut for my patients?

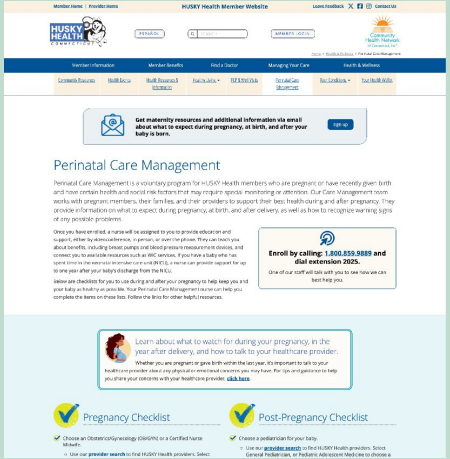
Post-partum support international's CT chapter



Hope After Loss

HOPE After Loss

Husky Medicaid Perinatal Care Management



References

Davoudian T, Gibbins K, Cirino NH. Perinatal Loss: The Impact on Maternal Mental Health. Obstet Gynecol Surv. 2021 Apr;76(4):223. doi: 10.1097/OGX.0000000000000874. PMID: 33908614.

Herbert D, Young K, Pietrusińska M, MacBeth A. The mental health impact of perinatal loss: A systematic review and meta-analysis. J Affect Disord. 2022 Jan 15;297:118-129. doi: 10.1016/j.jad.2021.10.026. Epub 2021 Oct 20. PMID: 34678403.

Mergl R, Quaatz SM, Lemke V, Allgaier AK. Prevalence of depression and depressive symptoms in women with previous miscarriages or stillbirths - A systematic review. J Psychiatr Res. 2024 Jan;169:84-96. doi: 10.1016/j.jpsychires.2023.11.021. Epub 2023 Nov 18. PMID: 38006823.

Silver RM, Reddy U. Stillbirth: we can do better. Am J Obstet Gynecol. 2024 Aug;231(2):152-165. doi: 10.1016/j.ajog.2024.05.042. Epub 2024 May 23. PMID: 38789073.

Quenby S, Gallos ID, Dhillon-Smith RK, Podesek M, Stephenson MD, Fisher J, Brosens JJ, Brewin J, Ramhorst R, Lucas ES, McCoy RC, Anderson R, Daher S, Regan L, Al-Memar M, Bourne T, MacIntyre DA, Rai R, Christiansen OB, Sugiura-Ogasawara M, Odendaal J, Devall AJ, Bennett PR, Petrou S, Coomarasamy A. Miscarriage matters: the epidemiological, physical, psychological, and economic costs of early pregnancy loss. Lancet. 2021 May 1;397(10285):1658-1667. doi: 10.1016/S0140-6736(21)00682-6. Epub 2021 Apr 27. PMID: 33915094

Zinaman MJ, Clegg ED, Brown CC, et al. Estimates of human fertility and pregnancy loss. Fertil Steril. 1996;65:503–509.

Wang X, Chen C, Wang L, et al. Conception, early pregnancy loss, and time to clinical pregnancy: a population-based prospective study. Fertil Steril. 2003;79:577–584.

Gold KJ, Sen A, Hayward RA. Marriage and cohabitation outcomes after pregnancy loss. Pediatrics. 2010;125:1202–1207.

Nikcevic AV, Kuczmierczyk AR, Nicolaides KH. The influence of medical and psychological interventions on women's distress after miscarriage. J Psychosom Res. 2007;63:283–290.

Bardos J, Hercz D, Friedenthal J, et al. A national survey on public perceptions of miscarriage. Obstet Gynecol. 2015;125:1313–1320.

.