

# Perinatal Loss: Recognizing Health Risks & Supporting Recovery

Sofia Noori, MD MPH

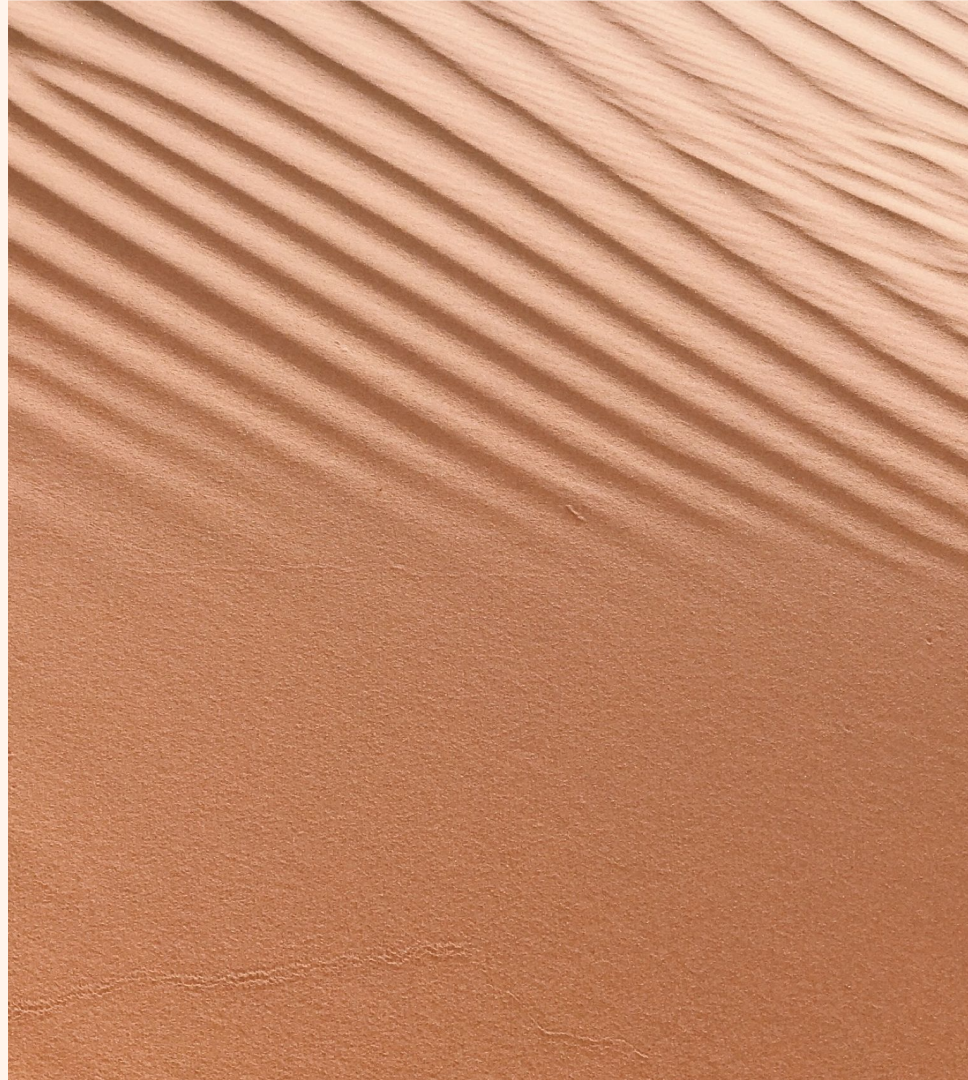
January 15th, 2026



# 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

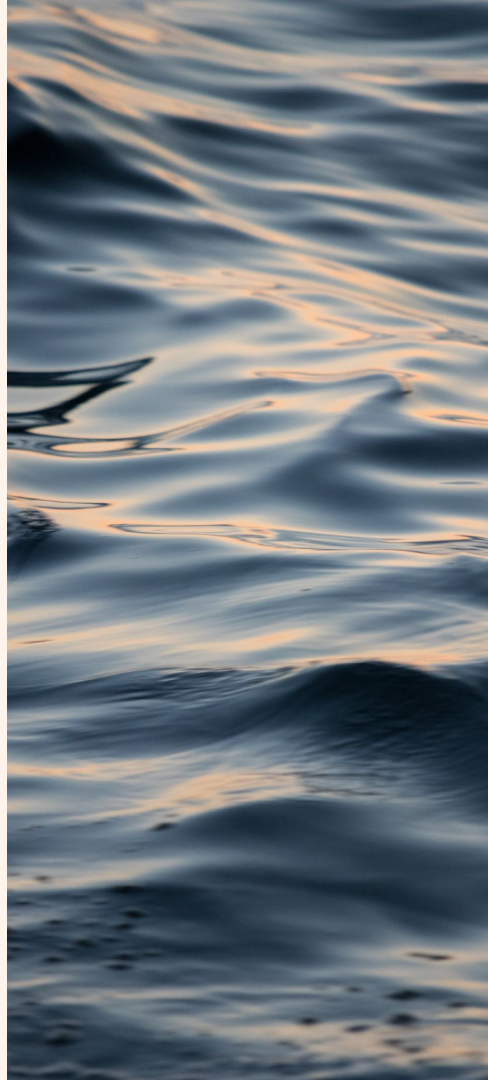
### **Education:**

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

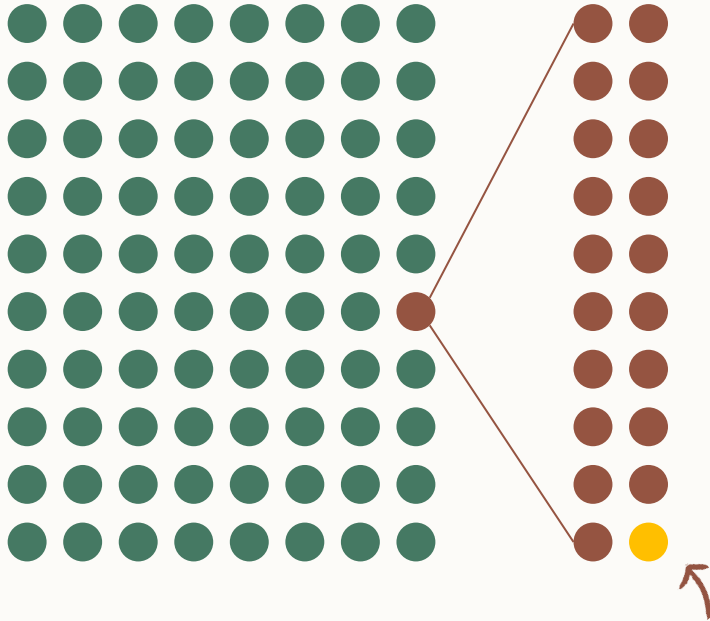
- 1 Define common terms used to describe types of perinatal loss
- 2 Review myths and misconceptions regarding perinatal loss
- 3 Understand the course of normal grief
- 4 Identify risk and protective factors for developing mental health conditions after loss
- 5 Learn how to sensitively screen for mental 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

## Little-to-no research to help drive care planning

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

## Hormonal fluctuations affect people differently

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

## 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:**

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Occurs in 10–35% of known pregnancies

## **Most causes are uncontrollable and unforeseeable:**

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

## **Disclosures by public figures help:**

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

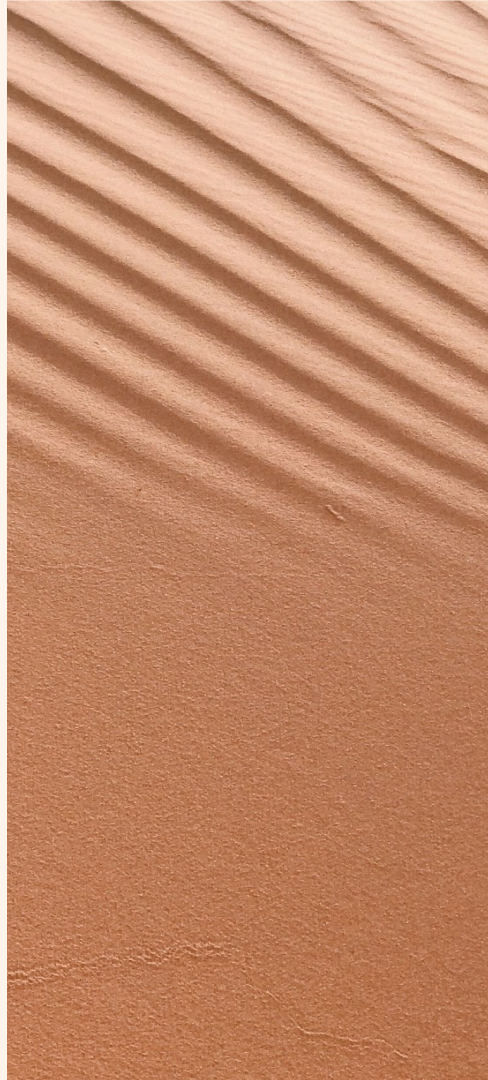
# After a perinatal loss, there is no one “right” way to feel



- 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

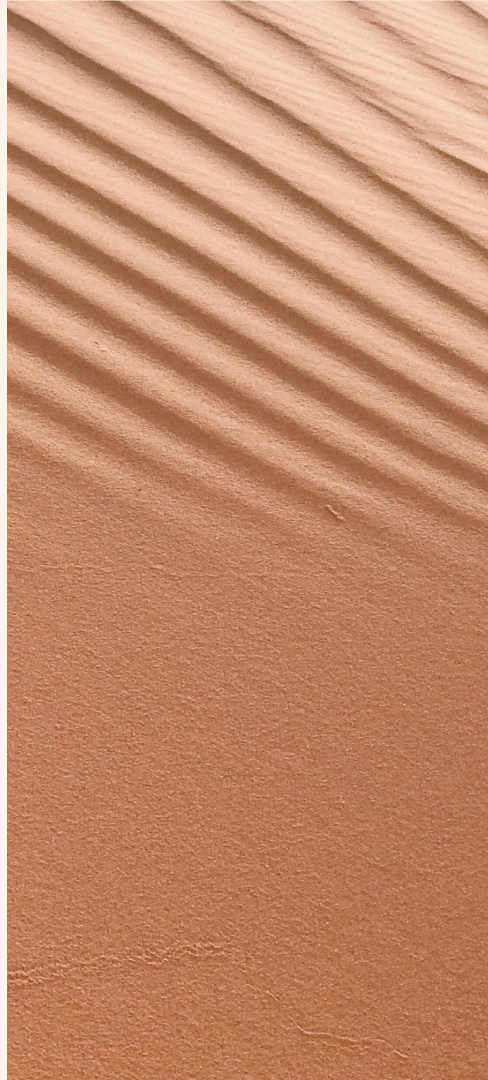
# Perinatal loss is a risk factor for mental health conditions

- 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

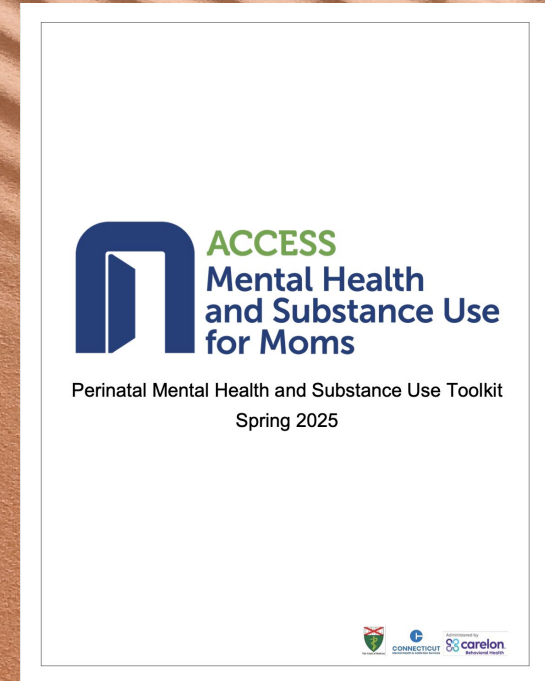
| Feature | Core Trigger  | Primary Mood/Emotion   | Key Symptoms  | Duration                       | Functional Impairment | Course   | Differentiating Points   | Specifiers/Subtypes  |
|---------|---|--|---|--------------------------------|-----------------------|--|--|--|
| MDD     | No specific external 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

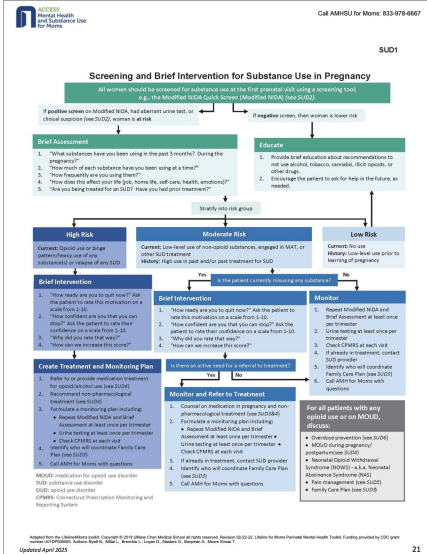
3 Overview of perinatal mental health conditions



# Practical guide to treatment for mental health conditions



Perinatal Mental Health and Substance Use Toolkit  
Spring 2025



# 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.”

# DSM-5 Criteria for PTSD

## **Criterion A (1 required)**

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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)**

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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)**

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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.

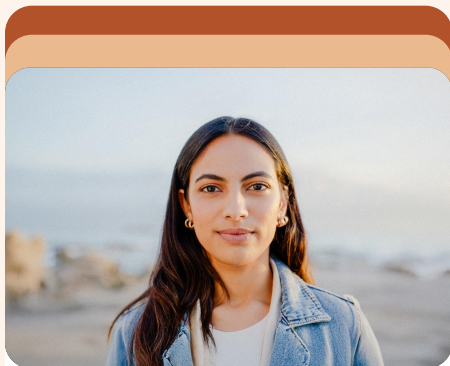
## Criterion H (1 required)

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

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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

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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.”

## **Reminding patients they aren’t at fault**

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

## **Normalizing diverse reactions**

“There’s no right or wrong way to feel about this.”

## **Listening over talking**

“Would you like a moment? I’m here to listen.”

## **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.”

## **Inviting supports into discussions**

“Please feel free to bring your partner to future appointments.”

## **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?”

## **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

The screenshot shows the homepage of the ACCESS Mental Health and Substance Use for Moms website. The header includes the logo and a search bar. The navigation menu lists: Home, About Us, How We Help, Provider Resources, Our Team, and Parents & Families. The main content area features a large image of a healthcare provider talking to a woman, with the text: "Your Link to Mental Health and Substance Use Consultation, Support and Resources". Below this is a video player with the text: "1 in 5 mothers are impacted by substance use and maternal mental health conditions". A testimonial quote follows: "The team's psychiatrist was amazing. That was one of the best experiences consulting. She was kind, intelligent, and had so much wisdom to share." ~Obstetric Provider, New Haven County. At the bottom, there is a call to action: "CHECK OUT OUR PROVIDER TOOLKIT! Perinatal Mental Health and Substance Use Toolkit – Spring 2025". A footer note says: "For more information about our toolkits, go to our Toolkit section on our provider resource page".

# What resources exist in Connecticut for my patients?

## Post-partum support international's CT chapter

The screenshot shows the website for Postpartum Support International's Connecticut chapter. The header includes navigation links: Home, About Us, Find Help, Contact, Membership, Donate. The main heading is "Postpartum Support International-Connecticut Chapter". Below this, a sub-heading reads: "PSI/CT's mission is to promote awareness, prevention and treatment of perinatal mental health challenges for the well-being of Connecticut families." A photograph shows a person kissing a pregnant woman's belly. A list of activities includes: "How we help..." (Resources for families and professionals, Listing of support groups for moms across CT, Events and trainings), "Get involved..." (Volunteer on a committee or at an event, Attend a training, Run a support group or become a PSI Coordinator, Become a member, Donate), and "Subscribe to our email list!". A footer note says: "Stay informed, inspired, and connected with everything you need to know about maternal mental health. By joining our mailing list, you'll get exclusive access to:"



## Hope After Loss



## Husky Medicaid Perinatal Care Management

The screenshot shows the Husky Health Member Website page for Perinatal Care Management. The header includes "Member Tools", "HUSKY HEALTH Member Website", and "Learn More". A navigation bar contains: Home, My Account, My Health, My Insurance, My Claims, My Billing, My Services, My Support, My Profile, My Settings, My Alerts, My Notifications, My Messages, My Calendar, My Reminders, My Notifications, My Alerts, My Notifications, My Alerts. A prominent call-to-action box says: "Get emergency resources and additional information via email about what to expect during pregnancy, at birth, and after your baby is born." Below this, the "Perinatal Care Management" section explains: "Perinatal Care Management is a voluntary program for HUSKY Health members who are pregnant or have recently given birth and have prenatal health and/or mental health needs that require special monitoring or observation. Our Care Management team works with program members, their families, and their providers to support their best health during and after pregnancy. They provide care for health conditions that exist during pregnancy, at birth, and after delivery, as well as how to recognize warning signs of any mental problems." A box encourages enrollment: "Once you have enrolled, a nurse will be assigned to you to provide education and support when you're experiencing, or worried about, these issues. They can help you with benefits, including lower copays and lower premiums in the future, and connect you to available resources such as 24/7 services. If you have a health plan, we can help you with the enrollment process and use 24/7, 24/7 care. A nurse can provide support for up to one year after your baby is born from birth to 12 months." Another box says: "Enroll by calling 1.800.555.8888 and dial extension 2025. One of our staff will call you to see how we can best help you." A section titled "Learn about what to watch for during your pregnancy in the year after delivery, and how to talk to your healthcare provider" includes: "Whether you are pregnant or gave birth within the last year, it's important to talk to your healthcare provider about any physical or mental health concerns you may have. For tips on how to get help, visit our website at [psihelp.com](#)." At the bottom, there are two checklist items: "Pregnancy Checklist" (Choose an obstetrician/gynecologist or a Certified Nurse Midwife; Use our provider search to find HUSKY Health providers; Select) and "Post-Pregnancy Checklist" (Create a plan for your baby; Use our provider search to find your healthcare provider; Select; Contact your provider, or Pediatric Advanced Medical to choose a).



# 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, Podsek 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, Nicolaidis 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.