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Debate Paper

Do Qualified Nurses and Midwives in Mental Health Improve Wellbeing of Miscarriage Women in Maternal Clinic?

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After a miscarriage, some women may have negative consequences regarding their experiences, and may suffer grief. Significantly, Gynecologists and registered nurses may lack the ability to provide necessary support to these women to pass this life stage. However, psychiatric and mental health training of midwives and nurses may improve the health and wellbeing of miscarriage women. In addition to that, It would be a kind of malpractice to ignore the efficacy of psychiatric and mental health qualification to manage miscarriage women in maternal health settings. The aim of this article is to prove the necessity of psychiatric health qualification for nurses and midwives in maternal health settings.

Keywords: Psychiatric health qualification, Miscarriage, Psychological wellbeing.

Do qualified nurses and midwives in mental health improve wellbeing of miscarriage women in maternal clinic?

After a miscarriage, some women may have negative feelings regarding their experiences, and may suffer grief (Ingrid & Richard, 2007). Gynecologist may lack ability to provide a necessary support to these women to pass this life stage. At the same time, registered nurses and midwives in maternal settings may have insufficient knowledge regarding these sensitive situations. Hence, gynecological competencies are not adequate for this level of practice. However, psychiatric and mental health training of midwives and nurses tacks developed skills for nursing practice that would be recommended to improve the health and wellbeing of miscarriage women.

The main goal of psychiatric practice for miscarriage women in maternal clinics is to reduce psychological consequences due to loss of fetus (Stratton & Lloyd, 2008). Many factors in a woman's life, such as emotional attachment to the pregnancy, lack of social support, and conservative views on abortion increase experiencing psychological distress after a miscarriage (Ingrid & Richard, 2007). Miscarriage is a traumatic loss event that influences a woman's sense of self and her hopes and dreams of the future (Ingrid & Richard, 2007). A woman who had a miscarriage is at risk of anxiety and depression (Jansson & Adolfsson, 2010). Moreover,

women who had miscarriage have a higher risk of postpartum depression (Jansson & Adolfsson, 2010).

Emerging evidences suggested that miscarriage could be associated with significant psychological consequences (Ingrid & Richard, 2007; Jansson & Adolfsson, 2010). As many as 50% of miscarriage women suffer from psychological morbidity in the weeks and months after loss (Ingrid & Richard, 2007). About 40% of miscarriage women were found to be suffering from symptoms of grief immediately after miscarriage (Ingrid & Richard, 2007). Elevated anxiety and depressive symptoms are common, and major depressive disorder has been reported in 10–50% after miscarriage (Ingrid & Richard, 2007).

In general, the physical consequences of the recovery after miscarriage is easy, but the emotion of psychological recovery can be longer and a more challenging process (Flenady & Wilson, 2008). Unlike physical management of women following miscarriage, the evidence on psychological management is less considered in maternal setting, specifically to manage miscarriage cases (Simmons, Singh, Maconochie, Doyle, & Green, 2006). Evidence about perceptions from women about their hospital experiences reflects how health professionals cared for them with little awareness of their feelings of distress and no effective interventions to support them (Stratton & Lloyd, 2008). However, it is important to increase awareness of the psychological consequences of miscarriage for women.

Encouraging gynecologists and other physicians to refer women who had miscarriage to psychiatric counseling can help

women access support services (Blohm, Friden, & Milsom, 2008). On the other hand, gynecologists, nurses, and midwives in routine practice within maternal clinic may have insufficient skills and knowledge regarding mental health assessment, diagnosis, and management to support women who have miscarried. Furthermore, Registered nurses and midwives in maternal settings should encourage women to articulate the nature of their loss to assist them in resolving the experience of loss (Flenady & Wilson, 2008). Psychiatric intervention using assessment, diagnosis, and intervention could be more functional and professional to enhance main goal.

Some opinions suggested to minimize the effect of negative feelings among women who had miscarriage that follow up visit with a midwife could improve wellbeing (Blohm et al., 2008). These opinions did not state how obstetric practice could influence negative perception of these women. Additionally, negative feeling is an indicator for psychological distress in miscarriage cases that require mental health interventions more than gynecological management (Hutti, 2005). Although there is a substantial lack of randomized controlled intervention studies in this area. Some studies reported that psychological follow-up is highly recommended for miscarrying women, and that psychological intervention is potentially beneficial (Adolfsson, Bertero, & Larsson, 2006).

In Addition, follow up visits to a midwife after one week, after five weeks, and after eleven weeks of the diagnosis of miscarriage had the broadest overall positive impact on the miscarrying women resolution of grief reaction and depression (Adolfsson et al., 2006). Women and their partners who have suffered miscarriage tend to need extended support on an individual basis in addition to the follow up assistance assessed by the midwives (Flenady & Wilson, 2008). Follow up visits may provide support intervention. But some midwives and registered nurse may provide unplanned psychiatric intervention for miscarrying women. At this level, the question that has to be answered, does psychiatric training assist health care providers in maternal setting to improve the psychological wellbeing of women who have miscarried?

Although some views state that there is no need for qualification in psychiatric skills to improve wellbeing in maternal settings. However, it is not clear that unqualified midwives, nurses, and gynecologists in psychiatric practice are able to manipulate psychiatric needs for those women experiencing miscarriage. Here, it is evident that psychiatric qualification and training is essential to enhance health care practice in maternal setting for women who have miscarried (Simmons et al., 2006). Regardless of routine practice of health care providers in maternal clinics and wards, psychiatric training will add significant skills that are explicitly required for target women.

Actually, one study utilized Swanson's Middle Range Caring Theory as applied on the caregiver includes being emotionally present, giving support, being competent, meeting each woman's own individual needs (Jansson & Adolfsson, 2011). The study concluded that giving proper care after a miscarriage it would enable every woman to have the power within their self to improve their wellbeing (Jansson & Adolfsson, 2011). However, previous studies implicitly showed that registered nurses, midwives, and gynecologists implemented psychological approaches for a woman who had miscarriage through implementing Swanson's theory of care concepts. Qualified health care providers as take for granted would rely on psychological approaches to enhance wellbeing for women who have miscarried. Health care providers on gynecologic wards and clinics would unconsciously provide psychological approaches to enhance well being for

miscarriage cases. Hence, giving training courses and lectures about psychological practice, and enforce systematic, planned, structured mental health practice would drive to more effective management for miscarriage cases.

Specifically, although some studies reported that web-based resources for health care providers and women following miscarriage is effective (Geller, Psaros, & Kerns, 2006). However, a qualified nurse in psychiatric practice can ease and facilitate utilizing of these resources. At the same time, qualified nurse can assess and evaluate effectiveness of using these resources in regard the need for more support and management, or providing another kind of psychiatric interventions. When miscarrying women go to good websites, they can get information that they want it. Nevertheless, whether a woman engages in individual therapy, group therapy or web-based forums, the key component of all therapy to women who had miscarriage is that they are not alone (Geller et al., 2006). In addition, psychiatric guidance by qualified registered nurse or midwives may add considerable approach that will help them progress toward recovery.

Briefly, psychiatric qualification in maternal settings could provide more advanced practice to health care providers who work there. It would cover unmarked area that is spontaneously ignored by health care providers. Psychiatric practice is essential to improve the wellbeing of miscarrying women due magnitude of psychological consequences after miscarriage. It would be a kind of malpractice, to ignore the efficacy of psychiatric and mental health qualification to manage miscarrying women in mental health settings.

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