

The influence of medical and psychological interventions on women's distress after miscarriage[☆]

Ana V. Nikčević^{a,*}, Andrzej R. Kuczmierczyk^b, Kypros H. Nicolaidis^a

^aHarris Birthright Research Centre for Fetal Medicine, King's College Hospital Medical, School, London, United Kingdom

^bDepartment of Psychology, City University, London, United Kingdom

Received 31 August 2006; received in revised form 25 January 2007; accepted 10 April 2007

Abstract

Objective: The aim of this study was to examine the impact of medical and psychological interventions on women's distress after early miscarriage. **Methods:** This was a prospective study of women attending for a routine scan at 10–14 weeks of gestation and found to have a missed miscarriage. An intervention group of 66 women had medical investigations to ascertain the cause of miscarriage, and at 5 weeks after the scan, they all had a medical consultation to discuss the results of the investigations. These 66 women were randomly allocated into a group which received further psychological counselling (MPC, $n=33$), and a group which received no psychological counselling (MC, $n=33$). They were compared to a control group of 61 women who received no specific postmiscarriage counselling. All participants completed preintervention and postintervention measures and 4-month follow-up questionnaires. **Results:** The scores on the outcome

variables decreased significantly with time for all three groups. In group MPC, compared to controls, there was a significantly greater decrease over time in the levels of grief, self-blame, and worry and, compared to MC group, a significantly greater decrease in grief and worry. In group MC, compared to controls, there was a significantly greater decrease in self-blame. In the MC and MPC groups, those with an identified cause of the miscarriage had significantly lower levels of anxiety and self-blame over time than those with a nonidentified cause. **Conclusions:** Psychological counselling, in addition to medical investigations and consultation, is beneficial in reducing women's distress after miscarriage. However, absence of an identifiable cause of miscarriage led to the maintenance of the initial anxiety levels, which should have otherwise decreased with time.

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Keywords: Psychological counselling; Miscarriage; Women's distress

Introduction

Miscarriage is the commonest pregnancy complication [1]. It is both physically and psychologically a traumatic experience [2,3]. High levels of anxiety, depression, and grief may persist in some women long after physical recovery has occurred [4–7]. It has been proposed that follow-up care, by the general practitioner (GP), health visitor or the hospital, should be offered to all women

after a miscarriage [6–12]. This could provide the opportunity for provision of information, explanation, advice, and reassurance and may lead to a reduction in women's distress, as suggested by several uncontrolled studies [11–15].

To date, there have been two controlled studies [16,17] examining the impact of psychological counselling shortly after miscarriage. One of these studies utilized grief counselling [17], whilst the other included provision of psychological debriefing based on the trauma framework [16]. Although the women perceived these interventions as helpful, formal evaluation of distress revealed no significant impact of such counselling on emotional adaptation. A possible reason for such an outcome may lay in the fact that no medical information concerning the miscarriage was provided as part of counselling. The

[☆] The study was supported by a grant from the Fetal Medicine Foundation (Charity No: 1037116).

* Corresponding author. Unit of Psychology, School of Arts and Social Sciences, Kingston University, Penrhyn Road, Kingston-upon-Thames, KT1 2EE, United Kingdom. Tel.: +44 0 20 8547 2000.

E-mail address: a.nikcevic@kingston.ac.uk (A.V. Nikčević).

majority of women desire to be provided with medical information concerning their loss, including the possible explanations of the cause of the miscarriage and the impact on future pregnancies [6–8]. Without such knowledge, the anxiety may not be fully alleviated and may preclude psychological adjustment. In a previous, uncontrolled study [15], we found that, in women who received medical and psychological counselling several weeks after miscarriage, the levels of distress at 4 months after the loss were much lower than those reported by other investigators following just a psychological intervention.

The aim of the present study was to establish the impact of the provision of medical and psychological counselling following miscarriage on women's distress. We also examined whether psychological outcomes varied between women in whom medical investigations resulted in an identifiable cause of the loss and those where no such cause was found.

Methods

Participants and procedure

This was a prospective study of women attending for a routine scan at 10–14 weeks of gestation and found to have a missed miscarriage. An intervention group of 66 women had medical investigations to ascertain the cause of miscarriage and, at 5 weeks after the scan, they all had a medical consultation to discuss the results of the investigations. These women were randomly allocated into a group that also had further psychological counselling (MPC) and a group that did not (MC). Groups MPC ($n=33$) and MC ($n=33$) were compared to a control group (CG) ($n=61$) who received no specific postmiscarriage counselling. Psychological assessment, by postal questionnaire, was carried out at 4, 7, and 16 weeks after the diagnosis of miscarriage. All women who took part in the study had a surgical evacuation of the retained products of conception within 4 days from the diagnosis of miscarriage. Excluded from the study were women with a history of perinatal death, elective termination for fetal abnormality and recurrent miscarriage, inability to speak and read English fluently, and those under current psychological or psychiatric care.

Groups MC and MPC were recruited from the Harris Birthright Research Centre, where women with a diagnosis of missed miscarriage were offered the option of further investigations, including fetal karyotyping and blood testing for lupus anticoagulant. At the time of the diagnosis of missed miscarriage, women were invited to attend the miscarriage follow-up clinic and were informed of the study. Those agreeing to participate were sent a study information sheet, consent form, copy of the first questionnaire, and a stamped addressed envelope. They were asked to sign and return their completed questionnaire prior to their 5-week

follow-up appointment. At this 5-week follow-up appointment, they all had a 20-min consultation with an obstetrician who discussed the results and implications of the medical investigations, as well as aspects of their general health and planning of future pregnancies. On the basis of computer generated random number tables, women were allocated to receive a single session of psychological counselling of 50-min duration (Group MPC). At the end of the medical consultation, the doctor opened a sealed envelope and, accordingly, invited the women allocated to MPC group to stay for the psychological counselling.

The counselling session with the psychologist was broadly based on the cognitive therapy framework. The main aims were encouragement of the expression of feelings regarding loss, normalization of such expressed emotions, exposure to the memories (e.g., to the images of the initial ultrasound scan and the events that took place subsequently by going over them and describing them in detail), cognitive restructuring (where evidence of self-blame for the event was apparent), and reframing and reorganising of the experience in the context of the available information as to the causes of the miscarriage. Worries concerning future attempts at reproduction were also discussed. The implicit assumption was that such an intervention would lead to the reduction in distress arising from the trauma of the loss and that it would facilitate emotional processing of the event. Two weeks after the follow-up and at 4 months post loss, the second and the third questionnaires, respectively, were mailed to the women.

The CG was derived from the consecutive series of women diagnosed with missed miscarriages at the antenatal clinics at King's College Hospital, Chelsea & Westminster Hospital, and Greenwich District Hospital, where the 10–14-week scan is also offered routinely but there is no dedicated miscarriage follow-up care. At the time of the diagnosis, the women were informed about the study and asked whether they would be interested in receiving further information by mail. Those who agreed and who satisfied the study inclusion criteria and the matching criteria were sent a study information pack. Further questionnaires, at 7 and 16 weeks after miscarriage, respectively, were sent to those women who accepted to participate in the study and who signed and returned the consent form and the first completed questionnaire.

Outcome variables

Anxiety and depression

These were assessed by the Hospital Anxiety and Depression Scale (HADS [18,19]), a 14-item screening instrument, with seven items assessing anxiety and a further seven assessing depression, each being scored from 0 to 3 so that the total scores range from 0 to 21 for each subscale; the cutoff point of 11 is the threshold score for probable psychiatric "casesness." Higher scores indicate higher levels of anxiety and depression, respectively.

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