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Backdating miscarriages and abortions in patients at practice-based gynaecological offices: Worth a question?

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Summary
Objective: The aim of the study was to investigate the prevalence of adverse obstetric history in women who consult practice-based gynaecologists and examine distinctive characteristics of the affected women.
Study design: We screened 921 women and acquired standardized obstetric and psychological data of 585 participants.
Results: Twenty-six percent of the screened women exhibited an adverse obstetric history (pregnancy loss, medically indicated or voluntary abortion) that dated back an average of 19 years. No noticeable general psychological issues could be ascertained among the affected women (somatic symptoms, depression, stress). 28 percent of these women stated to be still under emotional distress because of the gynaecological impact. These women indicated dysfunctional attribution patterns, pronounced coping efforts, stronger, longer lasting symptoms of grief, posttraumatic stress and depression.
Conclusion: About one fourth of this gynaecological outpatient sample exhibited an adverse obstetric history. Although most of these women don't show psychiatric symptoms of clinical relevance, gynaecologists should ask for backdating miscarriages and abortions and the extent

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of persistent psychological strain. This allows detecting those women who did not manage to handle this experience in a functional way. Support for a change in dysfunctional attribution and coping strategies as well as for a decrease in grief, posttraumatic symptoms and depression can be provided.

1. Introduction

We examined possible related psychological issues in women who experienced pregnancy loss, medically indicated abortion and/or voluntary abortion. A group of women with no adverse obstetric history was used as a control group.

1.1. Pregnancy loss (PL)

Literature on psychological distress following PL demonstrates that up to 50% of affected women develop psychological symptoms (Lok and Neugebauer, 2007) like grief responses, lasting for months up to several years (Brier, 2008; Lok and Neugebauer, 2007) or symptoms of depression respectively major depressive disorders (Neugebauer et al., 1997). Other psychological impairment can arise in terms of anxiety, lasting for several weeks (Nikcevic et al., 2007) up to months (Brier, 2004; Geller, 2004). The same also applies for posttraumatic stress responses (Engelhard et al., 2001).

1.2. Medically indicated abortion (MIA)

There is general agreement that MIA may be accompanied by psychological responses like pronounced grief reactions, depression, anxiety and posttraumatic stress (Kersting et al., 2009; Korenromp et al., 2005, 2007; Wool, 2011). Whereas the results of Geerinck-Vercammen and Kanhai (2003) indicate temporary psychological strain lasting up to six months, Davies et al. (2005) found that 41% were still experiencing strain after one year. Kersting et al. (2005) found ongoing symptoms of posttraumatic stress and grief responses after two and seven years.

1.3. Voluntary abortion (VA)

The evidence available regarding the psychological state following VA during the first trimester is contradictory. Many women consider the decision to terminate an unwanted pregnancy as a solution to a situation that is wrought with conflict and this way resulting in feelings of relief (Bradshaw and Slade, 2003; Kero et al., 2004). The percentage of women who experience psychological distress is often indicated as being less than 10% (Hemmerling et al., 2005). On the other hand, other authors report that a significant number of women suffer from ongoing posttraumatic stress, symptoms of anxiety or depression lasting for months, even years (Broen et al., 2005; Coleman et al., 2009; Fergusson et al., 2008; Pedersen, 2008).

In most of the earlier studies affected women were surveyed directly after the event or, in some cases, up to one year following the event. To our knowledge, a cross-sectional study has not yet been conducted in waiting rooms of practice-based gynaecologists involving a comparison of women with and without adverse obstetric histories.

One aim of this study is to identify the frequency of adverse obstetric history in patients referred to gynaecological outpatient treatment. A comparison with non-affected women was conducted in order to find out whether the affected women exhibit negative psychological responses as a result of their obstetric histories. We also examined the differences between affected women who experienced ongoing subjective distress and those who did not.

2. Material and methods

2.1. Study design, sample, and procedure

We performed a cross-sectional study with a random sample of 921 women, recruited in 13 gynaecological offices in Berlin during April 1st, 2009 and April 1st, 2010. Exclusion criteria were underage, current pregnancy and insufficient language competence. All participants were approached while waiting for their appointment. They were informed about the research project, handed out a screening questionnaire to fill out immediately and asked to fill out more detailed questionnaires at home and send them back anonymously to the research group by mail within two weeks.

For more detailed information on sample and procedure see Fig. 1.

All study procedures were approved by the ethics committee of the ''Charité'' — University Hospital, Humboldt University, Berlin. All participants gave their written informed consent.

2.2. Instruments

2.2.1. Screening

The screening questionnaire provides socio-demographic information and information on the progress and results of prior pregnancies. Women with adverse obstetric histories were given additional specific questions regarding the course of PL, MIA or VA.

2.2.2. Specific questionnaire (participants with negative obstetric history only)

Attribution and *coping* were measured using two instruments developed by Bergner et al. (2008). Attribution patterns were identified using 15 items scored on six-point scales and classified into four categories: ''self-blame'', ''stress during pregnancy'', ''insufficient medical care'' and ''regulative in nature'' (Cronbach's α between 0.70 and 0.82). This instrument was only applied to women with prior PL, since abortion involves an active decision-making process and is not an event associated with the