

Predicting Need for Follow-Up Due to Severe Anxiety and Depression Symptoms After Perinatal Loss

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Keywords

miscarriage
neonatal death
Perinatal Grief Screening
Instrument
stillbirth

ABSTRACT

Objective: To evaluate the ability of the Perinatal Grief Intensity Scale (PGIS) when used within 8 weeks of perinatal loss to predict intense anxiety and severe depression symptoms in women 3 months later (Time 2 [T2]).

Design: Prospective survey.

Setting: Participants were recruited from hospitals in Louisville, KY and via the Internet.

Participants: Women ($N = 103$) who experienced perinatal loss.

Methods: Data were collected using the PGIS, Beck Anxiety Inventory, and the Center for Epidemiologic Studies Depression Scale. We used logistic regression, odds ratios, and receiver operating characteristic curve analysis.

Results: The PGIS had 97.9% sensitivity and 29.6% specificity to predict severe depression symptoms and 95.2% sensitivity and 56.2% specificity to predict intense anxiety at T2. A baseline PGIS score greater than or equal to 3.53 predicted severe depression symptoms (odds ratio = 1.82, 95% confidence interval [CI] [1.46, 2.18], $p = .014$) and intense anxiety (odds ratio = 1.43, 95% CI [1.07, 1.82], $p = .029$) at T2. The receiver operating characteristic curves of the PGIS suggest the PGIS performs well at predicting (screening positive) for severe depression symptoms (area under the curve = 0.86, 95% CI [0.79, 0.94], $p < .001$) and intense anxiety (area under the curve = 0.86, 95% CI [0.78, 0.93], $p < .001$) after perinatal loss.

Conclusion: The PGIS accurately predicted intense anxiety and severe depression symptoms 3 to 5 months after perinatal loss. This instrument may help health care providers identify women who need further mental health evaluation after perinatal loss.

JOGNN, 47, 125–136; 2018. <https://doi.org/10.1016/j.jogn.2018.01.003>

Accepted January 2018

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The authors report no conflict of interest or relevant financial relationships.



Perinatal loss, which includes the early pregnancy loss of miscarriage and the late losses of stillbirth and neonatal death, affects approximately 1 in 4 women with each pregnancy (MacDorman & Gregory, 2015). It is often not recognized that the rate of stillbirth alone is more than 10 times the rate of sudden infant death syndrome (Cacciatore, Schnebly, & Frøen, 2009). These early and late perinatal losses may have profound, negative effects on bereaved parents (Burden et al., 2016; Huberty, Matthews, Leiferman, Hermer, & Cacciatore, 2016; Johnson & Langford, 2015) and have been associated with the development of severe anxiety, major depression, posttraumatic stress disorder (PTSD), increased suicidal ideation (Burden et al., 2016; Ellis et al., 2016; Heazell et al., 2016), and up to 4 times the rate of

divorce (Koopmans, Wilson, Cacciatore, & Flenady, 2013). In subsequent healthy pregnancies after perinatal loss, increased health care use (Hutti, Armstrong, Ziegler, & Myers, 2011), anxiety, and depression were common (Armstrong, Hutti, & Myers, 2009; Hutti, Armstrong, Myers, & Hall, 2015), and increased postpartum depression was found after the birth of subsequent healthy infants (Armstrong, 2007; Blackmore et al., 2011). In addition, perinatal loss is associated with severely reduced work productivity and increased economic deprivation for affected families (Cacciatore et al., 2009).

Despite the frequency of these losses and the associated deep anguish; suffering; and mental health, economic, and social consequences, they often go unrecognized by health care providers,

Reliable and valid clinical screening tools are needed to identify parents who are at greatest risk of developing intense grief after perinatal loss.

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families, and society in general (Ellis et al., 2016; Heazell et al., 2016; Ogwulu, Jackson, Heazell, & Roberts, 2015). They are invisible losses that often are not acknowledged by significant others, mourned in public, or socially supported, which leads to disenfranchised grief in parents (Cacciatore, 2013). Furthermore, highly intense grief may have physical consequences, including the development of major physical health problems such as hypertension, weight gain, diabetes, heart problems, substance abuse, increased risk of suicide, and ultimately premature mortality (Hvidtjørn, Wu, Schendel, Thorlund Parner, & Brink Henriksen, 2016). Thus, perinatal loss is an important health indicator for women and their families and a significant public health problem in the United States (Burden et al., 2016; Heazell et al., 2016; Huberty et al., 2016; MacDorman, Reddy, & Silver, 2015).

Investigators have examined factors that may predict highly intense grief for decades. Not including our work, the most consistent factors across studies that predicted intense grief after perinatal loss were poor mental health before the loss (Koopmans et al., 2013; Toedter, Lasker, & Alhadeff, 1988; Toedter, Lasker, & Janssen, 2001) and poor social support (Cacciatore, Rådestad, & Frøen, 2008; Huberty et al., 2016; Kersting & Wagner, 2012; Koopmans et al., 2013; McSpedden, Mullan, Sharpe, Breen, & Lobb, 2017; Scheidt et al., 2012; Shreffler, Greil, & McQuillan, 2011). Neither parental behavior (Hutti, de Pacheco, & Smith, 1998; Hutti et al., 2015; Hutti et al., 2017) nor gestational age (Bennett, Ehrenreich-May, Litz, Boisseau, & Barlow, 2012; Hutti, Armstrong, & Myers, 2013; Hutti et al., 2015; Hutti et al., 2017; McSpedden et al., 2017; Swanson, Connor, Jolley, Pettinato, & Wang, 2007) at the time of the loss were good predictors of grief intensity. Reliable and valid perinatal loss clinical screening tools are needed to identify parents who are at greatest risk of developing the most intense grief after perinatal loss (Heazell et al., 2016; Kersting & Wagner, 2012; Koopmans et al., 2013).

The Perinatal Grief Intensity Scale (PGIS) is a 14-item, self-report instrument with three subscales that are rated on a 4-point Likert scale

from *strongly agree* to *strongly disagree*. It is not a diagnostic tool. Rather, to our knowledge, the PGIS is the first perinatal grief instrument created to be a clinical screening tool, and it is administered ideally at approximately 2 to 4 weeks after perinatal loss. It was developed to identify women most likely to be severely affected so that early referral for appropriate professional mental health follow-up care could be accomplished for this highly vulnerable group (Hutti et al., 2015; Hutti et al., 1998).

The purpose of our study was to examine the predictive validity of the PGIS. The aims and hypothesis were as follows. Aim 1: To determine if PGIS scores obtained within 8 weeks of a miscarriage, stillbirth, or neonatal death would predict the probability of severe depression symptoms as measured by Center for Epidemiologic Studies Depression (CES-D) scale scores greater than 16 and severe anxiety as measured by Beck Anxiety Inventory (BAI) scores greater than 26. Hypothesis: Use of the PGIS within 8 weeks of perinatal loss would predict the probability of severe depression symptoms (CES-D > 16) and severe anxiety (BAI > 26) in women 3 to 5 months after the loss. Aim 2: To examine the types of assistance sought by women after loss, including individual, couple, group, or clergy-based counseling; face-to-face or online support groups; and prescription medication for anxiety, depression, or any type of psychological distress since the loss.

Background and Significance

Women experience a wide range of responses to perinatal loss, from little or no grief to grief responses that are variable, highly individualized, and highly intense (Adolfsson, 2011; Hutti et al., 2015). Most women will experience normal grief in response to perinatal loss and will be able to cope effectively with it over time (McSpedden et al., 2017). However, approximately 30% (Koopmans et al., 2013) of women who experience highly intense or complicated grief (CG) will report severe stress and often one or more of the following associated symptoms: severe and prolonged depression, suicidal ideation, anxiety, PTSD, and other psychological issues (Burden et al., 2016; Heazell et al., 2016) that may last up to 4 or more years after the loss (Heazell et al., 2016; Lok, Yip, Lee, Sahota, & Chung, 2010; Shreffler et al., 2011). Compared with women who experienced live births, women who

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