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To lose an unborn child: Post-traumatic stress disorder and major depressive disorder following pregnancy loss among Israeli women

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ABSTRACT

Objectives: Pregnancy loss (PL) can be a very difficult experience. However, the evidence regarding the prevalence and correlates of psychopathology following PL is inconsistent at best. The present study aimed to assess the prevalence of Post-Traumatic Stress Disorder (PTSD) and Major Depressive Disorder (MDD) following PL, and their differential predictors.

Methods: Participants were 97 women, ages 23–47, who have experienced PL starting from the 2nd trimester. They were recruited at the Hadassah Ein-Kerem Medical Center in Jerusalem, Israel. The mean pregnancy week of loss was 27.92. Participants completed self-report questionnaires assessing PTSD (PCL-5), MDD (BDI-II), sociodemographic variables and factors related to the loss.

Results: We have found high rates of probable PTSD (33.3%) and MDD (29.4%) among our sample, as well as high PTSD-MDD comorbidity. A more advanced gestational week of loss and shorter time since PL were positively associated with both PTSD and MDD. Younger age and lower religiosity were associated with more severe PTSD, but not MDD.

Conclusions: PL is a potentially-traumatic experience, entailing a heavy burden of PTSD and MDD. Mental health professionals are encouraged to closely monitor women following PL, particularly young mothers, who have experienced PL more recently, and at the advanced stages of pregnancy.

1. Introduction

Pregnancy loss (PL) constitutes a complex, highly distressing life experience for many expecting parents [20]. The term “early pregnancy loss” usually refers to perinatal loss which occurs up to the 20th week of pregnancy [1] and includes mostly spontaneous miscarriages. “Perinatal loss”, which occurs between pregnancy week 20–22 and one week post-birth, may include giving birth to a dead fetus/baby (Stillbirth), and the death of a baby during his/her first week of life [23]. In addition, a woman may undergo the termination of pregnancy via medical intervention, as a result of a genetic defect diagnosed in the fetus, or other medical complications from which the woman suffers. While rates may vary between locations, in Israel, where the present study was conducted, the rate of perinatal losses stands at 5.9 for every 1000 childbirths [22].

1.1. Psychopathology following PL

Since the 1980's, researchers from various disciplines have

examined the psychological implications of PL [30]. Evidence exists for the development of mood, anxiety and stress-related disorders following PL [8].

Perhaps not surprisingly, most studies examining psychopathology following PL have focused on grief among expecting mother (e.g., [18]). Studies have shown that grief reactions following PL may vary as a function of several factors, such as the gestational week of loss or the occurrence of previous losses [30]. A relatively large number of studies have examined affective disorders following PL, most notably Major Depressive Disorder (MDD). For example, a study by Janssen and colleagues [16] has shown MDD rates 6 times higher among women who have experienced perinatal loss compared to women who gave birth to a healthy baby. Other studies have yielded similar findings [20], showing that PL may lead to relatively high levels of MDD. Several studies have also assessed post-PL MDD longitudinally. For example, Engelhard and colleagues [7] have found a 13% depression rate one month after the loss, which remained stable 4 months post-loss.

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1.2. PL as a traumatic experience

As was noted, most PL studies to date have viewed this difficult experience from a more traditional grief perspective, mostly attempting to understand the scope and correlates of dysphoric symptoms (e.g., sadness, negative world views, longing for the deceased baby), as included in diagnostic constructs such as depression and complicated grief. Only recently have researchers also begun looking at PL as a potentially-traumatic experience, which may lead to the development of more specific post-traumatic symptomatology, most notably Post-Traumatic Stress Disorder (PTSD).

PTSD is the most common, well-studied, chronic implication of exposure to traumatic stress. According to the fifth edition of the Diagnostic and Statistical Manual (DSM-5; [2]) it includes 4 major symptom clusters: re-experiencing of the traumatic event, cognitive and behavioral avoidance of traumatic reminders, autonomic hyperarousal, and negative alterations in mood and cognition. Although PL seems to clearly meet DSM-5's traumatic event criterion (criterion A), relatively few studies have examined its association with PTSD. In a prospective study assessing PTSD following PL [7]. The rate of PTSD was 25% one month post-loss, and 7% four months post-loss. In another study, a PTSD rate of 12.3% was found among parents who have experienced PL. Although the vast majority of PTSD studies on PL have focused on women, evidence does show that male partners also may suffer from PTSD following the loss [31].

As can be seen, the field of PL-related psychopathology is slowly but gradually developing. However, this area of research still suffers from several noted limitations, which somewhat compromise the possibility of gaining a deep understanding of this experience and its psychological implication. These include using inconsistent terminology and definitions of PL across studies [37], applying inadequate, insufficiently validated study measures (e.g., [30]), and wide variance in terms of the timing of loss (very early to very late PLs). One limitation pertaining specifically to PTSD has to do with the application of PTSD criteria from outdated DSM editions, which presented a narrower, less complex definition of PTSD, compared to the one appearing in DSM-5. In addition, the vast majority of PL studies were conducted in English-speaking western countries, and thus very little is known about the implication of PL in other cultures, where pregnancy and childbirth are perhaps viewed differently. Finally, studies to date have yielded highly inconsistent findings regarding the predictors of psychopathology following PL. For example, while some studies have shown an association between gestational week of loss and PTSD, others have failed to find such a connection [21]. Conflicting results were also found regarding the role of parity [24], previous PLs [19] and age [15].

The present study aims to fill these gaps in research. In our study, we have applied a clear time threshold, examining only women who experienced PL after entering the 2nd trimester. In fact, the vast majority of our sample experienced late PLs, with a high rate of stillbirths. Thus, ours is a high-risk sample in terms of psychopathology. In addition, women were assessed using well-validated measures of psychopathology, according to the latest DSM edition. Finally, this is the first-ever quantitative study of PL in Israel, a society with unique social and cultural characteristics, quite unlike other countries where most PL studies were conducted to date.

Our two main research questions were:

1. What is the prevalence of PTSD and MDD among women who have experienced PL?
2. What is the role of socio-demographic (e.g., age, religiosity) and PL-related factors (e.g., week of loss, former losses) in PTSD and MDD following PL?

Table 1
Sample background characteristics.

	Mean/%	SD
Age	33.75	5.36
Level of education:		
High school	18.3% (n = 17)	
College student (currently)	5.4% (n = 5)	
Academic (B.A./M.A./PhD)	76.3% (n = 71)	
Family status:		
Married	94.7% (n = 90)	
Single	2.1% (n = 2)	
Divorced	1.1% (n = 1)	
In a relationship	2.1% (n = 2)	
Length of current spousal relationship (# years)	8.60	4.40
Currently has children	81.4% (n = 79)	
Religious orientation:		
Secular	22.7% (n = 22)	
Traditional	17.5% (n = 17)	
Religious-National	36.1% (n = 35)	
Orthodox	23.7% (n = 23)	
Cause of PL:		
Spontaneous miscarriage	8.5 (n = 8)	
Medical termination due to fetal defect	34% (n = 32)	
Intrauterine fetal death	41.5% (n = 39)	
Other	16% (n = 15)	
Experienced stillbirth	80.2% (n = 77)	
Time since loss (# months)	19.86	26.85
Gestational week of loss	27.92	7.81
Experienced previous PLs	38.1% (n = 37)	

Methods

1.3. Participants

Ninety seven ($n = 97$) women, aged 23–47, who have experienced PL between gestational weeks 14–42, were recruited for the study. Table 1 presents a comprehensive list of participant characteristics.

As can be seen in Table 1, our sample was characterized by a high rate of late PLs, with a mean gestational PL week of almost 28, and over 80% of the women reporting having experienced stillbirth. The range of months since the PL was large (1–144), with a mean of almost 20.

1.4. Procedure

All women who participated in this study received medical treatment for PL at the Obstetrics and Gynecology Department in the Hadassah Ein-Kerem Hospital in Jerusalem, Israel. The majority of these women (71.7%) had contacted the hospital's PL support groups, and were offered to participate in the study. An additional group of participants were contacted by the study staff directly, but have not themselves contacted the support groups. No differences in PL gestational week, stillbirth incidence, number of previous PLs, circumstances of loss and PTSD symptoms were found between those who did/did not contact support groups. All participants signed informed consent forms and subsequently completed self-report questionnaires.

1.5. Measures

Socio-demographic information was collected via a list of questions tapping age, education, household income, religious orientation, family status, number of children, and more.

PTSD Check List for DSM-5 (PCL-5; [34]) is a 20-item self-report questionnaire that measures PTSD symptoms in the past month. Items correspond directly with the 20 PTSD symptoms appearing in DSM-5 [2]. Participants were asked to complete the PCL-5 while referring to the specific event of PL. The self-report rating scale is 0–4 for each symptom (from “Not at all” to “Extremely”). The PCL-5 also has an established cutoff score of 38, to determine a probable PTSD diagnosis.

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