



Original research article

## Effect of counseling quality on anxiety, grief, and coping after second-trimester abortion for pregnancy complications

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### ABSTRACT

**Objective:** We sought to explore the relationship between counseling quality, measured by shared decision making and decision satisfaction, and psychological outcomes (anxiety, grief, and posttraumatic stress) after second-trimester abortion for pregnancy complications.

**Study design:** We conducted a cross-sectional study of women who underwent second-trimester abortion for complications. We recruited participants from Facebook and online support groups and surveyed them about counseling experiences and psychosocial issues. We used multivariate linear regression to evaluate relationships between counseling quality and psychological outcomes.

**Results:** We analyzed data from 145 respondents. Shared decision making and decision satisfaction scores were positively and strongly correlated in bivariate analysis ( $r=0.7$ ,  $p<.0001$ ), as were posttraumatic stress and grief scores ( $r=0.7$ ,  $p<.0001$ ). In the adjusted analysis, higher decision satisfaction was associated with lower grief and posttraumatic stress scores ( $p=.02$  and  $p=.01$ , respectively) and higher shared decision making was associated with lower posttraumatic stress scores ( $p=.01$ ).

**Conclusions:** Decision satisfaction and shared decision making have a positive effect on psychological outcomes after second-trimester abortion for pregnancy complications. Counseling quality may be especially important in this setting given the sensitive nature of decisions regarding pregnancy termination for complications.

**Implication:** These results highlight the importance of patient-centered counseling for women seeking pregnancy termination.

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### 1. Introduction

Approximately 3–4% of pregnancies are complicated by major congenital fetal anomalies [1,2]. The diagnosis of a fetal anomaly is usually made in the second trimester of pregnancy when ultrasonography is most accurate and often results in a woman's decision to terminate [3]. This diagnosis can be devastating for women given the unexpected nature and usually lethal fetal prognosis, and may hold negative emotional and psychological consequences that can persist long after abortion [4–6]. Severe maternal health conditions that complicate second-trimester pregnancies, such as severe preeclampsia, can have similarly devastating effects for women.

The decision to terminate a pregnancy should happen after a detailed discussion between the woman and her provider that is rooted in the patient's values and needs; that discussion might involve a

decision between D&E and induction as both methods are equally safe and effective [7]. Shared decision making involves consideration of the patient's self-identified values and preferences in medical decisions and creates a culture of patient-centeredness in medical decision making [8]. Studies suggest that improved patient-provider communication can improve patient satisfaction with both their medical care as well as their chosen decision, and can have a positive effect on health outcomes [9]. Moreover, multiple studies have found that the process of decision making is a key factor in post-abortion psychosocial reactions [6,10].

Research on counseling quality and abortion care outcomes is limited; however, one study about contraceptive counseling demonstrates that counseling quality is associated with improved satisfaction with the selected contraceptive method [11]. Additionally, improved counseling has been shown to improve psychological outcomes after miscarriage [12]. This study aims to determine if greater shared decision making and higher decision satisfaction are associated with improved psychological outcomes after second-trimester termination for pregnancy complications.

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## 2. Materials and methods

We conducted a cross-sectional study of English-reading women 18 years and older in the United States who had undergone a second-trimester abortion for maternal or fetal complications. We recruited participants using Facebook, Craigslist, online support groups and direct referrals from providers who care for patients undergoing abortion. We created and distributed the survey instrument using REDCap, a secure online survey platform, and collected information on demographics, reproductive history, pregnancy diagnosis, options counseling experiences, knowledge of the two abortion options (labor induction or D&E), patient-provider communication, depression, anxiety, decision satisfaction, grief, and coping experiences.

We measured three primary psychological outcomes after abortion: anxiety, grief, and posttraumatic stress. Our exposure of interest was counseling quality, measured by scores on shared decision making and decision satisfaction using validated instruments. The shared decision making scale (SDM-9) includes nine items with a six-point scale Likert scale [13]. The instrument explores how well the provider addressed how much the patient wanted to be involved in decision making, how well the provider conveyed information about choices, how much the provider valued the patient's preference, and other shared decision making items. We derived scores by summing the responses and then transforming the raw score into a score ranging from 0 to 100, with higher scores indicating more shared decision making. The satisfaction with decision scale (SWD) includes six statements with a Likert scale [14]. We used a modified version of this instrument based on interviews with patients who underwent abortions for pregnancy complications. The instrument assesses how the participant felt about the medical decision options and information presented to her by a provider, and whether she thought her decision was consistent with her values and was her own choice. Scores for this scale are obtained by summing the responses; scores ranged from 6 to 30 with higher scores indicating less decisional conflict and greater satisfaction.

We measured psychological outcomes of anxiety, grief, and posttraumatic stress, using the State-Trait Anxiety Inventory (STAI) form Y-2, [15] Perinatal Grief Scale (PGS) [16], and a modified version of the Impact of Event Scale (IES) [17], respectively. For these scales, the higher the score the more affected the participants were by these psychological outcomes.

Because this was an exploratory study, we recruited a convenience sample and did not have a pre-specified sample size. We aimed to enroll at least 50 women but did not limit recruitment. We offered no compensation to participants. University of California's Committee on Human Research approved the study.

We exported data from REDCap and performed analysis using Stata (version 14.1, College Station, TX). We calculated descriptive statistics using means and standard deviations for normally distributed data, and medians and interquartile ranges for non-normally distributed data. All scale scores were normally distributed in our population. We evaluated bivariate correlations between the counseling quality measures and each of the psychological outcomes. We used multivariate linear regression to control for potential confounders. We determined covariates used in the regression model a priori, using a directed acyclic graph and biologic plausibility for relationships between covariates and outcomes. We additionally used stepwise evaluation for covariates to include in the model, and we included any covariate with a *p* value less than 0.1. We considered *p* values less than 0.05 in our final analysis model to be statistically significant.

## 3. Results

Of the 164 respondents who completed the survey and met our inclusion criteria, 145 provided adequate data for this analysis. Demographic characteristics of all respondents are shown in Table 1.

**Table 1**

Demographic characteristics of national sample of 165 women who underwent dilation and evacuation (D&E) or induction termination as second-trimester abortion for fetal anomalies or other complications

Characteristic at time of abortion	n (%) or mean $\pm$ SD <sup>a</sup>
<b>Race/ethnicity</b>	
White	120 (72.7)
Non-white <sup>b</sup>	45 (27.3)
<b>Annual income</b>	
Greater than \$90,000	98 (59.4)
Less than \$90,000	41 (24.8)
Missing	26 (15.8)
<b>Highest level of education</b>	
College and beyond	132 (80.0)
High School or below	6 (4.2)
Missing	27 (15.8)
<b>Employment status</b>	
Full-time	107 (64.8)
Part-time or less	32 (19.4)
Missing	26 (15.8)
<b>Time from abortion to survey, years<sup>c</sup></b>	2 (0–6)
<b>Age at abortion, years</b>	31.9 $\pm$ 5.6
<b>Wait time from decision to procedure, days</b>	4.9 $\pm$ 3.8
<b>Type of living area</b>	
Suburban or rural	87 (52.7)
Urban	49 (29.7)
Missing	29 (17.6)
<b>Insurance type</b>	
Private	133 (80.6)
Public	2 (1.2)
None	2 (1.2)
Missing	28 (17.0)
<b>Gestational age at time of termination, weeks</b>	20.4 $\pm$ 3.5
<b>Termination procedure type</b>	
Dilation and evacuation	87 (52.7)
Induction of labor	46 (27.9)
Not specified	32 (19.4)
<b>Region of United States where procedure done</b>	
West	73 (44.2)
Northeast	24 (14.6)
Midwest	26 (15.8)
South	42 (25.4)
<b>Parity</b>	
Nulliparous	47 (28.5)
Parous	113 (68.5)
Missing	5 (3.0)
<b>Termination reason</b>	
Fetal complications	143 (86.7)
Maternal complications	6 (3.6)
Missing	16 (9.7)
<b>Shared Decision Making (SDM-9), score</b>	62.8 $\pm$ 28.5
<b>Satisfaction with Decision (SWD), score</b>	3.8 $\pm$ 1.0
<b>Anxiety (STAI)<sup>d</sup>, score</b>	44.8 $\pm$ 4.3
<b>Grief (PGS)<sup>e</sup>, score</b>	47.2 $\pm$ 12.2
<b>Posttraumatic stress (IES)<sup>f</sup>, score</b>	21.6 $\pm$ 11.0

<sup>a</sup> SD: standard deviation.

<sup>b</sup> Includes Hispanic, Black, Asian and participants who checked "other".

<sup>c</sup> Median (IQR).

<sup>d</sup> State Trait Anxiety Index, range = 40–80 with higher scores indicating more anxiety.

<sup>e</sup> Perinatal Grief Scale, range = 19–95 with higher scores indicating more grief.

<sup>f</sup> Impact of Event Scale, range = 19–95, with higher scores indicating more posttraumatic stress.

Respondents were mostly white, privately insured, and had high levels of formal education.

Shared decision making and decision satisfaction scores were positively and strongly correlated with each other ( $r=0.7$ ,  $p<.0001$ ), meaning that women who reported high decision satisfaction also reported more shared decision making with their provider during their decision process. Grief and posttraumatic stress scores were also positively and strongly correlated ( $r=0.7$ ,  $p<.001$ ), indicating that women who experienced more grief also experienced higher levels of posttraumatic stress after their abortion. A significant relationship between anxiety scores and grief or posttraumatic stress scores did not emerge from these analyses.

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