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The Prevalence of Post-Abortion Grief and the Contributing Factors

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ABSTRACT

Objective: To study the prevalence of post-abortion maternal grief and the contributing factors that might relate to its occurrence.

Design: Cross-sectional, descriptive study.

Subject: The 289 post-abortion women of less than 28 weeks' gestation without the history or during psychiatric treatment admitted at the post-abortion ward, Department of Obstetrics and Gynecology, Siriraj Hospital, between August 20, 2008 and March 19, 2009 were enrolled.

Materials and Methods: The studied groups were requested to complete the questionnaires relating the demographic characteristics, the history of the previous and present pregnancy and the Perinatal Grief Scale (PGS) within the first 24-48 hours after abortion. The collected data was analyzed to determine the prevalence and the contributing factors of post-abortion maternal grief.

Results: The prevalence of severe (despair), moderate (difficulty coping) and mild (active/normal) grief intensity were 4.8% (95%CI 2.9-8.0), 67.8% (95%CI 62.2-72.9) and 27.4% (95%CI 22.5-32.7) respectively. The four contributing factors of post-abortion grief were the patient age (<20 yrs) (OR 3.1, 95% CI 1.1-8.5), husband age (20-35 yrs) (OR 1.7, 95% CI 1.0-3.0), level of education (secondary school) (OR 1.9, 95% CI 1.0-3.5) and family income (<10,000 Baht/month) (OR 3.3, 95% CI 1.5-7.3). After multiple logistic regression test was done only one factor-'income <10,000 Baht/month'- remained significant ($p<0.05$).

Conclusion: The abnormal grief ('Difficulty coping' and 'Despair') after abortion occurs very often with the prevalence of 72.6% (95%CI 67.3-77.5). The screening of patients at risk such as those with age < 20 years, less than 'secondary level' education, and especially those with family income below 10,000 Baht/month is necessary for the prevention of any psychological sequel.

Keywords: post-abortion grief, contributing factors, PGS scores

Introduction

Abortion as a deathly event touches the core of human heart. It hence makes sense that for true healing, psychological aspects need to be attended

to. Whether or not the majority of women experience significant emotional problems after abortion is perhap debatable. However, there is no doubt that some women do experience significant problems; may be more than we (as individuals, health professionals and a society) care to realize.[1-3]

Grief is the most common reaction to abortion, with approximately 10-40% of women suffering from grief immediately after pregnancy loss.[1,4] Many women who do so show the symptoms similar to those presented after the bereavement of a loved one. The main symptoms noted are sadness, a yearning for the lost child, a desire to talk to others about the loss, and a search for a meaningful explanation of the loss. Yet, there are also features of the grief which are unique to the loss of miscarriage. Women may perceive themselves as a "failure" for not having produced a healthy baby, and may question their identity as a reproductive woman. Women may also grieve on the loss of their hopes for starting or continuing a family.[5,6]

The severity and duration of grief symptom have been varied.[1,2] After abortion, most women still have long-term emotional sequence. While some women show a "normal" resolution, others reveal pathological grief reaction following one of these three variant patterns: reversed grief (elevated - decreased - increased), delayed grief (elevated - reduced - low) or unchanged grief. The women who experience few or no grief symptoms immediately after abortion are unlikely to experience delayed onset of significant grief symptoms several months later. Also, women who still show elevated levels of grief after one year generally recover fairly well within two years. However, for a subset of women with initially high levels of grief that decrease by one year after loss, they may actually experience an increase in symptoms during the second year or more after pregnancy loss. For the case of prenatal loss, the grief is the greatest and most sudden, so early screening or detection may be useful to prevent psychological problem.

The incidence of all types of abortion – spontaneous and therapeutic abortion for any medical reasons (e.g. maternal illness or abnormal fetus) or criminal abortion at Siriraj Hospital in 2004 was 89.2 out of 1,000 pregnancies.[7] Nowadays, therapeutic abortion tends to be increasing because of the development of new technology, and the method of prenatal diagnosis.[5,8] For the mother, the perceived loss of fetus seems life devastating and causes grief with long-term emotional sequence, especially in those terminated due to fetal anomalies.

The goal of this descriptive study was to study the prevalence of maternal grief and its contributing factors by using the translated version of the short questionnaire of Toedter's Perinatal Grief Scale (PGS)[9-11].

Materials and Methods

The total 289 post-abortion women who were admitted at the Department of Obstetrics and Gynecology, Faculty of Medicine, Siriraj Hospital between August 20, 2008 and March 19, 2009 gave the consents to be the participants of this study. The inclusion criteria were the post-abortion women of less than 28 weeks gestation and were interested to participate in the study. The exclusion criteria were those with the history or during treatment of psychiatric problems and could not understand Thai language. The sample size of 289 cases was calculated with reference to the prevalence of 43.2% from the previous study of Prommanart N, et al (2004)[4] which was done in Thai population and evaluated at two weeks post abortion, whereas this study was done within forty-eight hours post abortion with the expected prevalence by observation of at least 60 $\pm$ 6% (at 95% confident interval). So the appropriate sample size was 289 cases (including incomplete data). This research was approved by the Human Research Ethics Committee of the Faculty of Medicine, Siriraj Hospital.

After consent forms were signed, the participants were asked to complete the self-answer questionnaire in private within the first 24-48 hours post-abortion. The questionnaire contained two parts. The first part was composed of demographic and obstetric information of the participants: patient' age, husband's age, marital status, education level, occupation, family income and previous illness. The history of previous pregnancy, parity and abortion were collected. The information of

the recent pregnancy: gestational age, type of abortion, antenatal care, prenatal diagnosis, ultrasonographic examination and method of termination were also collected from the medical record or by the interview.

The second part was the translated version of Toedter's Perinatal Grief Scale (PGS) short questionnaire comprised of three different subscales with 33 items of PGS. Those subscales- 'Active grief' (score >120), 'Difficulty coping' (score 77-120) and 'Despair' (score <77) - were used to demonstrate the variations of grief process. The sum varies between 33 and 165. A high score for 'Active grief' is normal in the period immediately after abortion. A high score for 'Despair' indicates delayed grief, and 'Difficulty in coping' is the link between 'Active grief' and "Despair'. The high score of 'Despair' is the more complicated form of grief.

The high score meant low grief while the low score meant high grief. For this research the authors use 'the score ≤120 as a cut-off point'. That is, the scores of ≤120 (including 'Difficulty coping' & 'Despair') was defined as positive for grief (abnormal grief), while the score of > 120 ('Active grief') means negative for grief (normal grief). Those who had abnormal grief (the positive group) were managed to consult psychiatrists as desire.

Statistical Analysis

The collected data was analyzed using SPSS (Statistical Package for the Social Sciences) for Windows version 13. The descriptive statistic was used to describe demographic and obstetric data of the previous and present pregnancy. The percentages of the prevalence of post-abortion grief at different intensity levels were estimated with 95% confidence interval. Student t-test and analysis of variance were used to identify the significant contributing factors as appropriate. The significant variables were further put into a multiple logistic regression model to disclose any independent significant contributing factors at p-value of < 0.05.

Results

As shown in Table 1, the total enrolled participants were 289 cases. The 210 cases (72.6%) had the PGS score of ≤ 120 (abnormal test) with 95%CI 67.3-77.5 and only 79 cases (27.4%) had the PGS score of > 120 (normal test) with 95%CI 22.5-32.7. Amongst abnormal test it was found that 196 (67.8%) and 14 cases (4.8%) were suspicious of 'Difficulty coping' and 'Despair' with 95%CI 62.2-72.9, and 2.9-8.0 respectively. So the prevalence of post-abortion grief was 72.6% (95%CI 67.3-77.5).

As shown in Table 2, the most common ages of the patient and husband in abnormal group were between 20-35 years (66.7 and 62.4%). Most of both abnormal (79.5%) and normal groups (83.5%) had already been married. Half of post-abortion women in abnormal group had finished the secondary school. The most common occupation of abnormal (42.4%) and normal (34.2%) groups were employee, with total income between 10,000 - 20,000 Baht/month in 41.9% of abnormal and 39.2% of normal groups respectively. The percentages of the women in abnormal group with family income of <10,000 Baht/month was about twice of those in normal group (25.2 and 11.4%).

As shown in Table 3, according to the information of the previous pregnancy, half of them had never been pregnant before. About 85 cases (29.4%) had at least one abortion before. The percentages of abnormal and normal groups with the history of prior abortion were 31.0 and 25.3 respectively. Most of them (94.9 VS 97.6%) had no associated problems during previous pregnancy.

As shown in Table 4, comparison between abnormal and normal groups, the most common gestational age of this present pregnancy was less than twelve weeks (53.8 VS 63.3%), the type of abortion was spontaneous (76.7 VS 78.5%) while in the therapeutic group was found in similar number (18.1 VS 17.7%). The similar percentages of abnormal and normal groups with or without ANC were revealed. Both abnormal and normal groups mostly had no prenatal diagnosis. There was no statistical significance in the difference among various methods of termination.

From Table 5, the mean PGS score of abnormal, normal and total cases were 99.7 ± 13.9, 131.4 ± 9.0 and 108.4 ± 19.1 respectively.

From Table 6 and 7, by using the univariate

analysis, four significant contributing factors were identified: patient age (<20 yrs) (OR 3.1, 95% CI 1.1-8.5), husband age (20-35 yrs) (OR 1.7, 95% CI 1.0-3.0), level of education (secondary school) (OR 1.9, 95% CI 1.0-3.5) and family income (<10,000 Baht/month) (OR 3.3, 95% CI 1.5-7.3), were found (p<0.05). After multiple logistic regression test was done only one factor-'income <10,000 Baht/month' remained significant (p<0.05).

From Table 8, in the abnormal group, there was a statistical significance in the difference among various groups of patient age, education and income (p<0.05).

Table 1. Percentage of grief as distributed by its severity (n=289 cases)

	Score > 120 (Normal)	**Score ≤ 120 (Abnormal)**		
	Active grief	**Difficulty coping**	**Despair**	**Difficulty coping & Despair**
Number (cases)	79	196	14	210
Percent (95%CI)	27.4(22.5-32.7)	67.8(62.2-72.9)	4.8(2.9-8.0)	72.6(67.3-77.5)

Table 2. Demographic characteristics of the study population (n=289 cases)

	Score > 120 (Normal)	**Score ≤ 120 (Abnormal)**	**Total**
	Active grief (79 cases) n (%)	**Difficulty coping & Despair (210 cases) n (%)**	**289 cases n (%)**
Patient age (yrs.)			29.3±7.5*
< 20	6 (7.6)	28 (13.3)	34 (11.8)
20 – 35	45 (57.0)	140 (66.7)	185 (64.0)
>35	28 (35.4)	42 (20.0)	70 (24.2)
Husband age (yrs.)			32.4 ± 8.2*
< 20	3 (3.8)	14 (6.7)	17 (5.9)
20 – 35	41 (51.9)	131 (62.4)	172 (59.5)
>35	35 (44.3)	65 (31.0)	100 (34.6)
Marital status			
Married	66 (83.5)	167 (79.5)	233 (80.6)
Never married	13 (16.5)	42 (20.0)	55 (19.0)
Separated / divorced	0 (0)	1 (0.5)	1 (0.4)
Education			
Primary school	17 (21.5)	57 (27.1)	74 (25.6)
Secondary school	33 (41.8)	105 (50.0)	138 (47.8)
≥ Bachelor	29 (36.7)	48 (22.9)	77 (26.6)

Table 2. Demographic characteristics of the study population (cont)

Occupation			
Housewife	17 (21.5)	56 (26.7)	73 (25.3)
Employee	27 (34.2)	89 (42.4)	116 (40.1)
Merchant	13 (16.5)	27 (12.9)	40 (13.8)
Government/officer	15 (19.0)	18 (8.6)	33 (11.4)
Business person	5 (6.3)	12 (5.7)	17 (5.9)
Agriculturalist	1 (1.3)	1 (0.5)	2 (0.7)
Others	1 (1.2)	7 (3.2)	8 (2.8)
Family income (Baht/month):			
< 10,000	9 (11.4)	53 (25.2)	62 (21.5)
10,000 – 20,000	31 (39.2)	88 (41.9)	119 (41.2)
> 20,000	39 (49.4)	69 (32.9)	108 (37.3)
Previous illness			
DM, Hypertension	13 (16.5)	23 (11)	36 (12.5)

"PGS scores" mean short version of Perinatal Grief Scale of Toedter et al.

Table 3. Data of the previous pregnancy

	Score > 120 (Normal)	**Score ≤ 120 (Abnormal)**	**Total (289 cases)**	**p-value**
	Active grief (79 cases) n (%)	**Difficulty coping & Despair (210 cases) n (%)**	**n (%)**	
No pregnancy before	38 (48.1)	112 (53.3)	150 (51.9)	0.66
Parity:				0.21
1	28 (35.4)	63 (30.0)	91 (31.5)	
≥ 2	13 (16.5)	35 (16.7)	48 (16.6)	
Associated problems				
No	40 (97.6)	94 (95.9)	134 (96.4)	1.2
Yes	1 (2.4)	4 (4.1)	5 (3.6)	
Previous abortion (85 cases)	20 cases	65 cases	85 cases	0.43
Never	59 (74.7)	145 (69.0)	204 (70.6)	
≥ 1	20 (25.3)	65 (31.0)	85 (29.4)	
Mode of delivery (139 cases)	41 cases	98 cases	139 cases	0.09
Spontaneous	28 (68.3)	81 (82.7)	109 (78.4)	
Operative delivery	13 (31.7)	17 (17.3)	30 (21.6)	

Table 3. Data of the previous pregnancy (cont)

Previous fetal outcome: (139 cases)	41 cases	98 cases	139 cases	0.67
Normal	40 (97.6)	93 (94.9)	133 (95.7)	
Abnormal	1 (2.4)	5 (5.1)	6 (4.3)	

Associated problems e.g. Post partum hemorrhage, fever
Statistical significance if p<0.05

Table 4. Data of this present pregnancy (n=289 cases)

	Score > 120 (Normal)	**Score ≤ 120 (Abnormal)**	**Total (289 cases)**	**p-value**
	Active grief (79 cases) n (%)	**Difficulty coping & Despair (210 cases) n (%)**	**n (%)**	
Gestational age (wks.)				0.07
≤ 12	50 (63.3)	113 (53.8)	163 (56.4)	
13-16	8 (10.1)	46 (21.9)	54 (18.7)	
>16	21 (26.6)	51 (24.3)	72 (24.9)	
Type of abortion				0.87
Spontaneous	62 (78.5)	161 (76.7)	223 (77.2)	
Therapeutic	14 (17.7)	38 (18.1)	52 (18.0)	
Criminal	3 (3.8)	11 (5.2)	14 (4.8)	
Antenatal care				0.52
No	45 (57.0)	109 (51.9)	154 (53.3)	
Yes	34 (43.0)	101 (48.1)	135 (46.7)	
Prenatal diagnosis				0.31
No	76 (96.2)	193 (91.9)	269 (93.1)	
Yes	3 (3.8)	17 (8.1)	20 (6.9)	
Ultrasonographic exam.				0.73
No	37 (46.8)	105 (50.0)	142 (49.1)	
Yes	42 (53.2)	105 (50.0)	147 (51.9)	
Method of termination				0.39
Uterine curettage	40 (50.6)	118 (56.2)	158 (54.7)	
Misoprostol ± curettage	34 (43.1)	73 (34.8)	107(37.0)	
Misoprostol + oxytocin	5 (6.3)	19 (9.0)	24 (8.3)	

Statistical significance if p<0.05

Table 5. The PGS scores in relation to severity of grief (n=289 cases)

	PGS score > 120 (Normal)	PGS score ≤ 120 (Abnormal)	Total population 289 cases
	(Active grief)	(Difficulty coping & Despair)	
Mean ± SD	131.4 ± 9.0	99.7 ± 13.9	108.4 ± 19.1
n (%)	79 (27.4)	210 (72.6)	289 (100)

Table 6. The significant contributing factors (by univariate analysis)

Contributing factors	OR	95% CI	p-value
Patient age (yrs.)			0.006*
>35	1.0		
20-35	2.1	1.2-3.7	0.014
<20	3.1	1.1-8.5	0.027
Husband age (yrs.)			0.031*
>35	1.0		
20-35	1.7	1.0-3.0	0.04
<20	2.5	0.7-9.3	0.17
Education			0.042*
Primary school	2.0	1.0-4.1	0.05
Secondary school	1.9	1.0-3.5	0.03
≥ Bachelor	1.0		
Family income (Baht/month)			0.003*
< 10,000	3.3	1.5 – 7.3	0.004
10,000 – 20,000	1.6	0.9 – 2.8	0.102
> 20,000	1.0		

Statistical significance at p<0.05

Table 7. Multiple logistic regression result to reveal the significant contributing factors

Family income (Baht/month)	OR	95% CI	p - value
< 10,000	3.3	1.5 – 7.3	0.004*
10,000 – 20,000	1.6	0.9 – 2.8	0.102
> 20,000	1.0		

* Statistic significance at p< 0.05

Table 8. Grief scores stratified by their significant contributing factors (n=289 cases)

Factors	Score > 120 (Normal)	P-Value	Score ≤ 120 (Abnormal)	p-value
	Active grief (79 cases)		Difficulty coping & Despair (210 cases)	
	Mean ± SD		Mean ± SD	
Patient age (yrs.)		0.55		0.03*
< 20	132.67 ± 11.29		93.36 ± 12.55	
20 – 35	132.16 ± 8.89		100.89 ± 13.79	
> 35	129.89 ± 8.87		100.36 ± 14.68	
Husband age (yrs.)		0.59		0.25
< 20	136.67 ± 11.02		95.00 ± 15.76	
20 – 35	131.20 ± 9.17		99.41 ± 13.61	
> 35	131.17± 8.75		101.55 ± 14.26	
Education		0.05		0.007*
Primary school	130.24 ± 6.63		101.09 ± 14.48	
Secondary school	134.24 ± 11.22		96.97 ± 14.31	
≥ Bachelor	128.83 ± 6.21		104.38 ± 11.19	
family income (Baht/month)		0.48		0.013*
< 10,000	134.00 ± 11.06		96.13 ± 15.46	
10,000 – 20,000	132.03± 9.19		99.25 ± 14.29	
> 20,000	130.28 ± 8.37		103.36 ± 11.64	

One way ANOVA

* Statistical significance at p< 0.05

Discussion

There is no argument that after perinatal loss or abortion the women would express different forms of grief with various intensity (active grief, difficulty coping or despair) regardless of the abortion types (spontaneous, therapeutic or criminal abortion). Grief is a dynamic process with high degree of normality. Women expressions are emotions, thoughts and behaviors. Nowadays there are tendency for the therapeutic abortion to increase in numbers, so grief after abortion may also be the problems in long term in some women. Thereby early detection and treatment of the problems may be necessary. That is to say we should try to identify women at risk of abnormal grief or have the contributing factors of grief before discharging them.

There are various tools for evaluation of grief.[4,12] One of the standardized and recommended instrument focusing on grief after abortion is Toedter's Perinatal Grief Scale. It is a simple and not time-consuming test with good validity and reliability test. The three subscales of grief are: 'Active grief', 'Difficulty in coping' and 'Despair'. The subscale 'Active grief' is the normal grief reaction. The subscale 'Difficulty in coping' describes the mental health including symptom of depression, feeling of guilt, lacking social support and problems in marital relationship. The subscale 'Despair' indicates more long-lasting effects of the loss and depends,

among other things, on a woman's coping strategy. In this research, the cut-off level of 'PGS scores $\leq$ 120' was chosen to differentiate the abnormal ('Difficulty in coping' and 'Despair') from normal grief with the hope of identifying those who are at risk of grieving morbidity.

As most patients admitted at Siriraj Hospital had no permanent houses in Bangkok and hence were impossible to make post-treatment appointment, the appropriate time for making the screening test was within the first 24-48 hours post-abortion or before discharge.

The prevalence of the abnormal post-abortion grief (PGS score $\leq$ 120) in this study was 72.6% (95%CI 67.3-77.5). Within this abnormal group, it was found that 67.8% (95%CI 62.2-72.9) and 4.8% (95%CI 2.9-8.0) were 'Difficulty coping' and 'Despair' respectively. The prevalence in our study was higher than other previous studies, especially from Prommanart N, et al.[4] The explanation was that the studies were done in different time periods, this emphasized the fact that nowadays abortion is an interesting topic because of the changes in obstetric service and the advancement in the detection technique for fetal anomalies.

In response to the intensive care and in concentration to find out those who are at risk of developing excessive grief, the authors were also interested in exploring their contributing factors. In Prommanart N, et al, the factors associated with PGS scores were low family income, having ultrasonographic examination, gestational age of more than sixteen weeks gestation and method of treatment.[4] Even though there is no conclusive finding about the grieving factors, the identifying before discharge of the contributing factors or predictors for women with no preexisting psychological background may lead to prevention of the problem[4-6,12].

The characteristics of 289 enrolled participants were that the average age of patients and husbands were 29.3 $\pm$ 7.5 and 32.4 $\pm$ 8.2 respectively.

Many demographic results were inclusive as many other studies.[3-5,12] However, it had been found that most common ages of the patient and husband in abnormal group were between 20-35 years. The percentage of the women in abnormal group with family income of <10,000 Baht/month was about twice of those in normal group. This suggested the possible association between the occurrence of abnormal grief and older patient and husband with low family income. Contradictory, the abnormal grief seemed to have no relation with the marital status, the education level or occupation.

From the examination of reproductive variables or previous pregnancy, there was no clear conclusion whether the factors like the prior successful labor, the parity status, the previous mode of delivery and the existence of associated problems during previous pregnancy had an effect on the emotional adjustment after abortion.[3-6] A large number of women had never been pregnant before. This study could not find the association between mode of delivery and grief as most of them was spontaneous delivery. Yet it could be revealed from the research that the women with the history of prior abortion or post loss had the tendency to develop abnormal grief response but without statistical significance.

It might be expected that pregnancy characteristics e.g. duration or type of abortion might influence psychological adjustment.[5,6,8,12] However, the investigation of factors relating to the pregnancy had shown conflicting results. This might be from the wide variation of pregnancy characteristics. The authors found no association between the gestational age or the antenatal care and the abnormal grief. The explanation might be that most participants (more than half) were in the first twelve weeks gestation and still had no antenatal care at that time, making interpretation of the results difficult. This study revealed no association between the prenatal diagnosis, ultrasonographic examination, or type of abortion and the abnormal grief. The severity of grief in different types of abortion depended on the ambivalence guilt issues, gestational age at time of loss, or maternal rating of number of loss.[3,8] There was also no association between every method for pregnancy termination and the development of abnormal grief. The reason was that most common method of termination of pregnancy under study was the same – 'the surgical method with administration of

analgesia'.

The mean PGS scores of abnormal, normal and total cases in this study were 99.7 ± 13.9, 131.4 ± 9.0 and 108.4 ± 19.1 respectively.

To identify the association of patient age and the occurrence of abnormal grief, those of older than thirty-five years old was the interested group because of high percentage of developing both maternal and fetal complications. As shown in Table 6 the younger mother had the tendency to have abnormal test.

Using the univariate analysis, four significant contributing factors were identified: patient age (<20yrs) (OR 3.1, 95% CI 1.1-8.5), husband age (20-35yrs) (OR 1.7, 95% CI 1.0-3.0), level of education (secondary school) (OR 1.9, 95% CI 1.0-3.5) and family income (<10,000 Baht/month) (OR 3.3, 95% CI 1.5-7.3) remained significant (P<0.05). It meant that those who had such risks had a tendency to develop abnormal grief.

Finally, after using multiple logistic regression analysis, only one contributing factor - low family income (<10,000 Baht/month) - remained significance. The women with low family income had more stress, especially from the family and social factors. The lack of social support was because everyone in the family had to work hard to earn the money, leaving the patient to be alone without marital support.

The realization of the importance of the high prevalence and the potential predicting variables could lead to the prevention of psychological morbidity in those at risk. Good social support from medical personal and partners as well as family to assist in the process of emotional recovery is necessary.

Conclusion

The abnormal grief ('Difficulty coping' and 'Despair') after abortion occurs very often with the prevalence of 72.6% (95%CI 67.3-77.5). The screening of patients at risk such as those with age < 20 years, less than 'secondary level' education, and especially those with family income below 10,000 Baht/month is necessary for the prevention of any psychological sequel.

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ความชุกของภาวะความเศร้าโศกหลังแท้งและปัจจัยที่อาจเกี่ยวข้อง

สมพงษ์ กาญจนภูสิต, วิบูลพรรณ ฐิตะดิลก, ศุภโชค สิงหกันต์

วัตถุประสงค์ *: เพื่อศึกษาหาความชุกของภาวะความเศร้าโศกหลังแท้งบุตรและปัจจัยที่อาจเกี่ยวข้องกับการเกิด*

ชนิดของการวิจัย *: การศึกษาวิจัยเชิงพรรณนาแบบตัดขวาง*

กลุ่มตัวอย่าง *: หญิงหลังแท้งบุตรใหม่ที่อายุครรภ์ต่ำกว่า 28 สัปดาห์ ที่รับไว้ในหอผู้ป่วยหลังแท้ง ภาควิชาสูติศาสตร์-นรีเวชวิทยา โรงพยาบาลศิริราช ระหว่างวันที่ 20 สิงหาคม 2551-19 มีนาคม 2552 รวม 289 ราย และไม่มีประวัติหรือกำลังรักษาอาการทางจิตเวช*

วัสดุและวิธีการศึกษา *: หญิงที่สมัครใจที่เข้าร่วมโครงการหลังจากที่ได้ลงนามแสดงความจำนงที่จะเข้าร่วมการศึกษา จะขอให้อ่านตอบแบบสอบถามด้วยตนเอง ข้อมูลที่ต้องการมี 2 ส่วน ส่วนแรกเป็นข้อมูลทั่วไป ข้อมูลสุขภาพ และข้อมูลทางสูติกรรมในครรภ์ที่ผ่านมาและครรภ์ปัจจุบัน ส่วนที่สอง เป็นข้อมูลที่ใช้ประเมินความเศร้าโศกหลังแท้งบุตร (Perinatal Grief Scale) เพื่อที่จะนำไปวิเคราะห์หาความชุกและปัจจัยที่อาจเกี่ยวข้องกับการเกิดภาวะความเศร้าโศกหลังแท้งบุตร*

ผลการศึกษา *: ความชุกของภาวะความเศร้าโศกหลังการแท้งบุตรในระดับ รุนแรง (despair) ปานกลาง (difficulty coping) และในเกณฑ์ปกติ (active) เท่ากับ ร้อยละ 4.8 (ความเชื่อมั่นที่ 95% 2.9-8.0), 67.8 (ความเชื่อมั่นที่ 95% 62.2-72.9) และ 27.4 (ความเชื่อมั่นที่ 95% 22.5-32.7) ตามลำดับ มีปัจจัย 4 อย่างที่อาจเกี่ยวข้องกับการเกิดภาวะความเศร้าโศกหลังแท้งบุตร ได้แก่ อายุของมารดา (น้อยกว่า 20 ปี) (ความเสี่ยง 3.1 เท่า ความเชื่อมั่นที่ 95% 1.1-8.5), อายุของสามี (20-35 ปี) (ความเสี่ยง 1.7 เท่า ความเชื่อมั่นที่ 95% 1.0-3.0), ระดับการศึกษา (ชั้นมัธยม) (ความเสี่ยง 1.9 เท่า ความเชื่อมั่นที่ 95% 1.0-3.5), และรายได้ของครอบครัว (น้อยกว่า 10,000 บาทต่อเดือน) (ความเสี่ยง 3.3 เท่า ระดับความเชื่อมั่นที่ 95% 1.5-7.3) มีเพียงปัจจัยเดียวที่มีนัยสำคัญทางสถิติ คือ รายได้ของครอบครัวที่ต่ำ (น้อยกว่า 10,000 บาทต่อเดือน)*

สรุป *: ความชุกของภาวะความเศร้าโศกหลังการแท้งบุตร (ระดับรุนแรงและปานกลาง) เท่ากับร้อยละ 72.6 (ความเชื่อมั่นที่ 95% 67.3-77.5) การคัดกรองกลุ่มเสี่ยง เช่น อายุน้อยกว่า 20 ปี ระดับการศึกษาต่ำกว่าชั้นมัธยม และโดยเฉพาะอย่างยิ่งผู้มีรายได้ของครอบครัวที่ต่ำ (น้อยกว่า 10,000 บาทต่อเดือน) มีความจำเป็นเพื่อช่วยป้องกันผลที่จะกระทบต่อสุขภาพจิต*