Psychological aspects of miscarriage: attitudes of the primary health care team

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SUMMARY. A questionnaire surveying the attitudes of general practitioners, health visitors, community midwives and district nurses towards the psychological aspects of miscarriage was distributed to a random sample of 50 staff in each professional group. The response rate was 78%. A large majority of all staff surveyed (76%) agreed that miscarriage is frequently associated with significant psychological distress and 90% agreed that women should be routinely encouraged to explore and discuss their feelings following such an event. Overall, health visitors and community midwives were seen to be the most appropriate members of the primary health care team to offer such counselling. The gap between perceived need and provision of care for women who have had a miscarriage is highlighted, and ways of narrowing this are discussed.

Keywords: spontaneous abortion; psychological factors; health professionals' attitude.

Introduction

MISCARRIAGE is a relatively common occurrence. A general practitioner with a list of 2500 patients could expect to see at least five such cases per year.[1]

Recent descriptive studies have indicated a significant level of psychological distress in women following spontaneous abortion.[2-5] There is little evidence, however, that this is reflected in the way these cases are currently managed. Indeed, there are indications that women who have a miscarriage receive insufficient support from health care professionals, including obstetricians.[6]

It has been suggested that women who have suffered a miscarriage might benefit from brief counselling aimed at facilitating the expression of grief and restoring or reinforcing the sense of self worth which is often damaged after a spontaneous abortion.[7] Reassurance, information and advice may also be needed and it has been suggested that a routine follow-up service should be available to all women experiencing miscarriage.[8] In two studies where follow-up appointments were routinely offered, 74% and 79% of women attended.[8,9] Although both studies reported that all the women who attended the follow-up appointment found the counselling beneficial, there have been no controlled studies evaluating the impact of such psychological intervention. Experience from other related situations characterized by loss, such as perinatal death, does suggest that such intervention may be of value.[10] If this is the case, it is likely that such intervention may be best delivered in the primary care setting.

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The aim of this study was to investigate the attitudes of general practitioners, health visitors, community midwives and district nurses to the psychological aspects of miscarriage. In particular, it was intended to explore how members of these groups perceived their role in the management of the problem.

Method

A sample of 50 general practitioners was selected at random from the Leicester family health services authority list of general practitioners. Similarly, random samples of 50 each of community midwives, health visitors and district nurses were identified from data supplied by the Leicestershire health authority. A simple questionnaire and covering letter were sent to each of these 200 members of staff in 1990. The questionnaire was designed to be anonymous and only the professional group of the respondents could be identified. Data on the respondent's sex and the type of area in which they worked (urban, rural or semi-rural) were collected.

The remainder of the questionnaire comprised five questions. The first concerned level of contact with women who had suffered a miscarriage — responses were graded as 'no contact', 'little contact' (one or two cases per year) or 'some contact' (more than two cases per year). The following two questions rated the respondent's level of agreement on a five point scale, first, with the suggestion that miscarriage is frequently associated with significant psychological sequelae, and secondly with the idea that women who have miscarried should be routinely encouraged to explore and discuss feelings of loss. The next question invited the respondents to indicate which type of professional they felt would be most appropriate for the provision of psychological support to women following miscarriage; they were given eight options plus 'other'. Finally, the respondents were asked how competent they perceived themselves to be in this role — very competent, fairly competent or not competent.

Comparisons were made between the responses from the different groups using chi square tests. The association between reported personal competence and contact with cases of miscarriage was tested using Spearman's correlation coefficient.

Results

A total of 156 out of 200 questionnaires were completed and returned, giving an overall response rate of 78%. Within the four professional groups, there was a considerable variation in response rate — 43 of the 50 general practitioners responded (86%), 43 community midwives (86%), 39 health visitors (78%) and 31 district nurses (62%).

A majority of the staff (56%) reported working in an urban area while the remainder worked in rural or semi-rural areas. All but one of the midwifery, health visitor and district nursing staff were women. Nine of the 43 general practitioners (21%) were women.

The majority of the professional staff (63%) reported 'some' contact with cases of miscarriage while 21% reported 'little' contact and 16% no contact at all (Table 1). There were highly significant differences in the level of contact reported between the four groups.

Seventy six per cent of all the staff either 'strongly agreed' or 'agreed' that miscarriage was frequently associated with significant psychological consequences (Table 2). Eight per cent

Table 1. Contact with cases of miscarriage among the professional groups.

	% of respondents reporting contact		
	Some[a]	Little[b]	None
General practitioners ($n=43$)	93	7	0
Health visitors ($n=39$)	62	26	13
District nurses ($n=31$)	6	32	61
Community midwives ($n=43$)	77	23	0
Total ($n=156$)	63	21	15

Chi square = 85.2, 6 df, $P<0.001$. n = total number of respondents. [a]More than two cases per year. [b]One or two cases per year.

Table 2. Level of agreement with statements among professional groups.

	% of respondents who:		
	Strongly agree/agree	Neither agree nor disagree	Strongly disagree/ disagree
Miscarriage is frequently associated with significant psychological sequelae			
General practitioners ($n=43$)	81	9	9
Health visitors ($n=39$)	79	13	8
District nurses ($n=31$)	68	26	6
Community midwives ($n=43$)	72	19	9
Total ($n=156$)	76	16	8
Women should routinely be offered an opportunity to discuss their feelings			
General practitioners ($n=43$)	84	7	9
Health visitors ($n=38$)[a]	92	8	0
District nurses ($n=31$)	90	6	3
Community midwives ($n=43$)	93	5	2
Total ($n=155$)	90	6	4

n = total number of respondents. [a]One health visitor did not respond to this question.

'disagreed' or 'strongly disagreed' with this assertion. There were no significant differences between the responses from the four professional groups. In response to the question of whether women suffering miscarriage should be routinely encouraged to explore and discuss their feelings, the vast majority of all staff (90%) either 'strongly agreed' or 'agreed' (Table 2). Again, there was no significant difference between the responses of the four professional groups.

There was a variation between the responses of the four groups about the professional group perceived to be most appropriate for providing psychological support following miscarriage. Forty two per cent of general practitioners felt that general practitioners were best suited (Table 3), 66% of health visitors felt health visitors were best suited while the greatest proportion of community midwives (64%) and district nurses (43%) suggested that community midwives would be most suitable.

Table 3. Professionals considered best able to offer psychological support.

	% of respondents regarding the following as best suited:				
	General practitioners	Community midwives	Health visitors	Psychologists	Other
General practitioners ($n=38$)	42	16	18	18	5
Health visitors ($n=35$)	0	17	66	11	6
District nurses ($n=30$)	0	43	30	17	10
Community midwives ($n=36$)	8	64	8	11	8
Total ($n=139$)	14	35	30	14	7

Chi square = 72.5, 12 df, $P<0.001$. n = total number of respondents; not all the respondents replied to this question.

The responses to the final item in the questionnaire, dealing with perceived personal competence in providing psychological support to women following a spontaneous abortion, demonstrated a very highly significant difference between the four groups (Table 4). Overall, 78% of staff felt that they were 'fairly' or 'very' competent. There was a significant correlation between reported personal competence and level of contact with cases of miscarriage (Spearman's R = 0.41; critical value = 0.16 (2-tail, $P<0.05$)).

Table 4. Perceived personal competence in providing psychological support to women following a miscarriage among professional groups.

	% of respondents feeling:		
	Very competent	Fairly competent	Not competent
General practitioners ($n=43$)	21	74	5
Health visitors ($n=39$)	10	74	15
District nurses ($n=31$)	6	35	58
Community midwives ($n=43$)	14	67	19
Total ($n=156$)	13	65	22

Chi square = 34.0, 6 df, $P<0.001$. n = total number of respondents.

Discussion

The high response rate to the questionnaire, together with the views expressed in this study, suggest that the staff questioned felt the psychological sequelae of miscarriage to be an important issue. A large majority of all staff agreed that miscarriage is frequently associated with significant psychological distress, and also that an opportunity should be provided for women to explore and discuss their feelings after this event. These results are perhaps predictable, given the leading nature of these two questions.

If such a high level of awareness exists among primary health care workers about the psychological trauma of miscarriage, the

question remains as to why there is a lack of reported systematic follow up for such women, and why women who have had a miscarriage report such high levels of dissatisfaction with the care and information given to them.[11]

There are a number of possible explanations for this discrepancy. The most likely explanation is that primary health care staff are not able to provide the counselling which they believe to be appropriate because of time constraints. The results of this study also indicate a lack of consensus between the various professional groups regarding those felt to be most suitable for offering psychological support and intervention. Overall, community midwives and health visitors were seen as being the most appropriate members of the primary health care team. Whether this is because of perceived skills or the availability of opportunities to offer such support is not clear. It may be that one professional group assumes that psychological support is being provided elsewhere. It would have been useful to have included a question in the survey asking whether staff believed they were offering counselling to women who had had a miscarriage.

Counselling has become an over-used and often misused term and there is undoubtedly a need to educate primary health care staff on what comprises counselling and the component skills. The vast majority of respondents in all four professional groups did not feel very confident to carry out counselling themselves. It is perhaps particularly relevant to consider the responses of the general practitioners in this respect, in that many women will visit their general practitioner after a miscarriage for sickness certification or for a physical check up. Although the vast majority of general practitioners in this study accepted the need for psychological support and counselling, less than half (42%) thought that they were the most appropriate people to be providing this, and only 21% felt very confident to provide such routine counselling.

At present, there is no formal system for following up women who have had a miscarriage. The setting up of such a system could narrow the gap between perceived need and actual provision of emotional care for this group of women. Follow up could be either hospital or community based. The usual practice is for hospitals to review only those women with a history of recurrent miscarriage. In two studies where systematic follow up was offered, this was provided in the hospital setting. In Hamilton's study,[8] 72 women admitted with bleeding in the first trimester of pregnancy were interviewed and given detailed verbal explanations. They were offered a six week follow-up appointment with a researcher, who asked them a number of questions about their experience and encouraged them to talk about their feelings. Turner[9] reports the setting up of a hospital-based miscarriage clinic separate from the hospital's other clinics. Efforts were made to increase inpatient counselling and the provision of information, and on discharge, all women were offered a follow-up appointment, to which their partners were also encouraged to attend. At the clinic, the previous counselling was reinforced, and the women were also examined and a cervical smear taken. The advantage of setting up a hospital-based follow-up system of this type is that central record keeping would facilitate systematic follow-up of all women admitted with early miscarriage. Hospitals may also have more resources available.

Community-based follow up, however, may be more acceptable to women on the grounds of convenience, and would probably be more efficient and cost effective in that it could build on existing resources and opportunities. It has already been noted that many women will consult their general practitioner after a miscarriage and contact may also have been made with the community midwife at the beginning of the pregnancy, and there may be contact with the health visitor through older children.

There are a number of options available for developing a community-based follow-up system. One option would be to encourage more systematic follow up by general practitioners, who could provide women with detailed explanation, advice and reassurance, and refer on to a specialist counsellor if necessary. Many general practices are now appointing counsellors to work with the primary health care team. Alternatively, the role of the health visitor could be expanded to include systematic home visits for all women who have suffered miscarriage. This option obviously has implications for the training of health visitors and their workload.

A further option is to set up support groups for women who have had miscarriages. Such groups could be either hospital or community based. In some areas, active self-help groups already exist and women could be encouraged to join these, although the benefits of attending such groups is not known.

Although it is widely agreed that a follow-up service is likely to be beneficial, this has not yet been demonstrated. A controlled study to evaluate the effectiveness of psychological support and counselling is clearly called for.

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