

COPING PATTERN AMONG MOTHERS WITH PREGNANCY LOSS

Thesis

Submitted for partial fulfillment of Master Degree in
Nursing sciences

Maternity- Neonatal Health Nursing

By

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**Ain Shams University
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2015**

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2015**



First and foremost praise and thanks are given to **ALLAH** who provided me, in his unlimited generosity with knowledge, and by his abundant aid this work has been done.

Prof. Kamilia Ragab Abo Shabana, Professor of Maternal and Neonatal Nursing Department, Faculty of Nursing Ain-Shams University, she refused to acknowledgment and says that it is her professional duties to teach and guide her students post graduate; she devoted her time for upgrading their knowledge and research issues. And she wants to take the thanks from GOD not from the student.

I would like also to express my sincere gratitude and deep appreciation to **Dr. Randa Mohammed Ibrahim**, Assistant Professor of Maternal and Neonatal Nursing Department, Faculty of Nursing Ain-Shams University. Who gave me the honor of working under her supervision, for her careful and great support in this thesis and for her valuable and precious experience.

Last and not least I am grateful to my **Family Members** who have contributed much by giving their time and cooperation to push me towards the fulfillment of this work.

Ghada Mounir Mohammed

Dedications

To my **Husband**, And All my **family**

Dr. Ghada Mounir Mohammed

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List of Abbreviations

ACOG	American Collage Of Obstetrician and Gynecologist
DIC	Disseminated Intravascular Coagulation
IUFD	Intra uterine Fetal Death
LNMP	Last Normal Menstrual Period
PTSD	post traumatic stress disorder
RCOG	Royal Collage Of Obstetrician and Gynecologist
SOC	Sense of coherence
STAI	state-trait Anxiety inventory
WHO	World Health Organization

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ABSTRACT

This study aimed to assess coping pattern among mothers with pregnancy loss. **Design** A descriptive study design. **Sample size** were used to recruit **two hundred and fifty** of women with pregnancy loss **sample type** A **purposive** sample. **Sitting** in delivery unit and postnatal units at Ain Shams University Maternity Hospital., **Three tools** for data collection were used in this study as follow: Structured interviewing questionnaire sheet, coping patterns scale, and State-Trait Anxiety Inventory (STAI). **Results:** findings of the present study showed that 71.6% of mothers had pregnancy loss in the third trimester. In addition, 44.8% of mothers had no apparent cause for pregnancy loss. Moreover, 89.2% of mothers and 86.4% of husbands had rejection response. Furthermore, (94.8%, 87.2%, and 85.6%) of mothers with pregnancy loss were used the following coping pattern social support, spiritual support and denial respectively. Finally, anxiety score improved significantly after one week with a significant rise of the score of positive aspects and a significant drop in the score of negative aspects. **Conclusion:** More than half of women with pregnancy loss didn't have knowledge about coping. In addition less than two third of women with pregnancy loss didn't have knowledge about its mechanisms. Furthermore, nearly one fifth of women with pregnancy loss were used coping mechanism. The majority of women with pregnancy loss were used the following coping pattern social support, spiritual support and denial., The anxiety score of women with pregnancy loss improved significantly after one week as there was a significant rise in the positive aspects and a significant drop in the negative aspects.

Key word: pregnancy loss, coping pattern.

INTRODUCTION

Pregnancy loss means death prior to the complete expulsion or extraction from its mother of a product of human conception, irrespective of the duration of pregnancy and which is not an induced termination of pregnancy. The death is indicated by the fact that after such expulsion or extraction, the fetus does not breathe or show any other evidence of life, such as pulsation of the umbilical cord, or definite movement of voluntary muscles. Heartbeats are to be distinguished from transient cardiac contractions; respirations are to be distinguished from fleeting respiratory efforts or gasps (*American College of Obstetricians, 2007*).

More while worldwide, this rate varies considerably depending on the quality of medical care available in the country in question and the definitions used for classifying fetal deaths. Underreporting in developing nations is common, which makes comparisons even more difficult. In 2009, the estimated global number of stillbirths was 2.64 million (uncertainty range, 2.14-3.82 million).The worldwide stillbirth rate declined by 14.5% from 22.1 stillbirths per 1000 births in 1995 to 18.9 stillbirths per 1000 births in 2009 (*Cousens, et al., 2009*).

Moreover, every day more than 7200 babies are stillborn a death just when parents expect to welcome a new life and 98%

of them occur in low and middle-income countries. High-income countries are not immune, with one in 320 babies stillborn a rate that has changed little in the past decade (**WHO, 2009**).

Also the recent estimates show that the number of stillbirths worldwide has declined by only 1.1% per year, from 3 million in 1995 to 2.6 million in 2009. This is even slower than reductions for both maternal and child mortality in the same period more over the five main causes of stillbirth are childbirth complications, maternal infections in pregnancy, maternal disorders (especially hypertension and diabetes), fetal growth restriction and congenital abnormalities (**WHO, 2009**).

Additionally Perinatal loss is associated with considerable psychosocial distress. A substantial proportion of women who suffered the loss of a child develop a psychological disorder. Depression, anxiety disorder, post-traumatic stress disorder and somatoform disorder all have been linked in various studies to grief reactions in response to perinatal loss (**Scheidt, Waller, Wangler, Hasenburg, Kersting, 2007**).

While **Coping responses** are partly controlled by personality (habitual traits), yet it is also partly controlled by the social context, particularly the nature of the stressful environment (**Carver, and Connor-Smith, 2010**).

However, classification of this coping pattern into a broader architecture has not yet been agreed upon. Common distinctions are often made between various contrasting strategies, for example: problem-focused versus emotion-focused; engagement versus disengagement; cognitive versus behavioral (*Weiten, and Lloyd, 2008*).

Yet **appraisal-focused strategies** occur when the person modifies the way they think, for example: employing **denial**, or distancing oneself from the problem. People may alter the way they think about a problem by altering their **goals** and **values**, such as by seeing the **humor** in a situation: "some have suggested that humor may play a greater role as a stress moderator among women than men". While, people using **problem-focused** strategies, yet they are trying to deal with the cause of their problems. They do this by finding out information on the problem and learning new skills to manage the problem. Problem-focused coping is aimed at changing or eliminating the source of the stress (*Brannon, Linda, and Feist, 2009*).

Meanwhile, **emotion-focused** strategies involve releasing pent-up emotions, distracting one, managing hostile feelings, meditating or using systematic relaxation procedures. Emotion-focused coping is oriented towards managing the emotions that accompany the perception of stress (*Brannon, Linda, and Feist, 2009*).

Also sensitive, caring and skilled nursing care for women experiencing miscarriage plays a crucial role in their long-term emotional recovery. For some women, miscarriage is a traumatic life event and may even be regarded as the most painful form of bereavement. However, miscarriage is often not viewed by society as bereavement. The emotional effects are often overlooked by researchers and healthcare providers, who focus primarily on the physical aspects of miscarriage (*Rachel, 2012*).

Therefore, nurses who work in gynecology and early pregnancy units should endeavor to provide sensitive and supportive care while managing their own emotions. Some nurses may cope well with care in these specialized units, while others may become emotionally overwhelmed. The stressful nature of providing care for women experiencing miscarriage should therefore be validated and recognized by those in nursing management and education (*Rachel, 2012*).

Yet interventions by staff have a profound effect positively or negatively, they will forever remember what staff said and did. The best medicine is the compassionate and sensitive care of medical staff. Greatest complaints- feeling traumatized by lack of sensitivity, responsiveness, communication, concern, validation of the loss, support of the family, and facilitation of grief rituals (*Gold, 2007*).

Moreover parental support "health professionals" should be aware of the psychological sequel associated with pregnancy loss and offer support, follow-up and access to formal counseling. For appropriate support can result in significant positive psychological gain. General considerations for parental support are following early pregnancy loss (*Royal College of Obstetricians and Gynaecologists, 2010*).

Significance of the study

There is an obvious increased attention to the coping and spiritual effects of pregnancy loss on mothers and their family from stillbirth and prenatal death. It is now recognized that the trauma of stillbirth can have long-term effects on the family as well as the mother. Depending on factors, which will be mentioned below, up to a fifth of women (and men) have prolonged depression or morbid preoccupation thoughts of the dead baby, misdirected anger, and a fifth of them suffer PTSD (posttraumatic stress disorder) in the following pregnancy. Increased obsessive compulsive disorder, marital discord and even suicide can occur. If the anxiety or mourning is unresolved, there could be a disturbance effect on the next born child, and certainly parents have been found to have elevated levels of anxiety during the subsequent pregnancy (*Hutti, 2005*).

No previous study was conducted in maternal and neonatal health nursing department faculty of nursing Ain Shams University investigating coping pattern among women with pregnancy loss, so this study was conducted to assess the previous mention statement.