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THE BENEFIT OF COUNSELLING TO PREGNANT WOMEN WITH A HISTORY OF SPONTANEOUS ABORTION: A CASE REPORT

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CASE REPORT **OPEN ACCESS**

ABSTRACT

Background: Abortion becomes a complication that can occur in pregnancy and cause psychological and physical distress. Spontaneous abortion can become trigger anxiety and depression during pregnancy. Midwifery who helps patients in perifer or rural areas need to concern about how to do early detection and counseling to reduce risk of psychological risk which can be elevated.
Objective: This report aimed to evaluate the anxiety and depression state with a history of spontaneous abortion in their first pregnancy.
Methods: This paper was a case report reporting a patient with a second pregnant condition. This patient has a history of spontaneous abortion in her first pregnancy. Evaluating process with Hamilton Anxiety Rating Scale (HAM-A) dan Hamilton Depression Rating Scale (HDRS) and follow-up after parturition period.
Results: Decreasing scores on HAM-A and HAM-D after counseling helped the patient to release her anxiety and depression during pregnancy. The patient is more prepared about signs and symptoms when she feels uneasy and overwhelmed and protects herself from another distortion cognition from spontaneous abortion.
Conclusion: Counselling had benefits to decrease anxiety and depression in pregnant women with a history of spontaneous abortion.

Keywords: anxiety, depression, spontaneous abortion.

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INTRODUCTION

Abortion becomes a threat of removing the product of conception before the fetus can live outside the womb. The WHO IMPAC sets a gestational age limit of fewer than 22 weeks, but some recent references set a gestational age limit of fewer than 20 weeks or a fetus weight of fewer than 500 grams.[1] Spontaneous abortion happens in 15-20% of pregnancies recorded through hospital statistics and this may be up to 30% using community-based assessments.[2] The number of abortions in Indonesia reaches up to 2.3 million annually.[3]

Pregnancy and spontaneous abortion might become stressors leading to anxiety and depression.[4,5] In case the medical staff provides no support to the women laden with psychological stress associated with abortion, some further long-term consequences, such as disturbances in the area of health and psycho-social functioning may occur.[6] Anxiety is the anticipation of a risk of unlucky evidence in the future, someone getting dysphoria or any other somatic disorders. Meanwhile, depression is a mood disorder that causes unhappiness and can be temporary or permanent.[5]

Midwifery needs to evaluate concisely not only the physical but also the mentality of the mother. For some psychiatric cases, midwifery needs to assess the risk to the mental health of their patient. Some cases need to be concerned like a history of spontaneous abortion. This condition got an impact on the mother to induce anxiety and depression, which can be followed up with Hamilton Anxiety Rating Scale (HAM-A) and Hamilton Depression Rating Scale (HDRS) for the screening and evaluation process.[7,8]

METHOD

This paper used a case study report from a patient with gravida state (G2P0Ab1) and a history of spontaneous abortion. Evaluating with HAM-A and HDRS at the first meeting and continuing with counseling (6 sessions when the patient got her antenatal care monthly). Re-evaluated after the parturition period.

Female, 26 years old, in her second pregnancy with four weeks of gestation and a history of spontaneous abortion. At her antenatal care appointment, she said about her worries and uneasy condition about her pregnancy, chest pain, headache, tension, fidgeting, and sleep disturbance. The patient got her

fixation ideation about this pregnancy will not go well as her pregnancy before. Another problem was identified such as poor relationship in the family (already treated not well by her in-laws, and a long-marriage relationship with her husband). Each antenatal care session was conducted with counseling to encourage her condition, provide emotional support, suggest routine antenatal care monthly, involve her husband and family in her wellness, and activate consultation liaison psychiatry as needed.

RESULT

At her first antenatal care, the patient got a HAM-A score of 21 (moderate anxiety) and an HDRS score of 14 (moderate depression). Re-evaluated after 6 counseling sessions in her antenatal care monthly got HAM-A score (5) and HDRS score of 3 (within normal limit).

Counseling material in each session to support a healthy pregnancy, maturation becomes a mother, reassurance, and relaxation method. In each counseling session, the patient stated about calmer condition, fewer worries, improving sleep quality even still had fatigue condition and shortness of breath due to the fetus's development inside. Family involvement was conducted to reduce the mother's stress and provide support in her daily activities.

DISCUSS

HAM-A and HDRS as a tool for measuring symptoms of anxiety and depression were helpful to diagnose and find the risk of development from the patient in the clinical setting. This evaluation needs awareness from the clinician (in this setting midwifery) in each session of the antenatal care period.[9,10]

Studies revealed that women with a history of spontaneous abortion felt decreasing in their quality of life and mental health disturbed than those without a history of spontaneous abortion.[11] Women with spontaneous abortion have higher rates of mood disorder (such as depression, bipolar disorder, and dysthymia up to 21%) than women without previous abortion history (up to 10.6%).[12] The number of spontaneous abortions in a woman and the history of their mental disorder are risk factors for depression in subsequent pregnancies.[13]

Up to 17.1% of pregnant women experienced severe anxiety, 45,7% had moderate anxiety and the remaining 28,6% had mild anxiety. Some factors contributed to the risk of anxiety incidences such as level of education, age, the period between abortion and pregnancy and their history of abortion did not significantly differ in the level of anxiety.[4] Psychological disorders experienced by pregnant women can harm the fetus, especially in early pregnancy.[14] In this case, the patient experienced moderate anxiety and depression in her first trimester due to her first abortion experience.

In each session of antenatal care, this patient needs to be followed up concisely about their mental condition and counseling was conducted. Women who had an abortion are more prone to anxiety and depression during subsequent pregnancies but do not appear during the puerperium.[15] Abortion treatment can emphasize psychological counseling and psychological management to reduce the trauma experienced.[16] Mental disorders could increase the rate of hospitalization and treatment needs. Negative emotions impacted by the mental problem can destroy the cognitive powers that women have blown their self-confidence, degrade them, and increased their stress condition.[6]

Counseling that provides good information and reassurance take patients' problem from uneasiness to an easy position that they can cope it well, with the purpose of fighting their dysphoria condition which impacted to mother and fetus.[17] In this case, the midwife conduct counseling, provide emotional support, and encourage mothers to carry out routine antenatal care session monthly, involving husband and family to take care of this pregnancy seriously.

CONCLUSION

.Pregnant women with a history of spontaneous abortion are at higher risk of experiencing anxiety and depression, especially in second-pregnant women with a history of spontaneous abortion in their first pregnancy. Clinicians such as midwives take a big role in providing psychological care and management of their mental health condition and need to assess concisely when bringing the antenatal care period up to parturition.

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