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## Case report

# Cognitive-behavioral therapy to miscarriage: results from the use of a grief therapy protocol

Terapia cognitivo-comportamental para perda gestacional: resultados da utilização de um protocolo terapêutico para luto

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## Abstract

**Background:** The grieving process due to a fetal loss has several features which should be considered in the clinical care of patients going through a miscarriage experience. Bereaved patients present greater demands for medical assistance, number of hospitalizations and are more vulnerable to psychosomatic problems than the general population. **Objective:** This paper aims to present a case report of miscarriage grief treated with a cognitive behavioral therapy protocol. **Method:** The therapy was composed by 12 sessions and the protocol involves the development of strategies to deal with the main somatic complaints, learning of new abilities, approach to cognitive and emotional alterations and training to handle behavioral problems. Results were evaluated by Beck Anxiety Inventory, Beck Depression Inventory, Beck Hopelessness Scale, and Goldberg's General Health Questionnaire (GGHQ). **Results:** Patient presented reduction in depressive and anxiety symptoms. Hopelessness also decreased. All the GGHQ factors presented reduction, with a marked decline in "desire of death" and "psychosomatic disorders". It was also noted an improvement in sleep quality. **Discussion:** The treatment showed itself effective in relation to the factors presented, apart from collaborating for a better quality of life and facilitating the social reinsertion of the patient.

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**Keywords:** Spontaneous abortion, bereavement, cognitive therapy, behavior therapy, thanatology.

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## Resumo

**Introdução:** O processo de luto pela perda gestacional apresenta várias particularidades que devem ser consideradas no atendimento clínico daqueles que passam por uma experiência de aborto. Pacientes enlutados apresentam maior procura por assistência médica e número de hospitalizações e são mais vulneráveis a problemas psicossomáticos que a população geral. **Objetivo:** Apresentar um caso de tratamento de luto decorrente de perda gestacional, com protocolo cognitivo-comportamental. **Método:** O processo terapêutico foi composto por 12 sessões e o protocolo envolvia desenvolvimento de estratégias para lidar com as principais queixas somáticas, aprendizagem de novas habilidades, trabalho das alterações emocionais e cognitivas e treinamento para manejo dos problemas comportamentais. Os resultados foram avaliados por meio das escalas: Inventário Beck de Depressão, Inventário Beck de Ansiedade, Escala Beck de Desesperança e Questionário de Saúde Geral de Goldberg (QSG). **Resultados:** O paciente apresentou redução nos sintomas de depressão e ansiedade, assim como em desesperança. Todos os fatores do QSG apresentaram redução, com forte declínio em "desejabilidade de morte" e "desordens psicossomáticas". Também foi notada melhora na qualidade de sono. **Conclusão:** O tratamento se mostrou efetivo em relação aos fatores apresentados, além de colaborar para melhor qualidade de vida e facilitação da reinserção social do paciente.

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**Palavras-chave:** Aborto espontâneo, luto, terapia cognitiva, terapia comportamental, tanatologia.

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## Introduction

In the bereavement process of foetal death after miscarriage, factors related to the diagnosis and treatment, motivations for the pregnancy and its planning, seem to be prominent in the process of miscarriage. The significance of the child to the patient, as well as the expectations in relation to the future of this child, the network of social support, and possible secondary losses will also be strong influencing factors<sup>1,2</sup>.

As part of the reaction to miscarriage, the person concerned may show several signs and symptoms<sup>2-5</sup>, both cognitive, emotional, and behavioral, as much as physical. In this aspect, special care should be given to the differential diagnostic between bereavement and depression<sup>6,7</sup> or post-traumatic stress disorder. Although the general characteristics of the process remain the same, their duration may be longer<sup>10</sup> than those that might be generally defined as normal for bereavement<sup>11</sup>, because of some of the peculiarities of this type of loss<sup>2,8,9</sup>.

The search for emergency medical services for people who have had a recent miscarriage is frequent<sup>12</sup>. Bereaved patients present greater need for medical assistance than the population in general. There is a greater number of hospitalizations and there is greater vulnerability to psychosomatic problems<sup>9</sup>.

The purpose of this work is to present a case study, in which cognitive-behavioral therapy was used through a standard therapeutic protocol for attending a case of bereavement as a consequence of miscarriage.

## Case study

A case of bereavement with the occurrence of miscarriage (partial abortion) that had happened seven months before the first therapeutic attendance. The patient, 26 years old, married, seven months

pregnant, which had been planned and was desired. Foetal death was confirmed through an ultrasound exam requested as part of a pre-natal routine. Held immediate hospitalization for labor induction.

Regarding the procedure, the patient reported that she “tried not to think about it”, although until now she does not understand “how one can give birth to someone who is already dead”. She added that she feels very frightened of becoming pregnant again, since she “would not be able to pass through the same kind of situation again”. As she was never given a reason for the occurrence, is questioned about her possible guilt about the event and she says that “can not have any peace because of it”.

She also thinks about the amount of time that the dead foetus may have stayed within her body and gets concerned with the fact that she had been “a bad mother” because she “did not even perceive that her child had already died”.

When she went home, she could not manage to sleep properly, always thinking of what had happened. She would wake up frightened after dreaming about the images of the induced abortion. Only after three months she managed to go into the room that she had prepared for her child.

The number of arguments with her husband increased significantly. She said that she felt “demanded to be well”, but that “could not manage to feel so”. She complained of demands from her friends and relatives, to try to get pregnant again. To think of having another child “makes her anxious”, but “just recently she has been thinking about it and would like to give it a try”, but she still feels a lot of fear that the same miscarriage process “could happen all again”.

As regards farewell rituals, she said that as soon as she gave birth “they took the child away” and she never saw it. A burial was done, but her husband requested that the coffin remained closed the whole time. They decided not have a vigil, since “there was nothing to be said”. The burial was quick and just the parents of the couple attended. Nobody else was informed.

After this, “it was as if nothing had happened”. People spoke to her “as if they had not known she had been pregnant and that her child had died”. On the occasions that she had tried to bring up the subject, she was discouraged by those who were with her, since it was “a very sad subject” and “one should not think anymore about it”.

In spite of trying to plan things differently for the future and think that she “was overcoming everything” she still felt very sad and still “had visions of the small coffin” and the induced abortion scenes. At these moments the saying goes that one should pray in an effort to “obtain some relief” and due to the latter an improvement was obtained. She has tried to get close to her husband again, but does not quite know how to do it. She wants to “go ahead”, but “does not know quite how”.

## Methodology

For the evaluation of the progress obtained with the treatment, the following instruments were used: Beck Anxiety Inventory (BAI), Beck Depression Inventory (BDI) and Beck Hopelessness Scale (BHS): self-report scales that measure, respectively, intensity of anxiety, depression and hopelessness. The classification was carried out on the basis of the instrument’s manual<sup>13</sup>.

The Goldberg’s General Health Questionnaire (GGHQ)<sup>14</sup> was also used, which aims at identifying the severity of the minor psychiatric disorders, dealing with five factors: 1) psychological stress; 2) desire of death; 3) doubt about ones own performance; 4) sleep disturbance and 5) psychosomatic disorders, apart from a score regarding general health.

Twelve sessions of clinical attendance were held with one week intervals between each of them, for three months. Using the model of cognitive-behavioral therapy, through a standardized protocol developed for cases of bereavement<sup>15</sup>, is valued the learning of new cognitive and behavioral abilities that allow the patient to readapt to their life, considering the need to reformulation of roles in the family system and society.

Through the psychoeducational function, a clarification is made regarding the phases of bereavement, as well as the cognitive, physiological, and behavioral alterations considered common during this period, reducing, in this way, the levels of anxiety. The main sentiments involved in the process were approached: sadness, anger, blame, anxiety, loneliness, abandon, shock, anxiety from the presence of others, relief.

The protocol also involves the development of strategies to deal with the main somatic complaints present at this moment. Cognitive alterations and the training to handle behavioral problems were also approached. Tasks to be done at home were recommended during the whole therapeutic process.

The data was collected during the three months of attendance, while BDI and BAI were applied weekly and BHS and GGHQ were applied at the beginning and the end of the protocol.

The research participant was informed regarding the objectives, the procedures and the purpose, as well as the possible uses of the data obtained, with assurance as to privacy rights. All the presently recognized ethical procedures were followed and the study was approved by the research ethics committee.

## Results

Table 1 presents the gross results, classification of the intensity according to the applications of BDI, BAI and BHS and the results of the 5 GGHQ factors, as well as the General Health score (in percentage), for each week of the treatment.

**Table 1.** Results: BDI, BAI, BHS and QSG

Week	Baseline	4	12
BDI	36 (G)	27 (M)	18 (L)
BAI	31 (G)	24 (M)	8 (I)
BHS	9 (M)	-	5 (L)
QSG – 1	93	-	60
QSG – 2	100	-	65
QSG – 3	88	-	45
QSG – 4	100	-	79
QSG – 5	90	-	60
General Health	93	-	46

S: severe; M: moderate; L: light; I: minimum; QSG-1: psychological stress; QSG-2: desire of death; QSG-3: doubt about own performance; QSG-4: sleep disorders; QSG-5: psychosomatic disorders.

The patient presented a reduction in the indices of depressive symptoms, initially severe, becoming light at the end of the application of the protocol. At this point it is worth mentioning that concerns with health (questions 15, 16 and 20 BDI) are influenced by the medical procedure to which the patient was submitted. The item “reduced interest in sexual matters” also shows itself directly influenced by a spontaneous abortion experience, as well as its clinical handling.

There was a reduction in anxiety, especially after the initial sessions, whereby the patient reported feeling relieved for being able to speak about a forbidden subject, which is a characteristic of this kind of bereavement, as well as of the guidance and practice related to the identification and modification of dysfunctional thoughts. Furthermore, the patient undertook relaxation exercises in a continuous way, as home tasks, during the therapeutic process.

All the GGHQ factors presented reduction, with a marked decline in the percentage referring to the desire of death (100 to 65) and those of psychosomatic disorders (90 to 60). An improvement in sleep quality was also noted (a fall from 100 to 79) as in the confidence regarding the patient’s own performance (88 to 45) which was con-

sidered important, since it facilitated the patient's ability to achieve her own objectives with greater facility and to be capable of putting new objectives into practise. As a result, it once again stimulated continuity plans for a new life. Improvement in the General Health factor was also shown, which represents the severity of the lack of mental health (93 to 46).

### Discussion

Considering the lack of standard therapeutic protocols, with proven efficiency, specifically on the subject of miscarriage in literature, this study presents a clinical case with a cognitive-behavioral focus with results evaluated by means of valid and reliable measuring instruments that present good psychometric parameters. It contains adequate standards for the society in which the patient is inserted, giving evidence of the progress obtained.

The treatment showed itself effective in relation to the factors presented, besides collaborating for a better quality of life and facilitating the social reinsertion of the patient. An evolution of the patient condition showed coherence in the type of bereavement and its causes, indicating the importance of an adequate model of assistance for the particularities of these cases.

Apart from being a first step for the better understanding of the therapeutic factors used in this specific type of bereavement on the basis of objective parameters, the study collaborates with the broadening of the cognitive-behavioural therapeutic limits, opening a new field of research.

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