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The impact and the psychological dimension of gestational trophoblastic disease: a case study

O impacto e a dimensão psicológica da doença trofoblástica gestacional: um estudo de caso

El impacto y la posición psicológica de la enfermedad trofoblástica gestacional: un estudio de caso

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This is a case study carried out in a city in the countryside of São Paulo, Brazil, in 2015 with the objective of understanding the emotional impact and the coping of a patient who experienced a trophoblastic pregnancy. A non-directive interview with a therapeutic character was used in the study and the interpretation of the data was made through thematic content analysis. There were two categories: "*The mourning process*" and "*The psychic imbalance and its symptoms*". Subjective suffering was observed, as well as the extent to which a complication during pregnancy together with personal aspects related to the life history (various processes of mourning) had shaken the patient. However, there was a recovery of her mental health through psychiatric and psychological follow-up. The professional care promoted the understanding, leading to resilience and, consequently, recovering the psychic balance.
Descriptors: High risk pregnancy; Psychological stress; Spontaneous abortion; Bereveament; Psychoanalysis.

Este é um estudo de caso realizado numa cidade do interior de São Paulo em 2015, com o objetivo de compreender o impacto emocional e o enfrentamento de uma paciente em gestação trofoblástica. Utilizou-se entrevista não diretiva com caráter terapêutico e, a interpretação dos dados se deu pela análise de conteúdo temática. Evidenciou-se duas categorias: "*Processo de luto"* e, *"O desequilíbrio psíquico e seus sintomas".*Verificou-se sofrimento subjetivo e, o quanto uma complicação na gestação conjuntamente com aspectos pessoais relacionados à história de vida (vários processos de luto) fragilizaram a paciente. Porém houve resgate da sua saúde mental através de acompanhamento psiquiátrico e psicológico. Em si, os cuidados profissionais promoveram a elaboração, levando aresiliência, com isso, o reequilíbrio psíquico.
Descritores: Gravidez de alto risco; Estresse psicológico; Aborto espontâneo; Luto; Psicanálise.

Este es un estudio de caso realizado en una ciudad del interior de São Paulo, Brasil, en 2015, con el objetivo de comprender el impacto emocional y el enfrentamiento de una paciente en gestación trofoblástica. Se utilizó una entrevista no directiva con carácter terapéutico y, la interpretación de los datos se dio por el análisis de contenido temático. Se evidenció dos categorías: "Proceso de luto" y, "El desequilibrio psíquico y sus síntomas." Se verificó sufrimiento subjetivo y, el cómo una complicación en la gestación conjuntamente con aspectos personales relacionados a la historia de vida (varios procesos de luto) fragilizaron a la paciente. Sin embargo, hubo rescate de su salud mental a través de acompañamiento psiquiátrico y psicológico. En sí, los cuidados profesionales promovieron la elaboración, llevando la resistencia, con eso, el reequilibrio psíquico.
Descriptores: Embarazo de alto riesgo, Estrés psicológico; Aborto espontáneo; Aflicción; Psicoanálisis.

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INTRODUCTION

Gestational trophoblastic diseases are a group of disorders of placental development known as hydatidiform mole. Hydatidiform mole (HM) is a complication of pregnancy with a potential for evolution to disease with malignant behavior and occurs in a proportion of one case for 1,000 to 2,000 pregnancies in the West[1]. A Brazilian study, based on hospital care in a single center, indicates the proportion of 1 HM to 215 pregnancies[1].

Two types of HM are recognized: complete (CHM) and incomplete or partial (PHM). They differ in morphological (macroscopic) aspect, histopathology and karyotype. These chromosomal abnormalities cause the early loss of the embryo and excessive proliferation of trophoblastic tissue; in the CHM, the egg has no active nucleus, so that the genes are of paternal origin and there is no fetus.

In PHM, the embryo is present, but it is usually non-viable or presents several malformations resulting from the fertilization of a normal secondary oocyte by two spermatozoids or one diploid spermatozoid[1].

Molar pregnancy usually begins with the signs of a normal pregnancy. However, the most common symptom is the presence of transvaginal bleeding as a dark secretion[2].

The diagnosis is confirmed by ultrasonography showing the uterus filled with small, round, dark areas resembling a bunch of grapes in the CHM. In PHM, the placenta is thickened with a gestational sac and/or embryo, dead or alive. Once the diagnosis is confirmed, the uterus must be emptied as soon as possible through a surgical procedure, under general anesthesia[2].

After uterine emptying, 80% of patients with CHM and 95% of those with PHM progress to healing without the need for any other treatment[2].

However, the remaining percentage will not have the hCG levels normalized, requiring other treatments to prevent more serious consequences. The problem is when abnormal placental tissue resumes growth; in this case, it can be said that the patient developed a gestational trophoblastic neoplasia[2].

Women with molar pregnancy should periodically go to a health service to be examined for spontaneous evolution or remission or if she will need treatment to achieve cure (remission after treatment)[2].

During follow-up, it is expected that patients do not become pregnant, because it is not be easy to differentiate the new pregnancy from the evolution to the trophoblastic neoplasia. Persistent or increasing levels of hCG are indicative of persistent trophoblastic tissue and of malignant transformation of this trophoblast, that is, an indication that gestational trophoblastic neoplasia is established[2].

The neoplasm may be an invasive molar, a choriocarcinoma, a placental trophoblastic tumor, or an epithelioid trophoblastic tumor. After examination is made, the neoplasm stage is determined and characterized by a physician[2].

With regard to chemotherapy, it is impossible to predict the total number of cycles; that depends on the peculiarities of each patient and several factors.

After completing the follow-up (six months of normal hCG levels in cases of spontaneous remission and 12 months of normal hCG levels after chemotherapy ends), the woman may become pregnant if she so desires, but there is a very small possibility of 1 to 2% of a new molar gestation[2].

In the psychological dimension, it is noted that psychological suffering is inevitable because all the biopsychic conditions indicate the possibility of being pregnant. However after the diagnosis of HM, the woman faces a complex disease, subject to progress with malignant potential, and has to go through a surgical procedure and deal with the loss of the real or imagined baby.

The diagnosis of HM causes a great impact on the woman and her relatives, for it is a serious, unknown disease, of low incidence in the population. Women who go through this experience are subjected to the stress of pregnancy loss, surgical procedure, possible chemotherapeutic treatment and delayed reproductive plan until complete remission[3].

Molar pregnancy can have an impact on the emotional state, the sexual and reproductive life, and the quality of life of women. It may trigger in some cases depressive symptoms, so that psychological intervention is necessary because this approach contributes to the confrontation and understanding of the diagnosis and the treatment, as well as to the elaboration of mourning related to gestation, reducing the level of anxiety, stress, fears and fantasies of the patient before the disease[3].

Considering the lack of studies in the psychological dimension, this study aims to understand the emotional impact and the confrontation of a patient with the trophoblastic pregnancy.

METHOD

This is a case study that represents a means to understand and explore the meaning that an individual attributes to a social and human problem[4].

Qualitative methods consider the subjectivity of the participant and of the researcher, the impressions, attitudes, irritations; all these aspects become facts and part of the interpretation[5].

The research strategy consists in a single case study from which a deep exploration of an individual is made[4]. The case is chosen by the researcher through attributes considered important for the study[6].

The research was carried out in the second half of 2015 with a patient in a specialized outpatient clinic in a city in the countryside of São Paulo, through a semi-structured interview previously scheduled and carried out at the health service.

The guidelines of Resolution 466 of 12/12/2012 was followed, and the person researched was given a fictitious name for protection.

Data were analyzed in depth through thematic content analysis[7], in which the first step is called pre-analysis and involves a quick reading for familiarization with the material.

The next step, called data analysis, involves the exploration and treatment (categorization/sub-categorization) of the material and later the presentation and interpretation of the results, with the aim to reach a deeper understanding of the content of the messages[7].

RESULTS

The participant "Valentina" was 30 years old, married, with 2 children, and was enrolled in the High Risk Pregnancy Care Service in a city in the countryside of São Paulo, where she was treated in the outpatient clinic because of the occurrence of a gestational trophoblastic disease of the type complete hydatidiform mole.

At first, the participant explained why she had been referred to the outpatient clinic:

I am doing a treatment that will take a year, I had a molar pregnancy and I want to get pregnant again, but first I need to do this treatment.

The reason for the discontinuation of her gestation due to the occurrence of a molar pregnancy, and her history in relation to her previous pregnancies, are described as follows:

Before the molar pregnancy, I had an ectopic pregnancy and as a consequence I had to remove a tube, underwent curettage to remove the fetus, at the same time my mother-in-law died and soon after that, my brother-in-law, who was a drug user, he also died. After the death of my mother-in-law, I think my brother-in-law missed her so much, and then he started to get into drugs, and he died during a fight on the streets, you know, it was very sad...

The patient also reported that three losses had occurred one right after another: the gestation, and the death of her mother-in-law and of her brother-in-law.

With regard to mourning related to the loss of the baby, she had been asked whether she externalized her feelings to her husband about the loss of the baby:

Oh, I did not say anything, do you know why? My husband was very shocked with the loss of his mother and brother too; I did not want to cause him any more pain. He was already very sad, so I would not even tell him that it was difficult for me to lose the baby. When I lost my baby, they put me along with the mothers who had just won baby, I thought was a great carelessness of the hospital to do this with me, put the mothers who lost their children along with the other women in the maternity. When I heard a cry of a child, I wanted to cry together.

Regarding the discovery of the diagnosis, she said:

I went to do the exams and brought my two children, I wanted them to see the ultrasound, but during the consultation the physician told me that I had to be sent as soon as possible to the hospital and that I would have

to remove the fetus, the tubes and the uterus, I did not even know the reason, my world collapsed, I started crying desperately and my poor children were very scared, I left them at home and went straight to the hospital. When I got to the hospital, the physician came with anesthesia, I was so afraid, but so afraid, that I would not let him apply the anesthesia, so they put a sedative in the serum, and that made me lose my strength, it was only so that they applied the anesthesia.

Valentina commented on the last sentence she told the physician:

Don't let me die, and then after I woke up from the surgery I asked to see my baby, what they had taken. When asked about what she saw, she said, *"Ah, it was not a baby, you know. It didn't have a face. Nothing. I saw a lot of springs, you know, several little springs, like a bunch of grapes.* (...) *It scared me, that was in the third month, and thank God the physicians said they did not have to remove the uterus or the tubes, and everyone in the hospital wanted to know about my case, because they said who had a rare disease that occurs one in every thousand...*

When asked about how she felt after this "fright", she reported:

Then, after all that happened, I started to have depression, I did not sleep at night, when I watched some news that the parents killed their children, I stayed awake up all night thinking that my husband was going to kill my children, or when I saw a spider on the TV I would start thinking the spider was real; can you believe once I couldn't sleep for eight days? These things I would only feel at night, you know, during the day I was okay. (...) *Then I started taking medicine, Clonazepam and Sertraline, and then I started to sleep again, and I was sent to psychotherapy, and I've been going to therapy for five months now; now I'm better. There's one thing: I do not feel like having sexual intercourse with my husband, you know, I think as I did curettage many times, my uterus became very sensitive and I do not know why I don't have desire anymore, but it must be because of this ...*

Despite these events, the patient still had the desire to have another child. She say:

I still want to get pregnant again, try again, in my other pregnancies, my children had even already chosen the baby's names.

When asked how psychotherapy could help her cope with these difficult times, she replied:

So I would leave feeling lighter, less distressed and less confused, you know, I even wanted to talk more with my mother, tell my problems to her, but I do not want make her worry, and with the psychologist is different. I know I can say everything but I know I'm feeling like I'm going to stop taking medicine and therapy too, I feel much better already.

At the end of the interview, Valentina pointed out that these events made her a mature person, and she smiled.

DISCUSSION

Two thematic categories emerged from the speeches, namely: *"The mourning process"* and, *"The psychic imbalance and its symptoms"*.

In the first category, the "*The mourning process*" experienced by the pregnant woman clearly showed how much the process of going through loss is complex and painful. After fetal death, the lack of encouragement to parents to talk about what happened and the absence of memories of the child are common and cause a feeling of unreality and emptiness[8].

Because Valentina had no one to share her grief with, there was no room for the elaboration and externalization of her pain. It is important to encourage the mourner by offering emotional support and allowing them to freely express their feelings, because when there is no room for elaboration, mourning can be ill-resolved, causing moments of anger, melancholy and episodes of strong emotion when remembering the loss[9].

Because mourning is a subjective experience, bereaved families need to be embraced, cared for, and respected in their particularities. Mourning can only be successful if the mourners are supported for as long as they need to live the feeling of loss, respecting their own rhythm. This is the only way to recreate reality[10].

The participant was also experiencing a process of family grieving (death of the mother-in-law and the brother-in-law) and the process of her interrupted gestation. She was, therefore, vulnerable; besides the fact that the pregnant woman and her husband did not have the necessary support, the whole family was suffering.

When grieving individuals are close to the people who love, embrace and share their suffering, they are able to accept his compassion and restore harmony in their inner world, so that fears and pain dissipate more rapidly. Although the participant's husband shared the same pain, the two were frail and emotionally destabilized.

The condition of the woman after the spontaneous abortion was of great emotional instability. Bearing the pain of having lost a child in contrast with the pregnant women

who had a successful pregnancy is a hard and painful. This experience was lived as being an exposure of her pain and her "failure", in view of the non-continuation of gestation.

The loss of a baby is a delicate and painful emotional experience. When such bereaved women find themselves in a maternity ward surrounded by pregnant women, puerperal women and newborn babies, the mother feels the sensation of leaving the maternity ward without her child in her arms.

The inability to become a mother tends to lead women to an interpretation of an inadequate femininity, with feelings of failure, incompetence and a low self-esteem, because it was an affective investment that ended abruptly. Expectations, desires, dreams, and fantasies existed, often before pregnancy, and in these cases, such feelings are abruptly frustrated[9].

However, we must remember that the intensity of suffering caused by the loss depends on the degree of emotional investment during pregnancy. Many women report that they are no prospects. They say losing a parent means to lose the past, but losing a child means losing the future[9].

The development of mourning consists of a delicate psychic movement. In cases of fetal death, contact with the real baby is only glimpsed through the ultrasounds; the lack of concrete contact makes it difficult the development of mourning the loss of the imaginary son.

This leads to a contradictory situation evoked by the intense psychic investment during pregnancy and immediate disinvestment after the announcement of death. What is lost is a virtual object, and this is lived with much ambivalence[8].

The second category entitled "*The psychic imbalance and its symptoms*" brings understanding about the patient's mental condition before the traumatic events.

It is possible that the patient developed depression with psychotic symptoms, delusions and hallucinations that came as a defense of the ego and an attempt to framing her experiences. It was also noted that the symptoms were manifested with greater intensity during the night; as this period of the day external stimuli are diminished and silence is greater, it provided a moment of subjective encounter of the woman with herself. Depression is a common consequence in patients who undergo spontaneous or induced miscarriages[9].

The loss of a child opens up a "hole", a narcissistic wound that leads mothers to severe melancholic pictures. It is common in the first moments their reluctance to get out of bed, not even to eat or bathe[14].

In view of the intensity of the events, the woman became incapacitated and had few resources to deal with countless losses and sufferings. With time and psychotherapy, she managed to regain strength.

Symptoms do not always cause negative consequences; they often work as a defense and a resource of the ego for the understanding of traumatic events.

The non-acceptance of the grieving process often extends for too long and can cause some diseases such as "melancholy", synonymous with depression. The non-internalization of the process of loss causes the person to remain attached to the past reality[15].

Mourning is a reaction to loss and not a pathological condition, so that it can be overcome after a lapse of time. However, in some people the same influences can produce melancholy, and this indicates a pathological predisposition to depression[13].

The mental features of melancholy are profoundly painful discouragement, lack of interest in the outside world, loss of the capacity to love, inhibition of all sort of activity, and decreased self-esteem as to finding the expression in self-recrimination, self-insults, self-criticism, culminating in a delirious expectation of punishment[13].

During mourning, it is the world that becomes poor and empty; in melancholy, it is the ego itself that impoverishes[13].

Creativity is important in the development of mourning. It is only by means of it that it is possible to re-signify the loss and its feelings[10].

The use of creativity allied with family and social support allows reality to be fed, so

that the pain does not prevent the capacity to carry on with life[10].

Klein[11] stresses that when suffering is lived to the fullest and despair reaches its peak, the individual sees his love for the object grow again, and he discovers that the beloved object can be preserved within him.

At this stage of mourning, suffering becomes productive, for painful experiences stimulate sublimation, and often awaken new skills, which start to be developed, as for example painting, writing[11].

In turn, other people manifest their creativity in another way. They expand their ability to appreciate reality, becoming wiser and more tolerant in their relationships with others.

It can be observed that after Valentina underwent a psychiatric and psychotherapeutic treatment, her symptoms were minimized and she rediscovered her mental balance.

Psychoanalysis can then offer a place of listening to the suffering of mothers who lose their child, so that they do not fall completely as victims, but rather that they contain their pain and promote an encounter with internal resources so as to "return" from death toward life.

But this requires patience because it is a delicate, long-term work that involves affective listening of her experiences of death[15]. In this context, we can think that it by embracing her experiences, identifying and giving way to her astonishment, that the patient finds structure and resumes the investment to return to life.

CONCLUSION

The patient underwent a series of steps of mourning. She had had two spontaneous abortions, one caused by an ectopic pregnancy and the other by a molar gestation. And in addition, she had gone through the loss of two family members, also causing mourning (her mother-in-law and her brother-in-law). These losses culminated in psychic imbalance.

The elaborations resulted in pathological mourning, mainly due to the lack of time to understand so many losses, besides the desire to have another child with the objective of breaking with the void left by a discontinued gestation and due to another dream, that failed to become true.

Psychiatric and psychotherapeutic care was essential at this critical situation enveloped by harsh losses and impacting situations.

Because this was a study of a single case, it is not possible to generalize the results; the confrontation of other pregnant women with similar situations may be different. Thus, we suggest that further research be conducted in future to expand the theme for both quantitative and qualitative aspects.

However, this study brings a contribution in a scenario where there is few works reporting the psychological aspects experienced by women with molar pregnancies.

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CONTRIBUTIONS

Gabriela Souza Granero was responsible for the design of the study, data collection, analysis and writing. **Irma Helena Ferreira Benate Bonfim** participated in the supervision of the study and revision of the article. **Álvaro da Silva Santos** worked on the writing and review of the article.

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