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The Effect of Group Counseling on Perceived Social Support and Mental Health of Women with a History of Failed Pregnancies

Abstract

Losing a pregnancy is a tragic event and causes the parents to lose emotional connection with their fetus and has side effects on their psyche, complicating their personal and social problems and can continue in the next pregnancy and cause fear. Loss of re-loss, frustration, disability, lack of self-confidence, and isolation in the mother. The main purpose of this study is to the effect of group counseling on the perceived social support and mental health of women with a history of a failed pregnancy. (15-45 years) is a non-pregnant woman referred to comprehensive health centersThe results showed that with the implementation of a group counseling program, although in the variables of physical syndrome, social dysfunction syndrome, depression syndrome and mental health in the experimental group before and after There was a significant difference in the intervention(table5), but according to the control group and the test results, it should be acknowledged that the group counseling program did not affect mental health, and its subscales(table4). Social support perceived by mothers with a history of failed pregnancies can be used to improve mental health in pregnant women. Ray took an important step in losing them and increasing their perceived social support.

Keywords: *Group counseling, Perceived social support, Failed pregnancy, Mental health, Women*

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Introduction

One of the natural desires of human beings is to have children and for the offspring to survive, which is a natural and biological phenomenon, in addition to being related to physical health. It is also closely related to mental health (Golshani et al., 2014). Pregnancy and motherhood are considered to be pleasurable and evolutionary events for women and include physiological changes and adaptations and psychological adaptations. This period, which often brings joy to parents, can be stressful for some women and a shock when it fails (Gravensteen et al., 2012). Losing a pregnancy is a heavy experience that changes a woman's perception of herself and can be considered a weakness and a source of stress that is often associated with psychological consequences (Bhat and Byatt, 2016). The desire to have a child is one of the most basic human motivations, and if the attempt to conceive fails, it can turn into a destructive and stressful event and lead to impaired mental health (Mosayeb Moradi, et. al., 2016).

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Annually, 15-12% of clinically known pregnancies are lost due to factors such as abortion, stillbirth, ectopic pregnancy, nulliparous pregnancy, and molar pregnancy (Chojenta et al., 2014), and 20 to 50% of pregnancies are aborted. The fetus or loss of pregnancy ends before 20 weeks of gestation (Markin, 2017). And about 1-2 out of every 100 births after 20 to 25 weeks lead to fetal death. Intrauterine death rates are 5 per 1,000 live births in developed countries and 36 per 1,000 live births in developing countries (Choudhary and Gupta, 2014). 3% of all pregnancies have significant abnormalities, with 58% to 98% terminating due to fetal abnormalities (Coleman, 2015). Fetal loss due to stillbirth, abortion, or termination due to fetal malformations as a traumatic event in life is known (Kersting et al., 2013)

Although pregnancy accidents are a relatively common occurrence, most parents who experience the storm of pregnancy loss try to recover from the event. For some families, this condition remains stable and severe and creates a new identity for them that arises from their grief (Gold et al., 2014). The importance of psychological changes following the loss of a fetus or infant has been demonstrated in several studies (Kolte et al., 2015).

A history of miscarriage may cause a negative experience in pregnant women, which in turn can lead to severe anxiety and depression in the next pregnancy. It can even cause psychological resistance in some women to accept a new pregnancy. (Mills et al., 2016) Bellieni et al. (2013) showed that abortion alters women's mental health by increasing levels of anxiety and depression. Psychological symptoms are associated (Bellieni and Buonocore, 2013) The rate of depression in the first two weeks after abortion was 42.1%, which after 26 months to 26.8% and after one year to 9.8% Will arrive (Hajnasiri et al., 2016). Gold et al. (2016) reported in a California study of 900 women, including 242 women with a history of live births and 377 women with a history of miscarriage, that the rate of depression in women with a history of miscarriage was 4 times Post-traumatic stress disorder was 7 times more common than women with a live birth history (Gold et al., 2016)

Anxiety and depression after experiencing fetal or infant loss can not only negatively affect the focus on the new pregnancy process, but can also affect important psychological processes such as maternal and fetal attachment that peak in the third trimester of pregnancy. (Gravensteen et al., 2018).

Various studies suggest that long-term missed pregnancies lead to increased stress in life and personal relationships, and marital problems. This is a devastating event in the family and its psychological effects can affect other children in the family and create a stressful environment. (Allahdadian et al., 2016) Longitudinal studies over two decades have shown If a person has a mild to moderate mental disorder, it has adverse effects on mother and child, and premature delivery and low birth weight, delayed growth, and poor mental health in the child are among its complications (Kingston et al., 2014)

The process of losing a pregnancy can lead to prolonged mourning and take a long time to return to normal, with less attention being paid to these women and their needs, both before and during the next pregnancy. Most of these women become pregnant again within 18 months without addressing their psychological and emotional issues, on the other hand, these complications affect not only women but also their partners (Gold et al., 2016). . If parents are not ready for the next pregnancy and are still in shock of losing the previous pregnancy, they will still be afraid of failing in the pregnancy (Boyle et al., 2015). This sudden and unexpected phenomenon may cause the person not to receive the necessary support from family and others, and even in societies with a low cultural level, the mother is blamed (Lok et al., 2004), which can have adverse effects on the mother's mental health. One of the most important factors affecting mental health is the amount of social support perceived or received by the mother (Riahi et al., 2008). Social support to obtain information, and assistance Emotional perception is referred to by others and through supportive social networks (Schwarzer et al., 2003). Evidence suggests that expressing support is an essential component of good mental and physical well-being and may help women strengthen their role and ability to adapt to postpartum life against stressors. Maternal social support during this period is a factor that reduces the effects of stress and enables the individual to deal effectively with stressful situations. Perceived social support for pregnant women can help improve healthy behaviors during subsequent pregnancies and prevent complications from anxiety, preterm delivery, low birth weight, and fetal brain development disorders (Sigalla, et. al., 2017). Numerous studies have shown that receiving social support from others reduces the psychological effects of stress and improves the situation (Adl, et. al., 2016). Social support is one of the important factors inhibiting the negative effects of stress and can act as a facilitator of coping with stress (Rad, et. al., 2011).

Theoretical studies and colleagues showed that 43.6% of pregnant women were suspicious of mental health. The highest mean scores were related to social dysfunction (7.81%) and the lowest was related to depression (2.86%) (Nazari et al., 2014). Studies by Allah Dadian (2016) have shown that insufficient support and training by healthcare professionals and the increasing need of these women to receive family support during this difficult period indicate a gap in this area that needs to be studied. Shows more (Allahdadian et al., 2016). In some countries, methods such as observing and embracing a dead child, taking a picture of a child, and performing a funeral service have been adopted to support bereaved parents (Huberty et al., 2018). There are various methods to reduce the symptoms of mental disorders in women with missed pregnancies, such as psychotherapy, medication, relaxation, semantics, film therapy, and electric shock (Hajnasiri et al., 2016). Mental health problems are identified with anxiety and depression. Counseling programs can help reduce psychological complications in women with missed pregnancies (Kingston et al., 2014) Caring for women who are at risk for anxiety. Their counseling and referral for more advanced diagnosis and treatment can reduce maternal and neonatal complications in addition to improving quality of life (Neisani Samani et al., 2016). Group counseling is a type of counseling in which one or sometimes two counselors are performed with approximately 8 to 10 participants. This method focuses on problems that are at the level of clients' consciousness (Moharrami et al., 2017). Although counseling can be done individually, group counseling, in addition to being cost-effective, can provide the necessary sense of security to interact spontaneously and freely with group members and reduce the patient's fear and anxiety due to a lack of awareness. And receive sufficient information about the disease process (Jahan Bakhshian and Zandi Por, 2011).

It is important to pay attention to the factors threatening mental health in women as a social and psychological issue. Bellieni CV(2013), Abortion and subsequent mental health: The risk that abortion may be correlated with subsequent mental disorders needs a careful assessment, in order to offer women full information when facing a difficult pregnancy. All research papers published between 1995 and 2011, were examined, to retrieve those assessing any correlation between abortion and subsequent mental problems. A total of 36 studies were retrieved, and six of them were excluded for methodological bias. Depression, anxiety disorders (e.g. post-traumatic stress disorder) and substance abuse disorders were the most studied outcome. Abortion versus childbirth: 13

studies showed a clear risk for at least one of the reported mental problems in the abortion group versus childbirth, five papers showed no difference, in particular if women do not consider their experience of fetal loss to be difficult, or if after a fetal reduction the desired fetus survives. Only one paper reported a worse mental outcome for childbearing. Abortion versus unplanned pregnancies ending with childbirth: four studies found a higher risk in the abortion groups and three, no difference. Abortion versus miscarriage: three studies showed a greater risk of mental disorders due to abortion, four found no difference and two found that short-term anxiety and depression were higher in the miscarriage group, while long-term anxiety and depression were present only in the abortion group. In conclusion, fetal loss seems to expose women to a higher risk for mental disorders than childbirth; some studies show that abortion can be considered a more relevant risk factor than miscarriage; more research is needed in this field.

Theoretical foundations

Badari failed

A miscarriage means the loss of a pregnancy product (fetus or embryo) for a variety of reasons: The abortion means the termination of the pregnancy before 20 weeks of pregnancy, if it occurs spontaneously, it is called a spontaneous abortion. Ashtari Mahini and changing the very old source of colleagues, 2013).

The importance of mental health in pregnancy

Pregnant women frequently face underestimated and yet unprecedented changes that occur in their lives, relationships, and bodies as they move toward parenthood. These changes can be challenging enough in a “normal” pregnancy and even more so in the face of depression, unresolved grief or loss, domestic violence, isolation, and other mental health issues. Professionals who work with pregnant women often see the need to provide emotional and psychological support to mothers to help establish the mother–child relationship on a solid foundation. Until now, very little has been done to help professionals understand how these other psychological and emotional factors compound the challenges mothers face during pregnancy and what actions and interventions may help (Spietz A 2002).

Lack of information or incomplete and incorrect information about pregnancy and its changes can endanger the mental health of pregnant women. Psychological disorders cause the mother to not pay enough attention to prenatal health and primary care, change eating habits, and resort to smoking, drugs, and harmful drugs that increase the risk of preterm delivery, low birth weight, and even abortion and can cause symptoms such as fatigue. Drowsiness or insomnia, anxiety, increased heart rate, high blood pressure, overeating or anorexia, headache, dizziness, tremors, back pain, recurrent vomiting, upset stomach, constipation, frequent urination, changes in sexual activity or sometimes heart, gastrointestinal, respiratory diseases, Skin, reduce resistance to infectious diseases (Rezaian Langroudi et al., 2014)

Perceived social support

Definition of social support

Social support has been defined as the level of love, assistance, and attention of family members and other individuals (Nasiri et al., 2016). Social support is defined in terms of the existence or availability of people who can be relied on. People who are known as caring, valued, and loved are friends, acquaintances, and family who provide objective services and information that make a person feel cared for loved, valued, and valued. To be slow and feel that it is part of the communication network (Tahmasbipour, 2012).

Social support is divided into two dimensions, which are structural social support and functional social support. Structural aspects refer to the position of the individual in the social structure. For example, participating in social organizations, maintaining social connections, and immersing oneself in close social networks. Such structural situations may increase the likelihood of access to support and resources and provide a protective function against adverse living conditions (Lee, 2019).

Researchers categorize the concept of social support into five categories: emotional support, evaluative, instrumental or tangible, information, and networks (Sarafino, 2019). Emotional support includes love and affection from a spouse, family member, or close confidant. Emotional support includes verbal and non-verbal communication, attention, and concern, and reduces confusion and anxiety by restoring self-esteem and the possibility of emotions. Information support is related to providing advice, information, or guidance. Information support includes providing information for guidance and advice that promotes perceptions of control by reducing confusion and providing strategies for dealing with problems in patients (Kaladi and Salahshouri, 2012).

Value support is related to expressing respect, encouragement, or agreement with a person's views or feelings, and a positive evaluation of a person compared to those who are worse off makes him or her feel valued, worthy, and credible. Value support is especially useful when assessing stress. Material relationships include direct help to the individual, such as doing housework or giving money and networking, giving the individual the feeling of belonging to a group with common interests and activities (Sarafino, 2019).

Research records:

A 2016 study by Gold et al. Conducted a longitudinal study of depression and post-pregnancy stress symptoms in Michigan, California. 900 eligible women were selected and 609 of them announced their readiness. 377 mothers experienced pregnancy loss and 242 women with a live birth history of mental health including symptoms of depression, post-traumatic stress disorder, pregnancy and experience of pregnancy loss, social support, and past and present treatment. Demographic status was assessed. Inclusion criteria: Women over the age of 18 who spoke English, and reported at least one case of prenatal pregnancy loss (from the 20th week of pregnancy to 28 days postpartum), were the results of this study. Showed that women with a history of pregnancy loss were 4 times more prone to depression and 7 times more likely to suffer from post-traumatic stress disorder than the general population. On the other hand, the results showed that women with high stress are less treated and are more likely to be anxious and depressed in these women who are already pregnant (Gold et al., 2014).

A 2014 study by Cheng ER et al, The Influence of Antenatal Partner Support on Pregnancy Outcomes Data were from 1764 women recruited from an urban-suburban group practice (Project Viva) and 877 women from urban community health centers (Project ACCESS), both in the Boston area. Antenatal partner support was assessed by the Turner Support Scale. Multivariable linear and logistic regression analyses determined the impact of low antenatal partner support on the outcomes of interest. In early pregnancy, 6.4% of Viva and 23.0% of ACCESS participants reported low partner support. After adjustment, low partner support was cross-sectionally associated with high pregnancy-related anxiety in both cohorts (Viva AOR 1.8; 95% CI: 1.0-3.4 and ACCESS AOR 1.9; 95% CI: 1.1-3.3) and with depression in ACCESS (AOR 1.9; 95% CI: 1.1-3.3). In Viva, low partner support was also related to depression mid-pregnancy (AOR 3.1; 95% CI: 1.7-5.7) and to smoking (AOR 2.2; 95% CI: 1.3-3.8). Birth weight, gestational age, and fetal growth were not associated with partner support. This study of two economically and ethnically distinct cohorts in the Boston area highlights higher levels of antenatal anxiety, depression, and smoking among pregnant women who report low partner support. Partner support may be an important and potentially modifiable target for interventions to improve pregnancy outcomes Cheng ER(2016).

The results of this study showed that with increasing social support, health behavior becomes more appropriate. This study was used to express the problem and discussion. A 2014 study by Chojenta et al. in Australia aimed to determine the impact of a failed pregnancy on women's mental health during pregnancy and postpartum. The data came from a large study in Australia called the ALSWH Women's Longitudinal Health Studies. In this study, data from 8200 women aged 31-36 years were used. For 1811 women who gave birth from 2009 to 2011, had a live birth and 12 months had passed since the birth, an invitation was sent to 584 people (178 people with a history of Pregnancy loss and 406 people without a history of pregnancy loss) responded positively to the invitation. Criteria for emotional assessment during pregnancy and postpartum were as follows: These individuals were asked to answer the following questions: During the first or second half of pregnancy, 3 months after birth, and 12 months after birth? The child has experienced symptoms such as anxiety, depression, stress or anxiety, sadness and low mood, decreased interest or enjoyment of doing something, guilt, or excessive worry. The results of the study showed that a previous history of a failed pregnancy was associated with a higher risk of mood disorders as well as a greater experience of anxiety disorders in the new pregnancy. These results indicate that pregnant women who have had a failed pregnancy experience are vulnerable as a population during subsequent pregnancies (Chojenta et al., 2014).

A study was conducted by Allahdadian et al. In 2016 a qualitative content analysis approach was to explain the strategy for improving the mental health of Iranian mothers with a history of stillbirth in Isfahan. The participants of this study were 20 pregnant women who were included in the study by purposive sampling method and were interviewed semi-structured. Due to the importance of maximum diversity in qualitative research sampling, participants were selected from different ethnic groups and different socio-economic conditions. Participants were invited to the project through files in health centers and by telephone. In the case of individual consent, written consent was obtained. In-depth semi-structured interviews were conducted based on the purpose of the study. Inclusion criteria included the willingness to participate in the interview, a history of at least one stillbirth in the medical record, and no history of mental illness. Data were recorded and analyzed by interview for 30 to 60 minutes. The data obtained from this study were analyzed by content analysis of the Lundman and Granehiem model. The results of this study showed that the provision of family care by healthcare providers is ignored. The need for family education and how families treat mothers is felt. Regular care training reduces maternal stress in future pregnancies. Healthcare providers pay more attention to the physical dimension and the psychological and counseling aspects are ignored (Allahdadian et al., 2016). The above research has been used to express the problem and the need to implement the plan.

A study conducted by Haj Nasiri et al. In 2016 intending to determine the effect of counseling on depression and anxiety

after legal abortion in Kosar Qazvin Medical Center during 2013-2014 was a quasi-experimental study in which 120 licensed pregnant women Legal abortions were selected by available and purpose-based methods. The intervention group was trained in an emotional cognitive-behavioral intervention program by a midwife. Individual and face-to-face counseling is provided for 30-45 minutes, one session before an abortion, and weekly telephone follow-up for up to 8 weeks. Both groups were assessed by Beck Depression Inventory and Beck Anxiety Inventory before the intervention. The members of the intervention group were consulted face to face during a 30-45 minute session. The results were cognitive and emotion-oriented. The results showed that the mean score of anxiety before the intervention in the intervention and control groups were 5.11 72 72.24 and 67.12 76 76.22 and P = 0.412, respectively. Two months after the intervention, the mean anxiety score of the intervention group was 70.1 10 10.1 (p <.0001) and reached 76.7. 11.66 (p <.0001) in the control group. The mean score of depression before the intervention of the two groups was not homogeneous (p = 0.028), so the mean difference in the reduction of depression score in the intervention and control groups was calculated and the difference in depression between the intervention and control groups was significant (p = 0.0001). ± 6/89, 12.56 64 64.9 (Hajnasiri et al., 2016). Given that the level of family support for mothers after abortion varies in different families, this can affect the extent and severity of depression and anxiety. The intervention in this research is telephone follow-up, and this research will be face-to-face. This study was used in the research discussion and problem statement.

Research Method

The present study is a quasi-experimental study of pre-test-post-test with the control group and follow-up. In this study, mental health and perceived social support are considered dependent variables and group counseling intervention is an independent variable. This follow-up was performed immediately and 6 weeks after the intervention. The study population of all women with a history of failed pregnancy (15-45 Years) and non-pregnant women referred to comprehensive health centers who have obtained a score above 23 on the mental health test. Inclusion criteria are 15 to 45 years of age, no child, no literacy, and no known physical or psychological illness according to Ms., not taking psychotropic drugs, obtaining a score of 23 and above on the mental health questionnaire. The exclusion criteria are unwillingness to continue to participate in the study and the occurrence of an unfortunate accident in the life of the person during the study,

which leads to anxiety and depression. The occurrence of severe family disputes during the study is the absence of more than two training sessions in the intervention group. The sample size in each group was calculated as 31 people, taking into account a 10% drop in sample size in each group of 34 people. This standard deviation was obtained based on a study by Golshani et al. titled "The effectiveness of life skills training during pregnancy on the mental health of pregnant mothers." At first, from the file in the health centers and bases of the community northwest of Tehran under the auspices of the Iran University of Medical Sciences, people with research criteria are identified and eligible people are invited to participate in the study by phone. After completing the informed consent form, these individuals will be assigned a 4-item randomized block allocation method and will be divided into two groups: group counseling and control, and the group will be determined before the intervention.

Research tools: Mental Health Questionnaire and Scale Questionnaire Social support is understood. The Mental Health Questionnaire Health Questionner-GHQ General was designed by Goldberg and Hiller in 1979 to screen for mental disorders. This questionnaire consists of 25 questions in the form of 4 subscales, each subscale of which has seven options. These subscales include physical symptoms, anxiety, social dysfunction, and depression. The Perceived Social Support Scale for Friends and Family is a questionnaire for measuring perceived social support from friends and family, published by Heller and Procidano. Is. This questionnaire consists of two separate sections, each section has 20 questions. . After explaining the objectives of the study and the method of work and attracting the participation of women, informed and freely informed consent was obtained. Then, by completing the GHQ-28 questionnaire, in case of obtaining a score of 23 and above, individuals with mental health disorders were selected and divided into two groups of control and intervention as a randomized block allocation method. In this study, 70 women with unsuccessful pregnancies were assigned by quadruple random allocation method in two groups of control (n = 34) and intervention (n = 34). Then, the demographic information form and social support questionnaire were perceived in both groups by interview. And the intervention was completed. The intervention was performed in a counseling room away from the noise and a place of 20 square meters.

Interventions were conducted in 6 sessions of 60 to 90 minutes by the researcher once a week. Meetings in groups of 8 people were conducted based on valid and valid educational content. To prevent information leakage between the control and intervention groups, educational interventions were held on even days of the week, and participants in the control group received the necessary training on breast and cervical screening. At the end of the sixth counseling session, the questionnaires were completed again by the intervention and

control groups. 6 weeks later, during the follow-up period, both groups completed the mental health and social support questionnaires again and provided the educational content booklet to the control group. SPSS software version 16 was used for data analysis. In this study, descriptive statistics (frequency, frequency percentage, mean and standard deviation) were used to analyze the data, as well as inferential statistics (Chi-square, Fisher's exact, independent t-test, repeated measures analysis of variance, Bonferroni test)

Data Analysis

Descriptive findings

Objective 1: "Determining and comparing perceived social support of women with a history of failed pregnancy before, immediately, and 6 weeks after intervention in control and intervention groups"

Table 1- Comparison of perceived social support of women with a history of failed pregnancy before, immediately, and 6 weeks after intervention in the control group

after 6 weeks		Immediately after		before		Time Social support Understood
percent	Abundance	percent	Abundance	percent	Abundance	
2/9	1	2/9	1	11/4	4	Weak (7-0)
8/6	3	14/3	5	11/4	4	Medium (14-8)
88/6	31	82/9	29	77/1	27	Intense (more than 14)
100	35	100	35	100	35	total
±82/16 2/82		16/3±32/22		15/21 ± 4/30		Standard deviation ± mean
F= 3/29 P =0/057						Analysis of variance of duplicate data

As can be seen

in Table 1, the social support of most women was severe at all three times. The results of repeated measures analysis of variance showed that there was no significant difference in perceived social support over time (P = 0.057)

As can be seen in Table 2, the social support of most women was severe at the three times studied. The results of repeated measures analysis of variance test showed that there was no significant difference in perceived social support over time in the intervention group (P = 0.69)

after 6 weeks		Immediately after		before		Time social support Understood
percent	Abundance	percent	Abundance	percent	Abundance	
0	0	0	0	2/9	1	Weak (7-0)
17/6	6	14/7	5	20/6	7	Medium (14-8)
82/4	28	85/3	29	76/5	26	Intense (more than 14)
100	34	100	34	100	34	total
17/2±04/85		16/2±85/64		16/3±63/28		Standard deviation ± mean
F= 0/36 P= 0/69						Analysis of variance of duplicate data

Table 3: Comparison of perceived social support of women with a history of failed pregnancy before, immediately, and 6 weeks after the intervention in the intervention and control groups

after 6 weeks	Immediately after	before	Time

Control		Intervention		Control		Intervention		Control		Intervention		social support
percent	Abundance	percent	Abundance	percent	Abundance	percent	Abundance	percent	Abundance	percent	Abundance	
2/9	1	0	0	2/9	1	0	0	11/4	4	2/9	1	Understood
8/6	3	17/6	6	14/3	5	14/7	5	11/4	4	20/6	7	
88/6	31	82/4	28	82/9	29	85/3	29	77/1	27	76/5	26	
100	35	100	34	100	35	100	34	100	35	100	34	Weak (7-0)
±82/16 2/82		17/2±04/85		16/3±32/22		16/2±85/64		15/21 ± 4/30		16/3±63/28		Medium (14-8)
t= 0/31 df= 67 p=0/75				t= 0/73 df= 67 p=0/46				t= 1/54 df= 67 p=0/12				Intense (more than 14)

As can be seen in Table 3, perceived social support before the intervention did not differ significantly between the two groups (P = 0.12). The results showed that perceived social support immediately after the intervention (p = 0.46) and 6 weeks later in the intervention group was higher than the control group (p = 0.75 but was not statistically significant()

Objective 2: To determine and compare the mental health of women with a history of failed pregnancy before, immediately and 6 weeks after intervention in control and intervention groups

Table 4: Determining and comparing the mental health of women with a history of failed pregnancy before, immediately, and 6 weeks after intervention in the control group

Analysis of variance of duplicate data	after 6 weeks		Immediately after		before		Time / Mental health subscales	
	percent	Abundance	percent	Abundance	percent	Abundance		
F= 8/14 P =0/001	70/6	24	57/1	20	40	14	None	Physical
	20/6	7	40	14	51/4	18	Light	
	8/8	3	2/9	1	5/7	2	medium	
	0	0	0	0	2/9	1	Intense	
	5/44 ± 3/72		5/54 ± 3/15		7/43 ± 3/07		Standard deviation ± mean	
F= 6/87 P =0/002	32/4	11	42/9	15	17/1	6	None	Anxiety
	58/8	20	51/4	18	65/7	23	Light	
	8/8	3	5/7	2	17/1	6	medium	
	0	0	0	0	0	0	Intense	
	7/50 ± 3/08		6/51 ± 3/45		8/77 ± 2/53		Standard deviation ± mean	
F= 9/11 P <0/001	23/5	8	48/6	17	17/1	6	None	Social dysfunction
	73/5	25	51/4	18	77/1	27	Light	
	2/9	1	0	0	5/7	2	medium	
	0	0	0	0	0	0	Intense	
	7/79 ± 2/10		5/94 ± 2/93		7/91 ± 1/80		Standard deviation ± mean	
F= 2/78 P =0/06	77/9	26	85/7	30	85/3	29	None	Depression
	19/1	6	14/3	5	8/8	3	Light	
	1/5	1	0	0	2/9	1	medium	
	1/5	1	0	0	2/9	1	Intense	
	4/29 ± 4/07		3/23 ± 2/70		4/44 ± 3/93		Standard deviation ± mean	
	50	17	42/9	15	91/2	31	None	mental health

F= 8/62 P <0/001	38/2	13	57/1	20	5/9	2	Light	
	11/8	4	0	0	2/9	1	medium	
	0	0	0	0	0	0	Intense	
	25/03 ± 10/77		21/23 ± 9/75		28/53 ± 8/62		Standard deviation ± mean	

Table 4 examines mental health and its subscales over time in the control group. As can be seen in the table above, before the study, most people had a mild level of physical health that immediately after and 6 weeks later, their physical health improved completely. Anxiety and social dysfunction were mild in most patients in all three periods. Also, most people did not have depression in all three periods. Most people did not have mental health before and 6 weeks after the intervention, but most people had mild mental health immediately after.

Table 5: Determining and comparing the mental health of women with a history of failed pregnancies before, immediately and 6 weeks after the intervention in the intervention group

Analysis of variance of duplicate data	after 6 weeks		Immediately after		before		Time / Mental health subscales	
	percent	Abundance	percent	Abundance	percent	Abundance		
F= 11/17 P <0/001	67/6	23	79/4	27	50	17	None	Physical
	32/4	11	20/6	7	41/2	14	Light	
	0	0	0	0	8/8	3	medium	
	0	0	0	0	0	0	Intense	
	5/06 ± 2/66		4/79 ± 2/21		7/06 ± 2/61		Standard deviation ± mean	
F= 6/43 P =0/004	58/8	20	73/5	25	32/4	11	None	Anxiety
	32/4	11	20/6	7	50	17	Light	
	8/8	3	5/9	2	17/6	6	medium	
	0	0	0	0	0	0	Intense	
	6/09 ± 3/90		5/91 ± 2/81		8/15 ± 3		Standard deviation ± mean	
F= 8/94 P <0/001	35/3	12	55/9	19	8/8	3	None	Social dysfunction
	55/9	19	41/2	14	85/3	29	Light	
	8/8	3	2/9	1	5/9	2	medium	
	0	0	0	0	0	0	Intense	
	7/29 ± 2/71		5/79 ± 2/78		8/26 ± 1/81		Standard deviation ± mean	
F= 5/22 P =0/008	79/4	27	97/1	33	479	27	None	Depression
	20/6	7	2/9	1	20/6	7	Light	
	0	0	0	0	0	0	medium	
	0	0	0	0	0	0	Intense	
	3/38 ± 3/37		2/29 ± 2/26		4/32 ± 2/68		Standard deviation ± mean	
F= 15/20 P <0/001	85/9	18	70/6	24	94/1	32	None	mental health
	44/1	15	29/4	10	5/9	2	Light	
	2/9	1	0	0	0	0	medium	
	0	0	0	0	0	0	Intense	
	21/82 ± 9/04		18/79 ± 7/08		27/82 ± 5/90		Standard deviation ± mean	

Table 5 shows mental health and its subscales in the intervention group over time. The above table showed that most people in all three periods had physical and mental health and did not have depression. Before the intervention, most people had mild anxiety, which improved completely immediately after and 6 weeks later. Most people had mild social dysfunction before and 6 weeks after the intervention, but most did not have social dysfunction immediately after.

Table 6- Comparison of mental health and its subscales in women with a history of unsuccessful pregnancy before the intervention in the intervention and control groups

Control		Intervention		group / Mental health and subscales	
percent	Abundance	percent	Abundance		
40	14	50	17	None	Physical
51/4	18	41/2	14	Light	
5/7	2	8/8	3	medium	
2/9	1	0	0	Intense	
7/43 ± 3/07		7/06 ± 2/61		Standard deviation ± mean	
0/59 P = 67 df=-0/53 t=				Independent t-test result	
17/1	6	32/4	11	None	Anxiety
65/7	23	50	17	Light	
17/1	6	17/6	6	medium	
0	0	0	0	Intense	
8/77 ± 2/53		8/15 ± 3		Standard deviation ± mean	
0/35 P = 67 df=-0/93 t=				Independent t-test result	
17/1	6	8/8	3	None	Social dysfunction
77/1	27	85/3	29	Light	
5/7	2	5/9	2	medium	
0	0	0	0	Intense	
7/91 ± 1/80		8/26 ± 1/81		Standard deviation ± mean	
0/42 P = 67 df=0/80 t=				Independent t-test result	
85/3	29	479	27	None	Depression
8/8	3	20/6	7	Light	
2/9	1	0	0	medium	
2/9	1	0	0	Intense	
4/44 ± 3/93		4/32 ± 2/68		Standard deviation ± mean	
0/88 P = 67 df=-0/14 t=				Independent t-test result	
91/2	31	94/1	32	None	mental health
5/9	2	5/9	2	Light	
2/9	1	0	0	medium	
0	0	0	0	Intense	
28/53 ± 8/62		Standard deviation ± mean		Standard deviation ± mean	
0/69 P = 67 df=-0/39 t=				Independent t-test result	

As can be seen in Table 6, there was no significant difference between mental health and its subscales in the two groups (P = 0.69)

Table 7- Comparison of mental health and its subscales in women with a history of failed pregnancy immediately after the intervention in the intervention and control groups

Control		intervention		Mental health and subscales	
percent	Number	percent	Number		
57/1	20	79/4	27	None	Physical
40	14	20/6	7	Light	
2/9	1	0	0	medium	
0	0	0	0	Intense	
5/54 ± 3/15		4/79 ± 2/21		Standard deviation ± mean	
0/25 P = 67 df=-1/13 t=				Independent t-test result	
42/9	15	73/5	25	None	Anxiety
51/4	18	20/6	7	Light	
5/7	2	5/9	2	medium	
0	0	0	0	Intense	
6/51 ± 3/45		5/91 ± 2/81		Standard deviation ± mean	
0/43 P = 67 df=-0/79 t=				Independent t-test result	
48/6	17	55/9	19	None	Social dysfunction
51/4	18	41/2	14	Light	
0	0	2/9	1	medium	
0	0	0	0	Intense	
5/94 ± 2/93		5/79 ± 2/78		Standard deviation ± mean	
0/83 P = 67 df=-0/21 t=				Independent t-test result	
85/7	30	97/1	33	None	Depression
14/3	5	2/9	1	Light	
0	0	0	0	medium	
0	0	0	0	Intense	
3/23 ± 2/70		2/29 ± 2/26		Standard deviation ± mean	
0/12 P = 67 df=-1/55 t=				Independent t-test result	
42/9	15	70/6	24	None	mental health
57/1	20	29/4	10	Light	
0	0	0	0	medium	
0	0	0	0	Intense	
21/23 ± 9/75		18/79 ± 7/08		Standard deviation ± mean	
0/24 P = 67 df=-1/18 t=				Independent t-test result	

As can be seen in Table 7-, there was no significant difference between mental health and its subscales in the two groups ($P<0.05$).

Table 8- Comparison of mental health and its subscales in women with a history of unsuccessful pregnancy 6 weeks after the intervention in the intervention and control groups.

Control		intervention		Mental health and subscales	
percent	Number	percent	Number		
70/6	24	67/6	23	None	Physical

20/6	7	32/4	11	Light	
8/8	3	0	0	medium	
0	0	0	0	شدید	
5/44 ± 3/72		5/06 ± 2/66		Standard deviation ± mean	
0/62 P = 66 df=-0/48 t=				Independent t-test result	
32/4	11	58/8	20	None	Anxiety
58/8	20	32/4	11	Light	
8/8	3	8/8	3	medium	
0	0	0	0	Intense	
7/50 ± 3/08		6/09 ± 3/90		Standard deviation ± mean	
0/10 P = 66 df=-1/65 t=				Independent t-test result	
23/5	8	35/3	12	None	Social dysfunction
73/5	25	55/9	19	Light	
2/9	1	8/8	3	medium	
0	0	0	0	Intense	
7/79 ± 2/10		7/29 ± 2/71		Standard deviation ± mean	
0/39 P = 66 df=-0/85 t=				Independent t-test result	
77/9	26	79/4	27	None	Depression
19/1	6	20/6	7	Light	
1/5	1	0	0	medium	
1/5	1	0	0	Intense	
4/29 ± 4/07		3/38 ± 3/37		Standard deviation ± mean	
0/31 P = 66 df=-1/005 t=				Independent t-test result	
50	17	85/9	18	None	mental health
38/2	13	44/1	15	Light	
11/8	4	2/9	1	medium	
0	0	0	0	Intense	
25/03 ± 10/77		21/82 ± 9/04		Standard deviation ± mean	
0/18 P = 66 df=-1/32 t=				Independent t-test result	

As can be seen in table (8), there was no significant difference between mental health and its subscales in the two groups (P = 0.18).

Discussion

Spontaneous abortion as the most common complication of pregnancy can lead to many psychological complications in the affected person. Numerous studies have been conducted in different countries on the effect of abortion on mental disorders. The results of some studies show that the majority of women can make difficult decisions, such as having an abortion, without experiencing any regrets or tensions. While many other studies have emphasized the relationship between abortion and mental disorders. In this regard, the present study examines the effect of group counseling on the perceived social support and mental health of women with a history of failed pregnancies.

The two groups were not statistically significant in terms of all demographic characteristics and were homogeneous in terms of those characteristics. The mean age of women in the experimental group was 27.29 39 5.39 and in the control group was 28.94. 5.30. Most of the women had diploma-level education, and most of them had a moderate income in both groups. Both groups did not have a statistically significant difference in terms of pregnancy status and most of the units in both groups were housewives. The homogeneity of the two groups in demographic variables can be considered with more confidence as the results obtained due to the effect or lack of effect of the intervention.

Regarding the first goal of the study "Determining and comparing perceived social support of women with a history of failed pregnancies before, immediately, and 6 weeks after intervention in control and intervention groups"(table 1-2-3),

the findings showed that the average perceived social support before intervention in the group The control was 16.63 63 63.28(table2) and in the experimental group was 15.21 ± 4.3 (P = 0.12)(table1), so the difference between social support before the intervention in the two groups was not significant. Therefore, the two groups of test and control were homogeneous in the perceived social support variable before group counseling and there was no significant difference. The mean of social support immediately after the intervention in the experimental group was 16.2 85 85.64(table2) and in the control group was 16.3 32 32.22 and P = 0.46)(table1), the difference in perceived social support immediately after the intervention between The experimental and control groups was not significant.

Social support at follow-up 6 weeks after the intervention was 17.2 85 4.85(table2) in the experimental group and 16.82 82 82.2(table1) in the control group (P = 0.75)) Perceived social support immediately after the intervention and 6 weeks after It was higher in the intervention group than the control group but was not statistically significant (P <0.05). Group counseling, despite increasing social support in the intervention group, but this difference was not significant in the two groups.

The results of a study by Hagigi, M(2020) entitled The Effect Of Individual Advocacy Counseling On The Level Of Perceived Social Support In Mothers With Pregnancy Loss showed that individual counseling in women with a history of pregnancy loss increases the social support perceived by The family has found that the observed differences can be due to differences in the way counseling is provided. In the face of crises, counseling is effective individually and is more effective than counseling as a group.

Another study conducted by Mohammadpour et al. Entitled The effect of counseling with men on the level of social support and perceived stress of their pregnant spouses, also showed that counseling with men is effective on social support and perceived stress of women. Because social support is a multidimensional concept, it may be influenced by time and environmental and cultural issues. Perhaps some of the reasons for this discrepancy are due to differences in the statistical population of the study. In a recent study, women with a history of pregnancy were unsuccessful, while in the study, Mohammadpour and colleagues were males, and different mental conditions of men and women were different mohammadpour (2022).

Regarding the next goal of the study "Determining and comparing the mental health of women with a history of failed pregnancies before, immediately, and 6 weeks after the intervention in the control and intervention groups"(table4-5-6), the findings showed that the mean of physical symptoms before the intervention in the experimental group was equal to 7.06 2.6(1table5) and in the control group is equal to 7.43 07 3.07(table4), and the value of P = (0.59), the difference of physical symptoms before the intervention, between the experimental and control groups is not significant. Be. The mean of pre-intervention anxiety syndrome in the experimental group was 8.15 3 3(table5) and in the control group was 8.77 53 2.53(table4) and the amount (P = 0.35, the difference between pre-intervention anxiety syndrome between the two The experimental and control groups was not significant. The mean of symptoms of social dysfunction before the intervention was not significant between the experimental and control groups. The mean of symptoms of social dysfunction before the intervention in the experimental group was 1.81 ± 8.26(table5) and in the control group is equal to 7.91 80 1.80(table4) and the value (P = 0.42), the difference between the symptoms of social dysfunction before the intervention, between the experimental and control groups is not significant. Pre-intervention depressive syndrome in the experimental group was 4.32 68 2.68table5) and in the control group was 4.44 93 3.93(table4) and the value was 0.88 (P = difference between pre-intervention depressive syndrome between the two The experimental and control groups were not significant. Finally, the mean of mental health disorder (general) before the intervention was 27.82 90 5.90(table5) in the experimental group and 28.53 62 8.62(table4) in the control group and the value was 69.69. 0 P = Mental health disorder difference before the intervention between the experimental and control groups It does not make sense. Therefore, the two experimental and control groups were homogeneous in the mental health variable and its subscales before group counseling and there was no significant difference.

The mean of physical symptoms immediately after the intervention in the experimental group was 4.79 21 2.21(table5) and in the control group was 5.54 3 3.15(table4), and the amount (P = 0.25, the difference in physical symptoms immediately after The intervention was not significant between the experimental and control groups, the mean of anxiety symptoms immediately after the intervention in the experimental group was 5.91 81 2.81(table5) and in the control group was 6.51 45 3.45(table4) and the value (43 P = 0.0, the difference between anxiety syndrome immediately after the intervention between the experimental and control groups was not significant. The mean syndrome of social dysfunction immediately after the intervention in the experimental group was 5.79 78 2.78(table5) and In the control group, it was equal to 5.94 93 2.93(table4) and the value (P = 0.83), the difference between the symptoms of social dysfunction immediately after the intervention, between the experimental and control groups was not significant. After the intervention, the experimental group was equal to 2.29 26 2.26(table5), and the control group

was equal to 3.23 70 2.70(table4), and the amount of P / 12 immediately after the intervention, between the two experimental groups and Control, is not significant. Finally; Mental latency (general) immediately after the intervention is 18.79 ± 7.08(table5) in the experimental group and 21.23 9 9.75(table4) in the control group and the value is P / 24 (difference in mental health disorder immediately after the intervention). , Is not significant between the test and control groups. Therefore, the two experimental and control groups did not have any significant differences in mental health variables and their subscales after group counseling. Although we have seen improvement in some subscales, this rate of reduction is not significant. Other expressions based on the information obtained from the intervention (group counseling) did not have a significant effect on mental health and its dimensions. The average of physical symptoms 6 weeks after the intervention in the experimental group was equal to / 06 66 2.66 5(table5) and in the control group is equal to 5.44 72 3.72(table4), and the value (P = 0.62), the difference between physical symptoms 6 weeks after the intervention, between the experimental and control groups is not significant. Anxiety 6 weeks after the intervention in the experimental group is equal to 6.09 90 3.90(table5) in the control group is equal to 7.50 08 3.08(table4) and the amount (P = 0.1, the difference in anxiety syndrome 6 weeks after the intervention, It is not significant between the test and control groups.

The mean of social dysfunction syndrome 6 weeks after the intervention was 7.29 2 2.71(table5) in the experimental group and 7.79 ± 2.10(table4) in the control group and the amount (P = 0.39, the difference in the disorder syndrome was In social functioning, 6 weeks after the intervention, it was not significant between the experimental and control groups, and the mean of depressive symptoms 6 weeks after the intervention was 3.38 37 3.37(table5) in the experimental group and 4.07(table4) in the control group. ± 4.29 and the value of P = 0.31 (P = difference of depressive symptoms 6 weeks after the intervention between the experimental and control groups is not significant. Finally, the average mental health disorder (overall) 6 weeks after the intervention, in The experimental group was 21.82 9 9.04(table5) and in the control group was 25.03 /10 10.77(table4) and the value was 0.18 (P = difference in mental health disorder after 6 weeks after the intervention between the experimental and control groups. Therefore, there was no significant difference between the two experimental and control groups in the mental health variable and its subscales 6 weeks after group counseling.

The result obtained is not in line with the results of the research of Karami et al. (2015) entitled Evaluation of the effectiveness of a codified educational-behavioral program on the mental health of pregnant women in Ahvaz in 2015. In the mentioned study, the results showed that the mental health score in the experimental group after the intervention was better than the control group. The results also showed that the intervention could be effective in the areas of anxiety, depression, and physical symptoms but did not affect the area of social functioning. Perhaps some of the reasons for this discrepancy are that the statistical population of the study included women with failed pregnancies, while the statistical population in the study in question included pregnant women. In another study conducted by Nazmieh et al. Under the title of the effect of coping therapy training on the general health of pregnant women at high risk of genetic abnormalities in the fetus in Yazd in 2016, the results show that education on Coping therapy in pregnant women at high risk for abnormalities has improved general health indicators, which is not consistent with the results obtained by this study.

Conclusion

In general, the findings indicate that with the implementation of a group counseling program, although there was a significant difference in the variables of physical syndrome, social dysfunction syndrome, depression syndrome, and mental health in the experimental group before and after the intervention, according to The control group as well as the test results should be acknowledged that the group counseling program had no effect on mental health and its subscales and perceived social support by mothers with a history of failed pregnancies. Given the prevalence of abortion and the adverse consequences of pregnancy, the importance of research in this area can be understood. According to the results of this research, it is possible to take an important step to improve mental health in women with missed pregnancies and increase their perceived social support, and since the midwife is one of the most effective and important members of the health care team with These are the women, the findings of the present study can be applied in various fields of midwifery such as education, counseling, midwifery services, and midwifery research.

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References

Adl, H., Shafi Abadi, A., and Pirani, Z. (2016) effectiveness psychotherapy. Journal of Applied Psychology, 10(2(38)), pp. 175-191.

Allahdadian, M., Irajpour, A., Kazemi, A. and Kheirabadi, G. (2016) Strategy for mental health improvement of Iranian stillborn mothers from their perspective: A qualitative study. Iranian Red Crescent Medical Journal, 18(1)

Bellieni, C. V. and Buonocore, G. (2013) Abortion and subsequent mental health: Review of the literature. Psychiatry Clin Neurosci, 67(5), pp. 301-10.
Boyle, F. M., Mutch, A. J., Barber, E. A., Carroll, C. and Dean, J. H) .2015 (Supporting parents following pregnancy loss: a cross-sectional study of telephone peer supporters. BMC pregnancy and childbirth, 15(1), pp. 291.
Ashtari Mahini, Adar Tal, Fereshteh Majlisi, Abbas Rahimi Foroushani, Abolghasem Pourreza (2013). Evaluation of abortion status and some factors affecting it in patients of Zanjan hospitals, Journal of Health System Research, 9 (7), 741-748.
Rezaian Langroudi, Raheleh. (2014). Mental health of pregnant women and consequences of childbirth in mothers referred to Fatemieh Hospital in Hamadan. Aflak Scientific Research Quarterly, 11, 21.
Sarafino Edward (2019). Health Psychology, (Translated by Nadim et al.) Roshd Publishing: Tehran
Karami Farshad (2015). The effect of social network on the academic performance of high school students in Babolsar, Master Thesis in Psychology, Mazandaran University
Kaldi, Alireza, Salhshouri, Parvaneh. (2012). Investigating the effect of social support on women's empowerment. Iranian Social Development Studies 4 (4); 7-22.
Chojenta, C., Harris, S., Reilly, N., Forder, P., Austin, M.-P. and Loxton, D. (2014) History of Pregnancy Loss Increases the Risk of Mental Health Problems in Subsequent Pregnancies but Not in the Postpartum. PLOS ONE, 9(4), pp.صفحه e95038.
Choudhary, A. and Gupta, V. (2014) Epidemiology of intrauterine fetal deaths: a study in tertiary referral centre in Uttarakhand. IOSR J Dent Med Sci, 13(3), pp. 03-6.
Coleman, P. K. (2015) Diagnosis of fetal anomaly and the increased maternal psychological toll associated with pregnancy termination. Issues L. & Med., 30, pp. 3.
Gold, K. J., Boggs, M. E., Muzik, M. and Sen, A. (2014) Anxiety disorders and obsessive-compulsive disorder 9 months after perinatal loss. General hospital psychiatry, 36(6), pp. 650-654.
Gold, K. J., Leon, I., Boggs, M. E. and Sen, A. (2016) Depression and Posttraumatic Stress Symptoms After Perinatal Loss in a Population-Based Sample. J Womens Health (Larchmt), 25(3), pp. 263-9.
Golshani, F., Golmohammadnejad, G. and Aghdasi, A. n. (2014) The Effectiveness of Life Skills Training in Pregnancy on Maternal Health. 7(26), pp. 89-101.
Gravensteen, I. K., Helgadottir, L. B., Jacobsen, E. M., Sandset, P. M. and Ekeberg, O. (2012) Long-term impact of intrauterine fetal death on quality of life and depression: a case-control study. BMC Pregnancy Childbirth, 12, pp. 43.
Gravensteen, I. K., Jacobsen, E.-M., Sandset, P. M., Helgadottir, L. B., Rådestad, I., Sandvik, L. and Ekeberg, Ø. (2018) Anxiety, depression and relationship satisfaction in the pregnancy following stillbirth and after the birth of a live-born baby: a prospective study. BMC Pregnancy and Childbirth, 18, pp. 41.
Hajnasiri, H., Behbodimoghaddam, Z., Ghasemzadeh, S., Ranjkesh, F. and Geranmayeh, M. (2016) The study of consultation effect on depression and anxiety after legal abortion. Iranian Nursing Scientific Association, 4(1).
Huberty, J., Matthews, J., Leiferman, J., Cacciatore, J. and Gold, K. J. (2018) A study protocol of a three-group randomized feasibility trial of an online yoga intervention for mothers after stillbirth (The Mindful Health Study). Pilot and feasibility studies, 4(1), pp. 12.
Jahan Bakhshian, N. and Zandi Por, T. (2011) The effectiveness of group counseling based on Lazarus multifaceted approach to patients MS on improving mental health and reinforcement social support. stady p, 7(2), pp. 65-84.
Kersting, A., Dölemeyer, R., Steinig, J., Walter, F., Kroker, K., Baust, K. and Wagner, B. (2013) Brief Internet-based intervention reduces posttraumatic stress and prolonged grief in parents after the loss of a child during pregnancy: a randomized controlled trial. Psychotherapy and psychosomatics, 82(6), pp. 372-381.
Kingston, D., Austin, M.-P., Hegadoren, K., McDonald, S., Lasiuk, G., McDonald, S., Heaman, M., Biringer, A., Sword, W. and Giallo, R. (2014) Study protocol for a randomized, controlled, superiority trial comparing the clinical and cost-effectiveness of integrated online mental health assessment-referral-care in pregnancy to usual prenatal care on prenatal and postnatal mental health and infant health and development: the Integrated Maternal Psychosocial Assessment to Care Trial (IMPACT). Trials, 15(1), pp. 72.
Kolte, A., Olsen, L., Mikkelsen, E., Christiansen, O. and Nielsen, H. (2015) Depression and emotional stress is highly prevalent among women with recurrent pregnancy loss. Hum Reprod, 30(4), pp. 777-82.
Lok, I., Lee, D. and Yip, S. (2004) Screening for post-miscarriage psychiatric morbidity AM J Obstet Gynecol, 191(2), pp. 546.
Markin, R. D. (2017) An introduction to the special section on psychotherapy for pregnancy loss: Review of issues, clinical applications, and future research direction. Psychotherapy, 54(4), pp. 367.
Mills, T., Ricklesford, C., Heazell, A., Cooke, A. and Lavender, T. (2016) Marvellous to mediocre: findings of national survey of UK practice and provision of care in pregnancies after stillbirth or neonatal death. BMC pregnancy and childbirth, 16(1), pp. 101.

Moharrami, S. M., Ghanbari Hashemabadi, B. A. and Asghari Ebrahimabad, M. J. (2017) Effectiveness of group counseling with structured approach on Family Function and Marital Satisfaction. Journal of Res. in Cli. Psychology & Counseling, 6(2), pp. 63-78.

Mosayeb Moradi., M., Jahdi., F., Seyed Fatemi, N. and Montazeri, A. (2016) The effect of counseling on anxiety levels of women with spontaneous abortion. Journal of the Iranian Institute for Health Sciences Research Payesh, 2, pp. 174-179.

Nazari, h., Farhadi, a., Jariayani, m., Hosseinabadi, r., Asgari, s. and Majidimehr, m. (2014) Mental health of pregnant women referred to Khorramabad health centers. scientific magazine yafte, 16(2), pp. 40-48.

Neisani Samani, L., Chehreh, H., N, S. F., Hosseini, F. and Karamelahi, Z. (2016) Relationship between Perceived Social Support and Anxiety in Pregnant Women Conceived through Assisted Reproductive Technologies (ARTs). Iran Journal of Nursing (IJN), 29, pp. 103.

Rad, P., Amir Ali Akbari, S., Sadeghniiat, K. and Alavi Majd, H. (2011) Relationship between sleep disorder and pregnancy depression in primigravidae referring to health–treatment centers of Ahvaz Jundishapur University of Medical Sciences in 2010. SSU_Journals, 19(4), pp. 454-462.

Riahi, M. E., Verdi Niya, A. A. and Por Hossein, z. (2008) the study of the relationship between social support and mental health. Quarterly jornal Eefah Ejtemaei, 10(39).

Schwarzer, R., Knoll, N. and Rieckmann, N. (2003) Social Support Introduction to health psychology. Oxford, England,

Sigalla, E. n., Rasch, V., Gammeltoft, T., Meyrowitsch, D. W., Rogathi, J., Manongi, R. and Mushi, D. (2017) social support and intimate partner violence during pregnancy among women attending antenatal care Moshi municipality, northern Tanzania. BMC Public Health, 17(240), pp. 45-56.

Chojenta, C., Harris, S., Reilly, N., Forder, P., Austin, M. P., & Loxton, D. (2014). History of pregnancy loss increases the risk of mental health problems in subsequent pregnancies but not in the postpartum. PloS one, 9

Lee, D. S., & Way, B. M. (2019). Perceived social support and chronic inflammation: The moderating role of self-esteem. Health Psychology, 38(6), 563–566

Mohammadpour, M., Mohammad-Alizadeh Charandabi, S., Malakouti, J., Nadar Mohammadi, M. and Mirghafourvand, M., 2022. Effect of counselling with men on perceived stress and social support of their pregnant wives. Journal of Reproductive and Infant Psychology, 40(2), pp.118-132.

Hagigi, M., Mohaddesi, H. and Rasouli, J., 2020. The Effect Of Individual Advocacy Counseling On The Level Of Perceived Social Support In Mothers With Pregnancy Loss: A Randomized Clinical Trial. Nursing And Midwifery Journal, 18(6), pp.510-518.

Nazmiye, F.A.T.E.M.E.H., Sheikhha, M.H. and Kamali Zarch, M., 2016. The Effects of Coping Therapy on General Health of Pregnant Women with High Risk of Genetics Abnormalities in their Fetus. SSU_Journals, 24(8), pp.607-617.

Cheng ER, Rifas-Shiman SL, Perkins ME, Rich-Edwards JW, Gillman MW, Wright R, Taveras EM. The Influence of Antenatal Partner Support on Pregnancy Outcomes. J Womens Health (Larchmt). 2016 Jul;25(7):672-9. doi: 10.1089/jwh.2015.5462. Epub 2016 Feb 1. PMID: 26828630; PMCID: PMC4985003.

Bellieni CV, Buonocore G. Abortion and subsequent mental health: Review of the literature. Psychiatry Clin Neurosci. 2013 Jul;67(5):301-10. doi: 10.1111/pcn.12067. PMID: 23859662.

Spietz A, Kelly J. The importance of maternal mental health during pregnancy: theory, practice, and intervention. Public Health Nurs. 2002 May-Jun;19(3):153-5. doi: 10.1046/j.0737-1209.2002.19301.x. PMID: 11967099.

Tahmasbipour, N. and Taheri, A., 2012. A survey on the relation between social support and mental health in students Shahid Rajaee University. Procedia-Social and Behavioral Sciences, 47, pp.5-9.

Goldberg, D. P., and V.F, H. (1979) A scaled of the General Health Questionnaire. Department of Psychiatry, University of Manchester, 9, pp. 139.