

PREGNANCY LOSS: WOMEN'S EXPERIENCES COPING WITH MISCARRIAGE

by

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## **ABSTRACT**

This research documents the personal stories of women who have gone through pregnancy loss and seeks to better understand their experiences coping with miscarriage. Through in-depth one to one interviews, I examine the positive and negative aspects of the participants' experiences, what impacted and influenced their coping, and how they were able to deal with and overcome their loss. This qualitative study uses a narrative approach to analyze seven in-depth interviews. A combination of holistic and categorical analysis is used in analyzing the study's themes and findings. My findings show that women benefit from having support during and after their miscarriage, particularly from their spouse, family, friends, and health care providers. Participants noted that they experienced silence and stigma surrounding miscarriage, and that a considerable aspect of their coping involved talking openly about their experiences. Given the widespread nature of miscarriage, this study is important to the field of social work because of the significance of better understanding the emotional effects, responses, and coping strategies that women find to be of comfort.

## **PREFACE**

This thesis is original, unpublished, independent work by the author, Ettl Shurack.

The University of British Columbia Research Ethics Board issued Certificate of Approval H11-03112 to undergo this study.

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## CHAPTER 1: INTRODUCTION

### **Background**

For most women, pregnancy is an emotionally charged experience representing the realization of dreams, hopes, and aspirations (Gerber-Epstein, Leichtentritt, & Benyamini, 2009). Unfortunately, not all pregnancies result in the birth of a child. Research shows that approximately one in four women will experience pregnancy loss at least once in her lifetime (Hamama-Raz, Hemmendinger, & Buchbinder, 2010). Studies estimate that miscarriages occur from 15-20% (Swanson, 1999) to 20-30% (Layne, 1990) of pregnancies, with the majority taking place during the first twelve weeks of a pregnancy (Geber-Epstein et al., 2009). It is during this first trimester when a woman learns of her pregnancy and is adapting to the emotional and physical adjustments that being pregnant involves (Gerber-Epstein et al., 2009). A miscarriage, however, derails a woman's envisioned plans; the thought of motherhood and a woman's changing role in her family and society (Brin, 2004).

There are a wide range of coping strategies that can be used in a variety of situations. Regardless of the experience, coping is an integral part of day to day living and a necessary component in navigating successfully through life's difficulties and hardships (Kalra, Kalra, Agrawal, Sahay, Unnikrishnan, & Chawla, 2010). Coping can be defined as the method in which a person handles stress and the way that a person deals with issues that are believed to be challenging or difficult (Kalra & et al., 2010). There are both positive and negative coping strategies. In this research project, 'coping strategies' refers to any method that women have used to successfully navigate through the difficult experience of miscarriage.

There have been a variety of studies investigating women's experiences throughout pregnancy loss. Some research has examined emotional responses and reactions following

pregnancy loss (Gerber-Epstein et al., 2009). Other studies looked at women's satisfaction with the medical care they received (Paton, Wood, Bor, & Hitsun, 1999). There were also those that studied the relationship between the partners in coping with the miscarriage (Hamama-Raz, Hemmendinger, & Buchbinder, 2010). I found the literature review to be especially beneficial for laying a solid foundation and rationale for my study, as well as creating and fine-tuning my conceptual framework. Nonetheless, there exist several gaps that I hope my study can address.

### **Purpose of Research**

This research aims to document the personal stories of women who have experienced pregnancy loss and provide enlightenment on how women cope, deal with, and manage following a miscarriage, and how they move forward from the difficult experience. I examine the positive and negative aspects of the participants' experiences, what impacted and influenced their coping, and how they were able to manage with and overcome their loss. While pregnancy loss affects both partners and the family unit as a whole (Cumming, Klein, Bolsover, Lee, Alexander, Maclean, & Jurgens, 2007; Abboud & Liamputtong, 2003; Cecil, 1994), the focus of my study is on the experiences of women.

I believe there are several potential benefits associated with this study. Firstly, it has been found that women benefit from having a forum to share their experiences (Castle & Phillips, 2003). My hope is that my study has given voice to women's experience of pregnancy loss, as miscarriage is an area that individuals, families, communities, and society on a whole are reluctant to talk about (Rowlands & Lee, 2010; Layne, 2003; Layne, 1997; Cecil, 1994). Many of the participants in my study expressed appreciation for having the opportunity to share their experience. Many of the women commented that it was beneficial

to feel heard and understood. Furthermore, they were happy to be part of a process that would bring more attention to the topic of pregnancy loss, and that potentially, their experience could help other women. It is important to encourage and highlight a participant's strengths and acts of resiliency, as it reveals in their own eyes ways in which they were agents in their proactive response to miscarriage (Wade, 1997). Secondly, my desire is that this research will be a resource and a compilation of 'tried and true' coping strategies that women who have experienced miscarriage found to be of comfort. This in turn can help women who experience miscarriage in the future to navigate their way through a most difficult process with greater ease and reassurance. Thirdly, I hope that my research will be a useful tool for social workers who are part of an allied health team in helping women cope with miscarriage and that can disseminate this knowledge to other medical professionals who are involved in women's health care.

### **Thesis Overview**

This thesis presents the results from a study on the experiences of women who have coped with miscarriage. The body of the paper begins with an introduction, which touches on the background on the topic, the purpose of the research, and an overview of the thesis paper. It then introduces a review of the existing literature pertaining to pregnancy loss and coping. The study's methodology follows, which outlines the methodological approach, recruitment, sampling, participants, data collection, data analysis, and the researcher's location and reflexivity. Following is presented the two types of data analysis that this study utilizes, holistic analysis and categorical analysis. In the section "Restorying: Holistic Analysis of Emerging Themes," a summary of each of the interviews with the seven participants is presented, followed by an overview of the similarities of the interview process

itself. The section “Findings: Categorical Analysis of Themes” discusses the nine themes found across the interviews followed by a discussion section that introduces the implications of the study to social work practice, limitations of the study, future research considerations, and conclusion. used and an Appendix that the overarching research questions and the sub-questions.

## CHAPTER 2: LITERATURE REVIEW

There are many terms for the process by which a pregnancy ends in the death of a fetus in utero. These include pregnancy loss, miscarriage, perinatal death, spontaneous abortion, chemical pregnancy, and stillborn (Chalmers, 1992). Language can either honour or dishonour the lived experience of the loss of a baby during a miscarriage (Jonas-Simpson & McMahon, 2005). Many women state that the medical language surrounding their pregnancy loss, particularly the term spontaneous abortion, is extremely hurtful as well as incongruent with their experiences (Cosgrove, 2004). Many women found this term to be painful and offensive (Van den Akker, 2011), as it gives the impression that they actively sought to terminate their pregnancy.

For the purpose of this paper, I primarily use the terms pregnancy loss and miscarriage. Although there is much ambiguity and inconsistency in terminology surrounding pregnancy loss (Jonas-Simpson & et al., 2005), particularly in literature from different countries, I use “pregnancy loss” as a general term referring to the end of a pregnancy at any stage of gestation, while a “miscarriage” typically refers to a loss during the first half of a pregnancy. I strive to avoid using language that women may find to be hurtful, and do not use terms such as spontaneous abortion or fetal death.

The experience of pregnancy loss is intertwined with the meanings and functions of being a woman, as it is connected to her belief in her fertility (Gerber-Epstein et al., 2009). The loss of the potential for motherhood deeply affects their meaning and role as women (Gerber-Epstein et al., 2009). Pregnancy loss often results in the loss of self-esteem in women as they begin to question their purpose in life due to the fact that they no longer see themselves in a maternal role (Hamama-Raz et al., 2010). Many women approach

miscarriage with sadness and anger, and view it as an incomplete rite of passage (Layne, 1990). Fertility, pregnancy, pregnancy loss, motherhood, and family dynamics are all topics that interplay with social work practice. More specifically, "reproductive loss experiences are interwoven with typical themes emerging in everyday social work practice, including mental health, self-conceptualization, social roles, and future parenting" (Price, 2008, p. 367). Yet, culturally, there is much silence surrounding pregnancy loss (Layne, 1990).

Guilt, anger, depression, and anxiety are common emotions for women following pregnancy loss, as they experience mourning and grief (Rowlands et al., 2010; Sejourne, Callahan, & Chabrol, 2010; Adolfsson, Bertero, & Larsson, 2006; Leff, 1987). In fact, one study conducted in the United Kingdom found that depressive symptoms are present in at least 20% of women following pregnancy loss, and the figure could be as high as 50% of women (Slade, 1994). A U.S. study found that 20% of women interviewed displayed highly symptomatic depressive symptoms two months following a miscarriage, and that, in general, results did not vary in women with differing numbers of living children, marital status, ethnicity, or educational levels (Neugebauer, 2003). Furthermore, 40% of women were found to experience intense sadness, and 20-40% suffering from anxiety symptoms (Lok & Neugebauer, 2007). A U.K. study found that of the 400 women interviewed, 28% had experienced a clinical threshold for anxiety following a miscarriage (Cumming, Klein, Bolsover, Lee, Alexander, Maclean, & Jurgens, 2007). A U.S. study involving an in-depth empirical literature review found that a substantial percentage of women experienced elevated levels of anxiety following a miscarriage (Brier, 2004). Although it has been found that the anxiety symptoms typically lessen after six months (Brier, 2004), the psychological and social effects are many fold and can last long beyond half a year (Van den Akker, 2011).

A variety of recent studies have associated posttraumatic symptoms with women who have experienced pregnancy loss. Schwerdtfeger and Shreffler (2009, p. 211) reported that "childless women who had experienced pregnancy loss or failure to conceive reported the lowest life satisfaction and highest levels of depression despite a considerable period of time (7 years) since the loss or first year without a conception." One month following their miscarriage, one study found that 25% of women had posttraumatic stress disorder (PTSD) and the severity of the symptoms was similar to that of other traumatized populations (Engelhard, van den Hout, Arntz, 2001). Furthermore, women with PTSD had an increased risk for depressive symptoms (Engelhard et al., 2001). Thirty four percent of women who had PTSD following their miscarriage also faced depression (Engelhard et al., 2001). Interventions specifically pertaining particularly to trauma may be a useful strategy for facilitating positive emotional adjustment and preventing longer term negative consequences (Lee & Slade, 1996). It has been found that the interventions for traumatically bereaved persons must go beyond grief facilitation, by acknowledging the trauma involved in the experience (Figley, Bride, & Mazza, 1997). Psychological debriefing, a form of crisis intervention, can be helpful in increasing positive emotional outcomes for women following miscarriage (Lee et al, 1996).

When discussing treatment and care, Cosgrove firmly states that "women experiencing a pregnancy loss have been underserved" (2004, p.118). Often, health care professionals do not see miscarriage beyond a physical occurrence, and thus do not recognize it to be a psychologically taxing experience (Cosgrove, 2004). A study by Simmons, Singh, Maconochie, Doyle, and Green (2006) found that it is vital that health care providers do not treat miscarriage as a routine complication or a simple perfunctory procedure as this is not

indicative of the meaning women associate with pregnancy loss. When asked about the medical care they received during their miscarriage, women have often reiterated the importance of not just physical care, but emotional support as well (Simmons et al., 2006).

An effective resource that has shown to impact a woman's coping is having a satisfying experience with medical professionals during the course of diagnosis and treatment for pregnancy loss (Rowlands et al., 2010; Abboud et al., 2003; Paton et al., 1999). Furthermore, contact with a social worker, counselor, or clinician has also been found to be beneficial, as they are able to support the woman in developing adaptive coping strategies that work for her and facilitate a speedier recovery from the pregnancy loss (Brownlee & Oikonen, 2004; Van den Akker, 2011).

One study examined the social and personal impact of the different obstetrical management methods on a woman's experience of pregnancy loss that occurred during the first trimester (Smith, Frost, Levitas, Bradley, & Garcia, 2006). The main three management methods involved surgical, medical, and expectant strategies (Smith et al., 2006). The women's experiences and beliefs pertaining to the strategies varied widely, yet it is important to consider their preferences in the management of the miscarriage (Smith et al., 2006). The women found there to be different advantages and disadvantages to each of the methods of management, based on their own personal situation (Smith et al., 2006). This demonstrates how personal beliefs and medical practices are interwoven. Furthermore, it shows how imperative it is for women to be informed of the various medical aspects that take place in the management of miscarriage, and for women to have the opportunity to be involved in the decision making process. A common theme in the study was the importance of both competence and compassion from the professionals involved in the medical treatments

(Smith et al., 2006).

Research shows that women have found it to be beneficial to be offered and to receive follow-up care with pregnancy loss as a way of coping psychologically (Van den Akker, 2011; Cosgrove, 2010; Adolfsson et al., 2006; Mahan & Calica, 1997; Lee et al., 1996). Follow-up care could be a venue to assess not only a woman's physical wellbeing following the pregnancy loss, but also her emotional wellbeing. Many women noted the importance of the explanation they received from the medical professionals for their miscarriage (Paton et al., 1999; Smith et al., 2006). They found it important to have all their questions answered, and the procedures explained thoroughly (Paton et al., 1999). Many women noted they were upset by professionals' medicalization of the miscarriage and they often felt a lack of emotional support as a result of the treatment and care only focusing on their physical symptoms (Simmons et al., 2006). While research shows a common experience of distress and emotional impact for women from varying backgrounds, pregnancy in medical practice does not appear to be recognized as a psychologically taxing experience.

Social support has been found to be an important aspect of a woman's coping with miscarriage. A partner's support is especially valuable for a woman who has had a miscarriage and strong communication between the two is essential during the grieving period (Hamama-Raz et al., 2010; Abboud & et al., 2003). Many women have found it important to have other women to speak with about their experiences with pregnancy loss (Rowlands et al., 2010; Cacciatore, 2007; Layne, 1997; Mahan et al., 1997; Antze & Lambek, 1996). Interpersonal support, whether it be via one's partner, friends, relatives, community members, religious or cultural group, or colleagues, is an important part of the

coping process (Mann et al., 2008). Support groups are a unique possibility to foster the opportunity for interpersonal support, especially for women who may not have others to speak with, or may not feel comfortable speaking with those in their immediate circles (Layne, 2003; Layne, 1997).

Furthermore, societal norms, policies, and legislation influence a variety of aspects pertaining to pregnancy loss. There are numerous dynamics that interplay with the meanings and understandings of gender and gender equality (Lombardo, Meier, & Verloo, 2010). Discourses that study the multifaceted aspects of gender, overcoming patriarchy, and the role of various power groups and dynamics are very important when seeking to understand how gender interplays with any social topic (Lombardo et al., 2010). Examining how gender is shaped, hierarchical forces at play, political representation, and empowerment of individuals is especially important (Meier & Lombardo, 2013). Gender identity, sexual orientation, socio-economic status, and race, tremendously influence practices and policies surrounding fertility and infertility, particularly the medical care and options available to various segments of the populations, and the societal attitudes that permeate the dialogue surrounding these topics.

On a broad level, gender politics involves examining, understanding, advocating for, and changing the roles and relations of men and women. Gender politics tremendously influence topics surrounding the family unit (Swain & Thornton, 2011). These political forces apply to all aspects of fertility, including pregnancy, labour, birth, miscarriage, stillbirth, abortion, as well as infertility (Cacciatore & Bushfield, 2008). They are relevant to the medical practices that are geographically available to individuals, which options are offered, which can be financially accessible by only segments of the population, and the

attitudes and societal expectations surrounding the choices made in these aspects of fertility.

Gender politics also relate to motherhood, how women view themselves and their roles, and their interactions and expectations of their partners (Price, 2008; Layne, 1990). Additionally, political systems play a role in an individual's sense of self (Saleeby, 2001). Furthermore, gender, can be expressed in a political manner (Burns, 2007). Thus, gender politics interplay with pregnancy, as well as pregnancy loss in the forms of social policy, medical definitions and practices, as well as historical contexts and societal expectations (Cacciatore & et al., 2008).

Thus, social policy, medical practices, and societal expectations are all intertwined. One study found reproduction and motherhood to be an important component of women's identity through Mexico (Castaneda, Billings, & Blanco, 2003), and yet the way midwives viewed pregnancy loss was critical and judgemental. The midwives saw miscarriage as a woman's failure to live up to her primary role as a mother and caretaker (Castaneda et al., 2003). Because women were primarily viewed in a caretaker role throughout society, medical practitioners also adopted this view, which then affected how they treated the women, both medically and emotionally. Thus, medical practices and societal expectations had a tremendous interplay.

Another social and political system involved is the notion of the ability to control reproduction (Layne, 2003). Both biomedical obstetrics, as well as the women's health movement, share the belief that the ability to control reproduction leads to a positive outcome in pregnancy (Layne, 2003). Yet, each come from a different perspective. The obstetrics field views this ability in terms of medical interventions, and how modern medical practices have increased positive outcomes for both the baby and the mother, and lowering unexpected

complications and infant morbidity rates. The women's health movement views this ability in terms of a natural labour and a woman's innate powers at birthing children (Layne, 2003). However, this emphasis on positive outcomes being within our control has actually contributed to maternal blame, including self-blame, when pregnancies do not proceed smoothly or end in miscarriage (Layne, 2003). Researchers on trauma have found that, in general, conversations surrounding unexpected loss are difficult for many to hear, as they force people to recognize that they are not in full control of outcomes in their lives (Brison, 1997). This applies furthermore to fertility, which merges topics of motherhood, infancy, and a baby's innocence.

Political systems and legislation have an impact on the way society views and responds to pregnancy loss (Buchanan, 2013). There is both a legal and medical distinction surrounding abortion, particularly in the differentiation of cases when abortion is medically advised (Castaneda et al., 2003). Pro-life and pro-abortion theories and debates are often heated and fueled by society's views on pregnancy, fertility, and motherhood (Castaneda et al., 2013; Buchanan, 2013). They pertain to expectations of women in their often unspoken of but assumed roles as caregivers and nurturers. Yet, the notion of a woman being in control of the options and choices that influence her decisions involved in fertility intersect with these societal assumptions. Furthermore, there is both confusion and pain when the medical terminology of "spontaneous abortion" is used for miscarriage (Van den Akker, 2011; Jonas-Simpson & et al., 2005; Cosgrove, 2004). Many women who would not have chosen an abortion, but find that their miscarriage is referred to as spontaneous abortion are hurt by the use of this term (Van den Akker, 2011). This portrays how worldviews, personal meaning, legislation, medical policies, and social norms all interact in the dynamics involved

in pregnancy loss.

Unfortunately, few studies addressed practical day to day forms of coping that women utilized, which is the focus of my study. Examining day to day coping strategies is beneficial because it is these seemingly small steps, behaviours, and approaches that help someone getting through the process. Having a better understanding of the unique and varied coping responses is helpful for social workers and medical professionals when it comes to guiding women who seek their services. The participants in this study had a broad range of coping strategies which they utilized. Some strategies they came upon on their own, through trial and error, or organically, while others came from recommendations, suggestions, and ideas from peers and family members.

## CHAPTER 3: METHODOLOGY

### Methodological Approach

A qualitative research strategy was used for this study because of its emphasis on learning and understanding the meanings that participants hold about experiences, and for its holistic perspective that values identifying the complex interactions of factors in any given situation (Creswell, 2007). Qualitative researchers "study things in their natural settings, attempting to make sense of or interpret phenomena in terms of the meanings people bring to them" (Denzin & Lincoln, 1994, p. 2). They "believe in rich, textured description that has the potential to move others" (Finlay, 2006, p. 3). Furthermore, I especially align with qualitative research as a method of inquiry because I believe it is important to hear the participant's voice in sharing their experience with me. This methodology sets up a framework for facilitating an understanding of the stories and experiences the participants have lived and told.

A narrative approach is used for this study, as it is best for portraying the rich and detailed stories or life experiences of a small number of individuals (Creswell, 2007). Narrative studies primarily utilize interviews to understand the stories of individual experiences, where patterns of meaning are identified (Creswell, 2007). MacIntyre, as cited in Mishler (1991, p.68) expounds, "It is because we all live out narratives in our lives and because we understand our own lives in terms of the narratives that we live out that the form of narrative is appropriate for understanding the actions of others." My narrative study was guided by a feminist lens, as I sought to report and understand the stories and personal experiences of women (Creswell, 2007). Furthermore, feminist research approaches are used particularly, as the study aims to be collaborative and transformative (Creswell, 2007).

Feminist research focuses on cultivating and promoting empowerment and emancipation for women, as well as other marginalized groups (Hesse-Biber & Leavy, 2007). A unifying goal of many feminist researchers is to encourage social change and social justice for women, as there is a strong link between feminist research and activism (Hesse-Biber & et al., 2007). Through delving into individual women's stories, we can influence social ideologies, as Hesse-Biber and Leavy (2007, p. 6) state,

"By documenting women's lives, experiences, and concerns, illuminating gender-based stereotypes and biases, and unearthing women's subjugated knowledge, feminist research challenges the basic structures and ideologies that oppress women."

My research pertains to the lived experiences of women who have had miscarriages, with a goal of better understanding pregnancy loss, empowering women to share their stories, promoting social change through eliminating stigmas involved in this topic and bringing more awareness of the emotional aspects of coping with pregnancy loss, and sharing this knowledge with the medical practitioners who provide care to women.

I gathered data through the collection of seven women's stories, I gave an account of their individual experiences, and I chronologically ordered the meanings of those experiences (Creswell, 2007). "People tell stories about their life experiences. Telling stories helps people to think about, and understand, their personal or another individual's, thinking, actions, and reactions" (Ollerenshaw & Creswell, 2003, p. 329). Through narrative interviews, I am able to appreciate the contexts that these experiences exist in, and more specifically to place the stories within the participant's personal and historical contexts. The narrative approach encourages the researcher to locate the participant's epiphanies, discoveries, and realizations through analyzing the stories shared by the participants

(Creswell, 2007).

### **Recruitment, Sampling, and Participants**

The sampling strategy that I selected to use for this study was convenience sampling (Creswell, 2007). I opted for this approach because the potential participants were not highly visible (being that miscarriage is rarely spoken about in public) and were difficult to access through other recruitment strategies. As this study was conducted under the University of British Columbia research ethics approval board, I utilized non-coercive methods in my recruitment. I did not target specific individuals to participate, and all of the participants were women who I had never met before.

Recruitment for this study involved circulating a research poster through various forums. After receiving permission from the Director of the University of British Columbia's (UBC) School of Social Work, the poster was distributed through the UBC School of Social Work Listserv, an email database for BSW, MSW, PhD students, alumni, and professors. Additionally, prior to posting my recruitment poster on online forums for women and mothers, I received approval from the site moderators.

Following a narrative approach, I chose to limit my study to seven participants because I wanted to include seven in-depth and thorough interviews involving stories, personal accounts, and lived experiences (Creswell, 2007). After providing potential participants with a description of my study, I emailed them a consent form to review and inform me whether they were interested in participating. I invited the first seven individuals who returned completed consent forms to participate in my study. I then notified the others who had asked for more information on the research that I had received the maximum number of participants for this stage of the study, and inquired whether they would consider

allowing me to contact them should I require more participants at a later stage of the study.

The selection criteria for participating in this study were: being a woman over the age of 19 who had a miscarriage; being open to speaking about one's experiences with miscarriage; being able to provide informed, voluntary consent; and able to converse in English, as this is the language the interviews were held in.

I was very much looking forward to a diverse sample, being that participation eligibility for the study was broad in scope in that all women who had experienced miscarriages were invited to participate, regardless of marital status, age, religion, family composition, and sexual orientation. I had hoped that a component of my analysis could look at how factors of social class, religion, political beliefs, ethnicity, number of children, and sexual orientation would intersect with and shape how women perceive, approach, and cope with pregnancy loss.

Table 1 below describes the number of miscarriages the participant had, the trimester in which the miscarriage took place, her age at the time of miscarriage, her relationship status at the time of miscarriage and following it, and the occupation for all seven participants. The similarities between the participants included that they are all Caucasian, heterosexual, middle-class, work in an education or social service setting, and have completed some post-secondary education. The differences between participants included their ages at the time of the miscarriage(s), their relationship status, religious practice, and whether they had children. The ages of participants at the time of their miscarriage ranged from 21 to 40, with all but three of the participants' cumulative 12 miscarriages occurring during their twenties. Five of the participants were married at the time of their miscarriage, one was in a relationship, and one was single. The participants who were married or in a relationship were all in

heterosexual relationships. The religions of the participants included Christian, Catholic, Jewish, and non-practicing. Five of the participants have children, and two do not. The time that had passed between when the miscarriage took place and the date of the interview varied from one year to 16 years.

**Table 1. The Participants**

<b>Participant</b>	<b>Number of miscarriages</b>	<b>Trimester in which miscarriage(s) took place</b>	<b>Age at the time of miscarriage(s)</b>	<b>Relationship status at the time of the miscarriage(s)</b>	<b>Occupation</b>
Eva *	3	1 in first, 2 in second	23, 24, 25	Married	Special Education Teacher
Becky *	2	2 in first	22, 23	Married	Teacher
Rachel *	1	1 in first	23	Married	Community Outreach Planner
Anne *	2	2 in first	28, 32	"On and off relationship", broke up after miscarriage	ESL Teacher
Marsha *	2	2 in first	32, 40	Married during first miscarriage, divorced following miscarriage, re-married during second miscarriage	Administrator for Non-Profit Agency
Jen *	1	1 in first	28	Married	Social Worker
Susan *	1	1 in first	21	Single	Victim Court Support Case Worker

*\* Pseudonyms were given to maintain the confidentiality and privacy of participants.*

## **Data Collection**

Prior to beginning this research project, the study was submitted to the University of British Columbia's Behavioural Research Ethics Board (BREB) for review and approval. Each aspect and stage of the study's recruitment, design, methods, procedures, transcription, and analysis has been examined to adhere to high ethical standards. I took utmost care in ensuring participants' privacy and confidentiality. All computer files were password protected and hard copies were stored in a locked cabinet. All identifying information was removed from transcriptions and pseudonyms were used.

Following receiving completed consent forms, I contacted each participant to set up a time for an interview. I informed them that interviews would last between one to two hours and we could meet at any location that was convenient for them. I also offered the option of conducting the interview over the telephone. I didn't expect all seven participants to select the telephone option. Given that they all either worked or were in university, perhaps they suggested this as the most convenient option. I researched design procedures for conducting telephone interviews and referred to Holt's (2010) analysis of the advantages and disadvantages of using the telephone for narrative interviewing.

Recognizing that this can be a sensitive topic to discuss, I outlined procedural consent with the participants at the beginning of each interview. I informed them that they could stop the interview at any time, they could choose to skip any questions, and they could take as long as they needed to think about and answer each question. I was aware of the importance of developing rapport when dealing with sensitive topics, and incorporated the various interview stages discussed by Corbin and Morse (2003); the pre-interview, tentative, immersion, and emergence stages.

I also acknowledge that in following a narrative approach, participants were welcome to and in fact encouraged to go on tangents. Many participants apologized when they began to go off topic or brought up ideas that were seemingly irrelevant, however I reassured them that it was helpful to my study for them to express themselves in full in whichever order they preferred. While transcribing my data, I found several situations where, during the interview, I wondered how the discussion was related to the topic at hand, yet after considering what led up to it, its relevancy was very clear (Owens, 2006). Because I am an ‘insider’ and have experienced pregnancy loss, I may feel I have a lot of knowledge in this area, but I recognized that the participant is the expert on their own experience (Ellis & Beger, 2003).

My interviews ranged in length from 65 to 113 minutes and involved seven participants. The in-depth one-to-one interviews incorporated a semi-structured approach involving open-ended questions, as well as a component of oral histories. Oral histories are a collaborative method of open-ended interviews where a researcher has a dialogue with an individual about various aspects of his or her life (Hesse-Biber & Leavy, 2006). I specifically utilized semi-structured interviews because while there were questions and ideas I wanted to touch on during the interview, I wanted the conversations to flow naturally and allow the participants to set the pace (Creswell, 2007). The oral histories component allows for an extended process of storytelling and listening and is a collaborative process of narrative building (Hesse-Biber & Leavy, 2006). They involve the gathering of personal reflections of events and their causes and effects (Plummer, 1983) and reveal the process which leads an individual to where she or he is (Hesse-Biber & Leavy, 2006).

My overarching research question was “What have been women’s experiences coping with miscarriage?” I included open-ended sub-questions in my interview reflecting the ideas

I hoped to explore in my study <sup>1</sup>. The sub-questions touched on ideas surrounding a woman's initial response and how it changed over time, the things that brought comfort during and after the miscarriage, support networks, effects on their relationship with their partner, spirituality, resources or programs that were utilized, encounters with the health care providers, the influence of having children prior to a miscarriage, the impact of the miscarriage on subsequent pregnancies, recommendations to women who experience pregnancy loss in the future, and recommendations to medical practitioners who work with women experiencing pregnancy loss. I had hoped to hear from participants both what they found helpful and effective during their coping and what they found unhelpful and ineffective. My reason for this is that I want to fully understand both the positive and negative aspects that were involved in their coping.

### **Data Analysis**

Following each interview, I immediately took notes, memos, and self-reflections. All interviews were audio recorded, and I transcribed each interview verbatim. There are a variety of analytic strategies that can be used in narrative studies. In this research study, I have chosen to use two processes of data analysis: holistic analysis and categorical analysis (Creswell, 2007). I also utilize features of Polkinghorne's (1995) approaches of narrative analysis and analysis of narratives. Narrative analysis involves the collection of descriptive events and the arrangement on them into a chronological plot line. Analysis of narratives involves the use of paradigm thinking in forming descriptions of themes that hold true across different types of stories. I see there to be significant commonalities between holistic analysis and narrative analysis, and also between categorical analysis and analysis of narratives. I employ a blend of Creswell's (2007) and Polkinghorne's (1995) strategies both

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<sup>1</sup> Refer to Appendix A for a full list of interview questions.

in my data analysis and rhetorical structure of the article (Clandinin & Connelly, 2006).

In my first approach of data analysis, I combine holistic analysis with narrative analysis. In the Restorying: Holistic Analysis of Emerging Themes section of this article, I re-story each of the seven in-depth interviews and "collect descriptions of events or happenings and then configure them into a story using a plot line" (Creswell, 2007, p. 54). In order to analyze the data using this strategy, I looked at each interview individually and read it numerous times on its own, until I was able to discover the participant's impressions, meanings, and metaphors. This strategy allowed me to identify stories within stories, locate the contextual experiences and the epiphanies connected to them, and interpret the larger meaning of a story. Each of the stories has a unique process behind it that potentially influences the overall process of coping with miscarriage.

In my second approach of data analysis, I combine categorical analysis with analysis of narratives. In the Findings: Categorical Analysis of Themes section of this article, I list and describe nine themes that I discovered across the stories. I use the same lens to explore patterns and themes which occur across the experiences of participants. In order to do so, once I have completed the narrative analysis, I read over the stories of each of the participants in each of the topics or categories in the interview. I identify similarities and differences amongst the participants' stories and identify the key ideas that are present across the interviews. I proceed by extracting the themes that create links and relationships between the stories, participants, and the overall coping strategies that the participants incorporated.

### **Researcher's Location & Reflexivity**

One unique aspect of a narrative study is that it involves the researcher recognizing his or her location in respect to the topic, and thus he or she "reflexively brings himself or

herself into the study" (Creswell, 2007, p. 214). I have had two miscarriages during the past six years, one prior to the birth of each of my children. It is important that I am constantly aware of my role as an 'insider' having experienced miscarriage, especially given "the fact that the researcher is part of the social world he or she studies" (Hammersley & Atkinson, 1995, p. 16). I recognize that my having had personal experience relating to my research topic affects everything from selecting the topic, methodological approach, data collection, analysis, and summarizing the findings. It is also important to note that interviews involve an interaction between the researcher and participant, engaging in a "fluid interactive process to generate a set of responses which formulate perspectives, observations, experiences, and evaluations pertinent to an overall research agenda" (Edwards, O'Mahoney, & Vincent, 2014, p.119).

I value the participants' willingness to share their personal, intimate, and private stories with me, and I feel that it is important that I have the same transparency with them. Whenever participants asked me questions about my personal experience during the interview, I felt it was important to answer them fully. Several of the participants expressed appreciation for the opportunity to speak with someone who was non-judgemental and who was interested in listening to their story. They valued feeling heard and understood.

Building rapport was an essential aspect in my study (Maxwell, 2005). In a narrative study, "study participants should be apprised of the motivation of the researcher for their selection, granted anonymity, and told by the researcher about the purpose of the study" (Creswell, 2007, p. 124). Prior to beginning each interview, in a brief introduction to my topic, I shared with participants that my research study was spurred by my personal experience with miscarriage. I felt it was important to share this with participants, being that

my personal experience was my primary motivating factor for selecting this topic, with literary reviews on the topic strengthening my resolve.

I recognize that there are "intimate relationships between the researcher and what is being studied" (Denzin & Lincoln, 1994, p. 4). I have found miscarriage to be a tumultuous and emotionally rigorous experience to go through. Many questions, dilemmas, thoughts, and aspirations collide simultaneously. Quite possibly, the most important aspect of my miscarriage experience has been coping and overcoming it. In speaking with women and conducting this research, I have found that each woman's experience in coping with miscarriage is unique and self-guided. What is comforting for one woman may not 'work' for another. What brings one woman into a positive space may bring out feelings of hurt and loss in another. Accordingly, it is important for women to develop ways of coping and utilize healing strategies that are individual to their own needs. Thus, it is imperative that I critically and systemically reflect on my views and experiences with coping throughout the entire process of this study, as I do not want to risk imposing my worldviews and standpoints on participants. Rather, I strive to engage in a dialogue and conversation involving their experiences, and to be conscious of the importance of mindfulness and active listening.

While explaining my study to those who inquired but were not involved in it, I received mixed feedback. The majority of people applauded my effort in bringing awareness to this topic, with both men and women stating that this was a topic that was often not spoken about. There were a few people who responded with remarks such as, "it bothers me when women overreact to a miscarriage. It's not such a big deal. They'll have another baby." This was said by a woman who had three children and had not experienced pregnancy loss. One man was perplexed, "I don't understand, isn't miscarriage common, like all women

experience it? So isn't coping normal?" These comments reflected a societal perspective that is truly a misconception regarding woman's coping following miscarriage. Other researchers have also found that some people respond insensitively to a woman's miscarriage (Mahan et al., 1997). Some people 'may minimize the loss by telling women "you can always have another baby," "at least you didn't get to know him" or "she probably wouldn't have been normal anyway.'" (Mahan et al., 1997, p. 148).

## **CHAPTER 4: RESTORYING: HOLISTIC ANALYSIS OF EMERGING THEMES**

“Narrative inquiry is stories lived and told” (Clandinin & Connelly, 2006, p. 20). In this section, I ‘restory’ the stories shared by participants, with attention to locating their epiphanies and identifying and interpreting contextual and conceptual meaning (Creswell, 2007). In the Theme Analysis of Findings section, I provide an overview and analysis of the themes and commonalities of the stories shared with me, which offers a valuable link between the interviews that I did.

### **Participant 1: Eva's Story**

Eva is married, works fulltime as a special education teacher, and is pursuing a post-graduate diploma following her Master's in Education. After the birth of her two year old son she experienced three miscarriages, two of which occurred during the second trimester, and one in the first. She was 24, 25, and 26 years old at the time of her miscarriages.

Eva was the first person to respond to my poster. She was anxious to participate and expressed a readiness to share her story. In fact, she began the interview by sharing how she feels about talking about her miscarriage. She said, "I'm very open about it. It's not something I'm private about. That actually helps me cope. It was a very good coping strategy for me." Her openness and honesty created for a very meaningful and rich interview.

In a poignant, honest, and straight forward style, Eva shared a diverse range of aspects of her experience coping with miscarriage. She readily identified what she felt were the positive and negative characteristics involved and appeared to easily bounce between the two. For every negative she discussed, she was quick to find a positive that had happened as a result. Eva identified that though she maintained an aura of contentment and serenity with everything that came her way, there were also times when she felt frustrated, questioning

"what's wrong with me, why is this happening?" Eva's statement, "I didn't realize I could be so strong," was a prominent theme which she frequently mentioned. A great deal of our conversation centred on the self-discovery that emerged from her experiences with pregnancy loss.

I learnt that I really could handle tough things. I always had two phobias when I got married: a c-section and miscarriage. I had a c-section with my first and I've miscarried too many times... I learnt that I'm way stronger than I think. That was in a way very encouraging for me. This is one thing I learnt I could overcome on my own through my own... I really learned that I have to find peace in myself; it has to come from me.

Eva later reiterated, "I feel like I became a stronger person and I learned a lot about myself through it. I didn't realize what a coper I could be in the end."

Throughout the interview, Eva affectionately spoke about her spouse and expressed tremendous appreciation for the support he had shown.

My husband was with me throughout. He went out of his way to make sure I felt comfortable in every way and shouldn't have to bother. He took over my household chores and everything. He took care of my son for me. He went with me to the hospital, and stayed with me. He was very calm, and really accommodated me in every single way, to make sure I feel good.

Eva contrasted the way she handled the miscarriage with the way her husband did. Although he was able to provide her with support in many ways, she concluded that she was responsible for her own coping and healing. She said,

Men just cope differently. They're like what's the big deal, they don't understand.

So the exact opposite way than I did. I remember when I found out, when the doctor told me, my husband was watching my son, I came out and I was crying, he asked what happened, and I said she couldn't find a heartbeat. And he was like, it's okay we'll have another one. Like that's it. And I'm like, you weren't the one who was throwing up for months, carrying this one, going crazy, gaining weight from each pregnancy. Not like I'm over it just because I'm no longer pregnant. Even though I was very close with my husband, this is one thing I learnt I could overcome on my own through my own.

Though their coping strategies differed, Eva reflected that her relationship with her husband became stronger following her miscarriages. She related, "we grew a lot. Every time after a hard experience and you don't crumble, it [a marriage] gets stronger. Eva spoke of the various responses people had following her miscarriages, and differentiated between the ones she found to be helpful and the ones that were not. As a matter of fact, Eva recounted,

I don't need pity from anyone. That was the most painful thing for me. When I came home from the hospital, and everyone quickly jumped up and gave me their chair, and I'm like I don't need that. Don't treat me like I have a newborn, I don't have a newborn.

At one family gathering, she recognized that her relatives were trying to be sympathetic by bringing their babies to the other room, or not discussing pregnancy in her presence, however she found this to be painful.

They weren't trying to be mean, but they were being overly sensitive for me, just in case I might get insulted. But I totally didn't. On the other hand, it was much worse. Just be open and honest. So I really learnt I had to overcome it on my own. Because

everything that people do could upset me. Because my hormones were going crazy. Because if they didn't get up from the chair, probably I would have been like why didn't they get up from the chair? And if they did get up from the chair...

Although Eva is open in talking about her miscarriage, she found certain conversations not to be helpful.

One of my aunts told me she had ten miscarriages, and everyone was telling me how many miscarriages they had, or how common it is to have a miscarriage. Or the worst was like your fetus wasn't healthy. It was sent for genetic testing and viral testing. And everything came back healthy.

Eva articulated that she felt that those people who offered their support without making excuses or sharing their own stories to be very helpful. She highlighted her sister's kind acts, such as bringing homemade meals, babysitting her son during doctor's appointments, which may have seemed small but made a tremendous impact.

She brought me soup. That was the nicest thing. Without words. I didn't need people to tell me all their stories or how common it is. That's not what I want to hear. Eva noted that the length of the pregnancy at the point where she miscarried didn't affect her emotional response. Some assume that the later a miscarriage takes place, the more difficult it is on a woman. Eva stated that of her three miscarriages, two of which took place around six months, the one that she miscarried at six weeks "was the hardest to overcome emotionally."

I've had three miscarriages. Two I needed surgery for, because they were very advanced and one I was just six weeks pregnant. The six week pregnancy was the hardest for me to overcome emotionally. With the other ones, I had general

anesthesia, they took the baby out, I didn't feel it. I had heavy bleeding, I bled for 6 weeks after, I had contractions, but I didn't have delivery contractions. With the six week pregnancy, I had heavy contractions Friday night and it was the most painful hardest pregnancy for me to overcome. Which was interesting. I wasn't really nauseous yet, with the other ones I was very nauseous. I found myself really down, and I'm not a down person ever, depression is not one thing I've ever faced. I'm very upbeat. So that was one thing that was very out of character for me.

Eva said that the relationships and rapport she had with her doctors affected her coping. She spoke of her experience with her health care providers with mixed feelings. She described her obstetrician in her first three pregnancies that she had as "unsupportive" and "rude." Although the doctor was one of the top specialists in her field, Eva found her experience with this doctor to be "very discouraging." Eva recounted, "she made everything look so gloomy and bad." After her second miscarriage, Eva decided to switch obstetricians. Regarding her new doctor, she stated, "He was so kind hearted, patient, and answered all my questions." Additionally, she spoke of having a good rapport with her family doctor.

Eva outlined various actions and approaches she took following her miscarriage. Firstly, she found that being open and honest was tremendously beneficial.

It was very hard for me keeping it a secret, people know I was pregnant, I was very far along. So if I speak about it in the open, this way it's much more comfortable for everyone. I was very honest and open to everyone, I said don't worry, don't feel bad for me, I'm okay.

Secondly, Eva stated that keeping herself busy was very beneficial. This was especially helpful when she was overcome with feelings of "I went through everything for nothing."

Through her coping strategies, she saw strength in herself that she had previously not recognized.

After my first miscarriage, I started college three days later for my post-masters. I also went back to work fulltime. So in a way, it was a very good distraction for me. I got right into it, I was very busy. I didn't even have time to think, and I overcame it. And then I got pregnant again, and lost the next pregnancy. So I learnt I'm stronger, I learnt coping skills on my own.

Thirdly, Eva showed tremendous appreciation and gratitude for the son she already had, "I just thought I have a gorgeous two year old and I was thanking God for what I have and if it's not meant to be, it won't happen." In discussing that she had already had a child prior to her miscarriages and whether it affected her coping, Eva commented, "For sure, I think it really helps that I have a child."

A fourth strategy that Eva found to be beneficial was seeking closure following her miscarriages.

I always asked to see the fetus. After surgery when they woke me up, I said I want to see it, don't put it away yet. So that gave me a lot of closure.

Eva also recommended the importance of gaining clarity and closure, by asking one's doctor all the questions one has surrounding the miscarriage.

Asking all the medical questions, why it happened, what are the chances it will happen again, how could I avoid it from happening. It just empowers me. It makes me feel more empowered and gives me more closure and direction for the future. It gives so much clarity, and clarity is what really gave closure.

## **Participant 2: Becky's Story**

Becky is married, works full-time as a teacher, and is completing a graduate degree. Following the birth of her 28 month old son she experienced two miscarriages at the end of her first trimester. She was 22 and 23 years old at the time.

Becky chuckled when she related that she had contacted me to take part in this research study because she wanted to see the results. She also stated,

I feel that there's very little to help people coping with miscarriages. So anything that I can do to contribute and help people going through it and cope with it, I definitely want to be a part of that.

Becky began the interview by contrasting the experiences she had coping with her two miscarriages.

The way I coped for each one was a little bit different. The second one, it was much more emotional than the first. Because the first time...I didn't even know I was pregnant. I was upset about it, but I got over it very quickly, just within a few days. Whereas my second one was at 13 weeks, and it was my second one. It was much harder for me to cope with it, it was especially a stressful time. After I had a D&C [dilation and curettage] procedure, I also had an infection and I was in the hospital for almost 2 weeks. So it was a whole saga, and then ended up being a whole experience; a bad experience, besides for having a miscarriage.

During our interview, Becky spoke primarily of her second miscarriage. She spoke of the trepidation and apprehension that she developed towards future pregnancies and the worry that of whether she would be able to have more children. She also cited what became her added appreciation for her son.

It definitely made me appreciative for what I have, but also nervous for the future, just hoping that the next time would go a lot easier with better results.

Although Becky had many doubts and felt tremendous uneasiness when she had her miscarriages she related that her view of the miscarriage changed over time.

Initially, I was very upset about it and I kept going back and forth. But now I can look back and say maybe it was all for the best. So as time went on, I was able to see that that's how it was supposed to be, I wasn't supposed to have a kid at that time. At the time when it happened, I didn't think like that. It was very upsetting. How come this is happening to me? Why do I deserve this?

Becky reflected on the positive aspects that emerged as a result of her miscarriage, and spoke very fondly of her husband's role in her coping.

My husband really kicked in at the time. He did everything... My husband gave me tonnes of emotional support. I cried a lot. I spoke a lot. He was a listening ear, and I could just speak and speak and speak... It shows me that through the hard times he was able to support me.

Becky attributed a great deal of the support she received to her family. "It was very positive to see that there were people who cared so much." Becky's mother's actions and sentiments were dearly felt. Her mother had offered to fly in from another state, which to Becky clearly showed her mother's commitment to supporting her. Becky reflected,

My mother kept saying don't worry, it doesn't mean you won't have more kids. And physically, she tried to help as much as she could from a different state, trying to get me cleaning services and to make things a little bit lighter.

Becky found a confidante in her sister-in-law, who had three miscarriages before having a

baby. This created a great feeling of hope for Becky, knowing that there was the possibility of there being "light at the end of the tunnel." Regarding her sister-in-law and the role she played, Becky remarked,

She was also very insistent on making sure that the doctors were doing the right testing. It felt like somebody had this experience, knew what to look for, because I was very lost. So with my sister-in-law, it felt like I had someone knowledgeable in the area and taking care of me. And just the support of knowing that she went through it and she got through it.

Visitors during Becky's stay in the hospital also played a pivotal role. This was an important aspect for her for a variety of reasons. She felt that visitors valued her feelings, and helped take care of things for her, including her children. Becky stated that although she felt that there was an unsaid assumption to be very private about one's miscarriage, she found speaking about her experiences played a vital role in her coping. She reflected,

I'm the type of person, I need to tell people what I'm going through. I found it very difficult that I had to – because miscarriage is like a voodoo type of thing, nobody talks about the fact that they had miscarriages. It's supposed to be very very private, and you don't talk about it. So I went out of that a little bit – I had to. That was my way of coping, telling people that I just had a miscarriage. Speaking with people really helped me move on.

Becky didn't tell her friends about her miscarriages immediately, but instead waited some time, a decision she later regrets.

I have friends who could have been supportive and I didn't tell them. I have friends who've gone through a lot of loss. I have a friend who lost a baby during labour, she

was stillborn. I should have and could have spoken with them, and that's something I regret I didn't do. I didn't do it. But I felt at the time I couldn't because there's privacy and people don't talk about it, but looking back I wish I had. I wish I told them.

On more than one occasion in the interview, Becky discussed the increased gratitude she has for her children. I found this increased appreciation towards her children to be a strong theme of one of the outcomes that came as a result of her experience with pregnancy loss. Becky reiterated,

Another positive [aspect of the miscarriage] was appreciating the kids that I have. How valuable they are to me. And how having kids is such a gift. How many things could go wrong, and it went right for me, once, so to just appreciate that.

Becky reflected on how having a son prior to her miscarriages "made it easier" to cope and how she found so much comfort in being around him after her miscarriage.

I definitely was able to look at him, and say I have so much. I had it once so it will probably happen again. If I didn't have a son, since it was two miscarriages, I would probably worry if I would have kids. But since I already had one, the likeliness is that I would have another one. When I came home [from the hospital], I could just say, this is what I have, I should be grateful for what I have. Just looking at the funny things he did the next day. Those are the things that really comforted me, just paying attention to what he was doing.

Another aspect that influenced Becky's coping was taking a vacation, albeit difficult to arrange.

... I was working then and I was also in school. But I just felt at that point, it was

something I needed, and that I wouldn't get my sanity back unless I took some time off. After that vacation I was able to come back to life.

Other than her husband, mother, and sister-in-law, Becky did not talk about her miscarriages with anyone else immediately following her experiences. Like Eva, Becky also did not want pity from others. She elaborated on this by discussing her having pity for herself. As Becky became more comfortable with what happened, she was more comfortable to talk with others.

And I feel like people would pity me. But as time went on, I had gotten more comfortable with the fact that I had miscarriages, and I didn't pity myself as much. And I didn't think they would have that pity for me. I was more comfortable with what had happened. It was easier for me to tell people. And not only that, I found it comforting to tell people, like an open book.

Towards the end of our interview, Becky revealed that she is currently pregnant. She again touched on the nervousness, which I sensed in the beginning to be something that was still on her mind, not just immediately following her miscarriage.

Now that I am pregnant, it [the miscarriages] comes up cognitively, just that I'm much more nervous than my first pregnancy. Every ache and pain, is something wrong? My back is hurting, does that mean the baby doesn't have a heart beat? Just nervousness.

When I asked Becky if there were any resources or programs she utilized, she responded "I wish I knew of them, but I didn't." She went on to discuss the support, or lack of, that she received from her doctors.

I wish my doctors would have been more supportive, especially after my first one

[miscarriage]. I switched doctors after that, he wanted to do a quick procedure, so he didn't give me anesthesia, so I was awake. Not only awake, but I felt every single ounce. So basically, he put me through labour, just because he didn't have enough time to go to the hospital. Not only that, he wasn't supportive. I don't think the words 'sorry for your loss' ever came out of his mouth. So a bad experience for the first one. The second one, my doctor was a little bit nicer about it, but I don't think he provided support necessarily.

She had wished that the various health care providers who were involved were more specific in the information they shared with her.

It was very very hard on me when I went to a radiologist and she just said there's no heartbeat, the baby's dead. That was hard to believe her. She said it once, and that was it... I wanted her to show me, what it looks in the sonogram, when it is breathing, when it's not. And also to take the time to explain to me... I kept asking my doctor, before the D&C, are you sure, are you sure? Because I was in denial. But I just wanted him to go through and explain how they know for sure.

Looking back, Becky stated that she would have felt a tremendous sense of relief if doctors would have discussed her fertility and the future outlook of pregnancy with her.

Also, right away my big question was will I be able to have kids again. I felt that they could have answered, this doesn't mean you won't be able to have children. Or something medically, that just because you've had two miscarriages doesn't mean you're not going to have any kids.

There are several recommendations that Becky made for women who experience miscarriage.

Number one, I would tell them to seek out someone who's been through it before. And if they can in any way find someone that they know if possible, because it's hard to just call a random person and hear their experience. But even a random person is better than no one. Number two, I would definitely tell them to take time off. I'm just talking even a day or two, not to go to work the next day or two days, and have to just go back into things. Number three, not to be scared to talk to people. To look for support. And to tell people this is what I just went through.

### **Participant 3: Rachel's Story**

Rachel is a married woman who works from home as a community outreach planner. She has a one year old son, and has experienced one miscarriage at the age of 23 years old, which took place at the very end of her first trimester.

I found Rachel's interest in speaking about her experience to be an emerging theme throughout our interview. She gained much comfort from the support of her husband, family and friends, and medical team through sharing her experiences. When I asked Rachel what interested her in participating in this study, she responded,

To me, the idea of talking is therapeutic. I haven't really talked about it for a while. I thought getting it out one more time could be therapeutic. And I thought that being part of something that could benefit people, I would definitely want to.

My interview with Rachel was the longest of the interviews I conducted. I feel one factor that accounted for this was that this exchange was more of a dialogue than an interview. While many of the other participants touched briefly on my overarching question, before promptly proceeding to my sub-questions, Rachel took her time discussing her experiences with me in an open dialogue manner. Of the seven interviews, it most embodied the

components of an oral history (Hesse-Biber & Leavy, 2006). It was some time before I asked her questions on specific topics.

In a detailed and reminiscent manner, Rachel shared with me the stages of her pregnancy. She recounted getting married and becoming pregnant shortly after. Both she and her husband were extremely excited about the prospect of becoming parents. She went on to speak of the various parts of her early pregnancy, involving spotting, finding a doctor, a trip to the emergency room, and the final stages of her miscarriage as well. Her journey was filled with much anticipation and hope, despite the disappointments throughout.

At an appointment where her doctor suspected that the previous reports suggested that the fetus stopped growing, she was given the option of scheduling a D&C for later in the week. Rachel recounted the fear of performing any procedures without confirming the status of the fetus one final time.

I said to her that before I do anything, I just want to have one more ultrasound, I just need to know that if I do a D&C, there needs to be a reason for it, I can't live with the fact that maybe there was a heartbeat and they couldn't find it.

The ultrasound confirmed what the doctor suspected, and Rachel went home to rest in the meantime, until she started experiencing significant cramping, at which point she and her husband took an ambulance to the hospital. Following her miscarriage which actually occurred without medical intervention once she arrived at the hospital, an on-call doctor told Rachel, "I'm telling you you'll be back here a year later." It turns out her son was born just under a year later. This hopeful and optimistic statement from the emergency room doctor resonates with Rachel to this day. She also recalls other sensitive statements made by staff at the hospital.

In the emergency room, I remember people telling me, oh it's not your fault, you didn't do anything. Nothing you did brought this on. And I went on the entire time believing that. I never at any point felt that I lifted too much or did too much. I never felt like that. The only thing it did feel was that at one point my husband was going through the immigration process and I was his sponsor. That's the only point, that sometimes when I think about it, that that might be connected. I still can't say. There's no way to know.

This doubt stayed with Rachel, until her doctor discovered and explained to her at a subsequent visit that she had what was called a bicornuate uterus, which may have affected the miscarriage. Rachel spoke of her relationship with her doctor and the positive effect it had on her coping.

My doctor was amazingly supportive and I appreciate how she told me her personal experiences. She herself has a bicornuate uterus and both her children were born by c-section. Which made me feel, like she did it, she has two healthy kids, I can do it. She was very reassuring.

As it turns out, I am very familiar with the term bicornuate uterus, as I have the same uterine condition, and like Rachel, my daughter was also in breech position and I had a c-section. Because Rachel stated that she gained significantly from her doctor sharing her bicornuate diagnosis and c-section experience, I decided to briefly tell her that I have a similar condition. At the end of the interview, Rachel exclaimed that she found the interview to be enjoyable and beneficial,

... Especially because I'm not just talking to some random person. But to someone who went through the same thing, has a bicornuate uterus, so there was someone to

relate to, as opposed to just filling out a questionnaire, which is one sided, or talking to someone who is strictly professional and doesn't really know what they are talking about.

Rachel described what it was like to become pregnant again several months later.

I lost that, I don't know how to say it, that naive part. When I got pregnant again, I was so nervous all the time. And I did have spotting again and went to the emergency room a few times. And every day was like, living day by day.

She shared with me what a relief it was when her son was born. At this point, we touch on several sub-questions. Rachel commented on the different effects of the miscarriage, short term and long term, referring to a "loss of innocence" and an "extra sensitivity."

I think immediately I felt like I lost something that I had a connection to, so I was very hurt in the beginning. And long term I lost a certain innocence I used to have, and I think not just when it comes to children, or pregnancies, but everything. So when things happen, not that I expect for something bad to happen, but now I am more aware that not everything is as perfect as it looks... I think I'm more sensitive to people who don't have children.

Throughout the experience, Rachel spoke of the miscarriage and the various steps involved in terms of "my husband and I." It was evident that this was a journey they went through together and she noted that it strengthened their relationship.

I have to say a lot was the support of my husband. I feel like he made himself very strong about it for my sake so he could be there to support. I feel like he dealt with it behind the scenes, so that when I was having a hard time with it, he could be there for me. So it was definitely a lot of his support, and just listening to me talk, cry,

whatever I wanted to do. I remember just being in bed for a very long while, and his having to do everything.

She took a week off work and staying in bed for a week was part of Rachel's coping mechanism. She was able to lie in bed, thinking about and processing her experience, and healing from the miscarriage. Rachel commented, that staying in bed was,

... unusual for me, because usually I'm very on the go. I can't just sit and do nothing.

I remember just wanting to do nothing. On a regular day, I'd go crazy doing nothing.

Rachel also expressed a need to take her time in coping, and processing the experience.

I think I was more quiet, and thinking a lot and trying to process it. I'm an emotional person, but not so much crying emotional, but talking. So talking a lot to my husband. I really think I gave myself a lot of time to take it in, accept it, no pressure.

I had the support of my husband and my mother, and not being rushed to do anything else, like just being able to lie in bed and deal with it.

Rachel also stated that she was very interested in reading other people's experiences and opinions, doing research, and discussing the options with her doctor. She found an online support website for women who have had miscarriages, and found comfort in "just knowing there was a forum out there and that I could post my questions and reading other people's."

Shortly after her miscarriage and uterine condition diagnosis, Rachel felt ready and interested to speak about her experiences to her close family and friends. She felt really supported by several people in her life.

At that point, I felt I needed the support, I needed to know I could talk about it. I was very into it is not a secret. I told my mother. She was very very supportive. I don't remember anything she did specifically, just the fact she knew, she brought over

dinner a few nights. I also have one aunt I'm very close to. She was supportive because we're such good friends, nothing to do with the fact that she had a personal experience. She called me up every few days asking how are you feeling, just someone I could talk to. I went ahead and I told my three closest friends. Two of them who were single then and I kind of felt bad because I don't want them to lose that innocence and be scared because they knew someone it happened to. But for myself, for selfish reasons, I just needed them to know.

Despite speaking openly with several people close to her, Rachel expressed her frustrations and perplexity about finding there to be silence and stigma attached to talking about miscarriage.

I remember through the whole thing, feeling not that I was going to put it on Facebook, but I feel like there's a certain stigma attached to it, a certain negativity. And it's kept a secret, kept so hush hush. I feel like you can't talk about it or people will think you're crazy. And it was bothering me, why does it have to be kept so hush hush? Not that I wanted to go tell everyone, but I felt that even if I wanted it, it would be such a big no no.

As with Eva and Becky, Rachel highlighted her experiences of not wanting others to feel pity for her.

I didn't want anyone's pity. I didn't want anyone to feel bad for me. In general I'm like that. And about a week later, or maybe two weeks later, my mother dropped off a present, she bought me a bunch of headbands thinking they'd look nice on me. I burst out crying when I saw them, I remember thinking she feels bad for me... I don't want your pity, I don't want your present. She was upset, she was offended that I

took it that way. And I remember making her take them back, because I didn't want them.

Unlike Eva's and Becky's miscarriages, Rachel's miscarriage occurred prior to the birth of her son, and this played a role in her overall experience. She reflected on the differences between having a miscarriage before or after the birth of a child, as this is a topic she has put thought into.

Before someone has children, they don't know what they're really missing. But then after children, you know what you're missing, but you can at least say at least I have my healthy child. But you know what you're missing, so when someone loses that, they know what they're really losing. I don't think it's clear cut one way or the other.

In discussing recommendations that she would make to other women, Rachel emphasized seeking support, whether it be from an online support group, or speaking with friends.

She also found there to be a tremendous benefit from having everyone involved in her medical care to be sensitive and caring. This included her obstetrician, the other doctors and nurses in the practice, and the emergency room medical team. She would suggest to doctors to take extra care in being sensitive and reassuring their patients that they didn't do anything to cause the miscarriage and by staying positive and telling them that they can get pregnant again.

#### **Participant 4: Anne's Story**

Anne is currently married, but was involved in an "on and off relationship" at the time of her miscarriage. She and her partner broke up shortly after the miscarriage. She spoke primarily about her second miscarriage, although she experienced two, both in the first trimester of pregnancy, at the ages of 28 and 32 years old. She was working as an English as

a Second Language teacher in South America at the time of her miscarriage, and is currently a full-time university student. She does not have any children.

Anne was the fourth woman that I interviewed. She began by telling me that she had two miscarriages, yet she said that the first miscarriage was not very traumatic because it took place at four weeks. Her second miscarriage took place between 9 and 10 weeks. Anne shared that one of the first things that comes to mind is that she never shared what happened with her mother. She related that because her mother is a staunch Catholic, she didn't feel comfortable telling her that she was pregnant.

Regarding her first miscarriage Anna said, "the first miscarriage I don't really have anything to say about it because I found out on a Friday and I miscarried that Sunday. So it was not that emotional for me." Anne's described her second miscarriage as much more involved and complicated. She was visiting Canada at the time, from Chile, and went on a trip to Seattle. It was on the trip to Seattle to visit her cousins that she experienced the miscarriage. Almost no one knew she was pregnant and nearly nobody knew she had the miscarriage.

I didn't have anyone to follow me through the process. I was in Toronto with my best friend, she finds out with me. I go to Vancouver where no one knows about it, and then I go to Seattle and I miscarry and my cousins finds out about it. So it was a very strange experience.

Anne related that when her boyfriend had found out she was pregnant he told her that he wanted to be with her and start a family. However, when she informed him that she had had a miscarriage, he no longer wanted to be with her and they broke up. Anne said that she felt that she didn't really have a support network and had to work through the miscarriage on her

own.

The other part of that component was that my boyfriend, my on and off again boyfriend, when he found out I was pregnant, he wanted to be with me and have this baby with me, and then when I miscarried he kind of just went off. So it was a very emotional experience, because I was expecting to have this relationship to continue and then maybe have a family with him and then I saw how flaky he was and that caused a lot of emotional turbulence. I saw how I could have a future with this person when he seemed to want a child with me and when I miscarried he didn't want anything with me and I saw how flaky he was. That was complicated for me because I thought why would you want to be with me with a child if you don't want to be with me by myself?

Anne told me about how she felt emotionally after her second miscarriage. She said that she became depressed and wanted to spend most of her time alone. She described herself as a very social individual and said that the change in her character was very unusual and really bothered her, yet she could not change it.

So I was very withdrawn for a while. I kept very much to myself afterwards. I was very depressed. I went back to Chile feeling quite depressed. And I was just very withdrawn, I didn't hang out with people very much afterwards. I went on a little trip by myself. I didn't interact with people very much afterwards. I didn't see any counselling. I didn't talk to anyone about it. I felt very alone...And I really was quite depressed. I was working, teaching, but I found I was not socializing as much. And I'm a very social person. And it was very opposite to my nature. I felt like I was in a funk and I didn't know how to get out of it. And I think I was like that for a

few months. Probably four months.

She further elucidated on how the miscarriage affected her demeanour, and her overall life.

I recognized that I didn't like the way I was behaving. I felt very isolated and that wasn't normal for me. I felt I wasn't very fun to be around. And I didn't like feeling like that. It was definitely motivated by my internal feelings about myself. That I can't keep sitting in this slump. It was definitely driven by my own sense of recognizing that I wasn't who I normally am. Some friends would tell me that I wasn't very well to be around. So it kicked me into gear more.

Anne said that one of the most emotional aspects was the fact that she had been getting used to the fact that she was going to have a child. She started to envision her life in a certain light and imagined herself being a mother. She said,

Right away, what had happened was that I got adjusted to the idea that I was going to have the child, so you start to create a future. You envision a future and imagine a child not that you know what it looks like but you had a vision of what it might look like.

For Anne, the lack of support that she had played a big role in her experience. Anne said she felt as though she didn't really have anyone to talk to or lean on during this difficult time. The friends that she did tell, didn't understand why a miscarriage would be so difficult. Anne felt that she couldn't tell her mother, for how her mother would react to her becoming pregnant. Though she told her younger sister, she felt her sister didn't fully relate to the situation, as she was several years younger than Anne. Anne said that having some support during that difficult time would have been very beneficial. Anne talked about the isolation she felt and that she was unaware of the effects that a miscarriage could have on her life.

I think it is really important for medical professionals to explain what can happen after a miscarriage. The longer you carry a child, I could imagine it would be worse than what I experienced. There's a lot of things going on emotionally for people. Especially when they choose to keep a child. So there's a psychological or emotional connection they are experiencing with this being. So professionals should be talking about the psychological effects of a miscarriage and also the physiological. The potential for depression, what to do about it, who to seek for help. This could apply to my particular incident because I was in transit. Maybe it's different for women who are in their hometown.

Two years following her miscarriage, Anne still did not feel completely like herself. She consulted with a doctor, who prescribed anti-depressants. She felt the anti-depressants helped her both from a physical and emotional perspective. Physically, she said she felt her body and hormones had not yet returned to their pre-pregnancy state, and that the anti-depressants helped facilitate that transition. She also spoke to feeling less grief following starting them. She shared,

I felt a lot better after I was on antidepressants. At the same time being on the antidepressants I didn't have as many feelings of loss, but felt this was for the better. I didn't have this child where I wasn't going to be a single parent. That life was going to be a lot easier and more flexible.

When asked if she had any recommendations that she would make for a woman who had experienced a miscarriage, she said the following.

I would recommend seeing a counselor. Because there was no one who could really sit and listen to my story and help me process the information and for it to have a

positive spin on it. Talking with people who couldn't really relate to me wasn't helping me at all.

### **Participant 5: Marsha's Story**

Marsha is a married woman who has three children and has experienced two miscarriages. Both miscarriages took place in the early weeks of her pregnancy, when she was 32 and 40 years old. She works as an administrator for a not-for-profit agency.

Marsha immediately made a distinction between her first miscarriage and her second miscarriage. When she had the first miscarriage she did not have any children yet, however when she had the second miscarriage she had two children already. Marsha spoke of learning two important lessons from her first miscarriage. When she was pregnant the very first time she found it to be a very daunting experience. Although she knew that she wanted to have children, she was not sure about the experience as a whole. After the miscarriage she realized that she really wanted to have children and that she was more excited to have children than she had even realized. This was the first thing she learned, that she really wanted to have children.

Secondly, she had wondered "whether god is good when horrible things happen." Having the miscarriage solidified her personal understanding that god is good even when things are bad. Regarding god being good even in difficult times, Marsha stated,

And even though circumstances don't necessarily dictate that, I knew that he was with me and that it was all going to be okay because he is good. So it was really pivotal for myself personally in knowing whether I wanted children or not and it really reaffirmed my faith.

Marsha said that though she grieved, her grieving period was short. She named her child

which she felt contributed to her ability to grieve and treat the miscarriage as a person rather than an idea. With the second miscarriage Marsha was in a very different place in her life. She was married to a different person than during her first miscarriage, and she had two children. The idea of having a third child was very intimidating and she wasn't sure she wanted to have another child. She said regarding being pregnant,

So the idea of having a third and having to cope with having a third was difficult. I've never been more torn probably in anything in my life. I am pregnant and I am happy and I am pregnant and I am incredibly unhappy. I wasn't sure how I felt about it at all.

She even said, "And again I found myself in that place not knowing whether I wanted to lose the baby or not."

The night that Marsha saw and felt signs that she was having a miscarriage, her husband told her that he had had a vision but wanted to wait until morning to tell her about it. The next morning Marsha went to the doctor and it was confirmed that she was having a miscarriage. When she came home her husband told her that he had had a vision of two boys playing together. He said that he felt that god was trying to tell him that their son was okay and that he was playing with her son Isaac (Marsha's first miscarriage) in heaven. Marsha said that knowing that her baby was okay and that he had a playmate who he was related to comforted her. She said, "I think my coping really came from faith and really believing that my babies were going to be okay and that I wasn't going to have the privilege of knowing them here."

Marsha said that though the two miscarriages were very different the feelings were similar. With the first miscarriage the negative was that she grieved alone as she did not

have the support of her husband at the time. But, the positive was that she realized she wanted children, and that god was indeed good. With the second miscarriage, the positives were that she had the support of her husband and they grieved together, and she felt that her two children from the miscarriages were together in heaven. The negative was the loss of a child.

Marsha spoke about her experience following the miscarriage and working through the pain. She said,

I think it was just really embracing the grief and I found that to be true regardless of what circumstance you face in life. If you can actually embrace your suffering you will move through it. You need to actually live in the pain for a little bit.

In other words, she felt that it was important to recognize what had occurred rather than be in denial of the situation and push off ones emotions.

Marsha also was very clear regarding the role that her faith and religion played in her coping. She said that it was her faith and her husband which provided her with the most support during her second miscarriage. Regarding her faith and the miscarriages she said,

I would say it totally strengthened it. I think it's when you go through really difficult things is when your faith comes to question. And you really have to ruffle what you really believe when challenged. In the case of is god good it's really easy for me to say that when things are going good but when they're not going well that's when your faith is questioned. It's those type of questions that come up in these cases.”

One point that Marsha realized once she became pregnant with her third child was that because she became pregnant within nine months of the miscarriage, had she not had the miscarriage, the child she had would not have been possible. This was an interesting point

which she not considered before.

Another important aspect of Marsha's coping involved for medical experience. Regarding her doctor, Marsha said,

Maybe just giving me the information of how common it was. Educating me on why the body miscarries. That something could have been wrong. And it's the body's way of getting rid of this thing that isn't going to be viable.”

Have the knowledge that miscarriages are actually a very normal part of a women’s life and that they are very common assured her that there wasn’t anything wrong with her. That being said, Marsha also felt that women have to have a support system in place, whether it is support groups, their religion and relationship with god, their spouse or good friends. Just having medical information can make one look at the situation as being sterile and it is important to attend to ones emotions.

### **Participant 6: Jen's Story**

Jen is married, has two daughters, and experienced one miscarriage during her first trimester. She was 28 years old at the time, and working as a social worker.

When Jen began speaking about her miscarriage, she talked about how she and her husband had wanted to start a family and were very excited when she became pregnant. She began envisioning how her life would change, and how her family would grow. The experience of having a miscarriage was far more emotional that she would have thought. Being a social worker, she was surprised at how much the miscarriage affected her. Jen became pregnant again very shortly after, and she thought about how if she had not had a miscarriage then her daughter would not have been born. So she was sad that she had lost the first child, but very happy to have the birth of her daughter and she said that in a way it

was redeeming.

Having a miscarriage also taught Jen other ideas which she feels are very important. It has given her a greater appreciation for the joys of parenting and how special of a feeling it is to have children. She said, “long term it has given me a lot more appreciation for the joy of children, the blessing that children are, the privilege it is to be a parent.” Another point she made was that she now empathizes with how difficult becoming pregnant can be for many women and how sensitive one has to be with regards to fertility. She had heard that is it important to be careful what you say to others regarding pregnancy, but soon after her miscarriage she was at a baby shower and another woman asked her when she was going to have a baby. Living out the situation has made her more acutely aware of the importance of sensitivity with regards to asking people about pregnancy.

It was interesting that Jen shared that during the immediate three days following the miscarriage she blamed herself and even apologized to her husband for losing the baby. Though she knew and identified this as being irrational, she couldn't help herself from feeling this way.

I would say things to my husband, I'm so sorry I lost the baby, I was blaming myself, even though I knew in my head... I hadn't run a marathon, even if I had, I knew enough of the literature, the facts and figures that it wasn't my fault, but I really went to that place emotionally.

When the three days were over, she overcame those feelings and thoughts and didn't think like that again.

One positive outcome was that Jen felt that it brought her and her husband closer. Because it was a loss that only they had, that only they shared, it connected them. He was

supportive of her and of him she said,

You find out who you're married to, or who you're partners with when you go through something like that... He let me cry when I needed to cry. And never mocked me.

And so that was key.

She said that even though other people would forget that she had a miscarriage, she and her husband would always know and share the experience of losing that child. Another helpful aspect was reading information about miscarriages and finding out that it is very normal. Also, Jen said that having a doctor who was able to answer her questions and walk her through the process was very helpful.

Jen talked about her faith and being a Christian. She said that her faith helped her know that everything would be okay. Going to church was a comfort and speaking with people and realizing that such a large cross section of people have experienced having a miscarriage. What was also helpful for Jen was to name her child that she had the miscarriage with. This made it more real for her and she was able to relate to the experience as having lost a child.

There was a lot of sense of meaning through my faith, there's a lot of room for celebrating life and death, so my close friends from church didn't scoff at me for naming the baby, not that I told a lot of them, it was a welcomed response. Nobody ridiculed me for the things I was saying or believing.

She stated that in her mind she had already planned this child's life until they were 18, so it made sense for the child to have a name.

In terms of recommendations for women who experience miscarriage, Jen recommended taking it slow and listening to your body. She said that it is very important not

to minimize the pain and to recognize what you are going through. Not to worry about what others think or how others have handled the same situation, rather that you need to do what is best for you. Whether that is attending a support group, connecting to your faith and spirituality, talking to close family and friends, or your spouse. Also, she recommends knowing the facts and seeking out medical advice. Understanding what is happening is extremely important and can really help with the healing process.

### **Participant 7: Susan's Story**

Susan was 21 years old and single at the time of her miscarriage, which took place during the first trimester. At the time, she was working in a health care setting, but currently works as a victim court support case worker.

For Susan, when she had her miscarriage, she immediately began looking at the miscarriage in a purely medical perspective. She also threw herself into her work and began working 10 hour days. She tried to forget that she was pregnant with a baby and used medical terminology to refer to what happened. She didn't tell anyone and avoided talking about it. Years later, when she was working with women, one of the women she was close with had a miscarriage and it brought up feelings from her own miscarriage and she saw a counselor for two sessions which helped.

She said that from the experience she learned to be sensitive to other women who have miscarried and also who may have had difficulty conceiving. She said that she learned a lot about grief and how grief can be different for different people. She stated,

I think it also helped firm up for me the idea that grief doesn't have to be about losing somebody you've known for a long time for it to have an impact. Grief is a lot about the ideas you have in your head and what you lose in relation to that.

As a positive, Susan felt that the experience solidified for her the notion that she wanted to have children. What was difficult is that she didn't really have anyone to share the experience with. She was single at the time and it was the product of a date with someone whom she didn't go out with again. She felt as though her family didn't understand and she didn't really have any friends to talk with. Susan stated that faith played a role in that she was very very angry with god. She felt that here is something that she deeply wanted and god took it away from her. So she didn't find any comfort in her faith.

Susan stated that she looked for information on support groups but the only thing she found was geared towards women who had had a stillborn or who had a miscarriage much later in her pregnancy. She said that it would have been helpful to have support groups which were geared towards women in the early stages of pregnancy.

Susan recommends that women make sure not to let the comments of others affect their grieving and how they experience miscarriage. She expressed that sometimes when women miscarry very early in a pregnancy people over look it as having been a traumatic experience and that isn't right. She believes that it is important that women be aware of the resources available to them and utilize them. Susan did share that she had an initial feeling of guilt and shame. She said,

Part of the other thing that prevented me from talking about it, or thinking about it, or allowing myself to grieve from it and process it was this feeling of shame and guilt, like I was responsible for this being that wasn't even born yet and I already managed to kill it.

Had she realized how beneficial seeing a counselor would have been she would have done so right after having had the miscarriage, instead of two years later. Susan still wants to have

children but is hesitant and nervous about getting pregnant again.

### **Interview Process Similarities**

There were a variety of similarities and differences among each of the seven interviews. I discovered nine themes, which I have divided into three main categories in the next section, Findings: Categorical Analysis of Themes. There were several themes regarding the interview process itself.

When asked what interested them in taking part in this study, the most common response was that the participants wanted to contribute to the published information, or lack of it, in their opinion, surrounding pregnancy loss. Several of the participants searched for information on the internet during and following their miscarriages, yet they found that very little existed. In her interview, Susan detailed,

There was nothing there when I wanted something, it was really great to see that somebody was interested in exploring it, and talking about it, and how can we support women better through this, and what do those experiences look like for women and what needs to happen, what helps, what doesn't help.

The second most common response to the interest in this study was sharing one's story. Many of the participants were excited at the opportunity to discuss their experience(s) of pregnancy loss with a woman who was fully interested in hearing it. Rachel further expounded, "I thought getting it out one more time could be therapeutic. I haven't really talked about it for a while." In discussing their desire to participate in this study, Jen and Susan, who both work in social services, elaborated on the notion of pregnancy being a silent topic, which will further be discussed in the seventh theme, Silence and Stigma Surround Pregnancy Loss. Thus, they were excited to see more research being done in this area.

## **CHAPTER 5: FINDINGS: CATEGORICAL ANALYSIS OF THEMES**

Through categorical analysis of the interviews, I discovered nine major themes in the stories of the seven women who have coped with pregnancy loss. The themes surround the experiences of the women who have had pregnancy loss, and more specifically delve into their responses and coping strategies. Themes one, two, and three surround the emotional experiences during and following the miscarriage. Themes four, five, and six involve coping responses and implications. Themes seven, eight, and nine touch on the roles of support and societal expectations.

### **Theme 1: Self-Discovery through the Journey**

Each of the women interviewed went through a journey of self-discovery in which they revealed a part of themselves they were previously unaware of. Eva reflected that she had discovered two distinct qualities about herself; "I don't need pity from anyone," and "I didn't realize that I could be that strong!" The idea of being able to cope through such a stressful and emotional experience and relying on oneself was prevalent through the interviews. Although the experience was an "emotionally turbulent" time for Anne, after going on anti-depressants, she felt stronger and more able to overcome challenges that came her way.

Jen, who described herself as being especially "pragmatic," was very emotional following her miscarriage. "And that was what took me by surprise," she reflected. She discovered a new dimension to herself, which she was previously unaware of. Jen went on to discuss that she feels that miscarriage is a difficult time but that one often uses the resources they have within them to cope with miscarriage, just as they would with other difficult times in their life. She believes that people cope with pregnancy loss in similar ways they would

cope with other traumas in their life. This held true for Susan who characterised herself as being hardworking. She said that following her miscarriage, "the workaholism kicked in." It was her way of coping with her difficult time, a strategy she has used in the past.

Many of the participants stated that they didn't expect miscarriage to affect them so deeply. Social and political systems that relate to reproduction and fertility can affect a woman's perception of self and her unique and individual experience with miscarriage (Cacciatore et al., 2008; Burns, 2007; Layne, 2003; Saleeby, 2001). These influences include the dishonouring language that is used surrounding pregnancy loss; the way medical practitioners view a woman's role in society and as a result how they treat miscarriage; the choice that women have in the medical treatment they receive; and the social pressures and emphasis on natural labour, and views on fertility. (Van den Akker, 2011; Jonas-Simpson & et al., 2005; Cosgrove, 2004; Castaneda et al., 2003; Smith et al., 2006; Layne, 2003). Thus, there are many systems that influence and interact with pregnancy loss, that women may not fully be aware of in advance. Several studies found perceptions of womanhood to be linked with motherhood, thus pregnancy loss can affect a woman's self-esteem (Hamama-Raz et al., 2010; Castaneda et al., 2003; Brison, 1997). This has a tremendous interplay with the components of self-discovery and realizations that women may come to following miscarriage, which affects their coping journey.

## **Theme 2: Intense Emotional Response During and Following the Miscarriage**

All of the women interviewed described intense emotional reactions during and immediately following their miscarriages. When describing their experiences, they used expressive words including "depression, sadness, insanity, fear, isolated, scared, confused, guilt, mourning, and grieving." The key difference between their experiences was the length

of time they experienced these responses. For some, it lasted a week, while for others it lasted several years. A study by Conway and Valentine (1987) also found that while the intensity of grieving did change over time, the impact of the pregnancy loss never completely disappeared. As in my study, the participants in their study also experienced shock, fear, anger, and intense sadness (Conway & Valentine, 1987). Madden's study (1994) also found that participants experienced emotions such as sadness, disappointment, frustration, and anger following their miscarriage. The feelings of loss that women experience following miscarriage are often not forgotten, whether the miscarriage occurred at six weeks or six months into the pregnancy (Buchanan, 2013).

Jen reflected, "I felt very raw for three days, and quite emotionally discombobulated. I was surprised by that emotional reaction and how I went to that place, what I call insanity. It wasn't logical. Like I went to this place, it's all my fault, I lost the baby." Anne mentioned at several points in our interview, "I was very very depressed." Two years later, after being on a course of anti-depressants, she felt they helped her tremendously. Marsha's experience was intense, yet the duration was not as long. "My experience with miscarriages, they were quite devastating, but short." Susan noted a transition in her experience "once I acknowledged that it was a loss, and it was real, and I'm allowed to feel like it meant something, and that it's not weird to be sad." She felt as though a weight was taken off her at that point. For Susan, following her miscarriage, she began doubting the choices she made during her pregnancy, she was filled with guilt. "In my head, logically and medically, I know that it's really really super not uncommon, and it's not because you've done something wrong. But I still had this feeling that had I started taking vitamins sooner, or had I been working less or exercising less, maybe it wouldn't have happened."

This intense emotional response speaks to miscarriage being much more than a physiological phenomenon. Unfortunately, many medical practitioners view pregnancy loss solely from a medical perspective and neglect the emotions that are also taxed (Lee et al., 1996; Reinharz, 1988). Yet, multiple studies show that women experience grief and feelings of loss following a miscarriage (Hamama-Raz, et al., 2010; Gerber-Epstein et al., 2009; Smith et al., 2006; Brin, 2004; Madden, 1994). Additionally, miscarriage has been found to be connected with clinical levels of depression and anxiety (Rowlands et al., 2010). Thus, women may be unprepared and surprised by their intense feelings following their miscarriage.

### **Theme 3: The Loss of an Envisioned Future**

Following their miscarriages, many of the participants discussed notions of life being unpredictable and uncertain. Several of them commented on the transition from womanhood to motherhood upon the discovery of being pregnant, even in the early days or weeks following the positive pregnancy test. Upon discovering they were pregnant, they began to see themselves as entering a new stage of their lives. Studies have found a strong connection for many women between their sense of self and motherhood, thus miscarriage has been found to bring many questions about one's identity and envisioned future (Gerber et al., 2009; Brin, 2004).

Anne describes her miscarriage as "not just a physical loss, but a loss of my future." Once she found out she was pregnant, she started to "create" and "envision" a future and imagine the child. Jen shared, "I immediately mentally clocked my whole life from that date. I had it all planned out. And pretty much, it wasn't long before the kid was eighteen in my head, mentally." Other participants also calculated various dates in their minds connecting to

their pregnancy, including when they would be visibly pregnant, when they would share the news of their pregnancy with others, and when they would go on leave from their job.

Pregnancy loss also involves a lot of questions, uncertainty, and confusion surrounding fertility, and apprehension about future pregnancies. Marsha who believes that both of her pregnancy losses were those of boys wondered, "did my body not like boys?" She went on to give birth to three girls. Several years following her miscarriages, Anne chose not to have children. She always wondered if biologically her body would have been able to, or "if something was wrong with me." She wondered what her future would have been like had those pregnancies not ended, and had she had children.

For the women who were unsure of their feelings towards the pregnancy, there is an added measure of doubt when it came to the miscarriage. Once they decided that they did indeed want to keep the pregnancy, yet had a miscarriage, they felt guilty about their initial feelings of apprehension. Marsha mentioned, "I wasn't sure how I felt about having children. And so being pregnant was a little daunting and I wasn't sure how I felt about it." She concluded that she was "incredibly sad" following her miscarriage, especially once she realized how excited she was about the prospects of having children. So while she was losing this pregnancy and the way she viewed the upcoming future with this child, her excitement was growing for the possibility of another pregnancy.

Susan, who did not yet have children at the time of the interview, discussed her interest in becoming a mother. While she recognized that the timing of her miscarriage would have been a difficult period to become a mother, as she was 21 years old at the time of her pregnancy, she spoke to feelings of disappointment and sadness at learning the pregnancy had ended, as motherhood was an experience she had really started looking forward to. She

stated, "I am at the point now where I'm starting to look at in the next couple of years or so having a baby. And I'm very afraid of miscarrying again. It gives me a sense of urgency in terms of awareness of that biological clock. And that I may have to account for some failed pregnancies, what if it's harder to sustain a pregnancy, and how many pregnancies I can handle, and what it means in terms of fertility."

In addition to pregnancy loss being a physiological, emotional, and mental experience, it has the possibility of affecting a woman's ideas of future, her sense of self, her life goals, and overall trajectory. Several women in the study spoke to the idea of a loss of naiveté or simplicity when it comes to pregnancy. They expounded that future pregnancies may be wrought with worry. Additionally, after discovering they were pregnant, they had envisioned a life trajectory that was abruptly ended, and did not proceed the way they had hoped or expected. There were few existing studies that addressed this dynamic that was involved in the coping. One study spoke to women feeling that a miscarriage was a rite of passage that was taken away from them (Layne, 1990). Another study spoke to how miscarriage can affect future parenting (Price, 2008). However, most of the studies focused on the present and how women's self-conceptions were affected immediately following the miscarriage.

#### **Theme 4: Developing One's Own Unique Personal Coping Responses**

Each of the participants I interviewed shared with me a unique and individualized way of coping. Their coping responses included the following strategies: time alone, traveling to another country, immersing herself in work, taking time off to cope, university studies, choosing baby names to bring life to the loss, a rubbing stone which the participant kept to this day, distraction, counselling, journaling, speaking with loved ones, a subsequent

pregnancy shortly after the miscarriage, and medication.

While one strategy worked for one participant, it may not have worked for another. Susan did not take any time off work, she went to work that very day. She mentioned that she worked 10 hours a day for the two months following her miscarriage. Becky, on the other hand, took three days off work and was then able to resume her regular schedule. Both Becky and Eva were studying in university in addition to working at the time of their miscarriage, and found that their busy schedule was a good distraction.

When reflecting on how she came to her coping response, Anne observed, "I think it happened organically. I recognized that I didn't like the way I was behaving. I felt very isolated and that wasn't normal for me. I felt I wasn't very fun to be around." At that point, she felt that it was important she make some changes in her coping mechanism, and decided to travel. While Anne did not discuss her experience with any friends or family, Jen found comfort in sharing her experience with friends from her Bible studies group.

Both Marsha and Jen gave names to the children they lost during their miscarriage. Marsha reflected, " I think it really helped me to grieve a person and not just an idea." Jen remarked, "coping wise, something that we did privately, together as a couple, was that we named the baby, and we had a sense of this was our child, this was our loss." Many of the participants spoke to an organic process of developing their coping response, one that arose from trial and error, and participating more in the strategies that were bringing comfort.

Coping is an important aspect of day to day living, and a strong component of managing through times of difficulty (Kalra et al., 2010). Coping involves handling stress in the moment, as well as long-term (Kalra et al, 2010). Recognizing individual coping strategies is tremendously important because everyone handles stress, difficulties, and

hardships in their own individual ways. On the whole, coping may be influenced by culture, religion, family, upbringing, personality, and temperament. In addition, it can be affected by one's day to day actions that they implement into their day. There were few studies that spoke to the practical day to day coping mechanisms which women employ following their miscarriage. Yet, for the women in my study, it appears that their day to day actions played an important role in their overall coping.

### **Theme 5: The Benefit of Spirituality, Religion, and Rituals**

The seven participants I interviewed had varying backgrounds, religions, faiths, and levels of observance or practice. One woman was non-practicing, one was Catholic but stated she was not especially religious, two were Christian, and three were Jewish.

A common question that came up amongst the participants who considered themselves religious or practicing of their religion was whether "god was good," especially in times of crisis. The unanimous answer amongst the two Christian participants and three Jewish participants was yes. They felt that even during times of crisis, god was with them and that the final outcome would be of a good result regardless of the process involved. These five women all commented that their faith was strengthened during their miscarriage. Furthermore, they all said that their faith is one of the factors that helped them get through their experience.

Susan, who identified as Catholic stated, "my belief in god wasn't affected. My relationship with god was affected in that I was angry. I was super super angry. I finally had something I wanted. It was yet another thing that was taken away." Eva, a practicing Jew, said that her faith was strengthened "a million percent." She remarked, "I just felt like this is from god, this is what he wanted." Becky, also a practicing Jew, noted, "immediately, I

definitely sat there wondering like why, why He is doing this to me? And at the same time, I also felt very a very close and spiritual connection, it made me feel also very appreciative for what I have." Rachel, a practicing Jew, found relief in visiting the burial site of a great sage, and praying there for a better outcome in future pregnancies. This coping strategy gave her hope in the future. Marsha, a practicing Christian stated, "I think it's when you go through really difficult things is when your faith comes to question. And you really have to ruffle what you really believe when challenged." Regarding belief, she reflected, "it's really easy for me to say that when things are going good but when they're not going well that's when your faith is questioned." Jen, also a practicing Christian, expounded, "there was a lot of sense of meaning through my faith, there's a lot of room for celebrating life and death, so my close friends from church didn't scoff at me for naming the baby. Nobody ridiculed me for the things I was saying or believing."

Having a miscarriage has the potential to either have a positive effect or a negative effect on a woman's religious belief. In addition to personal feelings of disappointment, some women have felt as though they have failed their church after going through a miscarriage (Feske, 2012). Feske (2012) writes that some Christian women who have experienced pregnancy loss feel as though their loss is invisible, and even when pastoral leaders become aware, they are not equipped to speak with or support them. Pastoral counsellor training on topics surrounding fertility and pregnancy loss may be beneficial. The women in her study also stated that fellow church members responded to hearing that they had had a miscarriage by telling them that they could try again, rather than understand that they felt grief (Feske, 2012). Of the people I interviewed, though, several mentioned being upset with god initially; however, none of them spoke of feeling as though they had failed

their religious institution. Rather, all the women in my study who self identified as practicing their religion stated that their spirituality and faith was strengthened.

One study found that both religious attendance and self-rated spirituality were inversely associated with grief (Mann, McKeown, Bacon, Vasselinov, & Bush, 2008). Those who attended religious services, as well as those who described themselves as religious or spiritual, were found to experience less grief following their miscarriage (Mann et al., 2008). "Religiosity may assist in coping with stressful situations by providing a way to contextualize untoward events and even consider them part of a greater purpose or plan" (Mann et al., 2008, p. 274). Many women who have had a miscarriage search for meaning to what is seemingly an unexplainable occurrence (Layne, 1990), and some turn to religion to seek that meaning (Mann et al., 2008).

Furthermore, the participation in religious or cultural activities may also provide an opportunity for interpersonal support (Mann et al., 2008). Attending services, classes, or programs in one's religious or cultural community, and being surrounded by like-minded people, can increase chances of feeling understood, encouraged, and supported by peers. This may explain why the researchers found that organized religious participation was inverse related with symptoms of grief, yet other measures of religiosity did not have as strong a connection (Mann et al., 2008). Although historically, there has been controversy between the relationship of religiosity and mental health, "the majority of well-conducted studies found that higher levels of religious involvement are positively associated with indicators of psychological well-being (life satisfaction, happiness, positive affect, and higher morale) and with less depression, suicidal thoughts and behavior, drug/alcohol use/abuse" (Moreira-Almeida, Lotufo Neto, & Koenig, 2006, p. 242).

## **Theme 6: Gratitude for One's Children and an Awe of Fertility**

While two participants had children prior to their miscarriages, five participants did not yet have children at the time of their only or first miscarriage. The differences in their responses to their miscarriages, more specifically their concerns and fears, are quite remarkable. Eva, Becky, and Rachel all spoke to the importance of motherhood in their life vision, and expressed that their strong desire to have children may have been intertwined with their sadness following their miscarriage. A strong fear of Rachel's was whether she would ever have children, while Eva and Becky both stated their sons were a comfort to them following their miscarriage. Eva said, "I just thought, I have a gorgeous two year old and I was thanking god for what I have and if it's not meant to be, it won't happen."

Following their miscarriage, many of the participants had developed an added sense of awe towards fertility and the birth of a child, which they no longer viewed as a perfunctory occurrence. Jen was quick to point out that one of the biggest impacts of her miscarriage was that "it has given me a lot more appreciation for the joy of children, the blessing that children are, the privilege it is to be a parent." Marsha also commented that the miscarriage confirmed that she did want children in the future, which was something she was apprehensive about. Susan also pointed out, "having a family is very much in the forefront of my mind. I kind of have my career set so that's my next big goal."

One study identified various characteristics that are associated with higher distress following pregnancy loss, including whether the pregnancy had been planned, how recent the loss was, not having subsequent live births, childbearing desires, and the importance the woman placed on motherhood (Shreffler, Greil, & McQuillan, 2011). Like the women in my study noted, having children brought comfort to them during their miscarriage (Shreffler et

al., 2011). Having experienced previous pregnancy loss can also increase depression and anxiety symptoms during a subsequent miscarriage (French, 2011). Women who were childless and experienced pregnancy loss or had failure to conceive reported highest levels of depression and lowest life satisfaction (Schwerdtfeger et al., 2009). Often times, women who have had previous miscarriages may get anxious as they approach the gestational point at which their previous miscarriage occurred (French, 2011).

### **Theme 7: Silence and Stigma Surround Pregnancy Loss**

The majority of the participants felt that it was not considered acceptable to talk about miscarriage and that it was frowned upon to share their experience with others. For some, it felt like a topic that was surrounded by silence. For others, it felt like an area that had a lot of stigma attached to it. There was a sense of miscarriage being a topic that is supposed to be kept quiet about, rather than discussed openly. Living or debating with socially imposed silence, Rachel said, "I feel like it's a stigma, you can't talk about it or people will think you're crazy."

Jen said that she shared the experience with four friends, and only with one of them did she regret speaking about it. She noted that that specific friend could not understand or relate to this topic. She reflected, "there's only so far that people will share the grief of miscarriage." Susan specifically avoided telling anyone from her Catholic church, "the church would not have been amused by me being pregnant with someone I went out with just once." Marsha, on the other hand, stated "I wasn't afraid to tell people that I had experienced a miscarriage but that's more my personality. Some people are more private but I'm not one of those types of people." She laughed, "if anything, I've had to learn not to tell everyone everything."

Both Marsha and Jen, who attended Christian churches, were comfortable sharing their miscarriage (and thus by default the fact that they had been pregnant), with the members and leaders at their church, while Susan, who periodically attended a Catholic church, was not. There were three key differences relating to these experiences. Firstly, Marsha and Jen were married, while Susan was single. As she mentioned above, Susan expressed feeling apprehensive about how her church community would view her being pregnant with someone she went on one date with. Secondly, Marsha and Jen were active members at their church, and participated in a full range of programs, while Susan said she attended her church from time to time, and thus possibly had not yet developed many social connections there. Thirdly, on the whole, Marsha and Jen both spoke more freely of their experience with miscarriage than Susan did, which could possibly be attributed to their personality styles. It would be interesting for further studies to explore whether one's specific religious affiliation may affect how comfortable a woman is with speaking about her miscarriage, which factors may induce or inhibit communication channels in her religious community, and whether silence or stigma comes into play.

Jen made note that this silence does not only pertain to miscarriage, but loss on a whole. "We're really quick to minimize pain, suffering, or the topic of death in our society in any way shape or form." She continued, "there's no visible wound that tells people that there's been a loss here unless I let them know, so it's silent. And sometimes women don't know how to give voice to it." Susan commented, "we need to break down that societal shhh it's just something that happened, we don't talk about it." Susan spoke a lot of societal expectations and norms. "In society, it seems we don't value something unless we can see it" she stated. Because this is not a topic commonly discussed, Susan had a difficult time

understanding her own feelings following her miscarriage. "I kind of assumed, if you're having a hard time with it, nobody else talks about having a hard time with it, clearly there's something wrong with you. I was kind of feeling, almost, shame, well, I think, shame is too strong of a word, but definitely not feeling normal for needing to grieve."

Many people underestimate the impact of pregnancy loss on a woman, and so the reactions and responses she receives may be insensitive or she may encounter silence (Mahan et al., 1997). Researchers on trauma (Antze & Lambek, 1996) have discovered how important, but at the same time how difficult, it can be for "those who undergo such disruptive events to find empathetic listeners who are willing to hear their stories" (Layne, 2003, p. 1889). One study discussed the silences and taboos surrounding pregnancy loss and saw ways that pregnancy-loss support groups was challenging these stigmas (Layne, 1997). Support groups challenge the notion that pregnancy loss is a silent topic, by bringing voice to the women in the groups. However, one limitation of support groups in general is that they are applicable solely to the participants involved, and thus do not necessarily bring awareness on a global scale. It would also be further beneficial to explore other strategies that are combating the social silence surrounding this topic.

None of the women in my study participated in support groups. Many said that in hindsight they would have enjoyed and benefitted from the opportunity, but they did not know that support groups existed. Several of the women said that they would have attended support groups in person, over the telephone, or through online forums. They encouraged medical practitioners and those involved in the care of women who experience miscarriage to become knowledgeable in the resources available in their communities, so they can guide women to appropriate services and resources.

## **Theme 8: The Importance of having Support: Partner, Family, and Friends**

Five of the participants were married at the time of their pregnancy and miscarriage, one was in a relationship, and one was single. One of the participants who had two miscarriages divorced following her first miscarriage and her second miscarriage took place during her second marriage. Five of the participants referred to their husbands as a strong source of support throughout their experience with pregnancy loss. Both the participant who was in a relationship that ended following the miscarriage and the participant who divorced following her miscarriage stated that their partners were not a source of support during their miscarriage. The participant who remarried at the time of her second miscarriage said her second spouse was incredibly supportive and helped her go through the experience.

In five of the six discussed marriages, the participants felt their relationship was strengthened as a result of the miscarriage. They felt that going through the experience together brought them closer. Jen emotionally stated, "You find out who you're married to, or who you're partners with, when you go through something like that. It built intimacy in our relationship, rather than took away from it." For some, it meant that the husband was there to cry with them. For others, it meant that the husband contributed to a lot of the household responsibilities while she was recuperating from the miscarriage. Regarding her husband, Jen mentioned, "he was just there and that was just enough support." She went on to say, "he let me cry when I needed to cry. And never mocked me."

The two women whose relationships ended following their miscarriage stated that their relationship was not in a good place prior to the miscarriage. Anne described her relationship as "on again off again" and mentioned that her boyfriend had asked her if she was really pregnant or if it was a strategy to resume the relationship. She had said, "when he

found out I was pregnant, he wanted to be with me and have this baby with me, and then when I miscarried he kind of just went off." She described this as a very difficult experience that added to the pain of the miscarriage. "That was complicated for me because I thought why would you want to be with me with a child if you don't want to be with me by myself?" Anne reflected.

During a marriage, spouses often encounter stressful experiences, yet some situations affect one partner more directly than the other (Smart, 1992). In a miscarriage, a woman goes through a variety of physiological symptoms, as well as emotional and mental responses. However, in many instances, her partner is also affected (Cacciatore, 2009). Their coping responses to the pregnancy loss may be similar, or they may vary greatly. The participants in my study all described support from their spouses in different ways. However, the shared similarity in what was considered supportive was when the partner was understanding of what she was going through, and readily available to assist her or be there for her in their own personal way. The participants who described their partners as not being helpful or supportive described them as being detached or not available or interested in speaking about the miscarriage.

Each of the participants also had a varied network of people who they felt provided them with support and comfort. For some, it included parents, siblings, relatives, friends, colleagues, mentors, or community members. Becky stated that her mother's offer to fly in at the time of her miscarriage "showed a lot of support." It meant a lot to her that there were so many people who cared. Jen shared that the women in her church group were supportive and readily available to speak. Several of the participants expressed that speaking with friends or relatives who have gone through miscarriage was especially helpful. Aside from feeling

heard and understood, they were able to ask questions or seek advice from the women who have had similar experiences. The support looked different for each woman, yet they found it valuable and helpful. Regardless of the source of the support, all participants found having support to be an important part of their coping and healing. Cacciatore (2007) found that being able to speak about one's experience with loved ones and having support from family and friends contribute to a woman's coping with pregnancy loss. Support from family and community has been found to be a very positive aspect of coping for women following miscarriage (Rowlands et al., 2010).

### **Theme 9: Rapport and Relationship with Health Care Providers**

One's relationship with the health care provider had an effect on the women's experience of coping. Rachel noted that she was surrounded by caring, compassionate, and competent doctors, whom she had a strong rapport with, which she felt helped alleviate some of the stress and was very reassuring. One doctor reassured Rachel that her hope was that Rachel's next visit to the hospital would be for the birth of a child. Jen also mentioned she had a positive experience with her team of midwives, who guided her through her miscarriage from start to finish, informing her of each step of the process, and equipping her with information.

Eva consulted a medical referral agency and was referred to a top specialist. However, she was disappointed with his bedside manner, as she found the specialist to be cold and rude, which made Eva feel discouraged. She spoke with the director of the referral program and was referred to another doctor, who she found to be much more sensitive and caring. Eva was impressed with the director of the referral program, who called her afterwards to ensure that everything was going smoothly with the new doctor and that she

was happy. Eva's family doctor was very helpful and provided her with guidance throughout her pregnancy. Eva said, "So I just felt that between the director of the referral program and my regular doctor and my husband, that was my support system and that was really what helped me while and during." Becky was upset about her medical experience during her first miscarriage, and switched doctors promptly afterwards. She felt that her doctor just wanted to get the surgical procedure done and move on with his day. "Not only that, he wasn't supportive. I don't think the words sorry for your loss ever came out of his mouth" she stated.

Many of the participants spoke to the benefits of having reading material on pregnancy loss. They remarked that there was very little information available online, and it was hard to decipher what was accurate. Upon discovering she was miscarrying, Jen immersed herself in reading material on the internet, and reflected "it said 40% of pregnancies end in miscarriages. And I was like, they don't tell you any of this. Someone should warn women of this." She said that being equipped with information would be beneficial for all women.

Susan spoke to the medical terminology used surrounding pregnancy loss. "That's what people were referring to it as, spontaneous abortion and non viable products of conception, it was extremely unhelpful." She went on to say that "I think that it's very dehumanizing and distancing and invalidating." Along these lines, there are a variety of studies that show that the medical terminology and language surrounding pregnancy loss can be hurtful to women (Van den Akker, 2011; Jonas-Simpson & et al., 2005; Cosgrove, 2004; Chalmers, 1992).

Many of the participants clearly expounded on the features of the relationship with

the healthcare provider that they found to be helpful and positive. They appreciated an empathetic and compassionate demeanour, being fully informed of all the information surrounding their experience, feeling reassured, sensitivity in language, being told of all the medical options and choices and feeling included in the decision making process, and being directed to reading material and printed resources. Studies have found women's coping to be impacted by having a satisfying experience with medical professions (Rowlands et al., 2010; Abboud et al., 2003; Paton et al., 1999). Furthermore, there has been an importance placed on having one's questions answered and procedures thoroughly explained (Paton et al., 1999). One study emphasised the tremendous advantage in women being included in the decisions surrounding her medical care (Smith et al., 2006). There were clear benefits seen when women were involved in the decision making of the potential management methods of their miscarriage (Smith et al., 2006).

## CHAPTER 6: DISCUSSION

### **Implications for Social Work Practice**

"A multi-level approach to miscarriage which involves support and education for women, their families, and health care professionals may help minimise the extent of women's distress after miscarriage" (Rowlands et al., 2010, p. 274). During pregnancy loss, a woman inevitably comes in contact with a variety of health care professionals. This can include her general practitioner or family physician, midwife obstetrician, emergency room doctors, nurses, specialists, researchers, social workers, mental health practitioners, and/or support staff. A woman's medical experience can either be a positive or negative one, and these health care professionals can have a significant impact on a woman's coping (Abboud & et al., 2003). Many women benefit from having a follow-up visit with their medical provider after their miscarriage (Adolfsson et al., 2006; Mahan et al., 1997). While medical professionals are trained to provide the physical treatment for women experiencing pregnancy loss, social workers also play a significant role in their care. "Social workers are in a unique and important position to intervene in the event of a perinatal death, given their training and expertise in attending to the emotional needs of individuals and families and assessing the crisis in relation to the family's social environment" (Brownlee & et al., 2004, p. 518).

For the medical care providers, treating a woman experiencing pregnancy loss can be a common or routine medical occurrence, whereas for each woman a miscarriage is a personal and delicate process (Abboud & et al., 2003). This sentiment has been common in my interviews and is prevalent in many studies, with Letherby (1993) powerfully stating that miscarriage is often seen by others as an insignificant loss that can be remedied by another

pregnancy. Yet, this is not the case; for many women miscarriage is a considerable loss. Unfortunately, despite the prevalence of miscarriage, or possibly because of its prevalence, many health care professionals do not recognize miscarriage to be a psychologically taxing event, which results in women not being routinely provided with follow-up care (Lee, Slade, & Lygo, 1996; Reinharz, 1988). Multiple studies show that women experience grief following a miscarriage and they cope with it in a variety of ways (Hamama-Raz, et al., 2010; Gerber-Epstein et al., 2009; Smith et al., 2006; Brin, 2004; Madden, 1994). I view this as not just a personal issue for women, but rather a societal issue that goes beyond the emotional experience for women themselves, which is linked with the banalization of suffering and its management being seen as a minor loss (Letherby, 1993; Cacciatore & et al., 2008). It is important for physicians in particular not to trivialize pregnancy loss, or say dismissive comments on its insignificance (French, 2011).

It is in this respect that social workers can assist women who have gone through pregnancy loss in three ways. Firstly, they can help the women directly by offering compassion, understanding, and sensitivity surrounding their pregnancy loss, as many women have expressed dissatisfaction with the emotional support given to them by medical professionals (Van den Akker, 2011; Brownlee et al., 2004; Paton et al., 1999). Many women benefit from suggestions about reading material (Mahan et al., 1997). Secondly, in addition to directly supporting women, social workers are able to offer awareness, guidance, and a leadership role to the medical professionals in increasing their sensitivity when treating women for pregnancy loss. Incorporating Jonas-Simpson and McMahon's (2003) Canadian study on the language surrounding pregnancy loss can potentially impact and improve the care that women receive. Thirdly, social workers can offer therapeutic services to women

following a miscarriage. One study examined the effectiveness of psychological support intervention involving a variety of clinical techniques for women who had a miscarriage (Sojourne et al., 2010). The three clinical methods included support, psychoeducation, and cognitive-behavioural therapy (Sojourne et al., 2010). It was found that each had a benefit in its own way, and that "a brief early single-session psychological intervention appears to be a particularly pertinent, efficacious and cost-effective method for addressing psychological distress following miscarriage" (Sojourne et al., 2010, p. 287).

Given the widespread nature of miscarriage, this study impacts the field of social work because of the importance of better understanding the emotional effects, responses, and coping strategies that women find to be of comfort. Social workers should seek to play an active role in supporting women in their coping. This can include a follow-up phone call for women after leaving the hospital and advocacy in seeking explanation for the medical procedures involved. I believe that it would be pertinent for the health authorities to conduct an evaluation of the follow-up programs and strategies that are being offered by hospitals and clinics for women who have experienced pregnancy loss.

Furthermore, several of the participants in this study experienced that there is much silence and stigma surrounding miscarriage. A study on the effects of support groups on post traumatic stress responses in women experiencing stillbirth found that support groups help with managing grief, and that connecting with women who have had similar experiences may be a useful strategy in reducing problematic psychological outcomes (Cacciatore, 2007). Support groups were also found to lessen the social silence that women experience during pregnancy loss (Layne, 1997). A further analysis of the benefits of a support group for women who have had miscarriages to speak openly about their experiences and connect with

other women would contribute much to this topic.

Many websites geared to women's health and fertility that discuss pregnancy loss speak to a variety of related issues, but unfortunately leave out the emotional and psychological components. Mainstream websites such as WebMD, MedicineNet, and Infertility Specialist, discuss prevalence, causes, symptoms, treatments, amongst other medical aspects of miscarriage, but do not address a woman's coping (Evans, 2012; Gaither, 2014; Stoppler, 2014). It is important to include the emotional and psychological components involved in pregnancy loss in both scholarly publications and mainstream articles geared to the general public. In scholarly articles discussing miscarriage, it would be beneficial for physicians and obstetricians to be aware of coping mechanisms involved in miscarriage, in addition to the medical management aspect. Having a social worker contribute to mainstream articles on miscarriage that are written by obstetricians would allow the public at large, both men and women, to view pregnancy loss as more than just a physical loss. It would allow women to be more accepting emotional response and guide them to resources in coping. It would also help their partners better understand the various dynamics involved in pregnancy loss.

I was relieved to see an article about miscarriage on the popular website BabyCenter (2012) begin with "the loss of a pregnancy can come as a terrible blow. As well as the emotional shock for you and your loved ones, you may find the physical symptoms hard to bear." Following the discussion of physical aspects involved in miscarriage, it had a section titled "I can't seem to get over my miscarriage. Where can I get help?" (BabyCenter, 2012). While this was certainly a step in the right direction, I believe that speaking about coping as a normal phenomenon following a miscarriage, rather than something that is unusual, would be

a more encompassing approach to take. This would help normalize the varied experiences that women face, and could alleviate societal misconceptions and stigmas surrounding pregnancy loss. There was also a link at the bottom of the article to BabyCenter's Online Community, where women can find support from other women who have experienced loss. This is a great resources where physicians and social workers can direct women.

### **Limitations of the Study**

One concern I had at the beginning of my interviews was conducting a narrative study over the telephone. However, in her article, Holt (2010) outlines the numerous ideological, methodological, and practical benefits of conducting narrative interviews over the telephone. Ideologically, having the interview over the telephone as opposed to face-to-face can limit what she refers to as the 'professional gaze' for women who feel marginalized (Holt, 2010). Furthermore, telephone interviews can serve to lessen the differentiation between participant and researcher, and the many aspects of differences in class, race, and age (Holt, 2010). Methodologically, being that there is a lack of non-verbal communication, everything had to be fully articulated by both the participants and the researcher. This aids in the sharing of stories and experiences, because telephone conversations are often rich in detail. Practically, having interviews over the telephone allows for more convenience for the participants.

One validity issue involved that I endeavoured to be aware of during my study is researcher bias in the formulation of the questions that I asked (Maxwell, 2005). I strove to ensure that I did not ask leading questions based on preconceived notions, existing literature, or personal assumptions. It was very important to me that the questions were not geared towards producing a desired result, and not tainted by my personal experience. Having an awareness of my own experience and views on miscarriage was very important. It was

imperative that I recognized that each woman has her own unique experiences and that there is an extremely wide range of coping strategies that women use.

### **Future Research**

The topic of how women experience and cope with pregnancy loss is very pertinent, yet under researched. Following my study, I have further developed an appreciation for the complexity involved in going through miscarriage and the variety of ways a woman copes with her loss. The following is a list of ideas for further areas of study.

In the literature, I found there to be a gap involving in-depth analysis of the effects of internal and external factors, as well as protective and systemic factors, in how women shape and respond to their experience of miscarriage. Standards of compassionate care in hospitals, support from friends and family, and opportunities to discuss one's pregnancy loss, whether it be in a formal or informal setting, are positively contributing towards women's coping in pregnancy loss (Cacciatore, 2007). These types of systemic changes are helping women speak more about their experiences, which in turn affect society's understanding, expectations, and responses to pregnancy loss (Cacciatore, 2009). In his study, Neugebauer (2003) touched slightly on some of the factors that may or may not affect depressive symptoms among women coping with miscarriage, but his discussion was limited. I was surprised to see his findings that generally speaking depressive symptoms following a miscarriage were not affected by marital status, ethnicity, educational levels, and number of children a woman has (Neugebauer, 2003). I expected factors of socio-economic status, ethnicity, culture, religion, ability, class, political beliefs, family composition, and sexual orientation to play a role in how a woman experiences, perceives, approaches, and copes with her experience of pregnancy loss. Unfortunately, I was not able to fully engage with this in

my own study, given the study's limited sample constitution.

In contrast to Neugebauer's study (2003), other studies have found factors such as age, religion, and family composition to affect a woman's coping with miscarriage. One study found increasing age to be a protective factor in coping, potentially linking increased maturity with efficiency in coping (Mann et al., 2008). These researchers also found participation in religious activities to aid with coping (Mann et al., 2008). Family composition plays a role in coping, as it was found that not having children was a factor that increased a woman's distress during miscarriage (Shreffler, 2011).

Studies have found that overall, religious involvement is usually associated with better mental health, particularly amongst people undergoing stressful circumstances (Moreira-Almeida et al., 2006). The use of rituals in mourning pregnancy loss has been found to offer grieving parents much healing (Brin, 2004; Van den Akker, 2011). The absence of cultural rituals for miscarriages has been found to potentially prevent women from getting closure (French, 2011). Deeper exploration of religion, culture, and spirituality in connection with coping with pregnancy loss would be an interesting area for future research to explore.

An additional method of inquiry to incorporate in research, analysis, and interviews can include creative mediums of self-expression, including journaling, art, and poetry. It would be very fascinating to use this mode of expression as a research strategy to explore reflections and inner thoughts of the participants during and following their miscarriage. Furthermore, there is a wealth of discussions on pregnancy loss on women's online forums and support groups, some of which are open to the public, while others are open to a select registered group. This may be a medium of information rich with data and expression which

a researcher can incorporate in his or her data. Another method of inquiry can include the use of focus groups, as the interaction and discussion amongst participants can bring about many insights and epiphanies.

### **Conclusion**

While there is risk for emotional distress when discussing sensitive topics, literature suggests that participants may in fact benefit from the opportunity to talk about their experiences (Castle & Phillips, 2003). Interviewing participants using a qualitative approach allows for them to disclose their full experiences, and often people appreciate the opportunity to have their stories heard genuinely and taken seriously. In my study, I hoped to validate the expertise that each participant brought to this particular area of inquiry, as this can be an empowering experience, knowing that their participation in this project may help women experiencing miscarriage in the future.

At the end of each interview, I asked participants for feedback on the interview process, which I incorporated as my interviews proceeded. I also asked them what interested them in participating in the study and whether they gained what they sought out in their expectations of participating. The participants spoke to the benefits of sharing their story and the hopes of helping women who go through miscarriage in the future. While coping is a very individual and unique process, many common trends have been identified through my interviews. It is my hope that my study can assist in the formulation of a resource packet for women who experience pregnancy loss in the future.

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## APPENDIX

### Appendix A. Overarching Research Questions and Sub-Questions

#### Overarching Research Questions:

1. I'd like to ask you, in your own words, what have been your experiences with pregnancy loss and miscarriage?
2. Can you please share with me your experiences of coping following your miscarriage. What I mean by this is the things you did to respond, carry on, survive, and thrive following your miscarriage, and this can include actions, thoughts, ideas, teachings, etc.

#### Sub-Questions:

1. How did the miscarriage have an effect on you, immediately and long-term?
2. What was your initial response and how did it change over time? Ie: step by step if possible.
3. What were your experiences following the miscarriage, both positive and negative?
4. Can you share with me how you managed following your loss?
5. What did you find to be of comfort throughout your experience? Ie: what brought a smile to your face? What did you find helpful in your coping?
6. How did you come to develop your coping response/strategies? Was it something that fell into place or did you seek it out?
7. Tell me about your support system during your experience? You can mention any people that apply to your experience, whether it be your partner, family, friends, community, spiritual leader, colleagues, medical team, etc.
8. Can you share whether you feel your relationship with your partner was affected?
9. How did you feel about people knowing or finding out about your miscarriage. Did you share it with anybody? How did it feel when people brought it up? Ie: was it helpful or unhelpful?
10. If applicable, would you say your spirituality, religious practice, and/or belief in god, were affected? If yes, how so?
11. If applicable, can you share if having children prior to the miscarriage affected your coping?
12. To this day, do you think about the miscarriage? If so, in which ways, when?
13. If applicable, has the miscarriage had an effect on your outlook of future pregnancies?
14. Were there any resources or programs that you utilized?
15. Did you receive the support of any professionals? Ie: doctor, OB, specialist, case manager, social worker, clinician, etc? If you didn't, do you wish you had?
16. What was your relationship like with your doctor? And do you think it affected your coping?
17. Were there any strategies or actions that you found not to be helpful during the experience?
18. What are the recommendations you would make to women in the future who experience pregnancy loss?
19. What are the recommendations you would make to doctors who are involved in a woman's care during and following pregnancy loss?
20. I'm wondering if there is there anything else you'd like to share with me? Or something

you think may be applicable to my study.

21. What interested you in taking part in this research project?

22. Can you tell me how you felt about participating in this study and the process involved?