EARLY UNINTENTIONAL PREGNANCY LOSS AS IT IS EXPERIENCED BY THE COUPLE: A PHENOMENOLOGICAL STUDY

By

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Abstract

This phenomenological study examined the experience of miscarriage from the couple's perspective. The study participants were six couples who had miscarried within four weeks of the initial interview. Data were collected in interviews and were analyzed concurrently. Themes were identified and validated by the couples as the interviews progressed. Findings from analysis confirmed that couples grieve following a miscarriage. This grief experience is represented by a composite of four interacting motifs called Discovery, Disclosure, Definition and Decision. Each motif is characterized by dominant emotions and behaviours. The composite interacts with the external theme of Health Care Interactions. Findings supported assertions that individuals within the couple relationship grieve incongruently. The grief experience is facilitated or hampered by the quality of health care interactions the couple experiences. Couples identified needs that were unmet during the experience particularly the need to talk through the experience at a later time and the need to have their losses acknowledged by their health care givers. Differences in Discovery were found between couples who had a prodromal phase of miscarriage and those who had a missed abortion. Couples who had a missed abortion experienced confusion in addition to the shock and disbelief encountered at this time.

Findings also supported the assertion that grief following a miscarriage is generally resolved within twelve weeks.

This description of the grief experience following a miscarriage will assist nurses to provide couple-centred care to facilitate resolution of their grief. Implications for practice, research and education are described to enhance the nurse’s ability to provide more effective care to miscarrying couples.
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CHAPTER ONE

Background To The Problem

For couples desiring a family, pregnancy is a time of challenge and hopeful anticipation. The first pregnancy represents one of life’s major transitions as the developing fetus becomes incorporated into their relationship and the preparations for parenthood are begun. Pregnancies necessitate many adjustments as the couple prepares for the final step, in our society, to adult responsibility. Unless the couple has close relatives or friends who have miscarried, or have experienced infertility problems, the couple approaches pregnancy optimistically believing that the pregnancy will end with the successful outcome of a healthy infant (Oakley, McPherson & Roberts, 1984).

Because human reproduction is surprisingly inefficient, healthy infants are not the outcome of all pregnancies. Clinically, 15-20% of pregnancies terminate spontaneously by the end of the first trimester (Cavanaugh & Comas, 1982; Neeson & May, 1986; Rock & Zacur, 1983). This figure is generated from the number of hospital admissions for treatment related to spontaneous abortion. In actuality, the number of spontaneous abortions is much higher for these statistics do not include women who abort entirely at home without need for further medical care, nor do they include women who are admitted to hospital for vaginal haemorrhage which subsequently is attributed to a spontaneous abortion.

Miller, Williamson and Glue (1980) found the incidence of miscarriage to be highest in the first two weeks after conception, tapering down significantly by the end of the first trimester. They monitored the serum human chorionic gonadotropin levels during the luteal phases of the menstrual cycles of 197 fertile women and confirmed 152 conceptions.
Spontaneous abortion occurred in 43% of those conceptions with 138 conceptions terminating at or around the expected menses. Fourteen conceptions progressed to clinical recognition before terminating. As indicated by these findings, the incidence of pregnancy loss is highest early in the gestational period. By the twentieth week of gestation, the incidence drops to 3% according to Neeson and May (1986). In the recent past, a woman losing a pregnancy in the early stages may never have known about her conception. She may have considered her period to be a little late, or to have skipped for one month. Today, pregnancies can be confirmed much earlier. Testing strips that determine the time of ovulation and generalized increased awareness of fertile periods of the cycle assist couples to time conceptions. Serum pregnancy tests permit diagnosis of a conception before the menstrual period is even missed. Home pregnancy test kits permit women to confirm their pregnancies about the time of the expected menstrual period. Women are now aware of their pregnancies earlier than ever before in history; and they are aware of them at a gestational stage when spontaneous abortions are most frequent.

A search of the literature reveals that early pregnancy loss has historically been investigated primarily from a physiologic or biochemical perspective. More recently, attention has been given to the psychosocial aspects of early pregnancy loss (Hardin & Urbanis, 1986; Hutti, 1984, 1986; McCall, 1988; Peppers & Knapp, 1980a; Stack 1984; Swanson-Kauffman, 1983).

The notion of grief resulting from pregnancy loss emerged in the literature only within the last twenty years. Early efforts to explore pregnancy losses focused on maternal grief responses to perinatal deaths (Kennel, Slyter, & Klaus, 1970; Wolff, Neilson & Scheller, 1970). The notion of grief in response to early pregnancy loss was not documented for another decade (Peppers & Knapp, 1980a). Grief and loss, however, were documented widely
in the lay press. People experiencing childbearing losses began to write about their experiences and generated self-help books to provide the help and nurturance for others that they felt was lacking in their own experiences (Borg & Lasker, 1981; Ilse & Burns, 1985; Oakley, McPherson & Roberts, 1984; Panuthos & Romeo, 1984).

Women have been the primary subjects in studies that have been done. The male perspective is largely unknown as are effects that early pregnancy loss may have on the couple as a family unit. Individual responses are of interest, but family theory tells us that beyond them, there is the couple's response. Since the family is a recognized client of nursing, it seems logical that the psychosocial aspects of pregnancy loss be investigated with a focus on the couple as a family.

Pregnancy losses, after the age of viability, subsequent to an antepartum misadventure, premature birth, or neonatal complication have been explored in the context of family (Furman, 1978; Lewis, 1980; Thiessen, 1985). The loss of a pregnancy at earlier stages of gestation is largely understood from anecdotal reports, generalizations from case studies and even from opinion (Hutti, 1986; Reed, 1984; Stephany, 1982; Wall-Haas, 1985; Wetzel, 1982). The literature, according to Reed remains at an early level of development. Yet it is from this knowledge base that nursing care is derived.

Couples experiencing a miscarriage encounter nurses in a variety of settings. From early pregnancy prenatal classes through to the recovery room, nurses care for them as they transit through the experience. Could nursing care be more artfully given if nurses understood the nature of the experience as it is described by the individuals who experience it? The following research project was undertaken to expand the current knowledge base in this area.
Problem Statement

Very little is known about the experience of an unintentional early pregnancy loss in the context of the couple as a family. What is claimed to be known is largely anecdotal, relates to the woman's experience and stems from the perspective of health professionals. Nurses must have an understanding of the experience as perceived by the people who live it if they are to provide care that is specific and appropriate to the circumstances of early pregnancy loss.

Purpose

The purpose of this study was to describe the experience of unintentional early pregnancy loss in the context of the couple as a family. Its intention was to understand the experience and any effects that it may have on the couple as a family by answering the question "What has it been like, for you as a couple, to experience this miscarriage?"

Operational Definitions

For the purposes of this study, the following operational definitions were used.

**COUPLE:** A couple is a man and a woman living together in a self-perceived committed relationship who are experiencing the miscarriage of a pregnancy. Whenever possible, couples experiencing the loss of a first pregnancy were chosen. The male partner is the biological father of the pregnancy.

**UNINTENTIONAL PREGNANCY LOSS:** This term is synonymous with the lay term of miscarriage which will be used from time to time for brevity. For this study an unintentional early pregnancy loss, or miscarriage, will be the unplanned loss of a confirmed pregnancy before fetal movements have been perceived by the mother. The loss may occur as a complete abortion, where the products of conception are entirely, spontaneously expelled; an
incomplete abortion where products of conception are partially, spontaneously expelled; or a
missed abortion, where a vital pregnancy terminates but is not spontaneously expelled.

Assumptions

The following notions are assumed to be true and therefore will not be explored.

1. The couple, considered as a family, is a recognized client of nursing.

2. The health of the couple is a reflection of the health of the individuals. Conversely, the
   health of individuals is a reflection of the health of the couple.

3. The significance of childbearing in the life of a couple is culturally specific.

4. Couples who have experienced a miscarriage are the repositories of the knowledge needed
   to understand the phenomenon.

5. Phenomenology, through the conceptual reconstruction of events is a valid way to achieve
   understanding of the experience of miscarriage.

6. The male partner is the biological father of the pregnancy.

7. Miscarriage is a significant event in the life of the couple.

Limitations

It must be remembered that the experience described in this research, and the themes
and concepts generated from those descriptions are highly subjective and relate only to the
sample population. In this study, the population was limited to Anglo-Canadians despite the
fact that there is much to learn from studying this phenomenon cross-culturally. The
experience of miscarrying the first pregnancy is the focus of this research. Couples who lost
a pregnancy through an ectopic location were excluded because of the additional variables of
abdominal surgery and threat to life that exist with this condition. This study was further
limited by the participants' willingness to disclose their true perceptions.
Insofar as the precepts of phenomenology will be honored, the conclusions will contribute to understanding of similar families experiencing similar circumstances. The results are not generalizable. It is also acknowledged that each partner has individual perceptions of the event in addition to the couple’s experience.

Additionally, the time and resource restrictions of a student researcher must be kept in mind insofar as they affect the depth and scope of the research.

**Ethical Considerations**

The following are ways that the rights of participants were protected during this research.

Permission to carry out this project was obtained from the Ethics Committee of the University of British Columbia.

Confidentiality was guaranteed through the use of a coding system that identified families numerically. Only first names were used on tape recordings and initials were substituted when the tapes were transcribed. The investigator, her thesis advisors and a typist were the only people to hear the interviews. Identities of participants will never be revealed in published or unpublished materials.

Confidentiality was further assured by giving the couple permission to remove anything they wished from the recordings. They were informed of this right prior to the beginning of the interviews. Informed consent was sought from each couple after they had read an explanatory letter and any questions they had were answered to their satisfaction. A sample of the explanatory letter is in Appendix A and a sample of the consent form is in Appendix B.

There were some benefits for the couples from this research. The ability to de-brief the experience through the process of the interview was seen as cathartic. The participants
were told that they would be sent a summary of the findings at the conclusion of the project. Additionally, their contribution towards any change in the way health care is offered to this client group may be seen as a positive outcome from an unhappy experience.

Summary

This chapter has identified the background to the problem that led to the study. The purpose, the problem statement, the research question have been explained. Terms were defined, assumptions and limitations were outlined and the ethical considerations were discussed.
CHAPTER TWO

Literature Review

There is a dearth of literature about the emotional sequelae of miscarriage. The lack of literature about this event signifies the importance that miscarriage is given by health care professionals. The first study to uncover that grief could be associated with miscarriage did so by accident while the researchers were investigating childbearing losses of greater gestation (Peppers & Knapp, 1980a). However the childbearing public was quick to identify perceived gaps in the health care system and responded with self-help literature reflecting the experiences of those who had gone before. Formal studies emerged in response to the self-help literature and focused primarily on the woman herself despite the fact that the male partner in the relationship potentially suffered a loss as well. This is borne out in the anecdotal reports that are available to date and will be discussed in this chapter. The exact nature of the loss and how it is experienced in the context of the family has never been explored. This actuality generated the themes that will be explored in this literature review. Grief and loss will be explored to understand the concepts that underlie our conceptualization of perinatal loss. Perinatal loss will be explored to determine current understanding of grief in the childbearing year. Finally, qualitative research involving couples will be discussed as the event of miscarriage commonly occurs within the context of a couple relationship.

Grief and loss

In 1944, Lindemann published his findings of the physical and psychological manifestations of acute grief. The population that he studied was composed of 101 individuals (primarily women) who had lost a significant other in a fire, or in hospital following an illness. From his interviews with this study population, Lindemann developed a framework for understanding the process of grieving. Five categories of symptoms commonly
manifested in acute grief were identified: somatic distress; preoccupation with the image of the deceased that results in feelings of isolation; guilt, including feelings of failure; anger, manifested in hostility towards others; and loss of patterns of conduct.

Lindemann asserted that grieving individuals progress through three processes to complete grief work. Initially, there is an emotional ‘letting go’ of the deceased which then permits the survivors to come to terms with, or to adjust to, life without the lost one which then allows new relationships to form and enables the survivors to get on with living. These processes of acute grief can be accomplished in 4 to 6 weeks. Individuals who do not evidence behaviours representative of these processes can suffer pathological grief which is described as "distortions of normal grief" (p. 144). Lindemann identified two categories of pathological grief: delayed reactions and distorted reactions. Individuals identified as exhibiting delayed reactions demonstrated the need to remain in control for various reasons. Husbands who need to be strong for their wives, and parents who need to be strong for their children are examples of this phenomenon. Grief reactions can be delayed from days to years and can be triggered by a subsequent loss or stressful event.

Individuals demonstrating distorted reactions can manifest a wide variety of behaviours that range from aimless activity to acute depressions and suicidal tendencies. Behaviours such as continuing to talk about the deceased as if return were imminent, or refusal to dispose of the deceased’s belongings are examples of behaviours in distorted reactions. Another common finding is preoccupation with a high level of activity that leaves no time for grieving. Distorted reactions can continue for days, months, or years. A subsequent loss can serve as a trigger to reawaken the unfinished grieving process.

Although its applicability to this group of people has never been tested and validated, Lindemann’s framework for grief and loss is frequently cited in the literature relevant to loss
Hutti (1984) questions the relevance of Lindemann's work for childbearing because an unspecified number of Lindemann's study population were psychoneurotic patients who lost a relative during treatment. In a review of 20 perinatal death studies published between 1969 and 1984, Lindemann's framework is cited eleven times which made it the most frequently cited reference for grief and loss (Hutti, 1984) for this population. Hutti questions the validity of studies based on Lindemann's framework because they are based on the assumption that childbearing losses are grieved in the same manner as the losses suffered by Lindemann's study population: an assumption that has never been challenged through rigorous investigation.

In 1965, Parkes published his findings of grief reactions in a population of 115 psychiatric patients who were hospitalized within 6 months of the loss of a significant other. Parkes identified two classifications of grief reactions. He labelled the first the stress-specific grief response which he posits only follows the death of a love object. The second, he labelled the non-specific grief response.

There are four variations of the stress-specific response. They are:

1. **Typical grief:** In typical grief, attacks of yearning for the deceased are alternated with periods of depression. Preoccupation with the deceased is common.
2. **Chronic grief:** The aspects of typical grief are present but remain prolonged.
3. **Inhibited grief:** Aspects of typical grief are not manifested. A covert response is implied.
4. **Delayed grief:** Aspects of typical grief are manifested after a period in which the expression of grief was not evidenced.

There are four variations of non-specific grief responses. They are:
1. **Psychosomatic reactions**: the grief response is manifested by somatic complaints that appear unrelated to the loss. A common finding is ulcerative colitis.

2. **Psychoneurotic reactions**: the grief response is manifested by acute psychiatric disorders such as phobias.

3. **Affective disorders not resembling grief**: A common finding is mania.

4. **Others**: the grief response is manifested by behaviours such as episodes of substance abuse.

In the review of the 20 perinatal death articles mentioned earlier, Parkes was cited as the authority on grieving eight times (Hutti, 1984). As Hutti further asserts in her article, "the generalizability of the findings [of the grief reactions of 115 psychiatric patients] to a group of mothers grieving for neonates or fetuses and who are assumed to be psychologically healthy is questionable" (p. 392).

Although these two authors are referenced widely in the perinatal death literature, their frameworks have never been validated through testing with the childbearing population. One major difference between these two frameworks is the population that was studied. Parkes' work was based on hospitalized psychiatric patients whose reasons for hospitalization were demonstrated illness following the death of a significant other. While an unspecified number of Lindemann's study population were psychoneurotic patients who lost a relative during treatment, he also studied individuals who had lost a significant other due to the tragedy of a fire, or to an illness. Presumably, this portion of Lindemann's subjects was representative of the general population at the time of their loss.

Peretz (1970) extended the work of Parkes and Lindemann by identifying new sources of loss. He contends that a grieving response can occur whenever someone is without someone or something that had meaning and value for the individual. This notion implies
that loss is an intensely personal phenomenon with great variance among people, for the
significance of the loss is directly related to the meaning of that which is lost. Thus, two
people encountering the same experience may interpret it very differently: one may perceive
it as a loss, while the other may not.

Peretz identified new sources of loss and expanded the concept. Loss may arise from
sudden or gradual, traumatic or non-traumatic events. Loss can be concrete, such as the death
of a person, or it can be symbolic, such as loss of self-esteem or anticipated loss. Loss is
both a real event, such as in a death, and it is a perception, which is how the individual
makes meaning of the loss in his/her own life experience. Four sources of loss were identified
in Peretz's work. They are:

1. Loss of a significant loved one. This loss may be complete such as in death, or partial as
   in divorce or illness where some valued aspect of the person is lost. The loss may be
   either temporary or permanent.

2. A change in the conceptualization of the self is another source of loss. The loss may refer
to the loss of an anatomical part such as in a mastectomy, or a physiologic process such
as easy respirations or fertility. The loss may a perception such as a change in self
   esteem or a social role such as mothering when the children leave home.

3. External objects can precipitate grieving if they are lost. Possessions, treasures, or
   homelands are examples of this type of loss.

4. Maturational losses occur during the normal course of development. A child who loses
   the special place of baby in the family, or the inability of a troubled young adult to return
   home are examples of this type of loss.

This perspective of loss enables the health care provider to expand the list of
possibilities in assessing clients. Although Peretz reiterates many of the manifestations of
grief denoted by Lindemann and Parkes, the expanded knowledge of the sources of loss and
the need to evaluate them in a value free manner allows the perspective of loss to remain
intensely personal and precludes assumptions and generalizations by the caregiver.

Volkan (1970) described symptomatology associated with pathological grief. He
differentiated pathological grief from normal grief by the need for professional intervention
before recovery could occur. He placed pathological grief at a mid-point along a spectrum
etween normal grief and full blown neuroses as a consequence to a known loss. This
pathological grief is identified as a clinical entity with common events and typical signs and
symptoms. Identified common events surrounding the loss are suddenness, lack of
participation in funeral rituals, concern about the burial of the deceased, concern about the
type of grave, and the inability or unwillingness to visit the grave. Past histories of people
exhibiting pathologic grief reactions included being sensitized towards separations such as
parents frequently away during childhood, and the existence of a special relationship with the
deceased that was not shared by siblings or others. Identified common changes in response to
the death are: changes in property or the environment and psychic changes where dependency
on the deceased is peremptorily terminated by the death.

Volkan further identified splitting of the ego and dissociative reactions in
pathological grieving. Splitting is a subtle response and can be seen in examples like the
setting of a dinner plate as if the deceased was coming home for dinner. Dissociative
reactions are more obvious such as developing amnesia surrounding the death scene to
prevent dealing with it.

Typically, individuals also demonstrate ambivalent attempts to be reunited with the
lost one through dreams where the lost one appears as alive, through verbalizing the
possibility of reincarnation, symbolizing possessions of the deceased, slips of the tongue
phrased in the present tense, and attempting to internalize the deceased by identifying with
the deceased through interests, activities or behaviours. This behaviour can be both positive
and negative. It is also important to note here that these views reflect a Western approach to
understanding grief and loss. Some Eastern philosophies refer to the departed in the present
tense which conforms with their belief in soul or spirit survival after death of the physical
body. The final category of typical findings is the manifestation of aggression which can be
overt or covert. Covert aggression is more difficult to identify and appears in comments that
reflect a sense of guilt or responsibility for the death. If the aggression is turned towards the
externalised loss object, suicide can result.

These manifestations of pathological grief are amenable to therapy using "re-grief" work (Volkan & Showalter, 1968; Volkan, 1970). In the context of supportive therapy, the
client returns to the earlier loss and through counselling, obstacles to the expression of normal
grief are removed permitting effective resolution of the original grief work.

Volkan's work is interesting as there are marked similarities between the conditions
that he claims predispose to pathological grief and the circumstances inherent in unplanned
early pregnancy loss. The formal linkage between pathological grief and early pregnancy loss
is sparse.

Perinatal Loss

Grief as a consequence of pregnancy loss emerged in the literature within the last 20
years. Early efforts to explore grief in pregnancy focused on maternal responses to stillbirths
or neonatal deaths (Kennel et al., 1970; Wolff et al. 1970). Kennel and colleagues built on
Lindemann's work to describe grief reactions and identify factors that predispose women to
pathological grief in response to the death of a neonate. Wolff and colleagues are notable
because they determined that attitudes and policies of hospitals and personnel affected the
grief process. They concluded that institutional flexibility is desirable and that the subsequent ability to conceive had no bearing on the participants’ ability to grieve. This finding was challenged by Peppers and Knapp (1980a) who extended the Kennell and colleagues (1970) study.

Peppers and Knapp (1980a) modified the mourning scale used in the Kennell study and used it to investigate grief following miscarriage, stillbirth, or neonatal death. They investigated differences in grief intensity between the three groups and found, to their surprise, that intensity was essentially the same for all groups. Two-way analysis of variance did reveal an interaction effect between grief intensity and difficulties with childbearing including infertility. Some discretion must be used in evaluating these findings insofar as the length of time since the loss event spanned six months to thirty-six years, and the ages of the subjects ranged from twenty-five to fifty-seven years. These weaknesses are acknowledged by the authors in their report, however their results are interesting in that they identified intense grief by some women experiencing early pregnancy loss at a time when the majority of studies, in the literature, focused on later perinatal losses. It is interesting to note that the emotional responses to early pregnancy loss were discovered, in the Peppers and Knapp study, by accident during investigations into later perinatal losses.

McCall (1988) investigated grief intensity in 15 women who had miscarried. Participants completed the Peppers and Knapp Grief Intensity Scale at the time of the miscarriage and six - ten weeks later. All women experienced some grief following the miscarriage though there were wide variances in intensity. The intensity of grief was significantly decreased at the repeat measurement six - ten weeks later. Her findings were consonant with the findings of Swanson-Kauffman (1983) who found that grief was resolved in about four weeks. Further support for the notion that grief may be resolved quickly can be
found in the works of Hardin & Urbanis, (1986); Leppert & Pahlka, (1984); Peppers & Knapp, (1980b).

However, grief can also take much longer to resolve. Hutti (1986) conducted an exploratory study into the miscarriage experiences of a primigravid woman and a multigravid woman. Both of these women felt that their grief was resolved about 10 months following the event. Berezin (1984) contends that it may take up to two years to feel ready to move on following perinatal loss.

Corney and Horton (1974) did identify pathological grief following spontaneous abortion in their case presentation of one woman who suffered sadness and depression following miscarriage. They contrasted grief with pathological grief which they defined as the inability to mourn a loss. Many of the factors outlined by Volkan were evident in the presentation of this case. The authors asserted that the unexpected loss of a pregnancy can predispose the woman to chronic sadness and preoccupation with the loss when factors such as ambivalence towards the pregnancy, lack of support and an unsuitable environment are present. Horton hypothesized that the prolonged sadness felt by women identified in other studies of spontaneous abortion, might be pathological grief.

Seibel and Graves (1980) investigated the psychological implications of spontaneous abortions. Their sample consisted of 93 women who were admitted to hospital for treatment for a miscarriage. Eleven patients did not complete all of the self-administered questionnaires. The questionnaires contained both forced-choice and open-ended questions. In addition, an emotional status inventory checklist was completed to determine feelings in relation to the miscarriage. It is not clear when these questionnaires were administered as the text indicates both the pre-operative area and the recovery room following dilatation and curettage. Predictably, women who had miscarried planned pregnancies reported more
feelings of unhappiness, depression and anxiety than did women who miscarried unplanned pregnancies. However, women who miscarried unplanned pregnancies checked off the same number of negative affect adjectives on the checklist as women who miscarried planned pregnancies, which suggests that even though the miscarriage was not viewed as an unhappy event, it was nevertheless unsettling emotionally. What is not clear from this investigation is just what was being measured. Even though it is not clear whether the questionnaires were completed before or after surgery, it seems prudent to question whether the results reflect just the miscarriage experience, the fear of surgery or some other phenomenon.

Women’s perceptions of first trimester loss were the subject of investigation by Wall-Haas (1985). Nine women were asked to complete a questionnaire about their miscarriage. Their ages ranged between 18 and 33 years and their educational levels varied between a high school diploma and two graduate degrees.

Their responses indicated that sadness, preoccupation with thoughts of the baby, anger and irritability were present at some level of concern. Five respondents placed these feelings at the moderate or big problem level. Eight women identified depression, six identified disbelief and five did not want to be alone following their hospital experience.

Anecdotal responses elicited in the questionnaire reiterated the feelings expressed by others in both the lay and academic press. Commonly, the women expressed the loneliness of the loss and the lack of societal recognition for their loss.

The length of time between the miscarriage event and this study brings the findings into question. Five of the participants completed successful pregnancies after the miscarriage and before the study. Recall accuracy and the effects of the passage of time were not addressed. Also, other variables such as previous miscarriage, prior successful pregnancies or other significant losses were not factored into the conclusions of this study.
Swanson-Kauffman (1983) completed a qualitative study of the experience of miscarriage as perceived by the woman in her dissertation research. This qualitative study generated six experience categories that women seemed to go through following a miscarriage. These experiences were common to the 20 participants who had experienced a miscarriage within 15 weeks prior to the interview. Only two had felt what they perceived to be fetal movement prior to the loss. Instead of eliminating them from the study, Swanson-Kauffman decided to build their perceptions of movement into the study.

The six experience categories were:

1. **Coming to know** which represents the period of time when the woman recognizes the mounting evidence that losing the pregnancy is not just threatened but inevitable.

2. **Gaining and Losing** depicts the unique manner in which all women assessed the meaning of the loss to themselves.

3. **Going public** reflects the experience of telling others about the miscarriage, which on occasion, requires informing of the secret pregnancy first. This was a troublesome time in the miscarriage process because of the lack of support and perceived unhelpful comments by others.

4. **Sharing the loss** is a reflection of the manner in which the woman copes with the loss. Those whose style is to lean on others tended to share the experience while those who lacked those supports tended to cope with a few others or cope alone.

5. **Getting through it** is a description of the means and ways of grieving. Length of grieving tended to reflect how much the loss was shared with the earliest resolution being in those women who shared their loss with many others.

6. **Trying again** depicts the woman’s plans for subsequent conceptions and her fears related to future losses that accompany them. Carrying a pregnancy past the time at which the
previous pregnancy was lost before the notion of security of the pregnancy could even be entertained was a common goal (Swanson-Kauffman, 1983, p.158-159).

In addition to identifying the common experiences of miscarriage, Swanson-Kauffman also identified 5 categories of caring. Categories of caring are defined as the "process which underlie behaviours which were perceived as caring" (p.220).

They are:

1. **Knowing** is a reflection of the need to have her loss truly understood in the context of her life. This knowing is the acknowledgement of the meaning of the loss to her.

2. **Being with** reflects the need to have others feel the loss with her. It goes beyond knowing to the communication of the understanding of some sense of her loss.

3. **Enabling** involves the construction of a psychological environment conducive to getting through the experience.

4. **Doing for** reflects the need to have others do for her until she is able to do for herself once again. They may be activities related to comfort, health maintenance, support, protection or restoration.

5. **Maintaining belief** is the expressed need to have others demonstrate faith in the ability to get through the experience and successfully complete a future pregnancy. Husbands were identified as very important belief maintainers.

All of these categories of caring facilitated the woman's ability to transit through the categories of the experience identified earlier. Although the categories of caring were common to all of the participants in roughly the same order as they are presented here, there is no time line by which each experience is completed. In fact, as Swanson-Kauffman cautions "conceivably, aspects of all six experience categories could be simultaneously
occurring at any point in time" (p.159). Also, the experience categories overlap as all human emotions and behaviours are not sufficiently tidy to be described as discrete entities.

As Hutti (1986) comments, the Swanson-Kauffman study is valuable for its "rich description of the miscarriage experience using well thought out, theoretically-based qualitative methodology."(p.378). But as good as this study is, it continues to tell the story according to the perspective of the woman. The man’s experience is largely overlooked in perinatal loss literature.

Cummings (1984) and Hardin & Urbanis (1986) present descriptions of the male perspective of early pregnancy loss. Cummings authored an essay about his own experience when his wife miscarried her first two pregnancies. Anger is prominent in this description of his feelings. The anger that he felt affected all areas of his life. His work productivity decreased, his attitude was negative. Jealousy towards other pregnant couples was felt as was intense frustration and anger at the lack of knowledge about the causes of miscarriage.

The father in the article by Hardin & Urbanis expressed his feelings in a diary that was later compared with the diary of his wife. This man, whose name was Jay, expressed the shock and suddenness with which miscarriage often strikes. His concerns were predominantly for the safety of his wife during the experience. He clearly expressed feelings of helplessness throughout the experience and the recovery phase because all he could do to directly influence what was happening to his wife was provide emotional support and relieve her of home duties. Jay played down the importance of this, but in view of Swanson-Kauffman’s findings, it is a very important role that probably is not given sufficient recognition. For Jay, any feelings of loss were not crystallized until he saw the fetus. Only at that time did the experience feel real. This contrasts with the experience of Cummings where the sense of loss was very real despite the fact that he did not report seeing the fetus.
In the Leppert & Pahlka (1984) study, the men showed evidence that the depth of their emotional response was related to the length of pregnancy with the fiercest reactions occurring in middle-trimester losses. Helplessness is a common feature for both Jay and Cummings. Both felt a need to do something for their wives. Cummings directed his efforts towards greater understanding by talking with various health professionals to be sure that everything that could be done, had been. Jay, however, directed his efforts towards caring for his wife, planning her return home and relieving her of home responsibilities.

Both of these men experienced many of the feelings associated with a situational crisis and both articulated the need to grieve following the experience. Predominantly however, the male role is directed away from feeling the experience and towards action which may relieve some of the feelings of helplessness but may preclude normal grieving. Men reported involving themselves in activities outside the home while feeling a diminished sense of self-esteem (Callahan, Brasted & Granados, 1983). This need to be busy may be a coping behaviour to relieve the feelings of helplessness in place of talking it through with their partner. The male experience of perinatal grief is often inferred from the woman’s report of her perception of her partner. This will be more distorted in its representation if communication between the couple is poor and each cannot understand the behaviour of the other. Attempts to understand perinatal loss from the perspective of the male are few.

LaRoche, Lalinec-Michaud, Engelsmann, Fuller, Copp, McQuade-Soldatos and Azima (1984) included eight fathers in addition to 30 mothers studied in a two year follow-up program following perinatal death between 20 weeks gestation and one month post birth. The participants were interviewed at 2 days, 3 weeks and 2 months following the death. A fourth assessment took place 1-2 years following the death. Assessment criteria were based upon
the work of Lindemann (1944) and Parkes (1965). It is implied, but not clearly stated that the men were included in this same interview schedule.

Data analysis procedures for the women’s data are explained but how the data from the fathers were analyzed is not explained in the article. However, their conclusions state that "fathers grieve differently. Their grief tends to be shorter and less intense" (LaRoche et al. p.18). This is an important finding since the partner may be the primary support person but unable to understand the length of time it might take for the woman’s grief to resolve.

Women who experienced a low total mourning score, in this study, were positively correlated with improved communication and an improved sex life lending credence to the clinical belief that actively promoting discussion of the loss between the couple aids in the resolution of grief. Conversely, women with a high total mourning score recorded deterioration in their marital relationship. Exactly what the deterioration was due to is not clearly explained in the article. The nature of the husband’s grief response was not defined and appears to be based on clinical impressions.

Total mourning scores were not affected by whether or not the mothers saw their babies but the scores on the depression inventory were. Mothers who saw or touched their babies had statistically significant lower depression scores than did mothers who did not see or touch their infants. Both depression and total mourning scores were highly correlated with funeral rituals. Those who had a grave site that could be visited or had some formal ceremony of grieving had lower scores than did mothers who had no such rituals.

Because the data from the eight men in this study are not laid out clearly in this article it is unknown whether these phenomena affect them in the same way. The low profile given to the men in this study is reflective of the literature in general but provides some helpful insights into the effects on the marital relationship.
Providing support and emotional first aid for people experiencing a miscarriage is in the literature. Leppert & Pahlka (1984) routinely included counselling sessions with couples following a miscarriage. Active counselling was begun as soon as the physical condition of the woman stabilized. This consisted of telling the couple that many people experienced a variety of unpleasant feelings about their miscarriages and they were invited to share their feelings with their caregiver. Telephone contact was maintained following discharge and was initiated by either the couple or the caregivers. At the four to six week check up a final counselling session of around thirty minutes was included. More sessions could have been planned according to need. These authors reported the torrent of feelings that were expressed when caregivers provided the opportunity for them to ventilate. Couples reported feeling relief that their feelings were being accepted as normal which substantiates the caring processes of knowing and being with outlined by Swanson-Kauffman (1983).

The Fetus and Newborn Committee of the Canadian Pediatric Society (1983) recommended the establishment of a perinatal support network for families experiencing perinatal losses. Although loss from miscarriage receives less attention than do later losses, the notion that support is needed is emerging into the consciousness of caregivers.

McCall & Wilson (1987) have also taken an active approach to the resolution of grieving following early pregnancy losses. More than 400 patients with conflict-determined symptoms after spontaneous or induced abortions occurring to themselves or a significant other were identified by these two psychiatrists. In an effort to facilitate their grief, these participants were invited to attend a ceremony of "ritual mourning" which included a prayer of relinquishment followed by Holy Communion (p.818). These authors contended that this service "[provided] almost immediate relief of the grief, and in most instances, the majority of the patient's symptoms" (p.821). Although they claimed this result, no statistics were
included. The authors do not discuss what alternatives could be employed given clients who were not from a Christian heritage background, or simply not spiritually or theologically inclined. The success of the intervention of ritual mourning could have some validity given the findings of Volkan (1970) discussed earlier.

These last three authors and their interventions all addressed the needs of the significant others in addition to the woman who experienced the loss. This is important because few pregnancies are experienced in isolation. Most, are experienced in the context of a marriage or similar committed relationship.

Grief and mourning are experienced at different rates and times for different individuals. Peppers & Knapp (1980b) contend that differences in attachment between women and men lead to the differences in grieving, and they label these different processes incongruent grieving. Where a woman may be actively grieving for her loss, her partner may only be experiencing feelings of disappointment. Their claims are substantiated by empirical evidence in their own work and by Bruhn & Bruhn (1984) in their work with couples following stillbirth. The conclusions of Callahan et al. (1983) corroborate the aforementioned findings. They summarized pregnancy and neonatal losses in the context of the family as a non-normative life event that has the potential for either growth or deterioration of the family unit.

These authors suggest that one plausible explanation for the impact of a loss in pregnancy is the age in life at which it occurs. Losses in later life are expected and even anticipated leading to an adaptation process, whereas losses during or following pregnancy occur early in the life span leading to a sensitization effect that will affect all subsequent losses. This sensitization is significant because it occurs before any natural adaptation process prepares parents for such deaths (Callahan et al.). The novelty of loss early in the
life-span, before graduated experience mitigates the pain, gives a pregnancy loss the potential to be the most significant death a couple will ever experience. It also increases the possibility of pathological grief in later life with the deaths of older relatives and friends and may be displayed in such behaviours as avoiding funerals and cemeteries (p.150). An analogy of this would be that if an individual’s first experience with earthquakes is perceived as minor, subsequent earthquake experiences are perceived in relation to the first experience. However if the first experience is perceived as major, then all subsequent experiences will be similarly perceived.

The quality of communication before the event is identified as a major variable in the survival of the marital relationship. If communication skills are good before the loss then the opportunity is present to further strengthen the relationship. If communication skills are not good, incongruent grieving and the differences in grief response can lead to breakdown of the relationship.

The dearth of studies of the effect of an early pregnancy loss in the context of the couple, in addition to the literature that reports the man’s perceptions from the perspective of the woman demonstrates the need to explore the phenomenon of miscarriage from the perspective of the couple together. The experiences of the couple, as described in qualitative research, will be the subject of the next section.

The Couple in Qualitative Research

There is a growing recognition that the family is an appropriate client for nursing (Christie-Seely, 1984; Friedman, 1986). The family as the basic unit of society serves as a mediating force between individuals and society. In the family, society’s expectations are modified to meet the needs and interests of individual family members. The individual is markedly affected by the family of which she or he is a part. Families in our culture serve
two functions. First, they meet the needs of individuals within them, and secondly, they meet the needs of the society of which they are a part.

There are two assessments the nurse can make in working with families. Individual assessments yield bits of information that are analogous to ingredients in a larger recipe. They are valuable and necessary assessments but the mix of ingredients is what needs to be assessed for the mix i.e. family, is where the real living occurs in society. As Friedman says: "if a nurse assesses only the individual and not the family, she or he may be missing the gestalt needed to gain a holistic assessment" (p.4). The family, represents a sum that is greater than the sum of its individual parts. The interdependent relationships that exist within families mean that stimuli that impact on one member will reverberate throughout the others.

Families are in continual states of change as members transit through their individual developmental stages and the family as a whole transits through its developmental course. Developmental changes stem from forces originating in the family, while external forces emanating from the society also place demands for change on the family. Families employ coping strategies and mechanisms to permit them to achieve family functions and their developmental tasks. Marriage, parenthood, and retirement are examples of developmental tasks that place demands on the family to reorganize.

Families also experience demands from unpredictable events such as illness or the absence of a family member. Any source of demand can be the source of family stress either separately or concurrently. One way in which family stress can be assessed is presented by Olson & McCubbin (1983). These authors present a model of family stressors that include prior strains and hardships as components of "pile-up" which is posited to be highly correlated with the inability to maintain family functions and a consequent drop in well being.
of the family members. They advance this notion of pile-up to explain the differences in coping that is evident in different families.

LaRossa and Wolf (1985) surveyed the articles written in the Journal of Marriage and the Family from 1965 to 1983 to assess the frequency of qualitative family research. They found that only 9% of articles written were exclusively qualitative while a total of 13% contained some qualitative aspects. The authors lament the lack of qualitative studies because "[researchers] can ill afford to dismiss an approach that is so well suited to mapping the dynamics of family systems".

Thompson & Walker (1982) caution that family research must be careful to not simply sample and report on two individuals in a relationship because this does not address the real issue of understanding the larger concept of the relationship between them. The value of conducting couple research is that the information gleaned is richer in content because two versions contribute to the data bank, but also the interaction between participants generates information about spousal behaviour that would be difficult to get by other methods (Allan, 1980).

Couple research generates richer data by several behaviours that are identified by Allan. Verbally or non-verbally, spouses will corroborate the statements of the other as well as supplement the information given. Responses may be modified by the spouse or in some cases may be challenged when conventional rather than honest answers are being given. Discussions about answers may generate further exploration by the couple and result in fuller explanations than the original questions did.

The researcher must also be alert to non verbal components of the interviews. Gestures and subtler body language provide valuable clues to the degree of agreement.
inherent in a response and can be used to spark further discussion which may or may not result in an altered account (Allan, 1980).

Since pregnancy and childbearing are seldom experienced alone, the effects of the experience will be felt by both parents as individuals and will be manifested by a change in the relationship. Consequently, when an essentially normal process is interrupted by the crisis of miscarriage the nurse must recognize that the client is essentially the couple as a unit and not simply the woman who miscarries. If nursing care is to be sensitive and appropriate to the needs of these clients then it is imperative that understanding of the phenomenon must be generated from the context of the couple as a family.

Later pregnancy losses have been explored phenomenologically in the context of the couple (Thiessen, 1985). Losses from the twentieth week of gestation to the end of the first four weeks of life occur in about one of every one hundred births (Statistics Canada, 1983). This means that perinatal death is an unexpected but also an atypical occurrence in the life of the family unit. However, earlier pregnancy losses occur at a rate that is variously quoted between one in four and one in five pregnancies. The likelihood of a couple experiencing this loss is considerably higher. It seems that it is now time to explore this phenomenon in the context of the couple as a family.

Summary

This chapter has explored the theories that underlie our conceptualization of the process of grief in Western culture. Grief has been identified as a consequence to early pregnancy loss by some authors. The extent to which grief occurs has only recently begun to be described. The nature of grief following early pregnancy loss has been well documented by Swanson-Kauffman (1983) but the nature of the couple’s response to this unexpected but common occurrence is unknown. Nurses recognize that the family’s response represents a
whole that is greater than its constituent parts. Why some couples encounter this experience and grow through it with minimum difficulty while others are incapacitated is a question of considerable interest. The accumulation of stressors is posited as one explanation. Given the foregoing, exploring early pregnancy loss in the context of the couple as a family and from the family's perspective appears to be a worthwhile endeavour.
CHAPTER THREE
Methodology

The aim of this project was to understand the experience of unintentional pregnancy loss as it is experienced by the couple. Phenomenology was the method employed as its precepts are congruent with this study's intention. The phenomenological method permits discovery of the meaning of experiences through analysis of subjective descriptions. "It is through the analysis of the descriptions that the nature of a phenomenon is revealed and the meaning of the experience for the subject understood" (Parse, Coyne & Smith, 1985, p. 16).

Phenomenology was developed as a method to understand lived human experiences by Edmund Husserl in the late 19th century in Europe. A student of existentialism, Husserl developed the phenomenological method as an alternative to the scientific method (Knaack, 1984). With the major successes generated by the natural sciences in the late 19th century, the philosophical knowledge base that had previously dominated was denigrated. The study of humans became objectified in the hope that human behaviour could be predicted as well as natural phenomena could be predicted (Omery, 1983). In the early part of the 20th century, Husserl's work was refined by other philosophers who, although they represent different variations on the theme of phenomenology, agree on it as a method of enquiry (Parse et al. 1985).

Qualitative methodologies have gained increasing credibility over the last three decades as the precepts guiding the scientific method of enquiry were seen to inadequately portray human experience. To depict human experience, a method that strives to interpret an understand rather than observe and explain is seen as having greater utility (Bergum, 1989). Phenomenology is one qualitative method that is used when nothing is known about a subject
because the primary requisite of phenomenology is that no preconceived frameworks or expectations be used as a guide to the gathering of data (Ornery, 1983).

Nursing purports to embrace the individuality or uniqueness of the individuals they care for. In this context commonalities are academically interesting but insufficient to guide nursing care for individuals whose experiences fall outside them. Because of nursing's holistic approach, nursing care is tailored to the uniqueness of individuals. Thus, phenomenology is a useful arrow in the quiver of research methods because it is effective when the goal is to understand the experience in a holistic way (Oiler, 1982).

In phenomenology, all data obtained from the participants is deemed relevant as it contributes to the understanding of the whole. Participants are experts because they have lived the experience and can articulate their perception of the event including any effects that their experience may have had on them (Ornery, 1983).

Sample Selection and Selection Criteria

Phenomenology places the participants in the role of expert witnesses. Qualifying witnesses are those who represent the phenomena under study by virtue of having experienced it. Although all families who have lived this experience will qualify, some may not be as articulate as others or as receptive to the investigator. The investigator utilizes all informants to gather data but uses some informants more than others (Field & Morse, 1985).

Sample size cannot be predetermined in phenomenological studies. Theoretical sampling allows for flexibility in sample size as the most articulate informants who can speak to the issue are used to gain relevant information. Adequacy of the sample size is obtained when the investigator encounters repetitions and redundancies in information, and no new information is forthcoming (Parse et al. 1985). When that point is reached the data are said to
be saturated (Glaser & Strauss, 1967). The final sample size achieved in this study was justified in the analysis of the data (Field & Morse). In total, six couples were recruited.

The sample population was drawn from couples experiencing unintentional early pregnancy loss. Initially it was planned that it should be the first pregnancy to either partner but in reality two couples who had had a prior pregnancy were included in the study because of an insufficient number of couples meeting the exact criteria. One couple had terminated a pregnancy within their relationship prior to their current loss and another couple had a child by the husband’s first marriage. Custody of that child was held by the child’s mother. The additional data generated by these individuals added another dimension to the data and was incorporated into the analysis. To facilitate the study, the couples resided within the Greater Vancouver Regional District, were Anglo-Canadians and were willing to meet with the investigator as a unit according to the protocol of this study. The investigator acknowledges that there is much to be learned from investigation of this same phenomenon in the context of other cultures, but as a beginning step for a novice researcher, it is more manageable if one cultural group is studied.

Couples were procured through referral from physicians, in the Vancouver area, midwives and nurses in the emergency and surgical day care units of a suburban hospital. The nature and purpose of the study was explained to the physicians and nurses and their assistance in referring suitable candidates was requested. Because this method was slow in generating participants, an advertisement was placed in two local community papers for four consecutive weeks without result. The most successful recruitment came from a physician who was sensitive to the issue of miscarriage and supportive of the project. Her practice generated three of the six couples.
The health care provider who encountered the couple made the initial request for permission to identify them to the researcher. A brief explanation of the project was given by the caregiver at that time. Agreeable couples gave permission to the caregiver to give their names and telephone numbers to the investigator who made the next contact by telephone and explained the project in greater detail. Couples who were still interested following the investigator’s contact agreed to participate in the project. At the first visit an explanatory letter was given to the couple to read followed by a consent form that again explained the study and subjects rights and protections. A copy of the consent form was retained by the couple. Following signing of consent forms the interviewing process began. Examples of the introductory letter and the consent form are in Appendixes A and B.

Eligible couples were interviewed within two to four weeks of the miscarriage and again a month later for elaboration of concepts. One couple’s second interview was delayed for eight weeks because of their scheduled holiday. All interviews were audio-tape recorded and transcribed. Analysis of the transcriptions during the project generated the focus of subsequent interviews. When no new data were forthcoming, the sample was said to be complete.

Data Gathering Procedures

Data were gathered through two unstructured tape recorded interviews per couple. Interviews took place in the homes of the participants by their request. Interviews were open-ended and lasted between 60 and 90 minutes each. Field notes were used to supplement interviews and included data about the physical setting, non-verbal interactions and impressions of the investigator as discussed in Field & Morse (1985).

The discussion was initiated through the use of an open ended comment: "Tell me about your miscarriage". The comment was directed at both partners and left to them to
decide who should begin the telling. Clarification was sought by the investigator and from time to time the partner's input was specifically requested. The first interview tended to focus on events leading up to the miscarriage and the event itself. The subsequent interview focused on clarifying items from the first interview and discovering how the experience was perceived as time passed.

Data Analysis Procedures

In phenomenology, data collection and analysis occur concurrently. Giorgi's (1985) essential steps guided the analysis of data from this study. Following each interview, the tapes were transcribed. Each transcript was then read entirely through as often as necessary to grasp a sense of the whole message. Awareness of the general message led to the next step of reading the transcripts very carefully to identify "meaning units" (p. 10). Meaning units represent the changes or transitions in meaning as the participant's story is told. Meaning units were noted in the margin of the transcript. They were phrased in the researcher's language representative of the context from which they were derived. Once the meaning units were established, they were again reviewed and the insights contained therein were identified to establish themes. The themes were then used to refine subsequent interviews. In the final stage the themes were organized into the outcome phenomenological depiction by abstracting the themes. Parse et al. (1985) refer to this process of analysis as contemplative dwelling with the data. Although the terms vary, the process is essentially the same. Quotes from the participants were included throughout the outcome description to provide a reference line for the reader to judge the validity of interpretation.
Summary

This chapter has explained the methodology used to conduct this study. The use of a qualitative method has been justified. Sampling procedures and criteria were explained as was the data gathering procedure. The chapter closes with a brief description of the process of data analysis. The outcome of the analysis will be discussed in detail in the next chapter.
CHAPTER FOUR

Findings From Data Analysis

In this chapter the outcome of data analysis is described. The chapter begins with a description of the participants followed by the phenomenological depiction of the event. Integrated throughout this chapter are quotes that provide the reader with evidence to validate interpretations.

Description of the Participants

Six couples volunteered to participate in the research. The men in the group ranged in age from 26 to 47 years and the women ranged in age from 30 to 40 years. Five of the six pregnancies were planned and although one of the pregnancies was unplanned, it was not unwelcome. The length of time to conceive ranged between one to four months for four of the couples. One couple had experienced two years of infertility for which no cause could be found. Their pregnancy was eventually achieved without any specific infertility treatment. Another of the couples had experienced a wait of a year while the husband underwent a vasovasostomy. From the time of the return of his fertility, their pregnancy was achieved in three months.

It was the first pregnancy for four of the couples. One of the couples had terminated a pregnancy at eight weeks of gestation two years previously at the start of their relationship. Another couple had a child by the husband’s previous marriage. Custody of that child was held by the child’s mother.

The occupations of the group varied. Two of the men were skilled laborers and four were professionals. Four of the women were professionals while the remaining two worked in business offices. All individuals had post secondary education ranging from vocational training to university degrees.
None of the couples practiced a formal religion together. One woman attended Christian services on a regular basis. Several participants described themselves as lapsed members of Protestant religions. One described himself as a former Roman Catholic and three people described themselves as worshiping or being renewed by nature with no dogma attached. Religion played little or no role in the lives of these couples.

The lengths of gestation of the pregnancies varied between seven weeks and fifteen weeks. Two of the pregnancies terminated spontaneously with the onset of cramps and vaginal bleeding. The remaining four were missed abortions that were diagnosed on routine ultrasound examinations. All but one of the women had a dilatation and curettage procedure done under general anesthetic. The remaining woman completely expelled the products of conception so no further treatment was required. The longest hospital stay was eighteen hours, the shortest was two hours.

**Description of the Experience of Miscarriage**

Analysis of the data led to the depiction of miscarriage as a composite experience composed of four interrelated motifs that together, as a group, are in interaction with a satellite theme that is external to, but an integral part of, the experience of miscarriage. This conceptualization is illustrated by Figure 1.

The four motifs represent the organization of feelings and behaviours that were expressed by couples in their interviews. The four motifs are labelled Discovery, Disclosure, Definition and Decision and are each characterized by dominant feelings and or behaviours.

The four motifs are highly interrelated. At first glance, they appear discrete and sequential but they overlap to the degree that aspects of each can be found in all. Discovery is the entry point from which couples move towards Decision wherein the experience is resolved. Movement through the motifs, is not progressively sequential whereby couples
FIG. 1 CONCEPTUALIZATION OF COUPLES' EXPERIENCE WITH MISCARRIAGE
proceed through stages one to four, rather it is a convoluted progression as couples loop back through the motifs until they eventually resolve the experience.

The external theme of Health Care Interactions emerged as significant for couples, markedly impacting on them during the experience. Either positively or negatively, most couples interact with the health care system during a miscarriage, and those interactions either facilitate resolution of the experience or they burden the couple with additional negative feelings. This theme is external to the motifs because it does not arise from within the couple's relationship, but in response to their interactions with the health care system. It is plausible that a couple may completely abort at home without medical attention and thus may only experience the composite experience and not this satellite theme.

The Composite of Motifs

Four interrelated motifs emerged from analysis of the data. They represent the experiences of all participants in the study, man and woman alike. They are Discovery, Disclosure, Definition and Decision. The term motif, was specifically chosen to connote the recurring nature, the looping back of these four aspects of the experience. Although each motif will be presented and discussed as a discrete entity, the reader is reminded to keep the recurring nature of a motif in mind.

Each motif will be described and illustrated by quotes that depict the behaviours that were evident and or the emotions that were predominant. Quotes are verbatim accounts of the couples' experiences as these motifs were common to all. The motif of Discovery encompasses awareness of the loss of the pregnancy and initiates the experience.

Discovery

Discovery encompasses that part of the experience related to realizing the pregnancy was over. Discovery was shown to be somewhat different at the outset for those couples
experiencing a spontaneous abortion. For couples who aborted spontaneously, Discovery began with the first symptoms that the pregnancy was not progressing as expected and ended with knowledge of the passage of the fetus.

...I started to spot very lightly which concerned me immediately because I didn’t think that was a good sign.

...............  

...the spotting started about a Wednesday, by Sunday, I started getting some cramps and I thought oh, oh this was something different these cramps. I didn’t really like the feel of them.

Concern for the survival of the pregnancy escalated along with the increase in symptoms.

Couples expressed it this way.

It had been getting steadily worse...And it’s funny that it happened to be just the night before, I don’t know that you can tell instinctively why sometimes you know things, I just...it had just sort of hit me that night, that it wasn’t going to turn out well.

...............  

...but then people were saying [name] you have to realize that this could mean that you know, things are starting to happen...

...............  

Couples who experienced a prodromal phase of miscarriage, confirmed their concerns with the passing of the fetus.

I was standing outside the door and [wife] said I think I’ve just passed it.

...............  

...I swirled the water around a little bit and I could definitely see that there was something else there...so I..(slowly and tearfully) put my hand in and I could see.

...............  

Couples who experienced missed abortions had no prior warning of the possibility of a miscarriage. Ultrasound examinations were planned because they were routine for the physician. For the most part, their ultrasounds were anticipated eagerly as the opportunity for a sneak preview of their babies.
...it was this magnificent test that we were going for as we had been looking forward to it for so long because we were actually going to be able to see this baby, and we had heard so many people talk about how wonderful these ultrasounds are. We counted down the days before we went for that darned ultrasound.

Several of the couples had experienced mild symptoms which they had reported to their physicians. In all cases in this study, because the physicians indicated that there was no cause for concern these symptoms were not perceived as threatening to the pregnancy. Mild spotting after intercourse was reported like this:

...I had spoken to a lot of people who had experienced the same thing so I was not concerned...and I told that to my doctor...and she said "Well, I don’t think it’s anything to be concerned about but since you’re going for your ultrasound on Tuesday we’ll see what the results of that are, but I’m not concerned about it"...so we weren’t either.

Another couple experienced an episode of abdominal pain that had resolved entirely. Their ultrasound was advanced by a few days and was arranged late in the business day. Their interpretation of events removed any concern for them.

...but [the appointment] wasn’t until later on in the day so I thought oh well, it couldn’t be that bad or they would have rushed me in a lot sooner...

For couples who had missed abortions, Discovery began when they were told their pregnancies were no longer viable following ultrasound examinations. They described their experiences this way.

...so they told us themselves and what he said to me at first is...he looked at us and he said, this is not going to be what you’re expecting...and he said, "I’m very sorry but what you’re experiencing here is a false pregnancy."

...it was the tech actually who told us..."Well, I hate to be the bearer of bad news" and I thought "bad news, what bad news?" He said yes, there is no heart beat on this baby. This baby has died.
Couples with missed abortions had no opportunity to anticipate the end of their pregnancies while couples with spontaneous abortions had some period of time to contemplate what was happening to them. Despite this difference, the emotions related to Discovery were the same for both groups.

**Emotions of Discovery**

Three primary emotions related to Discovery were evidenced. They were shock and disbelief, confusion and hope. Shock and disbelief were voiced by five of the six couples either in response to being told that the pregnancy had ended or upon seeing the embryo.

After passing the embryo, this couple expressed their feelings this way:

...naturally we were upset, and I don’t know, it’s a very hard thing to describe. I felt...pause...I couldn’t believe it, stunned...up till that point I didn’t believe it would happen because it just can’t happen to me...pause...to us.

............... 

This couple described how they felt when told that her uterus contained an empty gestational sac.

Well, I couldn’t believe it, you know it’s a real shock. I’ve never really felt something like that...so that was really a blow.

............... 

Shock and disbelief were expressed as numbness and detachment by this couple after being told that their baby had died.

...I just felt numb. I felt like I was looking in from the outside...I felt really detached, like really detached from everything and everybody.

............... 

Other couples expressed shock and disbelief these ways.

I just felt kind of ..sigh...stunned I guess!

...............
They were very certain, but I just didn’t believe…it’s hard to describe. I believe that it had happened. I found it hard to believe that it had happened to us.

Confusion was the emotion evidenced by couples who had a missed abortion. Because couples were largely unaware that this type of miscarriage existed, the diagnosis was perceived as an unpleasant and frightening surprise. The comment "we had never heard of this before" was stated often by the couples. In addition to the surprise of the miscarriage was the added burden of having no frame of reference to understand what had happened.

One couple spoke for them all when they expressed their confusion this way.

...never having heard of anything like this before, I always assumed as I think [husband] did that if you miscarry your body rejects it, so we were baffled as well as being shocked and hurt...

Hope was the final dominant emotion felt during Discovery. Hope was related to maintaining belief that the pregnancy might survive despite evidence to the contrary. Hope was expressed by couples during the prodromal phase of their miscarriage.

I wanted to be realistic with my mom and dad as well, I said,"I am spotting but we’re hoping that that’s going to go away and everything will be alright.

...so I felt like we were both kind of still very hopeful at that point...so you hold on to the hope a bit more and as [husband] says, he wants to be more positive and supportive and it’s going to be ok.

Following passage of the embryo, this couple expressed the hope that there might be a second twin still in the uterus.

...but I had to be reassured about things...like what if I’m carrying another?
Hope was felt even after ultrasound examination. This couple sought confirmation again when they saw another physician following their ultrasound.

...and [wife] seemed pretty hopeful. Before we went in she said, "maybe he’s going to find something that everybody else missed and we are going to be all right."

Hope served to maintain the possibility of a miracle and survival of the pregnancy until the latest possible moment. It faded only when irrefutable evidence was confirmed and reconfirmed by physicians. Hope emerged again in a different connotation in the Decision motif where it will be discussed again.

While shock and disbelief, confusion and hope were the dominant emotions of Discovery, information seeking was the dominant behaviour at this time.

The Behaviour of Discovery: Information Seeking

Seeking information from others was the dominant behaviour in Discovery and it began either when symptoms of a possible miscarriage began or when they were informed of their missed abortions. Books, friends and health professionals were the sources of information they sought.

Upon arrival home from the ultrasound department, this couple immediately searched books to make sense of what they were told.

...and we were like, flip, flip, come on (pause) ...and I remember reading it out loud to you about miscarriages and the cause, that’s what you (to husband were interested in.

Another couple, while waiting for their missed abortion to terminate spontaneously, discussed their situation with a homeopath.

[Homeopath] had never heard of this blighted ovum thing at all. But she gave me a homeopathic remedy I think it was. It’s supposed to work on the uterus.
This couple sought a second opinion to confirm their missed abortion. Only after hearing the diagnosis confirmed would they accept the inevitable.

Those weren’t the words I wanted to hear...and I guess that was probably when I started to cry. When I realized that I was going to have to accept that as the truth...

..................

Friends were an important source of information for many of these couples. Most couples utilized more than one resource to help them understand. This quote expresses the behaviours of many.

...so I was reading up on spotting...I was also talking to other friends who said oh yea, they’d had some spotting like that too.

..................

In summary, information seeking was the behaviour that accompanied the emotions of shock, disbelief, confusion and hope during the time of Discovery. Discovery ended with the realization that the pregnancy was over. What emerged out of Discovery was the motif of Disclosure which is the subject of the next section.

Disclosure

Disclosure represents the time when the knowledge of the miscarriage becomes public. Disclosure connotes behaviour and there are two dominant reciprocal behaviours: telling and story sharing. These two behaviours give rise to the emotions inherent in this motif. So entwined are the emotions in the behaviours of telling and story sharing that they cannot be separated and will be presented as a unit in this section.

All couples felt some degree of difficulty when telling others about the miscarriage because with each disclosure, they relived the experience emotionally. For four of the six couples, telling was the hardest part of the miscarriage as evidenced by this story.

...that was a lousy feeling, you know, telling people. That really was lousy. I didn’t enjoy that one bit.
There were common reasons why telling seemed to be difficult. The first was that imparting the news of the miscarriage caused distress in the recipients that they felt responsible for dealing with while they were still feeling fragile themselves.

It was hard telling people, in that people were really sad and affected by the story and I didn’t feel like I could have the energy to cope with their response very well because I was still feeling unresponsive.

The amount of difficulty varied depending on who the recipient was. Maternal grandmothers were deemed the hardest to tell.

I phoned my mother that night, but it was too hard. I mean we couldn’t go through telling. I mean you know actually saying it on the phone, I almost, you know, I was crying so hard it was just too much...

I, I, I, couldn’t cope with calling her. I just, I knew how disappointed she’d be.

Pregnant women were also difficult to tell.

I work in a small office. There’s four women, and one of them is due a week before I was, so it’s hard at work....I try to imagine how she feels and I’m sure she feels terrible, terrible you know for my loss and out of everybody she would be the most understanding...It kind of must take away from her excitement too when she’s around me because she avoids talking about it...she never talks about it unless I bring it up first. And yet her developing pregnancy is a constant reminder.

Telling friends and acquaintances generated socially awkward moments. Couples reported choosing the time to tell very carefully to minimize this awkwardness. But whenever the telling occurred, it was felt to generate discomfort as explained by this couple.

They really don’t know whether to say anything at all, and then if they don’t say anything, they think that you’ll think they don’t care about you. And it might only be that they don’t know what to say, they feel awkward.
Clearly, telling others about the miscarriage was difficult. One couple summarized the feelings of all when they said:

...but there’s a lot of emotions that happen. One, you know you’re going to bring, you’re going to make somebody else feel bad, two it’s going to be clumsy because they’re going to feel like they can’t say anything and you know they can’t and you don’t want them to have to try, and the third is that is reminds you again that you lost the baby.

Most of the couples reported difficulty with going public with the news of the miscarriage. However, telling others initiated a reciprocal behaviour that was heartwarming and helped to ameliorate the discomfort. Telling others prompted reciprocal Story Sharing which is the second dominant behaviour in Disclosure.

Hearing the stories of other miscarriages was surprisingly comforting to these couples because the stories helped to normalize the experience for them.

...everybody had a story, everybody knew of a person who had a miscarriage, or knew a person who had three miscarriages, or had one themselves, their mum did or they had one themselves and here I had known them for years and they had never told me...I found that very comforting...it makes the statistics seem more understandable, and makes you feel like you are not, you haven’t been singled out somehow.

It was comforting for these couples to know they were part of a community of others who had gone before.

...people coming out of the woodwork telling me you know that happened to me too or that happened to my sister, people telling me that they know other people that it happened to, not that I’m you know, it sounds kind of weird like I enjoy that it happened to other people, but that’s not it, but that it is not some kind of freak of nature that it happened to me.

...we’ve heard of so many people who have had miscarriages now, after the fact, and sometimes you know people, close friends that do, but because of this you’ve gone through...we’re really attuned to the number of people and it’s just amazing.
Story sharing also relieves the fear that miscarriage is an omen of childlessness for couples who miscarry their first pregnancy.

...I mean when something like this happens of course you start to think you know maybe I’ll never have kids. And someone who’s had four children and had [miscarriages] in between children just gives you that extra feeling that...it’s not too late...that your reproductive system isn’t hooped, it means it just wasn’t meant to be this time...

Most of these couples reported that their miscarriages were the first significant losses in their lives and that they were unsure of what was normal for this experience. The couples used expressions that conveyed the notion of not knowing how to feel and story sharing served to introduce them to the spectrum of feelings involved in miscarriages and thereby reassure them that they were normal.

...it makes me think that lots of people have felt this way too, and you know, there’s nothing wrong with the way that I’m feeling right now...that makes you feel better too...

Story sharing was an important comforting response to the difficulties generated by telling others about their miscarriage. Couples felt normalized by using the myriad of other miscarriage stories as yardsticks against which to measure their own experience. Story sharing also served to assist couples to make meaning of the miscarriage in the context of their lives and the stories served as seeds from which grew the motif of Definition which is the subject of the next discussion.

**Definition**

The motif of Definition represents the behaviours and feelings related to incorporating the miscarriage into the couple’s relationship. The emotion of sadness was dominant throughout Definition and the behaviours Communicating and Caring and Comforting served to process the sadness and bring the miscarriage event into perspective. As this motif is
played out, couples internalize the miscarriage experience, attach meaning to it and eventually begin to make plans about the future. As future plans are considered the motif of Definition fades and the final cluster motif of Decision emerges.

The Behaviours of Definition

Caring and Comforting

There were three aspects to the caring and comforting that the couples expressed with each other: Being Together, Doing For and Maintaining Normalcy. Being together was perceived as important to recovering from the miscarriage. Even though these couples were not always clear about what it was about being together that was important, they perceived it as comforting and a major force in their recovery. The amount of time couples needed to be together varied from a little to a lot, but its importance was affirmed by the couples in this study.

...It meant that I wasn’t going through it alone,...I was still very weepy, I needed him around, I needed him to be there for me because when I feel that way all I have to do is just look at him and you know I feel better.

............... 

...I don’t know what I would have done if I’d been alone, it would have been awful...even if it was the most awful thing, I really wanted to have [husband] there and go through it together...we went through it together, we needed to finish it together.

............... 

...I wanted to be there because I would have felt useless being out there in the waiting room...it meant that I was going through it as well...going through it along with [wife]. If I had sat out in the waiting room I would have felt a little angry...it helped me to be in there, it did...

............... 

The need to be together continued for varying lengths of time following the miscarriage. Couples identified a shift from usual independence at this time.
...the other thing is, in some small way it’s changed in that I didn’t want to be alone immediately after it happened for the next several weeks.

..............

...I know definitely when it first happened I didn’t really want [husband] to be anywhere but home at night, I didn’t want him going on any business trips, I did feel different...I’m usually quite independent, but I just needed him around.

..............

...I was anxious to get home [from work] because I wanted to see how she was doing and I guess I needed to be with her a little bit too...

..............

Even while couples expressed the need to be together, women also expressed the need for some time alone to cope with the experience.

I’d really recommend that for women, if they can to take time away and have some solitude and just be alone with your thoughts...

...............[husband] brought me home and then stayed a couple of hours and then went to work and that was just fine with me. My mum offered to come over and I, I just wanted to be alone.

...............One couple nicely summarized the contrasting needs of being together but also needing time alone when they said:

I had a healing process to go through and I just didn’t want to have to face anybody or talk to anybody or explain myself to anybody or anything...I just wanted that time for me and when [husband] came home it was for us.

...............Doing for each other was the second aspect of caring and comforting. Couples found ways to convey their feelings for each other to lessen the impact of the experience. Gestures of consideration were offered such as buying flowers and doing household tasks.

...[husband] brought me ice cream and pears in bed before I went back to sleep.

...............[husband] drove me home [from the hospital] about ten miles per hour, wonderfully, very, very thoughtful and had done some shopping.
Physical touching was also a common manifestation of doing for.

I just comforted her and she comforted me and that’s how we got through it really, that’s about all we did, held on to one another...at times we still are, but really for two days straight.

........................

And I went in and she was pretty dozy. I just held her hand.

........................

...we were both lying on the couch kind of hugging...we are really quite physical all the time actually, we are always touching or hugging...

........................

The final aspect of caring and comforting was the need to maintain normalcy periodically. Couples expressed how strange they felt during this time and they found it comforting to escape from the unreality of the situation by doing familiar things.

We needed just to do some ordinary things to kind of get back into the situation, swing of things.

........................

I always like going over and being with my parents and you know just to drop in any time...you know it felt good to see that everything was normal on that front...

........................

...and we opened a bottle of wine actually and I had a glass of wine for the first time in four months. Red wine, I love red wine, and so we opened a bottle of wine, and...it was just sort of a picnic.

........................

Interjecting these normal activities into their lives at this time provided these couples with moments of reality at a time when the miscarriage seemed to be overwhelming them. Caring and comforting behaviours were an important family of behaviours that together with communicating helped the couples to deal with their miscarriages.
Communicating

Communicating with each other about the miscarriage enabled couples to deal with their feelings, identify the nature of their loss and realize the effects of the miscarriage on their relationship.

...we talked about it quite a bit and I think that helps. I wouldn’t want to be married to a person with no communication, that would be awful.

[Husband] initiated a number of discussions, but I probably initiated more partly because I felt I needed to talk about it more. Talking helps.

...if either one of us had tried, had tried to hide what it was that we felt, it would have been murder. It would have been too much...you have to open up and talk to one another.

Talking about the miscarriage led these couples to define the nature of their loss. Perceptions of what was lost varied among the couples and some couples reported more than one type of loss within their own experience. Most commonly, couples reported a loss of ‘might have been’. Shattered dreams and foreclosed plans were common notions that were expressed.

...it was the loss of that expectancy of having the baby that brought the tears.

[the loss] was well more like our chance to be parents...it’s not so much the mourning of a life, as it was a mourning of something that we’ve lost.

...just sort of all my dreams revolving around that baby, and revolving around [husband] and the three of us as a family. We no longer were a couple we were a family already, and I had millions and millions of dreams of what we were going to do with that baby and all of a sudden it was all shattered, none of it was going to happen...

We had our lives planned thank you very much, and it all went away.
Couples also expressed their sense of loss of someone special. For these couples this early pregnancy represented a very real person.

It’s like a member of the family’s gone, we hadn’t seen it, but we loved it, so it’s like a member of the family, we lost a child...

.......... 

...here is this baby which was a very real being to us even though we had never seen him and it wasn’t being born, yet it was very real..pause..

.......... 

Two couples in this study, who had experienced major previous losses, experienced difficulty communicating with each other about the miscarriage. For them the loss of the pregnancy served as a trigger that resurrected feelings from their former losses. These two couples had the most difficult time in defining the meaning that the miscarriage had for them and resolving their sadness.

...then I said, "Why do these things always happen to me?" That, I’ve had problems with the divorce and all that, and that’s..long pause..I got the feeling that there was a child taken away from me there. And then this happened and, another loss. Just like every time you feel like you are going to get on track something just detours you.

.......... 

...also that I have this history of losing things, like my mother and friends, and every time another insult is added on top all that stuff comes up again...even though every time I think that I have dealt with it.

The final facet of the loss that was identified by the couples in the study was the loss of control. Loss of control was harder for some than others. This couple expressed the feelings of many when they said:

...the hard part is feeling out of control like you can’t do anything. You have to just let events take their course, there’s nothing you can do...

Communication also permitted these couples to identify the effects of the miscarriage on their relationships. Most of the couples reported changes in their relationship that were perceived as positive. Reported changes varied along a continuum from minimal to
significant. Couples identified the following in response to the question "How has this miscarriage affected your relationship?"

It's made it stronger...like he was strong for me, and he was tender for me and he was loving for me and that's what I needed...I was so relieved when he was there for me and when it happened we talked a lot about the way we felt about it, we cried together...we were closer, and we were stronger and there are times now when we'll kind of be snapping at each other but now to a certain extent we'll pull back...we're still a little raw, so it's made our relationship stronger and it's made us a little kinder to each other.

............... 

...down the road in eternity we're bound by that one experience that's been unique to both of us or uniquely ours because I haven't been pregnant before, [husband] hasn't been a father before so in some ways it has linked us and it has made that relationship tighter...

............... 

...taking comfort in each other. We know how to do that now.

............... 

Several of the couples identified a rearranging of priorities in their lives following the miscarriage. A redistribution of household chores was one effect.

...The other positive thing that has come out of this is that [husband] has been more involved in caring for the house. He's had lots of running and housework.

............... 

A redistribution of work-life priorities was another effect.

...I've realized that my home life is probably more important, important to me than I have probably even given it credit for. Or ever given credit to it. I feel that there is a benefit that has come out of all that because even today it's hard, I find it more difficult now to work longer hours at work and when something comes up, it sort of bothers me when something comes up and work keeps me from being at home.

............... 

Couples reported some negative changes in their relationships caused by different personal coping styles.

...when we have difficulties is when both of us feel that it is not ok [for each to have different experiences]. Intellectually I think I can manage it. I mean in principle I think that I will be able to live with [wife] through thick and thin, but when the hard
times come, it’s very difficult because we are so different in the way we react to crisis.

Well, I never found out until he told you that he still thinks about it because he never tells me that he’s thinking about it. [the miscarriage]. And I told him a couple of times in the last week that, that I still need as much support as I did the day after. And I don’t get it, I don’t get it. Even after I told him that I didn’t get it.

Couples in this study all reported discovering relationship effects as they defined the experience of the miscarriage for themselves. For the majority, a continuum of positive effects from mild to significant was reported. Negative effects on the couples relationship were recognized when coping styles conflicted. Relationships were either strengthened or strained but they all changed. All of the coping behaviours that were evident as couples made meaning of the miscarriage were aimed at resolving the crisis and ameliorating the sadness generated by the miscarriage. Sadness, the emotion of this motif will be discussed next.

Emotions of Definition

Sadness was the dominant emotion of this motif. It was described by both partners as having varying intensities at different times for each of them.

It was sad, the feelings were grieving feelings... I was so sad and it’s almost harder for me now than it was at the time. It seemed like a couple of days and [husband] forgot all about it but for me it’s still just as hard.

I’ll be at work and all of a sudden just out of, you know, I’ll think about it and get sad for a few minutes and then get back to work. It does come back every so often, you bet it does.

I felt so sad. Grieving feelings that was what I was feeling. Even when I went back to work I felt so sad and so fragile.
The sad feelings are still there [at second visit]. They don't come as often now but they still come.

Sad feelings were the dominant emotion during the Definition motif. The degree of sadness varied along a spectrum from immobilizing to disappointment however ameliorating the sadness was the goal of the behaviours that were dominant at this time. As the sadness began to retreat the couples began to entertain more positive notions about trying again. As this shift occurred, couples began to make decisions about the future. This is the subject of the fourth motif of the cluster.

Decision

As the miscarriage experience became integrated into the fabric of the couple's life, their attention began to shift from the present to the future. The notion of another pregnancy entered the picture, originating from themselves or by the questions of others. This notion occurred episodically in the other motifs and eventually coalesced into a motif that is comprised by the dominant behaviour of planning and the emotions of hope and fear.

The Behaviour of Decision

Planning exemplified the learning that took place during the miscarriage experience. Couples expressed very explicit ideas regarding behaviours they would employ prior to or as they were attempting to achieve another pregnancy. These ideas arose as couples processed the miscarriage experience and made decisions about how they could improve their chances for a successful pregnancy the next time.

And before we get close to the date of trying again I 'm going to go the cold turkey bit...cut out all the caffeine ...I'm trying to get my system all clear again.

I want to gain the weight back. I'm still down about five pounds and get back to eating right so I can cope and then I'll feel ready to have a baby.
I feel that I’ve had this experience so I’ll know in terms of planning...I don’t think I took enough of it into my own hands. I don’t think I was well informed enough.

I consistently harken back to the thinking that I did around the miscarriage...and realizing...that I’d made the right decisions to curtail my work activities and my career probably out of desire to have a family.

Emotions of Decision

While couples made many different kinds of plans to enhance the opportunity for a successful pregnancy the next time, they made those plans cognizant of the emotions of hope and fear that prevailed at that time.

So I’m sort of moving on and I feel a certain amount of excitement too about the next time as well as a lot of worry which I think will probably never go away.

That’s a fear you have I think when you have a miscarriage for your first. My concern now is that was it a fluke that I got pregnant? Will it happen again?

We have talked about it and we are both more anxious about the next pregnancy. I mean is it going to be another literally a repeat performance?

...We have decided to try again and we’re starting to get excited again about trying and getting pregnant, so that’s all very positive and I myself don’t dwell on the miscarriage at all.

I hope things will go well next time but I know I’m going to be really scared until, until at least I’m past when I lost the baby this time.

Five of the six couples in this study felt ready or almost ready to embark on another pregnancy by the time of the second visit. They had all made active decisions to try to conceive again. Ideas about a subsequent pregnancy entered their thoughts at different times.
following the miscarriage. At first, the thoughts occurred only fleetingly but they eventually arrived to stay.

I remember thinking right after the tech told us that there wasn’t any baby...next time it will be ok. I knew right then that there would be a next time. Then I didn’t think about it for awhile, but I remember I thought that then.

The decision motif is the final motif in the cluster that represents the miscarriage experience. Upon reflection, this composite of four motifs bears striking resemblance to descriptions of grief generated by other theorists. This notion will be further developed in the next chapter. The feelings and behaviours of the four motifs arise from within the couple however they are influenced by the impact of the external theme of health care interactions.

**Health Care Interactions**

Interactions with health care providers emerged as an important theme that is external to the cluster of motifs previously described. While it was possible for a couple to miscarry entirely without contact with health professionals, the vast majority would have had some interaction with the health care system. Perceptions of their health care were an important component of the experience for each of the couples in this study.

For better or for worse, the manner in which couples perceived they were treated by the health care team impacted on their ability to deal with the miscarriage. Two of the six couples changed their primary physician following their miscarriages and another refused a post-operative visit with the gynecologist. This woman explains how she felt during her first visit to the gynecologist eighteen hours after being told that her pregnancy was no longer viable.

...his entire attitude was (emphatically) one of it’s my job lady...like hey, you’re nothing special and move along...I was still asking him questions and he got up from his desk and walked to the door. I hadn’t even finished my end of the conversation
when he was dismissing me to go into his room...and so I said how long will this take? And he said to me LISTEN SWEETHEART... they are so busy at that hospital you’ll be lucky if you get it by six oclock and don’t leave the hospital or they take your name off the list...and that’s exactly his tone... so I was ready for tears again.

At the second interview, this woman still had not resolved her anger towards this doctor. Bad experiences lingered with all the couples and this woman spoke for them all when she said:

And I still feel angry about the way I was treated...I still remember it as a very bad experience. It’s such a sad time, he didn’t have to make it worse.

Nurses also received comment when they were felt to be unsupportive. This woman tells her experience in the recovery room following her dilatation and curettage.

...there was a nurse there that had to stay with me for an hour or so. She was pregnant, she was really pregnant and she started talking about her pregnancy and then she was nice and everything ...but it was more like she wasn’t recognizing what I had just been through. It doesn’t take much.

Emergency room nurses had a large impact on these couples as they were often the first professionals that were seen following or during the miscarriage.

I thought well, when someone’s having a miscarriage she should be treated with a little bit more gentleness. I thought do I have to sit here and wait with all these others who are waiting? I mean, I’m having a miscarriage. No one recognized that.

After the first nurse talked with [wife] another nurse continued to care for her and she was really nice. The difference was that the second nurse recognized that we were having a sad time. The first one made us feel like we were making too much of this.

Men also voiced their perceptions of the care that was offered to them. Men generally felt that their needs were not acknowledged or even considered as being a factor in the miscarriage. During the interviews men shared their need to have their feelings considered but admitted that they hadn’t really expected that they would be.
My emotional needs were not taken care of at all in the hospital but I guess that’s not their job.

........................................

...you feel like you’re forgotten. It’s like well, you know you’re tougher you can deal with it. That’s the impression you get.

........................................

Everyone always asks how [wife] is, no one ever asks how I’m doing.

........................................

Any gestures of caring that were extended to the husbands were gratefully received by the couples.

He [obstetrician] was explaining things to [husband]...he’s a very caring person. He seemed very aware of [husband], that you have a spouse, that you’re not there alone. So he took it upon himself to look after him.

........................................

And [Doctor] also told me that [husband] could come in and talk to her any time. Come with me or come by himself. So she recognizes that there’s really a gap there.

........................................

Just knowing I was included in the conversation made me feel less peripheral. That’s what I’d been feeling, peripheral.

........................................

Conversely, good feelings about care relieved an unnecessary burden. Whereas couples who were unhappy with their care needed to talk about it as if to exorcise the ghosts, couples did not have the same need to discuss their care if it was good. Kudos were awarded in passing but the need to elaborate and expound was not present.

...you know [Doctor] She’s just so easy to talk to. I can’t imagine how bad it would be if you didn’t have a supportive doctor.

........................................

He was really quite approachable and he spent quite a long time with us, so we really appreciated that.

........................................

I had never met him [obstetrician] before. The nurses told me I was lucky he was on. He was really nice, really caring, he said something like I’m sorry we’re not meeting.
under happier circumstances or something like that. He was nicer than my own family
doctor. I went back to him for my check up. He made us feel like it was normal to
have the feelings that we did.

How couples were received upon admission to hospital also left a lasting impression
on couples. Recalling events of the admission continued to generate strong emotions if the
perceptions were negative. As this husband said:

...I was getting a little mad because we stood there (at the admitting desk) for a good
five minutes while this lady was going on and on about who’s coming to the baby
shower...I was more than a little upset at that time.

A second husband put his feelings in stronger terms.

...because it is so inefficient it’s just a pain in the ass to have to be exposed to it...it
wasn’t as if we came in to save the baby, if we were going to save the baby we sure
as hell wouldn’t go near that hospital.

The powerlessness that people experienced on admission to hospital increased the
strain of the miscarriage. The need to be discharged quickly so that they could regain control
of their lives was common.

...sure I get admitted, I get stabbed to death, I get this IV stuff and so I have to keep
my arm like this, I get this gown on I can’t even do up the back because this arm
doesn’t work anymore, people are withholding information from me over here, like I
felt like I was sick...even though in a way I was no sicker than I had been 24 hours
previously. So I felt like the best place for me was to get out of there and be home
and just let whatever was going to happen, happen.

I wasn’t allowed to get dressed, I was in this large room. I guess I didn’t really want
to be there. I was not feeling very well and I actually wanted to leave. [Husband]
was starting to feel frustrated, like it had taken so long to get to know what to do.

The significance, attributed to the miscarriage, by health care workers had a strong
emotional impact on the couples. When couples felt acknowledged by their care givers for
their experience, their hospitalization and recovery were eased.
She [operating room nurse] said that she could see that I was really upset...and she was really compassionate and I think she understood. I think she knew how I felt...She had her hand on my arm and brought me the tissues and stuff like that...I just thought that she understood. She was really nice.

I felt very at ease because of the doctor, the nurse, the intern and it made all the difference in the world. If I had had callous people, it would have made a big difference to me. It was in their manner [that something meaningful had been lost] it was in their expression it was in everything.

Couples reported being very sensitive to the language used by health care workers. Couples acknowledged that they needed to be cared for sensitively and they related comments that were made with good intentions that had been hurtful.

She said it so matter of factly that it really hurt and she said, "Well" she said, "You know don't worry about it, you can try again"...it was really the wrong thing to say...she said it so coldly that that really upset me.

The nurse said "oh don't worry honey...there's lots more of those eggs where that one came from...

And I couldn't believe she said it but she said "you'll be pregnant again in no time and you'll forget all about this." I want to tell her that I might be pregnant again, but I will NEVER forget about this baby.

Overall, it became clear, and was validated by the couples in this study, that the care received during their miscarriage made the event easier or more difficult to deal with. This was the first hospital admission for many of these couples and the memories that were left to linger have imprinted a response that will affect future dealings with those institutions.

A final aspect of this theme which emerged from the data was the need to talk through the experience following a miscarriage. Five of the six couples commented on how helpful the opportunity to talk about the miscarriage had been. The process of participating in the research had touched a responsive chord which couples validated as therapeutic for them.
...[participating in the research] has been helpful because I don’t think there’s any misconceptions that I have about what [husband’s] thinking. We’ve talked about our feelings, our thoughts, our friends, our hopes our disappointments, so we’ve really covered the topic well and we do feel that it’s been very therapeutic...but it was hard for me to start talking about it.

......

...because that’s [the interviews] what I think I need. Like the physical part is all taken care of. Your body sees to that but somehow this ritual seems to be like a psychological dilatation and curettage...to just get you to complete that part and get on.

......

Couples descriptions of their experiences with miscarriage are poignant reminders of the importance of good interpersonal communication skills between health care professionals and they people they serve. All of the couples found their interactions with caregivers to be significant in how easily they processed the experience. The motifs described earlier represent the behaviours and feelings experienced by couples at various times during their miscarriages. The motifs were common to all as was the significance of interactions with caregivers.

Although the motifs were common, partners did not experience them in synchrony. As couples told their stories, it became evident to the investigator that partners often experienced the same things but at different times. For example, one partner was feeling hopeful that the pregnancy might be saved while his partner was questioning whether or not there would be a next time. The investigator reflected her observations back to the couple and they validated that it was common to be perceiving the same things differently, or perceiving them at different times. Further discussion led to the conclusion that this notion of 'together but separate' was the context in which the composite of motifs and the health care interactions occurred. In the next section of this chapter this context of together but separate will be discussed. Verbatim quotes will be used to illustrate the notion.
Together But Separate: Context of the Miscarriage Experience

Miscarriage was an experience that happened over time. For some couples, there was an anxious prodromal phase waiting for the miscarriage to occur. For others, the miscarriage was a sudden event that physically terminated very quickly. For all couples, the experience lingered for varying lengths of time as the couple processed the experience and incorporated it into their relationship. Each partner internalized and made meaning of the miscarriage in his or her own unique way which resulted in three possible representations of the experience: her story, his story and their story.

Individuals processed experiences as they occurred. When miscarriage happened, partners in a couple shared the same experience but perceived it differently or they both experienced the same things, but experienced them at different times. These perceptual and experiential similarities and differences reflected the degree of togetherness that existed throughout the experience. This ‘together but separate’ aspect of the experience was important to note for it provided the context in which the composite of motifs occurred.

Couples did not generate the notion of ‘together but separate’ as a component of the miscarriage but acknowledged its importance when it was reflected back to them by the investigator. This aspect of the experience was identified by the investigator as the couples told their stories. What became clear from the data was that no part of the miscarriage experience was immune to differing perceptions by the couples. The excerpts which follow indicate the variety of permutations of this notion revealed in the transcripts.

In presenting the quotes, the following symbols will be used: M = male partner, F = female partner, I = investigator.

This quote portrays the separateness that occurred as the possibility of miscarriage became a reality for this woman but not for her husband.
F. Well, no, do you remember (to husband) I'm just trying to jog your memory. Do you remember the night before when we went to the doctor's and there was bleeding then?

M...I wasn't concerned that anything major was going to happen. I thought that this just might be the way things normally develop, and I wasn't overly concerned that something major was going to happen at that time.

This woman had been discussing the possibility of miscarriage with her doctor in the presence of her husband. She spent the afternoon scanning every book she had for information about miscarriage. She illustrated her attempts to make her husband aware of the situation when she said:

I was really getting a bit panicky when the cramps started coming on stronger...so I thought that’s when I was at you almost like to read this...pay attention to this because this is what is happening...and [husband] wasn’t wanting to believe it yet.

............

When asked about his perceptions of his wife's attempts to focus his attention on her concerns, he replied:

...I guess I'm very optimistic in my thinking....I firmly believed it wouldn't happen.

............

Separate perceptions occurred for this next couple when told that her uterus contained an empty gestational sac. This woman expressed it this way.

I felt foolish, [husband] didn't of course, he didn't think there was anything to feel foolish about, but I did.

............

Conversely, couples can feel very together within moments of separate perceptions. Shortly after receiving their diagnosis of missed abortion, both members of this couple were unified in deciding on their needed treatment.

We both knew that we were going to get it done, we didn't have to discuss it or ask each other, we both just knew that it was going to be done today.
Separateness was also identified when partners described the meaning the miscarriage had for them. After hearing his wife talk about her sense of loss following the miscarriage her husband provided his perception.

...I would say it was almost completely that I wasn’t really experiencing much of a sense of loss as far as the actual fetus went and I think that carries through right to today. I think that, you know, I’m not sure how somebody could manoeuvre a question to get me to, to recognize the loss of the fetus as more important than [wife’s] feelings because I think that in terms of priorities, like [wife’s] the person that I love and she’s here and she’s the one that I’m more concerned with and I would certainly, you know a miscarriage is something that happens and I don’t want to see it happen because it hurts her and her feelings.

Another couple expressed the different meanings their miscarriage had for them this way.

M. In many respects it has been a good thing...this was something, well we both had to rely on each other to get through it, and it was sort of a positive thing. I almost felt like it was a shot in the arm...so I thought that is was quite significant for me.

F...I was very worried and I sort of had felt like in a defensive position...I guess that was what it meant to me...pause...and I was always trying to make everything really light...to try and cheer [husband] up that he wouldn’t be mad about this.

Seeing the baby evoked different reactions for partners. This couple clearly felt very differently on viewing the embryonic sac they retrieved from the toilet.

F...I’m so glad I did because it gave me a chance to hold the baby. Just even in my hand, and that’s real precious to me. And I don’t know what eventually happened to it, but for a moment I was able to hold it.

I.(to husband) Tell me what you felt when you saw the baby.

M....and it was at that point then I would think the words we were talking about before, disappointed somewhat for myself but probably more for [wife] sympathetic, that’s what I was feeling.

People who suffer missed abortions sometimes have the opportunity to see their babies during ultrasound examinations. The male partner in this couple expressed how seeing the baby helped him to deal with the miscarriage.
I was able to take comfort in the fact that I was there. It had all the appearances of normalcy, but it wasn’t, it wasn’t alive, and it made it easier for me. It made it easier for me to accept that it wasn’t alive.

His wife, however, felt quite differently about seeing the baby even on the second visit nearly two months later. She expressed her feelings this way.

...in some ways, I might rather have had one of those, you go to the washroom and have it pass through. I don’t know, my affections were even strengthened, they became stronger after seeing it in the ultrasound. So it was the combination of getting the good news and the bad news at the same time. Suddenly I was far more attached to the baby, then, then the bad news.

Another couple provided similar perspectives on when they felt the miscarriage would be over. Speaking for both of them this man said:

I don’t think it will ever be over because. It may change in that when we are, you know, our parents’ age...we might be comforting people in their childbearing years who have just lost a baby, so I don’t think that it will ever be over.

Different perceptions of when the miscarriage event was over were common. This couple expressed their differences this way.

M. What I mean is, that it’s never over. I really mean that it’s never over. I think that there will be an echo of this forever.

His wife, however, could foresee a time when, for her, the miscarriage would be over.

F...I think that it will be completed only for me when ... I carry a pregnancy to term.

The fact that individuals within the couples experienced different things at different times is important to note. But, it is also important to note that the couples felt that the experience was fundamentally different for each partner and that that was acceptable. While nodding in agreement, this man listened while his wife explained their differences this way.
...I don’t know if it’s a luxury or not, I think that’s the wrong word, but for lack of a better word, I knew he had the luxury of holding back a little. He could put up a barrier. I already knew this...

Another couple also expressed the acceptability of their differences.

...We’re quite, or I think we’re the classic opposites attract in marriage...but when incidents occur in life that are unexpected we just, we handle it the same way and [wife] always handles it the way she handles it, but they’re both exactly the opposite.

Couples experience a miscarriage together but make meaning of it individually. They experience the same things at the same time, and they experience different things at the same times and they experience the same things at different times. This notion of 'together but separate' is an important idea to keep firmly in mind for it provides the context in which the composite of motifs is experienced.

Summary

This chapter has described the analysis of the data that depicts the couple’s experience with miscarriage as a composite experience composed of four interacting and interdependent motifs that are impacted upon by the external theme of health care interactions. This description appears similar to the descriptions of grief generated by other authors. The motifs occur in the context of a 'together but separate' experience where partners may experience events differently or at different times. Dominant emotions and behaviours of each motif are described and excerpts from the interview transcripts are used to corroborate the analysis.
CHAPTER FIVE
Discussion of Findings

Chapter four presented the phenomenological description of a miscarriage generated by the analysis of the data. In this chapter, the description of the miscarriage is discussed in relation to the literature. A comparison between the conceptualization generated by this study and the frameworks of other grief and loss researchers will open the discussion. Then a closer look will focus on the individual motifs with their behaviours and emotions. The chapter will close with a discussion of the health care needs expressed by the couples.

The Composite of Motifs

Following analysis of the data in this study, the couple’s perspective of miscarriage is depicted as a composite of four interdependent motifs that occur and recur until the couple feels ready to embark on decisions about the future. Dominant behaviours and emotions characterize each motif. This conceptualization can be compared to the works of other grief theorists. Lindemann (1944), Engel (1964), Parkes (1965), Bowlby (1980) and Swanson-Kauffman (1983) have all developed conceptualizations of grief. In comparing the findings of these theorists with the motifs described in this study it becomes clear that couples who miscarry go through a process of grief similar to that found in response to other significant losses.

The findings of this study are particularly comparable to those of Engel (1964) and Swanson-Kauffman (1983). These theorists define the process of grieving as having component parts or a sequence that Swanson-Kauffman (1983) called experience categories and Engel (1964) called phases. Findings in this current study are labelled as motifs. All three authors intend the aspects of grief depicted in their frameworks to be interdependent; to occur and recur. While aspects of each component can be found in all others, as time goes
by each component has its moment of dominance. The similarities between these frameworks are shown in the following chart.

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<td>Discovery</td>
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The first motif of this study was Discovery. The behaviours and emotions dominant during Discovery are very similar to behaviours and emotions described in Engel’s Shock and Disbelief phase and Swanson-Kauffman’s Coming to Know. All are characterized by emotional numbing and gradual regression to a more dependent state. The second motif was Disclosure and bears much resemblance to Swanson-Kauffman’s Going Public and Engel’s Developing Awareness and Restitution. This phase encompasses the reaching out to social supports and the use of rituals to aid in the recovery process. The behaviours of Telling and Story Sharing evident in the Disclosure motif are similar to behaviours in the descriptions of Swanson-Kauffman’s (1983) experience category of Going Public. Telling others and discussing the loss yields a reciprocal response which provides social support and comfort during the time of mourning. Engel identifies the need to talk about the loss and repeatedly review the loss experience as a way to ventilate feelings, emphasize the reality of the loss and obtain social support. Definition, the third motif, has many parallels to Swanson-Kauffman’s categories labelled Sharing the Loss and Getting Through and Engel’s phases named
Resolving the Loss and Idealization. In this study couples describe the ways in which they process the experience as Caring and Comforting and Communicating. Couples review the loss together, share feelings, care for one another and define the nature of what was lost. These activities help to fill the void left by the miscarriage and enable the couple to voice their sadness. Both Engel and Swanson-Kauffman found that one way people process their losses is by thoroughly reviewing it through discussion.

In the fourth motif, Decision, couples begin to make plans for their future. Thoughts about the loss are much less frequent and memories of the loss begin to lose their sting. This motif is compatible with Swanson-Kauffman’s category of Trying Again and in Engel’s Idealization phase.

In the Decision phase of this study, couples identified notions that reflected coming to terms with the loss as well as bittersweet qualities of the experience. Engel (1964) called this phase the Outcome phase which is achieved when realistic memories of the loss include both the pleasures and the pain surrounding the loss. Similar behaviours were seen in Swanson-Kauffman’s phase Trying Again (1983).

In this study the composite of four motifs is portrayed as being in interaction with the external theme of Health Care Interactions. Couples identified that their interactions with health care givers had a significant impact on how they dealt with the miscarriage. When relationships with care givers were perceived as supportive and helpful, they were reported in appreciative terms. Poor relationships resulted in the investment of considerable energy to deal with them -- energy that was diverted from dealing with the loss.

Couples demonstrated anger and frustration towards care givers they felt were not helpful or hospital routines that imposed arbitrary limitations on their being together. These feelings needed to be ventilated as evidenced by the importance that couples gave them in the
transcripts. Engel (1964), Swanson-Kauffman (1983) and Bowlby (1980) also identify that the process of grieving can be interfered with by inappropriate interventions or conditions that are not conducive to healing. Similar findings were reported by Wolff et al. (1970) who concluded that the attitudes of personnel and policies of hospitals affected the grief process for parents and, as a result, they advised institutional flexibility. Couples, in this study, responded negatively to being separated in hospital which lends credence to the significance of the Health Care Interactions theme.

Couples described feeling that their losses were not recognized or that they were not treated respectfully. These findings are similar to those compiled by Cousins (1990). Cousins found that most complaints about physicians related to people feeling that they had not been treated with sufficient respect or sensitivity. This lack of respect or sensitivity is associated with an increased incidence of litigation. Although no litigation resulted from care given to the couples in this study, two couples did change physicians following their miscarriages and another woman refused a follow-up visit with the gynecologist she had been referred to. Couples were quick to describe the caregivers that were helpful or respectful and those that were not, lending support to similar claims made by others in the literature. Swanson-Kauffman (1983) identified five categories of behaviours expressed by health care professionals and lay persons that women, who have just lost a pregnancy, identified as caring: Knowing, Being With, Enabling, Doing For and Maintaining Belief. These same behaviours were found to be the behaviours that were conducive to facilitating healing in the couples’ descriptions of their health care interactions in this study. Conversely, the absence of these behaviours are the aspects of care that led to the anger and resentment against caregivers that couples in this study reported.
The representation of the couple’s experience with miscarriage as a composite of four interdependent motifs is similar to the findings of other grief theorists. The importance of relationships with health care givers is supported by other authors. Next, a discussion of the motifs in greater depth is provided beginning with a discussion of the ‘together but separate’ context which forms the backdrop of the miscarrying couple’s experience.

Together But Separate

Partners experience a miscarriage together but they process it as individuals. Evidence for this is the ‘together but separate’ context that was validated by the couples. The largest factor contributing to incongruent grieving is the fact that a couple is composed of two people and each has an idiosyncratic way of grieving (Rando, 1986). There is no correct way to grieve and each partner must be given the encouragement to express grief in a personal way (Kubler-Ross, 1969). Overall, couples in this study were aware and tolerant of the differences in reactions within their relationships.

Peppers and Knapp (1980a) posit that partners grieve incongruently because of differing emotional investments in the pregnancy. Lietar (1986) and Stirzinger and Robinson (1989) both attribute the different perceptions of loss between partners to the differences in male attachment to pregnancy and the fact that the pregnancy is not a physical reality for the man. Rando (1986) states that while some men may not begin to form attachments to the pregnancy until the woman’s body changes are obvious and movements are felt, other fathers begin identifying with the image of the fetus from the time of the positive pregnancy test.

Condon (1985) found that the way men and women relate to pregnancy is more similar than different. Men, in Condon’s study, demonstrated remarkably similar visual and emotional fantasies about their fetuses to those of their partners (p.280). Men, in this study,
showed varying degrees of emotional investment in their pregnancies which is similar to findings in the literature.

Sex role socialization may be another factor in the different expressions of grief that were observed between men and women. Men in our society have been conditioned to be in emotional control and maintain their roles as providers (Rando, 1986). Condon (1985) found that while men’s outward behaviours i.e. carrying on or being tough were very different from their wives’, their internal world experiences in relation to the pregnancy were very similar (p. 280). Condon concludes that this suggests that the cultural shaping of behaviour might conceal the similarities between men and women’s inner lives in relation to pregnancy. The appearance of not grieving and of carrying on may, in part, be more related to socialization than lack of attachment.

Two couples in this study who had experienced multiple or unresolved previous losses demonstrated the most incongruence in their grieving. This response is supported by findings from Rando (1986) and Callahan et al. (1983) who identify previous experience with loss as an important factor having either a positive or negative impact on grief reactions. Previous resolved losses may reduce the sting of the current loss as the individual can give in to the grief reaction with the expectation that time and attention to grief will help to heal it. Conversely, negative previous experiences influence coping behaviours and defense mechanisms. If loss was denied to avoid pain, or if multiple losses have occurred without time to resolve any one of them, the individual may be left depleted and unable to address the current loss.

All couples in this study verified the importance of good communication both between partners and with health care professionals. One couple was articulate about the difficulties they encountered when their communication was blocked for a time. They credited
participating in the research as the key that opened their lines of communication and allowed them to get back in touch with each other. Witzel and Chartier (1989) and Callahan et al. (1983) assert that couples with good communication withstand this incongruence more easily and couples who have communication difficulties may see those difficulties increase following their losses.

It is apparent that miscarrying couples will present with a variety of manifestations of loss given the variance of attachment, idiosyncratic responses, different prior experiences and sex role socialization that may influence perceptions of loss. The quality of communication that exists within the couple’s relationship has been shown to influence tolerances for incongruent grieving.

Discovery

In this study, Discovery represents the awareness that the pregnancy is over. Couples experiencing a prodromal phase, with related signs and symptoms, had some time to consider the possibility of a miscarriage but couples with missed abortions had a very different experience. They approached ultrasound tests with eagerness to get a first look at their babies but instead of the anticipated preview, these couples watched as technologists searched their screens for signs of life. The news of the end of the pregnancy came as a complete surprise to these couples and as a result they demonstrated greater difficulty coping with the news than did the couples who had some time to think about it. This is supported in the literature by Rando (1984) who asserts that losses that are entirely unexpected have a greater capacity to completely overwhelm. Recovery is longer and there is a higher incidence of complicated grief. The couples who had missed abortions in this study demonstrated confusion which the couples who spontaneously miscarried did not. When missed abortions occurred, people spent extra energy trying to make sense out of something that was entirely unfamiliar to
them. Before they could get on with the business of grieving they needed to clarify what this strange phenomenon was. No references to support this finding were found.

The behaviour of Information Seeking seen in the Discovery phase is recognized by Parkes and Weiss (1983) as integral to healing. Couples in this study who miscarried their first pregnancy gathered information to understand what had happened to them and to be assured that the miscarriage did not mean that they would never have healthy pregnancies. Parkes and Weiss assert that the loss experience must be understood so completely that all questions are answered before anxiety related to the loss is reduced.

**Disclosure**

The actions of Telling and Story Sharing that characterize this motif aided couples to gain understanding and make sense of what had occurred. What initially started out as painful information sharing resulted in a surprising and comforting result. The incidence of miscarriage is so high that most listeners had some experience with it and could share a story. In addition to explaining the loss and gaining understanding, Story Sharing normalized the experience for the couples and brought them into awareness of being a member of a special group. The importance of this is made clear by Moulder (1990) who describes the Miscarriage Association in Britain. One of its purposes is to put people in touch, either personally or through newsletters, with others who have miscarried.

In the United States and Canada a number of books have been written by lay people to impart the needed information and thus connect people who have had the experience with those who have gone before (Borg and Lasker, 1981; Oakley and McPherson, 1984; Panuthos and Romeo, 1984). This kind of communication allays the isolation that can be felt while grieving a loss that is not recognized by society and for which society endorses no rituals. There is no funeral, no condolence cards, no gathering of family to share the burden
(Panuthos & Romeo, 1984). Hutti (1988) asserts that not only are parents robbed of their baby, they are robbed of their loss. Lovell (1983) claims whereas the woman was referred to as a mother while still pregnant and her fetus was referred to as a baby, there is an abrupt shift after a miscarriage back to the terms woman and fetus. This action negates the brief time that the couple were parents by denying the existence of the baby and encourages the couple to forget an important part of their lives. Telling and Story Sharing aid in keeping the loss real and thus validates the need to grieve.

**Definition**

Caring and Comforting and Communicating are the ways in which couples processed the sadness and achieved integration of the miscarriage into the fabric of their lives. There were three aspects to Caring and Comforting: Being Together, Doing For and Maintaining Normalcy. Most of the couples wanted to be together throughout the experience and felt unhappy with the arbitrary separation that happened following admission to hospital. Swanson-Kauffman (1983) identified similar responses in her study. Rando (1986) and Thiessen (1985) both report feelings of increased closeness, compassion, caring and sensitivity between partners grieving a loss together.

Because a miscarriage is not a societally acknowledged loss, the couple is left alone with their grief to cope as best they can. Couples in this study identified the need to have their loss acknowledged by their care givers. When couples do not receive validation from their care givers they have only each other to rely on to cope with the loss. Personal growth is an identified phenomenon following loss however if personal growth is to occur, there must be public acknowledgment that what happened, really happened (Schneider, 1981).

Couples in this study also made changes in their lives together as a result of their loss. All of their relationships were different following the miscarriage. Home and work priorities
were reordered, new skills such as learning how to comfort each other were learned. Hardin and Urbanis (1986) and Cummings, (1984) both identify re-evaluating their lives and reordering their priorities. Rando (1986) describes reassignment of roles and responsibilities as necessary in reestablishing stability in the face of the changed situation. This reference is in relation to later losses in parenthood however it appears to be a common response following a loss.

Defining the nature of their losses enabled couples, in this study, to identify what it was that was lost. For some, it was a baby, for others it was an opportunity. Moulder (1990), Panuthos and Romeo (1984) Borg and Lasker (1981) all identify that there can be a myriad of losses that couples can feel when a miscarriage occurs. The nature of the loss does not diminish the amount of pain that accompanies the loss (Rando, 1984, 1986). Defining the nature of the loss moves the fetus from the realm of mental image to a more concrete existence which permits the couple to accomplish their grief work.

Five of the six couples in this study felt ready to plan for their futures within a twelve week period. This is similar to the findings of other authors who have found that when conditions for grieving are generally favourable, women tend to resolve grief within twelve weeks of the miscarriage (Hardin and Urbanis, 1986; Leppert and Pahlka 1984; McCall, 1988; Peppers and Knapp 1980b; Swanson-Kauffman, 1983).

Decision

As the sadness diminished, couples, in this study, began to make plans for the future. This is congruent with the final phases of grieving identified in the literature which are all marked by renewed interest in activities, reduced psychic preoccupation with the loss and the investment of energy in future plans. The loss is not forgotten but resides in a more comfortable place (Engel, 1964; Parkes and Weiss, 1983; Rando, 1984). This phase emerges
slowly, waxes and wanes in other phases of grief and like a musical motif is repeated until the theme is played out. The active planning evident in this motif can be likened to the plans that people make to establish their lives without the deceased. The plans centered around ensuring the safety of a future pregnancy by eliminating or changing anything that might have been seen to have been at fault the first time. This could be similar to the protectiveness that parents impose on surviving siblings when a child dies (Rando, 1986). It represents an effort to control the uncontrollable.

The emotions of hope and fear that characterize this motif also exist in other reestablishment phases. Swanson-Kauffman (1983) describes this mix of emotions as "ongoing fear of recurrent problems" and a "gained sense of vulnerability" (p. 211). Moulder (1990) provides many accounts of the mixed feelings that occur when making decisions about the future. They all reflect the same mix found in this study: hope that a healthy pregnancy would be attained and fear that another miscarriage would occur. One factor that affected the decision motif was the quality of the relationship couples had with their care givers.

**Health Care Interactions**

Health Care Interactions played an important role in the recovery of couples following miscarriage. The care givers’ responses either facilitated healing or they provoked anger which necessitated diverting energy that could have been spent in dealing with the miscarriage. Empathic, supportive responses from care givers validated the reality of their experience and normalized what the couples were feeling. Couples reported wanting to have their losses acknowledged. Moulder (1990) found that less than ten per cent of respondents in her survey identified the care giver as one of the three most helpful people at the time of the miscarriage while over forty per cent of respondents identified care givers as one of the three
least helpful people at the time of the miscarriage. In another study, Swanson-Kauffman (1983) identified the importance of empathic support as "categories of caring" (p.222).

Couples identified that participating in this research project had been helpful to their recoveries. All acknowledged their reluctance at the outset but found the opportunity to tell their own story in their own way had been helpful. One woman labelled it as a "psychological dilatation and curettage". The need to talk through a miscarriage after the event has been identified by other authors (Leppert and Pahlka, 1984; Moulder, 1990; Stirtzinger and Robinson; Witzel, 1989). Leppert and Pahlka (1984) advise a counselling session immediately following the miscarriage with a repeat session four to six weeks later. Their conclusion was reached anecdotally, however, the findings of this study would support the value of talking through the experience at a later time.

Men, in this study, reported that their emotional needs were not met during the miscarriage experience. They acknowledged that they hadn’t expected that they would be however it was clear that men have care needs that are not being met by current health care practices. Two anecdotal reports by Cummings (1984) and Hardin & Urbanis (1986) corroborate the findings of this study. Beyond stating that this study indicates that men need care and acknowledgement following a miscarriage, little comment can be made on men’s grief and care needs following miscarriage because the study to describe those phenomena has yet to be carried out.

Summary

In chapter five, the findings of this study are compared with the literature about grief and loss. The four motif conceptualization is validated by comparing it to the frameworks generated to describe other losses. Couples do grieve following a miscarriage. Couples
grieve in a unique way, and partners grieve incongruently with each other. Variances and similarities in grief experiences are described.

The current health care system does not address the care needs of men during the miscarriage nor does it address the psychological needs of the couple following an early pregnancy loss even though this need is identified in this and other studies.
CHAPTER SIX

Summary, Conclusions And Implications

This study was undertaken to understand the experience of miscarriage from the couple’s perspective. One major question was asked: What has it been like for you, as a couple, to experience this miscarriage? A phenomenological description of the miscarriage experience reveals that the couples in this study went through a grieving process following their miscarriages.

Phenomenology was the methodology used to conduct this study because this qualitative approach is used to understand lived human experiences. When little is known about a subject, phenomenology is useful to develop a foundational knowledge base. Phenomenology explores the topic through open-ended questions that allow the participants to reveal their perceptions in their own voices.

Six couples volunteered to participate. All were initially interviewed within four weeks of the miscarriage. Five of the six couples miscarried their first pregnancy. One couple had terminated a pregnancy early in their relationship. One couple had a child by the husband’s previous marriage. That child lived with her mother. Five of the six pregnancies were planned and although one was not planned, it was not unwelcome. All of the couples were interviewed two to four weeks following the miscarriage and again within eight weeks of the first interview. The interviews lasted sixty to ninety minutes each and were audio-tape recorded for later transcription.

Transcriptions of the interviews were analyzed by reading and re-reading the transcripts to identify themes. Anecdotal notes, taken during the interviews, provided additional information that placed the subjective content in context. As ideas were identified
they were validated with the couples and refined for subsequent interviews. In the final stage, the phenomenological description was validated by the couples.

The process of analysis portrayed the experience of miscarriage as a composite of four motifs that are interacting and interrelated. Each motif represented groups of behaviours and feelings that are identified with various times during the experience of miscarriage. The term motif was especially chosen for it connotes recurrence or repetition of elements that eventually make up the whole. Couples did not experience the motifs in a linear fashion, nor did they experience each of them only once. Rather, aspects of each could be found in all and people moved back and forth within the motifs until they eventually reached the Decision motif which concludes the experience. The four motifs form a composite of behaviours and feelings that each of the couples experienced during their miscarriages. These motifs were internal and arose from within the partners. They were labelled Discovery, Disclosure, Definition and Decision. They are comparable to descriptions of grief generated by other authors.

Couples enter the experience in Discovery and they exit from the experience when they reach Decision but the process that couples go through in the interim is not a linear one. Rather, behaviours and feelings occur and recur until the couple finally reach the Decision motif.

Discovery is the motif where the couples realized that the pregnancy will not continue. It began with the first symptoms of miscarriage and ended with the comprehension that there would not be a baby. Couples with a missed abortion had no premonitory signs of problems. For them, Discovery began when they were informed of the results of the ultrasound. The dominant emotions were Shock and Disbelief, Hope and Confusion and the dominant behaviour was Information Seeking.
Disclosure represents the Telling where couples had to inform others about their miscarriages. To some degree, this was difficult for all couples but the telling gave rise to a comforting reciprocal behaviour called Story Sharing. Story sharing was comforting to the couples because the stories of others helped to normalize their experience.

Definition represents the behaviours and feelings related to incorporating the miscarriage into the couples’ relationships. The dominant emotion was Sadness and the behaviours were Communicating and Caring and Comforting. Through the behaviours, the sadness was processed and the miscarriage experience was brought into perspective.

As perspective was gained, couples began to make plans for the future giving rise to the final motif of Decision. Decision represents movement from the experience of the miscarriage towards the future. The dominant behaviour was Planning and the emotions were Hope and Fear. Five of the six couples were ready to embark on another pregnancy by the time of the second interview.

All individuals experienced the four motifs but partners did not necessarily experience them simultaneously. Partners experienced the same things but often at different times. This together but separate experience was identified by the investigator and when validated by the couples became the background for the composite experience. Partners were, for the most part, tolerant of the differences in grieving as long as communication was good. Similar findings have been discovered by other authors who describe this together but separate notion as an aspect of incongruent grieving among couples who are grieving a loss.

Analysis also revealed an external theme called Health Care Interactions. The feelings arising from the couple’s interactions with care givers during the miscarriage make up this theme. For better or for worse, the couple’s experience with health care impacted on the composite experience making it easier to resolve or more difficult to recover from.
Commonly, couples expressed the need to have health care workers acknowledge that something significant had been lost. Couples expressed the need to be together and not be separated as they often were during hospitalization. Men, in particular, described feeling left out during the experience. Although men identified needs that they wish were met by health care workers, they admitted that they hadn’t expected that they would be.

Participating in this research was identified as therapeutic for the couples. All expressed reluctance at the outset, but the opportunity to tell the whole story in the way they needed to tell it served as what one woman described as a "psychological dilatation & curettage" that facilitated healing. The importance of providing the opportunity to talk a miscarriage through is substantiated in the literature yet follow-up visits commonly tend to focus on physical healing of the reproductive tract.

**Conclusions**

1. The major conclusion from this study is that couples’ experiences with miscarriage are represented by a composite of four motifs that are interacting and interrelated. The motifs are called Discovery, Disclosure, Definition and Decision. Each motif is characterized by dominant behaviours and emotions. This composite is similar to the descriptions of grief generated by other authors.

The behaviours that couples demonstrate as they process the miscarriage are:

**Information Seeking** which assists the couple in understanding what has happened and the impact the miscarriage will have on their childbearing;

**Telling** which is announcing the news of the miscarriage to others;

**Story Sharing** which is a response from others who recount their experiences with miscarriage;
Caring and Comforting which represents the Being Together, Doing For, and Maintaining Normalcy: ways the couple helps each other;

Communicating which enhances resolution of the miscarriage through Defining the Nature of the loss, Acknowledging differences in grieving and Realizing effects of the miscarriage on the relationship;

Planning which describes the lifestyle changes couples undertake to be ready for embarking on another pregnancy.

The dominant emotions of the experience are:

Shock and Disbelief characterized by feeling this can’t be happening;

Hope which is the wish that the pregnancy will continue despite evidence to the contrary;

Confusion which was an added burden felt by couples who had missed abortions and had no common knowledge that such a thing existed;

Sadness which was the common emotion of the recovery phase; Hope which resurfaced in anticipation of a successful pregnancy the next time;

Fear of another miscarriage which co-existed with Hope when the couple was ready to plan another pregnancy.

2. Partners process their grief individually experiencing different motifs at different intensities and sometimes at different times. This incongruence is called Together But Separate and is the context for the four motifs.

3. Discovery of miscarriage is different for couples who have a prodromal phase and those who do not. Experiencing signs and symptoms of an impending miscarriage appears to mitigate the shock of this phase. Couples experiencing a missed abortion without prior warning report confusion, which must be resolved, in addition to the hope and the shock and disbelief of Discovery. Confusion stems from unfamiliarity with the diagnosis of
missed abortion and realizing how common this event really is reduces the confusion and permits the couple to proceed with dealing with realization that the pregnancy is over.

4. The type of care and sensitivity of care givers enhances or impedes the couple’s ability to resolve the loss. Couples want to have their losses acknowledged and receive some support for their grief. Although both partners expressed unmet needs, men, felt that their feelings were not considered by care givers. Couples expressed the desire to be kept together and not arbitrarily separated by hospital routines.

5. It is important for the couple to talk through the miscarriage experience during the recovery process. The need for psychosocial care is also acknowledged in the literature but commonly omitted in practice.

The findings and conclusions from this study have implications for nursing practice, research and education.

Implications for Nursing Practice

This study has implications for nursing practice that includes acute care and community care settings. Nurses who practice in these settings must be prepared to acknowledge the loss that accompanies a miscarriage. As has been shown couples grieve a miscarriage in a similar fashion to other losses. Families must be able to trust that their feelings will be respected and their losses acknowledged.

Although a miscarriage is minor in relation to many conditions that present in an emergency room, nurses must remember that this is a death. It may be the death of a dream, but it may also be the death of a person depending on the couple’s orientation towards the pregnancy. Either way, couples will need to grieve to resolve the loss.

It seems clear that early prenatal care should include mention of the possibility of miscarriage and the various ways a miscarriage may be manifested. This cautionary advice
may help to reduce the confusion component of the Discovery motif. As more ultrasounds are done, more missed abortions will be diagnosed while they are still asymptomatic. The incidence of this type of miscarriage is sufficiently high that a cautionary comment would not be out of order in early pregnancy care.

The couple is a recognized client of nursing and as such the husband's response to the miscarriage ought to be part of the nursing assessment so that nursing care can be directed to meeting his needs as well. Couples presenting for care are experiencing a loss and are coming to grips with their situation. Separating them will pose an unnecessary burden and leave each feeling lonely and unsupported to handle the experience.

Acknowledging the loss will validate the couple's feelings and will help them to understand that their feelings are normal for the experience. Keeping the partners together as much as possible will help them support each other. It will also enable the nurse to assess the couple relationship by observing their interaction. Recognizing that each partner may be reacting differently and be experiencing different motifs will allow the nurse to explain the together but separate context of the experience and how it might affect them as a couple.

While routine assessments are being done, nurses can help both members of the couple explore how they will nurture each other through the ensuing weeks. By providing information about what people commonly experience, the couple will leave the hospital with some foresight that will allow them to be proactive in caring for themselves.

It is also important for nurses to create an environment where couples will feel safe in sharing whatever feelings they are experiencing. Providing privacy, tissues and a non-judgmental attitude will convey respect and caring and enable the couple to cry, hug or manifest whatever behaviour they deem necessary at the moment. Because many couples are uncertain how to behave in this new environment, the nurse can gently lead with enabling
statements like "many people have said" or "often people feel like" or "many people need to". The nurse can provide some indication of the spectrum of feelings that might occur which will permit the couple to find their own place of identification. This includes asking if the couple would like to see the baby if the fetus is passed in the hospital and always treating the fetus with respect.

It would be helpful to encourage the couple to talk through the experience with a knowledgeable person. This can be anyone the couple perceives as having the necessary counselling skills to assist them to work through their feelings. Nurses may wish to develop their own follow-up classes at the hospital or in the community and invite couples who have miscarried to attend on a drop-in basis.

Nurses who work in the community may encounter couples who have miscarried or may encounter couples before they miscarry. Many couples start prenatal classes in early pregnancy. Some comment about the incidence of miscarriage and how a miscarriage may manifest itself would provide a small knowledge base to assist couples if they do miscarry. Nurses encountering couples after they have miscarried may need to assist with grieving if the miscarriage was left unresolved at the time. Because unresolved grief can lay dormant for long periods of time, it may be helpful to include a complete pregnancy history in the care of all people so that losses or potential losses can be identified. Careful observation of responses may indicate the need for further discussion.

Nurses have the opportunity to shape societal attitudes. Developing brochures about recovering from a miscarriage is one way to publicly affirm significance of the issue. Providing appropriate literature for people who are supporting couples who have miscarried is one avenue to bring this issue into greater public consciousness. Because the incidence of pregnancy loss is so high, it will touch the lives of everyone in some manner, sometime.
Traditionally it has been viewed as unimportant in the scheme of things but current findings dispute this.

**Implications for Nursing Research**

This study has shown that partners grieve ‘together but separately’. It would be valuable to describe the experience from the man’s perspective and contrast his experience with his partner’s viewpoint. Developing a couple’s perspective means that some individual responses are not identified because they are filtered through the relationship before they are stated publicly. Comparing the experiences of each at varying times following a miscarriage would help describe the variance that might occur at any given moment. As the man’s culture becomes more understood, bridges can be built to span the gap between partners.

This study has focused on the couple’s experience with an unplanned loss of their first pregnancy. However, each couple brings with them an assortment of significant others who also must deal with the loss of the expected family member. Grandparents, siblings and close friends must all deal with their own reactions to the loss of the baby. Investigating a miscarriage from an extended context of a larger family is work that needs to be done.

Another study that could also be done is the nurses’ perceptions of first trimester pregnancy loss. Nurses are important contributors to the experience of families who miscarry and the congruence between the nurses’ perceptions of the experience and the clients’ needs has not been explored to date. The nurse’s perceptions of the event will affect the kind of care delivered thus this study is potentially very important.

Theories about miscarriage that have been developed to date must be tested and refined to build a theory base from which nurses can derive specific interventions that will be perceived as helpful and caring. To date, theories about miscarriage tend to lump all miscarriages together. This study has looked specifically at couples experiencing their first
miscarriage in a wanted pregnancy. The nature of repeated losses has yet to be described. Also, the differences in grieving between couples who abort spontaneously and those who have a missed abortion need to be explored further. To care for these couples more effectively the differences and commonalities need to be identified. Finally, the experience of couples who miscarry an unwanted pregnancy needs to be described.

An important area of research that is as yet untouched relates to understanding miscarriage in a cross-cultural context. What a miscarriage means for white Anglo-Canadian couples may be completely different, for example, for Native Indian or East Indian couples. As research evolves in the area of cross-cultural nursing, the perinatal period must be included.

Finally, couples reported the value of participating in this research in helping them recover from their miscarriages. A study investigating the value of routine counselling following a miscarriage needs to be done to compare the experiences of those who receive counselling with those in the control group.

**Implications for Nursing Education**

Theories of loss and grieving and nursing care approaches to dealing with individuals experiencing loss are taught in nursing schools. Continuing education in nursing must continue to focus on the manifestations of loss and the differing nature of losses. Emphasis must be placed on the experience of grief from the perspective of the grieving individual.

Loss is such a ubiquitous phenomenon in all fields of nursing practice that subtler losses may be diminished by the catastrophic losses that can occur. Nurses need periodic reminding that the nature of losses varies but the degree of pain felt in response to the loss is purely subjective and needs to be understood from the personal perspective of the griever.
This study has demonstrated the importance of health care interactions in facilitating or impeding the process of grief. Continuing nursing education must continue to focus on interpersonal skills as critical to the evolution of a nurse who is able to care for a variety of clients in a sensitive, caring manner. This could be a difficult challenge considering the explosion of technology that confronts the nurse on a daily basis. Technology that requires the nurse to adjust, apply, employ and monitor must never supercede the importance of the human contact in health care.

Summary

In summary, this thesis has described the experience of a first miscarriage within the context of the couple. The results indicate that couples grieve this loss as they do losses at later stages of pregnancy. While most couples resolve their grief within three months of the miscarriage, the opportunity is present for grief to continue unresolved or become pathological in nature. Sensitive nursing care that is tailored to the needs of the couple will facilitate a healthy resolution of grief that will enable the couple to grow in response to the loss.
Reference List


INTRODUCTORY LETTER TO PROSPECTIVE PARTICIPANTS

Dear

My name is Carolyn Iker. I am a Registered Nurse enrolled in the Master’s Degree Program of the School of Nursing at the University of British Columbia. I am interested in studying the effects that miscarriage has on couples as my thesis topic. I believe that it is important to explore human experiences by asking the people who live them to teach me about them. Gaining knowledge about miscarriage is important to improve the quality of nursing care.

Please consider participating in this study by agreeing to be interviewed as a couple about your experience of miscarriage. Interviews will last approximately one hour and two to three are planned. They will be scheduled at two weekly interviews following your miscarriage. Interviews will be held at your home or a location of your choice at a mutually agreeable time. Your privacy will be protected at all times. Any information that you share will be held in strictest confidence and you will never be identified in any published or unpublished materials. You have the right to withhold or remove any information that you desire. You may withdraw from the project at any time without jeopardy or prejudice to your health care.

Interviews will be tape recorded to ensure accuracy. Only your first names will ever appear on the recordings, and the only other persons to hear them will be the typist, who transcribes them and two faculty members who are my thesis advisors. Only your initials will appear on the typed transcripts. You will be given the names and telephone numbers of the faculty advisors. At the conclusion of the study the tapes will be erased.

If you agree to participate, please sign the accompanying consent form and retain a copy for your records.

Sincerely
APPENDIX B
CONSENT FORM

We agree to participate in the nursing research study EARLY UNINTENTIONAL PREGNANCY LOSS AT IT IS EXPERIENCED BY THE COUPLE to be conducted by Carolyn E. Iker R.N. B.S.N. who is a graduate student in the Master's program of the School of Nursing, University of British Columbia.

The study and our role in it have been explained to us. We understand that our participation is voluntary and that we may withdraw at any time without consequence. We understand that our participation includes two to three interviews as a couple, together with Carolyn, at a location of our choice. We understand that all information will be held in the strictest confidence and that we will never be identified in published or unpublished materials. We understand that the interviews will be tape recorded and then transcribed for analysis. We understand that we may erase or withhold any content as we see fit. We have received the names and telephone numbers of the thesis advisors at the University of British Columbia.

Our signatures on this form verify our intention to participate in this study. We have received a copy of this consent form for our records.

SIGNED________________ WITNESS________________

SIGNED________________ DATE:________________
SAMPLE QUESTIONS

1. Tell me about your miscarriage.

2. What was the hardest aspect of the miscarriage to deal with?

3. Tell me about your health care during the miscarriage.

4. Did you see the baby on ultrasound? Did you see the fetus? How do you feel about that?

5. How did you let others know about the miscarriage?

6. What role does religion play in your life?

7. What are the most helpful things that were done for you?

8. Is there anything that you wish was done for you but wasn’t?

9. Why do you think this miscarriage occurred?

10. Has there been anything in your experience as a couple that has affected how you dealt with your miscarriage?

11. How has this miscarriage affected your relationship?

12. What is the most important information that other couples who miscarry should have?