



eCOMMONS

Loyola University Chicago
Loyola eCommons

Master's Theses

Theses and Dissertations

1985

How Women Cope with a Spontaneous Abortion Occurring in Early Pregnancy

Ann Applewhite Flandermeyer
Loyola University Chicago

Follow this and additional works at: https://ecommons.luc.edu/luc_theses

 Part of the [Medicine and Health Sciences Commons](#)

Recommended Citation

Flandermeyer, Ann Applewhite, "How Women Cope with a Spontaneous Abortion Occurring in Early Pregnancy" (1985). *Master's Theses*. 3430.
https://ecommons.luc.edu/luc_theses/3430

This Thesis is brought to you for free and open access by the Theses and Dissertations at Loyola eCommons. It has been accepted for inclusion in Master's Theses by an authorized administrator of Loyola eCommons. For more information, please contact ecommons@luc.edu.



This work is licensed under a [Creative Commons Attribution-Noncommercial-No Derivative Works 3.0 License](#).
Copyright © 1985 Ann Applewhite Flandermeyer

HOW WOMEN COPE WITH A SPONTANEOUS
ABORTION OCCURRING IN EARLY PREGNANCY

by

Ann A. Flandermeyer

A Thesis Submitted to the Faculty of the Graduate School
of Loyola University of Chicago
in Partial Fulfillment of the Requirements for the
Degree of Master of Science in Nursing

December

1985

Acknowledgements

I would like to acknowledge Loyola University for the awards of Graduate Research Assistant and the Professional Nurse Traineeship. It is this funding that made my graduate education possible. This study was supported, in part, by a grant from the Alpha Beta Chapter of Sigma Theta Tau.

I wish to thank Dr. Dona Snyder, my advisor and committee chairman for her guidance and time during this research study. I also wish to acknowledge the assistance of Dr. Pat Ryan and Dr. Karen Haller as members of my thesis committee. Dr. Karen Haller also served as my mentor and encouraged me to undertake the implementation of this research study.

I am especially grateful for the support, assistance, and encouragement of my husband, Brian Flandermeyer.

Vita

The author, Ann Applewhite Flandermeyer is the daughter of Thomas Applewhite and Lorraine (Coleman) Applewhite. She was born March 6, 1956 in St. Louis, Missouri.

She holds an Associate of Arts in Nursing from Lake Superior State College in Sault Ste. Marie, Michigan. She graduated cum laude in May, 1976. She also holds a Bachelor's of Arts in Psychology from Webster University, St. Louis, Missouri, granted in May, 1979. She continued her education in nursing at Maryville College, St. Louis, Missouri. She graduated magna cum laude in May, 1983 and received the degree of Bachelor of Science in Nursing.

She has worked as a professional nurse for the past nine years in the field of Maternal Child Health.

January, 1984 she entered the Masters of Science in Nursing Program at Loyola University of Chicago. She was awarded a Research Graduate Assistantship for the school year 1984-85 and a Professional Nurse Traineeship for the Fall Semester 1985. Her expected date of graduation is January, 1986.

Table of Contents

	<u>Page</u>
ACKNOWLEDGEMENTS	ii
VITA	iii
TABLE OF CONTENTS	iv

Chapter

I.	INTRODUCTION	1
	Statement of the Question	3
	Definition of Terms	3
	Assumptions	4
II.	REVIEW OF THE LITERATURE	5
	Coping Theories	5
	Coping During Pregnancy	10
	Reproductive Losses	13
	Summary	17
III.	METHODOLOGY	18
	Overview	18
	Setting	19
	Sample Criteria for Inclusion	19
	Sample Description	20
	Description of Sample Population	21
	Interview Description	22
IV.	DATA ANALYSIS	24
	Introduction	24
	Stressors	25
	Coping Behaviors	30
	Summary	36
V.	CONCLUSIONS	38
	Summary	38
	Discussion	38
	Limitations	41
	Recommendations for Futher Research	42
	Implications for Nursing	43

	<u>Page</u>
References	45
Appendix A	50
Appendix B	54
Appendix C	56

CHAPTER I

Introduction

Ten to twenty percent of all pregnancies end in spontaneous abortion or miscarriage (Hillard, 1984; Siebel & Graves, 1980; Wall-Haas, 1985; Wetzel, 1982). This high incidence affects a substantial proportion of the female population. Most women have either personally experienced a spontaneous abortion or have a close friend or relative who has.

Spontaneous abortion is generally treated by performing a dilation and curettage (D&C), which is a ten to fifteen minute operative procedure that involves removing uterine tissue remnants to control bleeding. Overnight hospitalization is required. The woman's physical needs are generally well met. However, health care providers tend to intellectualize the phenomena of miscarriage in an attempt to approach it in a quantitative fashion. Before instituting care, the woman is subdivided into smaller units (e.g. cramping, bleeding), which are evaluated and treated. This reductionistic approach divides required care into small, clear interventions. It also removes the shroud or unmentionable mystique that surrounds the miscarriage experience. The experience is transformed into technical intervention that eases the nurses' ability to deal with it. When the woman returns home she often finds family and friends are reluctant and uncomfortable discussing the event (Stack, 1980). Inadequate social support leaves the woman undirected and unsupported in attempting to deal (e.g. "cope") with her emotions surrounding the spontaneous abortion.

Pregnancy is often referred to as a life crisis (Colman & Colman,

1971; Deutsch, 1945; Lederman, 1984). The associated emotions are intensely charged. Therefore, it is assumed that a spontaneous abortion is an emotionally charged event that requires coping. Coping is the process that individuals employ to resolve crisis. They obtain guidance from past experiences, "experts", and family in order to facilitate their coping process.

Health care professionals need to familiarize themselves with the concept of coping. Garland and Bush (1982) cite the following three reasons why nurses should study coping. First nurses need to be able to assess coping behaviors as adaptive or maladaptive. Then they can reinforce adaptive behaviors and discourage maladaptive behaviors. Second, nurses as a group are involved in daily stressful encounters. They need to be aware of their own coping abilities. Once their personal strengths and weaknesses have been identified, they can then be drawn upon for coping and for use to resolve weaknesses. The last reason to study coping is the need for more systematic investigation of how people cope with stressful situations.

The research project being discussed used a qualitative approach and explored individual perceptions and coping patterns following a spontaneous abortion. Four central stressors associated with the miscarriage were identified. Five subsequent patterns of coping or methods of problem solving were revealed. The data gathered provided insight for guidance of future nursing care and generated hypotheses for future testing. This increased knowledge base can be used to direct practice and promote more effective nursing care. The information generated by the above study will be helpful in structuring

psychological interventions to facilitate prompt efficient resolution of the miscarriage experience through coping. By resolving this crisis, the woman's repertoire of coping mechanisms will be expanded. Complete resolution will reduce future difficulties from arising out of unresolved conflicts surrounding the miscarriage.

Statement of the Question

The purpose of the research was to study coping behaviors as they occurred in the crisis situation caused by a premature termination of pregnancy. The population that was studied consisted of women who had experienced a spontaneous abortion during early pregnancy.

The specific question that the study addressed was: What patterns of coping are utilized by women who have experienced a spontaneous abortion in early pregnancy?

Definition of Terms

Coping - "refers to efforts to master conditions of harm, threat or challenge when a routine or automatic response is not readily available" (Monat, & Lazarus, 1977, p. 8).

Crisis - A very disruptive period when an extremely stressful event significantly taxes the coping abilities, with no resolution of the problem in sight (Friedman, 1981)

Early pregnancy - Pregnancy of 0 - 20 weeks from the beginning of the last menstrual period.

Miscarriage - Spontaneous abortion.

Spontaneous abortion - Spontaneous early termination of pregnancy.

Stressor - "Those experiences and/or concerns described by the subject as being disturbing or worrisome", (Snyder, 1985, p. 152).

Assumptions

- 1) Pregnancy is a significant developmental challenge in the life cycle.
- 2) Spontaneous abortion produces an acute situational crisis for the woman experiencing it.
- 3) The duration of an acute situational crisis tends to last from one to six weeks.
- 4) Patterns of coping are highly individualized.
- 5) Women will communicate their responses to the miscarriage in an interview situation.

CHAPTER II

Review of the Literature

The review of the literature includes three areas of discussion. First, four theories of coping are presented. The study focused upon coping with perceived stressors that surrounded the miscarriage event. A theoretical base is necessary to understand the concept of coping. The second section consists of a discussion of the psychodynamics of early pregnancy from both a psychoanalytic and contemporary framework. It is important to be familiar with the emotions of early pregnancy in order to understand the perceptions surrounding a spontaneous abortion. The third area of the literature review presents previous research regarding various reproductive losses, and demonstrates the paucity of research regarding coping with a spontaneous abortion.

Coping theories

Four broad theories of coping will be presented. Lazarus has been one of the first to carry out research and write extensively on coping with general life experiences (Cohen & Lazarus, 1973; Folkman & Lazarus, 1980; Lazarus, 1982; Lazarus, Averill, & Opton, 1974; Monet & Lazarus, 1977). Clarke (1984a, 1984b) has drawn from the work of Lazarus to formulate her own coping theory. Friedman (1981) examines coping from a family perspective. Cronenwett and Brickman (1983) have formulated a theory of four modes of coping. The above four perspectives were selected to provide a broad range of coping theories. None have been specifically applied to coping with miscarriage.

Lazarus model of coping

The concept of coping will be examined first according to the Lazarus Model of Coping (Cohen & Lazarus, 1973; Folkman & Lazarus, 1980; Lazarus, 1982; Lazarus et al., 1974). "Coping refers to efforts to master conditions of harm, threat or challenge when a routine or automatic response is not readily available" (Monet & Lazarus, 1977, p.8). "We regard coping as problem solving efforts made by an individual when the demands he faces are highly relevant to his welfare ... and when these demands tax his adaptive resources" (Lazarus et al., 1974, pp. 250-251).

Through the process of cognitive appraisal the individual evaluates the impact of environmental interaction upon his well being. Cognitive appraisal consists of two simultaneous processes: primary appraisal and secondary appraisal.

Primary appraisal is a conscious process of evaluating an event as being positive, neutral or threatening to the integrity of the individual. Secondary appraisal occurs concurrently on the unconscious level. This includes problem-focused and emotion-focused functions (Folkman & Lazarus, 1980). These are avenues of environmental interaction. Examples of problem-focused coping would be seeking information on the causes of spontaneous abortion or obtaining medical treatment for spotting. An example of emotion-focused coping would include the utilization of intrapsychic defense mechanisms such as intellectualization or denial; which regulate the perception of the event and not the event itself. Problem-focused and emotion-focused coping allows the individual to alter either the actual environment or

his perception of the environment to become more comfortable. After this alteration has occurred, the individual reappraises the situation. These cognitive processes are cyclic and ongoing (Ziemer, 1982).

One of the clinical studies used to substantiate Lazarus' Model "investigated the relationship between the mode of coping with preoperative stress and recovery from surgery" (Cohen & Lazarus, 1973, p.375). The findings indicated that "patients using avoidant modes of coping generally did best in recovery" (Cohen & Lazarus, 1973, p. 383). Patients that knew the most about their surgery, treatment, and possible complications had longer hospital stays. Perhaps knowledge of possible complications created a more complicated recovery. However, Cohen and Lazarus (1973) had no clear idea of the process involved linking additional information with post-operative complications.

Clarke's model of coping

Clarke (1984a, 1984b) has drawn from the works of Lazarus in formulating her own construct of coping. Her work was an academic endeavor without reference to clinical research. She sees coping as being initiated by a demand that originates either from within the person or his environment. Resultant coping is based upon cognition of the demand with coping occurring on an intrapsychic and behavioral level. When demand exceeds the coping ability, stress in the form of anxiety results. Conversely, when coping exceeds the demands, control and rewarding positive emotions result. Through coping, the demands or stressors have been mastered and the individual develops a sense of control over their environment. This is an important assumption

regarding coping. Clarke (1984a) equates ineffective coping with loss of control, reduced self-esteem, feelings of depression, and helplessness. Individual coping strategies are based upon demand levels and past coping experiences. A comfortable range exists where coping is most efficient. This range is also individually determined by intelligence, inherited disposition, physique and congenital conditions (Clarke, 1984b).

Cronenwett and Brickman's model of coping

Another approach to coping has been to identify and define four modes of coping according to the individual's sense of responsibility for both the problem and resolution (Cronenwett & Brickman, 1982). This sense of responsibility can also be described as the individual's perception of who is to blame for the past event and who is in control of future events. Cronenwett and Brickman's (1982) modes include: personal responsibility for both problems and outcome; not feeling responsible or blamed for the problems but responsible for the solutions; responsible for neither; blamed for problems but not responsible for the solutions. These modes are hypothesized to be mutually exclusive and exhaustive, and specify how people will help others or themselves. The helper or nurse will need to function in the same mode as the patient in order to help her cope. For example, if a woman does accept responsibility for both the problem and outcome then she views pregnancy (and miscarriage) as something she alone is responsible for. She may have the unrealistic expectation that if she acts right, a good pregnancy outcome is guaranteed. Then if problems do arise, she will feel solely responsible for a complicated pregnancy or

miscarriage. The nurse in knowing her coping style, can work to reassure her that she did the best she could and is not to blame. The opposite is true when the person will not accept responsibility for either the problem or solution. The lack of responsibility allows the woman to accept help, but it fosters dependency rather than competence (Cronenwett & Brickman, 1982). These assumptions were upheld in clinical research done by Rabinowitz (Brickman et al., 1982) in her dissertation. Rabinowitz (1978) interviewed 48 individuals to test the existence of these four modes of coping in the real world. She selected four groups of individuals that she presupposed would represent each mode. The moral mode representatives (responsible for problems and solutions) were graduates of Erhard seminars training, the enlightenment group (not responsible for solutions but responsible for problems) were members of the Campus Crusade for Christ, the compensatory group (not responsible for problems but responsible for solutions) were participants in a job training program, and the medical mode (not responsible for either) were college students waiting for treatment at the college infirmary (Brickman, et al., 1982). The behaviors of the subjects were indeed representative of their respective coping mode thus documenting that these coping patterns exist in a real-world setting (Brickman, et al., 1982).

Friedman's model of coping

Friedman (1981) examines coping from a family perspective. She equates family coping with family adaptation. A stressful event initiates the coping process. Crises results when family coping abilities are exhausted with no resolution in sight. There are three

phases of coping: the antestress period; the actual stress period; and, the poststress period. Anticipatory guidance is used to reduce stress before the event occurs. Coping strategies are implemented to return the family to a homeostatic state. The family has inner and outer resources as does the individual. Internal resources include the individual's repertoire of coping skills and family member's support and assurance in coping with the stressor. Examples of external resources are friends and health care providers. The greater the variety of coping stratagems the more effective the coping (Friedman, 1981).

Coping during pregnancy

Psychoanalytic interpretation of pregnancy

The psychodynamics of early pregnancy need to be explored before proceeding. Helene Deutsch (1945) was one of the first psychoanalysts to write extensively on pregnancy and childbirth. She was a student of Freud and wrote from a psychoanalytic perspective (Williams, 1977). Her writing was based upon in-depth case studies.

Deutsch (1945) identified two basic forces that are present during pregnancy: introversion and reality. Introversion refers to the narcissism that occurs with pregnancy. All of the parturient's psychic energy is focused on her bodily changes and the growing fetus. Later, this psychic energy becomes the energy source for love of the child after its birth. "The biologic process has created a unity of mother and child, in which the bodily substance of one flows into the other, and thus one larger unit is formed out of the two units. This same thing takes place on the psychic level" (Deutsch, 1945, p. 139). Reality refers to the mother's attempts to separate self from child.

The fetus is considered part of her own ego. Termination of pregnancy involves a loss of self. "This future reality for the time being has no independent biologic or psychologic existence, the child is psychologically what the fetus is biologically - a part of the mother's own self" (Deutsch, 1945, p. 139).

Contemporary interpretation of pregnancy and abortion

Rubin (1967, 1984) is a contemporary author who has written extensively about maternal experiences based upon clinical research. Rubin (1984) has described the presence of narcissism and ambivalence towards the pregnancy. Acceptance of the pregnancy and resolution of ambivalence are generally resolved by the time of quickening (Rubin, 1984) which occurs in the second trimester and confirms the presence of the baby. Ambivalence generates feelings of guilt (Friedman & Gradstein, 1982; Lederman, 1984). If the pregnancy is prematurely terminated before resolution of ambivalence, feelings of guilt may prevail (Leppert & Pahlka, 1984; Stack, 1980; Stephany, 1982).

Another consequence of miscarriage is that it may threaten feminine identity. The inability to produce a term pregnancy thus fulfilling the biological role of woman will "produce traumatic misgivings about the competence of self as a woman and as a person of worth" (Rubin, 1984, p. 25).

Spontaneous abortion is accompanied by feelings of powerlessness and loss of control (Stack, 1980). Neither the woman nor her physician could stop the loss. They couldn't override the physiological processes within her body. After the pregnancy has terminated, there are no formal acknowledgements of the fetus (e.g. death certificate) and no

cultural practices to facilitate mourning such as a funeral (Stack,1980).

There may also be an incongruent emotional response between the woman and the father of her fetus. The parturient woman has focused intense emotional energy on her pregnancy. When the pregnancy is prematurely terminated, these emotions need to be acknowledged and vented. Emotional catharsis is necessary to resolve the loss. Men become vested in the pregnancy later in gestation. They do not experience the subjective symptoms (e.g. fatigue, breast tenderness). Proof of the baby's existence comes later when the abdomen protrudes and fetal movement is palpated. When the loss occurs before paternal attachment has taken place, there is a different or incongruent perception of the loss (Friedman & Gradstein, 1982; Leppert & Pahlka, 1984). The wife may not understand her husband's lack of emotional reaction, and he may not understand her intense response. This incongruent reaction can prevent them from openly discussing the miscarriage. "Because unexpressed emotions often remain unresolved, the feelings that result when a couple loses a pregnancy can adversely affect a woman and affect her relationship with her partner if the feelings are not explored and put to rest at the time of the miscarriage" (Leppert & Pahlka, 1984, p. 121). Friends and family are uncomfortable discussing the miscarriage and they often encourage intellectualization and denial (Stack, 1980). All of the above factors lend themselves towards creating a world of isolation that surrounds the woman experiencing a miscarriage.

Friedman and Gradstein (1982) presented a case study of a woman who

recently experienced a miscarriage. It aptly reflected the difficulty many women have in resolving the loss "My usual methods for coping with stress have been pretty useless. I am a psychiatrist, and this somehow made me think that I would be able to handle my feelings rationally. I reasoned that many women go through things like this. ... I tell myself that I should be able to get through this without falling apart" (Friedman & Gradstein, 1982, p. 49).

Reproductive losses

There is a paucity of research regarding spontaneous abortion. Stack (1984) confirms this paucity by stating that a review of the literature reveals little attention given to the psychological effects of spontaneous abortion. Some authors group all reproductive losses together to compare and contrast. Others focus on one particular type of pregnancy loss. The following section will discuss spontaneous abortion, habitual abortion and stillbirth.

Spontaneous termination of early pregnancy

Kaij, Malmquist & Nilsson (1969) worked from a psychoanalytic perspective in their research. They compared two groups of women. The control group carried their pregnancies to term and the experimental group experienced spontaneous abortions. The groups were matched to control for seven variables: age, parity, marital state, length of marriage, occupation, domicile and the time between the last delivery and the original interview (Kaij et al., 1969). The data upheld the hypothesis that there are psychological influences on the occurrence of spontaneous abortion.

Leppart and Pahlka (1984) described the intervention given to 22

women who experienced a spontaneous abortion over a fifteen-month period. The women were interviewed and given time to ask questions immediately after they were physically stable. They were re-interviewed at 4-6 weeks following the incident. Two to three telephone contacts were also made between the visits. "The most astonishing finding was that once the women were given permission to express their feelings, they did so with great intensity" (Leppert & Pahlka, 1984, p. 120). The authors identified a grief pattern similar to that of any other death and emphasized the importance of openly discussing emotions and feelings surrounding the miscarriage.

Peppers and Knapp (1980) conducted clinical research comparing grief in three types of reproductive losses. The groups included women who had experienced a stillbirth, neonatal death, and miscarriage. The women were given a scale on which to rate their feelings of grief. The hypothesis was that "there would be no significant differences in the psychophysiologic responses of mothers regardless of the point in the perinatal period at which the fetus/infant died" (Peppers & Knapp, 1980, p. 156). The data upheld the hypothesis. The authors cited several questions for future testing. One is, "How do reactions of the husband and other family members affect her ability to cope?" (Peppers & Knapp, 1980, p. 159). Other variables that were cited as needing further investigation are the impact of past pregnancies on grieving, the hospital experience and social environment on grieving, and plans for future pregnancies (Peppers & Knapp, 1980).

Stack (1980) followed five women who had experienced a spontaneous abortion. He discussed the psychological framework present in early

pregnancy and how this relates to the reaction to a spontaneous abortion. Stack(1980, 1984) contends that the normal mourning response needs to take place after a miscarriage. However, a common obstacle is that the loss must first be recognized. The finality of it is hard to achieve. The problem centers on the absence of an observable person to mourn. Stack (1980, 1984) also undertakes a lengthy description of twelve unique factors that surround this special loss (e.g., unresolved ambivalence, identification of fetus with self, not seeing what she has lost, etc.). He ascribes these unique circumstances to be responsible for "the development of delayed, prolonged, inadequate or pathological grief reactions" (Stack, 1984, p. 165).

Seibel and Graves (1980) administered "a brief emotional-status inventory, modeled after the Multiple Affect Adjective Check" to 93 women who had experienced a spontaneous abortion and had been treated with a D&C. The authors were attempting to uncover the emotional response to miscarriage. They found a more intense emotional reaction "if the patient views her pregnancy loss as of greater magnitude than a simple miscarriage" (Seibel and Graves, 1980, p. 164). Even when the pregnancy was unplanned, the miscarriage was associated with feelings of depression or anxiety.

Other authors have discussed the psychological implications of spontaneous abortion without researching the topic (Stephany, 1982; Wetzel, 1982). There are also articles concerning miscarriage that appear in popular magazines (Hillard,1984).

Habitual abortion

Tupper and Weil (1962) compared two groups of pregnant women who

had experienced three or more previous spontaneous abortions. During their current pregnancies the control group was followed with two interviews. The experimental group was given supportive psychotherapy throughout the course of their pregnancy. No restrictions were placed on the women's physical activities and no medications were used. The control group had 26% live births as compared to the experimental group having 84% live births. The authors concluded that "supportive therapy more than any other form of treatment is capable of preventing pregnancy losses in habitual aborters" (Tupper & Weil, 1962, p. 424).

James (1962) was also concerned with the advantages of psychotherapy for pregnant habitual aborters. He did an extensive literature review and concluded that psychotherapy, when given to the pregnant habitual aborter increased the incidence of live births from 45% to 80%.

Stillbirth

A large number of articles have been written regarding the psychological impact of a stillbirth (Kellner, Donnelly & Gould, 1984; Kirkley-Best & Kellner, 1980; Lake, Knuppel, Murphy & Johnson, 1983; Lewis, 1979; Seitz & Warrick, 1974). A common theme was a discussion of the grief process following a stillbirth. The psychodynamics of separating self and baby are emphasized. The authors recommended ways to acknowledge the baby's existence and death. The consensus was to encourage the mother and father to hold the baby, take pictures, name the baby and give them remembrances of the baby's existence (e.g., footprints, birth and death certificate). By finalizing death, the parents can begin their grief process.

Summary

Pregnancy has been evaluated as a time of introversion and preoccupation with the fetus. It is also the general expectation that each conception produces a viable child. When expectations are not realized, a variety of feelings prevail, such as guilt, inadequacy, powerlessness, and isolation. These feelings are stressful to the individual and precipitate the need for coping. Patterns of coping are individualized and are employed to alleviate or reduce these stressors and thus restore equilibrium. Little has been documented regarding the perception of specific stressors surrounding a spontaneous abortion or the coping patterns that ensue. It was the purpose of this study to explore these stressors and coping patterns.

CHAPTER III

Methodology

Overview

A qualitative approach was chosen because it was felt that it best suits the study of coping with spontaneous abortion in early pregnancy. Miscarriage is a subjective experience that is defined through individual interpretation. The experience is perceived and lived by the individual. Thus, reality results from one's perceptions. These perceptions are unique to the individual and influenced by various individual characteristics such as religion, past experiences, culture, and intellectual capabilities. However, central to the individual's perception of miscarriage is the importance or worth bestowed upon the pregnancy. The conceptus can be viewed on a continuum from a cluster of cells to a baby.

Another reason why a qualitative approach was chosen is that there has been little previous research focused on the above topic. There are various coping theories that have been applied to general life experiences. There are no prevailing theories specifically regarding women's coping with miscarriage. Therefore it is appropriate that the study use a qualitative approach which demands that the researcher collect and analyze data without having been biased by pre-existing theory or expectation. In the absence of preconceived notions, there is no prescribed framework for data organization. It is organized as it is received. Categories can then be tested and validated in future data collection. "No data are ignored because of conflicts with the established criteria, operational definitions, or theoretical

frameworks" (Omery, 1983, p. 61).

The qualitative approach is consistent with the objective of the study. The objective was to describe the experience as it was perceived and not to interpret the outcome before the data was gathered. Home interviews preserved the "spontaneity of the subjects' living experiences" (Oiler, 1982, p. 179).

Setting

The patient population came from a large, urban, university-affiliated medical center. The initial contact with the prospective subjects was usually made through the emergency room, gynecology unit, or obstetrical unit where they received treatment. Several women were contacted at home by telephone since their hospitalized period was so brief.

Sample criteria for inclusion

The sample was one of convenience. Women meeting the sample criteria, who sought medical treatment from the facility during the data collection period (April 2, 1985 - July 16, 1985) were asked to participate in the study. A sample size of ten was obtained. Written consent was obtained. Confidentiality was guaranteed.

The criteria for inclusion in the study were:

- 1) married
- 2) ages 19-37
- 3) twelve years minimum education
- 4) English speaking
- 5) have had a similar hospital course;
 - a) had a D&C

b) not been hospitalized longer than 48 hours.

These criteria eliminated the single woman. The social support of a spouse was felt to be a major variable that needed to be controlled. Also excluded were women who developed complications requiring hospitalization greater than 48 hours. Exclusion of these created a more homogeneous group thus controlling for extraneous variables. However, it is recognized that this also reduced the representativeness and generalizability of the findings. The educational requirement was necessary to ensure a minimal level of literacy. It was also necessary for the women to be able to understand and answer interview questions.

Sample description

A total of ten women were included in the sample. All the women participated in the first interview with nine participating in the second interview. The researcher was unable to contact one woman at the time of the second interview. Nineteen interviews were completed.

All the women were interviewed in their own home, at their convenience. Ten variables were consistently documented (See Table 1). The following describes the sample population in terms of these variables.

1. All were married.
2. All were within the ages of 27-37.
3. Nine were caucasian and one was black.
4. Nine had experienced previous pregnancies and seven of these had living children.
5. Seven had no previous miscarriages and three had experienced

Table 1Description of Sample Population (N=10)

<u>Variable #</u>	<u>Variable</u>	<u>Occurrence</u>
1	Marital Status (Married)	100%
2	Maternal Age (27-32 yrs.)	50%
	(33-37 yrs.)	50%
3	Ethnicity	
	Caucasan	90%
	Black	10%
4	First Pregnancy	10%
	Subsequent Pregnancy	90%
	(living children)	70%
5	First Miscarriage	70%
	Subsequent Miscarriage	30%
	(living children)	10%
6	Gestation (7.5 - 12 weeks)	90%
	(20 weeks)	10%
7	History of Infertility	40%
8	Maternal Education (12 years)	10%
	(13-16 years)	80%
	(17 years)	10%
9	Religious Affiliation	
	Catholic	70%
	Lutheran	10%
	Baptist	10%
	None	10%
10	Significant Medical History	40%

- one or more previous miscarriages.
6. The gestation at the time of the miscarriage ranged from 7.5 weeks to 12 weeks with the exception of one woman who was 20 weeks gestation.
 7. Four had a history of infertility and six had no difficulty conceiving.
 8. Education ranged from 12 to 17 years.
 9. Their religious affiliations were seven Catholic, one Lutheran, one Baptist, and one with no preference.
 10. Four of the ten participants had a significant medical condition that could adversely effect childbearing. The disorders included insulin-dependent diabetes mellitus, multiple sclerosis, incompetent cervix, and exposure to DES. Of these four, all except the woman with an incompetent cervix had one or more living children.

Interview description

The prospective subjects were identified from their hospital admission records. Their medical records were evaluated for inclusion in the study based upon sample criteria. The researcher spoke with each woman to explain the study and answer questions. The women were invited to participate in the study and informed consent was obtained (See Appendix A). Confidentiality was guaranteed. No interview took place at this time. It was important to wait until discharge, so that the interview could occur in a familiar, comfortable setting, e.g. the woman's home. An interview time was scheduled for approximately one week after the miscarriage.

The first interview took place in the woman's home to preserve the "spontaneity of the subject's living experiences" (Oiler, 1982, p. 179). From the onset, the subject was reminded that she had the right to terminate the interview should it become too uncomfortable. No one felt the need to do this. Questions were open-ended and the interviews were tape recorded. See Appendix C for topics of discussion. All the subjects were asked to discuss similar topics; however, exact patterns of interaction varied. The subject was allowed the freedom to discuss the issues most pertinent to her experience. Seven of the women interviewed discussed their miscarriage for 15 to 25 minutes. The other three women interviewed discussed the questions for 25 to 45 minutes. The longer interviews reflected their need to talk and involved subjects with poor reproductive histories.

The second interview occurred in the subject's home approximately six weeks after the miscarriage. The format of the interview remained essentially the same. The subject again was reminded that she had the right to terminate the interview should she become too uncomfortable. Again, no one felt inclined to terminate.

The significance of the two interviews was their timing with respect to the miscarriage. The first interview occurred during the initial phase of the crisis when the woman was striving to restore equilibrium (Rapoport, 1965). The six week interview reflected significant attempts toward resolution of the crisis. The six week interval was also a feasible time frame for the present study.

CHAPTER IV

Data Analysis

Introduction

As previously discussed, the qualitative approach best suits describing coping with spontaneous abortion in early pregnancy. This approach can document and interpret the miscarriage experience from the woman's frame of reference (Leininger, 1985). The study's purpose was to use interviews to gain insight concerning the woman's perceptions surrounding her miscarriage, in order to be able to document what she felt were the associated problems and solutions (Stern, 1985). The researcher attempted to experience her feelings by listening to her description. After interviewing ten women, verbatim statements were studied critically to discover patterns or themes within the woman's natural life setting (Leininger, 1985). Data were coded by listing similar responses, noting the frequency, and making comparisons to identify patterns or categories (Stern, 1985). From examining these categories, similar stressors and resultant coping behaviors emerged. The researcher then reviewed the tape recorded interviews and validated the themes with statements from the women. The statements from the subjects have been grouped under related themes and then assigned headings according to the topic.

First the themes of stressors will be explored. A stressor refers to "those experiences and/or concerns described by the subject as being disturbing or worrisome" (Snyder, 1985, p. 152). It is the event or perception that precipitates coping. Then the themes of coping will be examined. Coping "refers to efforts to master conditions of harm,

threat or challenge when a routine or automatic response is not readily available" (Monat & Lazarus, 1977, p. 8). Coping is used to reduce stress by dealing with the stressor or with its effect on the individual (Clarke, 1984b).

Stressors

Four common stressors were identified. The first was the perception of the conceptus as a potential child with subsequent identification of the miscarriage as the loss of a child rather than a primarily physical event of bleeding and cramping. The second was the intangible nature of the loss. Even though the conceptus was perceived as a potential child, there was no visible "person" to see, interact with, or bury. The third was a sense of inadequacy in the reproductive role and the fourth was the stress of "untelling". This referred to the woman having to inform acquaintances who knew of the pregnancy that she had miscarried.

Perceived loss of child

A common thread among all of the women interviewed was that the miscarriage had been perceived as a very personal aspect of their life. It not only involved an intimate region of their body physically, but it had penetrated feelings and emotions at the core of their psychic being. Regardless of whether the pregnancy had been planned or not, the product of conception was envisioned as a potential human being. Thus, the spontaneous abortion was equated with loss of a child versus a physical disorder of cramping and bleeding.

It's been hard, you loose something, even though it was 10.5 weeks, I feel I lost a baby.

I've always felt that even when the sperm and egg met that it was

part of us, part of me, now inside me and it was always there.

I lost a child.

This perception of the conceptus as a unique individual was alluded to by all ten women regardless of the presence or type of religious affiliation. Furthermore, the miscarriage was associated with the loss of a unique, irreplaceable individual. The women mourned the loss of the perceived child.

I would like to had had that baby, but I don't feel that having another baby will replace it.

I was really fighting for this baby. My diabetes was under real good control. Most of the people that I know have had miscarriages and have been able to have more after that. Now, this is it for me, I can't have any more kids. ... It was my last chance and I feel like I blew it.

Intangible nature of the loss

Closely associated with the view of the conceptus as an individual is the intangibility of the loss of the potential person. At first it seems to be an incongruent response. However, even though each woman felt she lost a child, she lacked tangible evidence of its existence. The miscarriage occurred before quickening so there were no direct interactions with the child. Often times the woman saw no human form; only blood and "tissue". So, the "person" was never seen, never known, and never to be actualized. It was unlike the death of an individual who had lived and interacted independently with others. This was conveyed by the following statement.

When you try to console yourself, when some person has actually died, you think about the nice things. When you think about the baby, you think about the loss and there's nothing really to redeem it except the potential the baby had to be a real person. ... However, as time goes by, you let that go (the miscarriage experience) and you do have to let go. That's the only real thing about that pregnancy.

In addition, the miniature "person" had only subtly interacted with the mother. Vague interactions took the form of nausea, breast tenderness, bloating, and fatigue. The only one who felt the presence of the child was the mother and the indications of life were nebulous. Therefore, the loss was felt most intensely by the woman.

I feel so alone ... because these's no one in my immediate family or even close friends I have who have experienced it, because they don't understand. They don't know the emotions.

It's kind of funny because I never realized the devastation of it when people would be going through it. I don't know. It's a real different feeling. I hope it passes soon, I really do.

Some women said that they tried to envision what the fetus may have looked like. The lack of concrete imagery was haunting. It was distressing that other people, particularly relatives and friends would never see or know this person. No one would know or acknowledge that they had lost a child. A feeling of emptiness was often described.

I walked in with empty arms.

It's a very similar feeling, I don't know how to explain this, but you know how you feel after you have a baby and you know you feel kinda goofy a couple months after that. It's a similar feeling like that but it's an empty feeling. It's probably a feeling how moms feel when they go to term and have a stillborn. It's probably the same feeling. ... It's like you have nothing to show for what you felt even though it was only 11 weeks. ... It has to get better because if it doesn't you'll go nuts.

Inadequacy in reproductive role

All of the women interviewed brought up the question of the cause of their miscarriage. This was particularly frustrating, as frequently there was no known medical reason for the loss. Another haunting question was, "Will it occur again with a future pregnancy?" In searching for the answer to these questions, some blamed themselves or

felt that they had an inherent problem that was responsible for the loss.

This miscarriage was very unexpected. I had had three very normal pregnancies and I was like, How could this happen to me? I'm supposed to be the Mother Earth or something. ... I keep thinking what did I do wrong? I keep going through maybe I shouldn't have done this or that. Maybe since I've gained weight since my last pregnancy it has made me less healthy to have babies and I've gone through a lot of stuff like that and I know it's not even rational. I've gone through it all.

The sense of inadequacy in the reproductive role impinged upon a very sensitive and personal area. The ability to reproduce is taken for granted by most as being a "normal" biological occurrence. When a woman is unable to fulfill this basic biological task, she is faced with feelings of inadequacy and failure. For women who had no living children or had a history of infertility, the feelings were more pronounced, feeding into the additional fear that they would never be able to produce a viable child. These women also engaged in the longest interviews.

I'm afraid now that I'll never be able to carry full term. I'm to the point now to where I feel so inadequate. ... I feel that I stick out like a sore thumb because I have a problem or I had this happen.

Everyone else keeps having babies and I keep loosing them. ... All I want is a baby. Is that asking too much?

I don't know anyone with a similar experience. In fact, with most of my friends it's just the opposite. They keep having so many kids. ... I feel bitter. It isn't fair.

The above statements incorporate all the feelings of questioning the underlying cause of the miscarriage, feelings of personal inadequacy, and being afraid of remaining childless.

Stress of untelling

The last major stressor identified was "untelling". Untelling

refers to the stress of telling those who knew of the pregnancy that it no longer exists. All of the women had told family and friends about the pregnancy; so it was inevitable that they would have to tell of the loss. The general attitude was that the women dreaded seeing anyone soon after the miscarriage because they did not want to be faced with discussing it, especially with mere acquaintances. When confronted with the situation of seeing someone who did not know of the miscarriage the women felt awkward and compelled to minimize the impact of the experience upon their life.

You find yourself being light about it just because you don't want to get into it, because if you get into it, all you get into is all those negative things and there's really no point because all people say is; Oh, well, it was meant to happen.

It's hard because I had just begun telling everyone that I was pregnant and then people that I don't see very often, a week or so later, a week after the miscarriage would call up and say, How are you feeling? Are you having morning sickness? Then you had to say ... Well, it's all over with; and that makes it really hard too. Then they felt bad because they know they had brought up something that made me feel bad. It's a very touchy situation.

I may be silly but you don't want to embarrass other people because there are a few people that don't know what happened. So you know you're going to run into these people eventually and you don't want to get on the phone and say "Oh, by the way ..". You know. With some of the neighbors that knew it's like I know eventually I'm going to run into them and they're going to say something and I don't want to make them feel bad. ... But what are you going to do? Eventually it'll come out.

Everyone around me knows I had it and I think it's harder for them to approach me. They're all sorry, they just don't know what to say.

One woman so dreaded having to discuss it at work she contemplated quitting her job. She realized this wasn't going to be a viable alternative, so she said she would have to "either talk about it as though nothing happened or you cut them off and say I don't care to

discuss it". This would avoid an emotional display in front of her coworkers.

Coping behaviors

The responses to the foregoing stressors were identified as coping behaviors. Coping "refers to efforts to master conditions of harm, threat or challenge when a routine or automatic response is not readily available" (Monat, & Lazarus, 1977, p. 8). Five patterns of coping were identified. These included communication, emotional catharsis, searching for causality, putting the experience in perspective, and taking pride in past reproductive achievements. These five patterns of coping seemed to emerge in a particular order. The first interview revealed the first three coping patterns and by the second interview all five were evident. The most fundamental coping mechanism was communication. The women needed to communicate about or discuss the miscarriage. A variety of people were helpful in listening. However, the most significant person initially was their spouse. Emotional catharsis or venting of emotions occurred simultaneously with communication or followed shortly after. It seemed that when enough emotion was expressed for them to be able to clearly think, the women attempted to search for the cause of the loss. The general attitude was to rationalize the miscarriage as "occurring for the best" to prevent the birth of an abnormal child. The fourth coping theme emerged by the time of the second interview: putting the experience in a proper perspective. The affective portion had been significantly reduced, allowing for clearer thoughts occurring on an intellectual level. The final coping theme was that of taking pride in past reproductive

achievements. This referred to past pregnancies that culminated in a viable birth or in a successful conception. The women with children expressed gratitude for them and childless women felt that if they could conceive once that they could conceive again.

The only seeming correlation between a particular stressor and resultant coping pattern existed between the stressor: sense of inadequacy in the reproductive role and the coping pattern: pride in past reproductive achievements. These existed on a personal level and were related to feelings of personal inadequacy. All the other stressors and coping mechanisms interacted in a random fashion, seemingly concerned with the loss itself.

There was no attempt to evaluate coping mechanisms as being adaptive or maladaptive to the functioning of the individual (Roy, 1976). Patterns of coping remained highly individualized. However, there were broad commonalities among the group.

Communication

Discussing the miscarriage and emotions surrounding the event was the most commonly cited form of coping. The spouse was the focal person with whom the experience was discussed. The importance of his support through both open verbal communication and through physical presence was referred to by most of the women.

My husband has been very supportive. It really helps to talk about it.

My husband's been really good. He keeps trying to get me to talk about it. I feel bitter and sorry for myself. He helps me get through the mood.

My husband has been terrific. He's been so supportive. He's like, Hey, if you want to talk, I'm here ... and I know he's there. Just knowing, even though he can't give me any answers, it feels good to

cry on his shoulder. He's really been the only one I've been able to talk to.

He was very supportive. He just said "I'm sorry" meaning I'm sorry for you being my wife that you have to go through this physical and emotional and everything else. He was very supportive.

There were limits to the support offered by their husbands. Several women stated that their husbands were initially very sympathetic and receptive to discussing the miscarriage. However, as time passed, the husband dealt with the loss more rapidly than their wife and felt that their wife should also have resolved the loss.

He feels terrible but, men have a different way of coping with things. They have their quiet moments and yet they deserve to feel that way too. But yet he's to the point now to where he wants me to get moving. ... That's aggravating too, when you don't feel up to it.

I've talked about it to everybody, my sisters, my friend down the street who's a nurse and my husband. My husband helped the most. He thinks I should get over this real quick. But you're not going to. In that way it's kinda stressful with him. He thinks it's over with and we should get on with our lives.

Only one woman felt she could not talk about it with her husband. Her response was to seek out others in order to discuss the experience.

I talk to my girlfriend. I don't talk to my husband that much because he's really emotional about it. All he did was run up and down the hall crying the whole time.

Other women in the study also found it helpful to talk to relatives and close friends who too had experienced a miscarriage. The comparing and contrasting of their experiences was therapeutic in that it allowed the women in the study to vent their emotions and concerns to someone who "understood". It also helped the woman to not feel alone and to realize she was not the only woman who had experienced a miscarriage. Feelings cited were inadequacy, embarrassment, isolation, guiltiness, and bitterness. It was helpful for the woman to identify these feelings

in order to further cope with their existence. Most of the women alluded to the fact that communication with others, but especially with their spouses, greatly helped them in the coping process.

Emotional catharsis

Emotional catharsis refers to "the alleviation of fears, problems, and complexes by bringing them to consciousness or giving them expression" (Webster, 1970). The ventilation of emotion took the form of crying and emotional lability. The emotional display was often reserved for home or in the presence of significant others. Two women stated they didn't shed a tear while in the hospital but as soon as they went home "it all came crashing down". Other examples of the catharsis are:

With my husband and with two of my close friends I was really upset and cried and everything and then to the rest of the world I just acted as if nothing happened.

I cry a lot.

It's something that you just have to feel that way and get it out of your system because I really don't think anything makes you feel any better.

Go with every emotion that comes. Don't try to hide anything, the fear, the guilt.

These statements are consistent with the intimate nature of the miscarriage. The women have to "feel" and confront the emotions in order to reduce the affective portion of the loss. Communication was used as a support through this emotional turmoil. However, further or more sophisticated coping attempts were unsuccessful until the catharsis had occurred. The women stated they were too wrapped up with their emotions to think "straight". Emotional catharsis was aimed at restoring the individual's state of equilibrium.

Searching for causality

Searching for causality occurred early in the period following the miscarriage. It was referred to during the initial interview and, generally, emerged shortly after the communication and emotional catharsis patterns. It was the women's preliminary attempt to find reason for the loss.

Often the women were consumed with the unanswered question of why the miscarriage happened. The general response was that it was for the best to prevent the birth of an abnormal child.

I'm still looking for the answer why and what I have to come to terms with is that we may never find out why ... I guess it was nature's way of getting rid of its mistakes.

It was probably meant to be. It probably, (sigh) there was just something that wasn't forming right.

It was meant to be.

The baby was probably sick. It's nature's way of your body getting rid of something that shouldn't be there.

Rationalization was employed to give some purpose for the loss. If there was something wrong with the developing fetus, then the loss had a reason. Unknown causation of the miscarriage was too nebulous to deal with, so transforming it into a concrete cause made coping easier.

Another approach to rationalization was to plan for the future. This was facilitated by getting back to a normal routine.

It's not as though I can't get pregnant again or try again. So just getting back to a normal life makes it a little easier to deal with what's happened and to believe that in the future there's a chance everything will work out.

Searching for causality also occurred on a personal level.

I was very high risk so I look at it as God's way of telling me it shouldn't have happened.

Various approaches to searching for a cause existed. However, the desired outcome was to provide a concrete reason that could account for the miscarriage and thus reduce the stress of its occurrence.

Putting the experience into perspective

Being able to put the miscarriage into a proper perspective emerged by the time of the second interview. It involved being able to distance oneself from the emotions surrounding the loss in order to be able to develop a more objective view of the situation. It required the passage of time and the ability to resolve the acute emotional involvement. Once the women moved beyond their peak emotional lability, they attempted to view the experience in proper perspective.

Because time has gone by I don't think about it as much. But I think of it in the same way. It's not as intense. It's easier to think about.

I feel a lot better mentally. I've had more time to put things into perspective. When it first happened I was crying a little bit every day and I've gotten over that.

Time heals. ... I spend two or three hours a day thinking about it. It doesn't consume me any more the way it did in the beginning. ... I'm dealing with it a lot better.

All the women interviewed stated that as time passed they spent less time thinking about their miscarriage and that it was surrounded by less intense emotions. Nevertheless, it was an experience that still provoked a feeling of sadness and loss. The women further said that it was something they would never forget.

I don't think you ever really get over it. It'll always still be there. It'll be a little part of your heart that was pulled apart.

Taking pride in past reproductive achievements

Taking pride in past reproductive achievements refers to the woman's past success with conception and/or pregnancies. It could be

thought of as rationalization that is employed to reestablish a sense of security within the reproductive role. It's the answer to "Is something wrong with me?" Women with children spoke frequently about their past pregnancies. They found comfort in the thought of successful completion of a past pregnancy or in the production of a viable offspring. They were also fulfilled within the mother role.

Since I do have three nice normal healthy kids it's easier too. If I would of had the miscarriage before having the first child I think it would have been a lot harder.

I'm thankful for the one I have.

I have three kids too and that takes my mind off of it. It keeps me busy.

Among the women who had no children and/or who had a history of infertility, their past achievement was the ability to conceive. The prevailing thought was that if I can get pregnant once, I can again and surely I won't have any more miscarriages.

We had been trying so long to get pregnant. At least I know everything is working; the ovaries, the tubes aren't blocked, and that I can hopefully have a child of my own.

At least I know everything is working.

She (the infertility specialist) said too that I was able to get pregnant without any fertility drugs or anything. All she did was consult with me. And she was pretty reassuring and didn't know why I'd have to go back on Clomid or Pergonal.

Statements of this nature emerged at the time of the second interview and seemed to reflect some degree of resolution of the crisis.

Summary

The present study used a qualitative approach in order to gain insight into the perceptions and events surrounding miscarriage. This is a highly subjective experience that is dependent upon individual

perception. In-depth interviews were most appropriate in order to gather such subjective and individualized information. The miscarriage was perceived as a crisis situation that produced stressors that upset the subject's state of equilibrium and precipitated the need for coping. Four common stressors and five common patterns of coping emerged. The themes were validated with the participant's statements. The four stressors included: the perception of the conceptus as a potential child; the intangible nature of the loss; a sense of inadequacy in the reproductive role; and, the stress of "untelling". The five patterns of coping included communication; emotional catharsis; searching for causality; putting the experience into perspective; and, taking pride in past reproductive achievements. There seemed to be a sequential emergence of coping patterns, however there was no attempt to evaluate the effectiveness of the individual's coping behavior.

CHAPTER V

Conclusions

Summary

Ten women were interviewed on two occasions following spontaneous abortions. Contact with the women was established after their admission to an urban medical center for treatment of their spontaneous abortion. Informed, written consent was obtained and an interview was arranged at approximately one week and six weeks after the miscarriage. The interviews occurred in the participant's home and at her convenience. One week and six weeks were used to incorporate the acute phase of crisis and to explore attempts at resolution of the crisis.

A qualitative approach was employed due to the paucity of related research. The interviewer used open-ended questions in order to gain an understanding of the individual's perceptions surrounding their miscarriage. This is a highly individualized experience that required a personalized approach in data collection. Based upon the women's statements and recollections, certain patterns or themes of both stressors and coping patterns emerged. Commonalities were grouped together and validated with reflective statements.

Discussion

At the time of the first interview the women were noted to be experiencing a very disruptive period where they were consumed in crisis (e.g. miscarriage). Emotional lability was noted, along with many nervous mannerisms, such as nail biting, finger tapping and fidgeting. Some apprehension could possibly be attributed to the interview

situation which was unfamiliar for them. By the second interview, all women were composed, discussed the miscarriage with more ease, and lacked the same degree of nervous mannerisms. Statements were also made concerning being able to rationally think about the experience; of not being consumed with thoughts of it; and, of being able to look to the future. Various stages of resolution were reported.

The following is an attempt to formulate a description of the modal woman represented by the sample. Generalizations were made in order to summarize the emergence of stressors and coping mechanisms.

By the time of the first interview the four central stressors -- the perception of the conceptus as a potential child, the intangible nature of the loss, a sense of inadequacy in the reproductive role, and, the stress of untelling -- had confronted the woman. The modal woman had perceived the spontaneous abortion as a loss of child and was groping with the intangibility of the loss. She then experienced feelings of inadequacy and dreaded telling others of her mishap. She did not want to lose composure in the presence of acquaintances and feared they would either not acknowledge the loss, feel her emotions were unwarranted, or perhaps see her as a freak for not being able to produce a child. After all, what is more fundamental than reproduction? If she had failed in such a basic role, what then is her possible worth? The most fundamental aspect was to communicate to someone her thoughts, feelings and fears. Until she stated her feelings and acknowledged their existence she could not begin to know what she was up against. After presenting her feelings to another person, she not only recognized that the feelings existed, but also could receive

input from another individual. This was simultaneously accompanied by an actual "unbottling" of emotions. Intense episodes of crying relieved the pressure exerted from dealing with the emotions. Once the affective portion was vented, she could progress towards further coping with the spontaneous abortion. While still wrought with emotion, she attempted to search for causality of the loss. Statements rationalizing the miscarriage as nature's way of preventing abnormalities were prevalent. Further, general coping patterns surfaced by the time of the second interview. During this time, the emotional aspect had greatly subsided; she had received input from others as to their perceptions of the event or from other women with similar experiences. Then she had taken time to mull it over again and again. The next step in the coping process was to put the experience into perspective. This allowed her the luxury of placing the experience on the back burner. She would not forget it, nor would she dwell on it and continue to be consumed. A final task of the coping process related to the insecurities generated around the modal women's reproductive role. These were also confronted by the time of the second interview. The pride in past achievements was important in rationalizing her worth in the reproductive role. Women with children had the most "achievements" to counter the feelings of inadequacy. They also were occupying the "mother" role and the world at large would see them as fulfilled. Those women without children were comforted by their success at conception. However, they feared not being able to reproduce successfully. Rationalization made it possible for them to expect a future pregnancy and offered hope of a child. In turn, this hope made it possible to refute internalized notions of

inadequacy and eased this very disruptive period. Degrees of coping varied according to the individual. However, the above is a generalized progression of dealing with the experience. It was gathered from the women's perceptions and validated by their statements.

The Lazarus Model of Coping can easily be applied to the study. The women used primary appraisal when they consciously evaluated the spontaneous abortion (e.g. bleeding and cramping) as being threatening to personal integrity. Once the situation was perceived as a threat, the women sought medical treatment. Seeking medical treatment would be classified as problem-focused coping. During this time, on an unconscious level, the women were also engaged in emotion-focused coping. Specific coping techniques revealed in the study were initially communication, emotional catharsis, and searching for causality. The coping techniques altered the perception of the miscarriage in order for the women to achieve more comfort. By the second interview, reappraisal had occurred. The last two emotion-focused coping patterns of putting the experience into perspective and of taking pride in past reproductive achievements emerged. These further increased comfort and reduced the perceived intensity of the original occurrence (e.g. spontaneous abortion).

Limitations

The sample was one of convenience and consisted of a small homogeneous group. Data were obtained from a married, educated, predominantly white, middle class sample and its generalizability to other populations is questionable. Data were also gathered from the woman's perspective and are not meant to be applied to her spouse.

The duration of the investigation was six weeks. It is beyond the scope of the study to project long term consequences of miscarriage.

No attempt was made to rank the stressors in comparative intensities. Coping effectiveness was not evaluated and the specific interactions between stressors and coping mechanisms were not determined.

Interviews are subject to bias. However, the study was meant to give a basic awareness of the experience of miscarriage. The qualitative approach is an inductive means of investigation. This study has identified a fundamental awareness and understanding of the perceptions surrounding this type of loss. Specific stressors and coping patterns were identified. The investigation was successful at taking a beginning look at the experience of spontaneous abortion and has provided direction for further investigation.

Recommendations for Further Research

An important area in need of further investigation would be to follow a larger sample of women for an extended period. In a larger sample, the previously identified stressors and coping mechanisms could be confirmed and any others identified. There could also be an evaluation of the intensity of the stressors and the effectiveness of coping strategies. Another aspect worth noting would be the long term effects of miscarriage on parenting styles. Are people with poor reproductive histories more lenient and permissive parents?

It would also be interesting to document the effect of marital status upon the perceived stressors and resultant coping patterns surrounding miscarriage. How does the single woman perceive the loss?

Would the loss be as great? If so, how do the single woman's coping patterns correlate with the coping patterns of a married woman?

Another area that would be fascinating to explore is the impact of miscarriage upon the man. Does the father perceive it as a crisis and if so, what are the specific stressors and coping mechanisms?

The present study has only scratched the surface of the psychological implications of miscarriage. Much more work needs to be completed in order to gain a fuller view of the perceptions surrounding miscarriage.

Implications for Nursing

Perhaps the most fundamental implication that can be drawn from this study is that spontaneous abortion is perceived as the loss of a potential child and is accompanied by intensely felt emotions. Nurses should be aware of this perception in structuring care. Interventions should address not only physical aspects but also psychological needs of the individual. Specific interventions could consist of providing an opportunity for discussion of the miscarriage including empathetic listening and recognition of the impact of the loss upon the individual. Examples of probes for discussion could be: "Tell me what you are feeling". "This must be very difficult for you". "Would it help to talk about it?" The nurse can use herself as a therapeutic tool in providing communication resources to facilitate the woman's coping.

The study revealed that among the women interviewed, the spouse played a large role in supporting her coping attempts. Supportive measures can be employed to support the spouse or significant other as well. The nurse's mere presence can convey a feeling of care and

concern for the dyad. It would also be helpful to encourage the spouse or significant other to stay with the woman. During his stay, the nurse should offer privacy but not isolation.

Another important intervention would be to offer available information regarding the reason for the spontaneous abortion. Attempts should be made to dispel myths concerning causation. The intervention should be directed towards alleviating feelings of self blame and inadequacy (e.g. she didn't lose the pregnancy because she was working outside the home).

In the present era of abbreviated hospital stays, home follow up care is important. This can take the form of a phone call or home visit several days after the miscarriage. Women may be more receptive to discussion and/or have questions related to the loss at the time of follow-up. The nurse's most therapeutic tool is herself. These women appreciate knowing that someone is concerned and has acknowledged their loss. A holistic approach to health care would meet the woman's psychological as well as physical needs.

References

- Brickman, P., Rabinowitz, V., Karuza, J., Coates, D., Cohen, E., & Kidder, L. (1982). Models of helping and coping. American Psychologist, 37, 368-384.
- Clarke, M. (1984a). The constructs stress and coping as a rational for nursing activities. Journal of Advanced Nursing, 9, 267-275.
- Clarke, M. (1984b). Stress and coping: Constructs for nursing. Journal of Advanced Nursing, 9(1), 3-13.
- Cohen, F., & Lazarus, R. (1973). Active coping processes, coping dispositions, and recovery from surgery. Psychosomatic Medicine, 35, 375-389.
- Colman, A., & Colman, L. (1971). Pregnancy: The psychological experience. New York: Seabury Press.
- Cronewett, L., & Brickman, P. (1983). Models of helping and coping in childbirth. Nursing Research, 32, 84-88.
- Deutsch, H. (1945). The psychology of women, Volume 2. New York: Basic Books.
- Folkman, S., & Lazarus, R. (1980). Coping in a middle-aged community sample. Journal of Health and Social Behavior, 21, 219-239.
- Friedman, M. (1981). Family nursing: Theory and assessment. New York: Appleton-Century-Crofts.
- Friedman, R., & Gradstein, B. (1982). Surviving pregnancy loss. Boston: Little, Brown and Co.
- Garland, L., & Bush, C. (1982). Coping behaviors and nursing.

Reston, VA: Prentice Hall.

- Hillard, P. (1984). Miscarriage. Emergency Medicine, 15(13), 161.
- James, W. (1962). The problem of spontaneous abortion. American Journal of Obstetrics and Gynecology, 85, 38-40.
- Kaij, L., Malmquist, A., Nilsson, A. (1969). Psychiatric aspects of spontaneous abortion - II. The importance of bereavement, attachment, and neurosis in early life. Journal of Psychosomatic Research, 13, 53-59.
- Kellner, K., Donnelly, W., Gould, S. (1984). Parental behavior after perinatal death: Lack of predictive demographic and obstetric variables. Obstetrics and Gynecology, 63, 809-814.
- Kirkley-Best, E., & Kellner, K. (1982). The forgotten grief: A review of the psychology of stillbirth. American Journal of Orthopsychiatry, 52, 420-429.
- Lake, M., Knuppel, R., Murphy, J., & Johnson, T. (1983). The role of a grief support team following a stillbirth. American Journal of Obstetrics and Gynecology, 146, 877-881.
- Lazarus, R. S. (1982). Thoughts on the relations between emotion and cognition. Psychological Documents, 69. (Ms. No. 11728).
- Lazarus, R., Averill, J., & Opton, E. (1974). The psychology of coping: Issues of research and assessment. In G. Coelho, D. Hamburg, & J. Adams (eds.), Coping and adaptation (pp. 249-315). New York: Basic Books.
- Lederman, R. (1984). Psychosocial adaptation in pregnancy. New Jersey: Prentice-Hall.

- Leininger, M. (1985). Nature, rationale, and importance of qualitative research methods in nursing. In M. Leininger (Ed.), Qualitative research methods in nursing (pp. 1-25). Orlando: Grune & Stratton.
- Leppert, P. & Pahlka, B. (1984). Grieving characteristics after spontaneous abortion: A management approach. Obstetrics and Gynecology, 64, 119-122.
- Lewis, E. (1979). Mourning by the family after a stillbirth or neonatal death. Archives of Disease in Children, 54, 303-306.
- Monet, A., & Lazarus, R. (Eds.)(1977). Stress and coping. New York: Columbia University Press.
- Oiler, C. (1982). The phenomenological approach in research. Nursing Research, 31, 178-181.
- Omery, A. (1983). Phenomenology: A method for nursing research. Advances in Nursing Science, 5, 49-63.
- Peppers, L., & Knapp, R. (1980). Maternal reactions to involuntary fetal/infant death. Psychiatry, 43, 155-159.
- Rabinowitz, V. (1978). Orientation to help in four natural settings. (Doctoral dissertation, Northwestern University, 1978). Dissertation Abstracts International. (University Microfilms No. 79-09, 928).
- Rapoport, L. (1965). The state of crisis: Some theoretical considerations. In H. Parad (ed.), Crisis intervention: Selected readings (pp. 22-31). New York: Family Service Association of America.
- Roy, C. (1976). Introduction to nursing: An adaptation model. New

- Jersey: Prentice Hall.
- Rubin, R. (1984). Maternal identity and the maternal experience.
New York: Springer Publishing.
- Rubin, R. (1967). Attainment of the maternal role: Part I.
Processes. Nursing Research, 16, 342-346.
- Seibel, M. & Graves, W. (1980). The psychological implications of
spontaneous abortion. The Journal of Reproductive Medicine,
25, 161-165.
- Seitz, P., & Warrick, L. (1974). Perinatal death: The grieving
mother. American Journal of Nursing, 74, 2028-2033.
- Snyder, D. (1985). Psychosocial effects of long-term antepartal
hospitalization. In M. Rathi (Ed.), Clinical aspects of perinatal
medicine (pp. 149-163). New York: Macmillian.
- Stack, J. (1984). The psychodynamics of spontaneous abortion.
American Journal of Orthopsychiatry, 54, 162-167.
- Stack, J. (1980). Spontaneous abortion and grieving. AFP,
21(5), 99-102.
- Stephany, T. (1982, November). Early miscarriage: Are we too
quick to dismiss the pain? RN, 89.
- Stern, P. (1985). Using grounded theory method in nursing research. In
M. Leinger (Ed.), Qualitative research methods in nursing (pp. 149-
159). Orlando: Grune & Stratton.
- Tupper, C., & Weil, R. (1962). The problem of spontaneous
abortion. American Journal of Obstetrics and Gynecology, 83,
421-424.
- Waal-Haas, C. (1985). Women's perceptions of first trimester

spontaneous abortion. Journal of Obstetric, Gynecologic, and Neo-Natal Nursing, 14, 50-53.

Wetzel, S. (1982). Are we ignoring the needs of the woman with a spontaneous abortion? MCN: The American Journal of Maternal Child Nursing, 7, 258-259.

Williams, J. (1977). Psychology of Women: Behavior in a bio-social context. New York: W. W. Norton and Co.

Ziemer, M. (1982). Coping behavior: A response to stress. Topics in Clinical Nursing, 4, 4-11.

APPENDIX A

LOYOLA UNIVERSITY MEDICAL CENTER
MAYWOOD, ILLINOIS

School of Nursing
Department of Maternal Child Health

INFORMED CONSENT

Patient's Name: _____ Date: _____

Project Title: Coping with Spontaneous Abortion that Occurs in Early
Pregnancy

Patient Information:

Ten to twenty percent of all pregnancies end in spontaneous abortion or miscarriage. This high incidence affects a substantial proportion of the female population. Most women have either personally experienced a spontaneous abortion or have a close friend or relative who has. This study had been designed to increase our knowledge of how women cope with miscarriage. By participating in the study you will help us increase our understanding of the kind of experiences you are going through and thus enable us to improve the nursing care we can give to other mothers in similar situations.

If you decide to participate in the study you will be interviewed twice. Your interviewer will be a registered nurse who has eight years experience in maternal child nursing. She presently is a graduate student in the School of Nursing here at Loyola. She will not be a nurse who is responsible for providing care for you during your hospitalization. The two interviews will be scheduled at your convenience and will take place in your home. The first interview will occur one week after your miscarriage and the second will occur six weeks after your miscarriage. The interviews will vary in length depending on what you want to talk about and how you feel at the time, but should never last more than 60 to 90 minutes. They will be nonstructured to allow you time to talk about what you are feeling and what you think is important to you at the time, but the general focus will be on your miscarriage and how you and your family feel about it. The interviewer will tape record the interview. What you tell the researcher will be confidential.

Potential Benefits and Risks:

Your participation in this study will benefit you personally in that you will be able to discuss your feelings about and reactions to your miscarriage with a registered professional nurse. The information obtained from the study will also be of great value in improving the care offered to other women who, like you, have experienced a miscarriage.

There are no anticipated risks involved for you if you choose to participate in the study. If you, for any reason, feel uncomfortable

participating in the study, your participation will be discontinued immediately.

CONSENT

I have fully explained to _____ the nature and purpose of the above described research and the risks that are involved in its performance. I have answered and will answer all questions to the best of my ability.

Principal Investigator or Research Associate

I have been fully informed of the above described procedure with its possible benefits and risks. I give my permission for my participation in this study. I know that Ann Flandermeyer will be available to answer any questions that I may have. If at any time I feel that my questions have not been adequately answered, I may request to speak with a member of the Medical Center Institutional Review Board. I understand that I am free to withdraw this consent and to discontinue my participation in this study at any time without prejudice to my medical care. I have received a copy of this informed consent document.

I agree to allow my name and research records to be available to other authorized physicians, nurses and researchers for the purpose of evaluating the results of this study. I consent to the publication of any data which may result from these investigations for the purpose of advancing medical and/or nursing knowledge, providing my name or any other identifying information (initials, social security numbers, etc.) is not used in conjunction with such publication. All precautions to maintain confidentiality of the medical records will be taken.

In the event that I believe that I have suffered any physical injury as the result of participation in this study, I understand that I can contact Dr. R. Henkin, Chair, Institutional Review Board for Protections of Human Subjects at the Loyola University Medical Center, telephone (312) 531-3380. I understand, however, that the Food and Drug Administration of the United States Government is authorized to review the records relating to this project.

Patient

Witness to Signatures

Date

APPENDIX B

Appendix B
Biographical Information

Name:

Address:

Phone:

Years of Education:

Gravida:

Para:

Gestation (EDC):

Occupation:

Language:

Ethnicity:

Religion:

Medical History:

History of Infertility:

APPENDIX C

Appendix C

<u>Expected Themes</u>	<u>Sample Questions</u>
1) History Value of Pregnancy	1) Can you help me understand what has happened to you?
2) Ways of Coping	2) What has your response been to this? or How have you handled this? a) Have you discussed this with anyone?
3) Social support in coping	3) Can you help me understand how this has been difficult for you? Is it a problem in how you view yourself? a) In your relation to your husband, family or friends?
4) "Kinship" Sharing of experience	4) Do you know anyone who has had a similar experience? a) Would it be helpful to talk to them about it?
5) Coping. Identify the most significant factor to resolution	5) What has been most helpful to you? What else could have been of help to you?

APPROVAL SHEET

The thesis submitted by Ann A. Flandermeyer has been read and approved by the following committee:

Dr. Dona Snyder
Associate Professor, Maternal Child Health Nursing

Dr. Mary Patricia Ryan
Associate Professor, Community and Mental Health Nursing

Dr. Karen Haller
Assistant Professor, Maternal Child Health Nursing

The final copies have been examined by the director of the thesis and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the thesis is now given final approval by the Committee with reference to content and form.

The thesis is therefore accepted in partial fulfillment of the requirements for the degree of Masters of Science in Nursing.

November 19, 1985
Date

Dona J. Snyder
Director's Signature