

Research-based Practice with Women Who Have Had Miscarriages

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Purpose: To summarize a research-based description of what it is like to miscarry and to recommend an empirically tested theory of caring for women who have experienced miscarriage.

Design: The research program included three phases: interpretive theory generation, descriptive survey and instrument development, and experimental testing of a theory-based intervention.

Methods: Research methods included interpretive phenomenology, factor analysis, and ANCOVA.

Findings: A theory of caring and a model of what it is like to miscarry were generated, refined, and tested. A case study shows one woman's response to miscarrying and illustrates clinical application of the caring theory.

Conclusions: The Miscarriage Model is a useful framework for anticipating the variety of responses women have to miscarrying. The caring theory is an effective and sensitive guide to clinical practice with women who miscarry.

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[Key words: caring, miscarriage, theory construction, counseling]

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At least one in five pregnancies ends in miscarriage—the unplanned, unexpected ending of pregnancy before the time of expected fetal viability (Hall, Beresford, & Quinones, 1987). Women's responses range from relief to devastation with much variability in the time required to achieve resolution. This paper is a research-based description of what it is like to miscarry. The investigator suggests an empirically tested theory of caring for women who have miscarried. Conclusions are derived from a 15-year program of interpretive, descriptive, and experimental research. A clinical case study of one woman who miscarried illustrates both the effects of miscarriage and how the caring theory may be applied in practice.

Background

The Emotional Impact of Miscarriage

The initial investigation that launched this program of clinical research was a phenomenologic pilot study of five women who miscarried within 14 weeks of participating in the study (Swanson-Kauffman, 1983). The research question was: "What is the meaning of miscarriage to the woman who has recently experienced it?" Two women had no prior pregnancy losses, two had one previous miscarriage, and one had two previous miscarriages. All had at least one liveborn child. Tape-recorded interviews were open-ended and semi-structured. Questions were generated from a review of clinical, research, and popular literature. The goal of analysis was to define common themes among women's stories. Findings were critical for initiating a

program of inquiry about miscarriage and its aftermath. An important contribution of the pilot study was the conclusion that a woman's feelings about miscarriage could be understood only in the context of what being pregnant and having a miscarriage meant to her. For example, if being pregnant was perceived as a magnificent, exciting journey, with the delightful novelty of wearing maternity clothes, and the joyful anticipation of a dream fulfilled, then having that pregnancy end unexpectedly was experienced as the loss of a privileged role, a loved baby, and a wished-for future. If pregnancy was experienced as unplanned, poorly timed, and troubling, then the unexpected end of that pregnancy could be experienced as a relief from having to make some difficult decisions or major adjustments. The loss of an undesired pregnancy could also be experienced as a source of

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guilt and self-recrimination (“Did my not wanting this pregnancy cause my baby to die?”).

Understanding what a miscarriage meant to a woman was also essential to understanding her feelings. For example, if miscarriage was viewed as an inevitable outcome of some conceptions, the feelings might range from acceptance (“God’s will” or “Just not meant to be”) to searing questions about the meaning of life (“Why would we have been allowed to feel all this joy and then have it swept away from us?” or “Why me, why now?”). If the reason was attributed to the woman’s body, the feelings might range from honoring herself (“My body was wise enough to recognize an unhealthy conception.”) to despising herself (“What kind of a woman am I?”). These attributions of meaning to pregnancy and miscarriage were the filters through which women made sense of miscarriage, losses associated with it, medical care received, responses of others, and returning to her no-longer-pregnant self.

The Human Experience of Miscarriage

The next study was a phenomenologic study of 20 women who had miscarried (Swanson-Kauffman, 1983, 1985, 1986a, 1986b, 1988). Two specific aims were: (a) to describe the human experience of miscarriage, and (b) to describe the meaning of caring as perceived by women who miscarried. Criteria for inclusion were that women had not felt fetal movement before loss, were within 4 months of

loss, and could speak English. Participants had from zero to seven previous miscarriages and were between 7 and 16 weeks gestation at the time of the miscarriage. Each woman was interviewed twice in about 6 weeks. The first interviews took place in the participant’s home and lasted up to 3 hours. Most second interviews were by phone and lasted approximately 30 minutes. A detailed open-ended interview protocol was available, but most interviews began with the broad question, “What was miscarriage like for you?” Interviews then followed the informant’s leads.

The method for this study has been described by Swanson-Kauffman (1986a) and Swanson, Kauffman, and Schonwald (1988) and is based on Giorgi’s (1970) four basic steps in phenomenologic studies. (a) Bracketing is attempting to name and set aside bias before and throughout the study, remaining reflective, open to each informant’s personal experience, and aware that each informant’s personal experiences could unduly influence data analysis. (b) Intuiting requires trusting that by being open to each informant’s story, remaining critically self-reflective, and “dwelling deeply” in the data, the investigator will grasp the meanings of the phenomena. (c) Analyzing refers to the steps used to gather, arrange, and code data, and link data into meaningful units and illustrative categories. (d) Describing means incorporating the illustrative categories into a model that depicts the phenomena in a way that reflects the informants’ experiences and is considered believable by anyone who has

Table. The Human Experience of Miscarriage: Confronting the Inevitable

| Experience | Definition | Manifestations |
|---------------------------|---|--|
| Coming to know | The confusing painful process of balancing the mounting evidence of impending loss against hopes for a healthy pregnancy outcome. | <ul style="list-style-type: none"> • Having previous ideas about what it is like to miscarry • Having premonitions of this pregnancy not lasting • Recognizing the first sign that something is not right • Waiting after that first sign is like riding a hope-no hope rollercoaster • Having inner confirmation that this baby will no longer be • Realizing you are no longer pregnant may take quite a while |
| Losing and gaining | Recognizing and naming what was lost or gained through miscarrying. | <ul style="list-style-type: none"> • Identifying what was attached to • Clarifying what was lost • Recognizing what was gained through miscarrying • Realizing the meaning of what was lost or gained |
| Sharing the loss | Receiving (or not receiving) recognition and support for what it is like to miscarry. | <ul style="list-style-type: none"> • Having others (especially health care providers) recognize the event as a loss • Realizing that others (esp. partners) share a sense of loss • Receiving comfort and validation from others • Connecting with other women who have had a pregnancy loss |
| Going public | Going back into a fertile world as a no-longer-pregnant woman. | <ul style="list-style-type: none"> • Getting the news out about the miscarriage (and sometimes after-the-fact news about pregnancy also) • Encountering reminders (especially babies and pregnant women) • Having no outward sign of having experienced a significant loss • Dealing with the comments of others |
| Getting through | Getting to the point that the good times in the day begin to outweigh the bad. | <ul style="list-style-type: none"> • Going through physical loss and healing • Being overwhelmed by hormones and emotions • Returning to menses • Confronting the inevitable, making the “unreal” real • Feeling more like yourself again • Going through the due date of the lost pregnancy |
| Trying again | Deciding when, and if, to attempt conception while living with the ongoing fears of future loss. | <ul style="list-style-type: none"> • Resuming intimacy • Practicing birth control and avoiding pregnancy • Balancing medical advice and personal desires about when to try again • Confronting ongoing fears • Deciding when, and if, to try again • Getting past the gestational age of miscarriage • Dealing with anxiety during the subsequent pregnancy • Realizing that the newborn’s existence was possible because of the miscarriage |

experienced the phenomena described. The model derived from this type of phenomenologic inquiry may be viewed as a researcher's "claim." Evidence for the plausibility of the claim is provided by directly quoting study participants.

Two models were generated from this phenomenologic study of 20 women: the Human Experience of Miscarriage Model and the Caring Model. The Caring Model was further developed through two more studies of loss in childbearing (Swanson, 1990; 1991) and is now referred to as a middle-range theory of caring. For the 20 women in the study, miscarriage precipitated six inevitable, universal experiences: coming to know, losing and gaining, sharing the loss, going public, getting through it, and trying again (see **Table**). As women go through each of these experiences, they assign meanings to the events within the contexts of their own lives. As described in the pilot study, and further illustrated in the case study, how women view the pregnancy influences the meanings assigned to miscarriage.

The Caring Theory includes five basic processes that give meaning to acts labeled caring: knowing, being with, doing for, enabling, and maintaining belief (Swanson-Kauffman, 1986b, 1988 and Swanson, 1991, 1993, 1999). Caring is defined as a "nurturing way of relating to a valued other toward whom one feels a personal sense of commitment and responsibility" (Swanson, 1991, p. 162). *Knowing* means striving to understand the meaning of an event in the life of the other, avoiding assumptions, focusing on the one cared-for, seeking cues, assessing thoroughly, and engaging both the one caring and the one cared for. *Being with* means being emotionally present to the other. It includes being there, conveying availability, and sharing feelings while not burdening the one cared for. *Doing for* means doing for others what they would do for themselves if possible, including anticipating needs, comforting, performing competently and skillfully, and protecting others while preserving their dignity. *Enabling* means facilitating the other's passage through life transitions and unfamiliar events, including focusing on the event, informing, explaining, supporting, allowing and validating feelings, generating alternatives, thinking things through, and giving feedback. *Maintaining belief* means sustaining faith in the other's capacity to get through an event or transition and face a future with meaning, believing in others and holding them in high esteem, maintaining a hope-filled attitude, offering realistic optimism, helping them to find meaning, and standing by them no matter how the situation may unfold (Swanson, 1991, 1993, 1999).

The Impact of Miscarriage Scale

This study shifted the program of research from a qualitative interpretive approach to a descriptive quantitative design. The development of the Impact of Miscarriage Scale (IMS) included three phases (Swanson, 1999). Phase I resulted in 105 emic statements from 20 women's responses to four questions asked in the "Human Experience" study. The questions were (a) Were you attached, and to what? (b) What did you lose (through miscarrying)? (c) What did you gain (through your experience)? and (d) If you could sum it all up in one word or phrase, what would it be? These 105 statements were structured as survey items that respondents could rate for relevance to their experience.

In Phase II, the 105 items, an obstetric history form, and demographic questions were mailed to a convenience sample of 446 women with and without children who had experienced at least

one miscarriage within the previous 10 years. Through this study the 105 items were reduced to 30 psychometrically sound items. Construct validity was established by examining the capacity of the IMS to discriminate among groups of women for whom miscarriage would be expected to hold different meanings. Significant differences (independent *t*-tests, $p < .05$, two-tailed) were found for women with and without children, with and without a history of late-gestation pregnancy losses, and with fewer than three versus three or more miscarriages (Swanson, Kieckhefer, Powers, & Carr, 1990).

During Phase II of the IMS study, an open-ended question also was asked: "Please summarize your experience of miscarrying in one word or phrase." An inductive content analysis of the responses was conducted. Of the 446 participants in the mailed survey, 414 answered the open-ended question (Swanson et al., 1991).

Women's responses were reported according to depth of impact—from most to least painful. The first response was labeled "aching or hurt" ($n = 46$, 11.1% of the total responses). This response described miscarriage as being like a crushing, physical assault (a "punch in the gut") and was most commonly used by women who had also experienced late gestation losses. The second category "cheated or unfairly taken away" ($n = 45$, 10.9%) suggested that women felt robbed. Women with a history of infertility frequently used these words. The third category "disconnected-self" ($n = 27$, 6.5%), suggested that women felt guilt ("What's wrong with me?") or self-blame ("What did I do to deserve this?"). This response was one of the two most frequently given by women with a history of elective abortion. The fourth category, "woe-filled, grieving" ($n = 171$, 41.3%) included sad, depressed, loss, lost baby, and grieving. The category "life goes on" ($n = 103$, 24.9%) implied that while miscarriage was difficult to go through, resolution was possible. The final category, "valuable life experience" ($n = 22$, 5.3%), indicated that miscarriage was experienced as a good thing (i.e., a relief, a reprieve, or major learning experience). This response was the other descriptor most commonly provided by women with a history of elective abortion.

In phase III data were gathered from 188 women 1 year after miscarriage (Swanson, 1999). Factor analysis reduced the IMS to a 24-item measure consisting of one overall scale and four subscales: lost baby, isolated, devastating event, and personal significance. The combined subscales accounted for 59.3% of the total variance. Cronbach's alpha for the total scale was .93. Subscale alphas ranged from .79 to .86.

The Miscarriage Caring Project

This experiment was a repeated-measures, randomized Solomon four-group investigation of the effects of caring, measurement, and time on women's well-being in the first year after miscarriage. Enrolled were 242 women; 185 completed the year-long study. The intervention process was based on the caring theory described earlier. The content for three 1-hour caring-based counseling sessions was derived from the "Human Experience of Miscarriage Model." Treatment was effective ($p < .05$) in reducing overall emotional disturbance, anger and depression, as measured by McNair, Lorr, and Droppleman's (1981) Profile of Mood States. The passage of time was effective in enhancing self-esteem (Rosenberg, 1965) and reducing overall emotional disturbance, anger, depression, anxiety, confusion, and the personal significance attributed to

miscarriage. Women for whom measurement was delayed (they completed no outcome measures until 4 months after loss) were more angry and less likely to identify the loss as “a baby.”

The investigator conducted most of the counseling sessions for the Miscarriage Caring Project. These sessions along with clinical experiences of working with support groups, individuals, and couples provide the clinical data for the following exemplar. This clinical example is a composite case study of many women who experienced the loss of a well-planned, much-awaited pregnancy. Names are fictitious; although the events are not the exact events described by any specific individual or couple, they represent actual experiences.

Exemplar: Loss of the well-planned, much-desired pregnancy

Kurt and Anna waited almost 6 years to start a family. She was 30 and he was 32. They were deeply frustrated when it turned out that getting pregnant was more challenging than they had anticipated. After 6 months of trying, they were both assessed for infertility. Findings were inconclusive. Finally, after 9 months of trying, Anna’s period did not come at the expected time. Both knew that things could go wrong in the first 3 months and planned to keep news about the pregnancy private. However, when Anna uncharacteristically ordered a soft drink instead of wine while dining out with friends, they immediately caught on. After that, according to Kurt, “Everyone from Seattle to Minneapolis knew!” Kurt and Anna reveled in the early weeks of pregnancy, read books about expectancy, and nicknamed their baby “George.”

At 10 weeks gestation, Anna noticed that her breasts were no longer tender and for a fleeting moment thought it a bit odd. At 12 weeks, early on a Friday afternoon, Kurt accompanied Anna on her second visit to their midwife. They were unable to detect a heartbeat using a Doppler stethoscope. When the midwife asked if there was any chance their dates were off, a shiver of fear ran through Anna. An ultrasound exam confirmed their worst fears. The baby had no heartbeat and did not appear much larger than an eight-week old fetus. A dilatation and curettage (D&C) was scheduled for the following Monday. All weekend, Anna claimed that she kept trying to figure out if there was any way she might have miscalculated her dates. She described riding a hope-no-hope roller coaster. Saturday, early in the evening, Anna had mild cramping and dark spotting. Very early Sunday morning she woke up with severe cramping and passed “gobs of blood and tissue.” They scooped a less-than palm-sized mass from the toilet and called the emergency room. They were told to come in and to bring the collected tissue with them. Anna underwent a D&C in the emergency room. By sunrise they were homebound and no longer expecting their firstborn.

Eight days later when I first met Anna, she was polite but reserved. I began the counseling session with, “How are you doing?” She replied, “Well, it all happened 8 days ago, first I bled at home, then we went to the ER.”

As she told her story, I listened carefully and probed specifically for Anna’s own words to describe what she lost. At one point she said, “I know it doesn’t make much sense, but I feel like I lost someone I loved. But how can that be? I am not so sure it even made it to the stage of officially becoming a fetus.” I said, “It sounds like you lost your baby.” She responded, “Yes. It was our baby; it was ‘George.’ We talked to him at night. Kurt brought home a Mariner’s hat for the baby and said, ‘Boy or girl, either will be fine, as long as George

knows the right team to root for!’” I asked her to think about when Kurt became her husband and reminded her that it was actually at the point she turned to him and declared her acceptance of him as her husband that he acquired that role in her life. So, too, did George become her baby when she named and accepted George as a member of her family.

Anna cried frequently during that first session. She told me that she could not believe how overwhelmed she had felt since her miscarriage and described being overcome with bouts of uncontrollable sobbing. Her fear was that she would not be able to stop feeling so bad. I told her it had been my observation that the first couple of weeks after the loss were especially difficult because of hormonal disruptions. In effect, she was experiencing “post-partum blues” and she had good reason to feel sad. She looked quite relieved when I assured her that as soon as her body returned to its pre-pregnancy state she would shift from feeling like the sadness owned her to feeling like she owned the sadness.

I suggested that she and Kurt consider doing something to memorialize George. Anna looked intrigued and asked what I meant. I asked her to consider what they might do to honor their baby. I told her that I had planted a pink rosebush in memory of the daughter I miscarried. I knew of others who went to special places, such as mountains or lakes, and said prayers. Some women wrote poems. Others composed letters to the child. While I encouraged her to think about what might work best for her and Kurt, I suggested that they not rush to “fulfill an assignment” but instead wait until the moment seemed right.

As we closed the session, Anna said she knew she really wanted a baby but didn’t know if she could go through this again. She asked my advice on when to try again. I assured her there would be a time to try again and promised we would talk more about that in the next session. I recommended that, in the meantime, she and her husband not avoid intimacy, but that they avoid pregnancy until her menstrual cycle returned to normal. I also suggested that she not consider getting pregnant again until she could accept the reality that her chances of miscarrying again were the same as before this loss. While this advice seems blunt, it is a fairly effective way to enable women to take control and decide for themselves when they are ready to try again.

We met again 4 weeks later. This time Kurt came along. They arrived holding hands. I began by checking with Anna about her physical well-being. She said that she had finished her period about a week ago and was starting to feel more like herself. I asked her what it was like to menstruate this time. She replied, “Hard! What a strong reminder that I was no longer pregnant!” She said her flow was heavier with more clots than usual. I assured her that her response to menstruating was quite common and explained that for many women getting their first period after miscarrying could be quite difficult. Some women feel traumatized by seeing vaginal blood again and experience flashbacks to the events surrounding their miscarriage. Other women describe being scared because it suddenly occurs to them that their body is now ready to conceive again. Still others take comfort in menstruating because they see it as the body’s way of assuring them all is well. Many women describe their first cycle after miscarrying as coming later than expected, with heavier flow, more clots, and more cramping.

I then asked Anna how she was doing emotionally. She looked at Kurt and replied, “It is still hard, I find I am just not able to concentrate

at work. I am also having a real hard time being around Kurt's family. Both of his sisters-in-law are pregnant. One of them already has a 2 year-old son." Kurt added, "It is so hard to see Anna this way. Last night I came home from work and found her crying in front of the television. The news announcer had just shared that her male co-anchor was home enjoying his newly born son. The first words out of Anna's mouth were, 'I am so sorry, Kurt. I just keep wondering if you will ever get to take some days off to take care of our baby.' It just tears me up inside to see Anna beating herself up this way!" Anna's experience of having difficulty being near pregnant women, babies, or hearing birth announcements is very common. We discussed how Anna could handle her need to heal and give herself permission to take time away from Kurt's family.

I reassured both of them that Anna's sudden and unexpected bouts of crying and questioning were part of grieving. I said,

This kind of grieving, while hard, is a necessary process. Our hearts and minds operate on their own schedule and they need time to make sense of the seemingly senseless. Sometimes when it seems that only the mind is aware of the loss, it is possible to talk about the events of miscarriage in an almost unfeeling way, giving the appearance that you are doing pretty well. Some people might even question if you are "in denial" because you talk so calmly about such difficult things. When the heart feels the pain, you can behave in an almost mindless fashion. These are the days when it seems you just can't get anything done and you find yourself emotionally exhausted. When both the heart and the mind are fully in touch with the pain, you may feel overwhelmed. Each one of these states—intellectual awareness, mindless heartache, and heartfelt awareness—are all part of making the unreality of having a miscarriage become a real part of your life's story.

In this second session, we focused on how Kurt and Anna were able to share their loss. Kurt said his biggest concern was Anna. He acknowledged that it was really difficult to not have things turn out the way they had hoped, but he said he was more worried about Anna than sad about the baby. I asked what he felt he lost in the miscarriage. He thought for a few seconds and said,

I can't really say that it was as real to me as it was to Anna. It makes me angry that we waited so long, tried for so long, got pregnant, and then lost it all. They say it was probably a pretty random thing and the chances of it happening again are the same as before, not any greater. Of course, having been on the downside of one statistic, you do get a bit concerned. To tell you the truth, when I look at the bright side, at least now we know we can get pregnant. For a while there, I was wondering if that would ever happen.

Anna's response when Kurt talked was to hold his hand and nod. I said, "Anna, you were very clear that you lost a baby. Kurt, you seem not as firm on claiming that as your loss. How are the two of you with that difference?" Kurt jumped right in, "It was growing in her body, I think the whole thing was more real to her. Now that it is over, I think she really feels something missing. For me, I want a baby, but I guess I see this as more of a setback. I just want her to feel better and not be so hard on herself." Anna said she was comfortable with their different views and that she relied on Kurt's positive attitude. I then asked Kurt to tell me what it had been like for him to witness the miscarriage. He replied,

Really scary! It was so hard to stand by and watch her in pain and bleeding. I wanted to take her to the ER when she started spotting the night before. I couldn't believe it when they said to take it easy and come in if the bleeding got worse. I thought, "How much worse? How am I supposed to know what worse means?" When I drove her to the ER, I kept thinking, "Is she going to be okay?" The toilet was so filled with blood, I honestly wondered if she was going to pass out before we got there. When they said she needed a D&C, I thought, "So now they are going to scrape her. How much more can she handle?"

I asked Kurt, "Did you ever fear that you might lose Anna during all of this?" His eyes filled with tears and he said, "Yes, and I knew I couldn't handle that." Anna looked at him with amazement and said, "You never told me that. Did you really think you might lose me?" Kurt, looking almost relieved said, "Yes, Honey, I just want you to be okay." With that they both cried. I assured them that Kurt's response did not surprise me. As women, we are used to dealing with menstrual blood flow and cramps. Although miscarriage can be physically difficult, our tendency is to be more overwhelmed by what is lost than how it is lost. Partners, on the other hand, often need to be protective and in control—in a very uncontrollable situation. When the physical crisis is over, they often believe the worst is over. I complimented them for not judging the other's sense of loss. We then talked about how they could comfort each other. Anna said she needed to talk, be held, and allowed to cry. Kurt said he needed to quit rushing around. He also said he missed Anna, and wanted his partner back.

The discussion turned to their relationship. I asked them whether they had been able to resume intimacy. Kurt replied, "Initially I was afraid to touch her, so it was real okay to just cuddle." Anna added, "After about a week I told him I guess I really needed the closeness, so we started to make love." They seemed uncomfortable and Anna said, "Actually, it's kind of strange, but since I finished my period, I am reluctant to have intercourse." I asked if she was afraid of getting pregnant. "Yes!" She replied, "Oh, the thought of going through all of this again is more than I can handle." I asked if they were using birth control. They both groaned, "Why would we? It takes us so long to get pregnant that it seems ridiculous to use anything." We talked about balancing their needs for intimacy with their readiness to try again. They agreed that although they wanted another pregnancy, they needed to wait. They said they would consider using condoms for at least the remainder of this cycle.

We then talked about the responses of others to their loss. Both Anna and Kurt were disappointed in his parents' and siblings' responses. Kurt said he knew they meant well, "But mine is just not a talk-it-all-out family." Anna's parents lived far away. They called twice and sent flowers. Anna felt considerable comfort from a neighbor who also had miscarried in her first pregnancy. Anna said, "She didn't have to say anything. I could tell by the tears in her eyes that she knew how much it hurt." Anna felt patronized when a co-worker said, "Well, at least now you know you can get pregnant!" I asked her why a similar statement from Kurt was comforting. She replied that he knew what she was going through and it was more like he was holding on to hope for the two of them.

Our third session took place about 6 weeks later. Anna came alone. She immediately announced that the previous weekend they had bought a flowering plum tree in George's memory. They planted it in view of their kitchen table. Anna said, "This way George will always be [within] ear-shot of our dinner conversations."

She was feeling better and quite hopeful for the future. In fact, she believed that she was ovulating and reported they were actively "trying again." I asked how that felt. She said,

Both scary and exciting. I remember when you said not to try again until I could accept the fact that my chances of miscarrying again were one in five. At the time, that sounded awful. Now, okay, one chance in five for another miscarriage means four out of five for a baby. We want a baby. So this is how we get there. Anyway, I figure it will take us a few months, so I'm just trying to relax and figure if it happens right away—great! If not, that's okay too.

She went on to tell me how she wasn't really sure how she would respond if she did get pregnant. She said that she was torn between holding back or loving the baby. I asked her if she really believed she could control the love. She said, "Probably not, but I know I will be a nervous wreck!" We then talked about how to deal with the potential anxiety while not holding herself back from any joy that might be available to her. I asked about her normal ways of dealing with hard times, such as reading about situations she was facing, meditating, praying, or "handing it all over to a higher power." Anna said she was going to need close monitoring (as many ultrasounds as could be negotiated), so I suggested she find a care provider who would be willing to work with her. She also said she knew she needed exercise and relaxation to keep her anxiety in check.

Anna then said,

You know this was really hard, and I wouldn't wish this on anybody. But I must admit some good came from it. It made me realize just how much Kurt and I have going for us. It also made me more aware of what women go through when they miscarry. Before mine, I had no idea. And I learned ... I am a pretty strong person. I agreed to try again because I know I survived it once, and I will again if I have to. I can get pregnant. That is something I did not know before.

I asked her when the good times started to outweigh the bad. She replied, "I guess it really took me a couple of cycles. After I got my second period, I realized everything was back on track. We didn't really talk about pregnancy again until I got my next period. After that, I brought it up at dinner one night. He said, "Are you sure?" and I said, "I guess as sure as I am ever going to be."

Approximately 14 months later I received a birth announcement from Kurt and Anna. She wrote,

We are so happy. We look at Meghan and think, "How did we ever get so lucky!" Sometimes I think about our miscarriage and realize how strange it is that if I had carried that first pregnancy we would not have her. On George's due date we had a picnic under the plum tree and let the tears flow. How odd it was to be expecting and grieving on the same day. Every once in awhile I think about what George might have been like, but it doesn't hurt as much anymore. I guess this is the way it was meant to be.

Discussion

In the last few years an increasing number of descriptive cross-sectional and longitudinal surveys of the effects of pregnancy loss on individuals and couples have been reported. These studies have consistently documented the following. (a) Women grieve more actively, openly, and longer than do men (Theut et al., 1989; Theut, Zaslow, Rabinovich, Bartko, & Morihisa, 1990; Goldbach, Dunn, Toedter, & Lasker, 1991; Beutel, Willner, Deckardt, von Rad, & Weiner, 1995). (b) Women with later loss, i.e., more than 20 weeks gestation, have more depression and longer grieving than do women with earlier perinatal loss (Goldbach et al., 1991; Lasker & Toedter, 1991; Theut et al., 1989; Toedter, Lasker, & Alhadeff, 1988). (c) In samples restricted to women who miscarry before 20 weeks, gestational age at loss usually does not make a difference in intensity or duration of grief, anxiety or depression (Jackman, McGee, & Turner, 1991; Neugebauer et al., 1992a, 1992b, 1997; Prettyman, Cordle, & Cook, 1993; Thapar & Thapar, 1992; Tunaley, Slade, & Duncan, 1993). One exception is the

study by Beutel, Willner, et al. (1995) which clarified that miscarriage at a later gestational age was correlated with extended grieving but not with prolonged depression. (d) Compared to equivalent age groups of women in their childbearing years, women who miscarry have an increased incidence of anxiety, depression, and grieving that lasts from days to years (Beutel, Deckardt, vonRad, & Weiner, 1995; Cecil & Leslie, 1993; Cordle & Prettyman, 1994; Friedman & Gath, 1989; Garel, Blondel, LeLong, & Kaminski, 1993; Garel, Blondel, Lelong, Bonenfant, & Kaminski, 1994; Goldbach, Dunn, Toedter, & Lasker, 1991; Hamilton, 1989; Malmquist, Kaij, & Nilsson, 1969; Neugebauer et al., 1992a, 1992b, 1997; Prettyman, Cordle, & Cook, 1993; Robinson, Strirtzinger, Stewart, & Ralevski, 1994; Statham & Green, 1994; Thapar & Thapar, 1992; Tunaley, Slade, & Duncan, 1993).

The findings of the Miscarriage Caring Project indicate that while many of the responses to miscarriage healed with time, early intervention decreased overall emotional disturbance, anger, and depression in the first year after miscarriage. Further research is necessary to determine how caring might be offered in ways that are most sensitive to the diversity of women's and couples' experiences. An acknowledged limitation in the Miscarriage Caring Project and the studies leading up to it was that the women studied were predominantly Caucasian, partnered, and born in North America. Participants with diverse backgrounds in ethnicity, marital status, and sexual orientation were too few in number to generalize beyond the experiences of their personal stories.

Kurt and Anna's story exemplified many of the common responses to miscarriage. Like so many others who miscarry, they lost and gained, shared the loss, went public, got through it, and tried again. The uniqueness of each couple lies in how those experiences are played out in the contexts of their lives.

In using the Caring Theory, I began by trying to know what it was like for each of them to miscarry. Understanding their story (*knowing*), I couldn't help but emotionally respond. By my attentiveness and genuine responses, Kurt and Anna knew that what happened to them really mattered to me (being with). I listened for times when they avoided a difficult topic. Sometimes I put into words what they seemed unable to say ("Kurt, were you afraid of losing Anna?"). By my saying the difficult things out loud (doing for them what they seemed unable to say themselves), we were able to unleash some privately held, intrusive, discomfoting thoughts, thus enabling them to validate reality by talking it through, offering relevant information, and figuring out how to deal with the depth and harshness of their experience. Ultimately, just talking through the whole experience with a provider who maintained belief in their capacity to acknowledge, talk about, and make meaning helped Kurt and Anna find their own way of resolving the unexpected early ending of their first pregnancy.

Conclusions

As demonstrated in this program with multiple modes of inquiry, responses to miscarriage are closely tied to the deeply personal meaning individuals and couples hold about what it is like to be

expectant and to abruptly lose that pregnancy. The case study may be considered a prototypical example of the experience of a married couple who lost a planned, greatly desired pregnancy and who ultimately conceived and gave birth. The exemplar, while not unusual, can be misleading if it is interpreted as normative. The responses may differ with other participants; for example, an adolescent mother experiencing her second miscarriage, a surprise pregnancy experienced by parents of a 3-month-old child, a lesbian couple expecting their second child, an undesired pregnancy in a 25-year-old mother of five, a childless woman with recurrent miscarriages, a couple unable to support each other through the loss, and so on. The caring theory is offered as a model of providing care that is sensitive to the multiple potential meanings attributed to miscarriage. The program of research indicates that the events of expectancy and loss are uniquely experienced in the context of each woman and couple's lives. 

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