

CONFRONTING THE INEVITABLE: A CONCEPTUAL MODEL OF MISCARRIAGE FOR USE IN CLINICAL PRACTICE AND RESEARCH

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In spite of scientific evidence that miscarriage has negative psychological consequences for many individuals and couples, silence and dismissal continue to surround this invisible loss in North American culture and beyond. The grief and sorrow of miscarriage has important implications for clinical practice. It indicates a need for therapeutic interventions delivered in a caring, compassionate, and culturally sensitive manner. This research, based on data from 3 phenomenological investigations conducted with 42 women from diverse geographical locations, sexual orientations, and cultural backgrounds offers a theoretical framework for addressing miscarriage in clinical practice and research.

Miscarriage, a common loss confronting couples of reproductive age, requires compassionate responses and supportive care (Brier, 2008). Defined as an unplanned loss of pregnancy prior to the point of expected fetal viability, miscarriage is estimated to occur in 12% to 32% of all pregnancies (Cramer & Wise, 2000). Given the number of unreported or unrecognized miscarriages that occur 2 to 4 weeks after conception, some have asserted that the true rate is closer to 50% (Speroff, Glass, & Kaswe, 1999). Most women experience miscarriage as a traumatic, unforeseen, and unwelcome

Received 27 July 2009; accepted 27 February 2010.

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event (Beutel, Deckardt, von Rad, & Weiner, 1995). Although some are relieved when they miscarry (Madden, 1994), the majority of women perceive they have lost their baby and respond with distressed responses that may include grief, anger, depression, anxiety, self-blame, or guilt (Adolfsson, Larsson, Wijma, & Bertero, 2004; Cecil, 1994; Gerber-Epstein, Leichtentritt, & Benyamini, 2009; Janssen, Cuisinier, Hoogduin, & DeGraw, 1996; Nikcević, Kuczmierczyk, & Nicolaidis, 1998; Swanson, 2000; Swanson, Connor, Jolley, Pettinato, & Wang, 2007; Wojnar, 2005, 2007). Partner and social support have been consistently linked to women's ability to effectively cope with pregnancy loss (Adolfsson, Bertero, & Larsson, 2006; Ney, Fung, Wickett, & Beaman-Dodd, 1994; Swanson, Karmali, Powell, & Pulvermakher, 2003). Lack of social support and the failure of practitioners to offer compassionate care have been associated with prolonged emotional distress (Black, 1991; Bryant, 2008; Cecil, 1994; Puddifoot & Johnson, 1997; Reed, 1990; Van & Meleis, 2003; Wojnar, 2005, 2007).

The predominance of inquiry pertaining to women's emotional responses and recovery subsequent to miscarriage has been at the descriptive, predictive, and interpretive levels. There are a few intervention studies (Swanson, 1999a, 1999b; Swanson, Chen, Graham, Wojnar, & Petras, 2009) that provide evidence indicating women benefit from the opportunity to discuss their experiences with an empathetic practitioner. One promising theoretical framework to guide content for therapeutic interventions has been Swanson's phenomenologically derived Meaning of Miscarriage Model (Swanson, 1999b; Swanson-Kauffman, 1983, 1986). During the first year after loss and in two separate randomized controlled clinical trials, one with women (Swanson, 1999a) and the other with couples (Swanson et al., 2009), interventions guided by topics from the Meaning of Miscarriage Model led to significantly faster rates of grief resolution for couples as well as less depression, anger, and overall disturbed moods for women. Phenomenological studies (Adolfsson et al., 2004; Wojnar, 2005, 2007) conducted with different populations have supported and expanded Swanson-Kauffman's (1983, 1986) original Meaning of Miscarriage Model. These recent interpretive studies bring new insights that take into consideration experiences of women beyond the original 20 married heterosexual women Swanson interviewed over 25 years ago (Swanson-Kauffman, 1983, 1986).

Purpose

The purpose of this article is to present a theoretical model of what it is like for women to miscarry. The model was synthesized from three aforementioned phenomenological studies conducted with women from the United States, Canada, and Sweden (Adolfsson et al., 2004; Swanson, 1999b; Swanson-Kauffman, 1983, 1986; Wojnar, 2005, 2007). This synthesized model provides insight into women's lived experiences of unexpectedly losing their pregnancy prior to the point of expected fetal viability and provides evidence that there may be universal challenges associated with miscarriage and its aftermath, at least for these participants.

Background Studies

Three separate phenomenological studies contributed data that were included in the analysis that led to the synthesized model of miscarriage described here. They were conducted with women who experienced miscarriage and lived in the United States, Canada, and Sweden.

Swanson-Kauffman (1986) published one of the earliest descriptive phenomenological studies of miscarriage. In 1983 she conducted two in-depth interviews with 20 married women (18 Caucasian, one Latina, and one African American) who were within 4 months of having miscarried at 20 weeks gestation or less. Participants had a history of one to seven miscarriages. As was common medical practice at that time, all but one underwent dilatation and curettage. Some, but not all, were told that they would go through a grief process. None received supportive counseling, and most were told they should wait 3 or more months to try again. From this study, Swanson-Kauffman (1983) developed the Meaning of Miscarriage Model. It was a substantive model that described six common challenges experienced by the 20 women she interviewed: (a) coming to know—the confusing, painful process of balancing the mounting evidence of impending loss against hopes for a healthy pregnancy outcome; (b) losing and gaining—understanding and naming for oneself just what was lost and/or gained through miscarriage; (c) sharing the loss—identifying who is, or is not, available to acknowledge and share in the loss; (d) going public—returning to a fertile world as a no longer pregnant

woman; (e) getting through it—doing the physical and emotional work that it takes to get through the days and weeks after miscarriage; and (f) trying again—conceiving again (or not) while facing the ongoing fears of future loss (Swanson, 1999b; Swanson-Kauffman, 1986).

Since publishing her original phenomenological research, Swanson (1999a) described how the model could be used in clinical practice with couples. She also conducted two randomized controlled clinical trials using the Meaning of Miscarriage Model as the content for several caring-based interventions (Swanson, 1999a; Swanson et al., 2009).

Adolfsson et al. (2004) published a phenomenological study of 13 Swedish women who experienced from one to five miscarriages. Twelve were married, and one was single. Their ages ranged from 22 to 47 years old. They all came from a small town or surrounding rural areas; four were unemployed. Nine women underwent dilation and curettage; none received mental health counseling. Women were invited to participate in Adolfsson's et al. study after receiving care for miscarriage at a local hospital. Consistent with the phenomenological approach, the principal investigator conducted in-person interviews with women about their personal experiences of miscarriage. The central themes of Adolfsson's et al. analysis were "guilt" and "emptiness". Each woman felt guilt that her body had miscarried. Women searched for the cause of miscarriage in their actions. For example, they wondered if it was something they might have eaten or done. After miscarrying they experienced a feeling of emptiness. There were five subthemes: (a) feeling emotionally split, (b) bodily sensation, (c) loss, (d) grief, and (e) abandonment. The experience of abandonment in the Swedish sample indicated that women often felt misunderstood by their partner and disrespected by their care provider. Women felt they lost more than a fetus; they talked about having lost their dream of motherhood, a planned future with their baby, and the immediate status of being a pregnant woman. In a subsequent study, Adolfsson et al. (2006) offered a supportive intervention to women who miscarried using Swanson's (1991, 1993, 1999b) middle range theory of caring and the Meaning of Miscarriage Model as their theoretical frameworks. Findings indicated that women who received emotional counseling and a follow-up visit with a midwife experienced less distress than a comparison group.

Wojnar (2005, 2007) studied the experience of miscarriage from the perspective of 10 couples who self identified as lesbian, were in a committed couple relationship, and miscarried within 2 years of enrollment. They experienced anywhere from one to four miscarriages. They came from British Columbia, Canada, as well as the northwestern, northeastern, and southwestern United States. All had high school or higher education and had been in a committed couple relationship from 2 to 15 years. Four women underwent dilatation and curettage; the remainder waited for nature to take its course. All received some form of emotional support from practitioners after the loss, but the majority claimed it was insufficient. In the study, they participated in three interviews: First, women who miscarried and their partners were interviewed separately to gain insight into their individual experiences. Subsequently, they were interviewed together to better understand their couple experience.

Wojnar (2005, 2007) discovered that before one can appreciate what it is like for lesbians to miscarry, the unique circumstances that surround conception must be understood. The challenges encountered by lesbians include (a) confronting internalized homophobic attitudes about entitlement to have a family with children, (b) negotiating which partner will become the biological mother, (c) conceiving through means outside of the couple's intimate relationship, (d) locating a sperm bank with the "right" sperm or locating a donor that is acceptable to both mothers, (e) confronting judgments from some factions both in the lesbian and heterosexual communities about conceiving and raising children in the context of a lesbian relationship, (f) tolerating judgmental responses from some clinicians, (g) dealing with the lack of biological substantiation of the co-mother, and (h) living with uncertainty until such time as the co-mother's legal adoption of her child is completed. Hence, to appreciate the lived experiences of lesbians who miscarry one must also consider their unique plight of having to deal with societal sanctions regarding the entitlement of lesbian mothers and their partners to feel the joy of expectancy or sadness of miscarriage.

The overarching theme of the phenomenological model proposed by Wojnar (2005, 2007) was "We are not in control." This core experience captured the struggles that lesbians face when conceiving and losing their pregnancies. There were two

subthemes: “We work so hard to get a baby” and “It hurts so bad: The sorrow of miscarriage.” These subthemes indicate that the experience of lesbian miscarriage is compounded by the complexities of planning and achieving pregnancy as a same-sex couple.

There were five predictable stages informants went through during the miscarriage experience: (a) the hope–no hope ride—dealing with the threat of pregnancy loss; (b) living through the crash—experiencing physical and emotional trauma of miscarrying; (c) we were pregnant, and now we are not—letting the world know and receiving comments; (d) clarifying what matters most—identifying losses and gains; and (e) moving on—trying again or seeking alternatives. For the most part, these findings were consistent with Swanson-Kauffman’s (1983, 1986) research with heterosexual women from more than 25 years ago. A unique finding was that lesbians experienced a lack of control that began with the challenges surrounding conception and culminated with the sequence of events that unfolded subsequent to miscarrying. Wojnar (2005, 2007) also found that lesbian partners’ experience of miscarriage, although traumatic, often included awareness that their grief in its intensity, duration, and expression was different from their partner’s. Consistent with findings of prior research that the baby in the first or second trimester of pregnancy is generally less real to men than to their pregnant partner (Jordan, 1990), they tended to experience miscarriage as a loss of personal dreams, aspirations, and stability in the ongoing relationship with their mate, rather than the loss of a child *per se*. These feelings were often potentiated by the painful awareness that they lacked any biological or legal entitlement to their future child. Moreover, the legitimacy of their loss and grief was typically dismissed by practitioners, friends, family, and community. For the purpose of this investigation, only data obtained from the biological lesbian mothers who miscarried were used.

Methods

Descriptive phenomenology (Husserl, 1954/1965, 1970) was selected as a theoretical framework to guide synthesis of findings from the three background studies. Descriptive phenomenology is grounded in the belief that it is possible to discover “universal”

truths (essences) about the phenomenon under investigation and that individuals who have experienced the phenomenon have important knowledge and insights to contribute. Drawing from the Husserelian (1954/1965, 1970) philosophy of pure phenomenological description and relying on the four steps of Swanson-Kauffman and Schonwald's (1988) methodology, we reexamined data across the three background studies to describe events commonly encountered through miscarriage and the ways in which women experience those events. The four steps included (a) bracketing, (b) analyzing, (c) intuiting, and (d) describing. Although steps are presented sequentially, the method is a circular process. *Bracketing* is the researcher's attempt to set aside assumptions and preconceived notions about the phenomenon under investigation. *Analyzing*, the second component, involves multiple readings of transcriptions, coding for possible meanings embedded in informants' stories, and comparing coded data across informants for essential features of the phenomenon of interest. This step leads to a preliminary theoretical model. To verify whether the drafted model is a plausible reflection of the universality of experiences, critique is sought from individuals who have either lived or intimately witnessed (e.g., health care providers) the phenomenon. The third strategy, *intuiting*, is a deeply reflective process whereby the investigator becomes sufficiently absorbed in the experiences, struggles, and meanings of the informants that the phenomenologist empathetically comes to realize the other's plight as if it were her or his own. The fourth strategy, *description*, involves presenting the model (the claim) with sufficient evidence (quotes) to convince the audience of the model's empirical merits. Selection of what stays in the final model is based on what concepts or processes are common to the accounts provided. Producing a comprehensive model that parsimoniously captures the phenomenon mandates that the researcher achieve creative balance between bracketing (critical detachment), analyzing (data management), and intuiting (empathetic engagement). Although the strategies described here depict distinct steps in the phenomenological method, each moment of the descriptive phenomenological research process includes a blend of bracketing, analyzing, intuiting, and describing (Swanson-Kauffman & Schonwald, 1988).

In this investigation, bracketing was enacted as purposeful relinquishment of the superiority or inferiority of findings from

any of the three background studies. This was accomplished by putting up for scrutiny convictions held by each co-investigator about the key tenets of their previously derived models. The investigators held each other to the standard of producing sufficient data from all three samples to substantiate claims. For example, in Adolfsson et al.'s (2004) Swedish study, guilt after miscarriage was one of the core concepts. Swanson-Kauffman (1983, 1986) and Wojnar (2005, 2007) reported meager evidence of transient guilt in a couple of their informants. Because the concept of guilt was not central to the three samples it did not get a central position in the emerging revised miscarriage model. Likewise, the compelling challenges found in conceiving and being pregnant experienced by lesbians in Wojnar's (2005, 2007) study, though previously described in research investigating miscarriage after infertility in heterosexual couples (Freda, Devine, & Semelsberger, 2003), was not a central concern in Swanson-Kauffman (1983, 1986) and Adolfsson's et al. (2004) research. It was, therefore, relegated to a more peripheral position in the combined model. In contrast, after careful consideration of data across the three studies it became clear that Wojnar's (2005, 2007) central theme—"We are not in control"—was very relevant to the other two data sets.

Analyzing consisted of evaluating the three background models, going back to the original transcripts, and reviewing specific quotes for supportive evidence of the emerging synthesized model. Once consistencies in findings were identified across the three samples and exemplary quotes were selected, a preliminary model of the essential elements of miscarriage was drafted.

The intuitive phase was integral to developing a final model. It consisted of struggling through competing claims, going back to the data, realizing "aha" moments of consensus, drawing on the authors' clinical practice and personal life experiences, and arriving at common themes across the three data sets. Fusion of the three models led to a new whole that was more complete than its contributing parts.

The last process, describing, resulted in the miscarriage model depicted in the subsequent section. The stages of miscarriage became more clear and logical as we illustrated them both pictorially and textually.

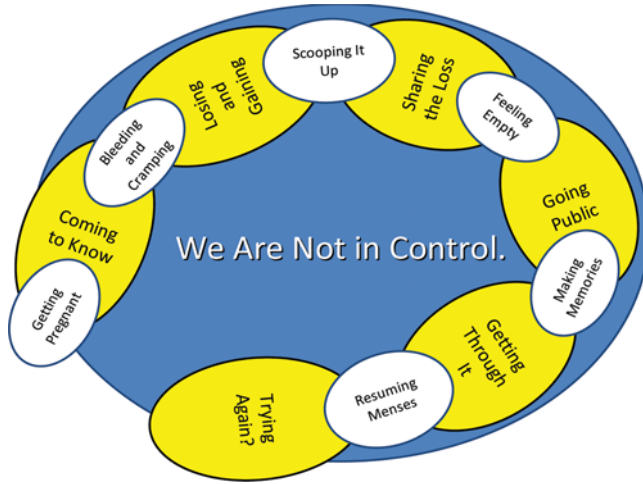


FIGURE 1 Miscarriage: Confronting the inevitable. *Note:* The small ovals represent common events and the larger ovals represent common experiences for the participants in these samples (color figure available online).

Results

Data provided by 42 women were used to produce the theoretical model “Miscarriage: Confronting the Inevitable.” It depicts the common experiences and events encountered by study participants.¹ As illustrated in Figure 1, when miscarriage occurred participants found themselves facing a cascade of challenging events and experiences that were beyond their control. The overarching theme—“We are not in control”—describes what it feels like to miscarry. It refers to the feelings of helplessness, powerlessness, and lack of control over sustaining pregnancy and living through the unexpected loss of pregnancy prior to the point of fetal viability. For example, over 25 years ago a married woman stated, “Loss of control encompasses it all . . . the planning, all the hope, the one thing that you want so much to control—you don’t. It is devastating. It just comes out of nowhere and gets you.” (Swanson-Kauffman, 1983, p. 186). From the same sample another

¹The term *inevitable* refers only to the experiences of women who participated in our three studies. The results described herein may not be inevitable for other women. See Limitations for additional remarks on this point.

woman stated, "It's something you hope for and all of a sudden, it's just wiped away from you . . . and you don't have no cure for it. I've been through hell." (Swanson-Kauffman, 1983, p. 187). Similarly, in 2005 one woman summed it up: "Our fertility, our getting pregnant, and losing our babies is beyond our control. We want to think we are in control, and maybe to a small extent we are, but really, stopping a miscarriage is beyond our control" (Wojnar, 2005, p. 70).

In order to truly understand the significance of miscarriage one has to recognize the meaning women attribute to the prospect of impending motherhood. Whether pregnancy was planned or unplanned, conceived through sexual intercourse or alternative means, the experience of miscarriage was framed by women's unfolding maternal identity. *Getting pregnant* refers to the events surrounding conception and early pregnancy. One Swedish informant explained,

We tried to get pregnant for more than a year. When we became pregnant it felt very good. It was the most happy day in my life. It was only then that I became happy. I felt, we have finally succeeded. I have always wanted a child. (Adolfsson et al., 2004, p. 1)

The Swedish woman's experience was consistent with the experience of one Canadian woman who recalled,

We were overjoyed with pregnancy news but I had problems with my progesterone levels from the beginning so I knew in my heart that our baby was in trouble though I never fully admitted it to myself or to others and I coped as best as I could until I miscarried. (Wojnar, 2005, p. 86)

How women come to grips with the reality of loss is captured by the experience of *coming to know*, which refers to the woman's realization that something is wrong. It involves contrasting the mounting evidence of impending loss against hopes of keeping the pregnancy and becoming a mother. Coming to know is characterized by moving through a series of hope/no-hope cycles that culminate with confirmation that the pregnancy is not viable. In the early 1980s one mother, an ultrasound technician, described,

At a certain point during work, I had a feeling "I'm losing this baby." I immediately put it out of my mind and I thought "No, I am not. No, I am not." Later, after everyone left, I scanned myself at work with nobody

else there. This was really interesting. When I looked in my uterus, it was a 12 week size, and I knew that, and I looked at the baby and I can't believe I did this, but I convinced myself that there was a heartbeat. I thought it was a little irregular and that the baby was a 12 week size. And it wasn't. And I knew it wasn't. But I told myself: "Everything's fine." (Swanson-Kauffman, 1983, pp. 169–70)

Although women with prior miscarriages may have more rapidly assessed what was unfolding, they still held out hope that this time it would be different. For example, in 2005 one woman remembered: "The second time around when I started cramping I knew right away what was going on and it was a horrifying experience. But, I still tried to convince myself it would go away if I just lie down and rest" (Wojnar, 2005, p. 15).

Bleeding and cramping were the physical symptoms that accompanied the coming to know challenge. Although the severity and range of physical symptoms varied from woman to woman, it tended to be a frightening, uncontrollable, and uncomfortable physical confirmation of the inevitability of loss. One Swedish mother recalled,

I knew if it became fresh light red bleeding I needed to call, and it did on Wednesday evening. I felt then that I was miscarrying. I called the emergency ward and they said to come in and they would do an ultrasound. It was there, the fetus was there, is what the obstetrician said. It was good news. But then when the bleeding kept going on and became stronger, and there was pain, I understood what was happening. (Adolfsson et al., 2004, p. 4)

The pain could be very intense. In 2005 one woman described,

There was just this incredible physical pain. So I was like "Ok, I am just going to try to breathe deeply and it was the only respite I had from the pain." And I got clammy and cold. I mean "shocky," I think. It was pretty scary. And then, just like that cramping stopped and I instantly felt better. And I hoped against all odds that it was just a bad food poisoning. And maybe five minutes later, I started bleeding. And I just knew I was miscarrying. (Wojnar, 2005, p. 93)

Losing and gaining captured the highly emotional experience of identifying for oneself just what was lost and gained through miscarriage. Across the three data sets, the majority of informants

equated their miscarriage with the loss of a baby. One woman shared,

For me miscarriage represented mostly a loss of a dream, in terms of things like my identity has been shattered, because my identity has always been wrapped up in the idea of me becoming a mother whether the baby was going to come from me or from her. (Wojnar, 2005, p. 111)

Likewise, a woman from the early 1980s study stated, “Two words, two parts, disappointment in the initial part and growth for what I have had to experience and learn and gain to get over it” (Swanson-Kauffman, 1983, p. 182). Participants from all three studies discussed ways that miscarriage impacted their intimate relationship. Although some acknowledged that the loss challenged their relationship, many believed that miscarriage brought them and their partner closer together. For example, one woman from the Southwestern United States shared, “We learned that we have a strong enough bond that we can make it through any tragedy together” (Wojnar, 2005, p. 112).

The physical events of miscarriage were frequently re-experienced as intrusive, intensely private, haunting moments. Many of the participants volunteered stories of “scooping it up.” They tearfully recounted what it was like to examine the fetal tissue for membranes, placenta, or recognizable body parts. One woman described this painful event:

I was at an important meeting that day. I kind of felt sick to my stomach and having cramps all morning. I thought I had a bad case of flu or indigestion. But, when I went to use the bathroom and started bleeding, I just knew I was miscarrying. I was scared of passing the baby into the toilet and couldn't bring myself to flush it down. I was crying and scooping it up, I was looking for it. I wanted to take it home with me. And it was one of the hardest things I had ever experienced. (Wojnar, 2005, p. 83)

A Swedish mother's story was also poignant:

Then I got a little crazy, “No I cannot flush it away.” I scooped it up and put it in a little box. No, I could not let it go, I needed to look carefully, look at what it was. It was not bigger than a five-krona piece. I was sitting and looking at it for a long time. Then I start crying uncontrollably. I thought of the baby who I never will get in my arms. Everybody said it was only a fetus or embryo but to me it was a human as soon as it started

growing, at least a baby. First I wanted to hold it for a long time, then I put it in a box with a little cotton...I could not sweep it into the dustbin. (Adolfsson et al., 2004, p. 8)

Women encountered mixed responses in terms of sharing the loss. Women consistently revealed that they wanted their loss to be shared, or at the very least recognized, by their partner or spouse, family members, health care providers, and close friends. When partners and others were emotionally available to women, the loss felt shared. A mother from the early 1980s study described how much her husband's compassionate presence meant to her:

It was like we both went through it together. It wasn't just me going through it. I can't imagine going through something like that by myself. I mean it was so hard on both of us, emotionally dealing with it. He felt like he wished he could have taken some of the physical part of it onto himself too. (Swanson-Kauffman, 1983, p. 228)

Feelings of sadness were compounded when women received less than compassionate support from their partner. For example, one mother felt isolated in the presence of her partner's matter-of-fact feelings about the miscarriage:

My partner thinks I am silly sometimes—you know, it is hard for her, because she wasn't as connected to the baby yet. I don't think she realizes the impact, when you lose something that little—but it's still a baby...I would get sad about this baby and the other babies I had lost in the past due to miscarriage. I am really still missing them. It was hard to be able to tell her, because she'd say: "Oh, don't cry you have other babies coming." (Wojnar, 2005, p. 88)

Women had mixed encounters with the healthcare system. Some found their health care providers empathetic; others did not. A woman from Swanson-Kauffman's (1983) study who felt attended to and comforted by her obstetrician stated,

During the whole weekend that I was here at home the obstetrician's office called and made me feel like I should never hesitate to call, 1:00 o'clock in the morning, whenever. It didn't matter. When I went back for the check up, he talked for a while to make sure I was doing OK. I never felt like I had just been processed through. (Swanson-Kauffman, 1983, p. 195)

In contrast, in 2005, a woman from the Southwestern United States reported,

In Urgent Care I had to see this doctor who clearly was homophobic. He was just really cold and he clearly was directing everything toward me and was dismissive of my partner. He asked: “do you want this person to stay here while I do the examination?” And I said. “Yes, I want my partner to be here with me.” He let her stay but did not say a word until the end of the visit when he said: “You are fine.” So that was a pretty nasty way to be cared for after a miscarriage. And that, pretty much, concluded the medical piece. (Wojnar, 2005, p. 97)

Similarly, another woman from Wojnar’s (2005) sample reported,

I miscarried at 18 weeks. In the hospital, on every form it went “baby boy X.,” which is my last name. So it bothered my partner very much. And even when it came to disposition of the body only I could sign, and that just broke her heart that she didn’t get to sign on it. And I kept saying “It doesn’t represent that you are not the mother” but she felt it did. (p. 98)

Feeling empty refers to the women’s comprehension that their womb had become barren. It refers to the physical void and emotional emptiness women realized for weeks or even months after their loss. One Swedish woman captured the sense of physical emptiness: “When I looked at the ultrasound scan it was only a dark empty aperture” (Adolfsson et al., 2004, p. 11). In contrast, a mother from Wojnar’s study captured the emotional vacancy:

I thought I knew what love was when I fell in love with my partner, I thought I knew what love was with my family, my mom, and my dad, and my sister—but I don’t truly think that there is anything like the love you have for your child. And so when I miscarried I lost part of my heart and experienced overwhelming emptiness. (Wojnar, 2005, p. 104)

Ultimately, women had to face the world as a no longer pregnant mother-to-be. While dealing with their sadness and emptiness, women struggled being in a world where others got to carry their babies in their womb or in their arms. *Going public* refers to the experience of living with the loss, letting others know about the loss, encountering other pregnant mothers and babies, and

dealing with responses, be they empathetic or dismissive. One Swedish mother stated,

My mother-in-law and everybody wanted to know. They had all been hoping I would become pregnant and they kept asking: "Are you pregnant?" I wanted to tell them off and say: "I have had a miscarriage, stop asking." I did not want to tell them we had been trying for several years. (Adolfsson et al., 2004, p. 7)

Likewise, a Canadian mother shared, "It was very hard on us having to share with people. It was like 'Last week we told you we were pregnant and now we are not'" (Wojnar, 2005, p. 108). Being of childbearing years, the women found it particularly hurtful living with their loss while dealing with pregnant coworkers, new babies at church, and television shows with happy expectant couples. A Swedish mother shared,

Another woman in the neighborhood got pregnant at the same time that I miscarried. They gave birth to a baby. That was the hardest. I had to congratulate them when they put their little baby in my arms and it was very hard. (Adolfsson et al., 2004, p. 3)

For some women, just hearing about losses of others was enough to re-open healing sorrows. One woman from Swanson-Kauffman's (1983) study was particularly shook up by having seen a TV personality whose pregnancy loss was public:

It was really too bad she lost her baby. And it just hit me like a ton of bricks again. This is how it sneaks up on you. Just out of nowhere. You think you're doing just really terrific and you start crying. (p. 207)

Making memories involved events, rituals, and objects that parents used to memorialize the life they carried and the significance of their unborn baby. Memories were made by simple gestures such as lighting a candle while reminiscing about the pregnancy, planting a tree or a rose bush, burying what they "scooped up" in special places, or hosting a small memorial service surrounded by family and friends. One woman from Wojnar's (2005) sample recalled,

We spread the baby's ashes in a place that is very special to us. We went out in kayaks, and deposited his ashes, just the two of us. And I feel that was a very nice way to say good bye, because now whenever we're there and we

go swimming, you know, we can feel his presence, and talk and think of him, and we both find it very healing. (p. 106)

A woman in Adolfsson's et al. (2004) study stated,

Of course I had to put it in a little box and buried it. I do not know if it was legal but I buried it in the flower bed of my parents' grave. I thought: Why not bury it in a cemetery? (p. 10)

The experience of *getting through it*, involves moving from preoccupation with the miscarriage to an emotional place where the good times in the day start to outweigh the bad. Across the three studies, women moved from finding it difficult to concentrate on daily tasks, crying, and feeling numb, to affirming stretches of time where they felt they were actually getting back to "their old selves." One woman in Swanson-Kauffman's (1983) study stated, "I am still mending. I have good days, good days and bad days...but not as often as I used to" (p. 203). Many emphasized one never gets fully over it—you get through it. For example, one of the participants in Adolfsson et al. (2004) study stated, "I don't dwell on it, but if I get pregnant, I might worry" (p. 9). An important aspect of getting through the miscarriage experience involved seeking answers to the question about why miscarriage happened. Across the three studies, women asked this question in both a concrete (e.g., Why did it happen?) and a metaphysical sense (Why me?). One Swedish mother lamented, "I am not religious but I would like somebody to answer 'why'? To me it is a mystery" (Adolfsson et al., 2004, p. 15). Although in the Swanson-Kauffman (1983) and Wojnar (2005, 2007) investigations feelings of lasting guilt hardly ever entered women's stories, in the Adolfsson's et al. sample seeking answers was often associated with guilt. Hearing from their health care provider that miscarriages occur for reasons beyond anything a woman could control, that pregnancies end because the fetus might not have been healthy, and that miscarriages are not uncommon helped women in Adolfsson et al.'s study alleviate their guilt and self-blame.

Resuming menses was an important event in women's narratives across the three studies. For some it was experienced as a flashback to the bleeding of miscarriage, for others it was a passage to fertility. Women had mixed emotions ranging from anger to

sadness to feeling relieved that their bodies finally provided physical evidence that they were able to conceive again. For example, one Canadian informant remembered, "When my menses returned I was really angry about it. I knew I could start getting pregnant again and I wanted to get pregnant but I felt like I lost my innocence about it" (Wojnar, 2005, p. 98).

Trying again is the experience of moving forward with hopes for a fulfilling future while confronting the possibility of additional losses. As women considered their next pregnancy, their fears often went beyond dreading another miscarriage; having recently experienced a loss of one kind, suddenly statistics of any kind felt threatening. Women worried about miscarrying again, not conceiving, or making an inappropriate choice to forego any further attempts at conception. For some the possibility of future loss led to a decision to avoid conception in the near or long term; for others it meant trying again as soon as possible. One woman recalled, "I was so relieved to start feeling like the old self again. I wanted to get pregnant, to start trying right away. But I was also wondering whether my body would work right. It was like questioning the fundamentals of womanhood" (Wojnar, 2005, p. 98). Launching the next pregnancy was described as an anxiety-laden time during which women weighed their own sense of healing and desires against medical advice and their fears of another miscarriage. A Swedish mother in Adolffsson et al.'s (2004) study relayed, "We are waiting to try again. We would like for everything to go well. I believe we will increase our chances if we wait for me to get back to my usual level of energy" (p. 18). In contrast, in 2005 one of the Canadian participants was somewhat philosophical:

I have two roads ahead of me and both roads would be just fine. But one road with the children—I feel more creativity and energized when I think about it, and the other road with my partner, just the two of us—I feel great about that too, but the one with children is more appealing and I would like to start trying again as soon as possible. (Wojnar, 2005, p. 117)

Some informants had become pregnant or given birth while in our studies. Of these, the majority revealed that their biggest fears subsided when they got past the gestational age of their prior loss or reached the point of fetal viability in their subsequent

pregnancy. Yet, some women continued to experience ongoing fears even after birth. For example, in 2005 one mother shared,

I wanted to become pregnant so badly but I was terrified I was going to have another miscarriage; there was hope because my fertility doctor wasn't really worried and my desire to have another child was stronger than my fears. But after I ended up becoming pregnant I was terrified about miscarrying until my twins were born. And I still can't believe sometimes they are really here and I check all the time if they are OK. (Wojnar, 2005, p. 116)

Discussion

Miscarriage: Confronting the Inevitable (Figure 1) represents the six common experiences of women who participated in our phenomenological studies of miscarriage and lived through six events that typically accompany miscarriage. Women shared their experiences of feeling not in control with regard to sustaining their pregnancy, stopping the bleeding and cramping, emptying their womb, confronting the reactions of others, or dealing with the potential outcomes of future pregnancies. Feeling not in control in the face of this inevitable cascade of events coexisted with the following experiences: coming to know, losing and gaining, sharing the loss, going public, getting through it, and trying again.

Although the exact expression of any one woman's grief was unique, there were features common to the participants. Similar to the findings of previous qualitative investigations, these features include sorrow over the loss of a baby, extinguished hopes and dreams, and a sense that oftentimes others just did not appreciate the impact miscarriage can have on an expectant mother's life (Abboud & Liamputtong, 2003; Bansen & Stevens, 1992; Gerber-Epstein et al., 2009; Harvey, Moyle, & Creedy, 2001; Letherby, 1993; Murphy & Merrell, 2009; Van & Meleis, 2003).

Why some women felt guilt after miscarriage and others did not warrants further inquiry. In some cultures, women must overcome folk beliefs that they somehow contributed to their adverse pregnancy outcomes (Layne, 1990; Schaffir, 2007; Van, 2001). In some circumstances, such as having a history of infertility, women have been described as feeling guilty that their actions had possibly brought on their miscarriage (Freda et al., 2003). Similarly, in the Swedish sample of Adolfsson et al. (2004), women were described

as experiencing guilt after miscarrying. It is possible that, in fact, the experience of miscarriage after infertility, as described by Freda et al. (2003) is different than miscarriage among fertile women. Possibly the guilt of women with a history of infertility is complicated by the distress of an inability to conceive easily by a natural means and within the context of their intimate relationship. Notably, in Wojnar's (2005) sample, lesbian couples who were also not able to conceive as a couple did not include guilt as a central issue in their narratives about miscarriage. It is possible that cultural differences regarding blame, causality, and personal culpability between North American women and Swedish women influenced a different sense of guilt across our three samples. It is also possible, however, that the differences might lie in: (a) translation of the meaning of the word *guilt* (might the English word *guilt* and the Swedish equivalent have a nuanced difference?), (b) data interpretation (might the Swedish women's queries "Why did it happen?" reflect more of a quest for meaning or, simply, a need for information?), (c) care provided to women (no women in the Swedish sample received mental health counseling), (d) timing of interviews (might it be that women from the two North American samples had already dealt with any transient feelings of guilt by the time they were interviewed?), (e) a lapse in bracketing (was it a blind spot in Wojnar's [2005] and Swanson-Kauffman's [1983] data analysis and interpretation?), or (f) other unknown factors.

Societal awareness of the impact of miscarriage and expectations for mourning subsequent to the early loss of a nonviable pregnancy continue to lag in western cultures (Callister, 2006; Layne, 1990; Schaffir, 2007). Perhaps this accounts for why the majority of women across our three samples encountered mixed reactions in terms of empathy and support from their partner, family members, health care providers, and close friends. Women's responses to miscarriage warrant supportive understanding from others. It is particularly important that healthcare providers at the time of loss and in subsequent perinatal care encounters treat women in a compassionate and culturally informed manner.

One promising model to guide clinical practice in obstetrical care or counseling is Swanson's (1991, 1993) theory of caring, which includes five processes that constitute the basic structure of caring. These are (a) maintaining belief, (b) knowing, (c) being

with, (d) doing for, and (e) enabling. Studies that have used Swanson's (1991, 1993) caring theory as a framework for therapeutic interventions with women (Swanson, 1999a, 1999b) and couples (Swanson et al., 2009) after miscarriage provide evidence that maintaining belief is at the core of effective therapeutic practice. By sustaining a hope-filled attitude, offering realistic optimism, and supporting women in their search to find meaning in miscarriage, providers can convey their belief in women's capacity to heal and face a future with meaning. Striving to know and be with women as they talk about their personal experiences with the events of miscarrying can support women's reflections on losing their pregnancy and help them decide whether, when, and how to move on to and deal with their next pregnancy. Doing for, in the form of providing the opportunity to talk, making referrals to more in depth counseling, recommending self help books, or voicing out loud the words women can't bring themselves to say can help women identify for themselves just what was lost through miscarriage. Finally, enabling, in the form of validation and supportive guidance helps women find ways to ultimately care for themselves or effectively seek the solace they need from others (Swanson, 1991, 1993; for additional information about use of Swanson's caring theory in counseling, see Swanson, 1999a, 1999b, 2009.)

Limitations

Findings are limited by the sample size, and lack of diversity in racial and educational backgrounds. Thus, the term *inevitable* should be understood to refer only to the experiences of the participants in our studies and not necessarily to all women. The majority of participants were Euro-Caucasian with at least a high school education. Women from different cultural, ethnic, and educational backgrounds may have described their miscarriage experiences differently than the women in this investigation. The time span of approximately 25 years between the first and last investigation and the geographical restriction to women recruited from three Western countries, provide possible further restrictions to the transferability of findings beyond the populations from which these samples were recruited. Research with women from diverse cultural backgrounds that tests the effectiveness of the proposed Miscarriage Model in clinical practice may be an important

next step helping to change societal beliefs about the legitimacy of grieving after miscarriage. Until then, the proposed Miscarriage Model may be cautiously applied in clinical practice with women from different cultural backgrounds.

Summary and Conclusions

This research, based on the findings of three phenomenological investigations (Adolfsson et al., 2004; Swanson-Kauffman, 1983, 1986; Wojnar, 2005, 2007) conducted over two decades and with heterosexual and lesbian women from various geographical locations, offers a theoretical framework to potentially guide research and clinical practice. Although some participants in this investigation received caring and compassionate care after miscarriage, others did not. Clinicians may want to take the time to evaluate their own beliefs, behaviors, and communication styles when caring for women who have miscarried. To facilitate healing after pregnancies unexpectedly end, practitioners are encouraged to consider and compassionately respond to women's common experiences of lacking control surrounding the inevitable events that accompany miscarriage.

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