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The miscarriage experience:

more than just a trigger to psychological morbidity?

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Abstract

Most quantitative research considers miscarriage a trigger to grief, anxiety and depression. The present qualitative study involved in depth interviews with a heterogenous sample of 13 women who had experienced a miscarriage up to five weeks previously. The women described their experiences using a range of themes which were conceptualised into three stages: turmoil, adjustment and resolution. For the majority, the turmoil stage was characterised by feelings of being unprepared and negative emotions. Some women who had had an unwanted pregnancy described their shock at the physical trauma of miscarriage but described the experience as a relief. The women then described a period of adjustment involving social comparisons, sharing and a search for meaning. The latter included a focus on causality which left a minority, particularly those who had had previous miscarriages, feeling frustrated with the absence of a satisfactory medical explanation. The final resolution stage was characterised by a decline in negative emotions, a belief by some that the miscarriage was a learning experience and the integration of the experience into their lives. This resolution seemed more positive for those with children and more negative if the miscarriage was not their first. Rather than being a trigger to psychological morbidity a miscarriage should be conceptualised as a process involving the stages of turmoil, adjustment and resolution. Miscarriage could also be considered a pivotal point in the lives of many women resulting in the reassessment of both their past and future experiences.

Key words: miscarriage, experiences, qualitative, coping, interpretive phenomenological analysis

Introduction

Miscarriage is a relatively common phenomenon occurring in 15-20% of known pregnancies with eighty percent of these occurring within the first trimester (Broquet, 1999). Miscarriage or 'spontaneous abortion' has been defined as the unintended end of a pregnancy before a foetus can survive outside of the mother which is recognised as being before the twentieth week of gestation (Borg and Lasker, 1982). Despite the frequency with which miscarriage occurs it has only been in the last 10 to 15 years that research has begun to identify and explore the

consequences of early pregnancy loss. Studies to date have concentrated on the psychological outcomes for women and most have used quantitative methods employing longitudinal designs, representative samples and standardised measures.

One main area of research has conceptualised miscarriage as a loss event assuming that after miscarriage women experience stages of grief parallel to that of the death of a loved one (Herz, 1984). The main symptoms identified are sadness, yearning for the lost child, a desire to talk to others about the loss and a search for meaningful explanations (Beutel et al, 1995; Herz, 1984; Athey and Spielvogel, 2000). In addition, research has highlighted grief reactions that are unique to the miscarriage experience. For example, women often perceive themselves as failures for not being able to have a healthy pregnancy and this loss is often not acknowledged by the community because there are no rituals that can be performed (Herz, 1984).

Other research has focused on depression and anxiety following miscarriage. Friedman and Gath (1989) used the Present State Examination (PSE) to assess psychiatric caseness in women four weeks post miscarriage. They found that 48% of the sample had sufficiently high scores on the scale to qualify as 'cases' patients which is over four times higher than that in women in the general population. When analysed these women were all classified as having depressive disorders. Klier, Geller and Neugebauer (2000) similarly, found that women who had miscarried had a significantly increased risk of developing a minor depressive disorder in the 6 months following their loss, compared to a cohort drawn from the community. Thapar and Thapar (1992) also found that women who had miscarried experienced a significant degree of anxiety and depression at both the initial interview and at the 6 weeks follow up compared to that of the control group. In contrast, Prettyman, Cordle and Cook (1993) used the Hospital Anxiety and Depression Scale (HADS) and found that anxiety rather than depression was the predominate response at one, six and twelve weeks after miscarriage. Further, Beutel and colleagues (1995) reported that immediately after the miscarriage the majority of the sample experienced elevated levels of psychological morbidity compared to a community cohort and a

pregnant control group much of which persisted up until the 12 month follow up. The authors concluded that depression and grief should be considered as two distinct reactions to pregnancy loss with grief being the normal reaction and depression only developing when certain circumstances are met. This study also showed that a large minority reported no negative emotional reaction post-miscarriage suggesting that a focus on anxiety, depression and grief may only tap into a part of the miscarriage experience.

A small number of studies have considered the experience of miscarriage from a cognitive viewpoint. For example, Madden (1988) completed 65 structured interviews with women two weeks post miscarriage and concluded that rather than self-blame, external blame for the miscarriage and the ability to be able to control the outcome of future pregnancies are predictive of depressive symptoms post miscarriage. Tunaley, Slade and Duncan (1993) drew upon the theory of cognitive adaption (Taylor, 1983) which focuses on meaning, self enhancement and mastery to explore the miscarriage experience. They found that 86% of the sample had established their own set of reasons as to why the miscarriage had occurred ranging from medical explanations to feelings of punishment and judgement which finds reflection in work on attributions for heart disease (eg. French et al, 2001) and breast cancer (Taylor, 1983). In terms of self enhancement, 50% of the sample made downward social comparisons with women who had reproductive problems. By comparing themselves with women that were worse off than themselves they were able to increase their own self esteem. The search for mastery was less visible. There was little evidence that the women in the sample tried to gain control over their lives in general. Although 81% of the sample believed that they could make changes to prevent future miscarriage they had little or no confidence in the difference these changes would make to future outcomes (Tunaley et al., 1993). These dimensions of coping find reflection in Blaxter's qualitative study of women's experiences of illness (Blaxter, 1983).

Therefore some quantitative research has explored the prevalence of psychological morbidity following miscarriage and has highlighted a role for grief, depression and anxiety. In addition,

other research has explored adjustment to miscarriage and the place of meaning, self enhancement and mastery. However, many of these studies rely upon existing tools to explore the psychological consequences of miscarriage (Prettyman et al,1993; Thapar and Thapar,1992; Seibel and Graves,1980; Friedman and Gath,1989). Although this is a useful approach to map the prevalence and changing nature of psychological problems it provides only broad insights and misses the complexity of the miscarriage experience.

In an attempt to address the variability of the experience qualitative methods have been employed. In an early study Hutti (1986) conducted in-depth interviews at two time points with two women. The results showed that although both women referred to a similar inventory of events, the significance that they attached to these events was different and dependent upon their previous experience. For example, one woman had had a previous miscarriage and was described as taking more control over her medical treatment and found her grief to be less severe than with her first miscarriage. In contrast, the woman who had experienced her first miscarriage represented the miscarriage as a 'severe threat to her perception of herself as a childbearing woman' (p. 383). On a larger scale, Bansen and Stevens (1992) focused on 10 women who had experienced their first pregnancy loss of a wanted pregnancy. The authors concluded that miscarriage was a 'silent event' that was not discussed within the wider community. The women were described as being unable to share their experiences and felt isolated as a result. When they did get the opportunity to talk about their loss, they realised how common miscarriage is and that was a source of comfort to them. The authors concluded that miscarriage constituted a major life event that changed the way in which women viewed their lives in the present and effected the way in which they planned for the future (Bansen and Stevens, 1992).

In summary, quantitative studies have focused primarily on grief, depression and anxiety and may have missed the richness of women's responses to miscarriage. Whilst qualitative research has begun to explore individual experience these studies have tended to concentrate on homogeneous groups and have provided only a limited view of the miscarriage experience. The present qualitative study was designed to address some of these issues and aimed to provide

detailed insights into the miscarriage experience with a focus on early miscarriage occurring in the first trimester. Further, by drawing upon the stories of a heterogeneous population the present study examined how biographical factors such as whether the pregnancy was planned, whether the pregnancy was wanted, whether the woman had had previous miscarriages and whether they had children already impacted upon how the miscarriage was experienced.

Method

Participants

The sample consisted of 13 women who had been diagnosed with a miscarriage within the first 14 weeks of their pregnancy. These women were recruited when they attended the Early Pregnancy Unit at a London Hospital. Sixteen women were approached at the unit, two of whom declined to take part in the study and the third was lost at follow up. The response rate was 81%. The sample's biographic and medical characteristics are shown in Table 1. The majority had had no previous miscarriages although three had had one miscarriage in the past. About half stated that the pregnancy had been planned and only three stated that the pregnancy was now not wanted. Only two women had children already. Most of the women received expectant management as a first line treatment approach and three of these went on to have surgery afterwards.

-Insert table 1 about here -

The age of the women in the sample ranged from 22 to 43 years, with the average age being 34.4 years. All lived in south east London. The majority of the sample classified themselves as white (n=10), whilst a small minority were of black African decent (n=2) or 'other' (n=1). There were no exclusion criteria in terms of previous reproductive history, age, foetal age at miscarriage or type of miscarriage. The only inclusion criteria was that the women had to have been diagnosed with a miscarriage within the first 14 weeks of pregnancy.

Once the relevant ethical approval and permission from the doctors and consultant had been obtained, the researcher attended the morning sessions at the unit. With the permission of the

patient, the researcher sat in on the scanning process and was present when the diagnosis was made. The women were then taken to the counselling room where the researcher explained the study to them and they were given an information sheet. Written informed consent was obtained from each participant.

Three weeks after their diagnosis, the participant was contacted by telephone and a mutually convenient time for the interview was arranged. As the study focused on the miscarriage experience, the three week period was set to allow the women time to experience both the physical and emotional aspects of having a miscarriage. The interviews were conducted, on average, five weeks after the initial diagnosis. All but one of the interviews were conducted in the women's homes.

The interview schedule

In order to gain a detailed account of the miscarriage experience, a semi-structured interview was used. This method of interviewing allowed for greater flexibility as the women led the discussion and issues raised by them were followed up by the interviewer (Smith, 1995). Questions asked included: 'How did you first realise that you were having a miscarriage?', 'Who did you talk to about it?', 'How did you feel about having a miscarriage?', 'Is there anything that you would change about how your miscarriage was managed?'.

The length of the interviews varied from between thirty minutes to an hour and were transcribed by the researcher. All identifying references were removed and each interviewee was given a pseudonym.

Data analysis

The data was analysed manually using the principles of Interpretative Phenomenological Analysis (IPA, Smith, 1996). All transcripts were read and re-read several times to ensure familiarity with the data. For each interview a coding sheet was constructed. This sheet contained all possible themes and sub-themes for each interview. References to original material were

recorded under each theme. From the individual summary sheets an overall list of themes was constructed. With continuous reference to the transcripts, connections between the list of themes were made. A table of themes with their various sub-themes was consequently constructed. All the verbatim transcripts were re-read to ensure that the themes were representative of the original material. Instances of each theme in the transcripts was recorded. Throughout the write-up process, themes and sub-themes were adjusted. Although IPA was designed for homogenous samples it was deemed suitable for this study as it enables an exploration of an individual's experience of event which can be placed within the context of their own biography.

Results and discussion

Analysis of the women's descriptions of their experience resulted in the emergence of a range of themes. Although these themes emerged from one interview conducted at one time point it was clear that the women were describing their experiences as dynamic rather than static as they had changed and developed over the time between the miscarriage and the interview. As a means to capture this dynamic process the themes were categorised into stages. These were labeled turmoil, adjustment and resolution.

The turmoil of miscarriage

Women's descriptions of the initial impact of the miscarriage drew upon the themes of shock, feeling unprepared and denial suggesting a stage of turmoil.

For example, one woman said:

“So it was kind of the shock, immediate finding out was a massive shock, because we weren't expecting that at all, we thought that it was all going fine and so that was a big shock at that point” (Gill)

Women also talked about feeling unprepared for the physical process of having a miscarriage and described the symptoms of bleeding and pain as being different to what they would have

expected. One woman described how:

“I had a tiny bit of bleeding um not so much that it worried me, over I think the course of the day, um in the night I woke up with really bad pain, then that made me think that there was definitely something wrong”. (Claire)

Another said:

“Because you think miscarriage and this sounds so crude, because you get this image of um like flushing, whoosh, you know it’s all gone, kind of like pulling the chain of the toilet you know and you think shit it actually goes on for days (laughs) and that was the weirdest thing, that you know I thought God I was really naïve about it.”(Georgina).

Such descriptions of shock and of being unprepared were particularly apparent in the accounts from women who were experiencing their first miscarriage as the reality of the miscarriage process was experienced as different to discourses of miscarriage in the public domain.

Several women who had had pregnancies that were wanted also spoke about their feelings of denial and upset:

“At the time it was just like, I don’t want this to be happening, don’t let this be happening, and as I say right up to the moment of the scan, even though it was fairly obvious that this was it, there was always that slightly irrational hope and denial of what’s going on and um and the horrible sense of loss when you sort of come out there definitely knowing.” (Sue)

“It is a bit of a devastating experience, you know um, you have all these feelings in your womb, your hormones are up and down.” (Brenda)

In contrast, women who had unwanted pregnancies had a different response set. Although they found the physical experience difficult and painful, emotionally they were less affected by the loss:

“Really for the miscarriage, um it didn’t really bother me because I mean I didn’t want to be pregnant really” (Belinda)

And:

“I didn’t have to decide in the end [about termination] so in that way psychologically it was a blessing.” (Jenny)

Women therefore described their initial experience of miscarriage as creating turmoil. For the majority, having a miscarriage went against their expectations of having a healthy pregnancy. A lack of knowledge, particularly for those who had not had a miscarriage before, resulted in them feeling shocked by the physical process and anxious about what was happening to their bodies. For some women who had not wanted the pregnancy the miscarriage was considered a relief. This supports previous research which has described miscarriage as a loss event and has highlighted similar experiences (Herz, 1984; Athey and Spievogel, 2000). It also supports some quantitative research using validated tools which have found a consistent increase in anxiety (Friedman and Gath, 1989; Thapar and Thapar, 1992; Prettyman, Cordle and Cook, 1993). However, contrary to many studies of miscarriage depression was not a commonly described emotion (eg. Thapar and Thapar, 1992). This may reflect the use of different terminology by the women in the present study whereby the current women’s sadness would have been classified as depression. It may also reflect the confounding of grief and depression in previous studies.

Adjustment to miscarriage

The women also described the various ways in which they tried to come to terms with having a miscarriage and how they used different techniques to boost their own self sense of self.

The main themes emerging were social comparisons, sharing and finding meaning. These themes can be conceptualised as illustrating an adjustment stage. Some described making downward social comparisons. Such comparisons were made with others who had reproductive problems. For example, Rebecca who had a history of two ectopic pregnancies and a previous miscarriage and had very much wanted the baby still managed to find something to feel 'lucky' about. She said:

“Like when I read about people who’ve had stillborn babies or they’ve miscarried like really at 20 something weeks, I mean that must be absolutely horrendous..... I couldn’t bear that and these poor people who have to give birth to a baby and everything when they already know it is dead.” (Rebecca).

In contrast, Penny’s pregnancy had been both unplanned and unwanted and she regarded her miscarriage as fortunate. However, she also made social comparisons and compared herself more generally with people in society who she felt had worse health problems than herself:

“No I don’t need to be you know unhappy, a lot of people, more people have AIDS or have cancer, they have worse things you know, so I have two friends with AIDS, so I think I am pretty lucky.” (Penny)

By making these comparisons, women reported feeling better about themselves and what had happened to them.

Some women also talked about focusing their attention on others as a means to direct attention away from their own feelings. For example, Alice whose pregnancy was unplanned

but had still wanted the baby focused on her sister's need for her:

“ I have to be there for my [pregnant] sister because she is not clued-up on babies and things like that and I said that I would be around to help her for a while until she knows what she is doing.” (Alice)

Women also described how being able to talk about their experience with others was an important part of the adjustment process. They found sharing to be beneficial as it allowed them to elicit the support that they needed.. Partners, friends and families were all cited as providers of various kinds of support For example even though Jenny stated that she hadn't wanted to be pregnant said:

“I just felt like telling people, it just helped me to get it out and to be calmer about it”.
(Jenny)

Some stated that the support they received was enhanced by having already shared their pregnancy with others:

“We didn't keep it quiet, most people do for the first 12 weeks or whatever, so, but in a way we were glad about that because it meant we could share the experience with people around us, they were very supportive and it wasn't a hush-hush grief that we were going through.”(Gill)

For some, sharing actually improved their relationships. At times this was with their partner:

“Well it changed things in making it much stronger, the relationship really I think, um because he [her partner] was so supportive throughout and you know an

unexpected presence”. (Sue)

At other times this was with a person who also revealed their own miscarriage experiences:

‘I related that I had had a miscarriage and then she opened up and she said that this was her third and I thought, wow you know, but she was fine when I was talking to her she was like, you could relate to somebody and I felt that I was relating something and also sharing and helping the person as well and so it was helping each other.’(Brenda)

Unfortunately a few women described how they did not get the support that they needed. For them the miscarriage was a lonely and isolating experience:

“When the miscarriage happened, he kind of blanked it out, you know, he kind of put a wall there and um he just acted as if I was never pregnant and it never happened and I suppose that was his way of dealing with it.” (Brenda)

This was also the case for Rebecca who had one previous miscarriage and two ectopic pregnancies:

“You know people would say, you know, you can try again, blah, blah, but she couldn’t say that to me, because she knows how many times I’ve [lost a pregnancy].” (Rebecca).

She felt that her friends and family did not know how to react to her repeated experiences.

A further component of the adjustment process was the way in which many women tried to find meaning in what had happened to them. For some this involved incorporating the

miscarriage into their broader life experiences:

“You know one realisation is that it’s actually another part of , you know, life experience, it’s another life event and it’s actually not such a big deal in the grand scheme of things.” (Melissa)

For many this involved a search for causality. Some cited medical reasons for the failure of their pregnancy:

“I am you know I am sure it was um a kind of usual genetic sperm and egg didn’t mix this time”. (Jenny)

Many blamed themselves for not taking better care of themselves, for drinking or smoking or being too active.

“I know I had just a tiny drop of alcohol on a couple of occasions and I thought well it was my fault that’s why, you know it didn’t grow.” (Brenda)

Several women cited external pressures such as stress at work or their job itself:

“I think it’s the job that done it actually. I do a lot of mopping and Hoovering and that’s... down there don’t it, so that’s probably what caused it”. (Alice)

Some were more philosophical about their loss and tended to talk about it in terms of fate or destiny. They accepted that what had happened to them was out of their control and accepted that miscarriage was just one of those things that happen:

“So I think, well, if this is meant to happen, it has to happen and that’s it.....I don’t

know if it was destiny, these things happen.”(Penny)

However, not all women could focus on a satisfactory cause and were frustrated that the medical community could not provide them with one. This made it difficult for the women to make sense of their loss and was particularly pertinent to women who had had a previous miscarriage:

“They say they can’t find, there is no reason for it, it’s just that the foetus hasn’t developed, but they don’t know why. So I mean I don’t know whether if your eggs aren’t of a good quality, I mean I don’t really know why it wouldn’t develop, you know I’ve asked, but nobody really seems to know.”(Rebecca)

And:

"Physically I'm left, I'm left still worrying if, you know, (I'm) lacking in something..... I haven't got a clue and nobody's been very responsive about that, but I do think that's because they let you miscarry three times before they start investigating." (Claire)

The adjustment stage therefore involved the use of social comparisons and a process of self enhancement which finds reflection in Taylor’s model of coping (Taylor, 1983). In particular, the women focused on those worse off than themselves as a means to improve their sense of self. In addition, the women described their use of social support networks and how sharing their experiences with others was beneficial to their psychological state and also helped to improve their relationships. This supports research concluding that women who have miscarried have a desire to talk to others (Beutel et al, 1995; Herz, 1984) but is in contrast to Bansen and Stevens (1992) who argued that the women they interviewed were unable to share their experiences. Previous studies have described miscarriage as a ‘silent event’ which can isolate women from those around them. Only a small minority of women in the present study described such an absence of support which may either indicate a

difference in the populations used or may suggest that social norms have changed over the past decade. The final strategy used to facilitate adjustment involved a search for meaning. In particular, many women expressed beliefs about the cause of their miscarriage and focused on factors such as medical causes, personal blame, stress and fate. This is consistent with Taylor's (1983) emphasis on causes as central to adjustment and is similar to Blaxter's (1979) work of women's explanations of illness and research exploring responses to heart disease (French et al, 2001). The themes of social comparisons and sharing appeared to be universal regardless of the woman's own biography as all women searched for self enhancement and drew upon their social support networks. However, although all women wanted to find a satisfactory cause not all believed that they had done so and expressed a frustration at medicine for providing ambiguous explanations. This seemed to be particularly apparent in the accounts of those who had had more than one miscarriage as their faith in their causal beliefs had been challenged by the occurrence of a subsequent miscarriage.

Resolution

After the stages of turmoil and adjustment the women described the ways in which they had begun to move on. Although the interviews were only up to five weeks after the miscarriage most women's accounts indicated a shift in their emotional responses to the miscarriage and a progression towards some kind of resolution. The main themes emerging were a decline in negative emotions, seeing miscarriage as a learning experience and an assessment of the miscarriage within the woman's past and future.

Many spoke about how their emotions had changed over the weeks subsequent to the miscarriage. Feelings such as anger and sadness started to subside as the weeks progressed. One woman said:

“The first week you don't realise that you're still the whole hormone system is

still pregnant and you then come down and the next week, I would say that almost your third week was the hardest. Then it sort of you know it's not that you sit around crying, but after the third week I felt very sad and um thankfully I don't feel like that this week." (Margaret)

Another said:

"I don't feel angry, which I did during some of that time, um I don't feel as sad, I don't feel as frustrated um I don't feel depressed, I did get quite depressed I think especially in the convalescence period." (Melissa)

However, for some the process of resolution was still underway and they talked about how it would take time before they would reach emotional stability once more:

"So I've just got to get on with it, time I suppose time will heal it anyway, you know, but yeah I don't know I just have my ups and downs at the moment." (Alice)

Women also described how they saw the miscarriage as a learning experience. They described how they had learnt about themselves and by focusing on the positive aspects were able to gain a sense of mastery over their experience allowing them to feel good about what they had achieved.

"As we kind of got through to the other side, it was almost like there was a purpose in it or something... it had been a massive teacher in a way even though it was painful and ... I don't know It's kind of taken life to another level." (Gill)

Similarly Jenny, who had been planning to terminate her pregnancy said:

“I think I learnt quite a lot from it and it did have a positive side you know.... It was like a kick up the bum, you know it was like don’t waste your life you know, don’t mope around doing this, make the most of it and I’m sort of in some ways happier and stronger than I was before it happened.” (Jenny)

Resolution was also characterised by the ability to integrate the miscarriage within the women’s broader life experience. For some this involved re evaluating their past. For example, Margaret believed that she should have tried to get pregnant earlier said:

“I think well my chances would have been so much better then. [I’m] 37 you know, I should have been more proactive then.” (Margaret)

For the majority, this involved re evaluating their future. In particular, this included an assessment of their chances of having another child which was influenced by their previous reproductive history. For example one woman, who had had a previous miscarriage and no successful pregnancies, described the anxiety and pressure that she felt in the following way:

“You know the sort of fact that I am not a parent as opposed to when you have a child and then you have a miscarriage and I think that makes a difference because I suppose what I am trying to say is that I felt additional pressures or stress on me due to the fact that I am not a parent yet and I’m having two miscarriages.” (Melissa)

Whilst another who had been planning to terminate her pregnancy explained how she would be afraid during a subsequent planned and healthy pregnancy:

‘One day I am going to want a baby and to want to be pregnant. I sort of think that I’ll face this when I get there, but I think that probably when I do want a baby and I’m pregnant, I will probably be petrified for the first 8 to 10 weeks or may be the

whole way through.” (Jenny)

In contrast one woman, who already had a son, explained that having a child made her less concerned about the miscarriage and less anxious about the future:

“We’re lucky we have one child who, I think that I would feel much much more obsessed with it, if we didn’t have a child.” (Margaret)

For some, this re evaluation of the future was in more general terms. For example, one women who had always focused on her job and had had an unplanned pregnancy said:

“I think it’s made me re-evaluate what I was going to do with the rest of my life.”
(Georgina)

This woman later explained how she felt about approaching 40 and described how some of her friends:

“have to have the car, and they have to have the second honeymoon.....the holiday... the children in private schools”

whilst other friends ask:

‘...am I happy, am I healthy am I whole, am I enjoying my life’

She felt that she was:

‘probably somewhere in the middle..... where do I want to be by that point in time, so I guess that the goals have changed” (Georgina).

Women therefore described a stage of resolution after experiences of turmoil and adjustment. This resolution was first characterised by a decline in negative emotions. Previous research has identified negative emotional responses to having a miscarriage and has highlighted the persistence of such feelings over time (eg. Prettyman, Cordle and Cook, 1993; Beutel et al, 1995; Thapar and Thapar, 1992). The results from the present study indicates that such quantitative studies using existing measures may miss the subtle development and dynamic nature of these feelings which change as each woman approaches a re establishment of her equilibrium. This resolution was also characterised by the ability to see the miscarriage as a learning experience and the assessment of the miscarriage within the woman's past and future. Bansen and Stevens (1992) argued that a miscarriage can impact upon how a woman evaluates her life. The results from the present study support this conclusion but suggest that this evaluation is not universal but influenced by the woman's own biography. In particular, having children already may facilitate a more positive evaluation whilst previous miscarriages and no successful pregnancies may facilitate a more negative re evaluation of the woman's own life story.

Conclusion

This study aimed to gain an intimate understanding of the miscarriage experience from the women's point of view. The results provide insights into rich and varied experiences which can be conceptualised in terms of three stages. The initial turmoil stage was characterised by feelings of shock, a sense of being unprepared for the physical aspects of miscarriage and negative emotions including grief, anger and anxiety. The women also described a range of strategies which were used to re establish a sense of self such as self enhancement, social comparisons, sharing and finding meaning. These themes illustrate attempts at orientation and a stage of adjustment. Finally, the women described a stage of resolution. For many this was characterised by a deterioration in their negative moods and suggests that the strategies of adjustment were effective at returning the women to a state of emotional stability. Many women also described the miscarriage as a learning experience and placed

the miscarriage within the context of their past and future. This suggests that the adjustment had not only re established the women's equilibrium but had also contributed to their emotional development. The women's accounts suggest that their responses to having a miscarriage were dynamic and fluid and had changed and developed between the time of miscarriage to the interview. The accounts also indicated an important role for the women's own biographies. In particular, factors such as whether the pregnancy was wanted, whether the miscarriage was their first and the existence of other children influenced their initial responses to the miscarriage and the incorporation of this event into the women's life stories.

Miscarriage is a common but complex phenomenon that can have a tremendous effect on a woman's life. Although previous research has concentrated on grief, depression and anxiety, these reactions are only part of the story. The results from this study suggest that the miscarriage experience can be conceptualised in terms of the stages of turmoil, adjustment and resolution and that rather than being considered a trigger to psychological morbidity miscarriage should be understood as a process which involves shifting emotions and active coping. This analysis finds reflection in research on coping, adjustment and the crisis of physical illness (Taylor, 1983; Moos and Schaefer, 1984). However, it should not only be analysed within this limited time line. It can be also be conceptualised as a pivotal point in a woman's life which results in the reflection and integration of their past, present and future.

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Table 1. Profile of women

	Previous miscarriage	Weeks pregnant	Planned	Wanted	Previous Children	Type of miscarriage	Treatment
Olivia	None	9	Yes	Yes	None	Incomplete	Expectant / Surgery
Brenda	None	10	No	Yes	None	Missed	Surgery
Gill	None	13	Yes	Yes	None	Incomplete	Expectant / Surgery
Belinda	None	9	No	No	Two	Incomplete	Surgery
Penny	None	9	No	No	None	Incomplete	Expectant
Alice	None	10	No	Yes	None	Incomplete	Expectant
Sue	None	9	No	Yes	None	Missed	Surgery
Rebecca	One 2 ectopics	12	Yes	Yes	None	Missed	Surgery
Margaret	None	11	Yes	Yes	One	Incomplete	Expectant
Melissa	One	12	Yes	Yes	None	Missed	Expectant / Surgery
Claire	One	10	Yes	Yes	None	Complete	Expectant
Georgina	None	7	No	Yes	None	Complete	Expectant
Jenny	None	8	No	No	None	Incomplete	Expectant