

# WOMEN'S EXPERIENCE OF EARLY MISCARRIAGE: A PHENOMENOLOGICAL STUDY

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## ABSTRACT

This paper describes the experience of three women who had experienced early miscarriage within the previous 12 months. Three major themes of loss emerged: the loss of a baby, the loss of the role of motherhood and the loss of the hopes and dreams the women possessed for their baby. These losses were complicated by the women's negative thoughts about the care they received while in hospital, their perceptions of health professional's negative attitudes, the lack of information given to them, and the lack of understanding shown by family and friends about their situation. The authors recommend a number of changes to practice including the need for an increased sensitivity towards women following early miscarriage.

## INTRODUCTION

Miscarriage, also known as spontaneous abortion, occurs before the legal age of life viability of 24 weeks gestation (Niven and Walker 1996). The rate of early miscarriage is thought to be approximately 30% at four weeks gestation, and 20% between four and 13 weeks gestation (Rajan and Oakley 1993). The incidence of early miscarriage is difficult to ascertain because many women may be unaware they are pregnant or interpret blood loss as a heavy period. In addition, it has been estimated that nearly 80% of all conceptions end in fetal death, the majority of these occurring without the knowledge of the woman (Rajan and Oakley 1993).

Thus, it appears that early miscarriage is a common event. This is supported by statistics collected at one Brisbane, Australia, hospital which revealed that 440 women in one year were hospitalized for surgical procedures related to first trimester miscarriage (Jacobs and Harvey 2000).

The importance of pregnancy loss is evidenced by an increase in research on the experience of stillbirth and late pregnancy loss (Boyle 1997; Gilbert and Smart 1992). However, in spite of aspects of fetal and neonatal loss being reported in the midwifery literature there still remains a paucity of research on the woman's experience of early miscarriage. Furthermore, the available research fails to focus on the psychosocial consequences and the social context of early miscarriage.

The lack of attention to the emotional aspects of care is also reflected in the medical management of early miscarriage. Often the woman is admitted to hospital to undergo the surgical procedure of dilatation and curettage (D and C) to remove any remaining products of conception (Hull et al 1997). Unless there are complications, the woman is discharged home after a couple of hours. Thus, the care given focuses on the physical management of the woman and implies that this is all that is required. Little if any consideration seems to

be given to her emotional wellbeing. The short hospitalisation and early discharge may in fact be a major contributing factor to this apparent lack of concern.

## THE PSYCHOLOGICAL IMPACT OF MISCARRIAGE

It is clear that the focus on community health care will continue to encourage early discharge of women following miscarriage. This is not just an Australian phenomenon. Hemminki (1998) for example, explored the Finnish health service for medical management of miscarriage and the rationale for practice. He concluded that many countries treat women as outpatients or encourage management by the woman's family doctor.

It is apparent that there is a lack of emphasis on how a woman feels about early discharge following miscarriage and a lack of concern for the emotional after effects of miscarriage.

There are, however, studies available that suggest that miscarriage has an emotional impact on the woman. A study that investigated the psychological impact of miscarriage (Neugebauer et al 1992) reported that women were in a highly symptomatic depressed state at six weeks and at six months after miscarriage. Similar findings have been supported in other studies of depression following miscarriage (Beutel et al 1995; Prettyman et al 1993).

Beil (1992) reported the presence of symptoms consistent with psychological trauma following miscarriage. Her study revealed that women experienced higher levels of current subjective distress than did men. The level of distress was positively related to the length of pregnancy and increased as the pregnancy advanced. Further studies have uncovered the poor effect of pregnancy loss on women (Ney et al 1994; Prettyman et al 1993; Rajan and Oakley 1993).

Bourne and Lewis (1991) displayed a lack of regard for emotional well being following early miscarriage. They suggested that grief following miscarriage should not be magnified and that it should not be considered as a serious loss.

In contrast, Mander (1994) contended that instead of belittling the grief that women experienced following miscarriage, society should accept the women's loss for what it means to them. Thus, even in the literature there is dissention in how society views early miscarriage and its effects on the woman. However, in spite of indications that miscarriage may have an emotional impact on the health of a woman, (Beutel et al 1995; Neugebauer et al 1992; Prettyman et al 1993) they are still likely to undergo early discharge and are just as likely not to receive any form of counselling following miscarriage.

## The need for the study

The literature highlights the importance placed on the medical care of women and the limited focus on the psychosocial consequences and the social context of early miscarriage. It seems dismissive for research to ignore the very person who is affected by miscarriage - the woman. The researchers contend that early miscarriage must be explored from a phenomenological perspective, as the experience of early miscarriage is an important issue in nursing care and the key to care is understanding the experience (Morrison 1994). As the event of miscarriage is a unique experience to each woman (Bansen and Stevens 1992) a phenomenological study would address the perceived limitations of previous studies. Furthermore, such a study would subsequently benefit women who have a miscarriage by providing the opportunity for understanding and the potential for changes in nursing practice. Thus, the following study set out to explore women's experience of the phenomena of early miscarriage.

## METHODOLOGY AND METHODS

A descriptive phenomenological approach (Husserl 1970) informed the exploration of the phenomena of early miscarriage. The researchers adhered to the definition of early miscarriage as being the loss of a foetus occurring up to 16 weeks gestation (Murphy 1998).

A major feature of phenomenology is the recognition that experience is the essential meaning of knowledge (Husserl 1970). Thus, the authors turned to the women's experiences to find out what it was like to live the experience of early miscarriage. The researchers were interested in the world as experienced from the participant's perspective. To avoid any bias and in keeping with the phenomenological tenet of bracketing (Husserl 1970), assumptions about miscarriage derived from experience and the literature were made clear in a written statement to remind the authors of the need to lay aside assumptions during data collection and analysis.

## The participants

A purposive sample of women who had experienced early miscarriage was sought. The purpose of selecting participants for a phenomenological study is not to meet statistical requirements but to demonstrate variation in the description of the experience (Munhall and Oiler 1986). The most essential aspect was that the woman had experienced early miscarriage and to ensure a ready recall of the experience, women who had experienced a miscarriage within the last 12 months were asked to participate. Participants were sought through an advertisement in a local Brisbane newspaper. The advertisement described the study and asked participants to contact the researcher (Harvey). Seventeen women

responded to the advertisement, however only three women meet the criteria of having experienced an early miscarriage within the last 12 months. Fourteen of the women had experienced their miscarriage more than 12 months ago. The researcher made arrangements to meet individually with the three women in a convenient place. All three women chose for the researcher to visit their home rather than attend a local clinic. To maintain confidentiality the women were given the pseudonyms of Chris, Sue and Ann.

### **Chris**

Chris was a 24-year-old married laboratory technician who had recently taken up residence in Queensland. Chris had never experienced a live birth. Her first, and only experience of pregnancy, ended in miscarriage at six weeks gestation.

### **Sue**

Sue, a 38-year-old housewife had given up work temporarily to devote more time to her young son who was at school. She had experienced 10 pregnancies with only one resulting in the live birth of her son. The other nine had ended as early miscarriages. Her most recent miscarriage had occurred at 11 weeks gestation.

### **Ann**

Ann aged 35 years, was the wife of a local teacher, a regular church attendee and a full-time mother to two young boys. Ann had experienced five pregnancies resulting in two live births and three miscarriages, with her most recent one also occurring at 11 weeks gestation.

Although each of the women had experienced early miscarriage it was felt that they also demonstrated variation in their experiences. It was anticipated that these three women would describe their subjective awareness of the phenomena to share a common understanding and to reveal the essence of the lived experience of early miscarriage.

The initial meeting with the researcher gave the women the opportunity to have their questions about the study answered, to receive a written and verbal description of the study and to read and sign an informed consent form. It also gave the women the opportunity to get to know the researcher and to hopefully feel comfortable talking with her. Following this, a date and time for the subsequent interview was arranged.

The women were assured that confidentiality would be maintained at all times through the use of a pseudonym for any subsequent publications or presentations and that the interview recordings and transcripts would only be available to the researchers. Ethics approval was obtained from the Griffith University ethics committee.

## **DATA COLLECTION**

Open ended, unstructured individual interviews were conducted with the women in their homes. Initially participants were asked to 'Tell me about your experience of miscarriage'. The women were asked to expand on their initial abstract descriptions and to provide more formal definitions of their experience. Additional questions were asked when necessary to gather these more formal descriptions and for further clarification. When the participants felt that they had described their experience and no further clarification was needed the interviews were considered to be complete. Each of the interviews lasted approximately one hour. The interview was audiotaped with permission of the participant. This enabled the researcher to capture the description as told, thereby ensuring accuracy of the data collection and enabling her to engage with the interview rather than concentrating on note taking.

## **DATA ANALYSIS**

Following verbatim transcription of each interview the transcripts were compared with the audiotapes for accuracy. Colaizzi's method was used for data analysis (cited in Valle and King 1978, p.59-61). Colaizzi's method was chosen as it is consistent with the phenomenological bracketing of held assumptions and is a method of analysis that has been shown to be valid and reliable by other phenomenological nurse researchers (Munhall and Oiler 1986).

This method involved the researcher becoming immersed in the descriptions of the experience. The researcher read the transcripts to gain understanding and clarification, while intuiting or wondering about the phenomenon under investigation in relation to the various descriptions generated by the three women. Significant statements about miscarriage were extracted from each transcript. The next step was to formulate meanings from each significant statement. The formulated meanings illuminated what each participant revealed about their experience. The researcher then sought to cluster the meanings into themes. Finally the themes were integrated into a description of early miscarriage. This paper presents a description of early miscarriage and discusses the emerging themes.

### **Credibility**

Comparing the transcripts with the tapes enhanced credibility. Furthermore, one of the authors, experienced in phenomenological research also reviewed the transcripts and assisted with data analysis. Reliability and validity were addressed throughout the collection and analysis of data. Confirmability and dependability of the results were achieved by comparing the findings with the

transcripts, the researcher's diary of the interviews and with the existing literature.

## FINDINGS - A DESCRIPTION OF MISCARRIAGE

Early miscarriage was perceived as a major event in the lives of the three women. This event symbolised the loss of a baby, the loss of the role of motherhood and the loss of the hopes and dreams the women possessed for their baby. This perceived loss brought feelings of grief, distress, pain and prolonged sadness as the women attempted to understand what was happening in their lives at that time. The perception of loss created emotional conflict and turmoil, which was conceived as overwhelming grief and distress.

The experience of miscarriage was negative as the women experienced fear and panic associated with a lack of understanding of what had happened to them. They sought explanation from those around them and they experienced disappointment when they perceived that those they believed would assist them did not provide the explanations and reassurance they so desperately sought. They experienced disappointment and frustration as a result of this lack of reassurance. Feelings of uncertainty and guilt engulfed them as they sought reassurance from their fears through their own explanation of what had caused their miscarriage.

This was not experienced as relief, but rather they became distressed as they recognised that health professionals were not able to help clients such as themselves who were experiencing distress after miscarriage. In fact, further distress was generated as they recognised that health professionals kept their distance to avoid confronting the situation.

Furthermore, feelings of isolation and loneliness were experienced due to the perceived inability of friends and others to enable the women to talk about their experience of miscarriage. Their attempts to speak about their experience were greeted with silence. Attempts to understand why they could not recount their experience resulted in feelings of isolation as they attempted to justify their actions. They felt comfort from the perception that their friends' actions were normal for people who had never experienced miscarriage. However, they continued to try to understand people's reactions and attitudes to their miscarriage. They experienced feelings of distress and isolation, as they perceived that they would never understand these reactions and believed that people who had not miscarried would never understand them.

In addition, the distress and pain experienced raised concerns about subsequent pregnancies. The women feared becoming attracted to the idea of pregnancy in case

they faced the loss of another baby, but at times they were preoccupied with thoughts of wanting another child.

## THE THEMES DISCUSSED

### Loss

The feeling of loss is an understandable feeling for a woman who has recently lost a baby. The torment and conflict felt by these women has been recorded in other studies. For example, Ney et al (1994) concluded that the loss experienced from early miscarriage produced internal conflict for women, which could lead to depression if left unresolved.

The loss of motherhood is an interesting concept to consider and one, which some individuals may find hard to understand when women miscarry early. For example, Chris experienced the loss of motherhood as significant. Her pregnancy gave her meaning and an understanding of motherhood. Although this was her first pregnancy, Chris felt she was a mother from the time of conception. Following her miscarriage, she immediately perceived the role of motherhood had gone and her life no longer held meaning for her. Moreover, she felt she and her husband were not accepted by society as a family unit because they had no children, but rather that they were a married couple. Sue and Ann also perceived a loss of motherhood. For them, being pregnant gave meaning to being a woman and a family unit. The loss of their baby brought confusion to their understanding of their world, a world that no longer held them to be pregnant mothers.

Feelings of being abandoned between the world of motherhood and non-motherhood were also common in other studies (eg Brown 1997; Moulder 1995). In spite of the importance of motherhood to these women they perceived that the world around them had also forgotten them as mothers.

### Uncertainty

The women described their concern and uncertainty about further pregnancy. The emotional pain and distress that they experienced left them feeling inadequate and without meaning in their lives. They perceived a lack of confidence and questioned their ability to ever bear children. This was in spite of two of the women (Sue and Ann) having previously borne live children. They began to explain their losses as being somehow related to their inadequacies. Thus, they perceived that they were to blame for their loss and that they were being punished. These findings are supported by Mander (1994), Gilbert and Smart (1992), and Koziol-McLain et al (1992) who also found that following early miscarriage, women became worried about conceiving again and their complacency about bearing children was shattered, making them feel vulnerable and a failure.

The strength of these uncertain feelings is demonstrated in Chris' grief reaction to her miscarriage. Her uncertainty was so dominant she perceived she would not be able to emotionally survive another miscarriage and as a result, she lost confidence in herself and her ability to 'manage' the world. She experienced emotional turmoil as a result of what she described as 'swinging feelings'. She described feeling normal for a while and then she felt as though she came crashing down as she felt her feelings swing to the other end of the pendulum where she experienced extreme distress and emotional unrest. It was during these times, at the low end of the pendulum, when she felt the need to be alone to reflect on the perception of her loss. She came to believe that she was 'not a nice person' and that was why the miscarriage had occurred. She experienced feelings of confusion as she tried to understand why the miscarriage should happen to her. Unable to understand the experience she again concluded that it was her fault.

### **Guilt**

The feeling that they were to blame was a common perception among the three women. The women experienced guilt feelings about their miscarriage believing they had done something to cause it or that there was something physically wrong with them. They felt they needed to find a reason for their miscarriage and believed the guilt lay with them, as after all they acknowledged that they were the incubators of the foetus. These persistent feelings of guilt made the women experience doubts about themselves and their ability to give birth. This led to further anguish and distress as they continued to blame themselves for their predicament. Nikcevic and Kuczmierczyk (1999), Koziol-McLain (1992) and Bansen and Stevens (1992) identified similar findings.

### **Clinical care**

A major theme of importance was the meaning the women gave to their clinical care. There were many clinical issues that the women perceived to impact negatively on them and which they felt subsequently affected their recovery. They perceived that they did not receive adequate information at the time of their experience of miscarriage. They believed this hindered their recovery, as they did not know what to expect. Furthermore, they perceived that this made them feel disempowered as they felt they had no control over their lives. It is interesting to note that even Sue who had experienced nine early miscarriages perceived that she had not been placed in control of her situation as she felt that information was kept from her.

Findings from other studies concur with these feelings (eg Nikcevic and Kuczmierczyk 1999; Boyle and Chapman 1997; Moulder 1995; Cecil 1994; Moohan et al

1994). These researchers found that medical staff did not discuss the cause of miscarriage or what to expect as a result of miscarriage and did not offer advice about available community help.

The women also perceived that health care professionals did not care or appreciate what they were experiencing. They believed that health professionals were only concerned about the physical aspects of their care and that they stayed distant from them so that they did not have to listen to or try to understand the women. The women perceived that this demonstrated a lack of care and concern for their wellbeing.

Friedman and Gath (1989) argue that it may be that health care professionals appear uncaring and ignore the emotional aspect of the miscarriage experience because of the brief time such women spend in hospital. Moreover, Murphy (1992) stated that the uncaring, distant approach adopted by health care professionals might be the only way in which they can cope with the intensely emotional situation. Keeping a distance from such women is of particular importance to nursing practice as caring has been described as the very essence of nursing and the central, unifying focus for nursing practice (Leininger 1984) and as such can not be offered from a distance.

Nurses throughout history have been considered as care givers. If nurses in particular are not considered to be caring the very basis of nursing practice is at threat. As a practice discipline, nursing is based on the interaction between nurse and client. A caring relationship sets a condition of trust that allows appropriate care to be offered. It is imperative that in order to ensure appropriate help an understanding of client's beliefs and needs is required.

### **Need for emotional support**

Rajan and Oakley (1993) suggest that it is necessary for mourning to be recognised as a natural, healthy, although painful process and that health care professionals should facilitate this process. Health care professionals should be aware of their vital role in helping women with their experience of early miscarriage and must inform the women of community support available to them.

The women in this study perceived they received emotional support from their partner but believed that their partners could only offer nominal support, as they did not fully understand the depth of their experience. The participants acknowledged their partner's feelings and experiences, but believed their partners did not suffer in the same way as they as a woman suffered following early miscarriage.

There is limited research on how early miscarriage impacts on partners of women who experience miscarriage (Murphy 1998; Puddifoot and Johnson 1997; Johnson and

Puddifoot 1996). These researchers suggest that men are affected by miscarriage and they report a complex set of thoughts and feelings and confusion about their role and expected behaviour. They conclude that men feel they have to ignore their own feelings to help their partner through the miscarriage. Further research on the emotional needs of women and of their partners may be necessary in order to understand the counselling requirements of both groups.

Family members also offered support to the women, however, some failed to offer support or to acknowledge that the miscarriage had occurred. This led to feelings of isolation and loneliness, which the women perceived, hindered their recovery. The women rationalized this behaviour by stating that only women who had experienced early miscarriage could understand their feelings. This perceived lack of understanding also led to hurtful comments being made while attempting to provide consolation. These comments only served to diminish and trivialise their loss.

Such feelings are further complicated by research (Gamlin 1995) that argues that people do not know how to help women in this situation, and yet offers no solution to combat this problem. If people cannot provide support, women will become isolated and lonely, believing that there is no one available who can help them.

The women in this study experienced a lack of support because they perceived that people were reluctant to talk about their experience. The lack of recognition of the difficulties experienced by women made miscarriage an experience that the women had to endure by themselves. They perceived the predominant societal view was that if a woman miscarried there was something wrong with the baby and that she could easily conceive again. This led to a silence from society that the women resented. They felt people viewed miscarriage as a medical complication of pregnancy rather than the loss of a dearly desired baby. Thus, the emotional aspects of their circumstance were avoided by society as a means of helping society adjust to a situation that is seen to be related to a foetus rather than an actual baby. Unless the unborn foetus is valued by society it may be difficult to challenge and to change such thoughts.

## **IMPLICATIONS FOR NURSING PRACTICE**

The findings highlight a number of areas that require consideration by the nursing profession. Many of these issues have been highlighted in similar literature. For example, Reed's (1992) study revealed that obstetric nurses felt that women who experienced early miscarriage did not require much emotional support. Furthermore, the nurses rated the emotional seriousness of miscarriage to be higher if the gestational age of the pregnancy was older

and therefore, priority of care would increase. Moreover, Rajan (1994) found that health care professionals did not provide sufficient support for women following early miscarriage. In addition, Bansen and Stevens (1992) noted that hospital staff had either a positive or negative effect on women's recovery from early miscarriage and any avoidance behaviour by staff could impede the mourning process. In light of the findings from the authors' research and the literature, it is important that nurses caring for women following early miscarriage ensure that they receive appropriate holistic care, rather than care that is focused only on the physical aspects of care.

Holistic care is defined as recognizing that 'health care proceeds from a balance of physical, spiritual, psychological and social needs' (Patterson 1998). Thus, the provision of health care must be explored from all perspectives. Furthermore, the caring relationship must reflect emotional wellbeing as well as physical care. Psychological care must become visible so that women feel their emotions are understood and attended to within a therapeutic environment. As these women are in hospital for such a short time frame it is suggested that the assignment of a primary care nurse may encourage an emotional commitment to care. Emotional support might also carry on if care is continued once women are discharged into the community. However, this study also raises the implication of early discharge for people requiring psychological support following early miscarriage. This issue requires further investigation.

This study supports giving women the opportunity to speak with health professionals during their hospitalisation as well as to receive an explanation of miscarriage to avoid the constant battering of their self-esteem. In addition it is argued that they should also be offered a follow up telephone call by nursing staff as a means of support while providing the opportunity to listen and to help overcome their tragedy. In the immediate future, it may be useful if women received information brochures about what to expect following miscarriage and that they be offered counselling from within the hospital and the community.

To assist these women it is imperative that health professionals show sensitivity to the women's needs to encourage perceptions of a caring response. Nursing care should allow provision for women to voice their feelings and concerns, to enable an acknowledgement of their loss. For this to occur there needs to be an emphasis in nurse education on the importance of providing emotional support, displaying empathy and using therapeutic techniques such as touch and massage to help emotional and physical healing.

In addition to caring for women, support is also required for the partners of women who suffer early miscarriage. As discussed earlier, there is limited research

on how miscarriage impacts on partners of women who experience miscarriage (Murphy 1998; Puddifoot and Johnson 1997; Johnson and Puddifoot 1996). This area would benefit from further research.

## FURTHER RESEARCH OPPORTUNITIES

This study has uncovered a need for further investigation in relation to early miscarriage and in particular to the needs of women and their partners. Furthermore, it would be beneficial to re-interview these women in 12 months time in order to see whether time has helped to heal them.

It is apparent that early miscarriage has not received adequate attention in both the literature and the education of nurses. Although nurse education focuses on the importance of the therapeutic relationship it appears that the limited hospitalisation periods experienced by these women may reduce the opportunity for therapeutic communication. This raises the need to explore and to make recommendations for nurse education on the process of improving therapeutic communication, particularly when patients undergo short hospital stays.

## CONCLUSION

This study found that the experience of early miscarriage was a major event in women's lives. The women perceived that no one understood the emotional upheaval of their situation. They believed that family, friends or society did not consider the experience of miscarriage as the loss of their hopes, dreams and their motherhood role. They perceived their feelings were brushed aside as being of little significance as the foetus at this stage was not considered to be a 'baby'. The emotional turmoil experienced by these women after many months demonstrates the importance of the establishment of a therapeutic relationship.

This study provides an understanding of the early miscarriage experience from the perception of the woman. This perception is extremely important to nursing practice, as it is nurses who are caring for such women during their limited hospitalisation period. This field of study has received little attention in the past.

## REFERENCES

Bansen, S.S. and Stevens, H.A. 1992. Women's experience of miscarriage in early pregnancy. *Journal of Nurse-Midwifery*. 37(2):84-89.

Beil, E.R. 1992. Miscarriage: The influence of selected variables on impact. *Women and therapy*. 12:161-173.

Beutel, M., Deckard, R., Von Rad, M. and Weiner, H. 1995. Grief and depression after miscarriage: Their separation, antecedents and course. *Psychosomatic Medicine*. 57:517-526.

Bourne, S. and Lewis, E. 1991. Perinatal bereavement: A milestone and some new dangers. *British Medical Journal*. 302:1167-1168.

Boyle, F. M. 1997. *Mothers bereaved by stillbirth, neonatal death of sudden infant death syndrome*. Sydney: Ashgate.

Boyle, F. M. and Chapman, R. 1997. *Enhancing general practice care for women following miscarriage*. Unpublished manuscript, University of Queensland.

Brown, H. J. 1997. Tanner's story: A phenomenological stance towards newborn death. *Canadian Journal of Nursing Research*. 29(4):21-31.

Cecil, R. 1994. I wouldn't have minded a wee one running about: Miscarriage and the family. *Social Science Medicine*. 38(10):1415-1422.

Friedman, T. and Gath, D. 1989. The psychiatric consequences of spontaneous abortion. *British Journal of Psychiatry*. 155:810-813.

Gamlin, R. 1995. Using hope to cope with loss and grief. *Nursing Standard*. 9(48):33-35.

Gilbert, K. and Smart, L. 1992. *Coping with infant or fetal loss, the couples' healing process*. New York: Brunner/Mazel Publishers.

Hemminki, L. 1998. Treatment of miscarriage: Current practice and rationale. *Obstetrics and Gynecology*. 91(2):247-253.

Hull, M., Joyce, D., Turner, G. and Wardle, P. 1997. *Undergraduate obstetrics and gynecology* (3rd edition). Oxford: Butterworth Heinemann.

Husserl, E. 1970. *Formal and transcendental logic*. The Hague: Martinus Nijhoff.

Jacobs, J.B. and Harvey, J. 2000. Evaluation of a miscarriage support programme of care. *British Journal of Nursing*. 9(1):1163-1168.

Johnson, M.P. and Puddifoot, J.E. 1996. The grief response in the partners of women who miscarry. *British Journal of Advanced Nursing*. 21:827-836.

Koziol-McLain, J., Whitehill, D. S., Stephens, L., O'Flaherty, E., Morrell, M. and Chapman, M. 1992. An investigation of emergency department patients' perceptions of their miscarriage experience. *Journal of Emergency Nursing*. 18(6):501-505.

Leininger, M.M. 1984. *Care the essence of nursing and health*. Detroit: Wayne State University Press.

Mander, R. 1994. *Loss and bereavement in childbearing*. Melbourne: Sage Publications.

Mooahan, J., Ashe, R.G. and Cecil, R. 1994. The management of miscarriage: Results from a survey at one hospital. *Journal of Reproductive Infant Psychology*. 12:17-19.

Morrison, P. 1994. *Understanding patients*. London: Bailliere Tindall.

Munhall, P.L. and Oiler, J. 1986. *Nursing research, a qualitative perspective*. Sydney: Prentice Hall.

Murphy, F. 1998. The experience of early miscarriage from a male perspective. *Journal of Clinical Nursing*. 7:325-332.

Murphy, S. 1992. *Talking about miscarriage*. London: Sheldon Press.

Neugebauer, R., Kline, J., O'Connor, P., Shrout, P., Johnson, J., Skodol, A., Wicks, J. and Sussner, M. 1992. Depressive symptoms in women in the six months after miscarriage. *American Journal Obstetrics and Gynecology*. 166:104-109.

Ney, P.G., Fung, T., Wickett, A.R. and Beamann-Dodd, C. 1994. The effects of pregnancy loss on women's health. *Social Science and Medicine*. 38(9):1193-1200.

Nikcevic, A.V. and Kuczmierczyk, A.R. 1999. Investigation of the cause of miscarriage and its influence on women's psychological distress. *British Journal of Obstetrics and Gynaecology*. 106:808-813.

Niven, C.A. and Walker, A. 1996. *Conception, pregnancy and birth: The psychology of reproduction*. Oxford: Butterworth and Heinemann.

Patterson, E. F. (1998). The philosophy and physics of holistic health care: spiritual healing as a workable interpretation. *Journal of Advanced Nursing*. 27:287-293.

Prettyman, R.J., Cordle, C.J. and Cook, G.D. 1993. A three-month follow up of psychological morbidity after early miscarriage. *British Journal of Medical Psychology*. 66:363-372.

Puddifoot, J.E. and Johnston, M. 1997. The legitimacy of grieving: The partner's experience of miscarriage. *Social Science and Medicine*. 45:837-845.

Rajan, L. 1994. Social isolation and support in pregnancy loss. *Health Visitor*. 67(3):97-101.

Rajan, L. and Oakley, A. 1993. No pills for heartache: The importance of social support for women who suffer pregnancy loss. *Journal of Reproductive and Infant Psychology*. 11:75-87.

Reed, K.S. 1992. The effects of gestational age and pregnancy planning status on obstetrical nurses' perceptions of giving emotional care to women experiencing miscarriage. *Image*. 24(2):107-110.

Valle, R.S. and King, M. 1978. *Existential phenomenological alternatives to psychology*. New York: Oxford University Press.