MISCARRIAGE: AN EXPLORATION OF WOMEN'S EXPERIENCE

A QUALITATIVE STUDY

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ABSTRACT

Miscarriage can result in significant psychological distress to women. However, many women experience a cultural norm which attributes minimal meaning to the loss. This is reflected in the lack of support experienced from interaction with both medical professionals and those within the individual's social context.

This qualitative study reports on the unique experiences of six South African women; their experience of other's reactions to their miscarriage; and their recommendations for better coping with the experience. Data was gathered using one semi-structured interview. Data reduction and analysis followed using a four-stage model of thematic outlines, coding, and comparisons (Marshall and Rossman 1998:152; Marck and Field 1994:9).

The objective of the analysis sought to compare the themes generated by the actual data collected with those described in other studies. In this way the findings of the study are generalisable to a larger population and allows for a greater sense of representivity (Silverman 1994:160). Comparisons were made between the women's experiences, as told by them, and Bowles' identification of the Four Domains of Miscarriage Distress Symptoms (2000).

The women viewed psychological support as essential in the process of coping; and acknowledgement of their loss as being the loss of a child, as a strong determinant of coming to terms with the loss. A strong need to have support from other women who had shared the experience was voiced.

Recommendations for improved intervention are made. In short the core recommendations are: the provision of patient follow-up; the provision of written material; and, specialist training for those working in the area of pregnancy loss.

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CHAPTER ONE
INTRODUCTION

1. Background to the study

My primary interest over the past years has been the human response to pain; more specifically emotional pain. Grasping the proverbial nettle and learning to integrate the scope of life's experiences into the living of life. Pain, in all its forms, comes to us as inescapable; its impact on our lives immense despite our sophistication. In an effort to bring meaning into, and control over our experiences, we slip with ease into the 'good – bad' role, tainted with dogmatic superstition. To recoup a sense of control we linger in the tunnels of blame – ourselves, others, God and evil.

It is not about procuring immunity from pain, but about learning to integrate it into our biographies; learning to attribute meaning and to manage these experiences.

Practice experience has shown that often the loss associated with miscarriage goes by unacknowledged, other than in the context of the medical model which views the human body as a biological and clinical organism. McAndrew (in Dominelli 1990:40) suggests that the emotional needs of women are generally not addressed by the medical practitioners attending to them (Field et al 1994:281). This thinking corresponds with the view of the female body being portrayed as a 'faulty machine' which can fail as a result of hormonal problems, historical or congenital psychological defects. Having a child is portrayed as fundamentally a biological and clinical experience which can either be 'put right' following dysfunction or the dysfunction be prevented (Nicolson 1998:3). With this view in mind I have chosen to draw on the writings of Jacques Kriel, a South African who has made a significant contribution in the area of transformation of the medical model.

In seeking to gain insight into how women experience miscarriage, it is important to consider the context and setting in which these experiences occur.
Social values and perceptions, be they from the medical profession or the value society accords to individuals, all impact on the way women perceive themselves and their value in society. Where miscarriages are acknowledged it is generally in the context of the medical model, providing little meaning to the particular life experience as a whole.

It would appear that research in the area of miscarriage is noticeably lacking, particularly in the South African context. It has been proposed that one reason why this limitation may exist, generally, is that miscarriages are seen as defiantly resistant to prevention and solution (Hey et al 1989:60). This, however, does not account for the lack of available information regarding how women experience miscarriage against their background of roles, expectations of womanhood and purpose. Neither does it account for the obvious dearth of supportive resources, (viz. counselling, accessible information) available to such women. This apparent lack may be viewed as either an assumption that emotional problems do not exist; or possibly, that those individuals experiencing problems are unable to cope (Dominelli 1990:40). This in turn contributes to often already fertile ground of guilt, self-blame and isolation.

It is, however, encouraging to note the recent increased recognition being given to women's health issues at various international levels. In the United States of America, a National Institute of Health task force on women's health issues predicts that women's health research will expand into the coming century and will no longer be divorced from mainstream medicine. The report concludes that studying women will "correct essentially male models of normal function and disease" (Volz 2000:11). Wetzel (2000:205) similarly notes that for the first time in history, in 1996, the United Nations focused on the global conditions of women. Similar policy development can be followed in South Africa, however, as Klugman cautions, policy is only as good as the capacity to implement it. While existing policy commitments such as 'a caring culture', 'health promotion' and 'community participation' are all cornerstones of the national health policy, they remain dependent on social, economic and cultural relations in society (1999:66).
While the above is indicative of more progressive thinking, the current reality of little attention to women's issues remains.

The meaning of miscarriage for women would, as in all experiences, be founded on the three pillars of what the individual considers to be knowledge, how the knowledge is used to make sense of the experience and how the experience is then incorporated into their biographies (Nicolson 1998:47). Given that the general response of society is to avoid dealing with the emotional aspects of miscarriage it can be asserted that women often lack the knowledge they need to make constructive meaning of their experiences.

Consequently, women often suffer in isolation, an element further encouraged by the nature of gender socialisation prevailing in South Africa. Gender socialisation is a crucial determinant in woman's sense of womanhood, role and purpose (Giddens 1989:162). Having children is seen as the crux of this socialisation; the completion of being an adult woman (Phoenix, Woollet and Lloyd 1991: 59).

Oakley's observation supports this notion as she states, "cultural femininity and biological reproduction are curiously synonymous in the proclamation of medical science about women" (in Nicolson 1998:2). The norm in female socialisation does not allow for deviation from this framework, thereby prolonging the process of coming to terms with the loss (Phoenix, Woollet and Lloyd 1991:48-55, Ireland 1993:153). Baruch (1999:94) similarly suggests that women who internalise the social norms expressed by the dominant gender roles often view themselves as defective. For many women infertility carries a shrouded stigma borne of shame and secrecy.

In the final analysis we are confronted by a social paradox with the common occurrence of miscarriages on one hand, and the shroud of silence which veils the experience, on the other. Practice experience has shown that miscarriage is treated as a social taboo with effort being channelled into avoiding and dismissing the experience. This stance merely serves to devalue the magnitude of the experience in the lives of the individuals concerned, and the mourning process deemed to be so critical in any loss. Field (1994:281) highlights the need each woman who has miscarried has, to make sense of her experience; moving toward an understanding which comes as the individual is 'allowed' to experience her pain in honesty with others.

It is suggested, by McAndrew (in Dominelli 1990:40) that the feminist approach of addressing the emotional concerns of women who have experienced miscarriages, reaffirms the individual's emotional health, regardless of whether or not they have entered motherhood.

The intention of this research has been to explore women's experience of miscarriage with the view to –

- Acknowledging miscarriage as part of womanhood; and,
- Working toward proposed supportive resources for women who have miscarried their children.

The study can consequently be viewed as fundamentally feminist in nature as it makes a study of this private experience, with affirmation and acknowledgement of women as the underpinning ideology.

2. AIMS

This thesis aims to draw on the experiences of six South African women in order to gain insight into their experience of miscarriage. In doing so, to begin to understand how the healing professions may better assist such women in integrating the experience of loss into their lives as a whole.

3. OBJECTIVES

The objective was twofold –

I. To gain insight into how women experience miscarriage; their own reactions; and their experience of other's reactions.

II. Secondly, based on these perceptions, to identify supportive resources needed in coping and dealing with the loss.

The essence of the aims and objective may be simple in statement, however, they impose various limitations on both the study and the findings:

A limitation encountered was the apparent lack of available South African literature on the topic. The majority of work referred to originates in western countries (predominantly the United Kingdom and the United States of America).

Another limitation of this study was the inconsistency in the degree of data analysis of each participant's information. This resulted from a variation in depth and quantity of information volunteered by each participant. Despite the varying depths, each participant offered some information on each of questions asked.

The study is also limited to the experience of women and does not make inquiry into the partner's experience.

4. OUTLINE OF THESIS

The thesis is contextualised by the Literature Review, chapter two.

Key focus areas are:

- A brief definition and description of miscarriage.
- Psychological consequences and models of coping. The four domains of miscarriage distress symptoms. Emotions, and related/associated disorders.
- Intervention considerations by the medical profession

The Design and Methodology chapter outlines the research design, methods, ethical considerations and limitations. The study followed a qualitative research method using a purposive, non-probability sampling design. The purpose of the qualitative methodology was to gain an understanding of the participant's experience, not to objectify, measure or test (Field 1994:11). Powell (in Carter et al 1996:7) asserts that feminist research should not only be concerned with rendering women's experiences visible but also to legitimate and authenticate the individuals and their experiences.

A qualitative research design respects these underpinning values and is consequently well aligned with the purpose and philosophy of the study. The instrument used to gather the data was an in-depth, semi-structured interview schedule guided by the following questions:

1. Tell me about your experience of miscarriage.
2. Can you tell me how others reacted and how you felt about these reactions?
3. What do you think women who have experienced miscarriages need in order to cope with the experience?

The women were interviewed once after which the audio recordings were transcribed.

The Data Analysis and Presentation chapter offers a discussion of the raw data with the view to describing individual experiences.

The questions were broad and consequently encouraged sub categories. An overview of the answers to these questions is presented and includes a thematic analysis and discussion. Bowles'(2000) identification of the four domains of miscarriage is used as a foundation for much of the discussion.

The study concludes with the chapter, Conclusions and Recommendations, providing closing comments to the findings.

Thoughts penned by Viginia Woolf (in Adams 1999:8) reflect something of the essence of this study; the inescapable connection between the experiences of the body and the mind.

> *... literature does its best to maintain that its concern is with the mind; and that the body is a sheet of plain glass through which the soul looks straight and clear, and, save for one or two passions such as desire and greed, is null and negligible and non-existant. On the contrary, the very opposite is true. All day, all night the body intervenes; blunts or sharpens, colours or discolours, turns wax in the warmth of June, hardens to tallow in the murk of February. The creature within can only gaze through the pane – smudged or rosy; it cannot separate off from the body like the sheath of a knife or the pod of a pea for a single instant; it must go through the whole unending procession of changes, heat and cold, comfort and dicomfort, hunger and disatisfaction, health and illness, until there comes the inevitable catastrophe; the body smashes itself to smithereens, and the soul, it is said, escapes. But of all of this daily drama of the body there is no record. People write always of the doings of the mind; the thoughts that come into it; its noble plans; how the mind has civilized the universe. They show it ignoring the body in the philosopher's turret; or kicking the body, like an old leather football, across the leagues of snow and desert in the pursuit of conquest or discovery. Those great wars which the body wages, with the mind a slave to it, in the solitude of the bedroom agains the assualt of fever or the oncome of melancholia, are neglected.*

Each individual experience is interpreted in the midst of the internalised norms and values adopted from the particular society, and as such, the interaction between the individual and her known world.

It is by no means anticipated that one such study will overturn perceptions and value systems. The exercise has simply been a consideration and an acknowldgement that there is possibly room for greater understanding of the experiences of those around us.

CHAPTER TWO
LITERATURE REVIEW

INTRODUCTION

This chapter seeks to build a logical framework for the research by reviewing related literature. It aims at understanding the experience of miscarriage from a psychosocial perspective. It is not intended to provide a medical description or in any way enter into a medical discussion. Simple medical references to descriptions and definitions serve purely to contextualise the broader discussions. Explanations around the medical reasons, symptoms and causes are quite readily available in medical journals and gynaecological texts.

Aligned with Marshall and Rossman's (1999:43) four-function paradigm of the literature review, the review attempts to:
Firstly, demonstrate the underlying assumptions behind the general research questions. Secondly, it will aim at demonstrating an understanding about related research and work surrounding the study; Thirdly, it identifies a gap in available research for South African literature; Lastly, the review of literature establishes the research questions by providing a context in larger empirical base.

To this end I have formulated the literature review to provide a logical framework for each of the core areas explored in the study:

1. Miscarriage defined and described in brief.
2. The women's own experience of miscarriage; her reactions.
3. Their experience of other's reactions.
3. Treatment/Intervention considerations.

1. MISCARRIAGE DEFINED AND DESCRIBED IN BRIEF

1.1 **Definition** – *'...any pregnancy loss, that is the loss of an embryo or foetus that occurs before 20 weeks gestational age, which is approximately up to the 5th month.*"(Hill 1997:1; Turkington 1999: 1; Polaneczky 1999:174) Turkington further elaborates by stating that most miscarriages occur during the first 14 weeks of pregnancy. The legal definition of a miscarriage in the United Kingdom is the spontaneous loss of a baby of 24 weeks or less.

After 24 weeks of gestation, the spontaneous loss of a baby is termed a stillbirth. When a baby dies in the womb but is not miscarried spontaneously, it is referred to as an intrauterine death. (Regan 1997:6).
The formal medical term for miscarriage is "spontaneous abortion" (Hill 1997:1).

1.2 Terminology and use of Language

> *"Words... should be discarded as soon as they begin to conceal what they ought to illuminate. Our terminology should be flexible in order to bring more and more of human experience into the range of our theory"* (Goldenberg in Field and Marck 1994:268).

A major problem identified with the medicalised interpretations and terminology surrounding miscarriages is their alienating language. Hey (in Hey, Itzin, Saunders & Speakman 1989:60) refers to the 'language of control'. According to Bloom (in Mirkin 1994:288) medical literature has constructed infertility as a social disease, interpreting it as a disorder of civilisation and modern living, involving culpable acts of omission and commission, largely on the part of the woman. The echoes of 19th-centuary physicians' and social critics concerns about women's health and their activism, are still heard in the current discussions of the causes of infertility.

Women's feeling of alienation from the medical vocabulary is frequently cited in research. Talk of 'foetus', 'products of conception', 'little bits of meat' and 'spontaneous abortion' are irreconcilable with the feelings of wanting a baby and having lost a baby. As Hey (in Hey et al 1989:60-63) reports one woman commenting – 'We had not been expecting a 'foetus'; we had not anticipated a 'product of conception joining our household'. While the terms are medically correct its use depersonalises the experience. Hey suggests that this process serves to keep both the threatening emotions and the professionals under control. There is a sense that the 'safe medical language' works fundamentally as a self-protection for professionals whose daily lives are often filled with potentially emotionally charged experiences.
The formal medical term for miscarriage is "spontaneous abortion". However, there is increasing disagreement with its use and dissatisfaction with the term as it creates confusion among patients (Hill in Cooper 1997:1).

A search of two major United States journals of obstetrics and gynaecology has shown that the word *abortion*, rather than miscarriage, to describe early pregnancy loss is 6 times more likely to be used compared with most other English language journals over the last 5 years. The use of *miscarriage*, with descriptive adjectives such as threatened, incomplete, and complete, is rather recommended. Similarly the term miscarriage is suggested rather than that of *missed abortion* (Hutchon and Cooper 1998:397).

However, Freeling (1998:1) suggests that changing terminology is no substitute for good consultation skills. A risk is that simply the use of the "correct" terminology, with no or little attention paid to the broader aspects of a consultation, could lead to professional complacency. It is suggested that the nature of the discourse used by a particular discipline will in turn guide their therapeutic approach (Degenaar in Kriel 2000:54). This would indicate the traditionally clinical and pathological/dysfunction-focus within traditional medical care.

There is the suggestion that distress in women who have miscarried would be reduced if changes were made in the language used by their professional carers. It is recommend that the word "abortion" should be avoided because the lay public interprets it as applying to a chosen termination of pregnancy. The authors cite alternatives that could be adopted such as 'delayed miscarriage' and 'silent miscarriage'. They refer also to a study group on early pregnancy loss, which recommended new medical terminology that avoids the word abortion for spontaneous early pregnancy loss. The language culture cannot be changed without a change in the medical literature. Editors of medical journals are urged to ensure that the term abortion is avoided when spontaneous pregnancy loss is meant (Hutchon and Cooper 1998:1081).

Concern over the terms of the procedures similarly exists, as the medical procedures for a miscarriage and an elective abortion are the same. Dilation and curettage (D&C) or dilation and evacuation. The same procedure for two distinctly different reasons may contribute to confusion as to whether the pregnancy ended by chance or choice (Renner, Verdekal, Brier & Fallucca 2000:65).

Different disciplines give different descriptions to phenomenon, each forming a language play of its own, with its own game rules. Degenaar (in Kriel 2000:54) distinguishes five such descriptions: neurological, physiological, behavioural, subjective and psychiatric. He illustrates by using the phenomenon of pain, suggesting that Neurologists speak about pain

in terms of nerve impulses. Psychologists talk and organise therapy around emotions. Philosophers focus on sensations, feelings, suffering and meaning. Kriel suggests that no single approach can or should claim to the only 'language game', the only strategy or method in dealing in a particular area.

Hey (et al 1989:61) claims that even within its own framework, the medical model's own terms are inadequate with respect to the actual physical account of miscarriage. Within the medical model the experience of miscarriage is measured against the experience of menstruation rather than labour. It is suggested that this management of the loss compares the pain of the loss with the 'humdrum business of monthly blood loss – as doctors are taught'. In this way the child metaphorically is removed from the picture together with the emotional element. The management of the loss is simplified in that easier and more comfortable meanings can be imposed on the woman. It is suggested that the quality of both short and long-term care will be inadequate with this view that the woman has 'only lost pregnancy tissue' or has 'only had a heavy period'.

The concern with terminology is not confined to the medical profession but extends to the broader social setting of each individual. The lack of understanding from those in woman's immediate social setting can often be more discomforting than the interaction with the medical profession, as a deeper level of understanding is often expected. Common-sense language from peers can be distancing and often serves to protect the sense of inadequacy often felt when confronted by potential raw emotion, fear and the death taboo (Hey et al 1989:63).

1.3 A Brief Description

1.3.1. Causes and symptoms

"human reproduction is a remarkably inefficient process" (Lockwood 2000:355)

Hill (in Cooper 1997:1) suggests that the loss of a baby through a miscarriage is "one of the most devastating events in a couple's life." Despite the ever-increasing provision of information on the subject, most people are unaware that approximately 50% of all pregnancies end in a miscarriage. Other researchers report figures closer to 20% of all pregnancies (Turkington 1999:1; Henderson 2000:12; Renner et al 2000:65; Swanson 2000:191; Eisenberg, Murkoff & Hathaway 1996:96; Berryman, Thorpe & Windridge

1996:84). However, it is almost certain the figure of 20% is an underestimate as it excludes miscarriages during the first half of the pregnancy and only reports on those experienced after 20 weeks (Renner et al 2000:65).

The most common cause is a genetic abnormality of the foetus. Not all women realise that they are miscarrying and others may not seek medical care when it occurs. 85% to 90% of women who have had one miscarriage subsequently have a normal pregnancy and healthy baby; 60% are able to have a healthy baby after two miscarriages. Even a woman who has had three miscarriages in a row still has more than a 50% to 75% chance of having a successful pregnancy the fourth time (Turkington 1999:1; Koontz 1998:50).
Hays (in Koontz 1998:50) comments that miscarriages caused by chromosomal or other genetic abnormality that cannot be prevented is a "normal part of reproduction, not a failure". A foetus that is so abnormal would have little survival chance and is consequently rejected at an early stage.

The reasons why a woman's pregnancy ends in miscarriage are numerous and often not clear. However, more than half the miscarriages that occur in the first eight weeks of pregnancy involve serious chromosomal abnormalities or birth defects that would make it impossible for the baby to survive (Turkington 1999:2). Other clinicians suggest higher figures of approximately 65% to 90% of clinically recognised early pregnancy losses linked to chromosomal abnormalities, with the occurrence of such abnormalities correlating strongly with increasing maternal age (Lockwood 2000:15).

These differ from inherited genetic diseases and probably occur during development of the specific egg or sperm, and therefore are not likely to occur again. In about 17% of cases, miscarriage is caused by an abnormal hormonal imbalance. In another 10% of cases, there is a physiological problem with the structure of the uterus or cervix. The risk of miscarriage is increased by: Smoking (up to a 50% increased risk); Infection; Exposure to toxins (such as arsenic, lead, formaldehyde, benzene, and ethylene oxide); Multiple pregnancy; Poorly controlled diabetes (Turkington 1999:2; Eisenberg et al 1996:97).

Doctors cannot prove emphatically that certain lifestyles cause women to miscarry, however recent research suggests some significant correlations between certain habits and

health conditions: stress, the lack of rest, caffeine intake, alcohol intake, cigarettes, amniocentesis (Koontz 1998:50; Dunbar 2000:1).

Olsen, Basso and Christensen (1999:49) report on a study regarding male factors and socio-economic indicators, as related to miscarriages, by stating that the risk of a miscarriage is probably determined by environmental as well as genetic factors. The genetic trait stemming primarily from the mother, however paternal genetic factors cannot be excluded.

2. THE WOMEN'S OWN EXPERIENCES OF MISCARRIAGE: HER REACTIONS

2.1 Psychological Consequences

The psychological consequences of miscarriage were largely ignored until the late 1980's (Reinharz in Zucker 1999:3). Bowles (2000:2) suggests that the situation is still one of sparse availability of scientific literature on conditions related to foetal loss, such as depression, anxiety and prolonged grief. In contrast to abortion, miscarriage is a reproductive difficulty that is unplanned. It is rarely viewed as providing a solution to the problem of undesired pregnancy, representing the loss of anticipated motherhood (Zucker 1999:3).

Clinicians report that for some women the event of a miscarriage can be traumatising. An increased concern has been voiced for greater attention of the evaluation and treatment of the psychological sequence following a miscarriage (Bowles 2000:2).

Practice experience has identified the perception that people often tend to dismiss a women's experience of miscarriage, or simply tell them to go have another baby. Clinically, depression is not screened for (Geller in Johnson 2000:1). Geller further cautions that women should be warned, by their obstetrician about the potential for these problems, especially those with a history of depression or anxiety symptoms. Psychologists and other attending clinicians are urged to be aware that a miscarriage in a woman's history is important.

The psychological consequences for women who have miscarried may vary tremendously depending on genetic makeup, past learning experiences and the extent to which maladaptive changes have progressed (LeDoux 2002: 281).

Individual characteristics, personalities, resources, beliefs, and their resultant cognitions and behaviours, coupled with the situational factors throughout the time of coping are among the strongest determinants of how the individual will fare both psychologically and physically, when faced with stressful experiences (Park 1998:2). In essence, people's interpretations depend on their personal and social resources as well as characteristics of the experiences.

Renner et al (2000:65) draws attention to reports by women who have had a miscarriage and describes the experiences as being quite different from those reported by other individuals who have experienced other types of loss such as a spouse, partner or parent. Lack of recognition that they have experienced a loss, is rather reported.

Satisfaction with social support suggests that social resources may enable people to interpret the stressful experience in a less threatening manner because of the positive context. It is also possible that opportunities for individuals to discuss and process the event are provided, thereby decreasing its aversiveness and possibly enabling people to make meaning and identify positive aspects (Lepore, Silver, Wortman, & Wayment in Park 1998:12).

2.1.1 **Finding Meaning and Coping**

The study of coping with traumatic and stressful experiences focuses on people's responses to circumstances, in terms of their attempts to alleviate their distress, and also to solve or resolve the problematic conditions that tax or exceed their resources (Lazarus & Folkman in Park 1998:4). Many versions of this basic transactional model have been proposed. These coping models traditionally describe the processes by which some people manage to maintain or restore their emotional equilibrium while others succumb to physical or psychological disorders.

Transactional models of coping posit that people's interpretations of an event determine how they respond in terms of their emotional reactions and their coping efforts. Interpretations are determined by many factors, among others, personality, worldviews, social support, socio-economic status, pre-existing physical and psychological adjustment, and previous experience.

The focus is on the interaction of characteristics of the person and the stressor, and emphasis is placed on the importance of the meaning of the stressor.

Park et al reports that probably the most consistent finding is that people more likely to report experiencing growth in response to stress are those possessing higher levels of optimism and hope. This correlation has been found in studies of people experiencing various life stressors, including bereavement. Several studies have reported similar findings in respect of spirituality or religiousness (e.g., Aldwin, Sutton, & Lachman, 1996; Park et al., 1996) as cited in Park (1998:8-11), religious participation (Tedeschi & Calhoun, 1996), and extroversion (Tedeschi & Calhoun, 1996). Belief systems and religious orientations may guide individuals confronting stressors to evaluate them and respond in certain ways, which then lead to particular levels of growth.

The individuals' satisfaction with their social support and experiencing more positive life events in the same 6-month period as that in which the stressful life event occurred, also predicted enhanced coping.

Coping involves a process of appraising the situation. An individual's appraisals of the extent to which events or situations violate her beliefs, expectations, and goals, largely constitute her assessment of the stressfulness of an event.

Primary appraisals -

such as the controllability of the event, the extent to which the event violates one's beliefs, expectations, and goals, and the extent to which the event is appraised as threatening versus challenging.

Secondary appraisals –

such as the extent to which individuals feel they have the resources to handle the stressful situation.

Several stress and coping models have been proposed to explain the processes by which stress-related growth and thriving may occur. The theories generally propose that people's initial responses to highly stressful situations are fraught with anxiety, distress, and confusion. According to most of these models, more stressful experiences disrupt a person's global meaning system, thereby providing more opportunities to experience growth (Tedeschi & Calhoun, 1995; Janoff-Bulman, 1992 in Park 1998:7-13).

The meaning of miscarriage for women would, as in all experiences, be founded on the three pillars of what the individual considers to be knowledge, how the knowledge is used

to make sense of the experience and how the experience is then incorporated into their biographies (Nicolson 1998:47). Given that the general response of society is to avoid dealing with the emotional aspects of miscarriage it can be asserted that women often lack the knowledge they need to make constructive meaning of their experiences. Consequently, women often suffer in isolation, an element further encouraged by the nature of gender socialisation prevailing in South Africa. Field (1994:281) highlights the need each woman who has miscarried has, to make sense of her experience; moving toward an understanding which comes as the individual is 'allowed' to experience her pain in honesty with others. Unacknowledged losses are more difficult to deal with and difficult to grieve (Dulwich Centre Newsletter 1996,3:1).

Against our commonsense understanding of life the recognition that a loss such as a miscarriage can happen can seem incompatible. Four themes of uncertain motherhood emerged from an exploration conducted by Field, Marck and Bergum (1994:268): Vulnerability, inner dialogue with uncertainty, search for care, and, living through possible motherhood. The uncertainty of a woman with a history of a miscarriage becomes central to her perceptions of herself as mother since the "natural order" of healthy pregnancy and childbirth did not necessarily translate into her experience. Feelings of bereavement and anxiety from experiences of miscarriage influence the journey through subsequent pregnancies (Berryman et al 1995:9).
Cognitive coping (or making meaning) is generally perceived to be a critical aspect of recovery following stressful experiences. It involves individuals' attempts to align the occurrence of the experience with their precrisis beliefs (such as beliefs in a just world and beliefs in their own invulnerability to harm).
When a situation is appraised as a violation, people can either change aspects of their global or situational meaning. That is, either make changes in their life to prevent future occurrences; or alter identify beliefs, which will lead to decreased aversiveness.
The individual may also attempt to assign more benign causes to the stressful situation or attempt to see the situation in a more positive light (Park 1998:8).

Religious coping is complex and may be especially related to reliance on one's personal relationship with God and on religious social support. A study of church members dealing with a variety of life events found that religious coping, spiritually based religious coping (receiving emotional reassurance and guidance from God) and good-deeds coping (living a

better life), proved to be helpful in coping positively with stressful events (Hettler & Cohen in Park 1998:10 and 11).
This manner of coping, however, was found to be influenced by other elements, such as the nature of the religious belief.

While the intention is never to underestimate the pain, despair and loss people may experience in the midst of their stressors, Park suggests that it is important to convey the idea that there is hope for the transformation of difficult, life-altering experiences; That coming to identify positive aspects of the stressful experience can be a viable option. Helping people to identify and nurture the positive resources and aspects of themselves following trauma and loss may assist in alleviating some of the long-term and even chronic suffering that many people experience.

Part of this paradigm shift involves changing cultural expectations. Individual differences and coping processes are contextualised within cultural expectations and beliefs regarding appropriate responses to stressful experiences. The societal understanding of illness is embedded in the broader world-view of that society. Consequently the view of healing depends on the view of the world and of people (Kriel 2000:1). Creating an awareness that the possibility of transformation and growth can exist as an outcome of trauma would possibly facilitate such a shift.
A more salient understanding of how people's personalities, resources, and coping efforts influence their behaviour following stressful experiences may lead to better provision of resources and interventions of helping professionals. Park illustrates by suggesting that if research continues to indicate that individuals with more social resources and more optimistic perspectives are more likely to grow and thrive following stressful encounters, interventions to promote those conditions could be developed and implemented. Psychotherapeutic and post traumatic interventions can likewise enhance post trauma coping.
Attention to the ethnic and cultural differences in expectations and beliefs may result in the development of more supportive social and cultural environment for enhanced coping.

2.2 Distress Response Symptoms

The nature and number of distress-response symptoms described in literature on miscarriage can be categorised into four spheres:

I. Psychological

II. Emotional

III. Physical

IV. Cognitive and behavioural

Domar (et al 1996:234) provides a comparison of distress scores, Figure 1, including infertility patients. The comparison is not specific to miscarriage but provides a context in which miscarriages frequently occur.

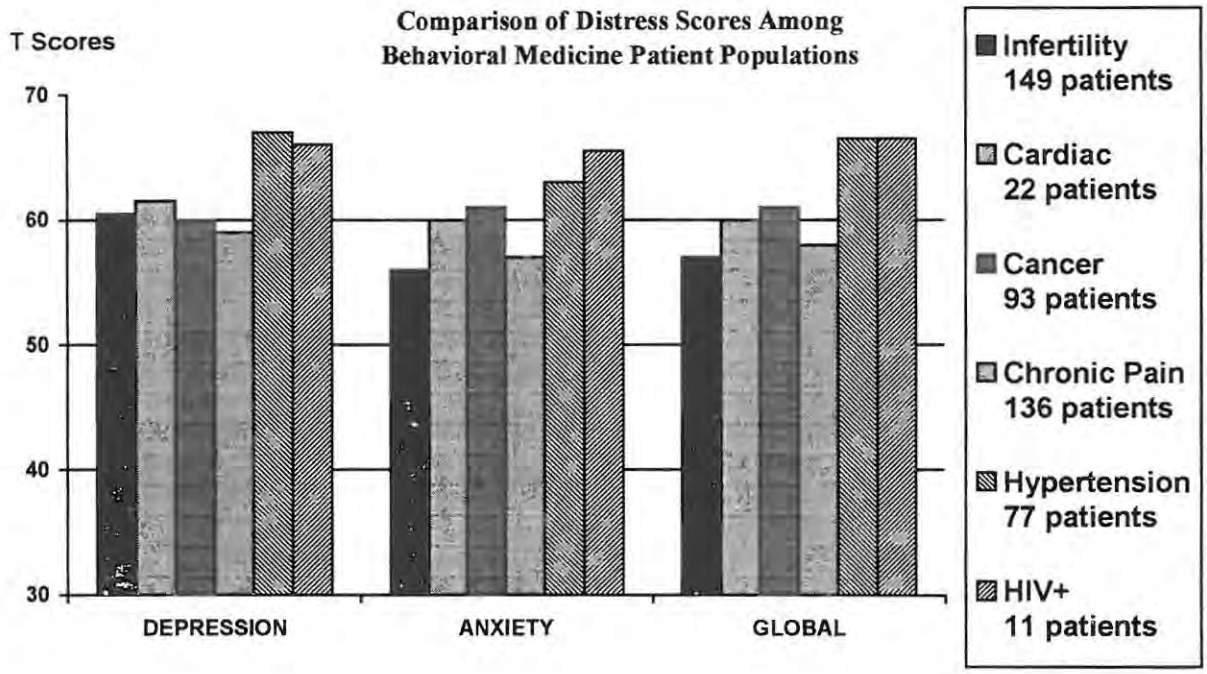

Figure 1

2.2.1 Depression

Depression results from an inability to make the appropriate adaptive response to stress (Duman in LeDoux 2002:280). Recent work has suggested that depressive symptoms and

anxiety are common among some women following miscarriage and that generally, miscarriage is often viewed as a traumatic event by the women who experience it (Zucker 1999:3). Depression is reported as a fairly common sequel to the acute phase of grief. Reports on typical symptoms of depression include lethargy, no desire for anything, changes in appetite and sleeping patterns, headaches and other pains, feelings of worthlessness and loss of confidence in self, not coping with daily routines, lack of concentration, irrational fear or behaviour, uncontrollable crying. Regan describes this as 'reactive depression' and suggests that is usually passes of its own accord, lasting for weeks to months (Regan 1997:247).

Based on this factor of unexpected loss and physical trauma associated with miscarriage, Zucker (1999:3) predicted that women who have experienced miscarriages will suffer from "higher levels of depression" and "intense emotional distress or trauma" than women who experienced other types of reproductive difficulties. The statistical data from Zucker's study confirmed that significantly more women who had miscarriages recalled experiencing depression and/or trauma than women who experienced other types of reproductive difficulties did.

Bhatia proposes that the grief reaction related to miscarriage is usually self-limited. It is suggested that if the reaction persists beyond eight weeks and self-esteem is reduced, the patient should be evaluated for an adjustment disorder with depressed mood or major depression.

Klock, Chang, Hiley and Hill (1997:1) provide evidence of 32% of a sample of fifty-seven women with recurrent miscarriages, could be classified as depressed. These subjects also reported higher than average levels of acute and chronic anxiety and lower marital adjustment. The findings indicated that having a living child was not a protective buffer against psychological distress. Geller, however, reported that the risk for depression was substantially greater for childless women (in Johnson 2000:1).

Findings appear to continue to be mixed about who is most at risk for depressive response, following a miscarriage. A study, conducted by Swanson (2000:191), using a path analysis based on the Lazarus Paradigm to predict Depressive Symptoms after Miscarriage, confirmed that women most at risk for increased depressive symptoms share the following characteristics:

- attribute high personal significance to miscarriage
- lack social support

- have lower emotional strength
- use passive coping strategies
- have lower incomes
- and do not conceive or give birth by 1 year after loss

The Lazarus Theory deals with emotions and adaptation.
The purpose of their study was to develop and test a theory based path model enabling prediction of the intensity of women's depressive symptoms at 4 months and at 1 year after miscarriage.
The Model constructs examined included:

Stage I

Contextual variables

gestational age, number of miscarriages, number of children, maternal age, perceived provider caring at the time of loss, and family income

Stage II

Interceding variables

perceived social support, emotional strength, and subsequent pregnancy/birth

Stage III

Primary appraisal of meaning

personal significance of miscarrying

Stage IV

Secondary appraisal

active or passive coping

Stage V

Emotional response

depressive symptoms

(The model accounted for 63% of the variance in women's depressive symptoms at 4 months and 54% at 1 year)

2.2.2 Loss - Grief

The authors of the works consulted generally indicated an understanding of the experience of miscarriage as an often-traumatic event, with reference to 'severe grief' and 'severe emotional distress' (Hill in Cooper 1997:3, Turkington 1999:4, Bowles 2000:4). Polaneczky (1999:1-5) notes grief, depression, sense of failure and anxiety about subsequent pregnancy in patients having suffered a miscarriage. She reports that for some a successful subsequent pregnancy can help resolve the feelings; however, for others the loss is mourned forever. The response to a miscarriage is in essence the experience of having responded to the notion of mothering a child; of having responded to the possibility of motherhood (Field and Marck 1994:125).

It is suggested that a miscarriage can cause feelings similar to the loss of a child or other member of the family (Turkington 1999:4). Hill observes that many women grieve as much over the loss of a baby in the first trimester as they do for a stillborn baby or for a child that dies months or years after the birth. He cautions that grief is unique and will be an individual experience (in Cooper 1997:3). Bereavement may be complicated as it is often a mourning of the loss of a future and expectations, not simply of an embryo (Slater 1999:2). Field and Marck (1994:282) report findings of the theme of buried pain repeatedly throughout their study. Where others had not acknowledged the loss of a previous child, it was reported that some women were left feeling unable to connect freely with a future infant.

While no bereavement is uncomplicated, Bowles identifies some of the possible contributing factors related to hope, bonding, meaning, validation and fulfilment of womanhood, responses of others, making amends for past "sins":

> *"Pregnancy is usually considered a special time in a woman's life. Hopes for the future, a sense of fulfilment as a woman, early bonding to the unborn child, and the expectations of one's partner and family, are factors that contribute to a complex emotional response to pregnancy. The meaning attached to a pregnancy may assume extraordinary importance for a woman. Besides validating femininity, having a child may be seen as the only way to save a marriage, to please a parent, to make amends for previous "sins" (such as an earlier induced abortion) or even to "replace" a child who has died. A couple struggling with infertility may have an even greater emotional (as well as financial) investment in a*

pregnancy. Thus, a spontaneous abortion can be extremely stressful for the mother, father, family, physician and others in the social support system."

It is noted that often when a miscarriage is followed by complicated bereavement, the primary care physician does not always consider the diagnosis of acute stress disorder or post-traumatic stress Bowles (2000:1)

Flemming poignantly describes the experience of pain in the following way -

" ...The result of these...and other encounters with pain was that I was diminished by it. It made me, for the first time, fearful. This type of fear is negative and narrowing. It serves no useful purpose. It is not always recognised by other people but gnaws internally and life, which could be full and vibrant, becomes mousy and colourless. The spark of the soul is muffled, hidden beneath layer upon layer of cottonwool security. ***Fear is essentially looking ahead with dread, and the dread is pain, the pain of sorrow or loss ... Living with any sort of fear is not living – it is partly living."*** (1990:21).

The fear of the unknown, the fear of adverse results of scans and tests is cited as a significant factor among women. Anxiety, caution, desperation and devastation are some of the terms noted by Berryman (1995:10-14) in her findings.

2.2.3 Guilt

Although women react differently, a miscarriage is for most of them an emotional as well as a physical experience and the personal significance will be much greater than the organisational definition allows. The miscarriage may also trigger many personal issues about a woman's fertility, her identity as a parent or her relationship with her partner, and her own attitudes to life and death. However women interpret the experience emotionally in the longer term, at the time, for the vast majority it will be a distressing and unexpected crisis involving some degree of physical discomfort or pain (Patton and Wood 1999:1).

Guilt and self-blame are reported as common emotions following a miscarriage (Regan 1997:247). Knowing why can become an obsession, which can in turn lead to the search to place blame somewhere specific. Often the individual places the blame on herself. Self-recrimination is nurtured as woman often report the view of miscarriage being seen as a punishment for ambivalent feelings related to the pregnancy (Hey et al 1989:69).

Thoughtless comments by others are often the fuel for this blame-placing and consequent guilt (Harkness 1992:177).

2.3 Disorders

Bahtia (1999:7) proposes that the grief reaction related to miscarriage is usually self-limited. It is, however, suggested that if the reaction persists beyond eight weeks and self-esteem is reduced, the patient should be evaluated for an adjustment disorder with depressed mood or major depression. Bowles (2000:1) identifies that when the distress response persists up to four weeks a diagnosis of acute stress disorder be considered. Symptoms persisting beyond four weeks should alert consideration of a diagnosis of post-traumatic stress disorder.

The major distinction between these two conditions is:
In *Acute Stress Disorder*, symptoms such as dissociation, reliving the trauma, avoiding stimuli associated with the trauma and increased arousal are present for at least two days but not longer than four weeks.
When the symptoms persist beyond four weeks, the patient may have Post-Traumatic Stress Disorder.
"Acute Stress Disorder (ASD) and Post-traumatic Stress Disorder (PTSD) in the Diagnostic and Statistical Manual of Mental Disorders, 4th ed. (DSM-IV), are described as consequences of exposure to an extremely traumatic event that arouses intense negative emotions in the individual involved." Diagnostic criteria for ASD and PTSD include dissociative symptoms, reexperiencing the trauma, avoidance of stimuli associated with the trauma and increased arousal. These symptoms impair psychological, social and occupational functioning.

2.3.1 The Four Domains of Spontaneous Abortion Symptoms

Bowles (2000:5) notes the striking similarities between descriptions of grief-related behaviours in miscarriage and those of ASD or PTSD after miscarriage. They are only distinguishable by careful review of the diagnostic criteria in the DSM-IV. Bowles provides insightful understanding of the distress-response symptoms following miscarriage

and it is to this end that I have drawn on his work to form much of the foundation of this section of the review.

A comparative review of the criteria of ASD/PTSD and the Distress-Response symptoms following miscarriage indicate the following, **Figure 2**:

The Four Domains of Spontaneous Abortion Symptoms:

Emotions/feeling states

Shock[*]

Numbness[[section]]

Guilt[[section]]

Anger[*][a]

Anxiety[a]

Depression

Self-blame[*]

Derealisation[*][sections]

Depersonalisation[*][sections]

Isolation[*][sections]

Physical symptoms

Empty feeling inside stomach[*]

Tightness in chest or throat[*]

Shortness of breath[*]

Weakness/fatigue[*]

Sweating[*][a]

Cognitive effects

Intrusive thoughts about foetus[*]

Hallucinations of a baby's cry/visual images of baby[*]

Phantom foetal movement[[section]]

Difficulty with concentration and decision making[a]

Fantasies about foetus[[section]]

Dissociative amnesia[[section]][sections]
Diminished situational awareness[[section]]

Behaviours

Difficulty sleeping (nightmares)[*][a]
Loss of appetite
Social withdrawal[sections]
Substance abuse/use[sections]
Avoiding medical facilities/personnel, pregnant women,
children, etc., to prevent reliving the event[*][sections]
Impaired social and occupational functioning[||]

The symbols denote the criteria areas of acute and post-traumatic stress disorder characteristics:

[*]--Reexperiencing the trauma.
[[section]]--Dissociative symptoms.
[a]--Increased arousal.
[sections]--Avoidance of trauma-producing stimuli.
[||]--Poor social and occupational functioning.

(Adapted by Bowles from Moscarello R. Perinatal bereavement support service: three-year review. J Palliat Care 1989(5):14 in Bowles 2000:13 and 14)

The symptoms of distress response after miscarriage include psychological, physical, cognitive and behavioural effects. It should be noted that patients with distress response after miscarriage often do not meet the criteria for acute or post-traumatic stress disorder. After a miscarriage, as many as 10 percent of women may have acute stress disorder and up to 1 percent may have post-traumatic stress disorder. This evidence is purely anecdotal with research needed to accurately quantify the extent to which the diagnostic criteria are applicable. Research data would provide an indication of other predisposing factors which could predict which women are most likely to develop ASD or PTSD (Bowles 2000:3).

Geller, as cited in Johnson (2000:1) identified a two and-a-half times greater risk of major depressive disorder and a five times greater risk of minor depressive disorder among women who have recently miscarried, relative to a community cohort. The risk for depression was substantially greater in childless women. Geller's findings emerged from a study conducted at the New York State Psychiatric Institute.

To provide further supportive research I refer to the illustrative case cited by Bowles (2000:4):

> *A 23-year-old woman who had a spontaneous abortion at 12 weeks' gestation reported a three-week history of feeling "numb and dazed" and emotionally unresponsive. She described frequently being in a dreamlike state in which things did not seem real. On careful questioning, she was unable to recall several aspects of her miscarriage. She was upset about reliving the experience over and over in her mind. She had difficulty falling asleep and was often troubled by nightmares about the miscarriage. Being present in medical facilities caused intense distress. The patient noted that her job performance had diminished, and she had become irritable at home and at work. She had usually enjoyed reading but now found it hard to concentrate. She was hypersensitive to sounds while trying to concentrate. In fact, she was startled so violently by loud sounds that her husband and co-workers had asked her what was wrong, to which she replied, "I don't know."*
> *The patient had no other medical problems and took no medications. She denied drug, alcohol or tobacco use. Findings on physical examination were normal except for mild tachycardia and excessive perspiring, consistent with anxiety.*

The researcher is unaware of any published studies examining the association between miscarriage and ASD. Bowles (2000:3) cites one study in medical literature concerning the relationship between miscarriage and PTSD.

2.3.2 Diagnostic Criteria for Acute Stress Disorder

A. The person has been exposed to a traumatic event in which both of the following were present:

1. The person experienced, witnessed or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.

2. The person's response involved intense fear, helplessness or horror.

B. Either while experiencing or after experiencing the distressing event, the individual has three (or more) of the following dissociative symptoms:

1. A subjective sense of numbing, detachment or absence of emotional responsiveness.

2. A reduction in awareness of his or her surroundings (e.g.," being in a daze").

3. Derealization.

4. Depersonalisation.

5. Dissociative amnesia (i.e., inability to recall an important aspect of the trauma).

C. The traumatic event is persistently reexperienced in at least one of the following ways: recurrent images, thoughts, dreams, illusions, flashback episodes or a sense of reliving the experience; or distress on exposure to reminders of the traumatic event.

D. Marked avoidance of stimuli that arouse recollections of the trauma (e.g., thoughts, feelings, conversations, activities, places, people).

E. Marked symptoms of anxiety or increased arousal (e.g., difficulty sleeping, irritability, poor concentration, hypervigilance, exaggerated startle response, motor restlessness).

F. The disturbance causes clinically significant distress or impairment in social, occupational or other important areas of functioning or impairs the individual's ability to pursue some necessary task, such as obtaining necessary assistance or mobilising personal resources by telling family members about the traumatic experience.

G. The disturbance lasts for a minimum of two days and a maximum of four weeks and occurs within four weeks of the traumatic event.

H. The disturbance is not due to the direct physiologic effects of a substance (i.e., a drug of abuse, a medication) or a general medical condition, is not better accounted for by brief psychotic disorder and is not merely an exacerbation of a pre-existing axis I or axis II disorder.

(American Psychiatric Association. Diagnostic and statistical manual of mental disorders, 4th edition. 1994:431-2)

2.3.3 Diagnostic Criteria for Post Traumatic Stress Disorder

A. The person has been exposed to a traumatic event in which both of the following were present:

1. The person experienced, witnessed or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.

2. The person's response involved intense fear, helplessness or horror.

B. The traumatic event is persistently reexperienced in one (or more) of the following ways:

1. Recurrent and intrusive distressing recollections of the event, including images, thoughts or perceptions.

2. Recurrent distressing dreams of the event.

3. Acting or feeling as if the traumatic event were recurring (includes a sense of reliving

the experience, illusions, hallucinations and dissociative flashback episodes, including those that occur on awakening or when intoxicated).

4. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

5. Physiologic reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

1. Efforts to avoid thoughts, feelings or conversations associated with the trauma.

2. Efforts to avoid activities, places or people that arouse recollections of the trauma.

3. Inability to recall an important aspect of the trauma.

4. Markedly diminished interest or participation in significant activities.

5. Feeling of detachment or estrangement from others.

6. Restricted range of affect (e.g., unable to have loving feelings).

7. Sense of a foreshortened future (e.g., does not expect to have a career, marriage, children or a normal life span).

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

1. Difficulty falling or staying asleep.

2. Irritability or outbursts of anger.

3. Difficulty concentrating.

4. Hypervigilance.

5. Exaggerated startle response.

E. Duration of the disturbance (symptoms in Criteria B, C and D) is more than one month.

F. The disturbance causes clinically significant distress or impairment in social, occupational or other important areas of functioning.

Specify if:

Acute: If duration of symptoms is less than three months.

Chronic: If duration of symptoms is three months or more.

Specify if:

With delayed onset: If onset of symptoms is at least six months after the stressor.

(American Psychiatric Association.Diagnostic and statistical manual of mental disorders, 4th edition, 1994:427-9)

Geller asserts that women who have had a miscarriage are eight times more likely to develop an episode of obsessive-compulsive disorder in the following six months than are women in the general population (in Johnson 2000:1-2).

There was no increased risk of developing any other anxiety disorder, such as panic disorder or phobia. All the women in Geller's study were interviewed at least once in the

six months following their miscarriage. The Centre for Epidemiological Studies Depression Scale and the Diagnostic Interview Schedule was administered. The findings of the research were consistent with what was noted in clinical situations with women who have miscarried. Similarities existed in anxiety symptoms, nervousness, and obsessive thoughts about self-blame and concerning not being able to conceive again. Geller reported a commonality among the research participants to feel the need to participate in rituals and compensatory compulsive behaviour to placate their feelings of loss and to prevent future loss.

3. THE IMPACT OF THE MEANING OF MISCARRIAGE TO OTHERS

Gender socialisation is a crucial determinant in woman's sense of womanhood, role and purpose (Giddens 1989:162). Having children is seen as the crux of this socialisation; the completion of being an adult woman (Phoenix, Woollet and Lloyd 1991: 59). Giddens further illustrates this by referring to children's classic storybooks, "Women who were not wives and mothers were imaginary creatures like witches or fairy godmothers" (1989:163). Oakley's observation supports this notion as she states, "cultural femininity and biological reproduction are curiously synonymous in the proclamation of medical science about women" (in Nicolson 1998:2). The norm in female socialisation does not allow for deviation from this framework, thereby prolonging the process of coming to terms with the loss (Phoenix, Woollet and Lloyd 1991:48-55, Ireland 1993:153). Baruch (1999:94) similarly suggests that women who internalise the social norms expressed by the dominant gender roles often view themselves as defective. For many women infertility carries a shrouded stigma borne of shame and secrecy.

Field and Marck (1994) report of numerous findings of women referring to themselves as "outsiders" by virtue of not having children. The valuative meaning attached to a miscarriage is consequently strongly influenced by this view. A participant in one such study reported the following perception about pregnancy regarding maturing and gaining entry into the adult world:

> *"It is important developmentally for an adult to have children, to go through recognised stages, rites of entry or passage in our society. If you don't enter those, there's a sense of being an outsider. Children are really important to have a sense that we're part of the mainstream and help us feel that we've come of age, reached a level of maturation."* (Field and Marck 1994:17)

It is this clash between social pressure to reproduce and the experience of miscarriage, amongst other reproductive difficulties, that may lead to a variety of psychological phenomena (Zucker 1999:1).

Reports by women who have experienced a miscarriage are often of friends and family responding in ways that seem to try to reduce the impact and importance of the event (Renner et al 2000:2 and Regan 1997:251). This invokes a sense of little support or understanding of what has been experienced. The loss appears to be unrecognised. Understanding comes as the woman experiences her pain as she finds others who would witness and genuinely share in it (Field 1994:281). What cannot be talked about cannot be made sense of and the individual cannot move on from it, this in turn means that safe passage through uncertain motherhood remains elusive for many (Field and Marck 1994:283). Hey (et al 1989:62) suggests that the sense of lack of support is partially exacerbated by the fact that we tend to have higher expectations of peer's understanding of our experiences.

Although the results of Renner study (2000:1) indicate that miscarriage is viewed as a loss, it is a loss with minimal grounded or valuative meaning for others. This suggests that the cultural norm of silence surrounding early pregnancy and miscarriage impacts on the miscarriage-response.

Physical aspects are the primary focus of the health care system and are generally attended to in a short time. However, the emotional aspects continue long after. As a result the support systems outside of the medical setting (e.g. family, friends, colleagues) become the primary factor affecting emotional care. Renner (et al 2000:2) refers to several other studies conducted by Madden, 1988; Reinharz, 1987, with the finding that women report friends and family reacting in ways that reduce the importance of the event by making statements that try to recast the miscarriage as a positive outcome ("It was better to have a miscarriage than a child with severe birth defects") or statements that focus on replacing the lost pregnancy with another ("You can have another child anytime you want"). These statements make it difficult for the woman to mourn the loss of her child and therefore do not offer support.

Luebbermann (in Renner et al 2000:2) comments that if the available self-help and coping guides are assumed to be representative of societal expectations on how to cope with medical or personal issues, we find these guides instruct the reader that "the first thing you must prepare yourself for is a lack of empathy and understanding at a time when you really need the most help and support".
Renner identifies that literature seems to suggest that both a confusing terminology and a norm of silence contribute to this disparity in loss-response.

In the final analysis we are confronted by a social paradox with the common occurrence of miscarriages on one hand, and the shroud of silence which veils the experience, on the other. Practise experience has shown that miscarriage is treated as a social taboo with effort being channelled into avoiding and dismissing the experience. This stance merely serves to devalue the magnitude of the experience in the lives of the individuals concerned, and the mourning process deemed to be so critical in any loss.

3.1 A Norm of Silence

Sociologists concerned with the study of reproductive and family issues report a norm of silence concerning the announcement of pregnancy. Once enough time has passed that the pregnancy has a high likelihood of resulting in a live birth, the silence is broken.
In technologically and medically advanced societies, life can be detected at earlier stages than ever before. This serves to make the pregnancy "real" at an earlier gestational period than was previously possible. This outcome results in the formation of early mother-child attachments, which in turn, result in a higher expectation that a pregnancy will result in a live birth than is statistically likely to be the case (Renner et al 2002:2 and 3)
There is similarly the 'complicating' factor of being able to 'see' the foetus, which may make it difficult to acknowledge that many factors still exist that could stop the process of development.
The duration of the pregnancy prior to miscarriage and the experience of seeing an ultrasound scan appear to be factors which contribute to the level of valuative meaning for others, in particular the male partners of the women (Puddifoot and Johnson 1999:1).

3.2 Ethnic and Cultural Influences

Ethnic and cultural environment largely dictate the expectations, beliefs and values of all participants in any experience. Bloom (in Mirkin 1994:292 and 293) draws attention to relatively recent western medical history. In 1931 medical experts attributed the causes of sterility to "modern women who transgressed the laws of nature". The American population crisis was said to be the responsibility of "fat women, academicians, public women, detached women and social corsairs." 19th century experts cast "women's failures" as "psychological aberrations". Infertility was depicted as a maladaptive disguise for the fear of, or hostility toward reproducing. As recently as the 1940' and 1960's the notions of "hypofeminity" and "female masculinity" emerged. Miscarriages were attributed to "habitual abortions" and "hostile mucus". Bloom finds that childless women in this era constituted a discarded group who were accused of selfishness. Literature suggests that this group were shamed in bringing their womanhood and character into question.

Rozario (in Ram and Jolly 1998: 154) highlights the experience of women in rural Bangladesh, whose culture views miscarriages, among other reproductive difficulties, as the result of evil spirits.

In South Africa the title of mother is a crucial indicator of women's strength and social standing. Lewis comments that for Black South African women, the title of 'mother' has little to do with individual women's experiences, but rather becomes a validating term which embodies the essence of their social standing (in Agenda 40 1999:39). The notion of discussion regarding reproductive issues or difficulties from the woman's perspective is not within accepted parameters of many cultures. Several studies have reported that communication between men and women about reproductive health ranges from minimal to non-existent. (in Agenda 40 1999:40).

> *Sex and sexuality are often the exclusive preserve of the African husbands, and if a wife initiates a discussion of family planning, she may threaten her husband's sense of control and generate mayhem within the family.*

(Biddlecom and Fopohunda in Maharaj Agenda 1999:39)

Against the background of this prevailing attitude it would be a natural progression to assume minimal acknowledgement of, support or understanding for the complexities of a miscarriage.

Until recently, literature in developed countries concerning women's emotional well being and meanings accorded to experiences has been scarce, especially the history of emotion, psychology and interpersonal relationships. Manderson (in Ram and Jolly 1998:27) comments on the added difficulty in drawing on these experiences of non-literate and often silenced women, in order to understand their experiences.
Dougherty (in Renner et at 2000:3) has suggested that there may be two types of culturally related meanings surrounding an individual's cognitive representation of miscarriage, namely:

3.3 Grounded Meaning and Valuative Meaning

Grounded meaning in this context, identifies the specific attributes, elements, and activities that surround the event. Grounded meanings are typically similar across all individuals within a culture. Renner interprets grounded meaning as 'concrete' meaning.
Valuative meaning is the significance attached to the grounded meaning. Valuative meanings are personal, experience-based and are often thought to be understood only by those who have shared similar experiences. This meaning has a significant emotional factor, not shared by grounded meaning.

The nature and respect accorded to an infertility-related experience such as miscarriage, predominantly depends upon the social evaluation attached to the issues such as childlessness, motherhood and women's autonomy (Bloom in Mirkin 1994:304).
Renner et al suggests that since miscarriage is an event that is largely unrecognised and shares a terminology with the socially volatile event of voluntary abortion, it is reasonable to suggest that a modest level of grounded and valuative meaning exists within the general population. A woman who has shared the same experience will almost certainly have acquired some increase in both grounded and valuative meaning. The discrepancy in valuative meaning between the woman who has experienced a miscarriage and those around her may be what explains the reports of seemingly unsupportive reactions.

Renner's study indicated that miscarriage is an event for which our culture has grounded meaning but little valuative meaning. Since the loss is not apparent valuative meaning is probably difficult for others to create. Others have not shared in the 'tangibility' and visibility of the pregnancy. It is suggested that women who experience the loss of a child, a stillbirth, or the loss of a loved one do not report the lack of support that women who have a miscarriage report (Renner 2000:9).
With the absence of valuative meaning, others have a limited ability to judge what to say to the woman. Minimal support during a traumatic time is consequently offered.
The study reported findings consistent with past research (e.g. Cole: 1987; Friedman & Gradstein:1982; Herz: 1984 in Renner et al 2000:9) that if the pregnancy was planned, the miscarriage was considered a traumatic event that would result in significant stress. However, if unplanned, the miscarriage was considered a loss, but not a traumatic or stressful event.

Renner's findings from the study, concluded that miscarriage is an occurrence that has grounded meaning for others but little valuative meaning. The reasons presented for this lack of valuative meaning include the fact that miscarriage is an event that is treated in "silence" culturally. The silence surrounding the early stages of pregnancy similarly contributes to the confusion of others regarding whether a pregnancy was planned. An early miscarriage similarly has few physical markers to observe a loss.
It is consequently suggested that lifting the silence surrounding the reporting of pregnancy would make it easier for the women who experience miscarriage to obtain social support.
Field and Marck (1994:286) present a process which the women in their study used as they appraised and coped with the perceived threat to becoming mothers:

There has been relatively little published research on the effects of miscarriage on the male partner. The partner is often assumed to be relatively impervious to such events (Puddifoot and Johnson 1999:1).
Puddifoot and Johnson report some interesting findings from the first large study in the UK. The Perinatal Grief Scale (PGS) was administered to the male partners of women who had miscarried. The outcome indicated a fairly similar scoring on overall grief. The manner in which the grief was handled varied with males more vulnerable to feelings of 'despair' and 'difficulty in coping' and displaying less immediate 'active grief'. High scores

on despair and difficulty in coping may indicate the risk of affective reactions in their daily lives (Lasker & Toedter 1991 in Puddifoot et al: 1999:4).
In terms of grounded and valuative meaning, as discussed previously, it could be construed that the male partners shared both the concrete and emotional meanings attached to the miscarriage.

The differing patterns for males and females confirm the intuitive generally accepted view that women would be more immediate in participating in active grief. The study revealed patterns that show unexpectedly high 'delayed' effects for men regarding their immediate and (and potentially longer term) future difficulty coping and feelings of despair.

One explanation of this may be due to the fewer opportunities men have for cathartic emotional expression during and immediately after the miscarriage. Social expectations and norms give rise to different responses, with women being expected to grieve and react most strongly in the immediacy of the miscarriage.
Puddifoot and Johnson report specifically on the remarkably high scores exhibited by those men who had seen an ultrasound scan.

4. INTERVENTION CONSIDERATIONS

> *"Whenever treatment directly neglects the experience as such and hastens to reduce or overcome it, something is being done against the soul. For experience is the soul's one and only noursihment"* (Hillman in Adams 1999:20).

> *"We need to get our antenatal work into focus, remembering that the process of childbirth is a continuous one...Antenatal care is an essential part of obstetrics, not a specialised stunt by itself, and the expectant mother is not an ambulant pelvis, but a woman with human needs, whose soul and body are closely interlocked...let us not forget the mother"* (Lancet, 7 July 1934, p.1198 in Oakley – the Captured Womb)

Despite the essence of the published extract dating back to 1934, it would appear that research in the area of miscarriage is noticeably lacking in the South African context. It has been proposed that one reason why this limitation may exist, globally, is that miscarriages

are seen as defiantly resistant to prevention and solution (Hey et al 1989:60). This, however, does not account for the lack of available information regarding how women experience miscarriage against their background of roles, expectations of womanhood and purpose. Neither does it account for the obvious dearth of supportive resources, (viz. counselling, accessible information) available to such women. This apparent lack may be viewed as either an assumption that emotional problems do not exist; or possibly, that those individuals experiencing problems are unable to cope (Dominelli 1990:40). This in turn contributes to often already fertile ground of guilt, self-blame and isolation.

From a medical perspective a miscarriage is rarely a medical emergency and may be viewed as a normal variation of early pregnancy. The view that it is more of a minor physical event contrasts sharply to the major emotional and personal significance it represents for many women. Hey reported that the feeling of exclusion from unmet needs met was primarily based on the reduction of the experience of miscarriage to a purely medical and physical event. This served to further devalue the complex experience of miscarriage (Hey et al 1989:58).
McAndrew (in Dominelli 1990:40) suggests that the emotional needs of women are generally not addressed by the medical practitioners attending to them (Field et al 1994:281). This thinking corresponds with the view of the female body being portrayed as a 'faulty machine' which can fail as a result of hormonal problems, historical or congenital psychological defects. Having a child is portrayed as fundamentally a biological and clinical experience which can either be 'put right' following dysfunction or the dysfunction be prevented (Nicolson 1998:3). Oakley (1979:279) reported that satisfaction with medical care reflects attitudes of criticism or deference. Her findings established the three most common complaints regarding hospital treatment as:

i. Feeling depersonalised
ii. Not being able to ask questions or not receiving satisfactory answers.
iii. Seeing too many doctors.

Perceptions too may differ vastly from woman to woman depending on knowledge, previous experiences and expectations. It is how a consultation is conducted that may influence whether a woman chooses to reveal such fears, anxieties and concerns to her medical carer (Freeling 1998:1). Miscarriage literature describes various responses and themes emerging as common to women experiencing miscarriage. However, in the midst

of shared emotions and lived realities, it is also noted that the intricacies of living through uncertain motherhood differ and are as unique to each individual as the very personal nature of the experience itself. Field and Marck (1994:283) report that caregivers who understand this distinctly individual nature of each experience are deeply valued by the women concerned.

Moulder suggests that the majority of the miscarriage literature provides guidance to health care professionals on how to provide appropriate support to women who have experienced a miscarriage. (in Renner et al:2000:1). However, ample evidence exists of patients' dissatisfaction with doctors' communication skills. Despite increased availability of information, many women still want to know more than that which is told by the doctor. Freeling identifies the patient's need to have an "absolute, uncritical confidence in their doctors' skills" (Freeling 1998:1). A study (Jewkes 1998) on the quality of care in family planning clinics in the Eastern Cape, South Africa, found that staff were equipped with sound clinical knowledge of procedures and processes but that poor attitudes prevented them from providing a good service (Klugman Agenda AGE Monograph 1999:52). Klugman cites various findings of women users of health services repeatedly reporting poor health worker attitudes as their main problem.

The frustration of searching for a caregiver who acknowledges the women's fears of a second pregnancy overrides the importance of recognition of the need for acknowledgement of the pain by others. Field and Marck (1994:281) report on this frustration, as one of their cohorts's articulated: "I couldn't find a doctor who could understand how concerned I was that it would happen again. The first family doctor that I came across said, 'Well these things happen and it won't happen again.' "
The physical aspects are the primary focus of the health care system and are generally resolved in a relatively short time, however, the emotional aspects continue long after the woman has left the health care provider (Renner et al 2000:1).

To enable the medical carer to better identify and address the individual's needs a consultation framework is proposed, the three-function model of the consultation.
The following model is suggested by Bird and Cohen-Cole (in Freeling 1998:2):

- gathering data to understand the patient;

- developing rapport and responding to the patient's emotions (to facilitate understanding and a sense of being understood); and
- patient education and behaviour management.

By way of this model the clinician is able to purposefully use the consultation as a skilful instrument to exchange information; to bring about action; and to arouse certain feelings. The process similarly addresses the three domains (cognitive, affective, and psychomotor). While the three-function model may present as simplistic and possibly obvious, ample examples of illustrative cases indicate that this process does not necessarily occur in the doctor-patient consultation process.

No single model can fully convey the complexity of the doctor-patient relationship, and the three-function model is by no means exhaustive but needs to be complimented by drawing on other concepts of the consultation process.
Robinson's study revealed a three-phase process by which physicians respond to emotional distress (2001:3-10).
Recognition – defined as acknowledging validity and genuineness.
Triage – defined as 'glossing over' the problem.
Management – defined in the medical sense as "a technique of treatment of disease".
In other words acknowledgement, prioritising and treatment. Despite these investigations, a solid model of physicians' response to emotional distress remains incomplete.

4.1 The Patient-Centred Clinical Method

The essence of this method is defined as the carer entering the patient's world to view the condition through the patient's eyes (McWhinney in Kriel 2000). Traditionally the health-care system is a pathology-based framework and not necessarily inclusive of the reality of the patient. The aim of the patient-centred method is to understand each case as unique in terms of the individual's expectations, feelings and fears. By using this approach the carer invites and encourages openness by the patient, thereby gaining an understanding of the meaning of the condition for that individual.

Field and Marck (1994:283) reported experiences of women suggesting that caregivers who encouraged women's concerns in their interactions made genuine differences in the

women's experiences. Reference is made to caregivers who show true concern, beyond medical concern, offering women the respect, comfort and tactful presence that can make their uncertainty endurable. Hey (et al 1989:60) suggests that the recognition of the loss as a loss of a future baby (embodying the complex hopes of motherhood) is more demanding both for the woman and for the medical carer. The simpler, less demanding option, is to medicalise the experience, containing it to the purely physical realm.

Swanson (in Field and Marck 1994:283) proposes a middle-range theory for caring. Caring is identified as including *Knowing* – striving to understand the event as it has meaning in the life of others. *Being with* – the caregiver being emotionally present; and, *doing for* another – meaning, to do what she would do for herself, if it were possible; *enabling* is facilitating movement through unfamiliar events, and *maintaining belief* – sustaining trust in the other's capacity to get through the event and anticipate a future of fulfilment.

4.2 Hospital Support Programmes

The Gynaecology Unit at the Mater Mother's Hospital in Brisbane, Australia, designed a support programme aimed at improving mental and physical outcomes for women experiencing miscarriage. The programme was designed by the staff of the unit. As part of the Miscarriage Support Programme a pilot programme 85 women were provided with a Care Information Package which included data on miscarriage and pathology. An offer of a follow-up telephone call three weeks following discharge was also made (James and Harvey 2000:35).

The evaluation of the programme indicated that the majority of the women found the package to be useful in addressing knowledge about miscarriage and identifying support programmes within the community. Others reported that it was a source of comfort and helped validate their feelings of loss.

4.3 Debriefing

Psychological debriefing is described as a systematic process that explores a person's experience, cognition, attributions of the event, and emotional reactions, in an in-depth manner. It likewise entails providing information about common reactions and coping

strategies. It is not to be categorised as merely talking about an experience and empathetically listening to someone in order to facilitate an understanding of typical reactions. (Stallard in Lumley 2001:2 and 3). Debriefing is aimed specifically at preventing Post Traumatic Stress Disorder (PTSD) and not depression. (Boyce and Condon in Lumley 2001:2).

It has only more recently been recognised that some medical conditions could induce trauma-response symptoms similar to those of Acute Stress Disorder (ASD) and PTSD. Although miscarriage may not seem to be in the same category of traumatic experience, some women are extremely vulnerable in this area and experience great difficulty recovering from the loss.

According to Bowles, prompt referral of patients with ASD/PTSD symptoms for trauma-related treatment gives them the best possible chance for early recovery. There is not consensus on the effectiveness of debriefing techniques, however, many therapists and carers cite positive outcomes.

Bohl (in Bowles 2000:9) found that using Critical incident stress debriefing (CISD) resulted in fewer long-term PTSD symptoms. The model was developed to accelerate recovery in persons who have normal reactions to abnormal events. Some women are classified in this category after suffering a miscarriage. Outcome research is still needed to support the assumption that early intervention following a miscarriage hastens the healing process (Bowles 2000:5):

Figure 3

Stages of the Critical Incident Stress Debriefing Process

Stage	Phase	Description
1	Introduction	Explains process, sets expectations
2	Fact	Patient describes traumatic event from a cognitive level
3	Thought	Allows patient to describe cognitive reactions and to make the transition to emotional reactions.
4	Reaction	Identifies the most traumatic aspect of the event for the patient and emotional reactions.

5	Symptom	Identifies personal symptoms of distress and transfers back to cognitive level.
6	Teaching	Educates about normal reactions and adaptive coping mechanisms, i.e. stress management.
7	Re-entry	Clarifies ambiguities and prepares for termination

Adapted by Bowles with permission from Mitchell JT, Everly GS. Critical incident stress debriefing. (Ellicot, Md.: Chevron, 1995 in Bowles 2000:14-15)

For many women dealing with the grief of a miscarriage is facilitated by the reassurance of their family and the support of their medical carer. However, for some women, an element of trauma exists. Occasionally the loss of an unborn child is perceived as a life-altering and unbearable personal catastrophe. Some women with these perceptions meet the criteria for ASD and, eventually, PTSD. In this instance intervention is needed such as that used with other trauma victims. For these patients, the best course of treatment is through the intervention of a physician trained in CISD.

Trauma-focused interventions can assist patients to achieve a better understanding of the event, recognise and accept the loss as a traumatic experience and successfully move on with their lives. Lumley (2001:1) emphasises the need for debriefing to be conducted by someone who can provide factual information and answer questions regarding the event.

History provides examples of misdiagnoses of PTSD as depression and/or anxiety. Regardless of the diagnosis, medical carers are urged to be aware of psychological problems following a miscarriage. There are various treatment interventions cited as being helpful such as psychotherapy and hypnotherapy. Kinkade (2001:1) notes that, firstly, physicians need to recognise the psychological complications of miscarriage and do something to help their patients and secondly, whether the diagnosis is clearly PTSD or not, psychotherapy and possibly medication can be offered. For patients who are assessed as having more depressive-type symptoms, antidepressants may be considered. The concern with the prescription of antidepressants is that a woman taking a regular prescription

medication often may assume that the medication had some role in possible subsequent miscarriages. Most women prefer not to take a medication, if possible, when they begin attempting a subsequent pregnancy.

Antidepressant medication is said to make the brain more adaptive and better able to overcome endangered states into which it was placed. The treatment itself does not give new memories, or directly substitute for direct experience, by placing the brain in a state in which new memory formation is facilitated, the depressed person may be able to learn new mental states and behaviours that override the modes that they had been locked into by depression. A therapist who has an understanding of the patient and of the underlying effects of the drugs may be in a position to serve as a guide to the recovery process. The individual could be assisted to turn to new and positive life experiences. According to LeDoux (2002:280), a brain on antidepressants can be brought back from its state of isolation from the outside world and encouraged to learn.

Current thinking suggests that depression is believed to involve altered circuits that lock one into a state of neural and psychological withdrawal. In this state the brain's ability to attend to, engage, and learn about the world is reduced. Positive treatment is consequently about assisting the person to reengage with the world.

Genetic makeup, past learning experiences and the extent to which the maladaptive changes have progressed all need to be considered before any one treatment is suggested (LeDoux 2002: 281).

There are clinicians who are opposed to the widespread use of drugs and argue for an approach to psychiatry based on love, trust, understanding and traditional psychotherapy (LeDoux 2002:275).

4.4 **Transforming the Clinical Model**– Integrating the world of scientific medicine with the human and social sciences

> *"The human person is not a body, and a mind which is an epiphenomenona of brain processes. The human person is an immensely complex, self-conscious, biological system in which all the systems function together. Persons cannot be understood in isolation from their bodies, or from the linguist and social system in which person-hood is established." (Kriel 2000:132)*

> *To say that, for example, a man is made up of certain chemical elements is a satisfactory description only for those who intend to use him as a fertilizer. (Muller in Adams 1999:19)*

Attention is drawn to the medicalisation of miscarriage. The healthcare system is essentially focused on addressing physical needs, the result being that more often than not women's psychosocial needs are overlooked. Attitudes of healthcare professionals involved in the care of women experiencing miscarriage are viewed as vital to emotional adaptation. However, they are often lacking in compassion or understanding (Patton and Wood 1999:3). The management of the miscarriage experience is likely to contribute significantly to the woman's emotional adaptation. While the experience of the patient may often be reported as negative, Reader (in Hey et al 1989:88) makes the observation that medical staff find the business of miscarriage depressing, with seldom any positive aspects to offer the woman the staff feel 'impotent'. She suggests that the answers to questions may appear cold and unfeeling as a result of a condition that no one can 'cure'. Hey proposes that this stance may exist due to miscarriage being defiantly resistant to solution, and with interventionism having failed significantly to prevent its occurrence. Consequently, some carers may distance themselves from the miscarrying woman, treating the event as a purely routine matter. It is further suggested that this 'reductive management of prebirth loss', through avoidance or procedure and routine, is also tied to the very nature of hospital life in which staff deal with life and death as part of their daily workload (1989:60).

Kriel suggests that profound transformation of the medical clinical method is needed if it is to address the whole complexity of the human person as a self-conscious living system. A new understanding of science, the nature of reality, and of the nature of consciousness is needed (2000:3). In similar thought, Spelman (in Field and Marck 1994:128) draws attention to the failure of the Cartesian mind-body dualism to account for the fact that the nature of the experience of pain is not neatly catalogued as something just our minds or bodies experience. To acknowledge the integration of women's experiences of pain is to understand the embodied nature of pain and its connections to the whole living person.

Several studies have sought to establish the precise nature of the relationship between healthcare professionals and women who have miscarried. Women who report greater

satisfaction specifically with the support and comfort provided following their loss also exhibit fewer depressive symptoms (Murray & Callen in Paton et al 1999:3). Lasker and Toedter (in Paton et al 1999:3) present similar evidence of the relationship between satisfaction and emotional adjustment. Their study found that this relationship was only significant for those women who had experienced early miscarriage. It is suggested that this group may be the one at risk for receiving the least recognition of their distress.
Other significant areas of dissatisfaction with care emerge from the literature as a lack of medical information (Paton et al 1999:2) and, a lack of explanation for the cause of miscarriage (Paton et al 1999:11). Attention does need to be paid to the fact that causes are often unknown.

Moulder's (1999:1) findings of junior hospital doctors in the United Kingdom reflect the traditional clinical method of the health care system. Yet, in the midst of the approach she identified a tension between the demands of the health care system, doctor's attitudes and skills, and the needs of women. Robinson (2001:15) similarly found that despite the clinical philosophy of primary care professionals suggesting that mental health care is an integral part of practice, an apparent discrepancy between these espoused ideals and usual clinical practice exists. Explanations of these findings include the reluctance of primary care physicians to label their patients and their use of observation and informal counselling as initial treatment. The tension between demands of practice, lack of resources, inadequate reimbursement, and various organisational factors also profoundly influence management (Robinson 2001:13).

Moulder's findings revealed that despite the fact that they have a pivotal role in caring for miscarrying women, they receive little preparation. The provision of information about women's needs would be beneficial when a gynaecological post is taken up, is suggested. The study investigated women's and health professionals' subjective experience and the Management of pregnancy loss. The findings presented a perspective of the health care system regarding a first trimester miscarriage, as follows:
It is defined in physical terms as a straightforward and fairly insignificant event with no history or context. A procedure requiring prompt and efficient medical attention. With fragmented and often impersonal care by staff working under pressure. Women were given little opportunity to talk about their experience during their brief hospital stay.

The hospital doctors in Moulder's study indicated awareness of this dilemma and openly criticised the care provided for miscarrying women as 'cruel', as 'low priority' and as failing to attend to emotional needs of the woman.

The GPs similarly described the system as 'unsympathetic' to women. These doctors viewed their role as 'picking up the pieces afterwards'. Nowhere in the findings was the quality of medical care provided questioned but all the women left hospital with unanswered questions. Those women who were critical of their care had experienced physically straightforward miscarriages but were emotionally distressed often because of the circumstances surrounding the miscarriage which were not acknowledged, (e.g. IVF, recurrent miscarriage). These women had less contact with professionals and yet needed to ask questions and to talk about their experience.

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The doctor who diagnosed the miscarriage and explained procedures was viewed as the most crucial contact by the women. Contact with other professionals was very limited. Following discharge from hospital, contact with their GP was self-initiated and haphazard.

The doctors in this study identified a tension in their role between attending to the woman's immediate needs which may be acute (severe bleeding, pain) and responding on an emotional level.
One hospital doctor described his role as the "technical medicine bit", the "Mr Fix it" and the "emotional bit". Robinson (2001:10 -12) consolidates the same perspective by combining the philosophy and skill dimensions. He proposes a 4-quadrant typology of physicians:
the Technician, the Friend, the Detective, and the Healer.
Doctor's differed in their views about the extent to which they thought they should respond to women's emotional needs. Issues such as training, adeptness and motivation to make sense of the distress need to be noted (Moulder 1999:3; Robinson 2001:12-15).
Discomfort with the feelings aroused in themselves together with a lack of confidence in their ability to handle women's distress, equated in some issues being actively avoided.
The doctors were surprised that women wanted certain information and were ill equipped to handle the issue. The hospital doctors indicated that they did not know what words to use and were concerned that they would add to the women's distress. The junior doctors in this study were unanimous in their view that they were unprepared for their task with

miscarrying women, beyond the immediate medical role. Robinson's (2001:3-12) research similarly noted a wide range of physician reactions to patients presenting with emotional distress or potential mental health problems. Some physicians apparently failed to recognise the emotional component. Physicians appeared to either actively ignore this problem, gloss over it, or actively manage the distress. When not explicitly focused on the feelings and emotions of the patient medical carers often miss them (Kriel 2000:139).

Similar reports can be found in South African studies. The Transformation of Reproductive Health Services Project (TRHSP), which was run over two years in three rural provinces in South Africa, reported the following:

> *Health care workers themselves believe that they deliver sub-optimal care to clients. They describe themselves as rude, uncaring, insensitive, and note that they treat clients selectively, providing better treatment to educated and well-off women and to men and worse treatment to illiterate or poor women* (Fonn et al in Klugman 1999:52).

Given the context of South Africa's lack of infrastructure, poor social services, reality of poverty and general inequality in respect of gender and race, particularly prior to the government change, the well-being of the majority of women was undermined. This doubtlessly impacted on the care and treatment of women experiencing miscarriage.

In 1994 the Women's Charter for Effective Equality (WCEE) was adopted at a national convention of the Women's National Coalition. Its presentation on health stated the following:

> *Equal, affordable, accessible and appropriate health care services, which meet women's specific health needs and which treat women with dignity and respect, shall be provided. Women should be made aware of their rights in relation to health services. Health services must be appropriately oriented to meet women's health needs and priorities ...*

The South African government's White Paper for the Transformation of the Health System in South Africa (Department of Health, 1997) recognised that access to services requires improvements in service quality. The White Paper commits the government to promoting a 'caring ethos'. In an effort to instil this a Charter of Community and Patient's Rights was defined, with health workers being rewarded for 'compassionate and caring

service'. This is said to be linked to the general campaign within the civil service called 'Batho Pele – People First'. The White Paper's objectives focused on, among other aspects, the improvement to the psychological well-being of people and communities (Klugman 1999:57).

It is a logical assumption to conclude that women's experience of miscarriage and the care received for both physical and emotional/mental health should fall into the above mentioned recognitions.

Moulder (1999:3 and 4) proposes an induction for doctors in their internship years. The following broad topics are proposed:

- Women's diverse interpretations of miscarriage (from major loss to minor crisis)
- The importance of acknowledging the emotional reality
- The system of care from GP referral to discharge from hospital and beyond to include a realistic understanding of the roles of different health care professionals.
- Talking about the miscarriage, explaining the cause and communication about the remains of the pregnancy
- Disposal policy and practice.

Looking beyond an induction-type orientation, Robinson proposes that physician education and practice improvement be tailored around the physicians' natural philosophical inclination and psychosocial skills (2001:13). The health carer's own philosophy (biomedical vs. holistic) and skill level (basic vs. more advanced) have important influence on the management of mental health problems. Robinson proposes that intervention could be more focused as a result of assisting clinicians to identifying their own style and approach to particular patient needs (2001:13).

Understanding individuals in a patient-centred manner draws on qualities not generally emphasised by medical education – "self-knowledge, moral awareness, a reflective habit of mind and a capacity for empathy and attentive listening"(McWhinney in Kriel 2000:139). In support of the patient-centred approach it is advised that in every new clinical situation an understanding of the individual's life experience and of their relationship to that particular life-situation is accounted for. Kriel proposes that it is insufficient to appeal to doctors to be more sensitive or to include additional training in ethics, communication

skills or the social sciences. To transform the science-based clinical method he suggests that a model is needed which recognises more ways of knowing the world and ourselves than the one of the sciences. He advocates that such a move will create dialogue between the insights of the human and social sciences and the scientific clinician (2000:45). Martin (in Lykke and Braidotti 1996:116 - 117) describes the essence of health as a sense of non-dualism, interconnectedness; caring for the whole person including all positive and negative aspects without judgement; a healthy organism connected with its environment. To Martin, health care implies healing not exclusively of body-mind, but also of the eco-social environment. An approach which views the boundaries separating people's concern for spiritual, psychological, physical, interpersonal, social, political or environmental well-being as arbitrary. Domar (et al 1996:xvii) provides insight into the realm of mind-body medicine providing a framework that focuses on patients understanding that hope, a sense of control together with human connections provide for healing for both mind and body.

While each specialised field is naturally necessary and useful, it is the inescapable interconnectedness which is emphasised as being the essence of true health care.

Conclusion

The void between ideal care and actual practice is certainly bridgeable. It is possible to have better outcomes for medical conditions and improved patient and provider satisfaction. A clinical method that is sensitive to the full complexity of the person can be scientific as well as being centred on the individual (Kriel 2000:139).

> *Doctors do not often think about illness. They think about particular diseases but rarely about the nature and essence of illness or disease. This is partly because the subject is extremely complex. At a metaphysical level, there is the whole question of the purpose of suffering; and there is the question of the meaning of the illness for the individual, its timing in relation to events in the person's life, and the consequences which might be expected to follow from having been ill. These issues are highly relevant for doctors wishing to look beyond the dieased circles, because psychological, social and even spiritual concepts are involved* (Bennet in Adams 1999:62).

It is my opinion that these issues are highly relevant to all involved in the pursuit of healing and restoration, in whatever capacity.

The literature reviewed in this chapter highlights the depth and complexity of the experiences of women in the face and aftermath of the miscarriage experience; it considers some of the psychological consequences and distress symptoms. In particular, the review notes how experiences are shaped by societal values and meanings, as is reflected in day-to-day interaction. The crucial and powerful role of those carrying the responsibility of medical carer is emphasised and is portrayed as inadequate and fundamentally lacking sensitivity.

I conclude this section by referring to Jacques Kriel's words once more, which seem to summarise the essence of this chapter,

> *"The human person is not a body, and a mind which is an epiphenomenona of brain processes. The human person is an immensely complex, self-conscious, biological system in which all the systems function together. Persons cannot be understood in isolation from their bodies, or from the linguist and social system in which person-hood is established." (2000:132)*

CHAPTER THREE
RESEARCH DESIGN AND METHODOLOGY

Introduction

The study followed a qualitative research method using a purposive, non-probability sampling design. The purpose of qualitative methodology is to gain an understanding of the participant's experience, not to objectify, measure or test (Field 1994:11). Powell (in Carter et al 1996:7) asserts that feminist research should not only be concerned with rendering women's experiences visible but also to legitimate and authenticate the individuals and their experiences.

A qualitative research design respects these underpinning values and is consequently well aligned with the purpose and philosophy of the study.
While the initial appearance of data gathering may be simple, the process is complex and presents a range of options and approaches. Different approaches often reflect and emphasise differing perspectives. The actions throughout all the research stages were influenced as much by what was encountered in the field as by what was anticipated in the project design (Rossman & Rallis 1998:118). This interconnectedness is illustrated by Marshall and Rossman's (1999:25 – 26) Cycle of inquiry.

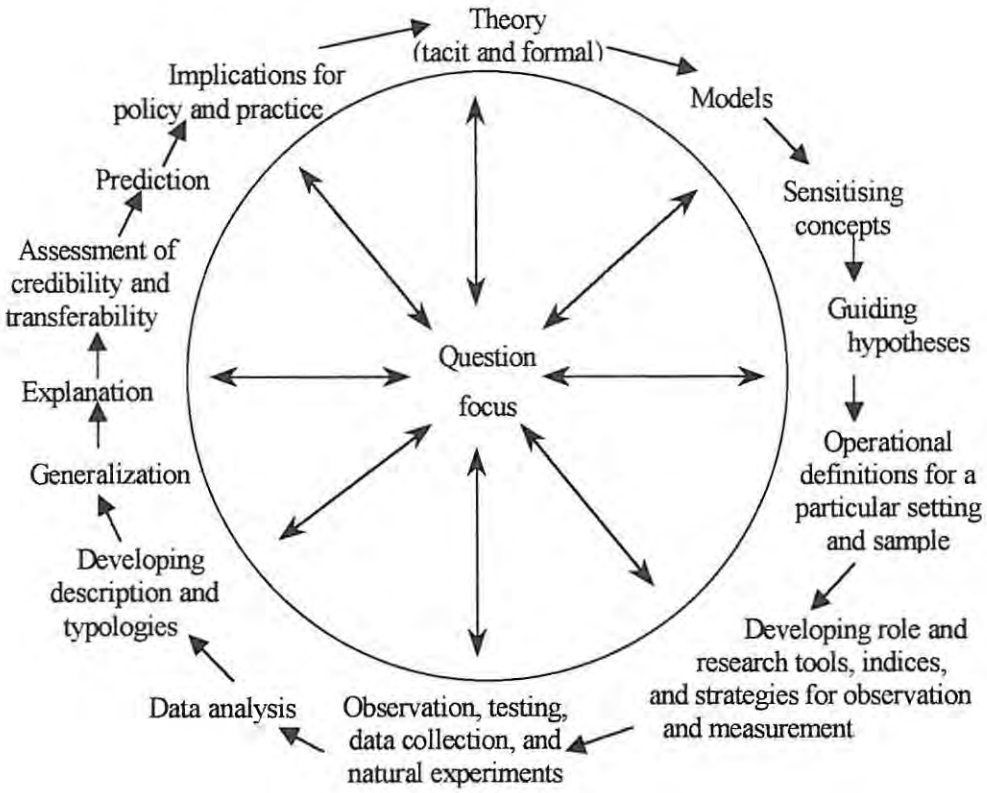

Figure 4. The Cycle of Inquiry

Figure 4 provides a schematic description of the dialectic relationship between theory, practice, research questions, and personal experience. The cycle of this figure implies that a research project may begin at any point in this complex process. If, for example, the general topic/focus emerges, possible research questions, potential sites and individuals or groups may be considered. This in turn may reshape the focus of the study. Considering people for the study also encouraged me to consider my own role in the scenario and possible strategies for data gathering. In this way research questions shaped decisions regarding gathering data.

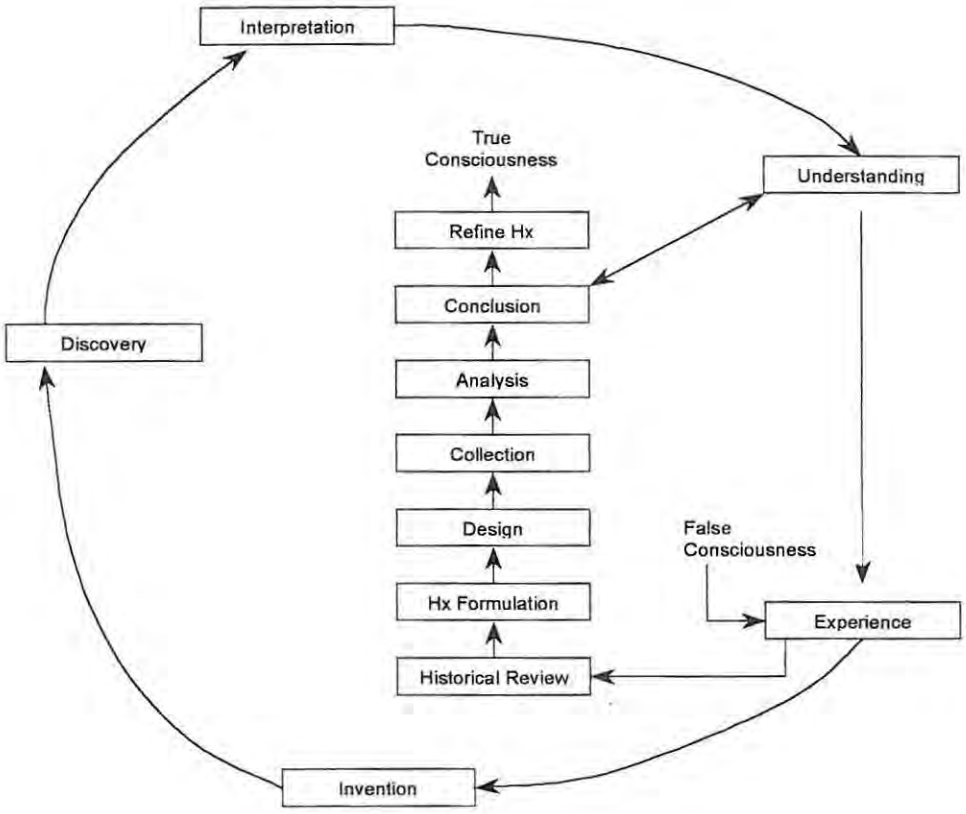

Figure 5. Global Eye of Critical/Ecological Inquiry

This second figure is a more radical inquiry process expressing critical, feminist and some post-modernist perspectives. It depicts the researcher looking critically at experience and the larger social forces shaping it. The focus is to identify expressions of domination, oppression and power in daily life. The goal is to unmask "false consciousness" and facilitate empowerment and emancipation of consciousness by reducing illusions of experience. It is based on the same processes of question posing, design, data collection, analysis and interpretation as the Cycle of Inquiry (figure 4).

The inquiry process followed by this study was a combination of the two cycles depicted above. The focus of the research was reshaped and refined as possible research questions were considered. In this way I can relate the development of the study to figure one in that the inquiry grew as the process developed. However, critical viewing of the experience and

the accompanying larger social forces were also present in the process (as depicted by figure 5). This emerged more specifically in the viewing of the women's experience of other's reaction and their experiences of the medical profession.

1. Data Gathering – Logical Rationale in support of a Qualitative Method

A qualitative method was assessed to be the most suitable approach to the study undertaken. Blummer (in Rossman et al 1998:123) comments, "The choices made in each part of the act of scientific inquiry should and must be assessed in terms of whether they respect the nature of the empirical world under study."

Many writers view quantitative methods, such as surveys, as treating the individual the basic unit of analysis in abstracting from social relations and positions. It is suggested that the survey assumes the form of social phenomena to be external and stable and able to be verbalised. It is consequently viewed as an inappropriate instrument for inquiry into experiences which are internal and expressed in non-verbal ways. It is argued that the measurement procedures generally employed in surveys often force experience into pre-determined and often inappropriate categories (Lee 1993:104). Feminist writers argue that the survey interview objectifies female experience and mutes women's self-expression (Lee 1993:108).

Justification for the design and method flow logically from the research questions and their surrounding conceptual framework. The logical rationale in support of the qualitative method is outlined in the following paragraphs. (See also Silverman 1994:171).

The characteristics of qualitative research are tabulated as follows (Marshall and Rossman 1999:3):

Figure 6

Qualitative research

- Takes place in the natural world
- Uses multiple methods that are interactive and humanistic
- Is emergent rather than tightly prefigured
- Is fundamentally interpretive

The Qualitative researcher

- Views social phenomenon holistically
- Systematically reflects on who she is in the inquiry
- Is sensitive to her personal biography and how it shapes the study
- Uses complex reasoning that is multifaceted and iterative.

A qualitative approach was utilised because the fundamental objective of the study was to gain insight and understanding into women's experience of miscarriage. The depth and insight into emotion and inner thoughts of the participants would have been at risk of being lost if the aim was for measurable and quantifiable data. The nature of the study embarked on also involved the disclosure of private information, which would similarly have been risked given a quantitative framework. According to Henwood and Pidgeon (in Hammersley 1996:16) qualitative methods are thought to meet several reservations regarding the uncritical use of quantification in social science practice. They refer more specifically to the problem of inappropriately attaching meanings where they are variable and renegotiable in relation to their context of use; the neglect of the unique nature and particularity of human experience; externally imposing 'objective' systems of meaning. Finch (in Shaw 1999:173) points to the advantages of qualitative research. Mention is made of flexibility; the natural setting; and, a concern with process as well as outcome. She highlights the value of explanations which are adequate at the level of meaning, in addition to an awareness of questions of causal adequacy, even when they cannot be fully resolved.

One of the approaches to qualitative research, suggested by Strauss and Corbin (1990:21), is the provision of accurate description in the analysis and presentation of the data. It is this approach which was selected as most relevant to the topic researched. The accomplishment of which did not demand presentation of all the data, but entailed sorting, selecting and interpretation.

Quantitative data are often considered to be 'hard' and qualitative data as 'real and deep'. The answer to the question of what to do if you want data that are real, deep and hard, is consequently not immediately apparent (Zelditch in Oakley 1993:209). However, it is believed that employing an approach of accurate description meets this query as far as is possible in this particular study.

2. Interviewing – The Instrument of Data Collection

> *Interviewing is rather like marriage: Everybody knows what it is, an awful lot of people do it, and yet behind each closed door there is a world of secrets.*
>
> *(Oakley 1993:221)*

With a qualitative approach, semi-structured interviewing was utilized as the tool of inquiry. This approach was deemed most suitable and to have the most respect for the nature of the sensitive subject. Its value also lies in providing greater breadth than other methods. The goal of the semi-structured interview is understanding. This is aligned with the aim of the research, to gain insight into women's experience of miscarriage. It is suggested that the interview becomes both the tool and the object, "the art of sociological sociability, an encounter in which both parties behave as though they are of equal status for its duration..." (Fontana and Frey in Denzin and Lincoln 1998:47).
Sieber and Stanley (in Lee 1993:3) present a definition of socially sensitive research as any study in which there are potential social implications or consequences for those represented by, or participating in, the research. Other researchers, such as Farberow (Lee 1993:3) equate sensitive topics with social taboo. Taboo topics are regarded as those which are weighted with emotion, inspiring feelings of awe or dread, as is often the case with the subject of miscarriage.

The nature of the study embarked on involved the disclosure of private information. Lee (1993:5) suggests that the disclosure of private information tends to be problematic as privacy produces pluralistic ignorance. Individuals only know about their own behaviour and find it difficult to judge the 'normality' of that behaviour as compared to other people. This perception was confirmed as most of the participants in the study tended to apologise for their emotions or thoughts: "...I know it sounds crazy but..."; "...I know it's really nasty to think this but...".

This factor could lead to an increased perception of intrusive threat as the researcher is presumed to know how the particular individual stands in relation to others. Intrusive threat similarly may be present during the research of emotionally charged personal

experience, such as bereavement, as a result of the levels of stress the research may induce (Lee 1993:6).

Oakley (1993:237) suggests that the 'proper' interview, in terms of the social research manuals, is unattainable. It is suggested that much of what is referred to as 'interviewer bias' can be more aptly described as interviewer differences, which is accounted for in the fact that interviewers are human beings, not machines, and do not work identically (Selltiz in Oakley 1993:237). Ethical dilemmas are generic to all interview based research. It is suggested that these dilemmas are greatest when there is least social distance between the interviewer and the interviewee, such as when gender-socialisation and critical life-experiences are shared. Rossman (1999:28) identifies that a strong autobiographical element often drives research interest in the applied fields. The qualitative researcher's challenge is consequently to demonstrate that this personal interest will not bias the study. It is noted that sensitive awareness of the methodological literature about the self in conducting the study and interpreting the data aids this process. Rossman suggests that the researcher needs to link her initial curiosity to general research questions, in the event that direct experience has fired initial interest, as in the case of this research.

Six semi-structured interviews were conducted in this study. The following questions provided the degree of structure:

4. Tell me about your experience of miscarriage.
5. Can you tell me how others reacted and how you felt about these reactions?
6. What do you think women who have experienced miscarriages need in order to cope with the experience?

Audio-recorded semi-structured interviews were used as the primary methods of data collection. Field notes were not taken during the interviews as it was believed that this would have been an inhibiting and distracting action for the participants. Notes were made following the interviews reflecting on any significant aspects of non-verbal elements.

Graham (in Reinharz 1992:18) suggests that the use of semi-structured interviews has become the principal means by which feminists have worked toward achieving involvement of their respondents in constructing data about their life experiences. This design did include the typically anticipated opportunities for discussion and clarification, allowing for exploration of the participant's views of reality, maximising discovery and

description. Bergum supports this view suggesting that such an inquiry provides for interpretation, description and reflection (in Field et al 1994:8).

The method, and consequently the questions, did not aim at prediction or control but at understanding with a mandate of not constraining the emergence of phenomena (Field et al 1994:7-8).

While the purpose of the research was not to generate theory a Grounded Theory approach was used in the interviews conducted. The investigation was underpinned by the identification of concepts that would facilitate understanding and, in this instance, enhance the care of women who have experienced miscarriages. It suggests a process in which the meaning and the lived experiences of the participants are important.
Grounded theory is defined as a method of discovering the reality of a particular social setting, allowing the researcher to gain a new perspective in a familiar setting. The goal is to generate theory that is grounded in the reality of the functioning social system (Stern in Field and Marck 1994:5). The origins of the theory are rooted in symbolic interactionism. The roots of symbolic interactionism are identified in the fact that the study emphasises the importance of the lived experiences of the participants. The aspects of which are developed through a process of negotiation with the reality of the lived world. The study focuses on the experience of the women; their experience of their own reactions and their experience of other's reactions. There is the notion that the women have defined their worlds by processing knowledge in various ways.

3. Sampling Procedure

The sample, its size and nature, proved to be a predominantly limiting factor. While the findings are presented against a backdrop of literature, often supporting the views presented, the findings can only serve as a sample of the greater South African population and cannot be generalized. The sample is multi-cultural but does not encompass all represented cultures in South Africa. It consisted of literate and educated individuals. This limits the applicability of the findings to other groups.
The study was not based on a random population sample and is not generalizable in the traditional quantitative sense. Its generalizability lies in the resonance it generates among women who recognize the identified patterns from their own experiences.

The sample was relatively homogeneous and it is not known how reactions could vary with influence of age. To the extent to which the women interviewed did not reflect the ethnic and socioeconomic diversity of other parts of South Africa, these findings may also be limited. Future research should attempt to include greater diversity.

Sampling criteria –

Participants were selected based on their representivity of the target population. Field (1994:6) suggests that such sampling requires three qualities be present in participants: knowledge of the topic (in this case the experience); the ability to reflect on personal experience; and a willingness to share the experience.

Participants were required to have the following characteristics:

- Women who had miscarried a child/children in the preceding two years (This was not adhered to as some women responded who had miscarried more than two years previously).
- Comfortable using the English language to articulate and express themselves. This was a limitation as it excluded other language groups to a significant degree.
- At a stage where they were willing to disclose and share their experience.
- Willing and able to allocate the time necessary to the interviewing process. This could have excluded participants with demanding schedules, family and employment commitments.

Candidates were recruited by way of an advertisement in the local community newspaper, the "GO magazine", which is distributed at no cost. The sample targeted participants of both the private and provincial health care systems. The nature of the recruitment was clearly a limitation in that it targeted women who were literate in English; had access to the newspaper (it is distributed in the suburbs of East London); and had access to a telephone. The advertisement read as follows:

HAVE YOU EXPERIENCED A MISCARRIAGE?

Participants are invited to take part in a postgrad research project exploring women's experience of miscarriage. Participation will be purely voluntary and will involve an in-depth interview. Confidentiality, empathy and respect in dealing with this sensitive matter are assured. Women who have experienced a miscarriage are invited to call Julia on ... (evenings) or 082 639 0392.

4. Data Analysis

Data reduction and analysis followed four stages (based on the model suggested by Marshall and Rossman 1998:152 and Marck (in Field et al 1994:9):

1. Organising the data
2. Generating categories, themes and patterns. Thematic outlines were developed to initiate further discussion within the texts. A thematic analysis of the transcripts was guided by identifying recurring words, phrases and portions of the texts that repeatedly stood out.
3. Descriptive coding was used.
4. Testing emerging understandings and considering explanations. In doing so contrasts and comparisons were drawn
5. Data display

The analysis strategy was based on a combination of analysis at the end as well as ongoing. Throughout the inquiry analytic memos, thoughts and ideas were written down. I continued to read and research related subject literature in addition to specific subject material on miscarriage. This practice assisted in keeping concepts fresh and fluid in my own mind and challenged my own thoughts throughout the process.

Analysis followed a phenomenological vein as it searched for themes of meaning in the participant's lives. Firstly, broad categories were identified with subthemes elaborating on the topography of the meaning. The research questions provided the starting place for analysis, by providing a framework of categories. This was a logical continuation from the conceptual framework which shaped the data gathering (Rossman et al 1998:172-178).

In terms of the continuum of analysis strategies depicted by Marshall and Rossman (1999:151), figure 4, the overall strategy of this study tended more toward the interpretive-subjective end of the continuum.

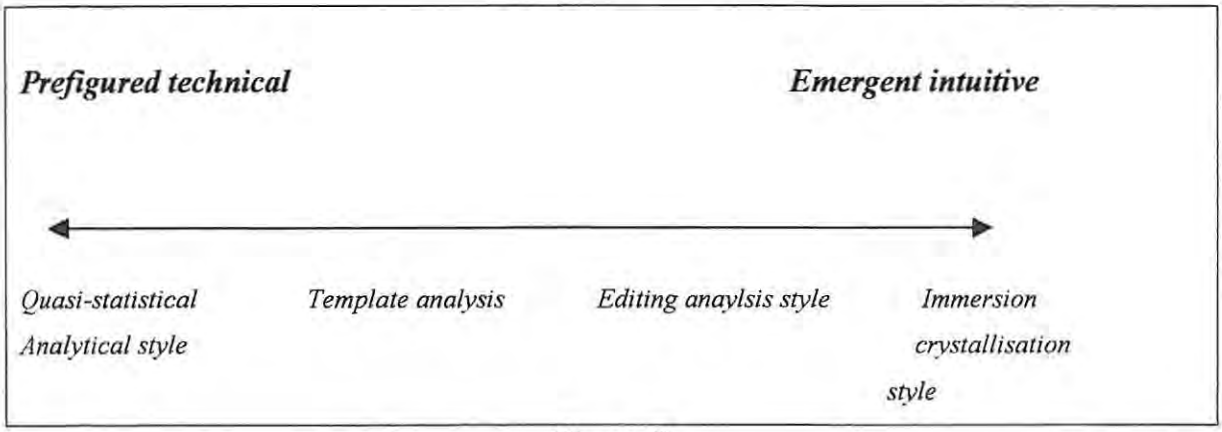

Figure 7

The data analysed was not easily convertible to standard measurable units; they varied in abstraction; frequency of occurrence and relevance. As a result I followed an analysis structure more in line with identifying and discovering significant characteristics of the participants.

6. Reliability and Validity

> *"By validity, I mean truth: interpreted as the extent to which an account accurately represents the social phenomenon to which it refers.*
>
> *(Hammersley in Silverman 1994:149)*

The issue of reliability was addressed by utilising a standardised method of audio recordings of the interviews. Transcripts were then prepared directly from the cassettes. I did not reinforce the reliability of this method by engaging other researchers in comparing the analysis.

Fielding and Fielding (in Silverman 1994:153) identify two main dangers in the reporting of qualitative research, to which attention was paid:

- The tendency to select data to fit an ideal conception, or preconception of the phenomenon.
- The tendency to select data which are more exotic, and consequently more conspicuous, at the expense of less dramatic data, which may well be indicative.

The view of validity in qualitative research ranges from acceptance to rejection on the basis that it is inappropriate in social research (the feminist position). I have aligned my thinking with the perspective of Hammersley (in Silverman 1994:155), who suggests three elements in considering issues of validity:

1. Validity is identified with confidence in our knowledge but not certainty.
2. Reality is assumed to be independent of the claims that researchers make about it.
3. Reality is always viewed through particular perspectives. This means that our accounts *represent* reality they do *not* reproduce it.

I chose to adopt Silverman's (1994:160) suggested validation method of generalisation to a larger population. Through a study of diverse literature I attempted to obtain information about relevant aspects of women's experiences of miscarriage. I then compared the experiences related to me in the research, to those described in other studies. In doing so a comparison with a larger scale enabled the establishment of a sense of representivity. Generalisabilty of cases was to theoretical propositions and not limited to populations.

Conclusion

This chapter has outlined the logical rationale in support of the qualitative method used in the study. In doing so I have sought to identify various limitations and areas of concern, which arose in the methodology of the enquiry.

CHAPTER FOUR
DATA DISPLAY AND ANALYSIS

Introduction

The fundamental objective in analysing the data presented by the participants was to answer the research questions. To this end I have categorised the data in the following way:

1. Individual's unique experiences of miscarriage.
2. The experience and impact of other's reactions on the individual.
3. Identification of what women need in order to cope with the experience.

The questions were broad and consequently encouraged sub categories. An overview of the answers to these questions is presented and is followed by a thematic analysis.

In keeping with the process of validation followed, that is generalisation to a larger population (Silverman 1994:164), a comparison was made between actual data gathered and that described in other studies identified in literature. In doing so a comparison with a larger scale enabled the establishment of a sense of representivity. Areas of the data are presented against theoretical propositions, such as Bowles' comparative analysis with Post Traumatic Stress Disorder and Acute Stress Disorder symptoms and identified distress symptoms experienced by some experiencing miscarriage (2000). In this way the data is not limited to populations.

DESCRIPTION OF THE INTERVIEWEES EXPERIENCES:

Six in-depth interviews were conducted. The following pages outline a summarised overview of the content in relation to the three broad categories, described by the guiding questions.

Key themes, reoccurring words and phrases which emerged in each interview, are then outlined. Each interview is dealt with separately in this initial overview. All names have been changed for the purposes of the study.

1. Anne's experience of miscarriage

Anne is a white female. She began by referring to her previous pregnancies. She had two children and then experienced a miscarriage in January 1989. There were no apparent problems with her first pregnancy but were with the second, in 1982. Her cervix was damaged during the pregnancy and during the birth. She was however, advised by the gynaecologist that she could carry another child again.

The third pregnancy was not planned, but both Anne and her husband were happy and anticipating the birth of their third child positively. Anne was 35 years old at the time. She described the pregnancy as being 'different' from the start, with excessive weight gain, unlike the previous two pregnancies. At 16 weeks the gynaecologist decided to put a stitch into her scarred cervix to strengthen it, as a precautionary measure. She was taking prescribed medication, also as a precautionary measure to try and prevent premature contractions. Following this procedure Anne began to exercise to try to control her weight gain, which she found frustrating.

> *"...he (*the doctor*) never said to me, don't exercise...but I think, in retrospect, I thought to myself that was stupid."*

Four days after the operation Anne experienced "fairly steady" contractions. She contacted her gynaecologist and was admitted to the Provincial Hospital maternity ward. She was placed on a drip overnight and the contractions abated by the following morning. However, after being moved out of the maternity ward into a general ward the contractions began again and she lost the baby later that afternoon.

Anne experienced feelings of guilt as the week preceding the miscarriage she had questioned whether she really wanted the child. She found this difficult to deal with together with the concern that her exercise programme had contributed to the miscarriage. Her approach in conveying her understanding of events was often from a logical analytical perspective, as she appeared to have knowledge of the reason for the miscarriage. However, while she articulated this on one hand, she made several references to guilt.

Anne described herself as *"feeling cheated and sort of empty – that if I wasn't going to have a baby I should do something else."* She made a job change, involved herself in activities at her church and joined Rotary. It appears that Anne used activities as a distraction and a coping mechanism. There was limited indication of discussion of the feelings associated with the miscarriage. It was some years later that Anne consulted a psychologist, initially about coping at work. She was employed at the hospital where she had lost the baby and was finding it difficult to cope with feelings of anger related to her treatment at work. She also referred to the possibility of related anger about the loss of her baby.

> *"I think it was a case of, time healed. It got better over time. But I did realise that, when I went to see the psychologist, it was something that needed to be talked about...it linked up with...I was very angry over the way they had treated me at work...– the authorities and I think there was a bit of anger from the baby as well."*

Anne described her experience using the word traumatic and referred to coping with guilt, questioning whether it was her fault.

1.1 The experience of medical carers

Anne's description of her experience in hospital was characterised by the following words and phrases: very distressed; not knowing what was happening; incredibly stressful; a lot of anger; frustration.

Her perception of the hospital experience can be described by a lack of respect for her privacy and exclusion as a partner in the process, by the doctor and hospital staff.

These observations are founded on the lack of privacy, lack of consultation, communication and explanation. There did not appear to be partnership between the medical carers and Anne, rather it seemed that she was treated as simply another factor in a common medical process.

A: *"...he said he couldn't keep me in maternity they would have to put me in the main hospital. Because he didn't want to discharge me because I was on the drip. I said to him take me to the private hospital – I'm not sure if there was a maternity there – but anyway – I was very distressed about that because I didn't want to go over to the main hospital.... And they wheeled me across and put me into one of those big*

wards, with however many – mostly old women, snoring and um...when I say old women it was probably just all the hysterectomies! You know – I really didn't know what was happening. I was already in a bit of a state by the time I'd gotten to the ward the contractions had already started. And – ya – it went on for about a few hours and they didn't seem to be able to get it under control. I think basically because the staff didn't know what they were doing. It was one of those fancy drips that controls the amount you're getting and they didn't seem to know about it whereas in maternity they did.

J: *That sounds like a huge stressor for you.*

A; *It was incredibly stressful for me, and then I also said to the sister, because at some stage I said to the sister – because the doctor did come and see me and said that it looks as though you are going to lose this baby. And I said to the sister – what happens? Will they take me to a separate ward or what? And she said, oh no, here. And I just looked at her and thought – I've got to produce this foetus in the middle of this busy ward! And I looked at her and said, no I want to be moved into a private ward. And they said, no they couldn't accommodate me. So I asked to see the matron – and eventually I had to fight for it – and that is – has, there's been a lot of anger about that. And I did eventually get into a private ward and I think I lost that baby at about 5 that afternoon."*

The literature reviewed revealed that from a medical perspective a miscarriage is rarely a medical emergency and may be viewed as a normal variation of early pregnancy. A more common view treated the experience as more of a minor physical event, contrasting sharply to the major emotional and personal significance it represents for many women. Hey's findings indicated that the feeling of exclusion from having needs met was primarily based on the reduction of the experience of miscarriage to a purely medical and physical event. This served to further devalue the complex experience of miscarriage (Hey et al 1989:58).

Anne described her experience as feeling like she was subjected to being *"part of a show"*, as she was in a general ward with other patients *"listening in."* Fourteen years later she still questioned why she could not be moved to the hospital of her choice.

J: *How did he(the doctor) tell you?*

A: *I mean he was just standing by the bed, and he said oh well...*

J: *Was this in the general ward?*

A: *Yes – the whole thing.*

J: *Do you think it should have been done privately?*

A: *Oh yes, I think the whole thing – I don't think I should have been subjected to...being part of a ...show. With people right next to you listening in. And I still don't understand why he wouldn't move me go to the private hospital. I don't think the wheelchair ride was any less traumatic than a car trip, he could've taken me in an ambulance if he felt that strongly about it.*

In transcribing Anne's interview, it became apparent that up until the actual miscarriage, she was able to describe the events and her experience with clarity. From this point on in the interview her sentences were characterised with phrases indicating lack of clarity in thought. It would appear that this vagueness also reflected the lack of communication and direction given by the medical carers. Field and Marck (1994:282) reported on the theme of buried pain repeatedly identified throughout their study.

A: *I can't really remember, but I can imagine it would have been, well if that's it, that's it. And I'll tell you about his reaction later on. Ya, I think there were probably one or two nursing staff with me when I lost the baby. I don't really remember how they were. I think I would have remembered if they had been unkind or unsupportive.*

You know the baby was born into a bedpan, you know, and I don't know

J: *Did you see the baby?*

A: *They whisked it away, and I said I wanted to see it. And they said they weren't sure if they could show me the baby. Then later Dr X. came back and he said they could show me, so they brought it back in the bedpan. You know...all I saw was...a mound of blood...(crying)...a little pile there.*

J: *Was the baby still born?*

A: *(crying)...I doubt it...I don't really know...but I doubt it... (crying)....there was actually nothing wrong with the baby – there was nothing wrong with the baby...it was a mechanical problem with me...*

J: *Was it a little boy or girl?*

A: *(crying)....a little boy....he told me it was a boy.....and threw this bedpan under my*

nose and then whisked it out again... What else happened, I can't actually remember. I tend to bleed, I actually had a post-partum haemorrhage after the second pregnancy and I nearly died, I was in Intensive care. So after this I bled, I actually had my boss from Cape Town, as a student she had been Miss X. to me, she had overseen the East London college. She was in East London that day and she came up to see me after I'd lost the baby. And I think I said to her that I thought I was bleeding badly. And she was standing in the room, and not the sort of person – I'd known her for years – but she was a Miss X. you know, not the sort of person, and they just whipped off the covers off me and sorted out all the blood and I just thought ah,...couldn't they just ask her to leave. You know, maybe they thought she was a friend of mine and it was good for me to have someone there – but oh...

J: *Didn't they not ask you at any stage if you wanted to be private?*

A: *No. Nothing like that. .... It was all very traumatic...*

Anne indicated that despite requesting that her husband be telephoned and informed of the miscarriage, he was not and arrived at visiting time unaware of what had happened.

"I had asked the sister to please phone him and tell him...and he didn't know...you know I couldn't believe it...that they didn't bother..."

There was no form of counselling offered from any medical or hospital staff, not while in hospital or following the miscarriage.

1.2 The experience of others – family and friends

Anne described her husband as being uncommunicative and unwilling to discuss the experience. She describes an interaction in the following manner:

" I don't remember...I think it was a couple of days afterwards that I said to my husband – I need to talk...about this, he said to me...there's nothing to talk about ...we were going to have a baby and now we're not...and that's it...(crying) – I mean that's him – that's how he lives. You know he doesn't cry over spilt milk and he often says it to me - you can't cry over something that's happened."

While Anne described her relationship with her mother as being a strong one, there was little acknowledgement of the experience from her mother:

A: *I don't recall her response to the miscarriage...I don't really remember*

J: *Have you spoken to her about it at any stage?*

A: *I don't know...I don't think, apart talking to the minister, and I didn't really talked to him about the details, I think the psychologist is the first person I've really talk about it to. I may have talked to friends about it, but...I don't remember.*

Anne's experience, as with all six women interviewed, correlated with several published studies on women's experience of other's reactions.
Reports by women who have experienced a miscarriage are often of friends and family responding in ways that seem to try to reduce the impact and importance of the event (Renner et al 2000:2 and also Regan 1997:251). This invokes a sense of little support or understanding of what has been experienced. The loss appears to be unrecognised. Understanding comes as the woman experiences her pain as she finds others who would witness and genuinely share in it (Field 1994:281).

Three interactions Anne recalled were between her son's schoolteacher, whom she mentioned her experience to. The teacher had also experienced a miscarriage and was sympathetic. The other interaction was with an aunt:

I remember silly things that people said, like I had an aunt who said to me that....you know these sort of things are usually for the best because there's usually something wrong with the baby.....and I could have throttled her, because I knew that there was nothing wrong with my baby – I accept that fact that that may be the case in others but I knew the problem was with me and not the baby.

The third person was the church minister who came to visit her regularly. She did not recall what they spoke about, but was positive about this support.

A: *I don't remember ...(apologised for the tears)....oh, now look I've got tears all over the glass and make up... (laugh)...I just know that he used to come quite regularly and sit and chat, I wasn't aware that it was counseling but I suppose it was. He is quite strong....um...ya...I don't remember...I did have supportive friends...I don't remember anybody particularly standing out. I think my friends were very good to me in a practical way – helping out with the kids and things...*

At one stage Anne commented:

"... just tracing the possibility of another anaesthetic for another gynae thing, and a friend of mine said how did you feel when the doctor told you – and I said (laugh) – I don't feel anything anymore! I've lost count of the number of anaesthetics I've had..."

1.3 Identification of supportive resources

Anne suggested a support structure where women can talk to other women who have experienced miscarriages. She envisaged this in either the form of a support-group or a one-on-one intervention. She indicated that she had not really talked about what had happened and believed that had she been given the opportunity she would have coped far better.

2. Bongiwe's experience of miscarriage

Bongiwe is an African Black woman who had practiced as a general medical practitioner for approximately thirty years, twenty-five of which had been in the United Kingdom. She had recently returned to South Africa to retire. Bongiwe experienced one miscarriage in 1973. She was married and had three children, aged nine, five and three years, and did not particularly want more and was a little upset at the news of her pregnancy. However, both husband and wife accepted it. Bongiwe went into premature labour at six months and the child was born with underdeveloped lungs and died. Bongiwe believed that she accepted the situation as she herself was a "de-sensitised medical person" and knew that there was nothing that could be done to save the child. She was surprised when she became upset a few days later, when she started lactating.

I think because when you are a doctor you see so much pain and you just have to get on with the work that you become de-sensitised and when something happens to you, you've learnt to put a damper on your feelings that you don't realise what is really happening to you until later.

Bongiwe described her experienced as being very painful, she had lost a part of herself. A feeling she carried with her for some months. She named her daughter and accepted the miscarriage on the basis that "it was just meant to be." Approximately six years later she attended a medical seminar on the subject of how to treat people who had experienced

miscarriages. This evoked pain and emotion in her, despite that she believed she had accepted it. She was caught unawares by the pain and had not realised the extent of the grief and pain, which she had unconsciously carried with her. Bongiwe's reaction is evidence of Renner's finding that while the physical aspects are the primary focus of the health care system and are generally resolved in a relatively short time, the emotional aspects continue long after the woman has left the health care provider (Renner et al 2000:1).

Her greatest regret is that she did not hold her baby in her arms and say goodbye and talk to her. Feelings of loss and pain characterised her description of the experience. While she had the knowledge of the reason for the miscarriage, Bongiwe still carried guilt with her since she had not wanted the pregnancy at first. Bongiwe described the loss of the hope of motherhood, the loss of the future of her child.

> *I would say it was a very upsetting experience. A big loss. Especially when you can see a perfectly formed baby and think that just a little bit longer I could've been holding that child in my arms, I could have seen her running, I could have taken her to school – you know it's the loss of all of those things.*

This perception mirrors the thinking of Field and Marck who suggest that the response to a miscarriage is in essence the experience of having responded to the notion of mothering a child; of having responded to the possibility of motherhood (1994:125). Similarly so a reflection of Zucker's understanding of miscarriage as representing the loss of anticipated motherhood (1999:3), and Slater's view on the complicated bereavement following a miscarriage, as it is often a mourning of the loss of a future and expectations, not simply of an embryo (1999:2).

Bongiwe did not experience that this loss impacted on her relationship with her other children.

Knowledge seemed to play a significant role in Bonigwe's acceptance and coming to terms with the miscarriage. Having trained as a medical doctor she was fully aware of the physical reason.

> *...when you're in a situation and you have no knowledge, you don't know what it's all about, you have a lot of fear and apprehension. Whereas when you know you*

are more at ease and look at it from a very different angle and you look for the solution. Whereas when you don't know you don't know your enemy.

However, what was evident was that while Bongiwe had incorporated the medical knowledge into her life experience she was caught off guard by the emotional impact. This demonstrates the significant weighting of the emotional aspect of the miscarriage experience. The meaning of miscarriage for women would, as in all experiences, be founded on the three pillars of what the individual considers to be knowledge, how the knowledge is used to make sense of the experience and how the experience is then incorporated into their biographies (Nicolson 1998:47).

2.1 The experience of medical carers

Bongiwe's hospital experience was set in 1973, in the midst of the apartheid era. Her experience was in a Provincial Hospital, which would have complied with apartheid practices and attitudes.

The greatest regret that Bongiwe carries is that she was not able to hold her baby and say goodbye. She blamed the medical staff for not allowing this as well as herself for complying with them.

B: They allowed me to look at her but they said don't hold her in your arms because you'll get attached to her. But what they don't realise is that you are already attached. You have all the emotions – you feel all the movements, you talk to her...

J: How did that make you feel when they said that?

B: At the time I just accepted it. I suppose you are numb. You know, it's like when you have just lost someone you love. So when you are numb you just go along with what someone says unless it really goes against your grain. So I just accepted it. It was only afterwards that I wished I hadn't and I wished that I insisted on it.

Bongiwe's perspective of the doctors was that they did not understand at all. She described them as authoritative whereas they should be treating the woman concerned as a partner in the situation.

They do not understand that you are connected with your child right from the time you know. So even if it had been at three months, you are connected with that child and there should be a lot of sympathy in the way that things are said.

Her experience of the nursing staff was similar as she recalled them not understanding why she was crying. Dominelli suggests that this apparent lack may be viewed as either an assumption that emotional problems do not exist; or possibly, that those individuals experiencing problems are unable to cope (1990:40).

2.4 The experience of others – family and friends

Bongiwe recalls that there was practically nothing said about the miscarriage at her home. She did not remember thinking that anything should have been done and attributes this to the shock and numbness following the miscarriage.

B: I think I was just shocked, I didn't sort of register that they should say anything. But there were friends that came round and they had a prayer with me and that helped. Because I suppose it was acknowledging that something had happened. And also a prayer to strengthen me at the time.

J: Who else knew you were pregnant and what was their reaction after the miscarriage?

B: Those who came round were those who lived in the same village as I did. And those who lived further away, they knew I was pregnant and they knew about the miscarriage and said that they were sorry about it. I don't remember feeling that they should have been doing anything. I think it was the same sort of numbness. And I suspect that, again, because I'd been in the medical field for a while and I accepted that these things happen. What was the surprise for me was the pain to follow. When we talked about it some years later. It was probably about 6 years later.

J: From that period from the birth, the miscarriage, from the birthing to when you spoke about it some years later was there virtually no discussion about it?

B: I spoke about her because I'd given her a name. And I'd think about her, but no, nobody tended to refer to her.

2.3 Identification of Supportive Resources

Bongiwe stressed the importance of talking to others who have shared experiences, since there is an empathy and understanding that can only come from actual experience. She identified group or one-on-one situations, however, cautioned against support groups, with the following statement:

> *Whether it's in a one to one or a group, where they share experiences, until they are comfortable with what has happened and maybe they move on and leave. The dangerous thing is for them to stay huddled in their pain. I think pain is something you need to deal with and move on with your life. Otherwise the groups are good but they can keep people in a 'scrum'*

On being questioned about her thoughts on how a hospital could respond, Bongiwe answered with the following:

> *The first thing is to treat a person like they are going through pain – they are in pain – to acknowledge that they are in pain and not just brush it off. While we are being trained we are always being told don't get involved and I think that's the wrong advice. Don't get emotionally involved. Medical staff are told not to get involved. And I think that while they are doing that they are negating the person's experience, they are negating their own pain as well – it's not just a one-way thing. So once they acknowledge that the person is in pain and try to find out. Because people are different they want to be treated differently. But the first thing is to acknowledge that the person is in pain and talk about it in that way. So that from then on you can get cues from the person and just talk about – honestly – what the person - don't feel that you are making the person feel pain, they are in pain already.*

Bongiwe made reference to dealing with all forms of unresolved emotional pain, in order to come to terms with new experiences:

> *I would like to say to someone who has had a miscarriage you need to work toward accepting it, accepting that painful as it is it is something that happened and it cannot be changed. Not to run away from any emotions that they feel, whatever they are but to examine them and try and see where they come from in their lives. Because a lot of emotion comes from previous pain. When you have a pain your*

sub-conscious dredges up previous pain, so any previous pain, even if it doesn't seem remotely connected with your experience at this time, deal with it, because when it dredges up there it means that it is there and needs being seen to. When you put a damper on some feelings it puts a damper on other feelings as

She suggested that women be granted the same respect that is given to those who have just experienced a death. That the mother be given the time and space to mourn, and then be helped to move on with their lives.
Bongiwe agreed that knowledge and education play a role in acceptance. She referred to the overemphasis of guilt and punishment in religion, in relation to the love of God, and suggested that spiritual leaders could play a role in correcting this perception.

3. Diane's experience of miscarriage

Diane is an African Black woman who experienced two miscarriages, the first one was in 1999 at the age of thirty-seven. She was married with a son and two daughters. Diane had previously terminated a pregnancy after learning that the baby had Down syndrome.

When Diane had the first miscarriage, she was taking prescribed anti-depressant medication. She explained that when she started bleeding she knew that she had lost the baby. Diane appeared to be overwhelmed with the thought that she had been "taking drugs" without any knowledge about the effect on the baby. She stopped the medication as she experienced unpleasant side effects. By the time she conceived again she had stopped taking the medication, and became very anxious when she started bleeding again.

Now I began to worry – what is this, what is happening?
Until it happens to you, you don't know how it feels. Just, you don't imagine that it could happen to you. Right, you know that it happens but you don't imagine it happening to you. Ok. So when the doctor showed me...I got worried that I had done something...
I suppose the first time I had to blame it on the drugs, but now I was 'clean' as far as I'm concerned and I was healthy. I had recovered, I was still recovering but I was better off than I had been before – so what now?
Now I don't have anything else to blame. Well, I'm not good enough to bear children.

You think all sorts of things and...

Diane referred to the word unworthy, to describe her feelings at the time, explaining it as being unworthy of carrying normal children or going through the pregnancy. She blamed herself and believed that she had done something 'wrong'. Diane's explanation to her eight-year old daughter was that "... maybe God didn't want it to happen...". A strong sense of feeling like a failure was conveyed in the interview, as she explained that she had felt like she had disappointed her husband.

Unworthiness... old age. There is something you did wrong – Why did I not be careful enough because I'd gone through this before, now I'm going through this again. It's me, you know. I couldn't put a finger on what I did wrong.

Diane did not provide any details on the actual miscarriages or the hospital experience. She believed that if she could have another child she would have closure. Her focus was on her interaction with others around her, family and colleagues. The symptoms Diane described correlated to those described by Regan in her findings of reactive depression, noted to be a common sequel to the acute phase of grief. Reporting on typical symptoms of depression including lethargy, no desire for anything, changes in appetite and sleeping patterns, headaches and other pains, feelings of worthlessness and loss of confidence in self, not coping with daily routines, lack of concentration, irrational fear or behaviour, uncontrollable crying (Regan 1997:247).

3.1 The experience of medical carers

Diane had been treated for depression prior to the miscarriages and had been admitted to St. Mark's hospital. She found this too painful to talk about.

She experienced her gynaecologist as helpful, although she could not recall specific information and appeared anxious that she did not know the reasons. Diane recalled the following comment,

D: My doctor was good – my gynaecologist – because he said to me – now look, you may act strong now but I think I know, I have an idea, that every woman who has lost her baby is traumatized. He offered to give me the names of somebody who I could call – I had the tel. Numbers that I could call.

J: *Can you tell me a little more about your experience with the medical profession? You've mentioned your doctor –*

D: *He was good – he tried to show me that I haven't failed in any way. But there could be medical reasons, but I don't know what those reasons as we speak. There could be a lot of things that lead to a miscarriage.*

J: *Did he give you any information?*

D: *...now I don't know. But now if I want to try again I wouldn't know what to do – I wouldn't know what medical treatment to get in preparation for that, so that when it happens I am strong enough medically and physically. You know – I would have loved to know. He said at our last appointment that if I decide to try again I must contact him.*

3.2 The experience of others – family and friends

Diane's description of her relationship with her husband was contradictory. Initially she explained that he was the one who had 'gotten her through it.' It seemed she appreciated his efforts at consoling her, even if they were not always helpful. It was the effort that she valued.

D: *He's the one who got me through it. He told me, if it had happened... maybe it's a blessing in disguise; maybe there was something wrong with the baby. Maybe in the long term it would have been stillborn – something like that. Trying to console me. You haven't bonded as such with the baby.*

J: *How did that statement, 'you haven't bonded as such with the baby', make you feel?*

D: *He did not understand. You become a mother just like that – the moment you conceive. I don't expect men to understand.*
His efforts to counsel me, console me, to try accept it, helped me through.

However, while she indicated that she appreciated his efforts there was a level of frustration regarding emotional needs not being met.

D: *At times I was furious with my husband...if – when - ...when I'm alone then - he would be watching TV in the room and I would think ...how could he be watching TV when I'm in such pain. But I knew that he supports me – I don't know what I expected him to do. I wanted the whole world to just stop and look into my pain.*

I know he supports me but he doesn't know how to show it. You need some actions, and he doesn't talk – I don't know if he feels threatened. I don't know. He just stays away from it and I must talk. and inside it's yearning for him to reach out to me.

There appeared to have been a great deal of frustration in not knowing how to deal with the pain she was experiencing, and a deep need for emotional support.

Diane actively avoided pregnant women, as she did not want to be reminded of what she could not have, or had lost and was unable to have.

Diane's experience with her sister, colleagues and friends was that there was limited acknowledgement on a superficial level. She did not experience any emotional support or a sense that "her pain" had been acknowledged. She blamed herself for not meeting this need, as depicted in her description of her relationship with her sister:

I don't know what I wanted form her. Because she came and she visited to see how I was doing, but to me, that was not enough...I don't know what she should have done to satisfy me... but I didn't put the blame on her – she doesn't know how I felt. Why didn't I stop her and say – sissie, come I want to talk to you. I was feeling the pain, which she had no knowledge of.

I should have just asked her – please give me some time – I just need to talk to you.

Much of the interview was characterised by self-blame and a desperate plea for acknowledgement of her pain from others.

You blame yourself for everything and think that you should have done this or that. I now know that I shouldn't, though at times I do.

Diane's focus was predominantly on what others could do for her. She appeared to believe that acknowledgment and support from those around her would enable her to cope better.

if for instance my immediate family knew about miscarriages – they would have known to sit with me and give me what I needed at the time. To be knowledgeable and give me what I need and to acknowledge. So it's not really not about me as a woman but it's about those around me. The support around you.

Diane did not experience support or sympathy from her colleagues at her place of work. Again she had expected more understanding from them and was disappointed by the lack of respect shown to her.

3.3 Identification of Supportive resources

Diane believed that general education of society regarding miscarriage would facilitate more understanding. Also, advice concerning how to avoid miscarriages and not placing a pregnancy at risk. There appeared to be a need for knowledge about the process of a miscarriage and the reasons behind it.

4. Helen's experience of miscarriage

Helen had experienced seven miscarriages and one entopic pregnancy, the first was in 1981. She was married with one daughter.

Helen began the interview by stating that she was inclined to "block out a lot of what happened". Her second pregnancy was planned and she and her husband were elated at the second pregnancy and very disappointed when Helen had a miscarriage. Following this she was prescribed hormonal and fertility treatments. Moving between Umtata and Butterworth she was changing doctors often and also miscarried "a few times". On one occasion she was sent to Cape Town to a gynaecologist to try and prevent another miscarriage. She lost the baby at two months. All the miscarriages were within the first three months. Helen indicated that the first one did not affect her to the extent that those that followed did. She became apprehensive and anxious as she focused increasingly on falling pregnant.

> *...you become so focused on one issue that you lose sight , of life in general that's going on around you. I almost had a selfish attitude. You know, I had to do everything to try and fall pregnant. I was trying too hard. I was really, really trying too hard. In some ways putting pressure on my husband as well.*

The interview was characterised by Helen finding fault with herself and self-reproach. References were generally about what she should have done; her "mistakes"; blaming herself for not asking "enough questions."

but I know also I didn't ask enough questions. And again it was my character – to be rather – I mean me talking to you like this you would never believe it if you had known me 10 or 20 years ago. (laugh)
I wasn't a very open person, possibly I'm just an introvert and very shy. So I would go to the doctor and tell him what was wrong and he'd write out the prescriptions and I'd just accept that and do whatever he said and I would never really enquire too much. So partly the fault was mine for not asking enough questions.

Helen referred to a period of depression following the last miscarriage approximately ten years ago. She said she was not aware that she was depressed at the time but having read literature on miscarriages and fertility issues subsequently, she recognised that she had been depressed.
Recent work has suggested that depressive symptoms and anxiety are common following miscarriage. Based on the factor of unexpected loss and physical trauma associated with miscarriage, Zucker predicted that women who have experienced miscarriages would suffer from "higher levels of depression" and "intense emotional distress or trauma" than women who experienced other types of reproductive difficulties. The statistical data from Zucker's study confirmed that significantly more women who had miscarriages recalled experiencing depression and/or trauma than women who experienced other types of reproductive difficulties did (1999:3).

Helen actively avoided baby showers. She recalled that she could not hold a young baby as she experienced it as too painful. She recalled deep sadness and hurt, but said that she never recalled feeling angry about it.

A turning point came when Helen conducted her own investigation into the disease she had contracted, Brucellosis. She had questioned a veterinary student who had advised her that the disease was contagious and all women students were always warned to be extremely cautious when handling contaminated meat. This was contrary to what the gynaecologist and doctors had been telling Helen. When she finally established the reason for her miscarriages she felt that she was able to "close the chapter on Brucellosis", as she had always wondered about the link. Helen could stop "blaming herself" as she had established the reason and could attribute some meaning to what had happened.

Cognitive coping (or making meaning) is generally perceived to be a critical aspect of recovery following stressful experiences. It involves individuals' attempts to align the occurrence of the experience with their precrisis beliefs (Park 1998:8).

She had blamed herself specifically since she knew that "the problem" lay with her and not her husband. Not being able to retain a pregnancy made her feel "inadequate".

> *I think you feel inadequate. You have this role model, or I did, about being a good wife, a good mother. We'd actually talked about having 6 children. (Laugh) and I think that I realised that I couldn't live up to my part of the bargain.*

Helen expressed the deep need to find closure and make sense of the experience of miscarriage in her own mind. She expressed it in the following way,

> *to me every single one of them was a child and in fact it hurt more that I never saw them. I think if I'd seen them and if I'd had the chance to maybe bury them - obviously you're not going to bury a 3 month old fetus, but if you've had a still born you can actually bury it. But it's this going to hospital pregnant and coming out not pregnant. Nothing happening in between. You're just put under anesthetic and then you're awake and you went home. There's no - there's no finality from the baby's side. I don't know how to explain it.*

Helen referred to avoidance of situations, which would remind her of inability to have a child,

> *I had such a longing for a baby – I couldn't easily go to a baby shower; I couldn't hold another young baby, it was just too hurtful.*
>
> *J: What did it make you feel?*
>
> *H: ...I don't know – um...that ...but I want a baby like this and I can't have one. Sadness, a lot of sadness. Not anger, I don't even recall being angry. But just hurt. I mean it was a pain inside when you saw that young baby and you saw the mother hugging it and ... you thought...well, I can't have one.*

Helen summarised her experience with the term "devastated", indicating that she experienced the accompanying emotions very difficult to cope with, even to the extent of defining what the emotions were. She recalled that she was unable to identify the emotions as anger or grief and was overwhelmed by emotional confusion. Helen's experience aligns itself with the findings of Lasker and Toedter (1994) (in Paton and Wood 1999:3) who suggest women experiencing early miscarriage may be at risk for receiving the least recognition of their distress.

4.1 The experience of medical carers

Helen referred to a deep level of bitterness and blame toward the doctors and hurt she had experienced. There was a distinct feeling of not being listened to and her thoughts not being taken seriously by the attending doctors and gynaecologists. Following the first miscarriage there was "quite a long time" when she did not conceive. As a result the doctor prescribed hormonal treatment. She described the unpleasant side effects on her emotions and mood-swings. The treatment continued for some years. There was no counselling and seemingly limited information.

> *No counseling. They gave me a small amount of facts. I think, looking back on it, there was a time when I blamed the doctors. I really, really was upset about them. I didn't even want to go to doctors, and yet it was absolutely essential.*

Helen explained that when living in Umtata she had contracted Brucellosis, from unpasteurised milk purchased from a local dairy. The doctors did not diagnose this until years later, at her insistence. She was continually suffering from ill health in the form of bronchitis and tonsillitis, among others. At her insistence in consultation with a doctor she requested that he test her thoroughly to assess what the problem was, as she had a strong sense that there was more to her health than had been diagnosed.

> *I had many, many gut feels about things and I think this is where I ...had a bad time with the doctors. I was sometimes saying things, which I felt and they wouldn't always want to believe. Anyway, he was very nice and he did all the tests...they picked up that I had Brucellosis. Now I had...they treated me for it. A couple of years later I got very involved in horse riding and on the veterinary side and I read a lot of veterinary books, and I actually picked up more about Brucellosis in cows, through reading the vet books. And discovered that it was a disease that made the cows abort their claves. So then when I saw the doctors I asked them could there be any connection with this. And they said No. It was more than one doctors and specialist too. I said 'can there be a connection', and they said 'no'. About 4 or 5 years ago I discovered that, I'm almost 99% sure that that was the reason. And what upset me then was that had I know then I wouldn't have gone to the expense & the trauma of fertility drugs because we weren't earning big salaries so it was a costly business. It was the hormones that were going up and down; taking your temperature every day; it was apprehension of watching the chart and everything*

and then telling your husband its got to be tonight and there was a lot of tension and I would never have done all that had I been given the right answer before.

The impression you get that you should know. You also get the impression – I mean you book the appointment for 3pm you sit in the waiting room and you wait until 4, 4.30pm. You're rushed in, 5 minutes later you are rushed out and I often felt that I mustn't waste the doctor's time. In fact now I'm beyond that. If I want to talk to him for ½ hour, I'll talk to him for ½ hour. But it's taken me 20 years to get there.

Helen referred to her "unquestionable trust", which she once had in medical doctors. Her perception of doctors changed from this to a realisation of their 'humanity'. Helen had thought of doctors as those who would cure you. When she did not find a "cure" her perception was challenged.

When I kept getting wrong answers and wrong diagnoses it really threw me.

Yet Freeling (1998:1) identifies the patient's need to have an "absolute, uncritical confidence in their doctors' skills."

A strong indication of self-blame emerged in Helen's recollections of her experience with doctors. Again she blamed herself for not asking "enough" questions. A study by Moulder (1999:1) revealed that those women who were critical of their care had experienced physically straightforward miscarriages but who were emotionally distressed often because of the circumstances surrounding the miscarriage which were not acknowledged, (e.g. IVF, recurrent miscarriage). These women had less contact with professionals and yet needed to ask questions and to talk about their experience.

4.2 The experience of others – family and friends

Helen made reference to family reactions to her miscarriages. The couple elected to tell the family about the first miscarriage but thereafter did not. She recalls her mother having experienced a miscarriage and assumed that she possibly understood more, however, there was no discussion between the two of them. Helen articulated her experience of her family as follows,

...the communication on a deeper level wasn't there. There was sympathy and there was compassion but on a very superficial level.

There appears to have been an unstated degree of pressure on the couple to produce a grandchild. The desire for a son in the family was conveyed as follows:

> *at that stage there were no grandchildren, on either side, beside my daughter and an adopted child, so – I know they would have been very excited about it.*
> *I recognise now that there was pressure on me to – it's a strange thing to say, but to produce a son – Not so much from my husband's point of view but from his family. We've get a very unusual surname and as far as we know we there is no other male in South Africa – other than the adopted son, my husband's sister's child. So I felt pressurized.*
>
> *I think also the way my mother had spoken; things from childhood and what my mother had said – I'm the eldest and then there's my sister and then I've got a younger brother. And just the way my mother had always spoken I know he was very important because of being a son.*
> *These are things you pick up and to me it was important I had a son, to carry on the name and to give my family a grandson. And it never came from them but it was what I had thought. It was pressure I put on myself.*

Helen's strongly internalised role model of being the 'good' wife and mother contributed to her believing that she was not "living up to her part of the bargain" by not producing a son, or simply another child.
A deep sense of inadequacy and failure was conveyed in her telling her story.

On several occasions Helen referred to the fact that she did not have a particularly close relationship with anyone whom she could confide in and share her burdens. She referred to this lack in her life as "one of my biggest mistakes." This is supported by the findings of Swanson (2000:191), using a path analysis based on the Lazarus Paradigm to predict Depressive Symptoms after Miscarriage. The study confirmed that women most at risk for increased depressive symptoms lacked social support, among other characteristics.

Reactions of others were sometimes experienced as hurtful and interpreted as uncaring. Helen recalled remarks made twenty years previously with marked clarity,

> *'but you're still young you can try again' – it's remarks like that that really hurt. I know people are well meaning, but at the time those are such hurtful remarks...and*

some of the remarks were – Oh well at least it wasn't still born, and you never saw it and you never knew what it looked like; or it wasn't it properly formed.

Helen's interpretation of these remarks was a lack of acknowledgement and a belittling of the importance of the baby she had just lost. While Helen emphasised the support from her husband she did not experience genuine emotional support and was not able to talk to him "at a deeper level". Several authors have indicated that unacknowledged losses are more difficult to deal with and difficult to grieve (Dulwich Centre Newsletter 1996,3:1).
The lack of sharing contributed to her shutting the feelings and thoughts out of her mind.

I'd come home and my husband would be very grateful that I'd be healthy. I think his main worry was that I would be healthy. I remember he once said – it hurt me terribly – but it made me see his view on it –he said that my going into hospital was just like going into hospital with a bad cold and making it better - he couldn't – I don't think he could relate to the baby unless it was born. I mean you can't unless it's growing inside of you. He was more concerned about my health – I mean every operation carries its risks. So he was glad that I was home and then life would just carry on. And because we never really discussed very emotional things life would jus carry on – it was the end of another episode.

And I think definitely a woman needs to talk about it – not just to shut it off or block it off – but to talk about it. And possibly a man can't fully understand

4.3 Identification of supportive resources

Helen repeatedly stressed the need to have someone to talk to, someone who had experienced a miscarriage, or who understood. She drew attention to the importance of having someone to validate emotions and feeling states.

if you could have somebody there to say to you that's it OK to feel angry and sad about it. I think the biggest problem is that you feel guilty for feeling all these things.

She did not view advice as needed but simply to be able to talk to a woman who "really understands". Helen suggested that it would be helpful to have someone to talk to about the child specifically. To share the mother's expectations, hopes and plans for the child; to talk about whether it was a boy or a girl. An acknowledgement of the child as a real

member of the family. Helen's bereavement was indeed complicated and was evidence of Slater belief that a miscarriage is often a mourning of the loss of a future and expectations, not simply of an embryo (1999:2).

5. Sheila's experience of miscarriage

Shelia is a white woman who had experienced five miscarriages and had two children in-between the miscarriages. She lived in Zimbabwe during this time. The interview was characterised by self-reproach, a deep sense of failure, guilt and anger. Guilt and self-blame were present in all six interviews, in varying degrees, both emotions are reported to be common following a miscarriage (Regan 1997:247). Despite the time that had elapsed since the miscarriages there was still a strong feeling of injustice about what she had experienced.

Sheila conveyed her story in a graphic and detailed manner with a strong emphasis on the impact of other's reactions and comments. Sheila summarised her experiences as follows:

> *I think that without really consciously knowing it you have this, this feeling of inferiority. Sort of useless, you know, here I'm a woman who can't even do the most natural thing in the world. I mean everybody is just – these black women are just popping out babies left right and center. I mean people who don't want babies are just having and here I am and I really want. I suppose that incredible feeling of inadequacy. And I suppose anger as well comes into it. I think that's basically – the whole thing is just based on that, you know.*

Emotions of anger and a sense of inadequacy were emphasised throughout. A feeling of isolation was described, as 'feeling like you're the only one in the whole world.'

The first miscarriage was at 20 weeks, in 1976. A strong sense of being unimportant and on her own was conveyed with little perceived support.

> *I went through full labour and had the baby. Ok, I found it was a bit difficult because obviously they were very busy with it being New Year's Eve and morning, the early hours of the morning. But I was basically left on my own going though labour...So that was actually very difficult – being on my own.*

Her comments were filled with self-reproach and fault finding in herself,

At that stage I was still very shy and very - - very worried about doing anything not – not considered normal. When I look back now it was really silly, but the one thing I did insist on knowing the sex... Ya – it wasn't easy but as I say, I was very shy and very worried about worrying anybody. What I should've done – is I should've said to them, "Please phone my husband and ask him to come and sit with me." That's what I should've done. But I didn't.

...they were just so busy that I didn't want to hassle anybody and I just quietly did my own thing (laugh) - - which was silly, in retrospect.

Sheila sought to make sense of, and rationalise the experience by telling herself that there must have been a reason and it was possibly best since they had not been married very long and were not financially very secure.
When a situation is appraised as a violation, people can either change aspects of their global or situational meaning or attempt to assign more benign causes to the stressful situation or attempt to see the situation in a more positive light (Park 1998:8). However, in the midst of the rationalisation she conveyed a deep sense of injustice, anger and a sense of being punished. In Sheila's view there were those around her who "did not love children as much as she did", who did not experience any difficulties having children.

S *And I thought – well – it's not fair – why me? You know. What have - what have I done, possibly, you know, to have - -*

J *Who were you angry with?*

S *I think just generally angry and then towards God – I think I just – I wasn't religious but I knew He was there, and everything – I sort of asked – why are you doing this to me? You know.*

In Sheila's mind there appears to have been a connection between her 'love for children' and the fact that she 'did not have an easy time.' She interpreted the connection as a possible feeling of being punished and attributed it to her poor self-esteem. A sense of inadequacy and inferiority permeated her descriptions of herself. Her relationship with her mother seems to have played an important role in this perception of herself.

Shelia's perception was that she had failed and conveyed a deep sense of guilt that she "hadn't managed to carry the baby and had failed." She referred to the days that followed as being filled with tears.

> *as I went along – I felt like a failure because here was the most natural thing in the world for a woman to have a baby – and I couldn't do it. You know. I did it so far – and I couldn't manage the whole lot.*

An added difficulty was when she began producing milk,

> *It was terrible. I was the same as with a normal – and that upset me. Because now I had milk and no baby to feed.*

There was conscious avoidance of related stimuli and Sheila explained that she avoided seeing a friend who was pregnant at the same time and carried full term with no difficulties. A sense of feeling "useless", that she had disappointed her husband, seemed to pervade her thinking patterns.

> *then she had the baby and I actually couldn't face anyone who was pregnant or had little babies. I went to the shops and if I saw someone pregnant I would burst into tears, well – I would just walk out the shop and burst into tears.*
>
> *So I actually – it was – horrible in a way, because I couldn't, at that stage, - I couldn't explain to them. My husband used to go and visit them. My husband sort of explained to them and they were very good. I didn't see them again until I had my son. It was just too painful – you know – I just associated it all the time.*

Subsequent pregnancies were described as fearful events. When she started miscarrying the second time her thoughts were, *"here I go again"*. Sheila recalled not wanting to talk to anyone, for fear of their reactions. She wanted to withdraw and "hide". Polaneczky (1999:1-5) notes grief, depression, sense of failure and anxiety about subsequent pregnancy in patients having suffered a miscarriage. She reports that for some a successful subsequent pregnancy can help resolve the feelings; however, for others the loss is mourned forever. Sheila was determined that if she was going to miscarry it would be early on in the pregnancy and not as with the first one. She consequently "did everything" she was not supposed to. However, despite the effort to 'test' the pregnancy, it did not continue beyond 25 weeks.

Sheila referred to the difficultly of having a miscarriage in a maternity hospital, and despite being in a private ward, she was very aware of the newborn babies arriving in the wards.

She mentioned that she 'cried a lot' but because of her upbringing, of always maintaining a 'stiff upper lip', she tended to cry when no one was around.
Following the second miscarriage Sheila became "very,very angry with God."

The following pregnancy resulted in her son's birth at 37 weeks. There was a brief time when the newborn baby was in a critical condition, after which his condition stabilised. Sheila began bargaining with God, in her desperation to try and see her son live;

> *I just prayed and prayed and prayed and I basically – (laugh) it sounds really stupid now. But I said, "God, if you - if you let this baby die I'm going, I'm going to take my life, I'm going to jump off that roof (laugh). I don't want to live anymore" (laugh). You know, it sounds really stupid now (laugh) but, I was just so angry, I was so scared something was going to happen to him.*

The deeply socialised family norm of bearing a son was evident as Sheila commented in the following way,

> *Is this really, really alive and it was a boy, which was – I'm the only girl and I had the only grandson, so of course, now I've done - managed to do something (laugh) that nobody else could. But – there again, in the back of my mind, you know, "Am I going to fail again?" Always this doubt – is it going to be all right? Is it going to be all right?*

Following her son's birth the couple had a daughter and then Sheila experienced a miscarriage of twins at 26 weeks, which was described as a traumatic experience. A rationalising process followed with little, if any allowance given for dealing with the emotions. Shelia described her state of mind and thoughts as follows:

S *... in some ways it was a relief. Because, there again, we hadn't planned them. What would we do know with the twins? My daughter was only little - she was just over a year old. So financially and not having family there and everything, but – that on one hand. The sort of panic on one hand. And then, what was so hard, was that I felt so positive about the pregnancy.*

J *For the first time?*

S *Yes. For the first time I felt so positive. It was sort of fatalistic – because now we hadn't planned, we didn't really want to have anymore now. And they had just arrived. I was sure that now I was going to have no problems.*

J *What were your feelings when you had lost the babies?*

S *Oh, well then, the anger, the emotions –*

J *Anger toward whom?*

S *Probably toward myself. Ya – I probably felt a bit guilty because of our initial reaction, oh no, what are we going to do? What are we going to do financially? How on earth are we going to manage? Not just another one, but another two. But at the same time I'd felt quite excited about having twins. Initially, I thought – it's not fair, why am I having them now? Why couldn't I just had them then and then I could've just had my family and not have had to go through all the – (laugh). So there was this continual roller coaster of you know, negative – positive, scared, or whatever, so – ya –*

Sheila recalled that in the ensuing years she suffered with sleep disturbances, battling to fall asleep and experiencing dreams of the miscarriages, the births and the pregnancies. She would replay the events in her mind. No counselling was sought. The symptoms described by Sheila correlate with criteria of Post Traumatic Stress Syndrome, as identified by Bowles (2000:5) in the domain of miscarriage distress-response symptoms.
The first intervention of any kind was approximately 20 years later when Sheila was prescribed anti-depressants, as she was 'not coping in general.' She described this time in her life as follows:

> *I just cried for nothing. Just, when I read – I felt totally down. I didn't want to do anything. I didn't want to sew or anything. I've always liked crafts and I didn't want do to anything. Everything was just hassle. I just wanted to sort of, go to bed and sleep. I just wanted to hide away. I didn't want to go anywhere, I didn't want to see anyone, do anything. I didn't garden anymore. I just became – quite a basket case.*

Some sense of closure was found when Sheila became friends with a couple whose eldest child was brain damaged and they had a newborn baby. Sheila helped with the baby and described it as being 'therapeutic'. It seems it was the first opportunity for her to nurture a newborn baby after the loss of the twins. It was after Sheila had the opportunity of helping care for this baby that she recalls the dreams and replays of her miscarriages ceased.

5.1 **The experience of medical carers**

Sheila had a range of experiences with medical carers ranging from positive to negative. Several references were made to her perception of her unimportance in the scheme of the hospitals schedule and being left alone during times when she required support. A sense of lack of support and care emerged as she reflected on the first miscarriage experience:

> *I found it was a bit difficult because obviously they were very busy with it being New Year's Eve and morning, the early hours of the morning. But I was basically left on my own going though labour – um – and, obviously – I had nursed so I knew – so I wasn't scared or anything. I knew what was going on. Um – and then of course I asked for a bedpan and baby came away – um – in those days – um – the nursing staff wouldn't let you see the baby and they didn't want to tell you what sex it was so I actually fought with her and I said, "I have to know" and she said, " but it'll upset you" and I said, "no, it'll upset me more if I don't know"...So eventually she reluctantly to me it was a girl and then I was quite happy. So that was actually very difficult – being on my own.*

Her sense of unimportance was nurtured further when her husband arrived at the hospital without having been notified of the loss of their child by the hospital. Sheila blamed herself for not being more assertive and her reflections were filled with self-reproach:

S *it wasn't easy but as I say, I was very shy and very worried about worrying anybody. What I should've done – is I should've said to them, "Please phone my husband and ask him to come and sit with me." That's what I should've done. But I didn't.*

And,

S They basically left me – um - -

J Did they know you were in labour?

S Ya – Ya – sort of, they kept coming in – "Are you ok?" and I would say, "ya, ok." (laugh)

So they were just so busy that I didn't want to hassle anybody and I just quietly did my own thing (laugh) - - which was silly, in retrospect. Ya – I was very shy.

Sheila appeared to make excuses for the lack of support from the nursing staff and commented that she could not have asked for a better doctor or gynaecologist. She viewed

the nursing staff as "sweet but basically didn't know what was going on". The hospital was a training one and most of them were student nurses. While Sheila spoke positively of her doctor she recalled a statement made by him,

> *He just said to me, you know, it's one of those things. So many women lose their first child and blah-di-blah. He said he could see there was nothing. For some reason it was just one of those things and um – not to worry. "Lightening doesn't strike twice in the same place," he said. Well – that was my GP.*

The statement rings an almost echoed note of Field and Marck (1994:281) who report on this frustration, as one of their cohort's articulated: "I couldn't find a doctor who could understand how concerned I was that it would happen again. The first family doctor that I came across said, 'Well these things happen and it won't happen again.'"

Another comment referred to was made by the hospital receptionist who was apparently attempting to make light conversation with Sheila as she returned to hospital while miscarrying for the second time. Her comment was "What have you been up to now?"

While Sheila excused comments and actions, or the lack thereof, of hospital staff and doctors, the comments encouraged her already fragile self-esteem and entrenched sense of failure and inadequacy. No counselling or any form of discussion was entered into by any hospital staff, either prior to or following the miscarriages.
The more positive experiences referred to were when Sheila spent several weeks in hospital prior to the birth of her son. She spoke of two nurses in particular who made her feel at ease and relaxed.

5.2 The experience of others– family and friends

It would appear that Sheila's relationship with her mother played an important role in her perception of herself:

> *I never really felt... I never really – I never had a good self-esteem. I never -- It probably goes back to my mom again - - I – always was a little bit plump. Ok. Her mother was a dancer and she had a thing about weight. And I suppose I felt that I had always felt I'd let her down. I was never good enough so that obviously carried*

through. My brothers were successful and she would pick on me. Um – you know – I know she didn't mean it, but it had an effect on me – they had excelled at sport. Our dining room was filled with all of their rugby photos. And when I got a – I was always in a swimming team but we never had a first team as such and the first year they decided to have a team photograph – it was never put up. – So that – I suppose – in the back of my mind – I thought – well, I'd always failed, now I'm probably going to fail again. So that was probably the sort of undercurrent all the time. Am I really going to succeed? Because I'd battled at school you see, I battled with everything. I'd done fairly well at my nursing. But, um – as I say my mom had this – she does unfortunately – I somehow I don't manage to do anything right. (laugh)

I think in the back of my mind – I think it's all connected with my moms – sort of – way toward me – and that kind of thing. You know I never quite managed anything (laugh). I never quite got there (laugh).

Sheila remembered that her mother had experienced miscarriages herself but it seems never discussed the experiences with her daughter. Their interaction during Sheila's miscarriages was described as "sympathetic" with her mother telling her that "everything would be alright." Sheila identified a polarity between her family of origin and her husband's family's communication styles. Her own family was described as a "very English background, so you didn't discuss anything – you'll be alright, stiff upper lip and don't cry, you'll be fine."

Her perception was that her mother was probably unable to discuss her own miscarriages as she had probably tried to "push them down and cover them up", never having allowed herself the opportunity of confronting the emotions associated with the experiences. Sheila indicated that she had a closer relationship with her father but never discussed any matters related to the miscarriages with him.

Sheila described her husband's style of communication as more open. She recalled that in general he encouraged discussion and reflection of feelings. This was, however, contrary to what Sheila conveyed happened with regard to the experiences of the miscarriages:

He's actually – not like other men, he doesn't have a problem showing his emotions – he'll cry. He was very upset but very supportive.

J *In what way? How did you know that he was supportive?*

S *Ag – it was just his – you know – he's just like that – he would sit and hold my hand and reassure me – "Don't worry it's alright, everything is going to be alright. Don't worry about it." You know. Sort of – "Forget about it and we'll just carry on." (laugh)*

Um – ya – in that way he reassured me. He wasn't angry or anything – it's just one of those things – mustn't worry about it and let's just carry on.

J *Did you find that helpful?*

S *Yes, ya. He was very supportive like that you know. I was very lucky because he's not one of those men who would tell me I'm useless. He did the opposite. You get these men who insist on a son or a daughter and you'd better make sure I get one.*

No discussion about any emotions associated with the loss, self-blame or sense of inadequacy were referred to as having been discussed between Sheila and her husband. It would appear that with 'good intentions' his approach was summarised in the statement,

"Forget about it and we'll just carry on – it's just one of those things – mustn't worry about it and let's just carry on."

The only reference to Sheila articulating her fear was responded to in the following way;

J *Did anyone every address how you felt?*

S *No – never, never. Just my husband used to. I would say to him, "I'm just so scared" and he would – also – say "Look, I'm sure it's going to be fine – don't worry about it, just relax. Don't be frightened. He used to say, "Try not to be frightened", because you know fear itself can cause problems.*

Sheila referred to her fear and anxiety in the subsequent pregnancies. This correlates with the findings reported by Field, Marck and Bergum (1994:268). Four themes of uncertain motherhood emerged from their exploration:

Vulnerability, inner dialogue with uncertainty, search for care, and, living through possible motherhood. The uncertainty of a woman with a history of a miscarriage becomes central to her perceptions of herself as mother since the "natural order" of healthy pregnancy and childbirth did not necessarily translate into her experience. Feelings of bereavement and anxiety from experiences of miscarriage influence the journey through subsequent pregnancies (Berryman et al 1995:9).

Sheila recalled several comments from family and others suggesting that she should not worry and that it was not that devastating since it was 'a bit soon' in the marriage. This thinking encouraged Sheila to think that it was possibly true, yet she still experienced the comments as hurtful and disregarding of her and her baby whom she had lost. Another comment recalled with clarity was, "Are you keeping well *this time*?" during the second pregnancy. Other comments implied that the second pregnancy was too soon after the first and that the loss was probably a "blessing in disguise".

A significant interaction occurred between Sheila and a Catholic priest, who visited her in hospital. Sheila's husband had been raised in the Catholic Church but he was not a practicing Catholic in adulthood. The couple had decided not to align themselves with a particular church, specifically not with Catholicism. A priest conducting hospital visits had recognised their surname and visited her. Sheila described the visit in the following way:

> *...his words to me, were basically, it you'd carried on – been brought up in the catholic church this wouldn't have happened; if you'd come to me the next time after all this – if you'd have come – so then – I was sure now – that I was being punished.*

Sheila's perception that she was 'not good enough' and that 'things happen because I'm bad,' was reinforced by this comment from the priest. She described the incident as having a 'devastating' effect on her as she wrestled with the thoughts that she was a 'bad person because she had not gone to church.' Thoughtless comments by others are often the fuel for this blame-placing and consequent guilt (Harkness 1992:177).

5.3 Identification of supportive resources

Sheila immediately identified the importance and value of speaking to another woman who had shared the same experience. This was viewed as a significant lack in her own experience and it was thought that had someone been available to her she would have able to cope better. Sheila's view was that the experience of miscarriage is 'so devastating, no matter when it happens', that support is essential. She continued to suggest that nursing staff are either too busy, or too disinterested to speak to women in hospital. Sheila's experience was that hospital staff are 'totally uninterested'. Education of male doctors was suggested to facilitate a greater understanding and empathy.

I think, ***Doctors****, I mean obviously men don't understand. They've never been there, they don't understand. I think they need some sort of education as well. You know, everybody is sorry and yes, you know they're sorry, but somehow sorry isn't enough (laugh). You need something a little – ya – women need support.*

Reference was made to the workingwoman who is not able to take leave from work. It was suggested that women did not allow themselves enough time to deal with the loss. Sheila suggested that as a result the experience is 'psychologically pushed back.'
Sheila likened the taboo and social discomfort of the subject of miscarriage to the manner in which disabled people are treated:

And people - they don't know how to react. I mean it's not their fault. They don't know. It's like us with disabled people. We don't know how to treat them, we don't know how to react. You don't know what they need and want.

Acknowledgement from others and having the opportunity of speaking to another woman, or women, who had experienced miscarriage was identified as essential for any women to be able to begin to confront her emotions and come to terms with the experience.

I think, somehow, one knows that there are a lot of women who have been through this in the world. But when it's you, you feel like you're the only one in the whole world. I don't know how other women handle it but it certainly took me many, many years. I would go to bed at night and I couldn't sleep. The sights would come back and the replays and maybe this or that, or why this or why that. Ya, it was many years. And then it slowly – also I suppose age as well.

6. Carmen's experience of miscarriage

Carmen is a white female who had experienced two miscarriages after trying to conceive for approximately five years. The couple were delighted at the news of pregnancy and Carmen described the experience of the miscarriage as devastating.
Carmen recalled having a 'strange feeling' that the first pregnancy was not in order. She did not discuss this with her husband or mention any of the physical symptoms suggesting that all was not well. She indicated that "deep down I was hoping that it wasn't all bad, but deep down I knew that it wasn't going to work.'

Due to a previously planned long weekend away with friends Carmen did not have a D&C immediately. She described the four days in the following way;

> *Oh, it was terrible. I thought, why me? What did I do that was so bad that I had to go through it? My husband didn't know how to deal with it properly. He tried to be supportive but he had...he didn't know how to deal with it properly. I was devastated. I cried – lots of tears.*

The majority of the group of friends whom they shared a cottage with did not know about the miscarriage. Carmen recalled feeling very angry and unsupported by family and friends.

> *There was anger. Because everyone around me seemed to fall pregnant so easily and had no problems and here we'd been trying for so long, and it just didn't work. Um...support from my family was...so-so. And also from friends was....they didn't know how to deal with it. It was a case of it's over, deal with it, forget – move one – there will be others.*

The predominant emotion underlying Carmen's recollections was anger. A strong sense of self-blame, self-reproach and being punished for being 'bad' were evident. She had convinced herself that she had been the cause for the early termination. A strong sense of failure and inadequacy existed as there was the belief that she had 'done something' to precipitate the miscarriage. It appears that Carmen had internalised the norm of the role of motherhood from a young age and the possibility of not fulfilling this role was perceived as devastating. Her identity of being a woman was in danger as she questioned her "use".

> *I felt completely useless...as a woman. I always wanted to be a mom and it made me feel hopeless to think that maybe I wouldn't be. I was just petrified that I couldn't carry a baby, that I couldn't have a baby and be a mother and we couldn't be a family. A complete failure as a woman.*

Baruch (1999:94) suggests that women who internalise the social norms expressed by the dominant gender roles often view themselves as defective.

Evidence of social withdrawal was present as Carmen recalled that she did not want to socialise with anyone who had babies and most definitely not see or interact with pregnant women. A strong sense of being an 'outsider' was conveyed.

C: You don't want to mix with anyone with babies

J: Why do you think so?

C: Because it's not yours. You aren't part of that group. You just, you just...there..you don't fit in. If you have a baby then ...you're a family.

J: And if you don't have a baby – where do you fit in?

C: You're almost – um – I shouldn't say you're an outcast, but people actually – but when they ask you when are you having a baby – you just want to punch them...they just don't understand, for them it's the most natural thing – for them you get married and have kids.

It was Carmen's perception of the subject of miscarriage being a social taboo that it is viewed as a threat to all those people who have children or are planning to. She viewed it as a threat to their "nice, secure little world...it's just a no-no." Carmen likened the miscarriage taboo to the subject of illegitimate pregnancies in the early 1900's where young girls would be sent off to have their babies. The sense of 'gaining entry into the adult world' is supported by Field and Marck (1994), who report of numerous findings of women referring to themselves as "outsiders" by virtue of not having children. The valuative meaning attached to a miscarriage is consequently strongly influenced by this view. A participant in one such study reported the following perception about pregnancy regarding maturing and gaining entry into the adult world:

"It is important developmentally for an adult to have children, to go through recognised stages, rites of entry or passage in our society. If you don't enter those, there's a sense of being an outsider. Children are really important to have a sense that we're part of the mainstream and help us feel that we've come of age, reached a level of maturation." (Field and Marck 1994:17)

This desperate search for finding meaning was evident in both physical and an emotional realm.

J: You mentioned anger – who were you angry toward?

C: Myself. Because I couldn't carry the baby. Because obviously I couldn't carry the baby. I thought there was something wrong with me. That's why the pregnancy had terminated so earlier. People said maybe it was because there was something wrong with the baby, but I thought it was me.

J: Did you blame yourself?

C: Yes.

J: Tell me more about that.

C: I don't know – I thought maybe I'd done something or eaten something or picked up something too heavy.

Despite being assured by her gynaecologist that up to 80% of first pregnancies resulted in miscarriage Carmen still blamed herself and perceived herself as not being 'good enough'. She described feeling 'empty' and tearful on return from hospital, "empty, almost like a part of me was missing but there hadn't been anything there..."

The experience of the second miscarriage was described in a similar manner with a greater emphasis on a sense of punishment and retribution from God. Carmen also explained that she felt more alone and unsupported on the second occasion than the first and experienced increased feelings of anger. Feelings of bereavement and anxiety from experiences of miscarriage influence the journey through subsequent pregnancies (Berryman et al 1995:9). The emotions related to the second pregnancy were described with the words "fear", "nervous" and feeling "petrified", as she worried that she might miscarry again.

J: What feelings did you have?

C: More anger.

J: Toward whom?

C: Toward God. I felt that He was doing it. And also because I'd seen the baby. There was actually little baby jumping up and down. I'd actually seen it. The first time there was no heartbeat. The second time there was a heartbeat and there was this little thing and then it was gone...

J: You said you felt very different to the first time.

C: Ya, I felt that God had taken a baby away from me. A real live little baby. The first child was just a blob. The second one was a baby. That's the only way I can describe it.

J: Why did you think it had happened?

C: I thought I'd done something wrong again.

Harkness reports that knowing why can become an obsession, which can in turn lead to the search to place blame somewhere specific. Often the individual places the blame on herself (1992:177).

Carmen began extending her search for finding meaning from the physical, as she tried to attribute the miscarriage to some physical activity; to a sense of being victimised and punished by God; to attempting to find fault with her interactions with others in the past.

> *I can't remember what I thought. But they were strange...had I said something wrong to someone? Had I...I can't remember. Or done something wrong somewhere along the line? I'd done something wrong somewhere and I was being punished.*

Field (1994:281) highlights the need each woman who has miscarried has, to make sense of her experience; moving toward an understanding which comes as the individual is 'allowed' to experience her pain in honesty with others.

Carmen used the term "emptiness" to summarise her own experience of miscarriage, the words "loss" and "helplessness" were also referred to. The second miscarriage was described with a sense of greater loss,

> *I hadn't noticed it but my body had started changing already. It was just an emptiness – more like a physical loss – nothingness.*

Cognitive coping (or making meaning) is generally perceived to be a critical aspect of recovery following stressful experiences. It involves individuals' attempts to align the occurrence of the experience with their precrisis beliefs (such as beliefs in a just world and beliefs in their own invulnerability to harm) (Park 1998:8).

Carmen indicated that she had blocked out the experience and believed that she had not necessarily dealt with her emotions. She described the experience as "closed".

6.1 The experience of medical carers

Carmen's relationship with her gynaecologist was perceived to have been the most supportive relationship throughout her miscarriage experiences. Field and Marck (1994:283) report that caregivers who understand this distinctly individual nature of each experience are deeply valued by the women concerned.

The couple had been trying to conceive for approximately five years prior to the first pregnancy and a strong relationship had developed with the doctor. Carmen recalled that the gynaecologist had appeared to be "upset as well and genuinely sorry." She described

his approach as thorough and believed that he accorded her the time she needed in consultation.

When Carmen went for the D and C her own gynaecologist was away and her experience of his partner was very different. She described his intervention as providing no support, "it was just a case of – 'you're going for a D and C so let's just get it over with. He didn't even come and see me afterwards."

No information, counselling or literature before or afterwards was offered by the hospital. The nature of this experience proved to be the norm for the other interviewees. It is also supported by research reports, one of which was conducted by Moulder (1999:1).

The findings presented a perspective of the health care system regarding a first trimester miscarriage, as follows:

It is defined in physical terms as a straightforward and fairly insignificant event with no history or context. A procedure requiring prompt and efficient medical attention. With fragmented and often impersonal care by staff working under pressure. Women were given little opportunity to talk about their experience during their brief hospital stay. The hospital doctors in Moulder's study indicated awareness of this dilemma and openly criticised the care provided for miscarrying women as 'cruel', as 'low priority' and as failing to attend to emotional needs of the woman.

The experience of the second D and C was under the care of her usual gynaecologist and was described as supportive and attentive. Carmen believed that this doctor was 'there if she needed him' and made her feel 'like someone actually cared'.

> *He was genuinely upset when I lost the first two babies. And throughout the third one he was there all the time. I could pick up the phone whenever I needed to and he was there.*

6.2 The experience of others - friends and family

Carmen described her husband's reaction to the miscarriages as being shock. Little reference to support was made, with several references made to his inability to deal with the experience.

> *My husband didn't know how to deal with it properly. He tried to be supportive but he had...he didn't know how to deal with it properly.*

I tried to speak to him about it but he was also a closed book by then. He couldn't deal with it.

Her perception was that her husband was 'hurting as well but did not know how to deal with it.' This inability to communicate their feelings was experienced as a "barrier" between the couple.

The year following the first miscarriage Carmen's husband suggested she seeks counselling. His view was that until she had confronted her feelings related to the miscarriage and learnt to relax she would not fall pregnant again.

The experience of the reaction from friends and family was described as follows:

Support from my family was...so-so. And also from friends was....they didn't know how to deal with it. It was a case of it's over, deal with it, forget – move on – there will be others.

This resulted in a feeling of little support and little if any understanding of the experience and the related feelings. The reaction to the second miscarriage was experienced as follows:

People were shocked. It was as though they didn't know how to look at you. If they said, how far are you, they would sort of say, well let's change the subject. They don't know how to deal with it.

Carmen recalled with clarity her conversation with her father on her return from the doctor.

C: I remember phoning my dad just after I'd gotten home form the doctor and I told him and his response was – you'd better talk to your mother. End of story, from him.

J: How did that make you feel?

C: That he didn't understand. Um – that he couldn't deal with it. And then my mom – I don't' know – I don't know if she's been through it – I don't know – she said, oh, no she was sorry and that – and they would be down the next week for the planned Christmas trip.

J: Was it spoken about again.

C: No, never referred to ever again.

There was a notion that her mother had experienced a miscarriage, but since it had never been discussed Carmen was not certain.

> *But that was just me overhearing her. But there was no talk about it. And that was* ***my mother****, and* ***she*** *can't talk about her losing a baby to her daughter because she doesn't know how to deal with it. And also because she comes from a generation where you don't talk about things like that. Heaven forbid if you talk about sex.*

Carmen referred to her relationship with her mother as not being close and her family upbringing as conservative and uncommunicative.

6.3 Identification of supportive resources

Carmen emphasised the need for women experiencing miscarriages to have contact with someone who had shared the experience. In this way the enormity of the experience could be acknowledged and understood. She recommended counselling; being able to speak to someone who understood and who could offer empathy and sympathy. The importance of being given the opportunity of articulating feelings was stressed.
It was suggested that the medical profession offer counselling or a support group.

CONCLUSION

Several themes emerged as common among the interviewees. These themes proved consistent with findings of research conducted by a range of researchers, as identified and discussed in chapter two.
In this way the findings of this study can be compared to a larger population and establishes a sense of representivity beyond the experience of the six interviewees, consequently validating the data (Silverman 1994:164).

Key responses identified were as follows:

<u>Negative impact on self-image:</u>

Sense of inadequacy in role of woman, wife and mother. Disappointment to husband and greater family.

Sense of failure as a person. Unworthiness and inferiority.

A sense of being physically and emotionally 'empty'.

Guilt

Self-blame and self-reproach pervading all areas of life.

A sense of being punished for being 'bad'.

Anger

Bitterness and frustration toward self and others.

A sense of being cheated.

Anger toward self, others and God. Bargaining with God.

A sense of being punished; injustice and retribution.

Social withdrawal

Avoidance of pregnancy related subjects, people and situations.

Feeling inadequate and actively avoiding social interaction.

A sense of isolation and the feeling of being unsupported.

Anxiety and fear

Particularly during subsequent pregnancies.

Shock

A sense of physical and emotional numbness.

Depersonalisation

Denial

Depression

Repression of emotion and detail of events.

Loss

Feeling physically and emotionally empty and hopeless.

Figure 8, page 106, provides a visual presentation of the four domains of miscarriages symptoms, as identified by Bowles (2000:5). He notes the similarities between descriptions of grief-related behaviours in miscarriage and those of Acute Stress Disorder or Post Traumatic Stress Disorder after miscarriage. They are only distinguishable by careful review of the diagnostic criteria in the DSM-IVA.

Figure 9, page 107, provides a thematic analysis of the data collected.

The findings of the study did not provide evidence as to who is most at risk for depressive response, following a miscarriage, but did collaborate with aspects of Swanson's study (2000). The study confirmed that women at risk for increased depressive symptoms attribute high personal significance to miscarriage and lack social support, among other criteria. All six women interviewed indicated, in varying degrees, that they did not experience emotional support to the extent they believed they needed. The women interviewed also attributed high personal significance to having children and consequently the miscarriages. This was evident in the perceptions of feeling inadequate and useless as a woman; failing in the role of woman, wife and mother; to feeling like a social outcast as a result of being childless.

Four Domains of Miscarriage Symptoms	**Criteria Charactersitics of ASD & PTSD**				
Emotions/Feeling States	Reexperiencing the Trauma	Dissociative Symptoms	Increased Arousal	Avoidance of Trauma-producing stimuli	Poor Social/Occupational Functioning
Shock	x				
Numbness		x			
Guilt		x			
Anger	x		x		
Anxiety			x		
Depression					
Self-Blame	x				
Derealisation	x			x	
Depersonalisation	x			x	
Isolation	x			x	
Physical Symptoms					
Empty feeling inside stomach	x				
Tightness in chest or throat	x				
Shortness of breath	x				
Weakness/fatigue	x				
Sweating	x		x		
Cognitive Effects					
Intrusive thoughts about foetus	x				
* Hallucinations	x				
Phantom foetal movement		x			
Difficulty with concentration and decision making			x		
Fantasies about foetus		x			
Dissociative amnesia		x		x	
Diminshed situational awareness		x			
Behaviours					
Difficulty sleeping (nightmares)	x		x		
Loss of appetite					
Social withdrawal				x	
Substance abuse/use				x	
** Avoidance	x			x	
Imapaired social and occupational functioning					x

* Hallucination of a baby's cry/visual images of baby
* *Avoidance of medical facilities/ personel, pregnant women, children etc. to prevent reliving the event.

Bowles (2000:5)

Figure 8

Four Domains of Miscarriage Symptoms	INTERVIEWEES - Self Identification						Total	%
Emotions/Feeling States	Anne	Bongiwe	Diane	Helen	Sheila	Carmen		
Shock		X	X		X	X	4	66.60%
Numbness		X	X		X	X	4	66.60%
Guilt	**X**	**X**	**X**	**X**	**X**	**X**	**6**	**100%**
Anger	X			X	X	X	4	66.60%
Anxiety	X		X	X	X	X	5	83.30%
Depression			X	X			2	33.30%
Self-Blame	**X**	**X**	**X**	**X**	**X**	**X**	**6**	**100%**
Derealisation							0	
Depersonalisation				X	X		2	33.30%
Isolation			X	X			2	33.30%
Physical Symptoms						X	1	16.00%
Empty feeling inside stomach							0	
Tightness in chest or throat							0	
Shortness of breath							0	
Weakness/fatigue							0	
Sweating							0	
Cognitive Effects								
Intrusive thoughts about foetus					X		1	16.00%
* Hallucinations							0	
Phantom foetal movement							0	
Difficulty with concentration and decision making					X		1	16.00%
Fantasies about foetus					X		1	16.00%
Dissociative amnesia							0	
Diminshed situational awareness							0	
Behaviours								
Difficulty sleeping (nightmares)					X		1	16.00%
Loss of appetite							0	
Social withdrawal			X	X	X		3	50%
Substance abuse/use							0	
** Avoidance			X	X	X	X	4	66.60%
Imapaired social and occupational functioning				X	X		2	33.30%

* Hallucination of a baby's cry/visual images of baby

* *Avoidance of medical facilities/ personel, pregnant women, children etc. to prevent reliving the event.

Figure 9

Miscarriage Domains Summary

The findings of the study correlated with reports by Paton and Wood in their study concerning grief in miscarriage patients and satisfaction with care in a London hospital (1999). As with the six women interviewed in this study, their findings indicating three significant areas of dissatisfaction with care:

1. Lack of medical information and lack of explanation for the cause.
2. Healthcare staff not addressing potential early symptoms of miscarriage with the same degree of gravity as that felt by patients.
3. A lack of compassion and sensitivity from healthcare staff.

The researchers refer to reports suggesting that the manner in which the miscarriage experience is managed is likely to have a significant effect on the woman's emotional adaptation.

The following chapter outlines some suggested implications for practice based on these findings.

CHAPTER 5
CONCLUSIONS AND RECOMMENDATIONS

1. CONCLUSIONS

The objective of this research was to gain an understanding of six women's experiences of miscarriage. The objective was threefold and sought to:

1. Understand and portray each individual's unique experience of miscarriage in respect of their own experience; and the impact of other's reactions on the individual.
2. Based on these findings to identify what women need in order to better cope with the experience.
3. Validate the findings, thereby increasing their representivity, by highlighting the similarities with findings of other researchers.

The experiences, reactions and emotions described by the six women proved to be remarkably similar to each other. The thematic analysis indicated that even in the face of differing cultural and social backgrounds similar themes and descriptions emerged. This was validated by the findings of other researchers, as explored in chapter two. Themes correlated with the reports of studies from other parts of the Western world. Guilt, self-blame and anger were aspects which all the women emphasised in varying degrees. These themes likewise proved to be significant findings in other research.

Five of the six women in this study had perceived their contact with the medical profession as negative; this was specifically related to the treatment received by the hospital staff, and or doctors. The intervention was experienced as either unsupportive and disrespectful or simply lacking and non-existent. Only one of the cohorts described her interaction and relationship with her gynecologist as positive and supportive. Her experience with another was negative. This shared experience is supported by similar findings reported by several researchers. (Moulder 1999:1; Klugman 1999:57; Hey et al 1989:60; Robinson 2001:13). It is of interest to note that this same finding is reported across a span of years and later studies do not necessarily report more positive medical-patient relationships and interactions.

Despite being close on seventy years ago, a 1934 publication of the Lancet resonates with an uneasy echo:

> *"...the expectant mother is not an ambulant pelvis, but a woman with human needs, whose soul and body are closely interlocked...let us not forget the mother"*
> (Lancet, 7 July 1934, p.1198 in Oakley – the Captured Womb)

The women interviewed all described difficulty in the ability to articulate their emotions and feelings at the time of the miscarriage. The experience of family member's reactions and their social environment was generally unsupportive with the perception that others did not know how to react, support or confront the loss and associated emotions. As a result a strong sense of isolation was conveyed by most of the women.
Key responses identified proved consistent with findings of research conducted by a range of researchers. Common themes included:

1. Negative impact on self-image and a deep sense of failure and inadequacy as a person.
2. Guilt; Self-blame and self-reproach pervading all areas of life.
3. Anger; Bitterness and frustration toward self, others and God. A sense of being punished; injustice and retribution.
4. Social withdrawal; Avoidance of pregnancy related subjects, people and situations. A sense of isolation and the feeling of being unsupported.
5. Anxiety and fear; Particularly during subsequent pregnancies.
6. Shock; A sense of physical and emotional numbness.
7. Depersonalisation
8. Denial
9. Depression
10. Repression of emotion and detail of events.
11. Loss; Feeling physically and emotionally empty and hopeless.

The shared experiences and emotions point to the universality of the experience of miscarriage and appear to transcend cultures, within the Western world. The study did not extend to include a wide range of socio-economic or cultural factors. Available research focuses predominantly on Western cultures and women conforming to allopathic medical treatment.

2. RECOMMENDATIONS

The recommendations offered by the respondents in the study were shared and all resounded with the same sense of conviction and passion: The importance of having another women to speak to who had also experienced a miscarriage; to have direct contact with someone who understood and could offer genuine empathy and acknowledgement.

2.1 Summary of respondent's recommendations

Anne suggested a support structure where women can talk to other women who have experienced miscarriages. She envisaged this in either the form of a support-group or a one-on-one intervention.

Bongiwe stressed the importance of talking to others who have shared experiences, since there is an empathy and understanding that can only come from actual experience. She identified group or one-on-one situations.

On being questioned about her thoughts on how a hospital could respond, Bongiwe answered with the following:

> *The first thing is to treat a person like they are going through pain – they are in pain – to acknowledge that they are in pain and not just brush it off. While we are being trained we are always being told don't get involved and I think that's the wrong advice. Don't get emotionally involved. Medical staff are told not to get involved. And I think that while they are doing that they are negating the person's experience, they are negating their own pain as well – it's not just a one-way thing. So once they acknowledge that the person is in pain and try to find out. Because people are different they want to be treated differently. But the first thing is to acknowledge that the person is in pain and talk about it in that way. So that from then on you can get cues from the person and just talk about – honestly – what the person - don't feel that you are making the person feel pain, they are in pain already.*

Bongiwe made reference to dealing with all forms of unresolved emotional pain, in order to come to terms with new experiences:

> *I would like to say to someone who has had a miscarriage, you need to work toward accepting it, accepting that painful as it is it is something that happened and it*

cannot be changed. Not to run away from any emotions that they feel, whatever they are but to examine them and try and see where they come from in their lives. Because a lot of emotion comes from previous pain. When you have a pain your sub-conscious dredges up previous pain, so any previous pain, even if it doesn't seem remotely connected with your experience at this time, deal with it, because when it dredges up there it means that it is there and needs being seen to. When you put a damper on some feelings it puts a damper on other feelings as well.

She suggested that women be granted the same respect that is given to those who have just experienced a death. That the mother be given the time and space to mourn, and then be helped to move on with their lives.
Bongiwe agreed that knowledge and education play a role in acceptance. She referred to the overemphasis of guilt and punishment in religion, in relation to the love of God, and suggested that spiritual leaders could play a role in correcting this perception.

Diane believed that general education of society regarding miscarriage would facilitate more understanding. There appeared to be a need for knowledge about the process of a miscarriage and the reasons behind it.

Helen repeatedly stressed the need to have someone to talk to, someone who had experienced a miscarriage, or who understood. She drew attention to the importance of having someone to validate emotions and feeling states.
She did not view advice as needed but simply to be able to talk to a woman who "really understands". Helen suggested that it would be helpful to have someone to talk to about the child specifically. To share the mother's expectations, hopes and plans for the child; to talk about whether it was a boy or a girl. An acknowledgement of the child as a real member of the family.

Sheila immediately identified the importance and value of speaking to another woman who had shared the same experience. This was viewed as a significant lack in her own experience and it was thought that had someone been available to her she would have able to cope better. Sheila's view was that the experience of miscarriage is 'so devastating, no matter when it happens', that support is essential. She continued to suggest that nursing staff are either too busy, or too disinterested to speak to women in hospital. Sheila's

experience was that hospital staff are 'totally uninterested'. Education of male doctors was suggested to facilitate a greater understanding and empathy.

It was suggested that women did not allow themselves enough time to deal with the loss. Acknowledgement from others and having the opportunity of speaking to another woman, or women, who had experienced miscarriage was identified as essential for any women to be able to begin to confront her emotions and come to terms with the experience.

Carmen likewise emphasised the need for women experiencing miscarriages to have contact with someone who had shared the experience. In this way the enormity of the experience could be acknowledged and understood. She recommended counselling; being able to speak to someone who understood and who could offer empathy and sympathy. The importance of being given the opportunity of articulating feelings was stressed. It was suggested that the medical profession offer counselling or a support group.

3. IMPLICATIONS FOR IMPROVING PRACTICE

The recommendations provided by the women themselves are self explanatory and simple. Based on these contributions my recommendation is that counseling and follow-up be viewed as part and parcel of any miscarriage intervention. Whether is it offered by a medical practice or treated as a referral to an appropriate counselor or therapist. It is my opinion that counseling should not be viewed as an 'additional step' in the face of apparent coping and adjustment difficulties; rather, that it be accorded the same importance as the necessary physical intervention.

In an effort to improve satisfaction with care, health carers may need to pay more attention to the psychological needs of women who have experienced miscarriage.

To this end, the following recommendations are suggested:

1. the provision of patient follow-up. This may take the form of individual counselling sessions and/or a support group. Additional time spent with patients to answer questions which may arise following the event.

2. the provision of written material to patients with the inclusion of details on common and possible emotional effects of miscarriage;

3. the provision of specialist training for those working in the area of pregnancy loss. Specifically related to communication skills, bereavement, a deeper understanding of the implications for the patient.

It is likewise recommended that future research include the study of these areas.

The issues referred to above are already identified in the SANDS Guidelines, 'Pregnancy loss and the death of a baby: guidelines for professionals' (SANDS, 1995) (Paton et al 1999:15). This study revealed little evidence of implementation and real attention to follow-up, communication, the provision of information and counselling and support.

Attention to these issues appears to significantly affect emotional adaptation to miscarriage and necessitates further research.

4. CLOSING COMMENTS

I am grateful for the generosity of the six women who so readily gave of their time and shared a profound part of their biographies with me. The depth and rawness of the pain shared during the interviews was sobering and does not pass by lightly. It is my sense that these women spoke for many others. I base this judgement not simply on a 'sense', but as validated by several other studies reviewed during the scope of this study. The issue at hand is not that miscarriage is a biologically common fact, the concern rather lies with the social taboo; the deeply ingrained sense of guilt and inadequacy resulting from failing to realise internalised social norms; communication patterns within families; mother-daughter relationships; the apparent failure of the medical profession to afford the time needed to address the loss, or simply to make a referral to someone who could.

The notion that much of the pain experienced was seemingly unnecessary is alarming. Interaction with the medical profession was conveyed as concerning and stands in stark contrast to the goal of healing and restoration.

The experience of this study has served to fuel the conviction that bridging the void between ideal care and actual practice is both possible and realistic. A clinical method that is sensitive to the full complexity of the person can be scientific as well as centered on the individual. An acknowledgement of the full range of the human condition. I conclude with a quote from one of the women interviewed,

...don't feel that you are making the person feel pain, they are in pain already.

It is the interconnectedness of the various specialised fields which embodies the essence of true health care.

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APPENDIX

Appendix 1: Interview with Sheila

INTERVIEW WITH SHEILA

Appendix 1

J Thank you for making the time for this interview. The purpose of the study is to explore women's experiences of miscarriage; to look at the impact of other's reactions; and to try to identify what women need in order to cope with the experience. I'd like to mention a few details before we begin.
The interview is strictly confidential, I will be using this tape recorder to make a recording purely for the purposes of transcribing the interview at a later stage. The tape will remain with me only, it's for no other purpose. No one else will hear these tapes.
I will also change your name and any other names you may mention.
Please feel free to stop the interview at any stage, it is your interview. It's up to you as to how much or how little information and detail you would like to give. Are you comfortable with this?

S Yes

J I have some guiding questions but essentially I really want you to tell me about your experience of your miscarriage.
Start wherever you would like to…

S I don't actually know what you're wanting – basically - -

J When did you have your first miscarriage?

S Well, they were all quite late. The first one was at 20 weeks, on New Year's Day. I started miscarrying on New Year's Eve.

J First child?

S Ya – um – I was admitted. I was under a very sweet gynae at that stage, but he was very old – and he was *catholic*, so, (laugh) he was very sweet. And obviously they gave me Valium and pethadyne to try and stop the - - . I went through full labour and had the baby. Ok, I found it was a bit difficult because obviously they were very busy with it being New Year's Eve and morning, the early hours of the morning. But I was basically left on my own going though labour – um – and, obviously – I had nursed so I knew – so I wasn't scared or anything. I knew what was going on. Um – and then of course I asked for a bedpan and baby came away – um – in those days – um – the nursing staff wouldn't let you see the baby and they didn't want to tell you what sex it was so I actually fought with her and I said, "I have to know" and she said, " but it'll upset you" and I said, "no, it'll upset me more if I don't know".
I'm just one of those people who – I have to know. So eventually she reluctantly to me it was a girl and then I was quite happy. So that was actually very difficult – being on my own.

J When you say you needed to know if it was a boy or a girl – what in you needed to know?

S I don't know. I just felt it was important that I knew what the baby was – a boy or a girl. And I actually even gave the baby a name.

J What was her name?

S Sonja – No –Melanie. Melanie was the first one. (laugh)
I don't know, it was important for me – and – she, as I say – maybe because it was so far on in the pregnancy as well, that also –

J Did you see her?

S No. No she wouldn't let me.

J Did you ask to see her?

S I didn't. At that stage I was still very shy and very - - very worried about doing anything not – not considered normal. When I look back now it was really silly, but the one thing I did insist on knowing the sex.

J And once they told you, you had a little girl – how did you feel then?

S Um – well, I suppose in a way it was a bit of a comfort knowing what the baby was.

J Yes.

S Of course, then a little bit later all the emotions came. Um – my husband came. I had the baby at about 5 o'clock, there about, in the morning. He came early, in a bit later, earlyish – as soon as he got up he came in. And they didn't tell him. He came to visit me thinking it was still ok. And of course I *burst* into tears and said " Did they tell you?" and he said, "No". and I said, "I had a baby and it was a girl, and everything you know."

J Was she stillborn?

S Um – I presume so – ya – I presume she was.

J Can I stop you and go back a little? Was it a planned pregnancy? What was the build –up to the miscarriage?

S (laugh)

J Let me put it this way. How did you - how did you and your husband feel about the pregnancy?

S Oh – we wanted the baby. But it was a bit early. We hadn't been married very long. But I was having problems taking the pill. I was getting migraines and stuff so I went off, and that was it. I didn't realise how fertile I was (laugh).

J Yes.

S One advantage I had over other women is I didn't have problems falling pregnant. It was just hanging on to them. So ya – we wanted the baby. We both loved children – which I think made it harder in a way. We actually had planned to have 4 – so – I suppose financially, I suppose it was a bit of a relief. It was so soon after we'd got married, but um – we wanted the baby, so – um – ya.

J How did you know you were miscarrying? What happened?

S I started having cramps and I knew to go – or I phoned – Actually – Can't remember – can't remember if I phoned – I think my husband phoned the doctor, my old GP. And he said, no, just bed rest, which I already knew. And the cramps sort of eased and them came back again and just didn't abate. So –

J Did you have bleeding or did you just go into labour?

S No, I went straight into labour with the first one. Ya.

J When was this?

S It was in '76. Ya, December, January and I had 5 hours labour – So you know –

J It must have been very traumatic?

S Ya – it wasn't easy but as I say, I was very shy and very worried about worrying anybody. What I should've done – is I should've said to them, "*Please phone my husband and ask him to come and sit with me.*" That's what I *should've* done. But I didn't.

J So, did he not know?

S He didn't know.

J Did he take you to the hospital?

S He took me to the hospital and they admitted me and hoped that maybe the contractions would go away or maybe not. And they were *so busy* – um – he went home and I sort of didn't – I didn't –

J At that stage one is hardly thinking clearly –

S Ya, I also – ya – you know – I was fairly independent –

J Did they not contact him?

S No – No. They basically left me – um - -

J Did they know you were in labour?

S Ya – Ya – sort of, they kept coming in – "Are you ok?" and I would say "ya, ok." (laugh)

J Where was this?

S In Zimbabwe.
So they were just so busy that I didn't want to hassle anybody and I just quietly did my own thing (laugh) - - which was silly, in retrospect.

J But at the time you do what you know best, you can't be too hard on yourself. Don't you think that it was the nurse's job?

S Ya – I was very shy.

J How did you feel then you were on your own there? What went through your mind?

S Um - - I don't really remember. I think I just kept wishing it, it wouldn't happen, but at that stage I knew it was inevitable. And um – I kept crying on and off – ag, you know – just the emotional side - -

J What emotions did you have?

S I think mainly the sadness of, you know, the thought of now I'm losing the baby that we wanted – but I suppose in other ways – it was a long time ago - - but - - I think – in a way – I kept saying to myself – obviously there's a reason – and - maybe it's just as well – sort of thing – because we hadn't been married very long and finances and everything, you know. – So initially I think those were mainly – tried to – I suppose – tried to find an explanation for why me? Why? - - Because, like my brother's wives – you know, they weren't particularly – they liked children – but I mean they didn't love children as much as I did and they didn't have any hassles and friends of mine who'd had to get married and have babies. And I thought – well – it's not fair – why me? You know. What have - what have I done, possibly, you know, to have - -

J Who were you angry with?
People, God, yourself?

S I think just generally angry and then towards God – I think I just – I wasn't religious but I knew He was there, and everything – I sort of asked – why are you doing this to me? You know. So ya – but I think that came a bit later with the emotions then - -

J You said that you went through this birth process and then your husband arrived and you burst into tears. Tell me what happened then?

S Ya – he came then – I said – and he sort of - - he came in and looked - like there was nothing wrong. And I said, "Didn't they tell you?" and he said "No". And of course I burst into tears and said I had baby at, whatever time this morning, and of course he was very upset as well. And of course, all the emotions came out and - -

J When you say 'all the emotions'?

S Well, you know the – I think the stress and everything just broke. I really cried then – um – and said – "I'm sorry" – you know because - -

J You're sorry about what?

S That I haven't managed to carry the baby (laugh).

J So, did you feel it was your fault?

S Um – not exactly – but I sort of – I felt like I'd failed. I hadn't managed to do –
There again – at the time I think I didn't really understand too much about the emotions I was having. Only later on when I sort of analysed them – and then – of course – I had another miscarriage so –

J When you say later on, was that with the next miscarriage?

S Ya – I think, as I went along – I felt like a failure because here was the most natural thing in the world for a woman to have a baby – and I couldn't do it. You know. I did it so far – and I couldn't manage the whole lot. And I think most women go through that and I think people don't understand that and I think that's –
I don't know if it's worse if you can't fall pregnant or if you fall pregnant and don't manager to carry for one reason or another. I don't know but – um – ya – but, at the time you're not really aware of it – but –

J Why do you think you weren't really aware?

S I think the whole emotional - you know obviously the hormones. I cried and cried, you know. People just had to look at me and I cried. Then they moved me to the ward because they'd left me in the casualty unit for the night because obviously I'd gone in late, you know. They obviously were sure I would miscarry during the night, or early hours of the morning so they left me. And they moved me to the ward and - um – then – I had to go in for a D & C, because I passed a clot the following day. And – um – and anesthetics generally make me tearful, so that didn't help.
Came out from anesthetic and I just cried and cried and cried. And – um –

J Can you recall what you thought when you came out of the anesthetic?

S No - um – no. The only thing I remember – it seem *so silly* , but I woke up and there was a beautiful bunch of flowers and it wasn't from my husband, it was from very good friends of ours – which was so silly. (laugh)

J But there was clearly a need for him?

S Ya – you know, they weren't from him and that upset me. Then I wanted to see him and they were actually very good in the ward. They actually phoned him and asked him to come and see me. So he came. It wasn't during visiting hours – so he came and sat with me and that was helpful. Ya – so - -
They kept me in for a few days just to make sure everything was ok.

J Tell me a little more about his reaction.

S He's actually – not like other men, he doesn't have a problem showing his emotions – he'll cry. He was very upset but very supportive.

J In what way? How did you know that he was supportive?

S Ag – it was just his – you know – he's just like that – he would sit and hold my hand and reassure me – "Don't worry it's alright, everything is going to be alright. Don't worry about it." You know. Sort of – "Forget about it and we'll just carry on." (laugh)
Um – ya – in that way he reassured me. He wasn't angry or anything – it's just one of those things – mustn't worry about it and let's just carry on.

J Did you find that helpful?

S Yes, ya.

J He was very supportive like that you know. I was very lucky because he's not one of those men who would tell me I'm useless. He did the opposite. You get these men who insist on a son or a daughter and you'd better make sure I get one.
There was a woman in out town whose husband wanted a son. She had five children and only the fifth one was a son. And she said, thank goodness she can stop. (laugh) She had four, one after the next, and they had no transport, nothing. They would walk – one here and one in the pram; one walking.
So ya, he was very - he didn't – obviously emotionally he was sad, you know. Apart from that he accepted it and I think in a way, because of the finances and everything, it was probably a relief.
That was basically it. When I went to the gynae – well, I'd been under my GP but when I'd phoned him that night he had called the gynae and then , of course, I had to go back for the six-week check-up. I got milk – which just added insult to injury.

J How did that feel?

S It was terrible. I was the same as with a normal – and that upset me. Because now I had milk and no baby to feed. Um – the other difficult thing at that stage was the guy who was bestman at our wedding. Him and his wife – we were very close to them – they were expecting their first child in March. My baby was due in May and, of course, she carried with no hassles. They were very sweet but I couldn't handle seeing her after that. I found it very difficult.

J In what respect?

S We went to visit just after I'd had the miscarriage and Her still being pregnant was hard enough. And then, shame, they stayed on a plot with a Polish couple, very sweet couple. But the lady came and said she was sorry, she made some comment like "Ag, don't worry – there'll always be another one", or something like that. And the comment upset me terribly.

J How did it make you feel?

S Wee, you know, there again – you sort of felt, "I'm useless", you know. And people don't understand. Why does she have to hurt me *now* ? I was very sensitive. Generally I'm more sensitive to people anyway and that just made it worse and after that I actually couldn't visit.

J Did the Polish woman make the comment?

S Yes.

J How did it make you feel to see your friend pregnant?

S It was very difficult, as I said, afterwards I couldn't see her again. I couldn't - -
J how did it make you feel? Did you feel angry, or bitter - ?

S I think all those issues, you know, well, you know – "She's managing and I'm not" The thought of seeing her pregnant. I think because we'd gone on together and we, you know – her husband – he was so thrilled about the pregnancy and kept chatting about it. They were very good, initially, with me. But I knew how he felt and I felt – sort of – I'd let me husband down. And then she had the baby and I actually couldn't face anyone who was pregnant or had little babies. I went to the shops and if I saw someone pregnant I would into tears, well – I would just walk out the shop and burst into tears.
So I actually – it was – horrible in a way, because I couldn't, at that stage, - I couldn't explain to them. My husband used to go and visit them. My husband sort of explained to them and they were very good. I didn't see them again until I had my son. It was just too painful – you know – I just associated it all the time.

J How long did that go on? The feelings when you saw pregnant women?

S It never really went away because of my history. Um –

J How long before you fell pregnant again?

S Chop, chop. Um – my gynae said to me – shame – he was *so sweet.* Took me by the hand and tapped me like this and then when I went for my check up he said everything should be find. He said "you go home and just fall pregnant again."

J How did that make you feel?

S It didn't upset me at all. He had such a gently manner. Such a fantastic bedside manner. Just his whole spirit was so gently and so sweet, you know.

J Did he follow up with you after the birth and the D & C?

S Ya – he took over as soon as I got to the hospital and my GP said I should see the gynae.

J And after the D & C? Did anyone see you?

S My husband sat with me.

J And of the medical staff?

S The gynae came because he had to discharge me and then of course I had to see him for the six-week check up.

J Was there any form of counseling or any literature offered?

S No – nothing.

J No explanations?

S He just said to me, you know, it's one of those things. So many women lose their first child and blah-di-blah. He said he could see there was nothing. For some reason it was just one of those things and um – not to worry. *"Lightening doesn't strike twice in the*

same place," he said. Well – that was my GP. He said the chances of lightening striking in the same place is fairly slim. So guess who had lightening? (laugh)

You know I had a wonderful GP and he delivered me. He was like part of the family. He said, "I know you like the back of my own hand" – he was very sweet.
So, as far as the doctors and the gynae I couldn't have had better. And look, the nursing staff were sweet. A lot of them were training, it was a training hospital – a lot of them were student nurses but basically they didn't really know what was going on.
I mean, I didn't really understand half the emotions that I was going through.

J You're not expected to. One doesn't always understand emotions, they just happen.

S I was a very emotional person anyway (laugh) so that just made it worse. So that was, ya – the experience I had with the first one. Then I fell pregnant with the second one quite soon after that.

J When was that?

S I lost the second baby just over a year after that. It was on the 3rd of March.

J At what stage?

S 25 weeks

J How did you feel when you were pregnant again?

S Scared. (laugh) Scared - - You know everyone was very supportive. My mom had had miscarriages. So she was – she was – quite – well she was – very sympathetic and that but she never really talked to me about it.

J Tell me about that – when you say she was sympathetic, how did you she show it ?

S Just showing of affection – "never mid my girl, it'll be alright' and she would hug me and that kind of thing.

J But never directly saying "How are you? What is happening?

S No – No. Just, "everything is going to be fine.

J What did you what from her?

S I don't know. My mom and I were never really very close. We never really sort of talked like that ever. She came from a very English background so you didn't discuss things like that. "You're gonna be alright so don't cry," stiff upper lip and you'll be fine. So that was difficult.

J So, you did find that difficult?

S Ya – I think – well it was just her – so I suppose I didn't really expect anything else.

J Would you have found it helpful if there had been direct talking?

S I think I probably would have, if she'd maybe shared with me, maybe what she had gone through. But I don't think – she probably wouldn't have been able to tell me because she'd tried to push them down and cover them up so she probably wouldn't have been able to tell me. That should be an interesting thing to explore.

J Is your mother still alive?

S Yes, she is but still lives in Zim. So I think that was probably, I was never encouraged to talk about things like that, anyway – it was sort of – everyone said they were sorry and you know and showed you concern – all the sisters, aunties and uncles and everybody.

J What did they say?

S Just, you know, we're really sorry. But the same old thing. Don't worry, everything is going to be fine. 'Don't worry', and 'it was a bit soon – ' (laugh)

J How did that make you feel? When they said this?

S Half of me agreed because we hadn't planned to have a family. But with my heart I thought – well, what do you know about it. You know (laugh) – *so do you think you are*, telling *me* such a thing. But I couldn't voice anything then. I was that – My husband actually had to drag things out of me. I never spoke.

J How did he do this?

S Just encouraging me to talk, you know, just kept asking me questions, encouraging me to talk. Just generally, I mean I never used to talk about anything. I was very much like my mother because. So – that – so he had to do a lot of coaxing. And then I learnt to assert myself too – sort of – hey you know, this – you know I wouldn't go into a shop and take anything back. I was like a little mouse, and he sort of forced me to do these things and now I can stand up for myself. I had to learn to stand up for my children. I think that was later on with awkward teachers and their learning problems and that, because that was close to my heart. So that spurred me on - - - So that's basically the first one.

J And then you lost the second one in march '77?

S Ya.

J Tell me about that.

S Oh – 25 weeks.

J You must have been showing at that stage?

S Ya – I was actually working at a dentist and I went - - No – no, I'd left the dentist because we wondered if the first miscarriage hadn't something to do with the x-rays. Ya – doctor said he didn't think it was but we didn't want to take a chance. So I'd left and I was helping my dad – he had his own business, I was working in the office.

J And you say you were frightened?

S Yes, I was. Ya. I was fearful that something was going to happen.

J Tell me a little more about how you felt about the pregnancy.

S Um – weary. Excited but very weary and um – very fearful.

J It is said that after a miscarriage the innocence of pregnancy is lost and can never be regained. Was this your experience ?

S Ya – I think what also made it worse for me was my cousin. We were fairly close, she also had – was pregnant when I was pregnant the first time; the second time and there were no problems. She just *carried* and there were *no hassles, no miscarriages*, no nothing. I was the only one who had miscarriages. I didn't know anyone else in the family who had miscarriages.

J Did your mother never talk about her miscarriage?

S No. She just mentioned she had had.

J Was it just a mention?

S No – she lost her first baby, around about the same - but they were twins. Um, and she spoke about that a bit, over the years – How hard it was and that she'd lost the twins but then, then she had my two brothers and then between them and me she had some early miscarriages – But - - nothing that seemed to disturb her too much - - it was very early – and you know – (laugh) – not to much of a big deal (laugh).

J Tell me about you second child.

S I was at work and everything was going fine, um – because I was very nervous and everything my GP sent me for a check-up to a gynae 'round about 20 weeks. Because he knew I was anxious. You know, just to give you peace of mind. So off I went and he checked me and said, 'no, everything should be fine and – *no problems.*

J How did you feel once you'd passed that 20-week mark?

S A little bit more confidant. Um – them I had a shoe. I went to the toilet, and 'oh, dear' a little bit of blood. So I phoned doctor and he said go straight home and go to bed – *which I did.*

J How did you feel them?

S Then I was – oh – upset – and then I was really scared – you know – here I go *again*. I wasn't very positive at all. Mainly scared and – he said no, no, no it'll be alright. Go to bed and you should be fine. But all the time I was sort of, you know – *Is it really going to be fine?* Sort of, I don't know.

J What I hear you saying over and over again is that everyone seemed to say ,"It'll be fine, don't worry.'

S Ya, Ya. They just brushed over it – 'I'm sure you'll be *fine.*'

J Did anyone ever address how you felt?

S No – never, never. Just my husband used to. I would say to him, "I'm just so scared" and he would – also – say "Look, I', sure it's going to be fine – don't worry about it, just relax. Don't be frightened. He used to say.

J It doesn't change that you *are* frightened though.

S Ya. But he used to say, "Try not to be frightened", because you know fear itself can cause problems. So, I went to bed and I was fine. And he wanted me to go and look at this house and I got up. We went to look at the house and got home and I was fine and them he went off somewhere and I got up and went to the toilet – at all of a sudden the gates just – I just *bled* . I mean I just – like a heavy period. And he'd just come home – and I was supposed to be letting him in – you know, opening the door. And I just *burst* into tears and he said, 'What's the matter, what's the matter?' And I could hardly talk and I said "I'm bleeding" and he said 'well, quickly let me in , let me in. And he phoned the doctor and the doctor said take her straight to casualty. So off I went again. And - but used – but – I was shaking too. I was shaking so much I could hardly talk, you know, the shock – the combination. I would just start shaking like a leaf and could hardly talk and I was bleeding quite heavily. So he took me through. And one of the girls ' worked with at the Dentist was now working as a receptionist at the hospital and she said, "Now Sheila, what have you been up to *now*?" You know- So I said, " No I'm bleeding again" and she

said " – Oh, no!" She said – Oh – I'm sorry, you know. But still you sort of – everybody – you think – what are they going to say, you know, you sort of almost don't want to talk to anybody because of their reactions, you know. They took me through.

J What did you feel when you say, you didn't want to talk to anybody?

S You sort of want to hide away, you know. I didn't expect to see anyone there that I knew.

J What were you afraid that they'd think?

S I suppose, there again, this feeling of inadequacy. Sort of – here she goes again, sort of thing. Ya – I suppose that –

J Can I go back to the comment, when the receptionist said "What have you been up to *now*?"

S "What are you doing *now*?" Well, I think she was saying the same sort of thing, *well*, what is happening *now* ? You know. We're going through it *again*, sort of thing. Which I suppose just reinforces your feeling of "oh, no" But at 25 weeks pregnant and the last one was 20 weeks and you sort of begin to think, well maybe I'm never going to have. My first 3 months I used to do everything I wasn't supposed to do. Because I was *determined* that if I was going to lose the baby it was going to be *early*, rather than late. I *wasn't going* to go through *that* you see, but of course it didn't happen like that (laugh).

J So did you almost want to test the pregnancy?

S Ya, just to make sure that this baby was going to hang on . Ya.

J And after those 3 months were over?

S A bit of relief. But still, obviously, the first pregnancy was fine but then the second you – I know was, from – after 3 months I was first weary and of course I got to 20 weeks and I thought "great". And then *25* – I thought - I'm getting there, sort of thing. But all the time there was this sort of fear. And I suppose people would sort of, you know, I can't remember exactly, but people would way – well, how are you keeping? Are you keeping well *this time* ? Sort of thing, you know. And you sort of .. Half of you know that they mean well but the other half of you thinks well, everybody is feeling negative, how on earth and I supposed to feel anything different? You know, their comments. My mom's sister, actually two of her sisters, shame, would say – they – they weren't very tactful (laugh) they would say, "\well, you know Sheila, it is very early after the first one", you know. Those sort of very olde English type comments. And I would sort of think, 'well you know it's really got nothing to do with you (laugh) - . Well, the doctor told me - - (laugh). Emotionally, he probably thought it was the best thing. And it – And when I look back on it if we'd decided to start a family much later and had to go through all his I would have been that bit older (laugh) when I eventually had (laugh).

J With your first pregnancy did it enter your mind at any stage that you could have a miscarriage?

S Um – Not – not really consciously - - I think I was always - -a bit weary – I suppose - -I can't explain it – I always felt that maybe – because I really loved children and um – that maybe I wouldn't have such an easy time. Because I nursed as well and it was kind of like nursing staff seemed to *always* have problems.

J Tell me a little more – "Because you loved children; you did nursing - ?"

S I suppose I knew a bit too much of what could go wrong.

J Because of the nursing?

S Ya, you know a lot more.

J Your comment, "Because you loved children... " Did you feel in some way you were being punished?

S I suppose – I never really felt – I never really – I never had a good self-esteem. I never - - - It probably goes back to my mom again - - I – always was a little bit plump. Ok. Her mother was a dancer and she had a thing about weight. And I suppose I felt that I had always felt I'd let her down. I was never good enough so that obviously carried through. My brothers were successful and she would pick on me. Um – you know – I know she didn't mean it, but it had an effect on me –

J But it was your reality.

S Ya – they had excelled at sport. Our dining room was filled with all of their rugby photos. And when I got a – I was always in a swimming team but we never had a first team as such and the first year they decided to have a team photograph – it was never put up. – So that – I suppose – in the back of my mind – I thought – well, I'd always failed, now I'm probably going to fail again. So that was probably the sort of undercurrent all the time. Am I really going to succeed? Because I'd battled at school you see, I battled with everything. I'd done fairly well at my nursing. But, um – as I say my mom had this – she does unfortunately – I somehow I don't manage to do anything right. (laugh)

J Going back to your comment – "Maybe it was because I loved children..."

S Ya, because I'd loved children so much it's sort of kind of like Murphy's Law. You get people who don't really want children but have them and people who really love children who can't. That sort of scenario. Because there were other people. I mean one of our distant relatives who *really* loved children and she couldn't have and friends of my mom who ended up adopting. It didn't worry me too much because we had decided that even before we got married that if there were any problems we both agreed to adopt. We were both keen. I think in the back of my mind – I think it's all connected with my mom's – sort of – way toward me – and that kind of thing. You know I never quite managed anything (laugh). I never quite got there (laugh).

J It's such an important relationship.

S It is. It is. And I think it's because of her background it was made ten times worse. Because still now, to get to talk to her – When we used to go home and see her we used to leave and I'd be tearful , "Now don't cry", she would say. You know. Because everything was stiff upper lip.

J No acknowledgement of feelings?

S No. No. No.

J You mentioned that during the first miscarriage you didn't feel able to understand your emotions but you went on to. You mentioned your husband maybe assisted you in this.

S As you go along the road, I think you – you learn to try and analyse myself – Why? Why have I felt like that? Why have I reacted like that? Because I was very, very sensitive and he used to try and help me to be sensitised I think, because I was so sensitive. I mean the slightest little thing that people said upset me terribly and again, I think it all goes back to the relationship with my mom. My dad and I got on much better but – I *never, ever* told, actually, I told my dad very much later, before he passed away – um – some of the things I felt.

J Did he ever ask you?

S No. No. He used to chat to me. But that kind of talk just didn't exist. I mean, you just didn't talk about anything like that, that was it, you know. Whereas my husband, on the other hand, their family talked about anything and everything. So, he would, I think –start to chat about things and slowly draw me out you know. So ya, - - So I think that was the main, sort of, stumbling block (laugh).

J The second miscarriage – you bled heavily; you were taken to hospital; you were shaking…

S Ya, then um – the gynae looked at me and asked what time I'd last felt baby move and he thought there might be a chance of saving the baby. And they then moved me across to the maternity ward where I went straight into the delivery room and it wasn't long after that, when I basically delivered - that baby was dead.

J Did you see the baby?

S So – um – but he was very sweet. He told me straight away that it was another girl –

J Did you give her a name?

S Yes, she was Sonja. Ya, and um - he came and explained to me that she was very small for her age. What had happened was that I'd had a placenta previa. You know what that is?

J Yes

S So, that was the bleeding – and that's why – obviously – everything had to come away – um – I was bleeding very heavily so they actually sent off for blood. I remember that. I have a thing about having someone else's blood. Don't like the thought of it. And I *don't* particularly like the thought of my blood in someone else's veins. It is *really* stupid. (laugh).
I hated giving blood to patients in hospital even. You know they have to have it but - and I remember thinking – Oh, Lord, please, I don't want blood. But at that stage I think my blood pressure and everything was very low and I'd actually calmed right down and I actually felt as though I was going to die and it actually didn't worry me. I was actually quite pleased at the thought that maybe I was going to. I sort of looked at the crib there that was empty and it sort of tore at my heart a bit and I thought – Oh well, maybe I'm going off too. You know. I don't know if he'd maybe given me something in my – because obviously they'd put up a drip at that stage. But I sort of felt floaty, you know, maybe I was going to go too (laugh) and it didn't worry me (laugh).

J Did you want to die?

S I suppose in a way – ya – the thought of going and getting out of all this hassle. Because at that time in Zim we had the terrorist war going on and all that so – there were a lot of – I suppose you could actually say it was similar to what we're going through here, you know. So – you know. The thought of going didn't – didn't phase me at all. I was *quite* happy at the thought I might go –(laugh) – you know.

J How old were then?

S Um – How old was? Um – must've been – um – 23. So ya, I had to stay in a couple of days because of the bleeding. The placenta had come away, obviously, without any problems.

J Did they do a D&C?

S No – I didn't have to have a D&C or anything, but it was very difficult because I was in the maternity hospital. I was in a private ward but the babies came backwards and forwards. So that was very difficult.

J Tell me about that.

S Yes, that was *really* adding insult to injury because I – that was very, very hard, I just wanted to get out of there. I just wanted to go home and – I cried a lot. But there again – the old home upbringing – I tended to cry when nobody was around, except when my husband came.

J How did the staff handle you?

S Um, they were- sweet – but there again – it was sort of – they were very busy and you know – you'll be ok. You know, you'll - (slight laugh) ...Then I became very, very angry with God. Because – Afterwards – the second miscarriage – when I was in hospital

J How long were you in hospital?

S I must've been in a couple of days because the first – there again I had baby – sort of – eveningish – um – it was just after my husband came home – well – he was home for the day, but it was when he would've come home from work – um –so – it was probably about six or seven in the evening and - I'd spent the night – I think they'd probably given me something to help me sleep. I'm not sure. They probably gave it to me in the drip. I wasn't really aware of it but I – I remember sleeping really well that night and I just remember the sister coming in and checking the drip and everything. And I didn't get blood, by the way. They made a botch up of the group and cross-match so I was very relieved and I responded well to the drip. So that was quite a relief. I was quite chuffed about that. Then the matron came in the morning and sort of – "how are you?", "I'm fine, thank you." – all very superficial. And then I had a visit. My husband was brought up in the Catholic church but he wasn't - sort of a practicing Catholic. We had decided we weren't going to bring up the children in a particular church. *Specially* not the Catholic. And in those days in Zimbabwe all the – the Catholics and the Anglicans and the priests and that used to come and visit the hospital everyday. And this very sweet, but very horrible (laugh) catholic priest came to visit. He actually recognised the name on the board and he knew that the family was catholic so he came to visit me – to sort you out. And his words to me, were basically, it you'd carried on – been brought up in the catholic church this wouldn't have happened; if you'd come to me the next time after all this – if you'd have come – so then – I was sure now – that I was being punished.

J Did you take his words to heart?

S Oh ya. My husband came in and – I was actually so angry with this man, I wanted to go and donder the whole lot (laugh) I wanted to kill the whole catholic church (laugh) Half of me was so angry. Who does he think he is? Who does he think he is? But the other half was then that doubt that came in. Maybe God *is* punishing me. Maybe, maybe I am a bad person, you know. Because I hadn't gone to church and all these things. So – it had a devastating effect on me. Because I really thought – in fact – still *today* I wrestle with that every now and then. That I'm not good enough, you know. Things happen and that's because I'm bad.

J From God's perspective?

S Yes. Intellectually I know that it's not, but the emotions – keep coming and telling it's different. It's hard – and then there was the next pregnancy and I actually changed gynaes. My GP referred me to a much younger one because he said he would be more up-to-date with all the latest techniques, you know. So I was back and forth and he said you're going straight into hospital until this baby arrives. *Eleven weeks.* But I went into early

labour – but I think there again, they weren't taking any chances. If there was the slightest chance that I was in labour they would send me to the labour ward and inject me and watch me for 12 or 24 hours and then go back down to the ward. It was difficult but at least I had – um – company. But in the mean time I had – my um – well, the same best friends of ours – she came to have her second baby and another friend of mine had come to have her baby and gone home. But the friend of ours, shame, her second baby was born with a cleft palate and harelip. So she had a really hard time. But we were in the same ward and - just across from each other.

J How did it make you feel when you saw that her baby wasn't perfect?

S - I was very sad for her. I thought, shame, you know, that is really awful, you know. But – there again, - it wasn't talked about, you know. Sort of – I didn't really know what was going on. She came down from the delivery room – I mean I didn't know she'd had her baby and they wheeled her in and I said, "Oh, Barbara, what did you have?" and she said, "a little boy", another boy and she was crying and I thought what was happening? And the doctor came in and I heard him talking and then later, you know, I said, what's the matter, and that's when she told me. And I thought shame, but at least they've got *one* that's ok. And I suppose, in a way, I thought at least she didn't have any miscarriages (laugh) sort of thing.. But no – I felt for her, you know. Shame, you know. Because they look so horrible. It must be an *incredible* shock and in a way I thought, well, I'm glad that never happened to me. There was something wrong – well, I always thought maybe there was something wrong with the babies and that's why I lost them. So that was some kind of comfort. So – you know – ya, I felt for her you know. Well, I thought – I'm glad I'm not in her shoes. But then, of course, I hadn't had my baby. I still had *2 months* to go. Um.

J And you were still in the maternity ward?

S Ya – all the moms and babies came and went – but I made some wonderful friends.

J Eleven weeks is a long time.

S Ya – and there were very nice staff. In fact two of the coloureds, they were called ward aids in those days. You know they just sort of helped with everything – they were wonderful. They kept me going – they had a wonderful sense of humor. They used to move me from one ward to another (laugh) to give me a different (laugh) view. But they always used to tease me, you know – "we're going to have a special plaque put on your bed. (laugh) There were a couple of others who came in for a few weeks, who'd had problems. But I was the longest stayer on that ward. So ya, that was very hard. And then the gynae had said that when I got to 36 weeks, then you can go home, because then baby should be fine. 36 weeks came and he didn't say I could go home and I was *so* cross and so *upset.*

J It must have been very stressful staying in hospital all that time?

S Ya – I couldn't – I was still at the stage where I couldn't just say "Well, you said I could go home at 36 weeks, so why can't I ?". I didn't say anything and then the one sister, shame, she was very sweet, came in and asked me what was wrong and she said "well, you must *tell* him." So the next day he came and I said to him I was very upset and everything – oh no – that's right – he – no – I'd left it a week – and then he still said I couldn't go home and then I was very upset.

J At 37 weeks?

S Ya – so then I was really upset and the sister said, you must talk to him and he said, well, because of my history he thought he would rather be safe but – um – he examined me and said well ya – you can go home so I was very happy. So I went home and I was home – well, theoretically I was 37 weeks but I think he wasn't sure and what's why he probably

– I think I was only 36 weeks. I went home and I was home for – not very long – just under a week – and I went into labour – and I had him – um but he was early and he was small and he had breathing problems, so that was – and he was born on the 13th (laugh). So that was – it wasn't a *Friday* the 13th - it was a Saturday the 13th (laugh). So I thought now is he going to make it? He was critical for 3 days. Oh and he was born on the 13th and they were all so superstitious.

J How did that make you feel?

S I just *prayed* so hard. I just prayed and prayed and prayed and I basically – (laugh) it sounds really stupid now. But I said, "God, if you - if you let this baby die I'm going, I'm going to take my life, I'm going to jump off that roof (laugh). I don't want to live anymore (laugh)." You know, it sounds really stupid now (laugh) but, I was just *so angry,* I was so scared something was going to happen to him.

J How did you feel when he was born? You had come full term and you had a son.

S Well, there again – he didn't breathe straight away so it was a relief, but – aaah – "*now* what's happened ?" It was like *every step* of the way there were problems, you know. And I kept saying to my husband, "What's happening, what's happening?" And he was panicking.

J Was he with you?

S Ya, he stayed with me. Baby was blue and not breathing an they battled to get him breathing and then he *cried* and I was sort of – (sigh) – a bit relieved – but then he was whipped off. It was literally, well, 'there he is' and off he goes and that was very hard, very hard. Because I literally just held him and saw him and then he was whipped off to the - - prem unit – and them I couldn't see him for 6 hours and that was *really* hard. But um – I had – (laugh) – I had – my gynae was away, down South and I had a professor who actually delivered him and he was *so* sweet (laugh) He was so scruffy and so casual (laugh). He looked like he'd just parked his horse at the door (laugh) and he came to see me after the delivery and a few hours later and sort of lounged in a chair at the bottom of the bed and still said, "now look, he is a bit small and his breathing is a bit of a problem, but you know, otherwise he's fine. He should be ok.

J How did that make you feel?

S Well, that made me feel a lot better. A lot more confident. But still everybody else's reactions – "I hope he's going to be alright for your sake", sort of thing, you know.

J Was this from the medical staff?

S Yes, from the nursing staff. You know, because I was back on the ward but they'd nursed me for – so they were just as anxious – I suppose they didn't want to give – false, sort of, positive feedback – or you don't know what their reactions , sort of is. Then we went up – as soon as a minute the six hours was up – boy – '*Please* can I see my baby?". I went up there and saw him. I wasn't allowed to hold him.

J What was your reaction when you saw him?

S Oh, you know – it was – disbelief – Is this *really,* really mine? Is this *really, really* alive and it was a *boy,* which was – I'm the only girl and I had the only grandson, so of course, now I've done - managed to do something (laugh) that nobody else could. But – there again, in the back of my mind, you know, "Am I going to fail again?" Always this *doubt* – is it going to be alright? Is it going to be alright? And, um then – went up – later when my husband came to visit again – went up. They were very good in the prem unit we were allowed to visit with husbands and everything, it wasn't a problem. They even let my mom-in-law go and see him, you know – just through the window – but still, in those

days the grandparents weren't allowed to see the babies. Even the husbands only saw the babies through the nursery window. There was no contact.

J How long did you stay in hospital?

S I stayed in for 10 days. There again, because of his breathing difficulties he was in the incubator for 6 days and them he moved to what they called the hotbox and they wanted to make sure that he was alright with feeding and everything wasn't a problem – and weight, of course.

J How did you feel when you took him home?

S Excited. Kind of unreal. It this really, really for real? It this for real? Also a bit nervous, because of my history and because he had been very sick.

J On the phone you mentioned you had another baby?

S Ya, now the next one wasn't really a miscarriage – it was a – neonatal death. A son born at 29 weeks and he didn't survive. He lived for 4 hours – um – there again – he shouldn't have died. There was no ICU, no machines, no respirator at the white hospital so he had to go right across town to the black hospital. And they left him unattended for 2 hours - - my gynae said he should have been alright – so we lost him – um – so it wasn't really a miscarriage, But I sort of briefly saw him. This is where that book I was saying – um – my biggest regret is that I didn't actually see him and hold him I sort of – I saw him with the – bag over his face and they rushed past to take him to the hospital. I wish now that I had insisted that I saw him. But there again, I thought maybe I was being a bit strange. But in this book they actually encourage, now in later years, they actually encourage the mother to see the baby and to hold it and everything and – that was very hard for me. I kept – because I never actually saw him properly I never actually saw him dead.

J Do you think that would have helped?

S Yes, definitely. I actually wanted to see him but I was too scared to ask. And obviously no one initiated it. And for many years afterwards I kept having these thoughts that *maybe* someone was going to phone me and say look there's been a mistake and he is actually *alive*.

J Because you didn't have that closure?

S Yes – ya – I wrestled with that sort of – this little twinge – maybe he got mixed up (laugh) and he's still alive, sort of thing, which was really stupid, because he was a *white* baby in a *black* hospital.. It was a bit – bit silly. But I suppose your emotions and everything. Um – having Mark, that's my son that survived, having him did help, obviously, because I kept busy with him. But it was still very hard and then I looked after friend's baby – um – soon after – which was helpful.

J In what way was it helpful?

S I think it sort of helped - that sort of – maternal feeling toward the baby that there was no – no outlet for.

J How old was your son?

S Mark was – he was – just before he turned two. No, no – a year old. He'd just had his first birthday. I had Matthew 3 days after his first birthday. Ya – they were all close, boom, boom , and boom. Matthew wasn't planned. That kind of just happened. (laugh) I didn't have any problems falling pregnant. At the drop of a hat. So ya – he wasn't planned but obviously we accepted it. We never didn't want - um – so ya, that was quite hard.

J If you had to think of a few words, a word, to describe your experience of the miscarriages, what would it/they be?

S I don't know – I don't know actually – um – just – I think – I think – that without really consciously knowing it you have this, this feeling of inferiority. Sort of useless, you know, here I'm a woman who can't even do the most *natural* thing in the world. I mean everybody is just – these black women are just popping out babies left right and center. I mean people who don't want babies are just *having* and here I am and I really want. I suppose that incredible feeling of inadequacy. And I suppose anger as well comes into it. I think that's basically – the whole thing is just based on that, you know. Because it just continued.

J Tell me what happened after Matthew?

S Then we came down south. And I fell pregnant with my daughter.

J Was Matthew born in '78,'79?

S Um – '79. He was born in May '79. So we went through the elections in May '80. I'd just fallen pregnant with my daughter. So my gynae – we went back for my 6-week check up. We asked him then and he said there's no reason why he should've died. He was actually very angry at the doctor there when he handed him over and that he'd been left unattended to 2 hours. And people said, why don't you sue? What for ? It's not going to bring him back. What I wish I had done now, is made a complaint to the Medical Council, if he'd done that again, you know, something would be done to protect other people. There was nothing I could do, you know. What's the use? We couldn't afford to sue. It's not going to bring baby back and it'll just make things ten times worse, you know. Ya – in retrospect I wish I had done that – the letter I actually wanted to go to him and say (laugh), "This is what you've done to me (laugh) Do you know the history , sort of thing. And there I felt very angry because so many black ladies, I mean they have 10, 12, 14 kids and you know most of those that were getting attention were going to starve anyway (laugh) and this precious little one we'd been waiting for had been pushed aside for no reason. So that was really hard. I actually began to hate the blacks. Which is wrong, because it's not all of them, you know. I don't hate them.
But he was handed over to a *white* doctor. But anyway – in retrospect that was – that's what I wished I had done then.

J And then you said you were pregnant with your daughter. Did you carry her to full term?

S Not quite. But she was close enough. She was the one I had the least amount of hassles with. So ya – I had one false alarm. So ya – that were my pigeon pair. But just after she was born they discovered she had a heart murmur. Now everything is going so right, now she's got a *heart murmur!* So I found that quite devastating. But that was fine and it cleared up. Then I – we decided – that was it – for the time being. We thought we'd have a break of about 5 years or so and have another 2. That was our plan. We weren't too sure but we had our pigeon pair and we were happy. As I said to you I battled to take the pill and I also had a vein in my leg they were worried about. So we tried the loop and unbeknown to me the loop fell out and it didn't work. My daughter was 9 months old and I fell pregnant with twins (laugh). How we knew it was twins we went to have the loop removed. I fell pregnant and I went to the gynae and I said it was definitely there. I used to check it *regularly.* And he said now we've got two choices. We either take it out now and have the chance of a miscarriage or we leave it in but there's the chance you'll miss later. I said to him (laugh) no, nothing later. If I'm going to lose it must be right now. You do it right now. So he couldn't find it and he said you'll have to go for a scan. And the doctor said, oh, there are *two* sacs. And I said I came to find out about a loop not *sacs* and he said no there's only one heart beat - - - But, how can that be? No, she said, sometimes there are two but one doesn't develop. And I thought, you know, it's just my luck! Right now at the *end !* Why couldn't I have *started* , when Mark was born. Why

couldn't I have had twins then (laugh, laugh). Anyway, so I thought, well it's sort of exciting but scary. Anyway, so she said, come back a month later to check. So I went back and there they were as right as rain, the two of them. You could see the little heartbeats. They were little babies. They were so *sweet. That* was quite exciting. So I said, oh well, it's probably a boy and a girl. All the twins in our family are a boy and a girl.
So she said, well that's interesting , so she did a test on the scan - then of course, it was the stitch. And I thought they were going to put a stitch in and I was bit nervous.

J When was this – in '81?

S Ja, so I was a bit nervous about the stitch because when I had my daughter I only had like 2 ½ hours of labour. I was very nervous but they said – there I was at the Joburg Gen. And you never saw one gynae every time. And, he said, well we'll see, maybe you'll be alright with this, you know, because they were one hundred percent sure, because I hadn't had problems with my daughter, you know. So, although I'd had a stitch in, they'd taken the stitch out and I'd carried her another three days, or something like that. So I think there's a bit of doubt now as to *maybe* the cervix *wasn't* the problem.

J What happened with the twins? How long did you carry them for?

S 26 weeks. And I went for my check-up. And he said, oh, your waters are bulging and he said you're not going anywhere. You're going to have the stitch put in. So he took me straight into hospital and, I mean I was in hospital but they admitted me and I went to theater and my waters broke on the table. So I came back from theater.

J And how did you feel?

S Well, I didn't know at first and then I suddenly felt wet and I called the sister. *They hadn't told me.* And she said, no it's alright your waters broke on the table and of course I just burst into tears and I thought, *Now what?* Now I'm going to have to stay in hospital, now I've got two other children and no one to look after them. I've got no family anywhere. Because Jenny was just over a year old and Mark was 2 ½ years old. No maid, no help, no nothing. And I thought, oh, no – *what* am I going to do? Anyway they said now that the waters have broken, now you have to stay put. And I couldn't – I thought, oh well, there's not much I can do about it. My husband was actually away in Durban. He'd gone to his sister's wedding. Jenny and I were supposed to be flying when I ended up in hospital. So I had to wait for him to come back. My cousin took my daughter. They'd been battling to have children for many years. And I was stuck here, I had no one to look after my daughter. My husband and son were in Durban and I was in hospital.

J And how long did you have to stay in hospital?

S Well I lost the twins.

J Did you lose them at that stage?

S No, I was in hospital a few days and then -

J Did you go into labour?

S I had one – like a - -like a wind pain and I hadn't been to the loo and I asked for a bedpan and the first baby was born and she was a girl and she was crying, so she was born live, so of course I shouted – I shouted and the sister came rushing in.

J Were you on your own?

S I was in a ward with other – I was in an antenatal ward. There were about six of us in the ward. So my husband was there and he didn't know what to do and he ran for assistance. And I didn't know what to do. Baby was crying. I tried to pick it up out of the bedpan but I had a drip up and she kept slipping. And I saw this little hand going like this (gestured). And I was devastated. I couldn't get baby out the bedpan and sister came in and she just opened the recusitation machine to open everything and she died - -

J It must have been *incredibly* traumatic.

S Ya – But now I still had the other twin, so they called the doctor and – the thing is I had no warning – I mean I had - no labour. It just arrived.

J And the second one?

S The doctor arrived and he came and he said no, now – we said, because they're not identical twins can't we save the one. And he said no, because they'll probably lose me because of bleeding. Now, I don't know – I have heard of second twins being saved but I don't know if they just didn't know about it then. But, anyway - so they then had to – they watched, well they then had to induce me so that I had - and the second was a boy. But um – he just took one breath and he – um – he was – you know he didn't cry – he just…

J How did you feel after that?

S Oh, that was – you know in some ways it was a relief. Because, there again, we hadn't planned them. What would we do now with the *twins*? Jenny was only little - she was just over a year old. So financially and not having family there and everything, but – that on one hand. The sort of panic on one hand. And then, what was so hard, was that I felt so positive about the pregnancy.

J For the first time?

S Yes. For the first time I felt *so* positive. It was sort of fatalistic – because now we *hadn't* planned, we didn't really want to have anymore now. And they had just arrived. I was sure that now I was going to have no problems.

J What were your feelings when you had lost the babies?

S Oh, well then, the anger, the emotions –

J Anger toward whom?

S Probably toward myself. Ya – I probably felt a bit guilty because of our initial reaction, oh no, what are we going to do? What are we going to do financially? How on *earth* are we going to manage? Not just another *one*, but another *two*. But at the same time I'd felt quite excited about having *twins*. Initially, I thought – it's not fair, why am I having them now? Why couldn't I just had them *then* and then I could've just had my family and not have had to go through all the – (laugh). So there was this continual roller coaster of you know, negative – positive, scared, or whatever, so – ya –

J So in total you had - ?

S Seven babies. Two survived.

J Looking back on it now, how do you feel about it now? You've told me about your emotions *at that time*. - -How did you feel, maybe, two years down the line, three years?

S It all affected me for many years.

J In what ways?

S I used to have dreams and would battle to go to sleep. You know, I used to have replays of the different - -

J Did you ever go for counseling?

S No, there again, it was something you never - really thought about.

J No counseling, no medication?

S No, nothing. It obviously had quite an effect on me because over the years - I have actually just started - anti-depressants a little while ago. I thought I was starting menopause.(laugh) Because my mom had gone through early menopause. She was 47. And I thought maybe I'm taking after my mom. And it was just over – just over a year – about 18 months ago.

J What were your symptoms? What made you go to the doctor?

S I thought I was starting menopause. I just *cried for nothing*. Just, when I read – I felt totally down. I didn't want to do anything. I didn't want to sew or anything. I've always liked crafts and I didn't want do to anything. Everything was just hassle. I just wanted to sort of, go to bed and sleep. I just wanted to hide away. I didn't want to go anywhere, I didn't want to see anyone, do anything. I didn't garden anymore. I just became – quite a basket case. And um – I went to the gynae – because I also was getting very painful periods, which I've never done before. And he said, no you're not going through menopause. And he sorted out the - I had a fibroid – and sorted all that out. And I carried on in the same – mode.

J Did you go to another doctor?

S No. what happened then I –our- our GP was away and I'd heard about a lady doctor and I said to Jenny, why don't we try this lady doctor and she hummed and hawed and eventually said yes. Because she's very shy. So I phone Dr.... and I said, could we come? And she said yes. So I took Jenny to her for colds and coughs, that sort of stuff and I was *so* impressed with her I said to my husband, now *I'm* going to her. And I needed to have a pap smear and that. So I went. And I told her a bit about my history.

J Did you tell her about the miscarriages ?

S No, I just told her about how I was feeling and that I'd been to the gynae and he'd said that I wasn't going through menopause, but I thought maybe it was starting *now* because I'd got worse. So she said, well, would you mind if I did some tests and she came back and said. no, it's depression. You have this serotonin – and she started me on anti-depressants and I couldn't believe. After she'd said you won't see a change until about, maybe about a month. She said phone me in about two weeks because I need to monitor, tell me how you're going. Well, the first two weeks were very hard. It may me very dry.

J What did she prescribe?

S Cipramil. And, my mouth was so dry and I had some headaches and that, and I phoned her but she said no, just bear with it and phone me in another week, or whatever.

J Did you, at any stage, discuss with the doctor your background about the miscarriages.

S No. not really. She sort of asked, but so much had happened that, um, she asked if I'd been through a lot of trauma, so – yes, because I'd lost my dad – lots had happened in the meantime. So that was now, very much in the past. When I went to Dr. X, he asked me how many babies I'd had. And I said seven. He said ***seven!*** (laugh) He was horrified.

But I said, only two survived. Oh, he said. (laugh) But that horrified look – *seven !* (laugh) Now I would have thought he would have had lots of that with all the women and babies (laugh). - -
So, ya, she was just so sweet and got to the bottom of things. I mean, I had spoken to three different other docs. About that I'd always suffered *dreadfully* with PMS. My husband deserves a medal. I mean, I was *impossible,* when I was premenstrual. My hormones and everything must have been really crazy, because I was impossible. So I'd spoken to – I'd read articles that had said there was help out there.

J What had the doctors said?

S Well, just sort of get on with it. You know, it's just one of those things. I'd always wanted to find a lady doctor. Because I'd always had the feeling that they would understand better. But it was obviously all linked. Probably all the traumas of all the pregnancies and the miscarriages.

J Did you speak to her about it all?

S No. No. I'd recently lost my dad and that was very hard. Because we'd been very close. So that had been very hard.

J Can I interrupt. This was when? When did you lose the last baby?

S About 19,20 years ago. What really helped me was when we got friendly with a young couple. Um, whose eldest child – was brain-damaged. We started going to a church and they were in the church and we got friendly with them and I used to help her with her. Then she had another baby and we helped them a lot with looking after the baby and I found that so therapeutic.

J In what way?

S I found that it - helped – somehow – it helped me with closure. I think that was a mistake with the twins. Because after Mark I had Matthew and then I had Jenny. Then two years after the twins, now it was causing havoc in our relationship, because I was so scared of falling pregnant that I - -

J Did you withdraw from your husband?

S Ag, ja, and it was PMS and it was terrible. Because I had no support. I had *no support.* And two years after the twins I, in desperation, I went and had my tubes tied. And, I thought that was a big mistake - -

J What makes you say that?

S Because, I regretted it later on. I wished then that I'd left it and that we'd had another child. Because of filling that gap. I never really got over the twins – And then when I looked after these two, it somehow – it was just what I needed and - they then moved on to Cape Town and that was very hard. And I remember saying to her, Thank you for sharing your baby with me.

J Did she know about your history?

S Ja, I sort of told her. But I didn't *reali*se how therapeutic it was, but it really was. And after that we started going – well, we had so much trauma. I mean both my in-laws passed away, a young cousin, we had a lot of deaths in the family and then my dad, there was just so much going on. So there was a lot of trauma and stress going around. But what finally triggered mine off, because the serotonin they say, is a stress or trauma is one of the main triggers – was my dad. As I say, she did a whole lot of blood tests and she hit the nail right on the head, and this was the first time she'd seen me. And there I'd been

asking for help and, from doctors and none – just carry on and be a basket case sort of thing.

J Can I just go back a little? You mentioned that for a number of years afterwards you had dreams about the children. Specifically about the twins?

S No, about all of them. The miscarriages, the pregnancies – everything.

J Did you find that they got worse? Did it ease? How is it now?

S Um, That's all gone.

J When did it change?

S I think mainly when I looked after the baby.

J So that was really a turning point for you?

S Ya. I really believe that was - they were sent here – not just for them but for me. Because the syndrome that their daughter had. They lived in Cape Town. This Dandy-Walker Syndrome. Now they lived in Cape Town and they couldn't find *any* information. And he was transferred here form Cape Town and the Foden Center here had *all* the information on it. So that had to come here, for them and then later on for me.

J Did you find that that brought a great deal of closure for you?

S Somehow, that helped.

J You mentioned that you also started going to church? I just want to look at that in light of your experience with the priest and feeling punished – Tell me a little more about that.

S Ya, Ya. Well, we lived in King and got the TBN there and one day, by chance, my son was fiddling with the TV and by chance he got this TBN, and funnily enough it was Jimmy Swaggert on and - now when I think of him I go – uhhh – but he got our attention and we thought well maybe we should go to church. We thought that the kids should go to Sunday School, but we didn't know where to sent them and that sort of pushed us into church. Look, I still battle with it on and off. Um – I still felt a bit guilty that we lost Matthew – maybe it was my fault – with the circumstances and all. Um, because they couldn't stop the labour and I was terribly sick with the drugs that they were giving me to stop the labour and we discussed it and thought, well, lets just let nature take it's course. And I think, I've always, in the back of my mind thought that I should have carried on with the drugs just a little bit loner and maybe he wouldn't have been born so soon – but then I think well, there must have been a reason. Now another thing with the twins that I found very helpful – the cousin that looked after Jenny – they had been trying to have a baby for years - she had – something with uterus – she couldn't fall pregnant – she had one early miscarriage which was really terrible for her. And I spoke to her about adoption – and she said no, they wanted their own or none at all. Then when I landed up in hospital and she looked after Jenny, and it was while they looked after her that they decided that *could* adopt. And they were on their way to Zim when I came out of hospital and she fell pregnant while they were on holiday! And she had a boy and later on a girl. So I always feel that I've given her my two. Because I had a boy and a girl. So I feel that I've given them up to make them realise that they could adopt and then they relaxed and had. So in a way that's given me, I felt, ya, some kind of meaning to the loss. That's just my way of looking at it. But I still feel that having had – had my tubes tied – I mean physically and emotionally it was probably the best thing I could have done. I felt that there's no way I ever want to go through *that* ever again. I've *now had enough* (laugh). So, in that way, um it was the best thing I could have ever done. But I think filling that gap was a problem. I think moving away from all the cousins and that having babies – because I *loved* children, and I had no contact. If I had had contact like I did later on it probably would

have been alright. But I think, then my daughter kept asking, why can't I have a brother or a sister. And of course, that didn't help at all. I think we should have waited a bit longer. And of course, the other thing is that that everything gets better as you go along – medical, science, treatments... so we would have probably been able to have baby without any hassles. But, anyway, that's life.

J When you look back what do you think you needed to cope better ?

S I think I needed somebody else who had been through the same situation, to talk to. Like a support group. I think that would have *really* – even just one person who could've just - I found myself one day just sharing with a lady who'd had a miscarriage. I actually just by chance went to visit her and found out she'd had a miscarriage – also quite far, I think about 16 weeks or so. And I just shared with her what I had been through. And she said it was *so* helpful. It wasn't her first baby but still. It doesn't matter when it happens it's just *so* devastating. I mean I know, a few ladies, when I was waiting to have – and I told my story and some of them were so horrified. And this one lady said she was so ashamed of herself because she was so disappointed because she had a little girl and everyone had said she must have a boy. And she said she was so ashamed of herself when she heard my story. It really shook her up.

J When you say that is what *you* needed, do you think that's what women need today?

S Absolutely. I think so. Look I don't know, but I think maybe even more so now, because I think the nursing staff don't even have a chance to say boo, or aren't too keen to say boo. I just recently had a carpal tunnel thing – and they're nice enough, but you're just a *dummy* in there, I mean they're *totally* uninterested. I mean we used to chat and, we were busy but we used to make time.
Look I had a very short stay but still.
I think also because there are so many working women – when they have a miscarriage they can't take off time. They go straight back to work and carry on. I can't see that psychologically they just push it back.

J Would you say that acknowledgement is one of the biggest things needed?

S Ya, I think, Ya. For me – after my second miscarriage I didn't want to go back to work.

J Why didn't you what to go back?

S Because of *people*. Because I was obviously pregnant and then I wasn't. And people - they don't know how to react. I mean it's not their fault. They don't know. It's like us with disabled people. We don't know how to treat them, we don't know how to react. You don't know what they need and want.

J We can find out though. Do you think it's also a process of educating people?

S Don't you think it's also about this thing that, ag, one in every four women have a miscarriage, so just get on with it, what's the problem, just get on with it and get over it. It's the same as menopause. People didn't use to talk about it. Now people are suddenly realising that women need that. I think, *Doctors*, I mean obviously men don't understand. They've never been there, they don't understand. I think they need some sort of education as well. You know, everybody is sorry and yes, you know they're sorry, but somehow sorry isn't enough (laugh). You need something a little – ya – women need support. I don't know, but I suspect that a lot of women feel ashamed of being in that situation. I don't feel ashamed of what happened. Angry, and felt inadequate, but I never felt ashamed. But I think maybe some modern women feel ashamed of it. There again, I don't know, one could maybe bring the churches into it – I mean this whole thing about abortion – it's kind of like – if you don't want the baby just have an abortion, and no problem. When you've been through a miscarriage – to go and have an abortion - I can't imagine the emotional – I mean they're starting to realise that they need support – but I

mean what's different. They've made a choice so maybe they've got more guilt but what is the difference between having a miscarriage, a natural abortion, or a chosen one?

J Do you think that literature given to women in hospital would help them in some way?

S Ya, I would imagine it would. I think, ya, somehow, one knows that there are a lot of women who have been through this in the world. But when it's you, you feel like you're the only one in the whole world. I don't know how other women handle it but it certainly took me many, many years. I would go to bed at night and I couldn't sleep. The sights would come back and the replays and maybe this or that, or why this or why that. Ya, it was many years. And then it slowly – also I suppose age as well. I always feel broody – I *can't wait* for grandchildren (laugh).

J Have you shared with your daughter what you've been through?

S Ya – I shared and we've never kept it from other people. I mean when my son had his 21st, my husband spoke about it – and said that he's very special – he was critical for 3 days – I say to people – my children are miracles, more than just an ordinary miracle. Because I really battled to have them…

J Is there anything else you would like to add? You have given me a lot of information.

S …I think I've said it all. I don't know? I think so.

J Thank you. I really appreciate you having shared this with me and for your honesty. Thank you so much.