

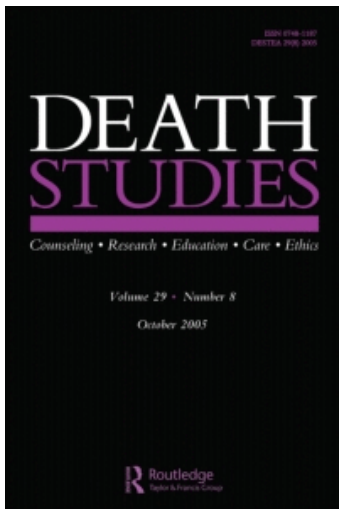
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Publisher Routledge

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Death Studies

Publication details, including instructions for authors and subscription information:

<http://www.informaworld.com/smpp/title-content=t713657620>

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Paula Gerber-Epstein ^a; Ronit D. Leichtentritt ^a; Yael Benyamini ^a

^a Bob Shapell School of Social Work, Tel Aviv University, Tel Aviv, Israel

Online Publication Date: 01 January 2009

To cite this Article Gerber-Epstein, Paula, Leichtentritt, Ronit D. and Benyamini, Yael(2009)'The Experience of Miscarriage in First Pregnancy: The Women's Voices',Death Studies,33:1,1 — 29

To link to this Article: DOI: 10.1080/07481180802494032

URL: <http://dx.doi.org/10.1080/07481180802494032>

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THE EXPERIENCE OF MISCARRIAGE IN FIRST PREGNANCY: THE WOMEN'S VOICES

**PAULA GERBER-EPSTEIN, RONIT D. LEICHTENTRITT,
and YAEL BENYAMINI**

Bob Shapell School of Social Work, Tel Aviv University, Tel Aviv, Israel

The study is a qualitative analysis of 19 interviews with Israeli women who have lost a first pregnancy to miscarriage. Neither the public nor health care professionals are fully aware of the implications and significance of miscarriage to the woman who has lost the pregnancy. The goal of this study was to understand and give voice to the women's experience. Five themes were revealed—the greater the joy, the more painful the crash; the nature and intensity of the loss; sources of support; life after the miscarriage; and recommendations to professionals. The experience of miscarriage was found to be grounded in the meaning of being a woman, as the loss of the pregnancy undermines the women's basic belief in their fertility and as a result threatens their meaning and role as women.

For most women the experience of pregnancy is profoundly emotional. Pregnancy represents the realization of a dream and a central stage in a woman's life. Sometimes, however, the dream turns into a nightmare when the pregnancy stops progressing, and the embryo that has been growing in the woman's womb dies. Although about a third of women have experienced at least one miscarriage (Corbet-Owen & Kruger, 2001; Kluger-Bell, 1998), only in the past two decades has the subject been investigated in the disciplines of social studies and psychology (Moulder, 1998).

Miscarriage is a spontaneous termination of a pregnancy at an early stage, before the embryo is capable of surviving outside the womb, and it is a common risk in a first pregnancy. Some 80% of miscarriages occur in the first trimester of pregnancy (up to the 12th week), when the embryo is felt by the woman as part of herself (Abboud & Liamputtong, 2003; Layne, 2003). During the first

Received 22 March 2006; accepted 02 August 2007.

Address correspondence to Ronit D. Leichtentritt, Bob Shapell School of Social Work, Tel Aviv University, Tel Aviv 69978 Israel. E-mail: ronitl@post.tau.ac.il

trimester the woman is mainly occupied in adjusting to the new physical sensations, symptoms, emotional instability, and the practical implications of her new situation (Teichman, 1998). A miscarriage puts an abrupt end to this natural process of bonding and to the expectation of the pregnancy's normal progress. The woman is faced with a traumatic event that gives rise to a distinctive and characteristic mental dynamic (Goldbach, Dunn, Toedter, & Lasker, 1991).

Neither the public nor health care professionals are fully aware of the implications and significance of miscarriage to the woman who has lost the pregnancy. Though studies of the phenomenon have appeared in recent years, few researchers have looked into the impact of the experience upon the women themselves (Abboud & Liamputtong, 2003; Corbet-Owen, 2003, Simmons, Singh, Maconochie, Doyle, & Green, 2006). The present study aims to observe the subjective experience of the woman who has miscarried a first and early pregnancy, and thereby help the women who have suffered this loss and found no support or sympathetic attention either from their immediate surroundings or from among the attending professionals.

The Experience of Miscarriage

There have been several up-to-date studies of the experience of miscarriage from the viewpoint of the women themselves (see, e.g., Adolfsson, Larsson, Wijma, & Bertero, 2004; Simmons et al., 2006). Corbet-Owen and Kruger (2003) conducted a qualitative study among eight women, which revealed that in consequence of the miscarriage the women expressed the need to understand what they had lost and to mourn it, as meaningful parts of the process of recovery. It was also found that the miscarriage made the women feel a sense of "defect" and "abnormality", as being "fertility failures" and "inadequate wives."

Miscarriage as a distinct experience was also studied by Abboud and Liamputtong (2003). They conducted a qualitative-phenomenological analysis, which revealed that the women felt loss, grief, sadness, alarm, fear, and guilt. The intensity of these emotions varied from woman to woman, being influenced by personal circumstances and the reactions of others. It was found that the women had difficulty dealing with the loss of their roles as mothers, which they had adopted as soon as they discovered they

were pregnant. They described how distressed and sad they felt in contact with other women who were pregnant, and months and even years after the miscarriage could hardly bring themselves to discuss the experience.

These studies and others (Abbound & Liamputtong, 2005; Adolffson et al., 2004; Cosgrove, 2004) have exposed the intensity of feeling and the importance of understanding the experience of women who lost their first pregnancies in early miscarriages. Furthermore, the studies have shown that it is possible to learn from the women themselves about this painful experience, and the importance of the social norms concerning motherhood and fertility.

The present study is the first effort to understand the experience of women in Israel who have lost a first pregnancy to spontaneous abortion. While the experience of each individual woman is unique, one should not lose sight of the social and cultural context of this experience (Cosgrove, 2004; see also Thompson, 1992). The social context of this study is the Israeli society where the unique constellation of Jewish religion, demographic competition with the Arab neighbors, fear of child loss in the military conflict, and child-centered everyday culture have contributed to a strong pro-natalist ideology that is both institutional and popular.

Israel is one of the strongest advocates of childbearing as shown, for example, by substantial government funding for fertility treatments—up to and including two children—and by the highest number of assisted-reproduction facilities per population in the world (Ben-David, 1992). This institutional pressure is grounded in Judaism where procreation is one of the central religious and moral imperatives: *Pru u-Rvu*—“Be fruitful and multiply”—demanded the Lord of Adam and Eve upon their creation. There is a clear continuity in the way the Israeli Jewish culture treats the issue of fertility until this day.

In modern Israeli society the normative proof of a woman's femininity still involves giving birth. Childlessness (even involuntary) bears a whole range of negative psychological and social ramifications for the affected couples and especially for women (Remennick, 2000). Because motherhood is almost synonymous with femininity, childless women are deprived of the most central element of their gender identity and, hence, personal integrity

(Whiteford & Gonzalez, 1995). Within this context this study took place.

Miscarriage: Theoretical Perspectives

A survey of the literature reveals three theoretical approaches that seek to account for the emotional distress caused by a miscarriage. The first approach considers the response and the emotional upheaval as bereavement. It is, in fact, a reaction to the loss of the embryo, similar to the loss of a loved person (Kluger-Bell, 1998; Moulder, 1998). At the same time, the literature indicates that a loss characterized by the absence of a concrete object complicates and aggravates the mourning process (Toedter, Lasker & Alhadef, 1988).

Where the first approach treats the miscarriage as the loss of the object, namely, the embryo, others see the main difficulty as a narcissistic loss (Pines, 1990). The developing embryo is felt, especially in the early months, as an indistinguishable part of the mother's body, of the woman's self, and its loss is perceived as a betrayal by her own body (Borg & Lasker, 1989). This type of loss is essentially different from the loss of a distinct, separate individual.

The third approach that seeks to account for the distress, reported in the literature, following a miscarriage, regards the event itself as a traumatic experience. According to Abboud and Liamputtong (2003), a spontaneous abortion is a trauma that affects the woman's basic belief system. A study of the psychological reactions following an early miscarriage found that 70% of the participants reported traumatic symptoms, including anxiety, difficulty in falling asleep, fear, helplessness, and repeated recollection of the experience, visualized as the ultrasound image of the dead embryo (Walker & Davidson, 2001).

All three approaches emphasize that the woman needs to mourn her baby, even if it never moved inside her and was only a tiny embryo or a cluster of cells. Her bereavement is for the lost idea of raising the child, of the changes that the baby could have brought about, and of herself as a mother (Kitzinger, 1984). This loss is not marked by any ceremony or social consideration (Bucay, 2001; Moulder, 1998), and provokes in the woman responses of shock, anger, grief, depression, guilt, and anxiety (Layne, 2003).

Other reactions are rage, aggression, or a search for the party responsible for the loss—the partner, the physician, or the woman herself (Corbet-Owen & Kruger, 2001).

The Experience of Miscarrying a First Pregnancy

A first pregnancy is qualitatively different from subsequent pregnancies. It marks the passage from childlessness to parenthood and is a time of emotional and psychological upheaval. It is a normative phase, but also a critical point in the formation of the feminine identity, preparing the woman for the next stage, namely, motherhood (Pines, 1990).

We may, therefore, say that the early interruption of a first pregnancy finds the woman at the height of a complex process, characterized by (a) a transition from childlessness to parenthood (Pines, 1990); (b) the incipient formation of the maternal identity and the self-image as the mother of the baby-to-come (Layne, 2000); (c) an almost-perfect bond between the mother and the embryo, which, being in the early stage, is still perceived as an inseparable part of her (Pines, 1990); and (d) preoccupation with wishes, fantasies, apprehensions, hopes, anxieties, and mixed feelings (Cohen & Slade, 2000). All these processes are at their height when the miscarriage breaks them off abruptly.

Method

The current research is a qualitative investigation based on active interview (Holstein & Gubrium, 1995) as a method of data collection and the thematic method as a means of data analysis (Patton, 1990). *Qualitative research* is the method of choice when underlying theories are not formulated, existing theories are questioned or, as in this case, when the phenomenon has received minimal empirical examination and requires an exploratory descriptive approach. Furthermore, qualitative research is especially suited for studying the individual's subjective experiences.

Participants

Nineteen women who had lost their first pregnancy participated in this study. Patton's (1990) guidelines for sampling suggest that the

logic and power behind purposeful selection of participants is that the sample should be information-rich. The selection of information-rich cases was achieved by “criterion sampling [where] researchers pick cases that meet some criterion” (Patton, 1990, p. 183). The criteria for this study were grounded in theoretical and ethical reasons and included being younger than 35 years of age, having experienced a miscarriage within the last four years, and being pregnant or young mothers at the time of the interview. The participants were located by the use of advertisements, personal connections, and the chain sample technique (Patton, 1990). The initial contact with the participants was by the telephone when the study was explained to them.

All participants were married women, aged 25–35; 18 were mothers and 1 was in the last weeks of pregnancy. All miscarriages occurred between the 6th and the 15th week of pregnancy. Most participants were professionals and had a university diploma. All

TABLE 1 Data on Participants’ Demographics and Pregnancies

Name	Age	Family status	Education (years)	Length of pregnancy (weeks)	Time since miscarriage (years)
Malkha	33	Married with 1 child	15	9	3
Dinah	35	Married with 3 children	12	8	4
Anat	30	Married (currently pregnant)	16	11	1
Gitit	25	Married with 1 child	15	11	1
Naomi	34	Married with 2 children	20	12	4
Miri	34	Married with 2 children	15	9	4
Tina	32	Married with 1 child	18	15	3
Debbie	30	Married with 1 child	12	12	2.5
Ronni	32	Married with 1 child	12	14	2
Nika	31	Married with 1 child	16	6	1
Michele	27	Married with 1 child	12	9	2
Nora	29	Married with 2 children	15	11	3
Zohar	33	Married with 1 child	15	7	2
Tamar	29	Married with 2 children	12	9	4
Sharon	31	Married with 1 child	16	12	2
Paula	32	Married with 1 child	15	10	1
Rivka	27	Married with 1 child	12	11	1.5
Tal	28	Married with 2 children	15	12	3
Ruth	30	Married with 1 child	18	9	1.5

Note. All names of the participants are pseudonyms.

but one identified themselves as secular, meaning that participants perceived themselves as not observing the rules and regulations of the Jewish religion. A summary of the participants' demographic and pregnancy information is presented in Table 1.

Interviews

Individual interviews were conducted. The median interview duration was approximately two hours, with a range from one to three hours. The interviews took place in the location most convenient for the participant. Seventeen were conducted at the participants' home, one in a coffee shop and another at the participant's work place. Interviews were audiotaped and interview notes were completed immediately. All interviews were conducted in Hebrew while using the active interview approach (Holstein & Gubrium, 1995).

The major goal of an active interview is to encourage the participant's narrative activity, which was always given priority over predetermined interview questions (Holstein & Gubrium, 1995). The following questions were used mainly as a starting point. The interview included questions about the time prior to the miscarriage, such as the process of becoming pregnant, the women's expectations surrounding the pregnancy, and their experiences at the short time of being pregnant. Participants were asked about their loss and its effect on their personal life as well as interpersonal relationships; their meanings toward the pregnancy loss; their way of coping; and their recommendations to other women who are experiencing the same ordeal as well as to health care professionals. Questions included, for example, "What does the phrase 'miscarriage' mean to you?" "What were your experiences with miscarriage?" and "How has this affected your life, your perception of self as well as your relationship with your partner?"

Thematic Analysis Procedure

Following the interviews, we began the task of analysis, extracting themes in order to make meaning of the data. Glesne and Peshkin (1992) outlined several steps to take in the process of thematic analysis in qualitative research: "Writing memos... developing analytic files, applying rudimentary coding schemes, and writing

reports” (p. 128). The analysis began by reading and rereading the transcripts, while highlighting words, phrases, and sentences that appeared to be of thematic significance (Patton, 1990). At this point, notes were made in the margin of the text without being concerned with the connections between the stories.

This early organization contributed to later development of themes. As we worked through each of the stories, we began to develop coding schemes to help identify sections that relate to one another and to specific themes. “As the process of naming and locating . . . data bits proceeds . . . categories divide and subdivide” (Glesne & Peshkin, 1992, p. 13). Definite connections in meanings were found among stories, which allowed us to put “like-minded pieces together into data clumps” (p. 133).

Following countless readings of the stories, highlighting significant elements, and coding and categorizing these pieces into data clumps, we examined this collection of categories to determine how they fit logically with one another. We worked together as a group of three women who are at different stages in life. Out of this group process, we were able to develop five themes and five sub-themes that accurately captured the experience of miscarriage in first pregnancy.

Language Translation Processes

The interviews and the analyses were completed in Hebrew. Only the quotations that were needed for reporting were changes from Hebrew to English. Extensive efforts were required by the three researchers to accurately represent the spirit of the participants’ meanings and to choose words that build the sentences in a way that represented the emphasis that was meant by the women. There are differences between the ways a sentence is built in Hebrew, compared with the way one constructs a sentence in English. As a result, several English words were needed to get close to the idea of one Hebrew word. The use of several words instead of one often reduces the intensity of the original statement.

Evaluating the Research Process

Validity in qualitative research has to do with description and explanation, whether or not a given explanation fits a given

description, and whether or not it is useful (Lincoln, 1995). Several methods were used to establish validity in this study. First, we worked as a group and checked our results with other colleagues from different disciplines. Second, the length of interviews allowed us to check consistencies in meanings expressed by the informant over time. Third, the detailed description of the analysis process and the quotes from participants are provided to the reader for evaluation (Rosenblatt & Fischer, 1993). Fourth, follow-up sessions were carried out with all of the participants who read the current manuscript and provided encouraging feedback concerning the accuracy with which these interpretations represented their views.

Ethical Considerations

The main ethical dilemma that we faced in this study surrounded the criteria for participation. The decision to exclude women who did not subsequently to the miscarriage have a child or at least an ongoing pregnancy was an issue of great debate among ourselves. The ethical standard of protecting the research participants guided our decision in the end (Beauchamp & Veatch, 1996). Nevertheless, we acknowledge that perceiving this decision as an act of protection, is culturally biased as well as the fact that not all women who were excluded would perceive our decision as an act of protection.

The current study received the approval of the University Institutional Review Board (IRB). The women were given an explanation of the research intentions. They were clearly told they could withdraw at any time (none chose to do so). They were informed of the potential risks of participation—that sensitive, emotionally charged issues were likely to be raised, which might arouse feelings they would find hard to deal with—as well as its benefits and told they would receive support and information from the researchers and would have the opportunity to speak out. All participants commented about the importance of this research and the opportunity it provided them to speak about an experience they rarely share with others.

Findings

Five central themes were revealed: (a) the greater the joy, the more painful the crash; (b) the nature and intensity of the loss; (c) sources

of support; (d) life after the miscarriage; and (e) recommendations to professionals.

The Greater The Joy The More Painful The Crash

The first theme addresses the great joy that surrounds a first pregnancy, and the crash that comes with the discovery that the embryo is dead. The women's stories opened with this theme. In other words, to understand the magnitude of the fall and the hardship of the miscarriage, the reader needs to be aware of the degree of joy, anticipation, and fantasies that accompanied the first weeks of this pregnancy. The women described the period when the pregnancy was planned, the natural maturation of the wish to produce a child: "After five years of living together . . . a relatively mature couple, age thirty [silence], we were ready" (Dinah, p. 1, line 10). Likewise, the start of the first pregnancy, and the first weeks of it, as a natural, expected, process that came about easily and bore no hint of the future. The interviewees described this period in their lives as full of excitement, optimism, and delight. These emotional intensities were the product of a new experience of being pregnant.

The moment you hear you're pregnant—whee! The whole world! you're floating . . . There was tremendous excitement, the whole business of the pregnancy, it was, like, something very new and fabulous . . . Everything was good, it was something very primary, very happy for both of us. (Malkah, p. 1, line 11)

This period is characterized by contentment, success, and control, feeling that events are progressing as the couple dreamed they would: the planned pregnancy is being realized. The correspondence between wish and reality gives rise to a whole world of fantasy that the couple indulges in about the family they are creating, the embryo-baby growing and developing in the woman's womb and in the future.

And right away the dreams, you sail away with dreams and thoughts, I already saw my own self with the baby, and could see where I was going and what I was doing, sailing off very far in the mind . . . This feeling of a 'high', of look, here I am pregnant, and here we have a baby, and already I see the baby as a soldier. You actually see all that. (Malkah, p. 20, line 556)

What we'll call him and what he will study . . . and right away starting to fantasize. (Ronni, p. 3, line 78)

The theme continues with a factual, highly detailed, description of the trauma experienced by the woman. "He informed us that the embryo was probably not alive. It was quite a shock to both of us. Everything stopped, everything crashed" (Gittit, p. 1, line 22). This section of the text that describes the events from receiving the bad news and no longer being pregnant ought to be broken, in the women's experience, into three scenes: (a) receiving the news; (b) waiting for the vacuum aspiration; and (c) the end of the—the vacuum aspiration.

THE NEWS: THE EMBRYO IS DEAD

The first scene took place in the doctor's examination room and centered on the information that the embryo was dead. The interviewees described this scene in detail—months and even years after the event, the women could reconstruct the moment apparently exactly. The announcement is perceived as sudden, and as a discord in the natural cycle of life. In their reconstruction the women referred to the day of the week, even the hour, when they heard the news, the physician's exact words, as well as their own verbal and non-verbal reactions. The ability of the women to reconstruct the event in such detail suggests that the experience remained engraved in their memory as especially difficult and painful.

We came for a routine check-up . . . 'Yes, I see a pregnancy sac, but I don't, I don't see an embryo, there is no embryo.' What does it mean, no embryo?! After the examination I try to ask questions, what does it mean, I'm sort of frightened, what - no embryo? . . . 'No, look, you've got nothing to worry about, you'll have a bleed in a few days.' And . . . that's it. Something like this, tossed into the air, and we're trying to ask, to understand. I'm not a stupid person [laughs]. What do you mean, no embryo! What do you mean, a bleed, no bleed! And - nothing. He simply brushed us off. (Malkah, p. 1, line 23)

I started to cry, but right away put my hand on my mouth, because I felt awkward . . . I sat in the doctor's waiting room, crying and trembling. (Anat, p. 3, line 68)

WAITING FOR THE VACUUM ASPIRATION

After the bad news, the women wanted to describe the time—short but distressing—of waiting for the vacuum aspiration. The

hardship of those days was intensified by the sense of carrying a dead embryo, as well as ambivalence about the curettage. Some of the women stated that until it was done, they regarded themselves as being in a risky pregnancy, requiring special care. The time was marked by nightmares, fears, helplessness, and a sense of going mad. These descriptions contrast with the contents of the mental world of conception. In describing the time leading up to the pregnancy the women emphasized their sense of being in control of the situation, being decisive, in command of their bodies and pregnancies; by contrast, the time of waiting for the vacuum aspiration was characterized by indecisiveness, loss of control over their bodies, and a feeling of having been betrayed by their bodies.

The thought of carrying a dead embryo inside me drove me crazy . . . There was a sort of transition, where earlier I said I didn't want them to touch, then I said, OK, come on, take it out already! I was terribly confused—on the one hand, take it out because it's dead, and on the other: don't touch, it's my child . . . I had very ambivalent feelings, I literally didn't know my left from my right . . . But then I tell you it was a long nightmare, I tell you that time [four days] was an eternity, it simply didn't pass. (Anat, p. 4, line 98)

Like the previous sub-theme, concerning the specific and relatively brief moment in the woman's life—the news about the embryo's death—the current sub-theme also refers to a short period of time, not more than a few days, but the text is quite different. The participants described waiting for the vacuum aspiration more in terms of inward observation than as a reconstruction of the scene (time, place, persons present), or as describing the drama to the interviewer. Moreover, while the start of the pregnancy and the moment the news was received were described as the couple's shared experience, the realization that the pregnancy was at an end and the wait for the vacuum aspiration were perceived as the personal experience of the woman alone.

THE VACUUM ASPIRATION AS AN INVASION AND PUBLIC ACT

The scene of the curettage, like that of the bad news, was recollected in meticulous detail, both in terms of an interior, personal experience and as an exact description of the process. The scene takes place in the waiting-room and in the hospital operating

room. The interviewees referred to the day and the hour when the procedure took place, to what was said and done as well as the way they felt and their body sensations.

Very difficult, the stage of signing, before going into the curettage . . . I remember every detail of what was said, what happened before I went into the operating room. I signed that I knew I might have a hole in the womb and could have some damage, and it could be the first and the last time I got pregnant. (Anat, p. 4, line 120)

You go into an operating room, freezing cold, you're fasting, you're alone. (Malkah, p. 3, line 72)

Then comes the curettage itself. This helplessness. Suddenly they strip off all your clothes and dress you in that gown, and take me down the corridor and tie me to the bed. And . . . It was horrible, I felt the inhumanity of it (Gitit, p. 7, line 198). No privacy, no . . . it's as if you're not there at all. (Naomi, p. 14, line 404)

When the medical procedure of the curettage is over it is the end of the pregnancy, and the emphasis of the interviews shifts to the experience of loss.

The Loss: Its Intensity and Nature

The second theme deals with the women's first reactions to the loss, and their effort to understand it.

THE INTENSITY OF THE LOSS

The loss of the pregnancy, with the collapse of the dreams and fantasies, leaves the woman feeling a deep pain, intensified by the suddenness and senselessness of the loss. The texts convey feelings of helplessness, grief, and a profound pain expressed in floods of tears. The descriptions are voiced with deep pain, even if they report events that ended years earlier. The women recall the spectrum of emotions and their intensity, and their choice of words reveals their anguish.

You don't expect . . . but when it happens to you, boom! Total surprise. It simply hurts, hurts in the heart . . . Really real pain, physical pain (Ruth, p. 8, line 231).

Very scared and distraught and confused very painful and depressing. (Tamar, p. 9, line 233)

As if I'm the only one in the world having a miscarriage. (Zohar, p. 6, line 172)

In the first few days after the miscarriage, as described by the women, their conduct was the normative one of bereavement: great sorrow and weeping, withdrawal into the house and lack of energy. Though none of the women used the term *shiv'ah* [the Jewish mourning week], they spoke of a week of bitter mourning.

I was at home for a full week. I cried. (Ronni, p. 4, line 89)

It was a week of mourning, but really tough . . . And crying, and again: What have I done to deserve this? . . . I remember we brought a tape of the ultrasound scan, it was just two-three minutes . . . the first we managed to record. So I sat and watched those minutes over and over again. (Tina, p. 3, line 63)

And you mourn, a real mourning process like any other loss . . . Mourning something you had and you don't have any more. And that's a lot of crying, lots, lots, a need to cry, a very great sadness. (Malkah, p. 6, line 151)

Some of the women describe a traumatic experience—suddenly the world collapses, they feel lost, scared, and broken up. These women describe a loss of control, whereas in others the trauma causes their world assumptions to change (Janoff-Bulman, 1992).

Suddenly, really, your whole world collapses and you've got nothing, not a thing! You can't see, can't see a light at the end of the tunnel. (Tina, p. 2, line 47)

As if I'd been naive and everything was going well and everything was fine, and then you lose it, because suddenly bad things are happening, that's what makes it so very traumatic. Tragic . . . It [the miscarriage] changed my understanding, I mean, it brought me down to earth. Suddenly I saw that bad things happen in the world. (Malkah, p. 10, line 275)

I didn't take into account that I might lose this pregnancy . . . I knew I was pregnant and pregnancy takes nine months, and then there's a baby, and all that. To me it was the end of the world. Honestly, I can tell you it was the end of the world. (Sharon, p. 2, line 34)

THE NATURE OF THE LOSS

Even years after the miscarriage, women still brood about what they lost. This issue comes up frequently in the different stories, in the attempt to understand and explain the sensations and emotions surrounding the miscarriage. They describe the difficulty of digesting the experience, because it meant the loss of someone they never knew, who was still a story, a dream, an expectation or a fantasy. This is how Gitit tried to understand what she feels she has lost:

It's something that didn't exist in fact, that I didn't know, it was more the loss of a fantasy than of something tangible. The loss of the fantasy, of the anticipation, the expectations and thoughts and hopes, and suddenly it all sort of crashed... In fact, you lose something that you never really knew... More a fantasy than something real. (Gitit, p. 13, line 357)

The loss takes on various forms. The difficulty of defining who, or what, the embryo was to them makes it hard for the women to comprehend the loss and give it meaning. Some of them did not even get to see their embryo by ultrasound, and those who did reported that they mainly heard a heartbeat, but did not discern a baby's shape. Their belly did not yet look pregnant, and the embryo was a reality blended with fantasies and expectations.

I felt I'd lost my embryo who was a part of me, that the past three months it was in my mind that I was pregnant. (Rivka, p. 13, line 350)

It's... sort of losing the whole story. But in fact it was a story, because it was nothing, it was something but that's not... It's something more emotional than physical that you could touch... I think it was chiefly the illusion. (Ronni, p. 3, line 84)

In addition to the loss of the fantasy about the embryo there are other losses—of a clear, planned course in life, of the natural development of life. 'A crossroad in life... Before that everything was very clear, there was a very clear, very planned, very orderly course. And suddenly, as I say, everything was disrupted' (Tina, p. 10, line 261). Some of the women describe it as chiefly the loss of the newness, the enthusiasm, the feelings and fantasies around a first pregnancy.

I think that a first pregnancy is a first pregnancy, and no sensations and emotions that come later are the same. There is never again the experience of newness that was there the first time. (Debbie, p. 4, line 110)

First of all, a first pregnancy is the first illusion... the realization of the illusions, of the stories. It's the first time, and I think it's a pretty big disappointment to lose it. (Ronni, p. 10, line 284)

The interviewees reported a fear of an even greater loss of damage to the womb, even a fear of losing the ability to conceive and be a mother.

I was already thinking I ought to adopt a child, because I already said I wouldn't be able to have children. (Nika, p. 5, line 114)

I was scared that they'd damage my womb. That was my biggest fear, that I might never be able to give birth to children because of this situation. (Anat, p. 2, line 53)

Thus the loss of a first pregnancy translates directly into the question of their future ability to have children, and threatens what some of the women regard as the woman's proper role: to be a mother. Some of the interviewees regard motherhood as the essence of being a woman, and said that unless they became mothers they would be incomplete. Some even maintained that for a woman not to be a mother was 'against nature.'

To my mind, the essence of a woman is to be a mother (Tina, p. 10, line 288). It's part of the aspiration of every woman to reach perfection. It's a kind of inner need, to fulfill yourself. (Malkah, p. 10, line 261)

The hardest thing for a woman to accept is that she can't give birth. When people say 'being a woman', to me by association it means a mother. (Miri, p. 8, line 225)

A woman who is not a mother is something against nature, something incomprehensible. (Ronni, p. 7, line 200)

The centrality of motherhood in femininity derives from the social-familial model on which the interviewed women had been brought up:

The main purpose in life was to be a mother, something that was impressed on me very strongly. (Tina, p. 10, line 288)

All my life I thought about being a mother . . . since I was a little girl and played with dolls, and until they took them away from me . . . Later I liked playing with children and looking after them . . . It was the first thing I knew I wanted all my life, more than what I wanted to study or what kind of work, it was clear to me. (Nika, p. 12, line 337)

The illusion is created not during the pregnancy but when we are small girls, when we're still playing with dolls, we already think about being mothers, about children, because it's in our nature. (Ronni, p. 11, line 312)

The loss of the pregnancy undermined the women's basic belief in their fertility and their ability to bear a child, hence their essence and role as women. The perceived deep-seated significance of miscarriage in a first pregnancy calls for an examination of the support systems that helped the women cope with this hardship.

Sources of Support

In recapitulating the personal experience of the miscarriage, the women referred to the presence and influence of people and institutions with which they were in touch during this period and who formed an integral part of understanding the experience. These included the partner, the birth family, and women who had had a similar experience. The women's responses to these people ranged from a sense of support and understanding, through the ability to perceive their behavior as a useless attempt to understand and support, to anger at the other persons' tendency to excessive pity or protectiveness.

The experience of the miscarriage is, first and foremost, the woman's experience and only hers. Not only is this the operative aspect of it (the woman is the one who went through it), it is reinforced by the interviewees' descriptions of their emotional experience. In parallel with the physical aspect, the women described the inability of the support factors, however central and important, to provide comfort and aid, or, alternatively, to provide support for some length of time.

Someone would say she understood how I felt. I don't know if she'd been through the same sort of thing or not, but she understands. It got on my nerves so badly! What do I care if you understand? So what if you understand, does it help me to feel better? No! It's so annoying! Patronizing! Frustrating! (Zohar, p. 4, line 90)

The informal sources of support (the partner, the family, friends) usually appear soon after the event and very quickly expect the woman to bounce back, forget, move on.

On the one hand, they understand, but its a very cerebral understanding, very cognitive. OK, so you've had some sort of crisis, or something, and it was very difficult, but you have to keep going, keep working. It'll be all right and you'll get pregnant again. That's it, that's what the society was communicating. (Tal, p. 3, line 78)

Despite the obvious gap in these texts between the "I" (the woman who had the miscarriage) and all those who try to help, it was possible to distinguish that the women attributed different meanings to sub-groups in the informal sources of support that

were available to them. Hence the present theme maintains the distinction between the partner, the woman's birth family, and other sources of support mentioned by the women.

The reactions of the partners also varied, ranging from about one-third the cases, who were perceived as sharing the women's pain, understanding and supporting her: "In my grief, he was there for me" (Anat, p. 17, line 466), and those who were described as unable to empathize with the woman's needs: "He couldn't understand it. He kept repeating that the doctor had said it would be all right. He stayed on the sideline!" (Naomi, p. 11, line 196). And at the far end of the range, the partner who was described as being at the woman's side when it was made clear that the loss of the pregnancy was hers and only hers: "My husband was not upset by it. He did understand my pain, he understood my need to mourn, it's not that he belittled it, but he wasn't especially moved by it" (Malkah, p. 8, line 217).

The woman who feels a need to describe and talk about what happened to her—"You look for people who you can talk to" (Naomi, p. 11, line 309)—seeks a response in her immediate surroundings, primarily her birth family, with the mother as its central figure. In each of the cases where the woman chose to turn to her birth family, the mother was found to be capable of understanding and containing the distress, the pain and the loss of the woman who miscarried. It seems that losing their first pregnancy provided the interviewees with an opportunity for a warm encounter with their mothers, and for reinforcing their relationship.

I have a mother, a trained nurse, so we went straight to her. It was the first lifeline we thought of. (Anat, p. 3, line 62)

My parents really surprised me—they're the sort where everything is fine, and everybody's feeling just great, there isn't much room for failures. And still in this case I felt I could cry in their presence and they accepted it, especially my mother. She was there for me. (Debbie, p. 4, line 95)

Yet, despite the importance of the mother, the woman's birth family tended to urge her to get back to her life and try to conceive again. Hence the leading source of support, in the view of most of the participants, was a group of women who had had a similar experience. These women were perceived as more supportive and understanding than anyone else. Most of the interviewees

even divided the women who supported them according to this criterion, whether or not they had ever had a miscarriage.

So I talked to Ronni. She also had it [a miscarriage]. Somehow it helped me to hear how she went through it. I remember she told me she really understood me very well, and I felt that she did. (Tal, p. 9, line 240)

You look for people you can talk to who can understand it. How can a woman understand if she hasn't been through it? She says she understands, but can't really, because she has a child in her arms. (Nora, p. 11, line 309)

The presence of a network of support, however limited, helped the women to cope with their loss. Nevertheless, the participants reported a major difficulty in trying to return to everyday life. This difficulty is described in the following theme, which deals with life after the miscarriage.

Life after the Miscarriage

The present theme concerns the way women cope with the return to everyday life after the loss, when they are still trying to overcome the sensations and experiences associated with the pregnancy that became a miscarriage, the shattered dreams, the yearning for a child. They must cope with upset plans, with the feeling that things should have been different. All this is happening while they encounter the surrounding society which goes on having fun, and with other women who succeeded in keeping their pregnancies and becoming mothers.

For some women this return to the routine is extremely difficult or almost impossible. They lack energy, they describe an inability to concentrate, to function as they used to, and even a wish that the world, or their own life, would stop.

I was unable to work during that time. I couldn't paint, I couldn't touch, didn't want to . . . I felt a kind of . . . sorry, revulsion . . . against this thing that I normally love so much to do, I could create from inside me. I smiled less, I cried all the time, and I couldn't talk. (Tamar, p. 18, line 491)

I felt I wasn't functioning the way I used to . . . couldn't concentrate . . . When I had to draft some document I'd find my thoughts wandering . . . I forced myself to get up in the morning and go to work. If I could have stayed in bed under the covers for a few months, and then maybe wake up, that's what I'd have liked. (Sharon, p. 4, line 105)

For others, the return to work and to normal functioning provided an escape from thinking and excessive brooding over the loss.

I'm very much in favor of returning right away to the routine. Otherwise the thoughts fill you up and then it gets worse. I need to be busy and work, and I need for my mind to be full, not to be in those thoughts. That's my way of coping. (Miri, p. 7, line 186)

At the same time, they all agreed that part of the difficulty of returning to everyday life lies in the attitude, or indifference, of the surrounding society. "You get questions about what happened and how, and you have to explain. I remember that every question or somebody's look threw me off. I remember that I'd go to the bathroom and cry" (Tal, p. 3, line 73).

Encounters with friends who were pregnant, or attending social occasions, were frequently mentioned in the interviews. The encounters aroused distressing feelings, including envy, loss and failure, and as a result the women expressed a wish to avoid such meetings.

Her pregnancy was a living reminder of my loss, and as it advanced I could see what I was not. (Malkah, p. 12, line 321)

It's something you can't deal with. It's this thing of girlfriends getting pregnant and giving birth and... It's really something you run away from, you run away from meeting people with children". (Naomi, p. 8, line 221)

Every friend of mine who got pregnant was to me—boom and shock! There, she succeeded and there, I didn't... Social occasions, if they were Births, it was like reopening the wound all over again... So I avoided them. (Tina, p. 9, line 244)

Nika described the difficulty of coping with the sensations and emotions that came up whenever she met with women who were pregnant or had children—she felt there was something wrong with her, or that she wasn't normal, but did not voice these feelings:

It seemed not normal to me, because each time we had to invent an excuse [for being childless], because we couldn't tell the real reason. This in itself made me feel very bad... I mean, it didn't seem right to feel this way. (Nika, p. 9, line 243)

The women described this stage as living with chronic illness, a situation that grows problematic, extended, and needs to be coped with day after day. This definition of the daily life of a woman who lost a first pregnancy, months and even years after

the event, indicates that although the miscarriage ends quickly, for the women the loss of the pregnancy is a long, painful process, and for some of them it never ends.

The Women's Recommendations to Society and the Professionals

The present theme deals with the recommendations and the message that emerged from the interviews. The message that some of the women wished to convey referred to all women, and emphasized the importance of choosing a doctor who suits the individual needs of each woman at this significant and sensitive stage in her life—namely, pregnancy—one who is capable of comprehension, support, sensitivity, and empathy for the pregnant woman.

Others stressed the importance of processing the experience of miscarriage, so that it does not linger and blight the woman's life and her ability to function for a long time. Seven of the participants recommended turning to professional counselors, especially when the immediate event is over, and when the surrounding society is not very attentive to the woman's difficulties and needs. Tina also suggested that the professional counselors develop the tools to deal with miscarriage and disseminate them.

If you don't do something about it in the beginning, and if you don't take care of it the way it should, then it could be like this and follow you for a very long time. I think it really is necessary to produce some kind of tools to help women to cope with this. Produce them and distribute them among all [counselors]. (Tina, p. 12, line 334)

Finally, a joint recommendation to the women, their doctors, and the people around them: Be with the women in their pain, let the woman who had a miscarriage mourn at her own pace, and let each of them experience the event and relate to it in her own individual way.

Emphasize this aspect, that it's all right to mourn, know how to say it to people—perhaps it's different for each one, one may need more time and another less... The professionals also must emphasize to these mothers, these women, that they're not alone, or that they're not freaks. (Tina, p. 11, line 309)

You have to give the woman her own personal space to go through the experience. (Gitit, p. 13, line 344)

Discussion

The purpose of the study was to understand the experience of a woman who miscarried early in her first pregnancy. The stories of 19 women who had a miscarriage early in the first pregnancy reveal that the loss of a first pregnancy is a painful and complex experience, which does not end with the surgical procedure or a few days later. The boundaries of the experience are much wider, and in some of the cases they never quite end. The complexity of the experience is further grounded in the fact that spontaneous abortion catches the women unprepared at the height of the creation of a new life.

Miscarriage is a personal, private, and intimate experience of the woman's, both physically and emotionally; but at the same time, it is also a social phenomenon common to very many women. The present section of this article is devoted to a comprehensive discussion of the main issues that arose in the study, as shown in the Findings section, in reference to theories and research data.

The Findings in Relation to Theoretical and Empirical Literature

The findings of the present study point to three central issues in the experience of an early miscarriage in a first pregnancy. The first focuses on the internal search to find meaning in the loss of 'someone' or 'something' that did not exist, of an unseen embryo. This issue concerns the complexities of the loss. The second issue deals with the inter-personal aspect and focuses on the presence of the partner in the situation. The third aspect treats the miscarriage as a social-cultural phenomenon and examines the woman's experience through this prism. Admittedly, most aspects of the miscarriage that were revealed in this study are not unique; yet, these negative experiences that were described were magnified by the strong social and cultural imperative of motherhood that exist within the Israeli society. All participants, and often the researchers themselves, fully internalized the dominant ideology presenting motherhood as essential, imminent and natural in women's life.

THE INTERNAL ASPECT: COPING WITH THE LOSS OF SOMETHING UNSEEN

The findings indicate that the women find it difficult to define and to understand what they have lost, or if they have lost anything

at all. This is due to the fact that it is a loss of someone who did not exist. The loss of an unseen entity produced a 'vague space', in which each woman defined and comprehended it in her own particular way: the loss of an embryo, the loss of an intangible part of herself, the loss of a dream, a fantasy, an expectation, a story, an emerging identity-role, the loss of a future baby, the loss of control over her body, the loss of the confidence of being a mother at some future time, or of the basic belief that says, 'I can do it. It won't happen to me.' Thus the loss is not only of the embryo, but of the future which was expected to follow the birth. Moreover, the newness, the excitement and the euphoria over the pregnancy are also lost.

The attempt to understand what has been lost gives rise to an important and complex issue: the loss of motherhood. Following the failure of their first attempt to produce a child, the participants regarded the miscarriage as potentially threatening a greater loss—the ability to bear a child, maternity itself. The fear of being unable to bear a child, to be a biological mother, heightened the basic significance of the miscarriage: the meaning of being a woman. The loss of the pregnancy undermines the women's basic belief in their fertility and ability to produce a child, undermines their meaning and role as women (Abboud & Liamputtong, 2003; Corbet-Owen & Kruger, 2001; Walker & Davidson, 2001).

Most women regard motherhood as a role and even as a central goal in a woman's life (Corbet-Owen, 2003; Friedman, 1996; Zucker, 1999). Both the psycho-dynamic and the feminist currents place considerable weight on motherhood in the woman's life (Corbet-Owen & Kruger, 2001; DiQuinzio, 1999; Erikson, 1968; Freud, 1933; Pines, 1990). In the psycho-dynamic view, as argued by Borg and Lasker (1989), being a mother represents the woman's self-fulfillment, the fulfillment of her role as an adult, a woman and a partner. According to Freud (1933), a woman's proper feminine development hinges on her bearing children—a woman who chooses not to do so is considered deviant and her feminine development is defective.

Alternatively, the feminist approach offers a multi-faceted view of the issue of motherhood. Some feminist theoreticians argue that motherhood is a source of control over, and restriction of, women (DiQuinzio, 1999). Others regard motherhood as an important resource for the feminine identity and the woman's most

important achievement, the basis for the woman's valuation as a member of society and a source of power for political participation (DiQuinzio, 1999). Therefore, the mothers are the ones who can bring about social change (Umansky, 1996). Yet despite their differences, all the feminist theories agree that women must have control over their lives, including their role as mothers, if they choose to do so. This theoretical worldview heightens the need to further examine the meaning of motherhood among young Israeli women - especially in view of the description in the literature that Israeli society perceives motherhood as the focus of the woman's existence (Remennick, 2000). A rigid social construction can be overwhelming, blocking other channels beyond the reality it presents.

THE INTER-PERSONAL ASPECT OF MISCARRIAGE

Studies made in recent years have emphasized the function of the partner as supporter and participant in the experience of spontaneous abortion (Abbott & Liamputtong, 2003; Corbet-Owen, 2003; Corbet-Owen & Kruger, 2001). Most of the participants in the present study hardly considered the possibility that their partners experienced loss. They did not consider that their partners wanted to support them. It is of course possible that some of the partners really did not share the women's experience, but it is also possible that they felt an equal sense of loss as did the women, but dealt with it in a different way. It is also possible that the intensity of the women's pain and loss made them take an egocentric view of the situation, which prevented them from recognizing other viewpoints, such as their partners'; the men, for their part, make no effort to share the women's feelings, for fear of making things harder for them. These speculations derive from clinical observations and should be examined empirically in future studies, because the dissonance produces failures of communication between the couple, with potentially long-term effects. On the contrary to the insignificance of their partner, the participants pointed at their mothers as an important source of support. Following the miscarriage the young women's mothers were the most supportive figures in their life. When asked about this unexpected result, in a follow-up session, the informants mention a sense of protection they experienced with their mothers and their mothers only. The protection the participants searched for and found in their mothers

seems to be basic and essential to human existence. Yet, the finding concerning mothers' role at times of miscarriage needs to further be explored in future research.

THE SOCIAL-CULTURAL ASPECT OF MISCARRIAGE

A woman who has failed to create a new life feels that her body has let her down, and views herself as disabled or defective. This is exacerbated if the social-cultural context she inhabits conveys a clear message echoing the biblical commandment to 'be fruitful and multiply', and woman's destiny to fulfill it (Borg & Lasker, 1989). A miscarriage, the abrupt end of a normal pregnancy, is not an isolated occurrence in a woman's life—it is affected by many factors, including cultural and social ones.

The present study has shown that the encounter between the internal reality of the woman who has lost her pregnancy, including her dreams about the anticipated baby, and the outward reality represented by her immediate surroundings—be it friends who have children or are carrying a pregnancy to term, or a society that goes on its way despite her loss—hinder her ability to cope. Consequently, the woman tends to avoid social occasions and interpersonal meetings. Coping with her bereavement for the unseen loss, on the one hand, and the social isolation, on the other, leave the woman on her own at a time when the surrounding society tends to forget what has happened and even expects her to bounce back to her usual existence and continue to plan for the future. The inner distress, the sense of emptiness, and the desire for a child, are intensified by the inability of the immediate society to make space for the woman and her loss (Abboud & Liamputtong, 2003; Corbet-Owen & Kruger, 2001). Society fails to allow for and legitimate the woman's mourning when the miscarriage occurs in an early stage of the pregnancy (Moulder, 1998).

The analysis of the social aspect of miscarriage reveals a complex picture—not only does society make little allowance for the lost pregnancy, the loss of a first pregnancy prevents the couple from fulfilling what society regards as an inseparable part of conjugal life and adult identity, namely, raising a family. Thus the woman's feeling of failure is due not only to the personal loss, but also to society's view of her failure to join 'the community of families' (Abboud & Liamputtong, 2003; Borg & Lasker, 1989).

Implications and Limitations of the Present Study

The contribution of the present study lies in the thorough and complex picture it paints of a unique phenomenon as perceived by the women themselves. The presentation of the experience of miscarriage and the discussion about it can improve its understanding by professionals, as well as by the women themselves. The interviewees in the present study actively participated in structuring the interviews and validating the data. Participating in the study and advancing the body of knowledge empowered the women and strengthened their ability to find additional meaning in the experience of miscarriage.

Nonetheless, the main limitation of the present study was the fact that the women chosen had already become mothers or were in advanced pregnancy, which undoubtedly influenced their meaning towards the miscarriage, as opposed to women who did not become pregnant again. The participants were at some chronological distance (between six months and four years) from the miscarriage itself, which presumably also affected the investigated experience.

RESEARCH IMPLICATION

Recent years have seen the publication of qualitative studies of the experience of miscarriage, but the research is still in early stages. The findings show that miscarriage is a complex and multifaceted phenomenon, comprising elements of trauma, concrete factors, a world of fantasies, elements of loss made more problematic by focusing on something that lived inside and died inside the body, a sense of responsibility and guilt, and the influence of the family, mainly the mothers, on the experience of miscarriage—all this in addition to the direct impact that the miscarriage makes on a central factor in the woman's life, namely, motherhood. All these require that scientists continue to investigate and comprehend the phenomenon.

PRACTICAL IMPLICATION AND RECOMMENDATION

The firsthand stories of the women who underwent an early miscarriage show that society will have to change its attitude toward the phenomenon. As Layne (2003) put it, society loves pregnant women, but only when the pregnancy is successful.

Pregnancy complications, including miscarriage, are confronted on a purely personal level. The public must be made aware of the prevalence of the phenomenon, comprehend it, and provide appropriate answers. The findings have shown that some of the women felt that neither the social establishment nor society was ready to face, and allow for, such a loss. The process of raising social awareness in this area lies in the sphere of interest and the professional expertise of thanatologists.

We must strive for a positive social interaction in response to miscarriage, including (a) emotional support, expressed as empathy, care, affection, reinforcement; (b) instrumental support, including concrete help; and (c) informative support, by means of relevant information, counseling, and guidance. The present study shows that there is a long way ahead, and, at least in Israel, it remains necessary to improve and soften the experience of women who have suffered a miscarriage.

References

- Abboud, N., & Liamputtong, P. (2003). Pregnancy loss: What it means to women who miscarry and their partners. *Social Work in Health Care, 36*(3), 37–62.
- Abboud, N., & Liamputtong, P. (2003). When pregnancy fails: Coping strategies, support networks and experiences with health care of ethnic women and their partner. *Journal of Reproductive and Infant Psychology, 23*(1), 3–18.
- Adolfsson, A., Larsson, P. G., Wijma, B., & Bertero, C. (2004). Guilt and emptiness: Women's experience of miscarriage. *Health Care for Women International, 25*, 543–560.
- Beauchamp, T. L., & Veatch, R. M. (1996). *Ethical issues in death and dying*. Upper Saddle River, NJ: Prentice Hall.
- Ben-David, A. (1992). Motherhood and gender: Reexamination of the family therapy myths. *Shiot, 7*(1), 14–19.
- Borg, S., & Lasker, J. (1989). *When pregnancy fails*. New York: Bantam Books.
- Bucay, J. (2001). *El camino de las lagrimas*. Buenos Aires, Argentina: Editorial Sudamerica.
- Cohen, L., & Slade, A. (2000). The psychology and psychopathology of pregnancy: Reorganization and transformation. In C. H. Zeanah (Ed.), *Handbook of infant mental health*. (pp. 17–32). New York: Guilford.
- Corbet-Owen, C. (2003). Women's perceptions of partner support in the context of pregnancy loss. *South African Journal of Psychology, 33*(1), 19–27.
- Corbet-Owen, C., & Kruger, L. (2001). The health system and emotional care: Validating the many meanings of spontaneous pregnancy loss. *Families Systems and Health, 19*(4), 411–427.

- Cosgrove, L. (2004). The aftermath of pregnancy loss: A feminist critique of the literature and implications for treatment. In J. C. Chrisler (Ed.), *From menarche to menopause: The female body in feminist therapy* (pp. 107–122). New York: Haworth Press.
- DiQuinzio, P. (1999). *The impossibility of motherhood, feminism, individualism and the problem of mothering*. New York: Routledge.
- Erikson, E. H. (1968). Womanhood and the inner space. In J. Strouse (Ed.), *Women & analysis*. New York: Grossman Publishers.
- Freud, S. (1933). *On femininity*. SE. 22:112–135. London: Hogarth.
- Glesne, C., & Peshkin, A. (1992). *Becoming qualitative researchers*. White Plains, NY: Longman.
- Goldbach, K., Dunn, D., Toedler, L., & Lasker, J. (1991). The effects of gestational age and gender on grief after pregnancy loss. *American Journal of Orthopsychiatry*, 61(3), 13–23.
- Holstein, J. A., & Gubrium, J. F. (1995). *The active interview*. Thousand Oaks, CA: Sage.
- Janoff-Bulman, R. (1992). *Shattered assumptions: Toward a new psychology of trauma*. New York: The Free Press.
- Kitzinger, S. (1984). *Women's sexual experience*. Jerusalem, Israel: Alshir.
- Kluger-Bell, K. (1998). *Unspeakable losses: Healing from miscarriage, abortion, and other pregnancy loss*. New York: Quill.
- Layne, L. (2000). He was a real baby with baby real things: A material cultural analysis of personhood, parenthood and pregnancy loss. *Journal of Material Culture*, 5, 321–346.
- Layne, L. (2003). Unhappy endings: A feminist reappraisal of the women's health movement from the vantage of pregnancy loss. *Social Science & Medicine*, 56, 1881–1891.
- Lincoln, Y. S. (1995). Emerging criteria for quality in qualitative and interpretive research. *Qualitative Inquiry*, 1, 275–289.
- Moulder, C. (1998). *Understanding pregnancy loss: Perspectives and issues in care*. Suffolk, Malaysia: Aardvark Editorial.
- Patton, M. Q. (1990). *Qualitative evaluation and research methods*. Newbury Park: Sage.
- Pines, D. (1990). Pregnancy, miscarriage and abortion: A psychoanalytic perspective. *International Journal of Psychoanalysis*, 71, 301–307.
- Remennick, L. (2000). Childless in the land of imperative motherhood: Stigma and coping among infertile Israeli women. *Sex Roles*, 43, 821–842.
- Rosenblatt, P. C., & Fischer, L. R. (1993). Qualitative family research. In P. G. Boss, W. J. Doherty, R. LaRossa, & S. K. Schumm (Eds.), *Sourcebook of family theories and methods: A contextual approach* (pp. 167–180). New York: Plenum Press.
- Simmons, R. K., Singh, G., Maconochie, N., Doyle, P., & Green, J. (2006). The experience of miscarriage in the UK: Qualitative findings from the National Women's Health Study. *Social Science & Medicine*, 63, 1934–1946.
- Teichman, Y. (1998). Abortion: Psychological aspects. *Psychology*, 1, 58–73.
- Thompson, L. (1992). Feminist methodology for family studies. *Journal of Marriage and the Family*, 54, 3–18.

- Toedler, L., Lasker, J., & Alhadeff, J. (1988). The perinatal grief scale: Development and initial validation. *American Journal of Orthopsychiatry*, 58.
- Umansky, L. (1996) *Motherhood reconceived: Feminism and legacies of the sixties*. New York: New York University Press.
- Walker, T., & Davidson, K. (2001). A preliminary investigation of psychological distress following surgical management of early pregnancy loss detected on initial ultrasound scanning: A trauma perspective. *Journal of Reproductive and Infant Psychology*, 19(1), 7–16.
- Whiteford, L. M., & Gonzalez, L. (1995). Stigma: The hidden burden of infertility. *Social Science & Medicine*, 40(1), 27–36
- Zucker, A. (1999). The psychological impact of reproductive difficulties on women's lives. *Sex Roles*, 40, 767–787.