

The experience of early miscarriage from a male perspective

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Accepted for publication 5 July 1997

Summary

- In the literature there is increasing awareness of the psychological consequences of early miscarriage for women.
- However, there is little on the feelings, needs and experiences of men whose partner has had an early miscarriage.
- This paper aims to describe the experience of early miscarriage from a male perspective using a phenomenological approach.
- Seven categories related to the experience of early miscarriage are discussed: Feelings, Loss, Characteristics and differences between men and women, Staff action and attitudes, What to do?, Coping and Time.
- Based on an awareness of the needs of both partners, it is suggested that nurses have a key role to play in delivering effective interventions after early miscarriage.

Keywords: early miscarriage, men, phenomenology.

Introduction

This paper aims to add to the understanding of early miscarriage by discussing the experience from a male perspective. In this paper, miscarriage is defined as spontaneous abortion with expulsion of the fetus before 24 weeks gestation (Stewart & Dent, 1994). Early miscarriage refers to pregnancy loss of up to 16 weeks gestation (Houwert de Jong *et al.*, 1990). Miscarriage is thought to be very common, with one in four pregnancies being affected (Everett *et al.*, 1987), and it is now increasingly evident that there can be adverse psychological consequences of a miscarriage. However, the focus in the literature is primarily on the woman and her perception and experience of the event, with little consideration given to the experience from a male perspective. Although there has been increasing pressure on men to assume a more active role in the process of childbirth and parenthood, their feelings, needs and expe-

riences relating to early pregnancy loss have been largely ignored. The aim of this study therefore was to describe the experience of early miscarriage from a male perspective utilizing a phenomenological approach. An overview of the relevant literature is presented, along with pertinent methodological considerations and a presentation of the main findings. It is contended that in order to provide appropriate sympathetic and holistic care after early miscarriage, the feelings and needs of both partners need to be considered.

Literature review

THE EXPERIENCE OF EARLY MISCARRIAGE FOR WOMEN

Increasingly, in the literature, attention has been paid to the psychological consequences of a miscarriage for women. Anecdotal accounts (Borg & Lasker, 1982; Oakley *et al.*,

1984; Moulder, 1990; Wright, 1994; Shuttleworth, 1995) reveal that miscarriage for some women can be an extremely painful and upsetting experience. Women describe their feelings of anguish, distress and pain, with some graphically describing their sense of loss, which is profound and deeply felt. The reaction to miscarriage seems to be unique to the individual and does not appear to be related to the gestational age of the baby (Peppers & Knapp, 1982). For some women miscarriage may come as a relief, but for others it is appropriate to consider miscarriage as loss (Oakley *et al.*, 1984; Leon, 1990), and this loss can provoke a grief-like reaction. Early miscarriage can be considered as an intangible loss with no formal mechanism, at least in Western societies, that allows the expression of grief through, for example, the ritual of a funeral. Models of grieving described by Parkes (1986) and Kubler-Ross (1987) can provide a useful framework for understanding such a reaction to miscarriage. However, Mander (1994, p. 6) warns that while these may offer a 'general pattern of grieving', it is important to recognize that not all individuals will fit neatly into these patterns.

Several authors have attempted to take a more systematic approach to identifying the psychological consequences of a miscarriage for women. Such consequences include depression (Friedman & Gath, 1989; Harker, 1993; Prettyman *et al.*, 1993), a grief reaction (Turner, 1991), and anxiety (Thaper & Thaper, 1992). However, many difficulties arise when reviewing such studies, and these may be summarized as follows:

- 1 Many studies consider both first and second trimester miscarriages together. It is not possible, therefore, to ascertain whether a miscarriage in the first trimester has more or less impact than one in the second.
- 2 There are variations in the time in which the women are followed up after the miscarriage has occurred. These range from four weeks to six months, with few studies providing a longer follow up. One longer follow-up study is reported by Cordle & Prettyman (1994), who found that two years afterwards the majority of the women surveyed were still upset by thoughts of the original miscarriage.
- 3 There appear to be methodological difficulties in attempting to identify and control all the variables in an individual's life that could affect the woman's response to miscarriage. However, as Prettyman (1995) concludes, there may be an important minority of women who are at risk of severe and enduring psychological problems after miscarriage.

Thus there is an increasing amount of literature that highlights the adverse effects of early miscarriage on women. However, despite this, a recurrent theme expressed

in the literature is criticism of health professionals for their apparent lack of awareness and support during and after hospital admission for women suffering a miscarriage (Campbell, 1988; Sands, 1991; Prettyman, 1995).

MALE PERSPECTIVES

There is little in the literature that relates specifically to men's experiences of an early miscarriage. The focus appears to be either on women's experiences or on men only as part of a couple or within a family unit (Lasker & Toedter, 1991; Cecil, 1994). If the man is mentioned at all, this is usually restricted to a small section or paragraph within a paper (Lewis, 1992; Stewart *et al.*, 1992).

A recent paper by Miron & Chapman (1994) is one of the few studies to focus specifically on the experience of early miscarriage from a male perspective. Using a grounded theory approach, they conducted in-depth interviews with eight Canadian men whose partner had had an early miscarriage. A key part of their findings identified that miscarriage for some men evokes strong feelings of sadness, loss and anger. Additionally, there was an expectation that men would support their partners, and from this the authors developed a 'theory of supporting'. They concede, however, that further research, preferably with a larger sample, would be needed to test the theory, particularly regarding its transferability to men's experiences of other forms of pregnancy loss. The authors conclude that health professionals need to understand what the experience means to both partners and to assist men to fulfil a supportive role by supporting them.

Additionally, Lasker & Toedter (1991), in developing and testing a perinatal grief scale, conclude that men are at risk of developing a chronic grief response because they are less likely to receive support and understanding.

Other accounts in the literature related to men and early miscarriage tend to be anecdotal (Borg & Lasker, 1982; Leroy, 1988; Kohner & Henley, 1991; Kohn & Moffitt, 1992). Kohn & Moffitt (1992), for example, consider men's experiences after a miscarriage. They acknowledge that men can 'bond' with the fetus in the early stages of pregnancy and can grieve as women do at the loss of the baby. However, there are pressures for men either not to grieve or, if they do, to recover quickly so as to remain strong for the woman.

Thus, despite increasing awareness of the impact of miscarriage on women, there is little in the literature that explores men's feelings after an early miscarriage. The purpose of this study, therefore, is to describe the lived experience of early miscarriage from a male perspective.

Methodology

A phenomenological approach based on the work of Husserl (1960) is taken. Underpinning Husserlian phenomenology is an assumption that in experiencing a phenomenon there is a basic 'essence' to the experience that is shared by all. The essence of the experience therefore is captured and a phenomenological description provided. Farber (1966), in discussing Husserl's approach, indicates that it is primarily a method of philosophy concerned with discovering how consciousness is experienced by the subject.

There are many different forms of phenomenology as other scholars have taken and modified Husserl's ideas. Heidegger (1962), for example, offered a significant modification of the phenomenology of Husserl. The phenomenology of Heidegger contends that it is not possible to view the world objectively, but that knowledge and understanding are needed to make sense of the world. Rather than attempting to search for commonalities in understanding, the task of the phenomenologist using this approach is to identify the uniqueness of the experience for individuals.

Spiegelberg (1982) describes the major steps in phenomenology (see Table 1). The first step in the phenomenology of Husserl is bracketing. Phenomenology begins in silence (Farber, 1966) so that the researcher can clear their consciousness to see the phenomenon they are attempting to describe. If this is to be accomplished, it requires intellectual discipline in order, as Husserl suggests, to suspend and bracket all preconceptions so that pure consciousness remains and the 'essence' of the phenomenon is uncovered. It is acknowledged that it is almost impossible to be entirely free from preconceptions but it is desirable and possible to control them in order to view the phenomenon under study. In this study, therefore, the literature relating specifically to men's experience of early miscarriage was not read until the analysis was complete. It was recognized that ideas from the literature on women's experiences and the researcher's own experience could have influenced her perceptions on this issue. Every attempt, however, was made to identify preconceptions in order to facilitate the process of bracketing and allow the next stage of intuiting to proceed.

Rizzo-Parse *et al.* (1985, p. 20) describe intuiting as being able to 'grasp the uniqueness of the phenomenon by

openly looking, listening and feeling'. The third stage, analysis, was facilitated by using Colaizzi's (1978) phenomenological method of data analysis as described by Beck (1994). Dialogue with the participants to validate the description of the phenomenon is seen as an essential step in Colaizzi's method of analysis. Once analysis of the transcripts was complete, the themes and clusters were identified and ordered into categories, which were then returned to the participants for verification. Four of the five participants returned the categorization of their interview unchanged, and only one suggested some minor changes. In addition, an 'expert witness' was asked to review the transcripts and perform categorization independently. A final report of the findings was sent to the participants in order to ascertain, as Oiler (1982) recommends, that they are recognized as 'true' by the individuals who had the experience.

The final step is to provide a description of the phenomenon in which its major characteristics are identified (Rizzo-Parse *et al.*, 1985).

Finding participants

The original plan was to recruit men whose partners had had an early miscarriage within the six-month period before the study began. This time period was selected on the basis of Harker's (1993) work which suggested that, at least for women, six months later was an optimum time for exploring the experience of a miscarriage.

Lee (1993) argues that there is a taboo in Western cultures surrounding sex, reproduction and death. Miscarriage embraces all three of these areas and is potentially a very difficult issue to research. Consequently, recruiting men to the study proved to be more problematic than had been anticipated. Initially, formal approaches were made to local branches of national charities concerned with education for parenthood and miscarriage for permission to explain to their members the nature and purpose of the research. It was hoped that by approaching women first they would 'sell' the idea of participating in the research to their partners. This proved to be completely unsuccessful. Women themselves were eager for their partner to participate but men were unwilling. After discussion and reflection several reasons were suggested for this. It may have been that talking about their feelings concerning miscarriage was too threatening. Conversely it may have been that they felt there was no need to talk about the event as they did not regard it as significant. It was also considered by the researcher that the time limit of up to six months after the miscarriage was too restrictive and too close for the participants to feel comfortable discussing their experi-

Table 1 The steps of phenomenology (Spiegelberg, 1982)

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|---|------------|
| 1 | Bracketing |
| 2 | Intuiting |
| 3 | Analysing |
| 4 | Describing |

ence. Accordingly, the time limit was increased to one year after the event, but again there was no response. Eventually it was resolved to abolish the time limit and widen the criteria to any man whose partner had had an early miscarriage. As more formal approaches had failed, the technique of 'snowballing' was used (Laws, 1990; Lee, 1993). Initial contacts are identified, and through their network of contacts further participants were identified. Eventually, five men agreed to participate in the research. The partners of the men had had at least one early miscarriage and this had occurred more than two years prior to the interview.

Gathering the data

The data were collected through the use of an unstructured interview. Initially, a preliminary interview was arranged to explain the purpose and format of the research and to obtain consent. Measures taken to preserve confidentiality and anonymity were discussed, and it was emphasized that participants could withdraw at any time without penalty.

The second interview was unstructured to allow participants the opportunity to tell their story. In this second interview all participants were asked the following question:

Can you tell me what happened when your partner had the miscarriage and how you felt about the experience?

Interviews lasted between 30 minutes and one hour and all were tape recorded.

Findings

After reading and rereading the transcripts, discussion with the expert witness and in light of the participants' responses, seven categories relating to the men's experiences of early miscarriage were eventually identified (see Table 2).

FEELINGS

This is the largest category and relates to feelings that participants expressed about the experience (see Table 3).

Table 2 Categories identified

Feelings
Loss
Characteristics and differences between men and women
Staff action and attitudes
What to do?
Coping
Time

Table 3 Feelings

Early feelings	Later feelings
Shock	Anger
Disbelief	Hurt
Upset	Frustration
Helplessness	Anguish
Hope	Guilt
	Concern
	Nothing
	Relief
	Alone
	Bereaved

A miscarriage can be a sudden, unexpected event that some participants were completely unprepared for. They described feelings of shock, disbelief, upset and helplessness: 'I couldn't believe it was happening to us' (Participant 5).

These initial feelings of shock and disbelief gave way to and merged with later feelings. Here the men described anger, hurt, frustration, anguish, guilt and confusion, with all feeling concern for their partners, who were crying and upset by the experience.

Each participant had a particular set of feelings that seemed to predominate: feelings of frustration and anguish, feelings of anger, feelings of helplessness, feelings of loss and bereavement, and feeling alone. For one participant in particular, although he felt concern for his partner, there was also a sense of relief that the miscarriage had occurred:

I also have felt in some respects somewhat relieved by not getting pregnant, in the sense that it – there's some security in what you already know (Participant 4).

All these feelings are in accord with those identified in the Miron & Chapman (1994) study, including those of the one man who felt relief at the loss of the pregnancy.

LOSS

In the men's accounts of the experience, they all noted and recognized that it was the vaginal blood loss that could signal the end of the pregnancy. However, as the analysis continued it soon became clear that miscarriage meant a more complex form of loss in that it represented the loss of future hopes and expectations:

You tend to picture the future, and it becomes clearer when you discover your wife's pregnant, so, you know, that's all gone, so there's definitely a loss (Participant 3).

Having children was seen as an important dimension of

being 'normal' in this society and thus the process of becoming a father and having a family was threatened by the miscarriage.

CHARACTERISTICS AND DIFFERENCES BETWEEN MEN AND WOMEN

There was a view shared by four of the five men that women have stronger and more intense feelings about miscarriage than men. They tended to explain this in physiological terms, commenting that the effects of hormones in early pregnancy are influential on women's emotions and their reaction to the loss. For men, however, there is an expectation that they should be stronger and tougher in order to support their partner and have no need to grieve or share their feelings:

I always had to be strong, so I always put my fear to the back of my mind – and I did after the initial shock – because it was simple to put the fears to the back of my mind and get on – with my life (Participant 5).

STAFF ACTION AND ATTITUDES

All of the participants' partners were admitted to a hospital for management of the miscarriage. For three participants this was considered to be helpful in that they were reassured that their partner had suffered no physical ill effects and would recover. However, four of the five participants also highlighted important negative aspects to hospital admission, primarily in relation to the way that medical staff had broken the news of the baby's death.

One participant related how after the scan they were asked to wait in a corridor:

They called us back in and, they said to us you know – the baby's dead kind of thing and uhm that to me was the most horrendous one without a doubt. I don't know if I was hard before but it was, it seemed so cold and calculated, and you know we both cried and we just went, simple fact was he said to go up to ward whatever it was in (hospital), you know and have a D and C, such is life, kind of thing (Participant 5).

He felt that there appeared to be no evidence that hospital staff were aware of the distress that he and his partner were suffering and how devastating the news was.

Another common theme expressed by four of the five participants was that the hospital experience meant that they were not treated as individuals. One participant described how their partner was labelled as 'the D and C in bed three'. Additionally, they felt that a miscarriage was seen as a kind of 'run of the mill' situation that did not deserve any special priority. One participant was told that

'we get five or six of these a day'. For these men, then, the misery of the miscarriage was compounded by the hospital experience.

These are not new problems relating to patients' hospital experience. There is some evidence (Campbell, 1988; Hutti, 1988; Jones, 1990; Wright, 1994) to suggest that hospital staff appear to be unable to cope with the emotional needs of these patients. It may be that staff are unaware of the emotional consequences of early miscarriage or that they may not have the necessary bereavement and counselling skills to help. Additionally the rush in surgical units to get patients to and from theatre may mean staff may have less opportunity to develop a supportive relationship with the woman and her partner.

WHAT TO DO AND COPING

To the men, the miscarriage was an extremely difficult situation. Their partners were crying, distressed and they were not sure how to handle the situation. They wanted to help their partners, but were concerned that their actions might make things worse:

It's hard when anybody's having a tough emotional time to . . . figure out what you should do yourself so as not to make matters worse, support them but not bring matters up that sort of thing (Participant 4).

They tried to comfort and console their partners, organizing distractions such as holidays, trying to stay positive, looking forward and focusing on their work. A common coping strategy the men used was to ignore things, try to forget the miscarriage and carry on with life as normal.

All participants also commented that they felt very alone in trying to cope with the experience. Most of the support they did get came from friends, family and their partner but not from health professionals. There was a suggestion that there should be more awareness among health professionals of the emotional impact of a miscarriage.

I think we both, we're both saying that if we'd had a little bit more counselling or support after the first one (miscarriage). . . . I think we felt left alone a bit too much (Participant 3).

TIME

Participants were recounting experiences that had happened two or more years ago. Despite some difficulties remembering the sequencing of some events, they could recall how they felt and how these feelings and emotions changed. For three of them, the passage of time was seen as healing, as the memory of miscarriage faded and subsequent children were born. For one, the passage of time rep-

resented the loss of hope that another child would be born. For another, despite the birth of another child, the memory remained painful.

Discussion

MISCARRIAGE AS BEREAVEMENT

The experience of early miscarriage, then, for these men was remembered vividly through the feelings evoked. For many there was a sense of sadness and loss, coupled with an uncertainty as to how to handle the situation. As well as coping with their own feelings, they were aware of an expectation and a need to support their partner. Additionally, there was a perception that early miscarriage provoked a more intense reaction for their partners than for themselves. The main focus of the findings supports the work of Miron & Chapman (1994).

Although the literature on men's experiences after early miscarriage is limited, there appear to be parallels between the experiences described by men in this study and other studies looking at the wider area of perinatal and neonatal loss. For example, Hughes & Page-Lieberman (1989) aimed to describe the experience of 51 fathers who had experienced perinatal loss (defined in the study as loss of an infant from the 28th gestational week). The categories and themes generated were similar to those identified in this study. These men also described the need to keep their feelings (of sadness, loss and anger) suppressed in order to support their partners. They also felt that the intensity, duration and expression of their grieving was different from and less than those of their partners, who were so obviously distressed by the experience.

Kimbire (1991) in a qualitative study exploring eight fathers' experiences after neonatal death (death of a live born infant within 28 days after birth), identifies similar themes. Again, feelings seemed to predominate, with these men also describing shock, anger, distress, sadness, guilt and helplessness. Kimbire discusses how the men felt alone in this experience, with few people available to support them. The men also identified that they felt there was a different pattern of grieving between themselves and their partners, again relating to the intensity, duration and expression of grief. The findings reported in these two studies are also supported by anecdotal accounts of men's experiences after perinatal and neonatal loss (Borg & Lasker, 1982; Leon, 1990; Kohner & Henley, 1991; Mander, 1994).

Some key themes emerge, therefore, from the literature on perinatal and neonatal loss. These appear to be similar to those identified in the present study and the work of Miron & Chapman on men's experiences after early mis-

carriage. Firstly, as Peppers & Knapp (1982) suggest, the feelings experienced appear to be similar regardless of the gestational age of the baby. Such feelings were also reported in Parkes' (1986) and Littlewoods' (1992) accounts of other bereavement situations, and those detailed by women experiencing early miscarriage (Oakley *et al.*, 1984; Moulder, 1990).

Secondly, men appear to recognize that there is a need and an expectation that they should suppress their own feelings in order to support their partner. Again, anecdotal accounts from men who have experienced perinatal and neonatal loss (Borg & Lasker, 1982; Kohner & Henley, 1991; Mander, 1994) suggest that men are restricted in their expression of grief when their baby dies. Such expression of feelings was also difficult for the men in the present study. All indicated that they felt concern for their partners who were upset after the miscarriage, but were cast in the role of supporter and comforter to their partners which they found difficult. Mander (1994) considers that men learn this role through the powerful process of socialization. However, this expectation to be strong may hinder the expression and eventual resolution of grief. Concern for their partner, the need to be strong and cultural expectations of appropriate male behaviour may mean that a man experiencing grief after miscarriage, perinatal and neonatal loss may not receive appropriate support.

Finally, there appear to be differences between men and their partners in terms of the nature, intensity, duration and expression of grief. Again, some of the men in this study and in the Miron & Chapman study report that their partner's grief was more intense than their own. They also felt that their partner took longer to 'recover' than they did.

THE REALITY OF THE BABY

The intensity of men's grieving may be related to the extent to which the fetus seems 'real' to them. This was an important concept expressed by the participants in this study. For example, the participant who felt nothing but relief was also able to explain this in terms of whether the baby seemed real or not, and whether he had become 'mentally engaged' with the idea of being a father:

I don't really feel for me, it had really struck me yet, that we were about . . . going to have a baby. You know to say that you're going to is one thing . . . to actually realize it's going to happen is another thing (Participant 4).

May (1982) suggests that for most of the pregnancy the man is in a 'not real not mine' phase and it is only in the later stages of the pregnancy that the baby becomes real to him. However, Sandelowski & Black (1994) suggest that if

the man attends the ultrasound in early pregnancy then he is almost in the same position as the women in terms of 'knowing' and accepting the reality of the baby. Certainly, for one participant the early scan was an important part in making the baby real to him:

We were able to see the scan, get a photograph of it – the whole thing became real (Participant 3).

Implications for practice

Although the findings of this study cannot be generalized to a wider population, some tentative considerations related to practice are put forward. Firstly, there needs to be increased awareness of the emotional impact of early miscarriage on both partners in order that more appropriate care can be given. There should be a recognition that potential parents as individuals are unique in terms of their response to the loss, and that early miscarriage should never be regarded as routine and 'run of the mill'. Attention also needs to be focused on effective interpersonal skills of health professionals, particularly in terms of how bad news is broken. Care given in the hospital environment can have an influence on the grieving process (Tom-Johnson, 1990). There should be a co-ordinated response in terms of provision of care after miscarriage. As Prettyman & Cordle (1992) highlight, there appears to be some uncertainty among community teams as to who is the most appropriate team member to provide follow up for couples if this is desired.

Finally, in participants' accounts nurses were virtually invisible, appearing to play no major role either as a positive or negative force. Nurses in hospital or the community have the potential and opportunity to take the lead in developing effective proactive interventions based on an awareness of how early miscarriage may affect both partners. Guidelines such as those offered by SANDS (1995) can provide a useful framework for delivering effective interventions.

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