

WOMEN'S PERCEPTIONS OF NURSING CARE AND MANAGEMENT
AFTER FIRST TRIMESTER MISCARRIAGE

by

JENNIFER R. MCGEE

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Thesis Chair: Mrs. Leslee A. D'Amato-Kubiet

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ABSTRACT

Spontaneous abortion, or miscarriage, is an event that affects approximately one in four women during their reproductive years. Despite the psychological and physiological trauma associated with the loss of pregnancy, few evidence-based practice recommendations exist to guide nursing care of women experiencing first trimester miscarriage. The purpose of this integrative review of literature was to examine research related to women's health care experiences of first trimester miscarriage and discuss common themes relating to nursing care. Inclusion criteria consisted of peer review research articles published after 2001 and available in the English language and women that experienced miscarriage during the first 12 weeks of pregnancy. Current literature was collected from Cumulative Index of Nursing and Allied Health Literature (CINAHL), MEDLINE- EBSCOhost and PsycINFO databases using combinations of various key words. Six qualitative studies and one quasi-experimental study met the inclusion criteria and were reviewed. The results indicated that nursing care of women experiencing miscarriage should include therapeutic communication, psychological support, and provision of information and follow-up care. While there is little research reviewing nursing interventions related to first trimester miscarriage, these themes may help guide the development of further research reviewing the efficacy and effectiveness of specific nursing interventions.

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INTRODUCTION

Spontaneous abortion, or miscarriage, is a common loss that many women throughout the world experience during their childbearing years. In the United States, approximately one in four women will experience a miscarriage, the most common type of pregnancy loss according to the American College of Obstetricians and Gynecologists (ACOG) (2011). A miscarriage, or spontaneous abortion, is commonly defined in the United States as the spontaneous loss of a fetus before the 20th week of pregnancy ("Miscarriage," 2010). While it is estimated that half of all fertilized eggs are spontaneously lost before a woman may know she is pregnant, approximately 15-20% of known pregnancies end in miscarriage ("Miscarriage," 2010) with 80% of miscarriages typically occurring before the 12th week of pregnancy (Gerber-Epstein, Leichtentritt, & Benyamini, 2009).

For women of reproductive age, pregnancy can represent the realization of a dream or an unexpected event in a woman's life; however, pregnancy and subsequent miscarriage are both highly emotional occurrences for any woman. While a woman is adjusting to being pregnant and preparing for the physiologic and emotional changes that occur with pregnancy, a miscarriage abruptly ends the usual progression of her pregnancy (Gerber-Epstein et al., 2009). The actual loss of pregnancy can affect women experiencing miscarriage in many physiologic and emotional ways. Miscarriage can also put a strain on relationships with spouses, partners, and friends, which often compounds emotional stress related to the woman's condition (Séjourné, Callahan, & Chabrol, 2010).

Problem

Miscarriage is a highly traumatic loss for many women (Gerber-Epstein et al., 2009; Murphy & Merrell, 2009; Séjourné et al., 2010). Despite the relative frequency of this event, few evidence-based practice guidelines exist to guide nursing practice in caring for women experiencing miscarriage in the first trimester of pregnancy. Many women express feelings related to inadequacy and being abnormal when they discover they are losing their pregnancies (Gerber-Epstein et al., 2009). Despite the amount of psychological and physiologic trauma a miscarriage can cause a woman, grief and bereavement support services commonly available for fetal death occurring after 20 weeks of gestational age are often not available for women experiencing miscarriage before 20 weeks gestation (Séjourné et al., 2010).

Women naturally express emotions of grief and loss following miscarriages that occur during any stage of pregnancy. During this time, many women also express dissatisfaction with their health care experience and the health care team. According to Murphy and Merrell (2009), areas of dissatisfaction included long wait times for treatment and poor communication of information and instruction. In a study completed by Séjourné et al. (2010), 86% of women in their sample (264 out of 305) were dissatisfied with the information provided about miscarriage, especially the psychological aspects of miscarriage.

Nurses spend a great amount of time caring for women during the miscarriage experience, more so than many other members of the health care team. In this role, nurses are ideally positioned to serve as a liaison between the woman post-miscarriage and related support services. As such, nursing care of the woman experiencing miscarriage is of utmost importance to the overall satisfaction and well-being of the woman's health during and after miscarriage.

Purpose

The purpose of this thesis was to conduct a comprehensive review of the literature and examine research describing different women's experiences of first trimester miscarriage. Common themes regarding psychosocial support and nursing care that emerged from these studies were discussed and reviewed. These findings further help define the role of the nurse providing care to these patients and provide direction for further research.

Method

A review of literature and synthesis of current research related to women's experiences during miscarriage in the first trimester was conducted. Current literature was collected from Cumulative Index of Nursing and Allied Health Literature (CINAHL), MEDLINE- EBSCOhost and PsycINFO databases. Inclusion criteria for this thesis consists of women having experienced a miscarriage during the first 12 weeks of a pregnancy, peer-reviewed articles, published after 2001 and available in the English language. Combinations of the following keywords: "miscarriage", "spontaneous abortion", "perinatal loss", "support", "satisfaction", and "patient care" were used. Conclusions from studies whose sample includes women who had a miscarriage later than the 12th week were included when the majority of the sample experienced miscarriage before the 12th week. Only results pertaining to first trimester losses were closely examined for this thesis.

BACKGROUND

The experience of miscarriage during pregnancy, particularly in the first trimester, is complicated for women and can affect their physical and psychological well-being. The physical loss of the fetus and the associated grief that goes along with miscarriage are highly complex conditions. Considering the loss is an unexpected one, it represents a rapid transition from a state of expectation and hope, to a state of death and grief. Early miscarriage is a common occurrence and is being more frequently identified by women because they can see positive results on a sensitive home pregnancy test even before a missed period (Stephenson, 2008). Many pregnancies at this early stage result in miscarriages that women are able to recognize as loss of a fetus, much more so than in the past. Certain risk factors exist that can predispose a woman for miscarriage. Likewise, complications can arise from the miscarriage itself or the medical and surgical treatment of the condition.

Risk factors

The risk for miscarriage increases as maternal age increases. The risk for miscarriage for any pregnancy with maternal age below 35 is about 20%, but may increase to as much as 80% by age 45 (Mayo Clinic, 2010). Also, a past medical history of more than one miscarriage also puts the woman at an increased risk of subsequent miscarriages (Mayo Clinic, 2010). Other risk factors for first trimester miscarriage include: smoking and tobacco use, excessive alcohol consumption, and physical conditions such as a short cervix. Likewise, endocrine disorders such as diabetes and thyroid imbalances, also place women at greater risk for miscarriage in the early stages of pregnancy (Mayo Clinic, 2010). In a cohort study performed with women between

gestational weeks 4 and 12 who had no obvious risk of miscarriage, several common factors were identified. These risk factors included: advanced maternal age (>33), lower body mass index, low serum progesterone concentrations and perceived higher levels of stress (Arck et al., 2008). To date, few studies have addressed post-miscarriage education performed by nurses that address risk factors identified prior to becoming pregnant.

Complications

Miscarriage can be categorized into four possible scenarios including threatened abortion, inevitable abortion, incomplete abortion, and complete abortion. When a woman is diagnosed with a threatened miscarriage, she can experience mild cramping and a small amount of vaginal bleeding, but will not have passage of fetal tissue and the cervical os will remain closed and intact (Ricci & Kyle, 2009). In a woman diagnosed with an inevitable abortion, there is characteristically heavy vaginal bleeding, cervical dilation, rupture of amniotic membranes, and possible passage of fetal tissue (Ricci & Kyle, 2009). With an incomplete abortion, there is leftover tissue left in the uterine cavity and this tissue can become infected and lead to sepsis, causing symptoms of fever, cramping, and excessive bleeding (Mayo Clinic, 2010). In the case of incomplete abortion, medical or surgical treatment may be recommended. Surgical treatment of inevitable and incomplete abortion may involve a dilation and curettage (D&C), which involves dilation of the cervix and surgical evacuation of the remaining tissue. This procedure can cause damage to the cervix and negatively affect future fertility. To date, few studies have addressed nursing care following a D&C. In a complete miscarriage, or spontaneous abortion, all

products of conception have exited the body, while in an incomplete abortion, some products of conception still remain in the body.

Psychological morbidity

Current research shows that the psychological consequences of miscarriage are common to all women following a miscarriage event and can be quite severe in some cases. Underlying problems with psychological care following miscarriage range from lack of emotional and physical support, lack of mental health screening following the event, and lack of follow-up care by the health care team. Patients experiencing later perinatal loss are typically offered psychological support however; women experiencing early miscarriage may be offered no psychological counseling or assistance at all. According to Lok and Neugebauer, this can be due to an assumption that women in the early trimester of pregnancy are unlikely to become attached to their pregnancies and do not think of the fetus in terms of being a viable life (2007). In reality, the grief associated with the loss of an early pregnancy is just as substantial as the grief associated with the death of a loved one (Lok & Neugebauer, 2007). Many studies have demonstrated that miscarriage is regarded by women as a more painful type of bereavement, because it occurs unexpectedly and is often the cause of unexplained factors (Evans, 2012). Few studies have explored the psychological consequences of miscarriage in the first trimester and even fewer have researched the effectiveness of specific psychological interventions provided by nurses. Thus, practice guidelines involving emotional and psychological support during miscarriage by the health care team are lacking.

RESULTS

Numerous studies were reviewed prior to selection for inclusion in this integrated review of literature. Seven studies related to the nursing management of miscarriage were included for clarification of the topic. All studies examined the experience of women having miscarriages occurring within the first trimester of pregnancy. Six of the study designs used qualitative methods of research including interpretative phenomenology, narrative analysis, ethnography, descriptive phenomenology, descriptive methodology, and grounded theory. One of the seven articles chosen for inclusion used a quasi-experimental design to capture quantitative data related to nursing care after miscarriage in the first trimester.

Therapeutic Communication

The theme of therapeutic communication emerged as an area lacking in nursing care of women experiencing miscarriage. Four of the seven articles closely examined the relationship of communication between clinical staff and their patients as a causative factor in women's dissatisfaction with their health care experience. In the first study, ethnographic methods were used to interview 8 women in a gynecological unit currently experiencing miscarriage or having experienced miscarriage in the past several years, as well as 16 hospital staff directly involved in caring for these women (Murphy & Merrell, 2009). Interviews with study participants occurred in their homes and focused on the experience of having a miscarriage as well as the treatment and care they received following the event (Murphy & Merrell, 2009). Staff interviews took place on the unit and focused on interventions and care provided (Murphy & Merrell, 2009). Results from this study suggest that miscarriage is not regarded as bereavement by all women or

health care staff; rather, the loss of the pregnancy and the subsequent grief surrounding the miscarriage would be better communicated from the woman to the health care team by a transition model, allowing for a wider psychological perspective for emotion (Murphy & Merrell, 2009).

In another study, narrative analysis was used to examine the responses of 19 women who experienced miscarriage in their first pregnancy (Gerber-Epstein, Leichtentritt, & Benyamini, 2009). During the interviews, the women in this study expressed that miscarriage is an individual experience, and as such, differs in progression and extent of grief (Gerber-Epstein et al., 2009). Communication between health care staff and women must respond to a diverse spectrum of grief and refrain making assumptions. For many women, the newness of the pregnancy and the fact that it felt like dream or expectation, rather than a reality, made their grief seem invalidated. Health care professionals may need to help validate the grief associated with loss of pregnancy in the first trimester through their communication, no matter the length of pregnancy or that it was only of brief duration (Gerber-Epstein et al., 2009).

In a study employing the use of interpretive phenomenology, 13 interviews with women treated at a clinic in Sweden were transcribed and examined for related themes and clusters of information (Adolfsson, Larsson, Wijma, & Berterö, 2004). Several themes related to therapeutic communication were identified. A number of the women interviewed were disturbed by the treatment they received from staff, including perceptions derived from verbal and non-verbal communication that their miscarriage was regarded by staff as a commonplace event and that their grief was inappropriate and insignificant (Adolfsson et al., 2004). Study participants felt negative and belittling attitudes towards first trimester abortion were communicated through the

health care staff's body language, such as shuffling feet and lack of eye contact, combined with a lack of empathy expressed through inappropriate remarks. Women also reported the negative perception towards expressed grief from first trimester miscarriage deterred them from contacting staff after discharge (Adolfsson et al., 2004).

In another study examining both patients and health care personnel, grounded theory was employed to gain insight from 100 women admitted to a gynecological unit (Wong, M.K.Y., Crawford, T.J., Gask, L., & Grinyer, A., 2003). The study took place in three stages including: initial Hospital Anxiety and Depression (HAD) scores from women post-miscarriage; results from questionnaires and semi-structured interviews; and interviews with health care personnel in focus groups (Wong et al., 2003). The researchers concluded through these interviews that many women felt a lack of compassion from their health care providers (Wong et al., 2003). Wong et al. determined that some health care personnel may develop a pattern of communication based on the normalization of miscarriage as a common occurrence (2003). Communication between health care staff and women is lacking in areas of compassion, empathy and understanding, and nursing care must address this absence of therapeutic communication.

Psychological Support

Three of the seven articles considered psychological support one of the main factors affecting women's dissatisfaction with care provided by their health care team and long-term ability to cope. In a quasi-experimental study including 134 female participants undergoing dilation and curettage (D&C) or vacuum aspiration (VA) for uncomplicated or unanticipated loss of pregnancy, the efficacy of three clinical support techniques were evaluated. Support

techniques included the following: an empathic listening approach encouraging emotional expression; a psychoeducational approach helping women to understand normal psychological responses; and cognitive behavioral therapy including cognitive reframing and problem resolution (Séjourné, Callahan, & Chabrol, 2010b). Participants were split into two groups consisting of an Immediate Intervention (II) group and a Deferred Intervention (DI) group. The II group participated in a psychological session comprised of the previously stated support interventions on the day of their surgical intervention, while the DI group participated in the same type of support session at 3 months following their surgical intervention. The Hospital Anxiety and Depression Scale (HADS) and the Impact of Events Scale – Revised (IES-R) were used to evaluate psychological responses to miscarriage (Séjourné et al., 2010b). Results showed that women in the II group showed lower scores and less intense symptoms of depression, anxiety, and posttraumatic stress disorder (PTSD) than those in the DI group, which showed more clinically significant depressive symptoms (Séjourné et al., 2010b). This lack of psychosocial support after miscarriage puts women at risk for severe, lasting psychological consequences.

In a study examining several factors affecting provision of care, 19 women were asked open-ended questions regarding their miscarriage experience (Gerber-Epstein, et al., 2009). Women responded they felt the need to express to health care professionals that not all women will have a strong psychological support system, such as a partner, family, or friends, to rely on post-miscarriage for meaningful psychosocial support (Gerber-Epstein et al., 2009). In fact, 7 out of the 19 participants recommended turning to professional counselors as soon as possible after

the initial loss (Gerber-Epstein et al., 2009). Nursing care must address the type of support system women have following their miscarriage and the need for formal psychological support.

In addition to therapeutic communication, another qualitative study identified themes related to psychological morbidity (Adolfsson, et al., 2004). The overarching themes of “guilt and emptiness” were established as independent perceptions, as well as five subthemes including: feeling emotionally split; bodily sensation; loss; grief; and abandonment (Adolfsson et al., 2004). The researchers indicate that many women felt they were responsible for causing the miscarriage in some way, such as by allowing too much stress in their life, and that they viewed the miscarriage as a personal failure (Adolfsson et al., 2004). Women also expressed a feeling of intense loss, not just of an embryo or fetus, but the loss of child, the loss of motherhood, and the loss of their role as a woman (Adolfsson et al., 2004). The researchers identified that emotions related to early miscarriage can persist for months and even years; in some cases, they can be associated with a psychological diagnosis warranting professional assistance (2004).

Provision of Information and Follow-up Care

In addition to therapeutic communication and psychological support, results also demonstrated a need for provision of information regarding the miscarriage itself, discharge information, and follow-up care. Four of the seven selected articles identified provision of information and follow-up care as areas lacking in regards to patient satisfaction and need. In an exploratory study, 305 women, ages 18-43, who had experienced one or more miscarriages completed an online questionnaire evaluating women’s preferences regarding interventions following miscarriage by using a 3-point scale (Séjourné, Callahan, & Chabrol, 2010a). The

results demonstrated that 91% of responders would have desired more support following miscarriage than what they were offered and 86% of responders felt their follow-up medical appointments were insufficient to cover and address all of their questions and issues following miscarriage (Séjourné et al., 2010a). In addition, 79.9% of women chose answer choices “not enough” or “not at all” regarding their satisfaction with information provided about what can be expected following miscarriage (Séjourné et al., 2010a). Regarding follow-up care, 93.4% of the sample chose “very useful” or “somewhat useful” when asked whether about the usefulness of being able to contact professional health care providers either by phone or internet when needed (Séjourné et al., 2010a).

Another study also explored data related to provision of information by using thematic analysis to draw conclusions from 172 detailed narratives from the UK National Women’s Health Study (Simmons, Singh, Maconochie, Doyle, & Green, 2006). The theme of “medicalization and the lived experience of miscarriage” emerged from their analysis and included the demonstration of need for more provision of clear information in these narratives (Simmons et al., 2006). Several of the narratives spoke of how unprepared many of these women felt for the actual event of miscarriage and the amount of bleeding they would experience both before and after the miscarriage (Simmons et al., 2006).

Several of the studies examined both women and health care personnel following early miscarriage, and the need for information and specific answers concerning miscarriage in the first trimester emerged as a major theme. Many women desired more specific answers to their questions, but in some cases realized that miscarriage does not always have a simple explanation (Wong et al., 2003). More specifically, Wong et al. also identified the need for a more detailed

follow-up plan of care after early miscarriage since many women were advised to seek further medical consultation only if they had any new medical problems develop (2003). Several participants identified their hospital stay as a difficult time to process information and the actual “blow” or realization of the miscarriage as coming much later, after their discharge (Wong et al., 2003). Adolfsson et al. also identified this problem among their participants as many women stated that they were simply incapable of handling more information at the time of their miscarriage (2004). Women felt that they would be a “disturbance” if they phoned the hospital to try and get more information later on (Adolfsson et al., 2004).

DISCUSSION

The purpose of this literature review was to examine the perceptions and attitudes towards nursing care and the health care team of women experiencing first trimester miscarriage and its implications towards future nursing care interventions. Results suggest that nursing interventions aimed at therapeutic communication, psychological support, provision of information, and consistent follow-up care, would greatly improve women's outcomes following miscarriage in the first trimester.

Therapeutic Communication

Study participants from 4 of the 7 articles expressed dissatisfaction with the communication or attitude displayed by staff. In particular, women felt that their grief was misunderstood or improperly interpreted by nursing staff and other health care providers (Murphy & Merrell, 2009; Gerber-Epstein et al., 2009; Adolfsson et al., 2004; Wong et al., 2003). There is a lack of awareness of body language displayed and patterns of communication used by health care staff (Adolfsson et al., 2004; Wong et al. 2003). Women interpreted nurses' body language that was not purposeful, such as lack of eye contact, as an indicator they were not important as an individual and did not warrant the nurses' time and care. Women also interpreted certain patterns of communication as an indicator that their condition was considered normal or common, rather than unique to their individual loss.

Although miscarriage can be a common occurrence, it is always important for nurses to validate an individual's emotional response to the event and to intervene with evidenced-based practice techniques for grief or physiologic needs when appropriate (Gerber-Epstein et al., 2009).

The perceived seriousness of the miscarriage should be congruent between the woman experiencing the miscarriage and the staff providing their care (Geller et al., 2010). Nursing care must also address the fact that women can react to their loss of pregnancy in different ways. Some women regard their loss as bereavement, while others do not (Murphy & Merrell, 2009).

Psychological Support

While some women would consider psychological care unnecessary following miscarriage, many women in retrospect consider that psychological care would have been helpful (Adolfsson et al., 2004; Gerber-Epstein et al., 2009; Séjourné et al., 2010b). Many women felt that after their miscarriage they experienced a loss of their role as a woman and a loss of self-esteem (Adolfsson et al., 2004). Research suggests that loss experienced from first trimester miscarriage is equally substantial as the loss of a loved one, such as a parent or child (Lok & Neugebauer, 2007). The loss of role beliefs and self-esteem combined with the grief of losing a pregnancy can contribute to the development of psychological morbidities such as depression, anxiety, and PTSD. The occurrence of psychological morbidities can be reduced by immediate therapeutic intervention in the arrangement of formal support with a grief counselor or psychiatric evaluation (Séjourné et al., 2010b). In addition to formal support, many women also identified their lack of an informal support system in the form of family and friends as a major contributor to the development of poor psychological outcomes (Gerber-Epstein et al., 2009). When psychological needs are identified and addressed earlier on, the potential for future psychological morbidities can be prevented.

Provision of Information and Follow-Up Care

Many women identified a need for more information about miscarriage in early pregnancy and formal follow-up instructions with health care providers following miscarriage (Adolfsson, et al., 2004; Séjourné et al., 2010a; Simmons et al., 2006; Wong et al., 2003). Specifically, women felt that they were not prepared for the actual event of miscarriage, including the amount of bleeding considered normal (Séjourné et al., 2010; Simmons et al., 2006). Information provided in both verbal and written forms may help promote recovery in women experiencing miscarriage (Stratton & Lloyd, 2008). Nursing care includes the responsibility to educate women about expectations after discharge and to assess the woman's understanding about the information presented to them by their health care provider.

Women also described the lack of a formal follow-up plan of care. Follow up care planning varied greatly following first trimester miscarriage. The range of follow up care extended from minimal follow up, with women being instructed to call their provider only if they had new medical problems develop, to more intense follow up, with others being offered next day well-woman evaluation (Wong et al., 2003). Due to negative perceptions of health care providers following early miscarriage, some women felt that they would be a disturbance if they called their provider or the hospital unit where they were discharged (Adolfsson et al., 2004). In addition, women perceived difficulty fully understanding health care instructions and information at the actual time of their miscarriage and before discharge from their health care facility, but they had many questions about miscarriage post contact with their providers. Many women desired a formal follow-up appointment to ask questions, receive information, and

discuss their experience (Stratton & Lloyd, 2008). Women need to feel that contact with providers or their health care facilities are available without feeling criticized or ridiculed.

LIMITATIONS

Limitations of this study include a lack of research regarding the appropriateness and effectiveness of specific nursing interventions for women post first trimester miscarriage. Many studies included small sample sizes, reducing the generalizability of their conclusions. Several studies employed thematic analysis in their interpretation of interviews with study participants, allowing for error in interpretation of content and meaning. In addition, all research studies reviewed for results were conducted in countries outside of the United States, including the UK, Wales, Sweden, Israel, and France. Conclusions from these studies may differ according to cultural values and perspectives.

RECOMMENDATIONS FOR NURSING

Psychological support through nursing care should begin with therapeutic communication and an awareness of the woman's psychological needs following the loss of pregnancy, specifically when the loss occurs in the first trimester. Communication between health care staff and women must allow for a broad spectrum of grief reactions to miscarriage and must not normalize the experience of miscarriage (Adolfsson et al., 2004; Gerber-Epstein et al., 2009; Séjourné et al., 2010b). Nurses should refrain from making comments that minimize women's emotions and should also avoid comments that provide false reassurance. Nursing care that addresses psychosocial needs by facilitating further formal psychological care and referring women to professional counselors and support groups in appropriate situations is highly desirable for many women experiencing first trimester miscarriage. Nurses are well positioned health care providers to support women with adequate information regarding physical symptoms in the weeks following the miscarriage and implications for conception and delivery in the future, increasing the responsibility of the nurse to confirm that women understand their discharge instructions and where to call with questions or concerns (Lok & Neugebauer, 2007). Nursing care of women following first trimester miscarriage is most meaningful when aimed at purposeful communication, when understanding of their loss of pregnancy is accepted, proactive follow-up instructions and care are offered, and when validation of individual psychological and physiologic needs of the woman are presented by health care providers in an open and non-judgmental manner.

APPENDIX: TABLE OF EVIDENCE

Table 1: Table of Evidence

Reference Article	Population	Study Design	Factors Examined	Intervention Details	Findings	Implications for Practice
<p>“Guilt and emptiness: women’s experiences of miscarriage”</p> <p>Adolfsson, A., Larsson, P.G., Wijma, B., & Berterö, C. (2004)</p>	<p>42 women were contacted who had been treated for miscarriage at a clinic in Sweden. 15 women responded and were interviewed. 13 interviews are used as the basis for this study. All women were above the age of 18 and had a pregnancy that lasted less than 16 weeks</p>	<p>Interpretive phenomenology</p>	<p>Using interpretive phenomenology, taped interviews were transcribed verbatim and examined for similar themes and clusters of information.</p>	<p>Patient interviews lasting between 45-100 minutes</p>	<p>The major theme identified as the essence of the experience of miscarriage was that of guilt and emptiness. Five other subthemes were identified: feeling emotionally split, bodily sensation, loss, grief, and abandonment.</p>	<p>Healthcare professionals need to be able to evaluate these women and understand how they should be care for emotionally.</p>
<p>“The experience of miscarriage in first</p>	<p>19 women who experienced miscarriage in their first</p>	<p>Narrative analysis</p>	<p>Examined responses to individual interviews using open-ended questions including questions concerning the</p>	<p>Individual interview</p>	<p>Five themes emerged from the interviews: the greater the joy the more</p>	<p>Participants stressed the need for positive social interaction in</p>

<p>pregnancy: the women's voices”</p> <p>Gerber-Epstein, P., Leichtentritt, R.D., & Benyamini, Y. (2009)</p>	<p>pregnancy, age 25-35, miscarriage occurred between weeks 6-15 of their pregnancy</p>		<p>time prior to the women's miscarriage, their loss and its effect on their personal life and interpersonal relationships, how they cope, and their recommendations to women who are experiencing miscarriage.</p>		<p>painful the crash; the nature and intensity of the loss; sources of support; life after the miscarriage; and recommendations to professionals.</p>	<p>response to miscarriage including emotional support, instrumental support, and informative support.</p>
<p>“Negotiating the transition: caring for women through the experience of early miscarriage”</p> <p>Murphy, F. & Merrell, J. (2009)</p>	<p>8 women in a hospital gynecological unit currently experiencing miscarriage or having experienced miscarriage in the past several years. 16 hospital staff involved in caring for women having miscarriages were also interviewed</p>	<p>Ethnography</p>	<p>Employed interviews with patients focused on the experience of having a miscarriage and the treatment and care they received. Staff interviews focused on their role in providing interventions and care to these patients.</p>	<p>Patient interviews took place in their homes and lasted between 35-90 minutes. Staff interviews took place on the unit lasting between 22-60 minutes</p>	<p>Women's reactions to the news of their miscarriage can be unpredictable and varied. Some patients felt that they were considered low priority in getting treatment as compared to other patients. Many women's emotional and physical needs were not met in a busy, surgical gynecological</p>	<p>Women experiencing miscarriage have varied emotional and psychological responses to their condition. A transition model better encompasses the emotions felt by these patients such as anxiety, shock, ambivalence, distress, and relief, than a model of grief</p>

					unit. Some women regard their miscarriage as an occasion for bereavement, while others regard it as a transition period.	would. This wider psychological perspective and reaction to miscarriage should better guide nursing care of these patients.
<p>“Support following miscarriage: what women want.”</p> <p>Séjourné, N., Callahan, S., & Chabrol, H. (2010a)</p>	<p>305 women, ages 18-43, most experienced a single miscarriage (63%) and most experienced miscarriage in the last 12 months (81%)</p>	<p>Descriptive phenomenology</p>	<p>Examines the necessity of post-miscarriage support in general and whether or not participants would have desired more support following their own miscarriage, as well as the effectiveness of several proposed interventions including: Informational brochure, in depth discussion with HCP, follow-up with psychiatrist/psychologist, information for suggested psychiatrists/psychologists, group therapy, psychological counseling, improved medical service delivery,</p>	<p>Online questionnaire using a 3-point scale</p>	<p>86% of respondents felt that their medical appointment was insufficient for addressing the questions and issues following miscarriage. The most common complication experienced by women following miscarriage was fear about future pregnancies (82.3%). Most</p>	<p>Most women experiencing miscarriage appear open to psychological support and counseling if it were more easily available. Women would like to have more positive contacts with HCPs and be more easily able to contact them. Many HCPs do not feel adequately trained for</p>

			possibility of contacting professionals at any hour.		women thought that an in-depth discussion with the HCP, group therapy, and the possibility of contacting professionals at any hour would be very useful.	dealing with the issues of miscarriage.
<p>“The utility of a psychological intervention for coping with spontaneous abortion”</p> <p>Séjourné, N., Callahan, S., & Chabrol, H. (2010b)</p>	134 women who had a DC or VA for the uncomplicated and unanticipated loss of a pregnancy	Quasi-experimental	66 participants in Immediate Intervention (II) group, 68 in the Deferred Intervention (DI) group, all completed the Hospital Anxiety and Depression Scale (HADS) and the Impact of Events Scale – Revised (IES-R) at 3 and 10 weeks as well as 6 months following study enrollment	Psychological support interventions from three clinical techniques (support, psychoeducation, Cognitive-Behavioral Therapy). II group received initial intervention on the day of their surgical intervention, and DI group received initial intervention at 3 months post-miscarriage.	Women in the II group showed lower scores and less intense symptoms of anxiety, depression and PTSD than those in the DI group at 3 weeks post-miscarriage. Significantly more women in the DI group showed clinically significant depressive symptoms at 10 weeks after the intervention.	Systematic counseling should be provided at the time of the event, with no delay, especially to women who are at higher risk for psychological distress or have specific circumstances predisposing them to greater difficulties in facing miscarriage.
“Experience	172 detailed	Descriptive	Emerging themes from	Thematic	Four themes	Women felt

<p>of miscarriage in the UK: Qualitative findings from the National Women’s Health Study”</p> <p>Simmons, R.K., Singh, G., Maconochie, N., Doyle, P., & Green, J. (2006)</p>	<p>narratives from the UK National Women’s Health Study (NWHS) which is a nationally representative survey of women’s reproductive histories.</p>	<p>qualitative</p>	<p>analysis</p>	<p>analysis of narrative accounts of miscarriage from the NWHS using systematic coding</p>	<p>emerged: (1) searching for meaning in miscarriage, (2) justification of motherhood, (3) medicalization and the lived experience of miscarriage, and (4) support.</p>	<p>they needed to identify a “cause” of the miscarriage. Care should be taken by HCPs in terminology used to describe the miscarriage, and the news should be communicated by competent, caring staff. HCPs need to be able to recognize both the physical and emotional pain of miscarriage. Care must be individually based.</p>
<p>“A qualitative investigation into women’s experiences after a</p>	<p>100 women admitted to a gynecological unit in a general hospital with the diagnosis</p>	<p>Grounded theory</p>	<p>The study took place in three stages: initial HAD scores from post-miscarriage patients, results from questionnaires and semi-structured interviews,</p>	<p>HAD (hospital anxiety and depression) scale, mailed questionnaires as 1 week and 8 weeks post-</p>	<p>Seven themes emerged: (1) need and desire for formal follow-up plans, (2) poor</p>	<p>The key factor in current dissatisfaction with care seems to be lack of communication</p>

<p>miscarriage: implications for the primary healthcare team”</p> <p>Wong, M.K.Y, Crawford, T.J., Gask, L., & Grinyer, A. (2003)</p>	<p>of miscarriage, age of 18 years, and ability to speak English as well as 71 healthcare practitioners</p>		<p>and finally interviews with HCPs in focus groups.</p>	<p>discharge, semi-structured interviews and focus groups with HCPs</p>	<p>understanding of initial events, (3)need for information and specific answers, (4)normalization of miscarriage by the HCP, (5)guilt and false assumptions, (6)variability of care and skills deficiency, and (7)suggestions for further improvement.</p>	<p>n. Certain attitudes of HCPs can also create barriers to communication and prevent the detection of psychiatric morbidity.</p>
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