THE EFFECTS OF MISCARRIAGE

ON SIX MARRIED COUPLES

By

KATRINA H. BRIGHT

Bachelor of Arts
University of Missouri
Columbia, Missouri
1971

Bachelor of Science in Education
University of Missouri
Columbia, Missouri
1971

Master of Arts in Education
Central State University
Edmond, Oklahoma
1976

Doctor of Philosophy
University of Oklahoma
Norman, Oklahoma
1982

Submitted to the Faculty of the Graduate College
of the Oklahoma State University
in partial fulfillment of the requirements
for the Degree of
DOCTOR OF PHILOSOPHY
July, 1986

THE EFFECTS OF MISCARRIAGE

ON SIX MARRIED COUPLES

Thesis Approved:

Alfred Dalbey
Thesis Adviser

Brent M. Snow

Bob Hahn

N. Jo Campbell

Norman N. Durham
Dean of the Graduate College

In loving memory

of

Jon Mynton Vermillion

1938 - 1983

ACKNOWLEDGMENTS

I have always loved education, and perceived myself to be a learner. In my many experiences in the educational process, I have been most fortunate to study and learn from caring, capable, concerned and professional individuals whose relationship with me has often taken on the characteristics of colleague. To them, I owe a debt of gratitude.

To the members of my committee, Dr. Bob Helm, Dr. Brent Snow and Dr. Jo Campbell, I say thank you for your encouragement, challenges and support throughout my work at Oklahoma State University. To my Chairman and Dissertation Director, Dr. Al Carlozzi, I extend heartfelt thanks for ceaseless support and understanding while I struggled with the demands of this work on both professional and personal levels.

To the medical staff who participated in this study and to the individual couples who gave of their time to share in this work, I am greatly appreciative. Without their willingness to cooperate, I would have found it impossible to do this study.

I also want to express my thanks to Theresa Hoffhines and Jeanie Caldwell who typed the manuscript to perfection. And to my husband, Dennis, who found it in himself to be present and active in this work, making this second doctorate possible. He has as always, my love and deep affection.

K.H.B.

TABLE OF CONTENTS

LIST OF TABLES

CHAPTER I

INTRODUCTION

Mental health practitioners have in recent years increased their attention to situational distress (Wiess, 1976). The realities of life involve all humans in some loss experience of significance throughout their lives (Stearns, 1984). Therefore most human beings will experience loss at one time or another and find themselves in crisis. A crisis is a situation in which a person faces an obstacle to a life goal that is insurmountable using ordinary methods of problem solving (Caplan, 1961). Crisis experiences evoke a multiplicity of complex emotions that are not just painful for the individuals in crisis, but also reduce the individual's capacities to be effective in their problem-solving (Wiess, 1976).

A miscarriage is presented in this study as a specific situational distress in which the couples involved find themselves in a life crisis event. By definition a miscarriage, or the more medically correct term of spontaneous abortion, is a specific type of infertility issue. Menning (1980) suggests that during infertility investigation and treatment, the experience of a crisis state is common for the infertile person. She continues by saying:

> Crisis can be succinctly defined as a disruption in the steady state, or a period of disequilibrium. There are some elements common to any state of crisis: (a) a stressful event occurs that poses a threat which is

> insoluble in the immediate future. (b) The problem overtaxes the existing resources of the person(s) involved because it is beyond traditional problem-solving methods. (c) The problem is perceived as a threat to important life goals of the person(s) involved. (d) The crisis situation may reawaken unsolved key problems from both near and distant past (p. 314).

Infertility is defined as the inability to achieve pregnancy after one year of regular sexual relations, or the inability to carry a pregnancy to the delivery of a live birth (Menning, 1982). Since one in every six pregnancies ends in a miscarriage, the probability of infertility due to miscarriage is significant (Menning, 1977).

For couples who miscarry the realization that they are in a crisis state concerning pregnancy and childbirth comes as a complete shock (Menning, 1982). Previously these individuals focused their decisions about childbearing on whether and when to have a baby (Shapiro, 1982). For approximately five million Americans, the conception of and successful delivery of a living child will prove to be impossible (Menning, 1982). The infertile couple seems to be consumed by the processes of conception and childbirth which erodes their feelings of self-confidence, competence and control, and they have lost the familiar feelings that come with success and accomplishment of a goal (Mahlstedt, 1985). The couple whose infertility is linked to miscarriage is thrust into an acutely painful experience and robbed of their real goal--a living child (Menning, 1977).

People in crisis are generally more open and susceptible to the influence of others, especially from significant others in their social

or professional spheres (Wiess, 1976). Vulnerability to secondary distress increases during a crisis because people are generally unprepared for their own reactions during stress (Wiess, 1976). Most expectant parents are ill-prepared and uninformed about miscarriage. It never occurs to them that their pregnancy may not end in a live birth. This lack of preparation increases their susceptibility to the stress that a crisis event often dictates. Weiss (1976) reports that "Because they can neither control nor understand their responses, they become fearful that there is something fundamentally wrong with them" (p. 218). The frustrations that the couple feel often influence them to close out their adaptation work prematurely (Wiess, 1976). Kaplan and Sadock (1981) report that most chronic depressions represent those acute depressive episodes that were not adequately recognized or poorly treated.

If inquiries could be made as to the impact of infertility on the marital relationship and investigations conducted of the effect of miscarriage as a life crisis event, then perhaps an increase in understanding and insight as to the dimensions of infertility on the marital relationship could ensue. Quoting Caplan (1961):

> In other words, if we know how families in this crisis deal with the crisis problem in a healthy way, and if we can spot those who are showing signs of not dealing with it in this way, our knowledge of the healthy ways of dealing with crises will allow us to intervene and to steer the latter families on the healthy path. What is very important is that this can be done without

having to know why it is that the unhealthy families were on the unhealthy path (p. 19-20).

Significance And Purpose Of The Study

There is general agreement within available research that confirms the relationship between life events and depression (Kaplan & Sadock, 1981). A life event of the significance of pregnancy is reported by Caplan (1961) as being a period of susceptibility to intercurrent crises that may present themselves to be greater than usual crises. This increased susceptibility to crises means a reduced capacity to deal with life problems because of the metabolic changes in the female's body (Caplan, 1961) and both partners' depleted energies rendering them less able to meet each other's emotional and physical needs (Mahlstedt, 1985). The loss of closeness in the marital relationship (Mahlstedt, 1985) renders the two people worlds apart and is sometimes the breaking point for couples (Caplan, 1961). The purpose of this study is to attempt to discover consistencies in the behaviors of couples who have experienced miscarriage that may lead to more refined hypotheses about the impact of miscarriage on the marital relationship.

Added to the significance of the life event of pregnancy on the marital relationship is the added dimension of infertility due to miscarriage. Compounding the physiological events that occur during miscarriage is the frightening fact that most couples are rarely prepared for loss during the pregnancy (Menning, 1977). Most American couples plan their families as carefully as they do career choices, educational opportunities and investments in the stock market (Menning, 1980). Shapiro (1982) has estimated that although 15 percent of the adults of childbearing age in the United States are infertile at any

given time, little attention is being paid to subsequent problems affecting the marital relationship.

The information in this study may have relevance to the health care practitioner, marriage and family therapist and others in the helping professions. The information may provide insight and understanding into alternative methods for dealing with couples who face the crisis of infertility due to miscarriage. The primary usefulness of this case study is to refine hypotheses concerning the effects of miscarriage on the marital relationship before these hypotheses are submitted to more rigorous tests.

Assumptions Underlying The Study

The following assumptions are inherent to this study:

1. The sample consisted of couples who have experienced a miscarriage within three years of data collection.
2. Respondents answered all inventory items truthfully.
3. Respondents in the sample group are not significantly different from the infertile population as a whole.

Limitations Of The Study

The following limitations are inherent to the study:

1. Only couples with no living children were included in the study.
2. Only couples whose pregnancy was medically confirmed were included in the sample group.
3. This study included a limited number of subjects; therefore, generalizability to all couples who experience miscarriage is not possible.

Research Questions

The experiences of nine couples whose pregnancy ended in miscarriage and the effects the miscarriage had on the marital relationship are discussed in this study. Also considered was the impact of a miscarriage as a crisis event in the lives of couples in the case study. Specific research questions addressed were:

1. What do couples who have experienced a miscarriage report about the event itself?
2. What do couples who have experienced a miscarriage report about the event as it relates to their marital relationship?
3. How do couples who have experienced a miscarriage perceive the event?
4. What information is obtained from the infertile couples in this study that can lead to areas of further research and exploration?

DEFINITION OF TERMS

The following terms are used throughout this study and are defined below.

Infertile Couples . This term refers to any couple who is currently unable to carry a pregnancy to a live birth or to any couple unable to achieve a pregnancy.

Miscarriage . This term was defined for this study as any confirmed pregnancy up to and including 24 weeks gestation that spontaneously aborts.

Confirmed Pregnancy . This term was defined for this study as any pregnancy verified by blood tests, urinanalysis, and/or physical examination by a physician.

Overall Marital Satisfaction (FACES-II) . This is a measurement obtained from the Family Adaptability and Cohesion Evaluation Scales, Couples Form (Olson, Portner, and Bell, 1982, p. 5).

General Life Events (FILE) . This is a measurement obtained from the Family Inventory of Life Events and Changes (McCubbin, Patterson, and Wilson, 1982, p. 69).

Cohesion . A dimension on the FACES-II instrument that is the degree to which family members are separated or connected to each other by means of an emotional bonding.

Adaptability . A dimension on the FACES-II instrument that is the extent to which a couple is able to change and be flexible within the family system as related to power structure, role relationships, and relationship rules in response to situational stress and developmental stress.

Life Crisis . A construct relating to the situation in which a person faces an obstacle to a life goal that is insurmountable using the ordinary methods of problem-solving.

CHAPTER II

REVIEW OF THE LITERATURE

The review of the literature relevant to the topic of this study consists of four sections. A summary of the crisis literature with specific references to pregnancy and infertility as crisis events is followed by an outline of the grief and loss literature. Literature dealing with the impact of infertility on the marital relationship and information on the habitual aborter are also presented.

Miscarriage as a Crisis Event

A crisis evokes a complex of emotions that are more than just painful; crises reduce individual's ability to be effective in dealing with problems (Caplan, 1961). The energy needed to contain or control the flood of emotions with the people in crisis distracts them from basic life tasks, and they discover that the majority of their time is spent just coping with their emotions (Caplan, 1961). A uniformity of symptomatology seems to surface as situation-specific reactions are displayed almost continuously by practically everyone in those situations (Wiess, 1976).

A crisis is a situation as defined by Caplan (1961) in which individuals face obstacles to important life goals that are currently insurmountable through the utilization of customary problem solving methods. Within the crisis, individuals generally face periods of disorganization, upset, and abortive attempts to find solutions prior to adapting to the crisis situation (Caplan, 1961). Situational distress

is manifested by individuals through similar reactions or symptom incidence (Wiess, 1976). The tendency toward impulsive and irrational behaviors by individuals in crisis produce reactions similar to neurotic and psychotic behaviors and character disorders (Wiess, 1976).

Caplan (1961) writes that pregnancy is a life event high in susceptibility to intercurrent crises which seem greater than usual. He writes of the process of pregnancy as one where individuals find themselves in a reduced capacity for problem solving because of the stress of the metabolic changes in the body indigenous to pregnancy. The mood swings that accompany pregnancy, including the ambivalent feelings toward pregnancy itself plus changes in appetite, further impact on the crisis state. Caplan (1961) continues by suggesting three additional influences on the individual experiencing the crisis state of pregnancy. First is the introversion and passive condition of the pregnant female. She enters a posture of sitting back and waiting when her pregnancy reaches approximately 12-15 weeks gestation. She becomes accustomed to receiving instead of giving. Secondly, an individual experiences a change in the Ego-Id Equilibrium toward the end of the pregnancy experience. At this time the pregnant female is voicing concern for her fantasies and may even experience a revival of childhood memories. Thirdly the attitude toward the future infant is both an attitude toward the physical child-to-be and also an attitude toward the relationship-to-be.

Caplan (1961) continues:

> The attitude of the husband to the fetus may not be the same as the attitude of his wife (p. 89) . . . not all women, but many women, will have night-dreams and day-dreams, and

> imaginations, and thoughts and plans about what kind of a baby they are going to have, and what is going to happen to the baby (pp. 90-91).

The fantasy of the birth experience, relationship to the child, what the child will look like and what kind of future the child will have occupy the thoughts of most expectant husbands and wives (Caplan, 1961). Conspicuously absent is any thought about the loss of the baby, because rarely is the couple prepared for the miscarriage of the fetus (Menning, 1977).

By definition a miscarriage is the spontaneous abortion of a fetus up to the age of viability, loosely set at 24 to 26 weeks of gestation (Steadmans, 1981). Beyond the pain of losing a baby, a miscarriage or stillbirth is a terrifying event because it is usually totally unexpected, abruptly over in a matter of minutes, or agonizingly tedious and drawn out for days or even weeks (Menning, 1977). Reports Menning (1977):

> For both the man and the woman the sight of blood, especially if it is heavy and thick with clots, may be unnerving. Both are often surprised by the intensity of the cramps experienced as the cervix thins and dilates. The woman is actually in labor and, depending on the length of gestation, it may take a number of hours of strong uterine contractions to dilate the cervix sufficiently to expel the fetus (p. 77).

People in crisis usually become more open and susceptible to the influence of others, particularly from significant figures in the sphere of influence of those in crisis (Caplan & Killilea, 1976). Infertility

is not a mere cause of stress and anxiety to those affected; it stands as a major life crisis (Menning, 1977). Individuals in a crisis situation often doubt their strengths and abilities, and during the frustration and confusion that follow the individuals tend to feel weak and impotent (Caplan & Killilea, 1976). Families in crisis need to be reminded of their past achievements, and they need assistance to be reminded of their competencies and previous successes (Caplan & Killilea, 1976).

Goetz (1965) reports that the general attitude of the medical community toward miscarriage is to view the event as a natural way to rid the body of a defective product. The patient is often told to expect a day or two of unpleasantness before being able to resume her daily routine with little or no side effects (Goetz, 1965). For other women who abort, there is often an actual avoidance of details concerning the event and/or the feeble offering of well-meaning cliches by family and friends (Poland, 1977). "Logical or not, it was my feeling that my womanly birthright . . . my ability to conceive and bear children . . . was being threatened" (Goetz, 1965, p. 85).

It is reported (Aladjem, 1980; Menning, 1982; Pritchard & MacDonald, 1980; Shapiro, 1982) that between 10-20% of all pregnancies end in miscarriage. Because of the sheer numbers of potential patients, an effective means to intervene relies on the ability to recognize and assess the special needs of the patients and plan appropriate care (Pritchard & MacDonald, 1980). Furthermore, early intervention and evaluation could provide early recognition of maladaptive behavior and enable proper sources of support and referral to be made (Pritchard & MacDonald, 1980).

As reported by Fulton (1970), four factors are influencing the psychological impact that Americans feel toward death. These factors are (a) a changing American viewpoint from a religious perspective to a secular one, (b) a changing American family from a large, extended family to a small, nuclear one, (c) a changing medical community that is increasing its attention on death issues, (d) a changing in time and place concerning the very incidence of death itself.

The positive side of the needs expressed by the infertile couple is that they are open to the influence and guidance of others as they work to cope with their situation (Menning, 1977). A significant method to aid in coping is to assist the infertile couple to deal with their infertility as a loss or grief experience, thereby enabling them to process their feelings in a positive way (Menning, 1977). In general the literature supports the relationship between life events, stress and depression, thereby making it important to the understanding of depression to analyze triggering events, and individual reactions to loss (Kaplan & Sadock, 1981). With this relationship in mind, let us turn our attention to the process of grief.

The Process of Grief and Loss

From Sigmund Freud : Collected Papers , translated by Riviere (1959), the thesis is presented that a correlation between melancholia and mourning seems to be justifiable because of the general picture of the two conditions. Mourning is generally the reaction a person has to the loss of a loved one, or to a love object, which Freud suggests could be the fatherland, liberty, or an ideal (Riviere, 1959). Quoting Freud (Riviere, 1959) on profound mourning, or melancholia:

Profound mourning, the reaction to the loss of a loved

> person, contains . . . feelings of pain, loss of interest in the outside world--in so far as it does not recall the dead one--loss of capacity to adopt any new object of love, which would mean a replacing of the one mourned, the same turning from every active effort that is not connected with thoughts of the dead. It is only because we know so well how to explain it that this attitude does not seem to us pathological (p. 153).

Freud continues by suggesting that the reality of working through grief is a process that cannot be accomplished in a moment, but when the work of mourning is completed then the ego becomes free and uninhibited again (Riviere, 1959).

The feature of "peculiar painfulness" is an unexplained concept of mourning, according to Freud (Strachey, 1959). Anxiety and pain then become a reality to the danger of a loss of an important love object (Strachey, 1959). Freud expands these ideas by stating (Strachey, 1959):

> Mourning occurs under the influence of reality testing; for the latter function demands categorically from the bereaved person that he should separate himself from the object, since it no longer exists. Mourning is entrusted with the task of carrying out this retreat from the object in all those situations in which it was the recipient of a high degree of cathexis. That this separation should be painful fits in with what we have just said, in view of the high and unsatisfiable cathexis of longing which is concentrated on the object by the bereaved person during

the reproduction of the situations in which he must undo the ties that bind him to it (p. 172).

Robert Wiess (1976) suggests that stressful situations take three forms: (a) Crisis form is characterized by a sudden onset of symptoms and is limited in duration and presents the individual considerable stress, (b) Transition form is a period where homeostasis is reestablished or individual changes take place, and (c) Deficit form is a situation where the individual admits to a loss or deficit due to the crisis condition. In reporting Wiess' model for crisis behavior, Caplan and Killilea (1976) suggest five blocks to a healthy resolution of the crisis: (a) Obsessive review is the first stage that could block resolution. The individual cannot stop thinking about the crisis even though there is a need to do so, (b) Anger, guilt and related emotions could surface in such intensity that resentments or blaming behaviors preoccupy the individual, (c) Uncertainty regarding self emerges to weaken goals and commitments the individuals may have made, leaving them vulnerable and highly suggestible, (d) A tendency for false starts and impulsive behaviors often surface during crisis experiences as individuals attempt and reject new modes of behavior, and (e) Feelings of self-doubt and a loss of self confidence can emerge if the individuals assume that they have serious character imperfections. A high level of anxiety usually follows this ideation resulting in an inability to function properly and resolve the crisis.

Bowlby (1961) suggests that the psychological process accompanying loss and grief is a subjective state that can be reported in three stages. (1) Protest is the first state accompanying mourning where the individuals keep their focus on the lost object. (2) Despair is state

two where the individual recognizes a disorganization of personality with a need to reorganize toward a new object. (3) State three is detachment in which the reorganization of grief work is complete.

Bowlby (1961) further suggests that a study of grief and mourning could be done in its own right even though the history of psychoanalysis has approached such a study as a depressive illness and melancholia in adults. Healthy mourning is then not considered pathological by Bowlby (1961), who writes that those who have discussed the nature of the processes engaged in healthy mourning have agreed that the mourners have completed a withdrawal of emotional concern from the loss object and have prepared the way to make a relationship with a new one.

The work of Kaplan and Sadock (1981) consists of a collection of stages of grief and definitions of loss relevant to the fields of psychiatry and psychology. They cite the three stages of Parkes: (a) Stage one is numbness, which lasts for the first few days after the loss, (b) In stage two, the individuals experience both a yearning for the lost love and a protest against the loss, and (c) Stage three is a disorganization of behavior that is characterized by apathy, aimlessness and despair toward the future.

Engel (1964) concludes that the process of grief has two primary functions, idealization and identification. Idealization occurs as all hostile feelings toward the lost object are repressed in order to allow the emergence in the mourner's mind of a distinct image of the loss object. Through recurring thoughts and reminiscences, the mourner is able to idealize the loss (Engel, 1964).

Through the process of identification as presented by Engel (1964), the mourning episode is further exacerbated. Identification allows the

mourner the opportunity to adopt the qualities and attributes of the lost object (Engel, 1964).

Further definitions of grief as presented by Engel are cited by Kaplan and Sadock (1981). In their writing grief is a specific reaction to a particular causal factor such as an object loss. Grief involves suffering, feelings of incapacitation that are long-lasting, and fulfills the criteria for a discreet syndrome including symptoms, a predictable course, and consequences. Quoting Engel in Kaplan and Sadock (1981):

> The loss of a loved person or consequence of the death or separation from a loved object have been identified as a precipitating factor in the onset or the intensification of such diverse diseases as asthma, pulmonary tuberculosis, peptic ulcer, ulcerative colitis, diabetes, coronary occlusion, myocardial infarction, cardiac failure, thyrotoxicosis pernicious anemia, leukemia, and multiple sclerosis. Schmale's early studies of illnesses indicated that, preceding the onset of illness, 31 of 42 patients had been unable to cope with an imagined or real loss (p. 384).

Lindemann (1944) defines grief as a definite syndrome with psychological and somatic symptomatology. The length of the grief reaction depends on how successful the grief work is. The mourner must become freed from the bondage to the deceased, form new relationships and readjust to the environment from which the deceased is absent (Lindemann, 1944).

A depressed mood, sleep disturbance and crying spells are three common symptoms in normal bereavement as presented in the findings of a

study by Clayton et al. (1968). It was further reported (Clayton et al. 1968) that fewer than 50% of the subjects in the study experienced difficulty concentrating, loss of interest in television or news, anorexia or other weight loss with only 2 percent of the bereaved seeking psychiatric assistance.

Horowitz (1978) views the mourning process as a complete entity centering one's response to the loss in past experiences with separation and loss. Other contributing factors include cultural and family definitions of appropriate grief responses and the mourner's psychic structure and level of development (Horowitz, 1978).

The classic work of Kubler-Ross (1969) offers the grief and crisis literature a strong framework for stages of grief. The five stages of grief are as follows: (a) The first stage is denial and isolation where the individuals in grief defend by refusing to admit to the reality of the loss and isolate themselves from social contacts or reality. When denial can no longer be maintained, individuals move to stage two, (b) Anger is the primary feeling in stage two with rage, envy and resentment emerging also, (c) Stage three is bargaining where the individuals work toward changing the situation by offering exchanges, barters and bargains, (d) Stage four is depression which is reached when the individuals realize that no amount of bargaining will change the situation, and (e) The final stage of grief is acceptance in which the indviduals adjust to the reality of their situation with peace and dignity.

Considerable literature exists relating mental health and spontaneous abortion (Deutsch, 1945; Cappon, 1954; Javert, 1957; Tupper, Moya, Stewart, Weil, and Gray, 1957; Mann, 1959; Grimm, 1962; Kaij,

1969; Simon et al. 1969; Kennell et al. 1970; Corney & Horton, 1974; Seibel & Graves, 1980). A summary of this research follows.

An early researcher, Deutsch (1945) reported his observations. He observed that spontaneous abortions were often linked to psychogenic factors.

Cappon (1954), Javert (1957), Tupper et al. (1959) and Mann (1959) conducted research concerning the spontaneous aborter and maternal identification. The mothers of habitual aborters were reported to be dominant, intolerant, possessive and punitive. A similar causal relationship between the habitual aborter and maternal identification was assumed by Grimm (1962).

The findings of Kaij, Malmquist and Nilsson (1969) suggested that women who miscarry often share an early life bereavement experience. Their findings led to the speculation that if the woman experienced the loss of her father early in life, her normal psychosexual development may be slowed. Therefore, successful motherhood may be of primary concern for these women (Kaij, et al. 1969).

Simon et al. (1969) conducted research concerning the psychological implications of 32 women who miscarried with 46 women who elected to abort. In the miscarriage group, 13 of the 32 women report feelings of depression with none of the women in the elective abortion group reporting psychiatric symptoms.

Four significant factors contributing to pathological grief following a loss were related to miscarriage by Corney et al. (1974). These factors are: (a) a history of an ambivalent relationship as in an unplanned pregnancy, (b) a sudden, unexpected death, as in a spontaneous abortion, (c) external events that prevented the expression

of feelings of loss such as the isolation of the patient from her husband during treatment, and (d) an absence of mourning at the normal and expected time as in perceived pressure to become pregnant again immediately.

Four common feelings expressed by women who miscarry were reported by Seibel and Graves (1980). Those feelings were commonly labeled: (a) unhappiness, (b) depression, (c) hostility, and (d) anxiety. Seibel and Taymor (1982) concluded that fewer than 5% of all infertility cases are linked to emotional factors. Further, their assumption remains that psychological factors associated with infertility result from the infertility itself rather than causing the infertility.

Stack (1980) identified twelve factors that the woman who miscarries experiences. They are: (a) a miscarriage prior to others even knowing about the pregnancy, (b) embarrassment in discussing the miscarriage, (c) unresolved ambivalence concerning the pregnancy, (d) consideration of the fetus as a part of herself, (e) lack of experiencing the sensation of movement of the fetus, (f) no opportunity to view the fetus after the miscarriage, (g) no funeral, (h) no recognition by others as to the significance of the event, (i) encouragement by others to deny or intellectualize, (j) usually no time for preparation for the loss, (k) guilt, and (l) a sense of helplessness.

Mahlstedt (1985) developed eight categories of loss that reflect the specific issue of infertility as a grief experience. The loss of a relationship with an emotionally important person may relate to the loss of the fetus itself or to family relationships and friendships that may be severed because of well-intentioned but insensitive remarks made to

the infertile couple. Loss of health, important body functions, physical attractiveness or acceptance of self and body image is experienced by the infertile couple both physically and sexually. Loss of status or prestige in the eyes of others is felt by infertile individuals due to the value society places on parenthood. Loss of self-esteem and pride in oneself is category four. Loss of self-confidence and an adequate sense of competence or control is felt by infertile couples who are often people who have a history of success. Loss of security in occupational, financial, social and culural roles manifest. Loss of a fantasy, and the hope of fulfilling that fantasy overwhelm the infertile couple who have been unsuccessful in bringing a baby into the world. Loss of something or someone of great symbolic value trusts the infertile couple into the paradox of experiencing grief for the child that never was and a yearning for the child that may never be.

Menning (1977) has delineated a process of grief specific to the issue of infertility--that process begins with surprise. The infertile couple is surprised to learn that achieving a pregnancy and live birth may not be possible for them. The denial phase surfaces next as the couple struggles with the catastrophe of infertility. A sense of isolation is stage three as infertile individuals decide to keep their infertility issue private and withdraw from others whose success in childbearing is too painful for the infertile couples to be around. Anger emerges next as the infertile couple surrenders much of the control over their bodies and their destinies and target that anger at the situation and themselves. A sense of guilt and unworthiness follows as the infertile individuals try to establish a cause-and-effect

relationship between their infertility and their life histories. Depression then surfaces that can be either normal or pathological in nature. Pathological depression is characterized as a "smokescreen behind which some more powerful and frightening feelings lurk (p. 109)." Normal depression is used to identify a legitimate state of sadness, despair, lethargy and vague symptoms of distress. The final feeling experienced by the infertile couple is grief in which the shock, disbelief and suffering being experienced slowly give way to a sense of recovery, accompanied by signs that the grieving couple have successfully freed themselves from their lost object of love. Even though the grief may be reactivated, the pain and suffering are never again as acute as was earlier experienced (Menning, 1977).

The Impact of Miscarriage on the Marital Relationship

The many losses and multiple stresses of infertility leave many couples depressed and angry because they have lost control over whether or not they will become parents--a loss most people never even consider, let alone face--and that fact enrages them (Mahlstedt, 1977). She continues:

> Because both the man and the woman are hurting, tired and under great pressure, they feel depleted of physical and emotional energy. They may become less able to fulfill each other's needs and thereby suffer a loss of closeness, to the point of feeling worlds apart (p. 337).

The whole process of conception and childbirth takes over the infertile couple's lives and impacts on the marital relationship especially if there is a diagnosed infertile partner and fertile partner (Menning, 1977). Anger, both expressed and repressed, has significant effects on

the couple and their relationship (Mahlstedt, 1985). Couples need an opportunity to express their anger and resentment toward each other in an effort to increase their communication skills and problem solving mechanisms (Shapiro, 1982).

Wiess (1976) states that people in transition may have difficulty articulating their needs because they are unsure as to the identification of their problems. So extensive may be the disruption to their previous relationship that they may be totally unable to recognize how to begin rebuilding (Wiess, 1976). The strains on the marital relationship may be so severe that the marriage will not survive being broken on this particular rock (Caplan, 1961). The marital partners need a way to express solidarity, love, affection and comfort (Caplan & Killilea, 1976).

Three significant needs must be maintained by the couple if a successful marital relationship follows the crisis of infertility, according to Caplan and Killilea (1976). First the couple needs guidance from others based on past experiences. Secondly, they need a way to counteract feelings of despair and helplessness by the continuing presence and expression of love. Thirdly, they need to see their loss in a realistic perspective and continue to treat each other with love until their lives can be rebuilt or "a permanent source of alternative emotional satisfaction is found (p. 31)."

A final area of impact upon the marital relationship due to infertility is the area of human sexuality and its relationship to self-image. As Caplan and Killilea (1976) write:

> The clarity and security of a person's self-image and his confidence in the stability of his own identity are a

> major source of his fortitude in grappling with life's problems. In particular they provide the foundation upon which he bases his courage in facing the complexities of the unknown and his tolerance of frustration during periods of struggling with the temporarily insurmountable problems of crisis, or coming to terms with the long-term privations of loss (p. 30).

Menning (1977) suggests that sexuality is the area of the self-concept most likely to be threatened by infertility. These concepts about the self, sexuality and sex-role are the ideas or sets of ideas that individuals hold about themselves (Menning, 1977). Sexuality is defined as the individual quality and character of being a man or a woman (Menning, 1977). Rosenberg and Sutton-Smith (1972) suggest that even though genetic and hormonal variables are unquestionably influential in determining a person's sexuality, sex-related behaviors and experiences are necessary for normal adult sex-role behavior in higher species. "The most important area of change in the lives of males and females are childbirth and childrearing (Rosenberg & Sutton-Smith, 1972, p. 89)." If infertility prevents individuals from completing what they perceive to be appropriate sex-role behavior, then an assumption of defects in their sexuality becomes a barrier to the marital relationship itself (Menning, 1977).

Men and women respond very differently to the issue of infertility (Mahlstedt, 1985). Early anthropologists have concluded that sex-role behaviors develop simply in more primitive cultures with males becoming warriors and foragers and women becoming housekeepers and childbearers (Rosenberg & Sutton-Smith, 1972). As societies become more complex the

relationship of sex-role to morphology is only indirect (Rosenberg & Sutton-Smith, 1972). With society and tradition influencing attitudes and behaviors toward human sexuality (Menning, 1977) individuals respond accordingly. Reports Mahlstedt (1985):

> A man's silence sometimes confuses and upsets a woman, because she believes that the silence means that her husband is not as involved or concerned as she is. That perception might be accurate--some men do not feel the need for children as intensely as some women; boys are not as likely to grow up thinking of themselves primarily as fathers. And the woman's loss of being pregnant is not experienced by men. However, the perception that a husband is not as upset could also be inaccurate; perhaps he simply does not express his feelings as openly, as often or as intensely as his wife (p. 343).

Rosenberg and Sutton-Smith (1972) believe that as both the sexual and economic status differences between men and women become less crucial in dictating feelings and behaviors, then the assumption can be made that relevance and meaning in life can become more accessible. Likewise, both genders can now focus on experiencing and finding meaning through that experiencing, rather than focusing on attaining a tangible, rationalized goal (Rosenberg & Sutton-Smith, 1972).

Hicks and Platt (1970) state that happiness and stability are two norms used to assess marriages in contemporary society. If events occur within the relationship between the husband and wife that add stress to that relationship, then changes in the happiness and/or stability levels would result. These reviewers noted that stability and happiness were

"phenomena difficult to measure" (p. 553) and suggested a major shift in research emphases to include a clear observation of the role of the husband in the marital relationship. Role relationships may be more critical to marital happiness than any other single variable (Hicks & Platt, 1970).

Consistent with the idea of role relationships is the indication of a strong relationship between levels of depressed mood and marital dissatisfaction. Kerns and Turk (1984) reported that global marital satisfaction was related to the degree of perceived support in the marital relationship. Similar findings by Coleman and Miller (1975) and Weiss and Aved (1978) substantiate the proposition that a life event of strong depressive characteristics has an impact on overall marital satisfaction. If high depression contributes to marital dissatisfaction, then life events which trigger depression, like miscarriages, may also trigger periods of marital dissatisfaction that are situation-specific.

Ferguson, Horwood, and Shannon (1984), Glenn and Supancic (1984) and Burns (1984) all presented research on marital relationships and divorce. Ferguson et al. (1984) reported breakdowns in marriages were related to a series of family formations and social factors including planned pregnancy. A planned pregnancy was defined as a pregnancy where neither partner was contracepting at the time of conception with some hope of having a child. Unplanned pregnancy could then be seen as a conception in spite of contraception or a pregnancy that ended in miscarriage.

Glenn and Supancic (1984) discussed the correlates of marital dissatisfaction in the United States. Their research suggested that the

emphasis on socioeconomic factors of occupation, income, education and similar socioeconomic variables may not be justified. The overall differences between the higher and lower categories and divorce statistics were not very large.

Burns (1984) investigated a large number of structural and attitudinal variables that have regularly been found to be associated with marital dissolution. Among those variables was parity of marriage. High-conflict situations concerning control, power and equality in the marital relationship contributed to marital dissatisfaction.

Cochrans and Bean (1976) conducted a study of the difference between husbands and wives in their demands for children. The results revealed considerable differences in the marital pattern of relationship based on whether the wife is in the labor force, her income level and the degree to which she has mutually acknowledged influence on the family decision-making process. Further research focusing on the pattern of interaction between spouses toward the issue of family size is suggested.

The issue of children as a factor in marital satisfaction was addressed by Luckey and Bain (1970). It was reported that satisfied couples found their marriages enhanced by each other's companionship. Couples who found little in the way of companionship relied on their children primarily for satisfaction.

Chadwick, Albrecht and Kunz (1976) reported that adequacy of role performance of both self and spouse and spouse's conformity to expectations emerged as the strongest predictors of satisfaction derived from playing family roles. It was noted that the variables in the study were limited to family related variables only and did not investigate

the impact of outside experiences to the marital relationship. It was further suggested that the dynamics of the marital relationship might be more fully explained by looking at "the family as part of a larger network of social systems" (p. 439).

The Habitual Aborter

Aberman, Elliott, Creasy and Dhadial (1975) conducted a study of 3467 mothers presenting with a spontaneous abortion in comparison to a control series presenting with a live birth. Fetal products recovered in 1384 abortions were examined to determine their chromosomal structure. The women who aborted chromosomally normal tissue more often had a history of previous repeated abortions. This suggestion of recurrence was especially true when the women were compared with age-matched controls.

The work of Glass and Golbus (1978) concerns itself with the question of abortion probability and then gives critical consideration to a number of the possible causes of habitual abortion and their treatment. Among the psychologic factors considered as causes were a rejection of the psychodynamic implications of the habitual aborter as women who come from homes in which the mother was dominant and the father was ineffective. These researchers suggested that psychologic support in the form of frequent visits, sympathetic counseling, and ready access should be a part of the care of couples wih habitual abortion (p. 264).

Tupper and Weil (1962) published a report on the problem of spontaneous abortion that dealt with the treatment of habitual aborters by psychotherapy. Both positive and negative results were found. Negative results included no evidence that deficiencies in diet, lack of

hormonal support, trauma or travel play any real part in the causaton of spontaneous abortion. On the positive side, there was evidence to support the premise that habitual aborters were basically immature women unable to accept mature feminine resonsiblity, or independent frustrated women who yearned for the rewards of the male world. Also evident in this study were characteristics of the husband of the habitual aborter as being absent, uninterested in the wife and uninterested in the pregnancy.

James' (1963) classic work on the habitual aborter concerned the efficacy of psychotherapy. His research implies that psychotherapy has a beneficial effect on this disorder. Of the 19 cases in his study about 80% of the pregnancies resulted in live births. Evidence was also presented to suggest that fewer than 45 per cent of similar pregnancies would yield live births.

In his psychiatric investigation of habitual abortion, Mann (1956) admits to a limited amount of knowledge in the literature regarding the psychology of the habital aborter. He reports a succession of divergent treatments including hormone-therapy, vitamins, surgery, prophylactic interdictions and psychotherapy. Each treatment had evidence of success. Mann (1956) continues:

> In the face of such divergently successful therapeutics, the question arises as to the possibility of the curative process hinging not on any "proved" specific curative agents, but, instead upon some extra specific factor present in all the cited therapies. This common factor may well have to do with the therapist's personality (p. 591).

Summary

A review of the literature relevant to the topic of this study has been presented in this chapter. Four major areas of research were reviewed. Those areas included a summary of crisis literature with specific references to pregnancy and infertility as crisis events; an outline of the grief and loss literature; the impact of infertility on the marital relationship; and a profile of the habitual aborter.

CHAPTER III

METHODOLOGY

Introduction

The research design for the case study on miscarriage as a life crisis event and its impact on the marital relationship is discussed in this chapter. The chapter sections include presentations of the instrumentation for the study, subjects, procedures, analysis of the data pilot study and summary.

The case study sample consisted of six married couples residing in a large metropolitan area of a city in the Southwest. Three (3) of the couples were people who had experienced a miscarriage within six months from the time data were collected. One (1) of the couples had experienced a miscarriage within seven to twelve months from the time data were collected. Two (2) of the couples were people who had experienced a miscarriage within one to three years from the time data were collected. The decision to divide the couples into these three groups was made by the researcher in an attempt to determine if length of time since the miscarriage would be reflected in the data gathered in the study. Potential case study participants were identified from the patient records of participating health care professionals who referred their patients to the researcher for purposes of the study. The six (6) couples participating in the study were chosen by random selection from the pool of 34 eligible couples. Informed consent was obtained from

each person participating in the study and anonymity was provided each participant. All couples selected for the study were from the same medical clinic in an attempt to control for confounding variables across medical clinics. An attempt was made to identify nine couples to participate in the study, three couples for each Group. However, because the pool of eligible couples was restricted to childless married couples from the same medical facility, no other couples could be found who met all necessary criteria. The decision to restrict the study to married couples with no living children was made as an attempt to control for the probability of differentiations of the effects of other children to the subjects perception of loss.

Instrumentation For The Study

When dealing with marriages the emphasis for the traditional psychodynamic approaches on individual subjects needs to shift to allow for the study of both the individuals involved and the relationship between them (Pincus, 1974). The instrumentation chosen to support this study was both an assessment of life crises and a marital satisfaction scale developed through a national survey of families across the family life cycle. The life crisis instrument was the Family Inventory of Life Events and Changes, (FILE) (McCubbin, Patterson & Wilson, 1982). The marital satisfaction scale was the Family Adaptability and Cohesion Evaluation Scales-II, (FACES-II) (Olson, Portner & Bell, 1982). The inventories were developed through the office of Family Social Science at the University of Minnesota over a five year period from 1977 to 1982. Additional information was collected by means of a researcher-designed interview.

FACES-II was developed by Olson, Portner, and Bell, (1982). Two

dimensions of family behavior, cohesion and adaptability are assessed. Family cohesion assesses the degree to which the members of a family are connected to or separated from the family unit.

Family cohesion is defined by the authors as the emotional bonding that family members have toward one another (Olson et al., 1982). Specific concepts used to measure cohesion are emotional bonding, boundaries, coalitions, time, space, friends, decision-making, interests and recreation. There are four levels of family cohesion. These levels are called disengaged, scores of 0-56.9; separated, scores of 57.0-65.0; connected, scores of 65.1-73.0; enmeshed, scores greater than 73. Mid-range scores are called separated or connected.

Family adaptability is defined as the ability of a family or marital system to change its power structure, role relationships, and relationship rules in response to situational and developmental stress (Olson et al., 1982). Specific concepts used to measure adaptability are family power related to assertiveness, control and discipline, negotiation style, role relationships and relationship rules (Olson et al., 1982). Family adaptability relates to the extent to which the family system is flexible and able to change (Olson et al., 1982). There are four adaptability levels labeled rigid, scores of 0-43.0; structured, scores of 44.0-55.0; flexible, scores of 50.1-56; chaotic, scores greater than 56, with flexible and structured levels being the mid-range. For both dimensions, the mid-range levels are hypothesized to be most viable for healthy family functioning (Olson et al., 1982).

A circumplex model has been designed by the authors to identify the sixteen distinct types of marital and family systems that the inventory renders by combining the four cohesion levels and the four adaptability

levels. Four of these types are extreme on both dimensions and known as extreme types. Four of these types are in the mid range on both dimensions and called balanced types. Eight types are extreme on one dimension and called balanced types. Eight types are extreme on one dimension and moderate on the other and are labeled mid-range types.

Each of the 30 items on the FACES-II scale is answered twice in order for the respondents to answer once for how they currently see their family (perceived). The second response is an assessment of how they would like their family to be (ideal). Factor analysis was handled separately for items on the cohesion and adaptability measures of the 13 cohesion factors and 9 adaptability factors, the first four factors of each dimension accounted for 75% of the variance (Olson et al., 1982).

Research on the initial 50 item FACES-II was conducted with a sample size of 2,412 individuals. The total sample was divided into two equal subgroups. Cronbach alpha estimates for each of these groupings and for the total scale is reported in Table 1.

Table 1

FACES-II

	Cronbach alpha estimates		
Scale	Sample 1	Sample 2	Total Sample
Cohesion	.88	.86	.87
Adaptability	.78	.79	.78
Total Scale	.90	.90	.90

A test-retest reliability study conducted in 1981 used data from the 50 item version of FACES II. A four to five week interval lapsed between

the first and second administration of the instrument. A total of 124 individuals responded to the survey. The Pearson correlation for the 50 item FACES II scale was .84; it was .83 for cohesion and .80 for adaptability (Olson et al., 1982).

FACES-II renders two scores, one for cohesion and one for adaptability. The final range for an individual's score on cohesion is between 16-80. The range for the adaptability score is between 15-70. The cohesion score relates to four definitons of family: disengaged, separated, connected, or enmeshed. The adaptability score relates to the four constructs of chaos, flexibility, structure, or rigidity.

Original research with the FACES-II instrument was developed from a sample size of 2,213 individuals. The Cohesion scale has a mean of 64.9 and a standard deviation of 8.4. The Adaptability scale has a mean of 49.9 and a standard deviation of 6.6. Of the 2,213 individuals used in the original research, 315 individuals were determined to be enmeshed, representing a simple percentage of 14.2% of the total sample. Eight hundred eighty-eight individuals were determined to be connected, representing 39.9% of the sample; three hundred forty-three individuals were disengaged, repesenting 15.4% of the sample; six hundred eighty individuals were determined to be separated, representing 30.5% of the sample (Olson et al., 1982).

The family cohesion and adaptability inventory was designed and tested originally by Sprenkle and Russell as part of their dissertation work. Sprenkle (1978) focused on the dimension of the family adaptability. He examined the interaction processes of 50 couples, 25 of whom were in marital therapy and 25 of whom were not in therapy, and found that differences in leadership patterns, creativity,

supportiveness and responsiveness did exist between the two groups when a simulated crisis was enacted (Sprenkle, 1978).

A follow up study (Russell, 1980) tested 31 non-clinical families and adolescent girls, emphasizing both the cohesion and adaptability dimensions. Results indicated high functioning families obtained moderate cohesion and adaptability scores, and low functioning families scored at the extremes of the two measures (Russell, 1980).

Two studies used the FACES-II (Olson, et al., 1982) and the Inventory of Parent Adolescent Conflict (IPAC) (Barnes & Olson, 1982) with families. Portner (1981) matched 55 families with one adolescent in family therapy with a control group of 117 non-problem families. Non-problem families scored in the balanced area of the Circumplex Model, while problem families scored in the extreme areas. Using the same instrumentation and the same 117 non-problem families, Bell (1982) compared the control group to 33 families with runaway children. He found descriptions by the mothers and adolescents of the 117 families to be in the balanced area as compared to the families having runaway children.

FILE was developed by McCubbin, Patterson, and Wilson (1982) to assess the pile-up of life events as experienced by a family. FILE is a 71-item self-report instrument recording the normative and non-normative life changes of a family unit. Also included in the assessment are certain life events a family experienced prior to the year in which the assessment is gathered. These events are presented as those that generally take longer to adapt to or may be chronic in nature (McCubbin, et al., 1982).

FILE renders a total score for family life changes. Subscales

scores are not considered by the developers of the instrument to be as empirically stable as would be desired (McCubbin, et al., 1982). Therefore the total scale score is the one suggested for use in further research.

Factor analytic procedures with an obligue rotation were used to determine the underlying dimensions of the construct validity of FILE. The authors report a "limitation of the factor analysis was the wide variance in the frequency of occurence of the items which affected the distribution and in turn, the factor analysis (Olson et. al., 1982, p. 73)."

Coefficient alpha reliability estimates were computed to indicate internal consistency. Cronbach's alpha for FILE is .81, with a variation in the subscales from .73 to .30. A test-retest reliability study was conducted at an interval of five weeks rendering a total scale Pearson correlation of .80 (Olson et al., 1982).

Interview Schedule

Three sets of primary interview questions were written by the researcher to assist in the data collection process. To aid in the investigation of the 2nd research question of the experience of the miscarriage on the marital relationship subjects were asked:

1. When the miscarriage occurred, how often did the two of you discuss the event?
2. How would you describe the quality or depth of your communication?
3. Now, how often do you discuss the miscarriage with your spouse?

4. Now, when you talk about the miscarriage, what do you talk about?
5. What is your perception of the effect of the miscarriage on your marital relationship?
6. What has changed for you in your marriage due to your experience of miscarriage?
7. What decisions have you made concerning future pregnancies?

To aid in the examination of the 1st and 3rd research questions relating to the miscarriage itself and to a miscarriage as a life crisis, subjects were asked:

1. I would like for you to describe the events that happened during the miscarriage as you remember them. Think about the medical, psychological, family related and marital events, and tell me what you remember.
2. How would you describe the feelings that accompanied those events?
3. How do you think your feelings are similar? dissimilar? concerning the miscarriage?
4. What effect has time had on the way you view your experience?
5. Assuming the medical stresses that a person experiences during a miscarriage, what other kinds of stresses do you feel you experienced during the miscarriage?

To aid in the consideration of the 4th research question for areas of further research generating from this study, the subjects were asked the following questions:

1. What do you know about miscarriages? What causes them?
2. What would you like to say about your experience that would help other couples who may find themselves in a similar situation?

Copies of the interview questions are included in the Appendix. Secondary questions and inquiries were used when only general information is offered by the subject to the primary question.

Procedures

Information for the case study was collected by means of a personal interview, conjoint interview, and two instruments used to assess marital cohesion and adaptability and life stresses. The two instruments were the FACES II and FILE.

Couples were interviewed by the researcher in both conjoint and individual sessions. As the couple met with the researcher, they were advised of the research design and instrumentation. Prior to meeting with each couple the researcher randomly selected the order of interview by toss of a coin, to decide who began with the written assessments and who began with the oral interview. While one member of the couple was being interviewed, the other member was provided a private area in which to fill out the two assessment tools. The couple was then asked to trade places so that the assessment tools could be gathered on the spouse that had completed the interview, and the interview could be held with the spouse who had just completed the assessments. When both members of the couple had completed the individual portion of the study, the researcher then asked for a conjoint session. To facilitate in the reporting of information, each participating couple was randomly assigned a number between one and nine.

Analysis of the Data

Information from the interviews and assessment tools is presented in narrative and table form on a couple by couple basis as well as a cross-couple basis as suggested by Yin (1984). A single-case data collection and analysis with a cross-case analysis design is utilized. The single case data collection shall consist of the FACES-II and FILE scores for each participant. The information reported by each participant during the individual interview as well as the information reported by the couple during the conjoint interview is included in a case-by-case system.

The cross-case analysis is included in the body of the study. Information reported by each participant, each couple and scores from the FACES-II and FILE are presented in narrative and table form. Cross-case findings, policy implications, and research applications are reported as well.

Pilot Study

Two couples were selected to participate in a pilot study. Couple B failed to complete the pilot study because of a sudden illness in the family. Couple A participated in the pilot study as scheduled. Table 2 represents raw score and category information from FILE, cohesion raw score and category information on both the perceived and ideal measures of FACES-II and the adaptability raw score and category information on both the perceived and ideal measures of FACES-II.

Table 2

Data From Pilot Study

Instrument	Raw score	Category[a]	Respondent[b]
FILE	54	High Stress	HA
FILE	56	High Stress	WA
FACES-II	72	Perceived Cohesion Connect	HA
FACES-II	79	Ideal Cohesion Enmeshed	HA
FACES-II	72	Perceived Cohesion Connected	WA
FACES-II	72	Ideal Cohesion Connected	WA
FACES-II	49	Perceived Adaptability Structured	HA
FACES-II	64	Ideal Adaptability Chaotic	HA
FACES-II	57	Perceived Adaptability Chaotic	WA
FACES-II	63	Ideal Adaptability Chaotic	WA

a) Areas are indicated where appropriate.

b) The H refers to Husband; W to Wife; A to couple A.

Interview Analysis

Couple A was a Caucasian couple married 11 years at the time of the interview. Husband A was 30 years old, a college graduate with no living children. Wife A was 37 years old, a college graduate with one child, a 10 year old son. This was a second marriage for both husband and wife. Couple A reported experiencing two miscarriages, the first occurred in 1982, the second in 1983.

Husband

Husband A had vivid memories of the events surrounding both miscarriage experiences. He was especially accurate in his description of the event from a medical perspective. He reported that he had been trained as a medic in the U.S. Army. He was less able to discuss his feelings concerning the event, labeling them as hidden by the "ostrich syndrome". He also stated that he felt like the marriage was under stress in other areas that required more of his attention than the pregnancy. He did not elaborate on these other areas. He mentioned his belief that God had a hand in the miscarriage as an explanation of its cause. He reported that over time, he had learned to understand the impact of his "ostrich" behavior. When he reflected on the events of the first miscarriage, he felt guilty and remorseful. He had not "been there" for his wife in pertinent ways, because his wife had "nearly bled to death". With the second miscarriage, he remembered feeling as if he had a second chance to make things up to her. He reported that he had handled events "100% better" with the second miscarriage.

Wife

Wife A was easily able to recount the events of both miscarriages. She concentrated her responses during the interview on the first

miscarriage. She remembered minute details of her experience with her personal obstetrician, the Emergency Room staff and physician, and her postpartum visit to her obstetrician. She was clear and direct in her presentation of details and equally clear in stating her feelings of anger, hysteria, panic, loneliness and fear. She reported that she clearly remembers feeling like she was going to die. She was less clear describing the actual medical procedures performed on her while she was hospitalized. She stated that she felt as if God had sent her the physician in the Emergency Room. She was able to elaborate on the details of her relationship with him with ease and clarity. Her first miscarriage was experienced while on a vacation visiting relatives. So she remembers feeling "confused as to what was actually happening" and tending to minimize the event. She reported that over time she has become "less depressed" and "more able to talk to her husband and others" about her experiences.

Conjoint Session

Both spouses agreed that the discussion of the miscarriages were daily occurrences while the pregnancies were threatened. Wife A remembered minimizing the severity of the first miscarriage. Husband A remembered being the one who finally called a local hospital for instructions as to the care of his wife. Except for that one incident, Wife A reported initiating all the conversation and procedure concerning the first miscarriage. During the second miscarriage, both spouses reported initiating conversation concerning the miscarriage. Both spouses reported good depth and quality of communication during the second miscarriage and less depth and quality of communication during the first miscarriage.

Similarity of feelings centered around loss and grief issues, guilt and responsibility. Wife A admitted to a unique physical experience of loss that she said Husband A could not biologically experience. Husband A admitted to feelings of despair over the loss of someone who would be like him. He also said that he regretted not being able to share the birth experience with his wife. He also reported that he did not feel as much support from others as he perceived his wife was receiving.

The couple also reported a lack of resolution concerning birth control issues. No future pregnancies are planned, but decisions concerning sterilization methods have yet to be made.

Couple A would have us know that the grief and crisis experience of miscarriage is "difficult for everybody". "There is no coffin, no funeral" to validate the loss, "but there's no baby either to take home with you". They suggested that family and friends could have been more "supportive, sensitive and mothering" and less "nonchalant, or shocked". Wife A remembered feeling more supported by her mother-in-law than her own family adding that "my family wasn't too nurturing".

So Wife A suggested that "you should get counseling" or "join a support group, both the husband and the wife". Husband A thought that husbands needed to "become more sensitive" and "give it all you've got" in an effort to develop this sensitivity.

Summary

Information accumulated during the pilot study led to the development of subject selection, procedures and an analysis of data as presented above. This study followed a case study design. The information obtained from the study was presented according to the guidelines of case study research as developed by Yin (1984).

Instrumentation for the study consisted of the Family Adaptability and Cohesion Evaluation Scales, FACES-II (Olson et al., 1982) and the Family Inventory of Life Events and Changes, FILE (McCubbin & Patterson, 1981). A personal interview with the researcher was also included in the design of the study. Information from the interviews and assessment tools were presented in narrative and table form on both a couple-by-couple and cross-couple basis. Case study findings, policy implications and research applications were also reported.

CHAPTER IV

ANALYSIS OF DATA

Data for the case study were processed in two ways. Data from the Family Inventory of Life Events and Changes (FILE) and the Family Adaptability and Cohesion Evaluation Scales-II (FACES-II) were hand scored. Data from the individual and conjoint interview sessions were summarized in paragraph form.

The hand scoring of the FILE rendered one score for family life changes. The scoring of the FACES-II instrument renders four scores: Perceived Cohesion, Ideal Cohesion, Perceived Adaptability and Ideal Adaptability.

All data from FILE and FACES-II are presented in Table form. Tables have been designed so that information from FILE and FACES-II can be presented independently of each of the couples in the study. Additionally, other tables present only FILE data, categories and subgroups for all subjects in the study, and only FACES-II data, categories and subgroups for all subjects.

As data for the FACES-II measure of family life satisfaction are presented, four balanced levels are identified. These levels will be a combination of the cohesion and adaptability scores. The two moderate or balanced levels of cohesion have been labeled separated and connected. The two moderate or balanced levels of adaptability have been labeled flexible and structured.

All data from FILE and FACES-II are presented in Table form. Tables have been designed so that information from FILE and FACES-II can be presented independently of each of the couples in the study. Additionally, other tables present only FILE data, categories and subgroups for all subjects in the study, and only FACES-II data, categories and subgroups for all subjects.

As data for the FACES-II measure of family life satisfaction are presented, four balanced levels are identified. These levels will be a combination of the cohesion and adaptability scores. The two moderate or balanced levels of cohesion have been labeled separated and connected. The two moderate or balanced levels of adaptability have been labeled flexible and structured.

For each dimension, it is hypothesized that the balanced levels are more viable for healthy family functioning and the extreme areas are generally seen as more problematic for couples over time (Olson et al., 1982). The labels attributed to the instrument assist in further understanding the dynamics of particular kinds of marriages and the setting of treatment goals (Olson et al., 1982).

It is assumed that within a marriage, individual members will not see their relationship in exactly the same way as their partner. By comparing the perceived and ideal measures for both husband and wife, it is possible to assess the level of satisfaction with the current marital system. It also provides information regarding how each individual would like to see the family system change (Olson et al., 1982). Comparisons of the perceived and ideal measures between marital partners provide a more complete picture of the marital relationship. It is important to note that couples who render scores outside of the moderate

range may function well as long as both partners like it that way (Olson et al., 1982).

Presentation Of The Data

Of the six couples who participated in the study, three couples were from group A whose miscarriage had occurred in the last six months. These were Couples 1, 2 and 3. Couple 4 was from group B, couples who had experienced a miscarriage from 7 to 12 months ago. Group C, consisting of couples whose miscarriage was experienced more than 12 months ago, includes Couples 5 and 6.

Summaries of the individual and conjoint interviews with the six couples in the study were presented in paragraph form. Data from FILE and FACES-II were presented in the following tables.

Table 3

Couple #1 Stress Levels, Perceived and Ideal Cohesion Scores and Categories and Perceived and Ideal Adaptability Scores and Categories

Instrument	Raw Score	Category[a]	Respondent[b]
FILE	57	Moderate Stress	H1
FACES-II			
Perceived Cohesion	70	Connected	H1
Ideal Cohesion	72	Connected	H1
FACES-II			
Perceived Adaptability	55	Flexible	H1
Ideal Adaptability	62	Chaotic	H1
FILE	c		
FACES-II			
Perceived Cohesion	72	Connected	W1
Ideal Cohesion	74	Enmeshed	W1
FACES-II			
Perceived Adaptability	57	Chaotic	W1
Ideal Adaptability	62	Chaotic	W1

(a) Subgroups are indicated where applicable. (b) H1 = Husband in Couple 1; W1 = Wife in Couple 1. (c) Respondent did not complete file.

Table 4

Couple #2 Stress Levels, Perceived and Ideal Cohesion Scores and Categories and Perceived and Ideal Adaptability Scores and Categories

Instrument	Raw Score	Category[a]	Respondent[b]
FILE	61	Low Stress	H2
FACES-II			
Perceived Cohesion	57	Separated	H2
Ideal Cohesion	68	Connected	H2
FACES-II			
Perceived Adaptability	51	Flexible	H2
Ideal Adaptability	58	Chaotic	H2
FILE	59	Moderate Stress	W2
FACES-II			
Perceived Cohesion	74	Enmeshed	W2
Ideal Cohesion	76	Enmeshed	W2
FACES-II			
Perceived Adaptability	49	Structured	W2
Ideal Adaptability	60	Chaotic	W2

(a) Subgroups are indicated where applicable. (b) H2 = Husband in Couple 2; W2 = Wife in Couple 2.

Table 5

Couple #3 Stress Levels, Perceived and Ideal Cohesion Scores and Categories and Perceived and Ideal Adaptability Scores and Categories

Instrument	Raw Score	Category[a]	Respondent[b]
FILE	56	Moderate Stress	H3
FACES-II			
Perceived Cohesion	76	Enmeshed	H3
Ideal Cohesion	74	Enmeshed	H3
FACES-II			
Perceived Adaptability	56	Flexible	H3
Ideal Adaptability	65	Chaotic	H3
FILE	53	High Stress	W3
FACES-II			
Perceived Cohesion	77	Enmeshed	W3
Ideal Cohesion	79	Enmeshed	W3
FACES-II			
Perceived Adaptability	45	Structured	W3
Ideal Adaptability	53	Chaotic	W3

(a) Subgroups are indicated where applicable. (b) H3 = Husband in Couple 3; W3 = Wife in Couple 3.

Table 6

Couple #4 Stress Levels, Perceived and Ideal Cohesion Scores and Categories and Perceived and Ideal Adaptability Scores and Categories

Instrument	Raw Score	Category[a]	Respondent[b]
FILE	67	Low Stress	H4
FACES-II			
Perceived Cohesion	71	Connected	H4
Ideal Cohesion	72	Connected	H4
FACES-II			
Perceived Adaptability	53	Flexible	H4
Ideal Adaptability	59	Chaotic	H4
FILE	61	Low Stress	W4
FACES-II			
Perceived Cohesion	68	Connected	W4
Ideal Cohesion	68	Connected	W4
FACES-II			
Perceived Adaptability	50	Flexible	W4
Ideal Adaptability	60	Chaotic	W4

(a) Subgroups are indicated where applicable. (b) H4 = Husband in Couple 4; W4 = Wife in Couple 4.

Table 7

Couple #5 Stress Levels, Perceived and Ideal Cohesion Scores and Categories and Perceived and Ideal Adaptability Scores and Categories

Instrument	Raw Score	Category[a]	Respondent[b]
FILE	63	Low Stress	H5
FACES-II			
Perceived Cohesion	75	Enmeshed	H5
Ideal Cohesion	76	Enmeshed	H5
FACES-II			
Perceived Adaptability	65	Chaotic	H5
Ideal Adaptability	65	Chaotic	H5
FILE	61	Low Stress	W5
FACES-II			
Perceived Cohesion	73	Enmeshed	W5
Ideal Cohesion	74	Enmeshed	W5
FACES-II			
Perceived Adaptability	61	Chaotic	W5
Ideal Adaptability	62	Chaotic	W5

(a) Subgroups are indicated where applicable. (b) H5 = Husband in Couple 5; W5 = Wife in Couple 5.

Table 8

Couple #6 Stress Leve ls, Perceived and Ideal Cohesion Scores and Categories and Perceived and Ideal Adaptability Scores and Categories

Instrument	Raw Score	Category[a]	Respondent[b]
FILE	64	Low Stress	H6
FACES-II			
Perceived Cohesion	71	Connected	H6
Ideal Cohesion	72	Connected	H6
FACES-II			
Perceived Adaptability	59	Chaotic	H6
Ideal Adaptability	64	Chaotic	H6
FILE	65	Low Stress	W6
FACES-II			
Perceived Cohesion	70	Connected	W6
Ideal Cohesion	70	Connected	W6
FACES-II			
Perceived Adaptability	61	Chaotic	W6
Ideal Adaptability	61	Chaotic	W6

(a) Subgroups are indicated where applicable. (b) H6 = Husband in Couple 6; W6 = Wife in Couple 6.

Table 9

Stress Levels and FILE Scores For All Participants

Subject	Raw Score	Category
H1	57	Moderate Stress
W1	a	
H2	61	Low Stress
W2	59	Moderate Stress
H3	56	Moderate Stress
W3	53	High Stress
H4	61	Low Stress
W4	61	Low Stress
H5	63	Low Stress
W5	61	Low Stress
H6	64	Low Stress
W6	65	Low Stress

(a) Respondent did not complete FILE.

Only one respondent scored in the High Stress range, and only one respondent failed to complete FILE. Three respondents scored in the Moderate Stress range, with all other respondents rendering Low Stress scores.

Table 10

FACES-II Scores and Cohesion Categories For All Participants

Subject	Perceived Cohesion Raw Score	Category	Ideal Cohesion Raw Score	Category
H1	70	Connected	72	Connected
W1	72	Connected	74	Enmeshed
H2	57	Separated	68	Connected
W2	74	Enmeshed	76	Enmeshed
H3	76	Enmeshed	74	Enmeshed
W3	77	Enmeshed	79	Enmeshed
H4	71	Connected	71	Connected
W4	68	Connected	68	Connected
H5	75	Enmeshed	76	Enmeshed
W5	73	Enmeshed	74	Enmeshed
H6	71	Connected	72	Connected
W6	70	Connected	70	Connected

Five of the respondents perceive their marital cohesion as enmeshed, and think an ideal marital relationship is enmeshed. Five other respondents describe their current marital cohesion level and an ideal level as connected. One respondent perceived her relationship to be connected and the ideal to be enmeshed. The final respondent perceived his current marital cohesion level to be separated, and the ideal level to be connected.

Table 11

FACES-II Scores and Adaptability Categories For All Participants

Subject	Perceived Adaptability Raw Score	Category	Ideal Adaptability Raw Score	Category
H1	55	Flexible	62	Chaotic
W1	57	Chaotic	62	Chaotic
H2	51	Flexible	58	Chaotic
W2	40	Structured	60	Chaotic
H3	57	Flexible	65	Chaotic
W3	45	Structured	63	Chaotic
H4	53	Flexible	59	Chaotic
W4	50	Flexible	60	Chaotic
H5	65	Chaotic	65	Chaotic
W5	61	Chaotic	62	Chaotic
H6	59	Chaotic	64	Chaotic
W6	61	Chaotic	61	Chaotic

Of the 12 participants, five perceived their ability to adapt as chaotic, five others perceived their ability to adapt as flexible, with the two remaining respondents endorsing structured as their current adaptability level. All respondents thought the ideal adaptability level to be chaotic.

Interview Analysis - Group A

Couple 1

Couple 1 is a Caucasian couple married 15 years at the time of the interview. Both partners work full-time outside the home. They have experienced two miscarriages. One was at 3 months prior to the study and the other was 22 months prior to the study. For purposes of research, the most recent miscarriage is being considered. However, some references of a comparative nature were made to the first miscarriage by the couple, and are included in the narrative.

Husband

Husband 1 described the most recent miscarriage with clear and accurate language. He often used comparisons between the two miscarriages, calling the first experience "a rip-roaring one" that had his wife "yelling in pain" and him "mainly concerned about finding the doctor." The second miscarriage "wasn't so bad" and "we had O.B.'s instead of a G.P. this time, and they seemed more used to it." The first pregnancy was "accidental" while the second one was "planned." "I was ready to accept another one in the family now. I'm not so engrossed in myself and immature." When the second miscarriage occurred, he reported feeling "real disappointed," "out in left-field," "shocked and fearful." "I kept thinking about what I could do to maybe save the pregnancy, like maybe something shifted out of place." He also commented tht he had learned that most miscarriages occur because of "genetics." He said that he is "not as emotional now" and reports "no resentment" remaining. "It's just something that happened that didn't seem to be as hard on me as her." "She went on a 10-day buying spree, I guess as her post-partum depression." He also said that he is "better

able to talk about it now," and "I don't take babies for granted as much."

Wife

Wife 1 stated that the second miscarriage "wasn't as abrupt as the first." She started "spotting for about eight days, and I rationalized and repressed things during that time." She gave clear and vivid details of the various medical procedures stating that during an ultrasound she "observed the cyst and saw no movement, no heartbeat." She felt "upset", "disappointed", and "knew nothing could be done." She said that "after the D. & C., I felt real good and tried to put everything behind me." This worked "okay for the first week or so" but then she felt "progressively more depressed" with the "weekends the worst." She experienced a "2-3 day crying jag" and was helped to clarify her feelings of loss when "a mother figure" friend called her and helped her talk about her feelings. She said that she thought "about 90% of miscarriages in the first three months of pregnancy are "blighted ovum," "grotesque" fetal development or "something just goes wrong." "It's Nature's way of weeding out, probably." Over time, she expressed feeling as if the "disappointment isn't quite as hard." "I'm not so devastated because I controlled my excitement with the second pregnancy because of the first one." She also reported "still feeling somewhat angry at a friend who just recently got pregnant."

Conjoint Session

Both spouses agreed that when the first miscarriage threatened, they discussed their disappointments about the event, their concern about maybe saving the pregnancy, their confusion about whether their general practitioner could take care of them. They also reported

talking about the possibility of the event limiting the wife's ability to sail that season. The second miscarriage has led to discussions of disappointment as well as planning for future pregnancies. They report their feelings are "fairly similar" and they continue to discuss fertility-related issues. They report feeling "less satisfied at only being a couple" and feel "a little more limited since they are tied to their M.D. for treatment." Wife 1 is currently taking ferility drugs.

They perceive that their marital relationship "could be enhanced" if they had a child. They "don't do as much long-term planning" now and "sex is procreation these days." They report that their relationship has taken a shift "of us and on to family."

They reported additional stress was felt "by having to tell our folks." "My wife's mother was very involved in her daughter's pregnancy." She "called a lot" and that caused "some strain" because she was "critical" in some of her comments.

Couple 2

Couple 2 is a Caucasion couple married 1 year at the time of the study. Both partners work full-time outside the home. Their first pregnancy ended in miscarriage approximately four months before participation in the research.

Husband

Husband 2 remembered that his wife was "pretty sick a lot" during the pregnancy. She had a lot of spotting on Wednesday night, but didn't tell me." The next day, after some tissue was passed we went to the doctor's and "I sat in the waiting room" and "didn't get called in "til after the D. & C." He reported feeling "scared for her" because she was in pain. "I felt sad too even though the pregnancy was a surprise."

Husband 2 said that he had "learned miscarriages were fairly common" even though he didn't know what caused theirs. "Maybe something's just not right in there."

Over time, he said that he is "wanting to wait awhile before another pregnancy is attempted." "This is a new marriage, you know. We were only married for six months at the time of the pregnancy."

Wife

Wife 2 reported that this was an "unplanned pregnancy" that really surprised her--she remembered thinking "how did I get pregnant?" and felt like "something was wrong" from the very beginning. She said that she also felt "under a lot of pressure" from her famly. "I'm from a big Catholic family that was saying, 'our baby's gonna have a baby' and it put a lot of pressure on me."

When the miscarriage started, she said "I distinctly remember feeling three really severe pains." She waited until the morning to call her doctor and had her husband take her in for an examination. A D. & C. was performed in the office and she reported that "the pain was so bad I decided then and there that I'm never gonna have children." She remembers feeling "relieved" that the pregnancy ended in miscarriage and that "made me feel selfish."

She was unable to say what causes miscarriages, but she does feel like "there is a reason for mine. I'm a waitress and I might have strained myself carrying heavy trays." She also suggested that "being on the pill for three years" before the pregnancy may have been a factor in her miscarriage.

Over time, she has likened her miscarriage to "it being like a death in the family." "I denied that to protect myself" in the early

days following the miscarriage. "Early in the pregnancy, I was not attached to it, so I didn't feel bad." She also reported that "it's harder for me now because I still think about being pregnant." "May will be really tough" because her delivery would have occurred in May had the pregnancy gone full term.

Conjoint Session

Both spouses agreed that they had a lengthy discussion about the pregnancy and miscarriage on the day they went to the doctor. Subsequent discussions have been limited because "we didn't want to hurt each other, so we didn't talk much." They describe their communication pattern, however, as "open even though we did hold some things back and stayed within ourselves."

They described their feelings about the miscarriage as being dissimilar. The husband said he felt "confused and unaware of what was happening." The wife said that she was "more relieved." They did report one occasion around Christmas when they discussed the miscarriage after having seen a niece at a family gathering.

They stated that their marriage had changed to be "more realistic, more responsible" as a result of the miscarriage. "It also brought us closer together because God has given us this little slap in the face to prepare us for the next time." Therefore they state that "they know God is watching us" and they try "to spend quality time together."

Couple 3

Couple 3 is a Caucasian couple in their early twenties. Husband 3 is a college student, who also works full-time. Wife 3 works full-time outside the home. The miscarriage occurred approximately five months before the study, during this couple's first pregnancy.

Husband

Husband 3 had clear memories of the miscarriage from both a physical and emotional perspective. He described the early threats of the miscarriage when his wife began bleeding. He reported that the telephone contacts with the doctor's office left him feeling confused and with a sense of "being given the run around." Even though his wife had started bleeding 3-5 weeks after the pregnancy was confirmed, "all they told her to do was lay down and elevate her feet." He continued, "when we called the doctor, we were told you could have a period when you're pregnant." His wife continued to bleed and "it got more painful, so we called the doctor a few more times, but she wouldn't see us." My wife "was in horrible pain and I was worried about her, physically and mentally. I also felt sorry for her."

He described his feelings as "disappointed in the doctor, but I wasn't disappointed" in my wife. He was also critical of the doctor for "not knowing we were Rh factor. I'm Rh- and she's Rh+." "When we finally got to the doctor's office, it was a fiasco. No one showed any interest or compassion." "It also happened during the first week of school and I was working 40 hours a week. I was distracted a lot."

When asked to comment on the causes of miscarriages and his knowledge about them, "I understood that evidently something was wrong with it, but I found that out from people at our church. We had the Rh factor and physically she may have lifted something or strained herself." He also reported that one church member had said that a miscarriage could occur if a "cat jumps on a pregnant woman's stomach."

Over time, he reports "constant reminders, daily reminders" about the miscarriage. "Other people having babies", "my sister has a new

baby now." He was also reminded that his wife "gave all her baby stuff away immediately after the event." "I really don't think it was an accident. It was what was supposed to be, what God wanted. We'll have a very special child one of these days."

Wife

"Just about the time I started to show and get excited about it, I started to bleed", said Wife 3 when asked to describe the events of the miscarriage. "I was still down in bed, but the bleeding got heavier and heavier. They just told me not to worry about it." The couple went to the Emergency Room of the hospital over the weekend, where an ultrasound was performed. No movement was seen, and the couple was sent home. "They told us we had an appointment for 10:00 a.m. Monday" with the doctor. "When I got to the doctor's office, I thought I would be seen immediately. But I was told that the doctor didn't see patients on Monday, and that they had no record of an appointment for me. So I went home. They made an appointment for me Tuesday or Wednesday and I had the D. & C. then."

She reported having "real mixed emotions" about the pregnancy. "It was hard on me, and unplanned." My husband "was still in school." "We live quite a distance from the doctors and the hospital, so all the trips back and forth were difficult." She stated that she was feeling "frustrated and angry" during the miscarriage.

She also said that she "has done a lot of reading" about miscarriages and pregnancy and she also "has a medical dictionary." She recalled reading about the "Rh disease" and feeling "angry that the doctor's office did not know that on me." She believes now that "something was wrong with it" when asked why the miscarriage occurred.

Over time, she reported that the event "took its toll later. I had five friends who were pregnant" so there are "still a lot of reminders" as they discuss their pregnancies. In comparing their situations to hers, she reported having "no ultrasound run early" nor "initial blood tests" that might have helped "learn something" about the pregnancy.

She continued her discussion by commenting on her work situation. "I had a real hard time at work." She described her boss as "cold-hearted" who "chose to pick on me" and showed "no compassion." "It was a difficult week", because she was also "looking for another job." Prior to the interview she had changed employment and ultimately learned that her previous employer had also "had a miscarriage and is pregnant again."

Conjoint Session

Both individuals agreed that they "talked about the miscarriage a lot" while it was happening. "It was the only topic of discussion. Everyone was calling giving advice." They both also agreed that the quality of their communication "was 9 on a 10-point scale." They also share similar feelings of anger and frustration toward the health care professionals and "we won't go back."

Their current conversations are future oriented about "family planning" issues. "We don't discuss the miscarriage much anymore", said Husband 3. "I try to protect her from it if she's feeling down."

Neither reported much change in their relationship as a result of the event. Husband 3 said, "Maybe she's matured some, me too. I don't feel so isolated." They had also "learned a lot medically" about miscarriages. They also said "about our feelings, and everything that happened, it's okay. You're not the only ones who've miscarried."

Interview Analysis - Group B

Couple 4

Couple 4 is a Caucasian couple in their early 30's. They had been married almost five years at the time of their first pregnancy. That pregnancy ended in miscarriage about eight months prior to their participation in the study. Wife 4 is currently pregnant and due to deliver in the Spring.

Husband

"Everything happened so quick" said Husband 4 in regard to the miscarriage. "We found out on a Tuesday that she was pregnant and about a week later she started spotting." The bleeding continued off and on for "about five weeks" before she "had a D. & C. in the doctor's office." He reported that the event was "painful for my wife and I couldn't believe the insensitivity of the doctors and nurses who asked 'how will you pay?'."

When asked to describe his feelings about the miscarriage, Husband 4 said, "there wasn't time to really get excited before getting let down." "I really felt sorry for her." "Now I guess I feel more confident and hopeful that God will take care of us."

He responded that he had learned a lot about miscarriages from his wife. "She's well read." He said that there are "different types of causes for miscarriages, like implantation, biological, or something wasn't right."

Time has made it "easier to talk about now. This pregnancy is better, like the body got rid of some stuff" it didn't need to make a healthy pregnancy possible.

Wife

Wife 4 said that she had a medical confirmation of her pregnancy when "I was still real early, only three weeks along. But I started spotting right away "and it continued for 8-10 weeks." The miscarriage wasn't too bad, no hospital or anything, just real severe cramps."

She described herself as feeling "relieved when it was finally over, and somewhat frustrated." The doctors were "very straightforward with their opinions, but I expected a miracle." When the D. & C. was performed, she reported feeling "panicky and worried about future pregnancies." She also confirmed feelings of "not feeling like a real woman that threatened my femininity."

She has read extensively in the area of miscarriage, pregnancy and loss, which has been helpful to her. She stated that her parents "have no history of miscarriage" and thought that her miscarriage was due to "the pill" or "tennis" or something. "My life was being scrutinized."

Over time the miscarriage event had "softened" in her memory. "When something hurts you real bad" it takes time to get over it. "Nature was playing its course."

Conjoint Session

Communication during the weeks of spotting when the miscarriage threatened occurred daily, and for about two weeks after the D. & C. Both individuals said the depth of communication "could have been better" but they both still described their communication as "better than the average couple." Husband 4 said that he limited some of his communication with his wife by "trying not to be too threatening."

Both husband and wife shared feelings of pessimism" with a sense of being "closed off" and "not telling anyone" about the miscarriage.

Initially, both agreed not to talk about the event, but have changed. They have partiipated in discussions with others who have had miscarriages.

They believe that they "feel closer" to each other since the event. Husband 4 said that "he felt sorry about all the pain she had experienced." The miscarriage is perceived as a "turning point" event. "It was the first serious thing in our relationship we had no control over," reported Husband 4. He continued, "It has caused us to think deeply and reassess our relationship."

Interview Analysis - Group C

Couple 5

Couple 5 is a Caucasian couple whose first pregnancy ended in a miscarriage about 14 months before participating in the study. Couple 5 has been married more than three years, and Wife 5 was pregnant again at the time of the interview.

Husband

Husband 5 remembered bits and pieces of the miscarriage event. He reported that his wife started "spotting on Thursday or Friday." "She went to the doctor the next Monday or Tuesday." During the doctor's appointment she "found out it was a miscarriage." He also stated that "she had stopped growing" before the spotting started.

He said that he felt "excited about the pregnancy", and also had some "money worries, since we're both self-employed." He added that the "pregnancy was planned though." He also recalled feeling "apprehensive", "disappointed" and "upset." At one point he was "concerned for her life" after he rushed her to the Emergency Room when she fainted in the shower. "I was trying to blame something" for what

had happened when the miscarriage finally occurred.

He said that he thinks miscarriages are "Nature's way of protecting the species" so that the "weak won't develop." He reported having no contact with the doctors who treated his wife and asked no questions of them as to the cause of the miscarriage.

Over time, he did not report thinking much about the event. "It's historical; I'm removed from it." He added, "I'm still not through with it though."

Wife

Wife 5 recalled that "it was Thanksgiving time, and I was just trying to make it through the dinner with family members." "We hadn't told anybody in the family about the pregnancy."

The miscarriage itself occurred spontaneously several days after an ultrasound revealed no heartbeat. Wife 5 reported that the doctor gave her the option of scheduling the D. & C. or allowing the miscarriage to occur spontaneously. She and her husband "discussed it together and opted to abort spontaneously." She also said that the D. & C. that was performed in the doctor's office was "painful."

She said that she felt "scared" when she fainted, and "naturally very upset when it first happened." She felt "okay" about not having told anyone about the pregnancy because "others feel awkward if someone miscarries."

She stated that she thought miscarriages occur when "something's not right." "It is for the best" and "God's way of handling the abnormal." She has also learned about miscarriages by "reading the literature from the doctors."

Over time, she reported "no real change in perception" about the

miscarriage. However, she was "extra careful with the first three months" of her current pregnancy until she "knew it wouldn't happen again."

Conjoint Session

Both individuals agree that they had "limited discussions" of the miscarriage while it was threatening. "Both of our families were there for Thanksgiving", so opportunities for time alone to talk were kept at a minimum. However, they both said that when they did discuss the events surrounding the miscarriage they communicated "excellently." They both admitted to feeling "resigned to the fact that the miscarriage would happen."

They "never" discuss the miscarriage. However, with regard to the current pregnancy, they "waited for the first three months" before discussing it. They also reported "no changes" in their marriage due to the miscarriage and "no effects" on their perception of the marital relationship due to the miscarriage.

Couple 6

Couple 6 is a Caucasian couple, married about ten years at the time of participation in the study. Both individuals work full-time outside the home. They experienced a miscarriage approximately two years ago.

Husband

Husband 6 described the events of the miscarriage by saying his wife "was bleeding a lot. We tried to call the clinic, but didn't get a very good answer." The couple went to the Emergency Room later that same evening. "By the time we made it to the hospital, I knew she had miscarried."

He labeled the feelings around the event as "traumatic." "At first

I was upset with her because I thought she should have stayed in bed more. But I lightened up when I got to the hospital." "I was nervous and concerned about her activity level increasing the chance for a miscarriage." While waiting in the Emergency Room, he felt "relieved and also irritated." He reported that "there was a lack of interest from the doctors and the on-call staff at the hospital."

He reported that he didn't know much about miscarriages, but has learned that "about 25% of all pregnancies end in miscarriage." He stated, "that's nice to know." He said that he was told that her miscarriage "was an undeveloped fetus."

Over time, he reports "no ill feelings against anything or anyone concerning the miscarriage."

Wife

Wife 6 began her summary of the events of the miscarriage by talking about her first visit to the doctors' offices. She reported an "assembly line feeling" with a "lack of personal care." When she began "to hemorrhage at work, she called the doctor's office." The nurse told me to take it easy, but that I had probably already miscarried." "Her comments really upset me and sounded cold." Later that evening Wife 8 reports that the bleeding began to increase. "Then I thought I had miscarried." After calling the emergency number for the doctors, I was told to come in to the office the next morning." A D. & C. was performed in the hospital then, and Wife 6 described the staff as "very supportive."

She felt "worried and upset" with a sense of "urgency" about the pregnancy. "I was not understanding what was happening to me." She also expressed concerns about the medical treatments performed on her.

She believes that "pain could have a permanent cellular imprint on her unborn child." She wondered if the pain she felt during her initial examination confirming her pregnancy had any bearing on the miscarriage. She also reported a feeling of "hopelessness" and a sense of "not being in a real collective state of mind." She described the moments immediately following the D. & C. as "touching" and filled with "tenderness" as she wondered "what is this" that was living inside me?

She continued by saying that she "did not know very much" about miscarriages. She got some "general information" from her doctors and was told that her pregnancy terminated because of a "blighted ovum."

Over time, Wife 6 has been able to "distance" herself from the event and reported that she "really hasn't thought about it for several months." She also said that she sees "no real difference in feelings from then until now," and these feelings are "intensified" whenever she sees a baby now. However, she relates this intensification as a "positive thing."

Conjoint Session

It was agreed that Wife 6 spent more time reviewing the details of the miscarriage after it happened than her husband. During her discussions of the event, she reported that her husband was very supportive. They both agreed that this process was "good" and "helpful" and that they communicated "well."

They reported "coming together emotionally" during the event and the husband's presence during the D. & C. procedure was "very helpful." They "talked extensively" about the miscarriage until Wife 6 "came to a resolution about the event." She reported that talking to her mother-in-law and a lady at work who had experienced a miscarriage was

very helpful. Also a brother and sister-in-law said to "hang in there, 'cause these things happen'" and the couple reported this discussion to be very comforting.

They report some changes in their relationship since the miscarriage. They state that they "seem closer" and "smoother." "The experiencing of this situation together was one more common experience, common reality that we share." They have made no clear decision about future pregnancies, although they report "sometimes feeling as if we should decide."

CHAPTER V

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Summary

This study has used a case study design to investigate the relationship between miscarriage and marital satisfaction. The phenomenon of miscarriage as a life crisis has also been addressed. The intent of the research has been multi-purpose in nature. Information concerning the event of miscarriage as a life crisis is ambiguous in the literature. Even though infertility has been documented as a crisis area, recent research resulting in the development of life crisis inventories have omitted items relating to infertility issues. With limited exceptions any item on a life event scale that dealt with pregnancy issues was couched in language relating to fertility, not infertility.

Secondly, couples who experience a miscarriage often experience a medical emergency as the fetus spontaneously aborts. This study has attempted to address the effects that a miscarriage may have on the marital relationship. The level of emotional bonding evidenced by the couple and their ability to adapt to the demands of attending to the miscarriage during the emergency situation were recorded.

Thirdly, information was collected from couples whose miscarriage experience ranged from a recent happening to a past event. An attempt was made to assess the effect that time might have on the miscarriage event. Couples who had experienced a miscarriage within the last six months were identified as Group A. Group B couples had experienced a

miscarriage from six to twelve months before the study was conducted. Couples who had experienced a miscarriage over one year ago were assigned to Group C.

Conclusions

The research question pertaining to miscarriage as a life crisis event was documented by identifying the perception the couples in the study had about the event. Each couple reported that the event of the miscarriage had the characteristics of a crisis, as understood to them. The miscarriage was unexpected, sudden, and fully absorbed their lifestyles. Work and school schedules were interrupted, and communications between spouses were generally focussed on the miscarriage. Concern for the health and well-being of the wife was expressed by every husband interviewed. Two of the six men also reported a fear that their wives may not survive the miscarriage. Four of the couples actually used the term "crisis" when asked to describe the events of the miscarriage. Therefore, it is supported by the study that these couples view their miscarriage as a life crisis event.

Inspection of the data collected from FILE indicated that 7 of the 12 respondents scored in the Low Stress Range. Only one respondent scored in the High Stress Range on FILE. It would appear that a miscarriage, although viewed as a crisis by the participants in the study during the interview session, was not sufficiently weighted on FILE to render Hih Stress scores among the participants that were expected.

The case study also dealt with the issues and details of the miscarriage itself as remembered by the participants. Each person in the study was asked to recall the events of the miscarriage during an

individual interview session. This was done to allow each participant to share her or his personal story about the event. Interestingly, every couple except one recounted almost identical versions of the event. In the case were a couple in the study may have had more than one miscarriage, details concerning the multiple events were clearly defined, without confusion or contradictions between partners.

Stories between members in a couple matched in areas of dates, time hospital or medical procedures and interactions between husband and wife. All but one couple remembered when the miscarriage occurred, what medical procedures were performed, which medical facility and personnel attended them and how they felt during the event. Individuals reported similar information concerning what support they had from family and friends, what medical support they received and what additional support they felt they needed.

The couple that reported contradictory and vague information about the miscarriage seemed to have some unique marital characteristics. They reported that they had limited discussion about the miscarriage when it happened and have never discussed the miscarriage since it occurred. However, both reported that they have thought about the events of the miscarriage, and have elected not to discuss the event with their spouse because they do not perceive any benefit from discussing it. It appears that both members of this couple have resigned themselves to the situation independently. Also, this couple agreed during the conjoint session that contradictions in the detail of the event were minor and generally insignificant. Also, this couple was pregnant during their participation in the study. They may have presented themselves more conservativly, minimizing the significance of

the miscarriage as measures of protection and caution. This couple also denied any change to their marital relationship or impact on their relationship as a result of the miscarriage.

Changes in or effects on the marital relationship were also areas of investigation generated by the research questions. Information was gathered by means of the Cohesion and Adaptability scores of FACES-II as well as through the interviews. The assumption that individual members would not see their marital relationship in exactly the same way was not validated on FACES-II on either scale. Only one couple failed to score in the same category on the cohesion dimension. On adaptability, 3 couples scored identically and 3 did not. Interestingly though, every individual scored in the chaotic category on the Ideal Adptability measure. This would indicate that the participants were interested in being partners in a relationship that could easily and quickly adapt to role changes.

The authors of the adaptability measure suggested that the more moderate levels of adaptability were characteristic of healthier relationships. However, the authors also stated that any relationship will function well if both members of the relationship like it that way.

Discrepancies in the findings between this study and the original design of the instruments used could be related to a number of factors. Original research on the adaptability scale was performed on only 50 couples. It is possible that the 9 couples in this study were not representative of couples in the original research sample. The characteristics of couples in this study were limited by the selection process to Caucasian, middle-class, childless couples with both partners working outside the home. The autonomy, professionalism and

independence of the individuals in the study would also lead to the conclusion that leadership roles within the marital relationship could be easily and quickly interchanged.

During the interviews five of the couples suggested that their marital relationship changed in a number of ways because of the miscarriage. They reported feeling closer, more mature, less isolated because they had experienced the event together. One couple also reported feeling less content as a couple, less satisfied, less complete. Two of the couples were pregnant at the time of the research and the other four couples were also dealing with fertility issues. Three of the couples were actively attempting pregnancy with one of the women in this group taking fertility drugs to increase her chances for conception. Only one couple reported no clear decision or discussions concerning the issue of further pregnancies.

Each couple was asked to comment about the miscarriage in regard to suggestions to other couples who might find themselves in a similar situation. Each couple responded to that question with positive and hopeful comments. They suggested that others avoid blaming themselves and remember that many couples experience miscarriages. Knowledge of the number and frequency of miscarriages was reported as helping the couples in the study to reduce the stigma that they may have done something wrong.

Five couples also said that sharing the feelings of loss with each other was very helpful because often family members or friends would minimize the event and its loss with awkward or prying comments. To be told "It's God's will", "You'll have another one" or similar comments were not viewed as helpful by any of the participants. However, one

participant did say that she found it helpful to remind herself that such comments were just inept ways that people who cared about her chose to relate to her. She viewed it as their way of trying to help and indigenous to the fact that most people don't know how to relate to people who have experienced a miscarriage. Those wives and husbands who had the opportunity to talk with other couples who miscarried all reported that sharing time to be helpful. These indiviuals would urge others to seek out people who have experienced a miscarriage and talk about the event to them. Having someone to share the loss helps to lessen the trauma. It also was seen as helpful in putting the event into a more realistic perspective. Only one couple would suggest to others that a miscarriage "is no big deal. It's only as significant as you let it be." This couple would have other couples know that it is permissable to experience a miscarriage and not perceive it as a crisis event, with lasting impact on the marital relationship. While this is not the majority opinion of the couples in the study, several other participants would want other couples to know keeping fertility and infertility isues in perspective is advisable.

One wife seemed to summarize the issue well by reminding herself that it is not a human rights issue to demand that individuals have children to duplicate themselves. She would suggest that anyone who feels incomplete as a person because he or she has not had a biological child would do well to examine those perceptions of incompleteness. Other participants echoed her sentiments, concluding that the couple is an important entity that transcends "making babies." "If a miscarriage is the worst thing that ever happens to us," said one respondent, "then we are really lucky." Said another, "Just love each other and go on."

The couples in the study had all been selected from the same obstetrics practice in an attempt to find participants with similar socio-economic backgrounds. When they were asked to comment on their perceptions of the medical community and its response to their loss, reactions were mixed. One husband reported that he was not allowed to be with his wife while the D. & C. was being performed. No other husband reported being denied access to his wife at any time she was at the hospital or physician's office. Since all patients were treated by the same physicians, these discrepancies add confusion to the findings. It is assumed that they reflect the confusion and feelings of loss that this couple may have been experiencing at the time. Also, this couple was the youngest couple in the study. They may have found it difficult to assert themselves within the medical community and ask for time together.

Three of the six couples did suggest that they had needs during the miscarriage that the medical community did not meet. These were generally of a psychological nature, with only one couple suggesting that they question the efficiency of their medical care. It appeared that some people in the study perceive the Emergency room physicians, nurses, technicians and other support personnel to be callous and unavailable to them. These couples reported telephone conversations to the physician's office that left them feeling confused about what to expect. Five of the couples said that they were not prepared for the amount of blood the wife would pass or the severity of the cramps she would experience. All the women agreed that the D. & C. in the physician's office was a very painful experience. Two husbands thought that the office staff was minimizing the situation and delaying

treatment for their wives by suggesting that they "take it easy and put their feet up." One husband was offended by the medical clerk asking him about paying his bill while he was trying to comfort his wife after her D. & C.

On the other hand, each participant reported that the physicians were "excellent", "the best in the business." They tended to specifically defend the physician and blame their confusion or concern on some unnamed staff member or generalized "they." The couples did report that they were surprised that no one could tell them why they had miscarried with any sense of assurance. They also expressed a desire to know why the miscarriage occurred. Several couples expressed a desire to have more information about miscarriages available to them. One wife suggested that a "debriefing" session with the physician several weeks after the miscarriage would have helped her resolve some of her guilt about perhaps causing the miscarriage. She cautioned the medical community not "to become callous" to miscarriages because the event is "a brand new experience to the patient."

All of the couples in the study were asked details about the first pregnancy experience between them that had resulted in miscarriage. For the couples who had experienced more than one miscarriage, it became apparent during the interviews that the first one was perceived more as a crisis than subsequent ones. During the time that the first pregnancy is threatened, and during the time the miscarriage actually occurs, "it is the most important event in a couple's life."

Recommendations

Recommendations evolving from this case study are being made in three major areas. Issues regarding the effects of the miscarriage on

the couples who experience it will be addressed. Further suggestions to the medical community and counseling communities will be offered. Finally research considerations will be presented.

For couples who experience a miscarriage, it is recommended that care be taken to view the event in clear and realistic terms.

1. Be prepared to face the issues of fertility and infertility that are thrust upon the couple whose pregnancy ends in miscarriage.
2. Make those preparations by gathering together as much information as is available to you on the subject of miscarriage. Determine what type of information is best suited to your needs by reviewing the available information.
3. Talk to your spouse about your feelings and your needs and try to develop a method to resolve those feelings and meet those needs that make sense to you.
4. Do not expect your perception to be identical to your spouse's perception, or anyone else's perception. Realize, however, that your perception of the event is valid for you. Allow yourself to feel whatever it is you feel, however little or however much.
5. Remember that there is no right way to grieve or resolve any event. What is important is working to resolve the experience in a way that makes sense to you.
6. The world seems filled with well-meaning friends and family who will try to tell you why you miscarried.

Decide for yourself if you want to listen to their interpretations, advice or suggestions. You have the right to walk away from those situations offering you no comfort.

7. Share your concerns about your pregnancy and its loss with your medical personnel. Obtain accurate, factual information.
8. Ask for additional consultation with your physicians about your miscarriage if you feel the need.
9. Ask for a psychological referral if you have the need for additional support as you resolve your loss.
10. Report any irregularities by staff in your medical treatment directly to your attending physicians. If you feel office or hospital staff were inappropriate in their dealings with you or unsympathetic to your needs, your physicians have a need and a right to know that.

For the medical community, several recommendations seem appropriate.

1. Recognize that a miscarriage, especially during the first pregnancy of a childless couple is usually viewed by them as a frightening, even life-threatening event. However routine the case may appear to you, it is not in any way routine to them.
2. Because of the crisis nature of aborting couples, feelings and sensitivities are heightened. Casual comments or insensitive remarks are often interpreted

by the couple in an exaggerated manner. Therefore, care should be taken to minimize the possibility of being misunderstood.

3. Development of a written fact sheet concerning the possible events of a spontaneous abortion should be made available to all couples whose pregnancy is threatened. Care should be given to explain the sequence of events of a typical miscarriage in language non-medical people can understand. This written statement should also include instructions to the couple concerning when to call the doctor or go to an emergency room.
4. An in-office protocol should be established for the care and treatment of the aborting couple. This treatment plan should recognize that both the wife and husband are involved in the process. Support staff involvement as to billing procedures and follow-up care should be carefully reviewed and appropriate procedures established.
5. An after-crisis follow-up visit with an office staff member should be offered to all couples who miscarry. The staff member offering this consultation time should be trained to support the couple in non-medical areas as well as medical ones.
6. A psychological consultation should be made available to couples, if desired by them.
7. A self-help referral to organizations such as The

Compassionate Friends should be offered to the couple.

For the counseling community, the following recommendations are being made:

1. Miscarriage should be viewed as a crisis event for the couple. The help needed to work through the grief cycle could be offered by counseling professionals, if the professionals refrain from minimizing the impact of the miscarriage.
2. Counseling professionals should take careful fertility histories of their clients who are receiving marriage or family therapy to determine if grief work from a past miscarriage is incomplete.
3. Fertility and infertility issues differ in their intensity and prevalence throughout the clinical population. Counseling professionals need to be aware of the relevant literature in the area to provide their clients a more complete professional service.
4. Sensitivity to the special concerns of the infertile couple, with appropriate referrals available could greatly enhance the potential that the infertile couple could be supported appropriately as they work to resolve the issues relevant to them.

The following are possible implications for further reasearch:

1. The collection of data for couples who miscarry should continue in the area of its effects on the marital

relationship. As sample size increases and data are available for a larger number of couples, research could be designed to investigate relationships between miscarriages and the marital relationship.

2. Within the parameters of life crisis research, a clear void of assessment tools measuring infertility as a life crisis event exists. Further research should attempt to develop instruments that reflect the need to address this issue.
3. Organizations that have as their mandate the support of infertile couples should make their services known to professionals. In that way, referrals could be made more easily between those couples in need of services and the services themselves.

SELECTED BIBLIOGRAPHY

Alberman, E., Elliott, M., Creasy, M. & Dhadial, R. (1975). Previous reproductive history in mothers presenting with spontaneous abortions. British Journal of Obstetrics and Gynaecology , 82 , 366-373.

Aladjem, S. (1980). Obstetrical practice . St. Louis: C.V. Mosby Co.

Boulby, J. (1961). The process of mourning. The International Journal of Psychoanalysis , 42 , 317-340.

Burns, A. (1984). Perceived causes of marriage breakdown and conditions of life. Journal of Marriage and the Family , 46 , 551-562.

Caplan, G. (1964). Principles of preventive psychiatry . New York: Basic Books, Inc.

Caplan, G. & Killilea, M. (eds.) (1976). Support systems and mutual helps: multidisciplinary explorations . New York: Grune and Stratton.

Caplan, G. (1961). An approach to community mental health . New York: Grune and Stratton.

Cappon, D. (1954). Some psychodynamic aspects of pregnancy. Canadian Medical Association Journal , 70 , 147.

Chadwick, B., Albrecht, S. & Kunz, P. (1976). Marital and family role satisfaction. Journal of Marriage and the Family , 38 , 430-439.

Clayton, P., Desmarias, L. & Winokur, G. (1968). A study of normal bereavement. American Journal of Psychiatry , 125 , 64-74.

Cochrane, S. & Bean, F. (1976). Husband-wife differences in the

demand for children. Journal of Marriage and the Family , 38 , 297-308.

Coleman, R. & Miller, A. (1975). The relationship between depression and marital maladjustment in a clinical population: a multitrait-multimethod study. Journal of Consulting and Clinical Psychology , 43 , 647-651.

Corney, R. & Horton, F. (1974). Pathological grief following spontaneous abortion. American Journal of Psychiatry , 131 , 825-827.

Deutsch, H. (1945). The psychology of women, Vol. 2: motherhood . New York: Grune and Stratton.

Engel, G.L. (1964). Grief and grieving. American Journal of Nursing , 64 , 93-98.

Ferguson, D., Horwood, L. & Shannon, F. (1984). A proportional hazards model of family breakdown. Journal of Marriage and the Family , 4 , 539-549.

Freud, S. (1957). Mourning and melancholia, in The Standard Edition of the Complete Psychological Works of Sigmund Freud , Vol. XXII. London: The Hogarth Press.

Fulton, R. (1970). Death, grief and social recuperation. OMEGA , 1 , 23-28.

Glass, R. & Golbus, M. (1978). Habitual abortion. Fertility and Sterility , 29 , 257-265.

Glenn, N. & Supanic, M. (1984). The social and demographic correlates of divorce and separation in the United States: an update and reconsideration. Journal of Marriage and the Family , 46 , 563-576.

Goetz, H. (1965). When your patient has had a spontaneous abortion. RN , 28 , 85-90.

Grimm, E. R. (1962). Psychological investigation of habitual abortion. Psychosomatic Medicine , 24 , 369.

Hicks, M. & Platt, M. (1970). Marital happiness and stability a review of the research in the sixties. Journal of Marriage and the Family , 32 , 553-574.

Horowitz, N. H. (1978). Adolescent mourning reaction to infant and fetal loss. Social Casework , 59 , 551-559.

James, W. (1963). The problem of spontaneous abortion. American Journal of Obstetrics and Gynecology , 85 , 38-41.

Javert, C. T. (1957). Spontaneous and habitual abortion . New York: McGraw-Hill.

Kaij, L., Malmquist, A. & Nilsson, A. (1969). Psychiatric aspects of spontaneous abortion-II. The importance of bereavement, attachment and neurosis in early life. Journal of Psychosomatic Research , 13 , 53-59.

Kaplan, H., & Sadock, B. (1981). Modern Synopsis of comprehensive textbook of psychiatry III . Baltimore: Williams & Wilkins.

Kennell, H., Slyter, H. & Klaus, M. (1970). The mourning response of parents to the death of a newborn infant. The New England Journal of Medicine , 283 , 344-349.

Kerns, R. & Turk, D. (1984). Depression and chronic pain: The mediating role of the spouse. Journal of Marriage and the Family , 46 , 845-852.

Kubler-Ross, E. (1969). On death and dying . New York: MacMillan.

Lindemann, E. (1944). Symptomatology and management of acute grief.

American Journal of Psychiatry , 101 , 141-148.

Luckey, E. & Bain, J. (1970). Children: A factor in marital satisfaction. Journal of Marriage and the Family , 32 , 43-44.

Mahlstedt, P. P. (1985). The psychological component of infertility. Fertility and Sterility , 43 , 335-346.

Mann, E. (1956). Psychiatric investigation of habitual abortion. Journal of the American Academy of Obstetrics and Gynecology , 7 , 589-600.

Mann, E. C. (1959). Habitual abortion. American Journal of Obstetrics and Gynecology , 77 , 706.

McCubbin, H. & Patterson, J. (1981). Broadening the scope of family strengths: An emphasis on family coping and social support. In N. Stinnett, J. Defrain, K. King, P. Knaub, & G. Rowe, (Eds.). Family Strengths 3: Roots of Well-Being . Lincoln, Nebraska: University of Nebraska Press.

Menning, B. E. (1977). Infertility: a guide for the childless couple . Englewood Cliffs, New Jersey: Prentice-Hall.

Menning, B. E. (1980). The emotional needs of infertile couples. Fertility and sterility , 34 , 313-319.

Menning, B. E. (1982). The psychological impact of infertility. Nursing clinics of North American , 17 , 155-163.

Olson, D., McCubbin, H., Barnes, H., Larson, A., Muxen, M., & Wilson, M. (1982). Family Inventories , St. Paul: Family Social Science.

Pincus, L. (1974). Death and the family . New York: Random House, Inc.

Pizer, H. & Palinski, C. (1980). Coping with a miscarriage . New York: The Dial Press.

Poland, B. J. (1977). Reproductive counseling in patients who have had a spontaneous abortion. American Journal of Obstetrics and Gynecology , 127 , 690.

Pritchard, J. A., & MacDonald, P. C. (1980). Williams obstetrics . New York: Appleton-Century-Crofts.

Rosenberg, B. G. & Sutton-Smith, B. (1972). Sex and identity . New York: Holt, Rinehart and Winston, Inc.

Russell, C. (1980). A methodological study of family cohesion and adaptability. Journal of Marital and Family Therapy , 6 , 459-470.

Seibel, M. & Graves, W. (1980). The psychological implications of spontaneous abortion. Journal of Reproductive Medicine , 25 , 161-165.

Seibel, M. M., & Taymor, M. L. (1982). Emotional aspects of infertility. Fertility and Sterility , 37 , 137-145.

Shapiro, C. H. (1982). The impact of infertility on the marital relationship. Social Casework Journal of Contemporary Social Work , 63 , 387-393.

Simon, N., Rothman, D., Goff, J., & Senturia, A. (1969). Psychological factors related to spontaneous and therapeutic abortion. American Journal of Obstetrics and Gynecology , 104 , 799-808.

Sprenkle, D., & Olson, D. (1978). Circumplex model of marital systems IV: Empirical study of clinic and non-clinic couples. Journal of Marriage and Family Counseling , 4 , 59-74.

Stack, J. (1980) Spontaneous abortion and grieving. American Family Physician , 21 , 99-102.

Stearns, A. K. (1984). Living through personal crisis . Chicago: The Thomas Moore Press.

Tupper, C., Moya, F., Stewart, L., Weil, R., & Gray, J. (1957). The problem of spontaneous abortion I. a combined approach. American Journal of Obstetrics and Gynecology , 73 , 313.

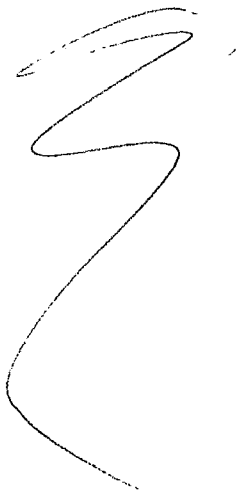
Tupper, C. & Weil, R. (1962). The problem of spontaneous abortion. American Journal of Obstetrics and Gynecology , 83 , 421-425.

Weiss, R. & Aved, B. (1978). Marital satisfaction and depression as predictors of physical health status. Journal of Consulting and Clinical Psychology , 46 , 1379-1384.

Weiss, R. S. (1976). Transition states and other stressful situations: their nature and programs for their management. In G. Caplan and M. Killilea, support systems and mutual helps: multidisciplinary exploration (213-232). New York: Grune and Stratton.

Yin, R. (1984). Case Study Research: Design and Methods . Beverly Hills: Sage Publications.

APPENDIX



INTERVIEW QUESTIONS

Individual Session (30 minutes - 45 minutes)

1. I would like for you to describe the events that happened during the miscarriage as you remember them. Think about the medical, psychological, family related and marital events, and tell me what you remember.

2. How would you describe the feelings that accompanied those events?

3. What do you know about miscarriages? What causes them?

4. What effect has time had on the way you view your experience?

5. Is there anything that we have talked about together that you do not want discussed when your spouse joins us?

INTERVIEW QUESTIONS

Conjoint Session (60 minutes)

1. When the miscarriage occured, how often did the two of you discuss the event?

2. How would you describe the quality or depth of your communication?

3. How do you think your feelings are similar? dissimilar? concerning the miscarriage?

4. Now, how often do you discuss the miscarriage with your spouse?

5. Now, when you talk about the miscarriage, what do you talk about?

6. What has changed for you in your marriage due to your experience of miscarriage?

7. What is your perception of the effect of the miscarriage on your marital relationship?

8. What would you like to say about your experience that would help other couples who may find themselves in a similar situation?

9. Assuming the medical stresses that a person experiences during a miscarriage, what other kinds of stresses do you feel you experienced during the miscarriage?

10. What decisions have you made concerning future pregnancies?

VITA

Katrina Harry Bright

Candidate for the Degree of

Doctor of Philosophy

Thesis: THE EFFECTS OF MISCARRIAGE ON SIX MARRIED COUPLES

Major Field: Counseling Psychology

Biographical:

Personal Data: Born in Pawnee, Oklahoma, May 5, 1948, the daughter of Robert H. and Francille L. Harry. Married to Dennis D. Bright on December 29, 1974.

Education: Graduated from Northwest Classen High School, Oklahoma City, Oklahoma, in 1966; received Bachelor of Science degree in Education and Bachelor of Arts degree from Missouri University in 1971; received Master of Education degree from Central State University in 1976; received Doctor of Philosophy degree from Oklahoma University in 1983; completed requirements for Doctor of Philosophy degree at Oklahoma State University in July, 1986.

Professional Experience: Classroom Teacher, Hallsville, Missouri, 1971 to 1972; Admissions Counselor, Columbia, Missouri, 1972 to 1977; Instructor, Bethany Nazarene College, 1978 to 1982; Psychology Intern, Oklahoma State Department of Health, 1985 to present.