The Impact of Miscarriage on the Subsequent Pregnancy: Thematic Analysis

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Abstract

Introduction: *The impact of spontaneous miscarriage on the psychological state of mind of the women who went through this experience has recently become increasingly important, getting more and more in the focus of specialized researches.*

Objectives: *The purpose of the current study was to examine, through thematic analysis, the impact of spontaneous miscarriage experiences on maternal-fetal attachment during pregnancy so that we can identify the specific psychological themes.*

Methods: *A sample of pregnant women (n = 24) with prior miscarriages filled in a questionnaire designed to identify both the experiences of women who have gone through miscarriages and their effects on the current pregnancy and the Maternal-Fetal Attachment Scale (M. Cranley, 1981). Then we initiated the qualitative analysis according to the six-step structure of the process proposed by V. Braun and V. Clarke (2006).*

Results: *Following the thematic analysis process, four main themes were identified: Emotional charge, Avoidance of a new loss, the Protection shield, and the Maternal-fetal relationship, each of them having 1 to 5 subtopics.*

Conclusions: *The current study highlights both the specific and the complexity of the emotional dynamics of pregnant women with a history of spontaneous miscarriage, and emphasizes on the fact that they become preoccupied with certain fears which determine distinct mechanisms and behaviours through which they seek to manage from one trimester of gestation to the next, aspects that clinicians should monitor and follow up throughout pregnancy.*

Keywords: miscarriage, pregnancy, perinatal loss, prenatal attachment

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I. Introduction

Spontaneous miscarriage defined as involuntary loss of the conception product before reaching fetal viability (Gotsch, F. et al., 2009) is the most common of the pregnancy complications. The World Health Organization describes spontaneous miscarriage as the expulsion of the conception product weighing less than 500 grams and up to 22 weeks of amenorrhea (since last menstruation) or 20 weeks of gestation.

From the point of view of the gestational age at which spontaneous miscarriages happen, we can distinguish between the early spontaneous abortion, which occurs before 12 weeks of pregnancy and late abortion, which occurs after 13 weeks of pregnancy. In addition to this, a woman can go through one miscarriage experience, known as single miscarriage or multiple spontaneous miscarriages included in the group of abortive diseases and infertility category. According to the generally agreed international statistics, 1 in 4 women undergo spontaneous miscarriage experiences, out of which 50% then undergo yet another spontaneous miscarriage and more than 80% of the spontaneous miscarriages happen in early stages.

The single spontaneous miscarriage it often perceived and treated by physicians as *an accident*, a common situation, although the experiences of women who go through this type of prenatal loss are very intense, having complex physiological, psychological and social implications. The main feature of the physiological symptomatology of the spontaneous miscarriage is the haemorrhage accompanied by uterine contractions that increase in intensity and frequency leading to partial or total expulsion of the conception product from the uterine cavity, which can occur in one, two or even three stages. For pregnancies of up to seven weeks, ovulatory expulsion can be produced completely, at one time, during menstruation. After eight weeks of gestation, spontaneous miscarriage can take place in two stages or in three stages, the fetus being expelled first, then the placenta and ultimately the obstruction. If abnormal haemorrhages occur and persist, an evacuation or hemostatic curettage is required.

The impact of spontaneous miscarriage on the psychological state of mind of the women who went through this experience has recently become increasingly important, getting in the focus of specialized researches. When reviewing the main studies conducted with this in view, we found that they can be structured into two categories. One of the categories includes studies on the emotional states of women which emerge immediately after the miscarriage and last up to 2-3 years after the incident. The second category includes research on the emotional states and/or on the maternal-fetal attachment that occur during the following pregnancies. Thus, Theut et al. (1989), Thapar and Thapar (1992), Janssen et al. (1996), Fertl, Bergner, Beyer, Klapp and Rauchfuss (2008) highlight the significantly higher prenatal anxiety of pregnant women with a history of spontaneous miscarriage compared to primary pregnant women and also to those without a history of loss. On the other hand, Franche & Mikail (1999) show that the increased pregnancy anxiety scores of pregnant women with a history of prenatal loss are significantly correlated with the scores of their personal responsibility regarding fetal health.

In their research, Armstrong and Hutti (1998), Armstrong (2004) emphasize that maternal prenatal attachment is significantly less developed in pregnant women with perinatal loss in their previous history than primary pregnant women. Having a different approach, Denise Côté-Arsenault (2007) argues that emotional states that appear and persist after a perinatal loss depend on the extent to which women represent the lost baby as a person, regardless of the number of pregnancy week in which the loss occurred.

Given that in pregnancies following prenatal loss because of spontaneous miscarriage, the challenges are rather emotional than physiological, in this study we set out to investigate. Through thematic analysis, the impact of spontaneous miscarriage experiences on maternal-fetal attachment during pregnancy in order to understand as much as possible the specific psychological themes. The reasons I chose a qualitative research is that in its specificity, the thematic analysis allows detailed description, identification and exploration of experiences lived by pregnant women during current and previous pregnancies, spontaneously stopped from evolution, which facilitates the decryption and understanding of the consequences of the spontaneous miscarriages on emotions, thoughts, needs and behaviours that are specific to pregnancy (healthy practices, relationship with obstetrician, announcement of the pregnancy to others, relationship with the fetus, etc.).

II. Methods

Participants

The sample of participants in this pilot study consisted of 24 pregnant women aged 22 - 39 years (M = 31.67, SD = 3.77) with a gestational age of 7 to 36 weeks of pregnancy, (M = 22.58, SD = 10.09). Out of

these, 16 pregnant women went through a single spontaneous miscarriage experience, 7 pregnant women went through two spontaneous miscarriages, and one pregnant woman experienced three spontaneous miscarriages. The participants were recruited from a private prenatal services centre in Bucharest, as well as by publishing an informative announcement online, on blogs for future parents.

Participants were informed of the purpose of the study, the way of deployment and the confidentiality of their responses. In addition to this, they received and signed a detailed agreement form for participation in the study.

In structuring this sample, three selection criteria of pregnant women were considered:

1) history of at least one spontaneous abortion,
2) Romanian nationality (due to the fact that we intend to also follow to what extent different cultural and mythological aspects intervene in the pregnancy management);
3) minimum age - 18 years.

Table no 1 shows the sociodemographic characteristics of the sample.

Measures

The independent variable, the history of spontaneous abortion, as well as the sociodemographic variables (age, gestational age, marital status, level of education etc.) were collected both in an anamnesis form and also during the semi-structured interview.

In order to qualitatively decrypt the experience of spontaneous miscarriage and its effects on the ongoing pregnancy, I configured a semi-structured interview protocol. Consisting of 41 questions, the semi-structured interview - The Impact of Spontaneous Miscarriage on Current Pregnancy is based on specific literature and it covers four distinct directions: the current pregnancy, the previous pregnancy (ended in spontaneous abortion), the post-miscarriage period or the intermediate time between incomplete pregnancy and the current one, the interferences between the incomplete pregnancy and the current one. I preferred such an instrument, as the open questions facilitate and encourage at the same time the narration, the detailed description of the situations experienced and the participants' expression of their emotions and needs, beliefs and thoughts.

Procedures

Each participant completed the anamnesis form, the Materno-Fetal Attachment Scale (Cranley, 1981) and the semi-structured interview guide, The Impact of Spontaneous Miscarriage on Current Pregnancy, in a private environment within the prenatal care centre premises and these two processes were not conditioned by a pre-established time limit. The interview was recorded using audio devices with the consent of the participating pregnant women.

After analysing the audio recordings, I found that the average duration of the interviews was 60 minutes, ranging from 85 minutes to 45 minutes. Once the data was collected using the two instruments - the Maternal Fetal Attachment Scale (Cranley, 1981) and the semi-structured interview protocol - The Impact of Spontaneous Miscarriage on Current Pregnancy, I initiated the specific qualitative analysis according to the six-step procedure proposed by Braun, V. and Clarke, V. (2006). The six steps of the thematic review process recommended by the two researchers are: transcribing data and checking the accuracy of the transcript, coding the data, identifying the themes, reviewing the themes identified and generating a thematic "map", defining and naming the themes, making the report.

Table no. 1 - Demographic Variables Sample

Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
Age	24	22	39	31.67	3.77
Gestation	24	7	36	22.58	10.09
Miscarriage	24	1	3	1.38	.576
Valid N (listwise)	24				

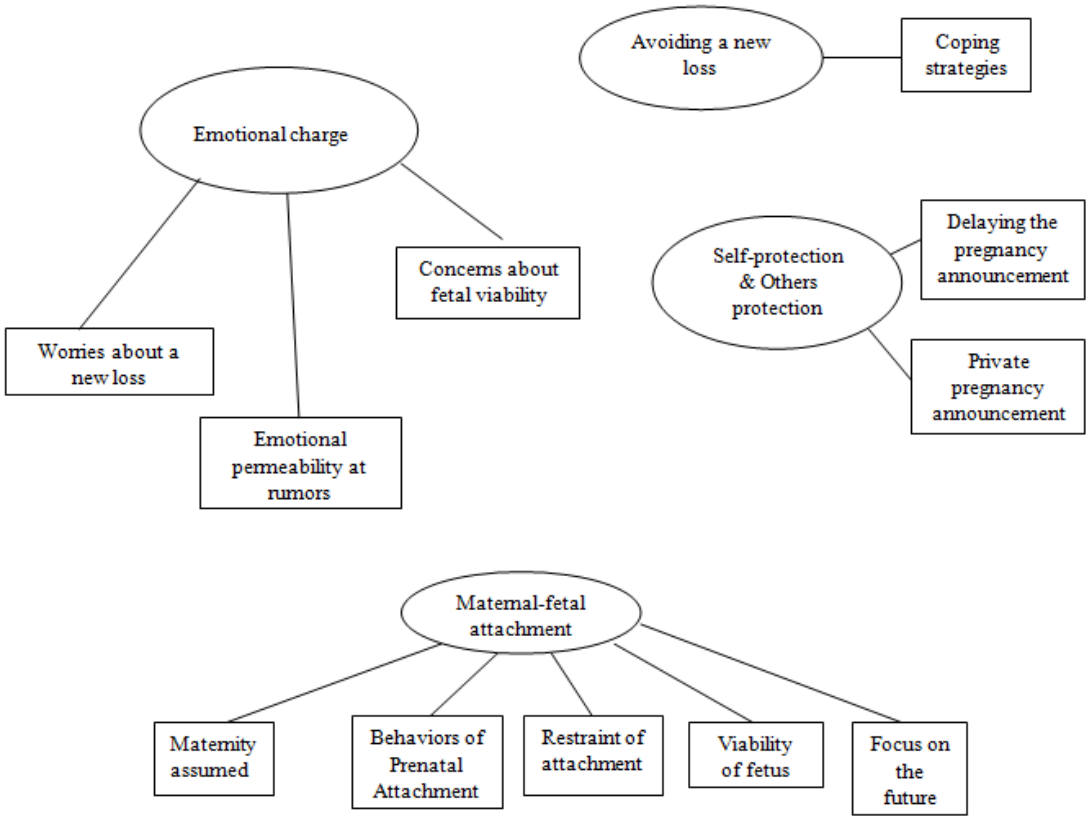
To be able to carry out a thematic analysis of the interviews, I first transcribed them in an electronic workbook, assorting all the answers to each item of the interview into a specific category, based on a certain categorization criterion. This way of organizing the data facilitated direct and fast access to the material undergoing the qualitative analysis, meaning to the concrete examples, and it ensured the clarity and objectivity of their processing to identify the specific semantic and dormant themes and sub-themes.

Following this first transcription phase, I sought to identify the first patterns of response generated directly by the work data, which I then subjected to a detailed analysis for coding, integrating them into a specific category and identifying the relationships between them.

III. Results

Regarding the impact of early spontaneous miscarriage experiences on the following pregnancy, I identified four main themes: the emotional charge, avoidance of a new loss, the protection shield, the maternal-fetal relationship, each of them having 1 to 5 subtopics (Figure 1).

Figure 1: Psychological themes



The Emotional Charge as a theme refers to the emotional states associated with the spontaneous miscarriage experience that pregnant women undergo during a later pregnancy. When questioning these emotional states experienced during the current pregnancy, their responses referred both to their type and to their intensity. All 24 pregnant women included in this study accused intense states of specific anxiety within the first three months of the current pregnancy, namely concerns about a new perinatal loss, concerns about the viability of the fetus, and a state of emotional permeability that was accentuated by what others were saying about the pregnancy (e.g. rumours, information, experiences, etc.) identified as sub-topics.

A first threshold in overcoming the emotional challenges experienced during the current pregnancy is the time variable. Thus, breaking the number of gestation weeks when the previous spontaneous miscarriage occurred is a very important moment for them. Moreover, they are guided by this time reference indicator, and overcoming it helps them engage emotionally in the pregnancy.

"In the first quarter, I was afraid of losing the pregnancy, that it would happen just as it did last time. I carefully counted the weeks of pregnancy. Once I had passed the 9th week when the previous spontaneous

miscarriage happened, I thought it was a success factor in the current pregnancy."

Given that doctors rely on chromosomal abnormalities or genetic malformations as causes for spontaneous abortion, pregnant women's concerns are increasingly focused on the possibility that these malformations might occur during the current fetus intrauterine development. The tendency to accentuate these fears is usually present until specific investigations are performed, such as Triple test, which occurs in the beginning of the second trimester. Thus, the first three months of pregnancy are dominated by the uncertainty of the viability of fetuses.

"Is everything okay?", I was asking the doctor all the time. Everything was about the fear the child might not be well, because of the loss I had suffered. I then suffered a lot.

On the other hand, pregnant women refer to the outside influences, from others (family, friends, colleagues, and gynecologist) or from different sources - books, online articles, which intensely resonate in their psyche with a direct determination on their behaviours during pregnancy.

"I was influenced by all sorts of things. I was receiving information even without asking. [...] A friend told me that I was not allowed to travel for more than 4 hours by car, that it shook me, so I did not leave Bucharest. Other friends told me not to dye my hair, so I did not do it anymore."

From the expressions of pregnant women about their emotional manifestations, two aspects have particularly attracted my attention. The first aspect relates to the concrete connection between the emotional states experienced in the current pregnancy and the experience of the spontaneous miscarriage with which the previous pregnancy had ended. The second aspect refers to the interferences between the verb tenses used, namely the past tense (when they talk about the previous pregnancy) and the present tense (when they talk about the current pregnancy). In their narratives, the two temporal situations rapidly alternate and merge into a chaotic manner so that further clarification questions are required in order to establish the pregnancy they refer to when they speak. So, the experience of the first weeks of the current pregnancy tends to interfere with that of the first weeks of the lost pregnancy by spontaneous miscarriage or even incorporate it as a reference parameter for the prenatal behaviours during this period.

The theme **Avoiding a New Loss** is taken over by the message *I do not want to lose this pregnancy (also)!* and it captures the ways in which pregnant women with a history of early miscarriage seek to prevent a new perinatal loss. From their responses, I noted that they develop different strategies of existential coping throughout the entire current pregnancy. These strategies become all the more pervasive as the ones around them do not offer the emotional support that they need. Moreover, they tend to minimize the importance of their miscarriage by saying that "other women have suffered much more perinatal loss", "it is not such a big deal and all they need is to relax," or that "many women are going through such situations." This attitude determines an accentuating belief that something is wrong with them and an amplification of their emotional conflict. In addition, pregnant women feel pressure from others and even from themselves to overcome their difficulties and rejuvenate emotionally as quickly as possible in order to provide true chances for intrauterine development of children. Therefore, they are in a position to quickly find and activate the coping mechanisms to ensure the survival of the fetuses.

During the current pregnancy, women manifest a prudent attitude through the hyper medicalization of their state as a mechanism for coping, and through a greater compliance with the medical act: obstetricians' indications, preventive or medical treatment, more effective additional medical investigations, but also by engaging in behaviours to avoid as many risk factors as possible: eating, relaxing, avoiding hair dyeing, applying nail polish, exercising, etc.

Through their behaviours, pregnant women aim to ensure the viability of the fetus in the current pregnancy. I consider these behaviours as part of the group of coping mechanisms focused on solving the problem, which Folkman and Lazarus (1980) mentioned that are becoming the primal focus, especially in situations where something can be built or repaired.

The theme of **the Protection Shield** focuses on the pregnant women's need to protect themselves and others from suffering in case of a new reproductive loss which sounds like that: *In case of a new loss, I do not want to suffer as much as I did before* (self-protection) and *In case of a new loss, I do not want others to suffer as much as the first time* (protecting others).

For this reason, the current pregnancy is announced much later compared to the previous pregnancy, ended up in spontaneous miscarriage,

namely after the first three months of pregnancy. Three reasons for this attitude were identified.

The first reason is about the fact that during the first three months of gestation the incidence of spontaneous miscarriage is the highest, therefore the highest risk for a new reproductive loss.

The second reason is about the need to ensure the viability of the fetus, a need that is satisfied through a variety of medical procedures - ultrasounds, medical analysis, detailed investigations that are performed especially at the end of the first trimester of pregnancy.

The third reason considers specific aspects about family and community mythology. No matter if they are formulated as messages transmitted by family members or other social groups of belonging, or if they take the shape of their own superstitions, the belief that the new pregnancy must be announced only after the first three months of gestation and not earlier becomes an unwritten rule.

"I announced that I was pregnant after three months of pregnancy. My mother-in-law told us to do that."

"It's what we have heard that it's better to do, to announce later."

"[...] maybe a superstition, I don't know, the negative energies around me. The first time (n.b. during the first pregnancy) I announced it. Then I also heard this, but mainly it was what I thought it was ok to do, I mean to announce it later this time."

On the other hand, the news of the new pregnancy is communicated to a limited number of people (max 4 -5 persons), and often they are the closest to them - family members, friends and colleagues. In such a limited social context, pregnant women feel much better protected than in an extended one. The rationale behind this attitude is represented by the difficulty of telling others about a new spontaneous miscarriage, the difficulty they faced in their previous experience.

It is what makes me able to assimilate this behaviour of the anticipated grief, a concept introduced by Lindemann (1944) and which captures the preparation for death, either during or before an inevitable loss or death. Although it is not an inevitable loss, but only a potential one, their behaviour seems to be similar to the anticipated mourning. This is even more meaningful in the context of what Therese Rando mentioned (1986), who argues that this kind of mourning can also be determined by the losses previously suffered. Therefore, because of the loss suffered in the previous pregnancy, pregnant women tend to anticipate in an explicit or implicit form, the risk of a new loss, which justifies the prenatal practices and behaviours, including their prenatal attachment to the fetuses.

The Maternal-Fetal Relationship is the fourth topic identified in this qualitative research and it captures the specifics of the relationship between pregnant women and fetuses. Following the centralization and analysis of the pregnant women's responses, and after identifying the patterns of response, I found five subtopics: assumption of maternity, prenatal attachment behaviours, restraint of prenatal attachment in terms of emotions, the viability of the fetus and focus on the future.

Women become aware of what motherhood experience really means to them starting from a previous pregnancy spontaneously terminated with miscarriage, when they experience their first representations of them being mothers and of their babies and when they have their first emotional inner contradictions and manifestations of prenatal attachment, all that beyond the specific physiological symptoms. Despite the limited number of weeks of gestation (up to 12 weeks) in which the first pregnancy prematurely terminated, and which can be considered a context of initiation in pregnancy, it can be noticed that they become available on an emotional, cognitive and social level to accept the new pregnancy, stressing **the assumption of maternity**.

"After the first experience, we realized that we really wanted a child, that we could raise a child. The fact that I got pregnant the first time made me see myself as a mother."

The prenatal attachment behaviour, as a sub-topic of the maternal-fetal relationship, refers to the manner in which pregnant women behave and interact in their direct and indirect relationship with their fetuses during pregnancy. Although prenatal attachment can be described concurrently in terms of behaviour, emotion, and cognition, this subtopic considers the maternal-fetal attachment in terms of behaviour exclusively.

During pregnancy, pregnant women with a history of miscarriage commit themselves to different behaviours to create and maintain a connection with the fetuses. Some of them talk to them and comfort them; others say they "scold" them when they move too much or too suddenly, while other pregnant women are looking to be heard in an impersonal manner by

reading aloud parenting or specific books, noting that they feel embarrassed to talk directly to the fetuses.

Despite the maternal-fetal attachment behaviours manifested by pregnant women with a history of spontaneous miscarriage, we noticed a rather limited variety of these compared to the existing prenatal attachment practices.

Restraint of prenatal attachment in terms of emotion as a subtopic refers to their conscious, deliberate efforts to defeat their joy, delight and enthusiasm to be pregnant again, due to their need to protect themselves against possible suffering in the event of a new prenatal loss. In the context of initial confirmation, pregnancy tests and / or trans-vaginal ultrasounds, during the current pregnancy, which for each participant, is a desired and planned one, I note a state of emotional effervescence that fractures rapidly with the excitement of the fears of pregnant women, fears related to the potential risks of pregnancy viability, repetition of spontaneous miscarriage experience.

"We were very happy and I was trying to control myself. The first experience made us more cautious, not willing to enjoy too much this time around. (..) I did not feel too connected as a mother."

Once they feel and recognize the first fetal movements, pregnant women with a history of miscarriage become hyper-vigilants of what is happening in their body. So, these movements become for them the expression and proof of the child's life and integrity in their womb. Exceeding the first trimester of the current pregnancy as a period of time does not implicitly determine the dissolution of specific anxiety about **the viability of the fetus**. Despite the fact that medical analysis and periodic ultrasounds attest to the healthy development of the fetus, pregnant women need to constantly ensure that their fetuses do not stop spontaneously again from evolution. To ensure this, they give great importance and dedicate a significant part of their time and attention to identifying fetal movements. Thus, fetal activity is not only an indicator of the condition of the fetus, but it also becomes a mechanism for serving some psychological maternal needs.

"I wanted her to keep moving because that meant life to me. It meant that she was there and she was okay. I had to make sure she was okay constantly. I had given this a lot of time, I paid attention when she moved, I had to feel her move all the time, to see if she moves, or if she doesn't move. "

Focus on the future, the fifth sub-topic captures the need for pregnant women to anchor in the immediate future of childbirth, often avoiding the present interaction with the fetus. This is especially highlighted in the case of their first spontaneous responses to the description of the maternal-fetal relationship, both through their content, namely precise references to the experiences expected after birth, and through the future tense of the verbs used in their expressions. I consider that this behaviour of pregnant women with a history of spontaneous miscarriage can be understood on the basis of experiential avoidance, a process that S. Haven (1996) describes on the one hand by rejecting contact with unfavourable experiences, including body sensations, thoughts, memories, emotions, etc. and, on the other hand, by adopting measures to influence their frequency, their form of manifestation or the circumstances that favour their occurrence.

IV. Conclusions

The current study brings forward important evidence for the complexity of emotional dynamics of prenatal women with prior miscarriages. Spontaneous miscarriage is a loss experience in which women lose a potential baby no matter if that baby is desired or not, and it marks an important milestone in their personal and family history. Exploring the experiences of miscarriage and how they affect the following pregnancies are two facts considered to be included in the psycho-medical prevention and intervention methods.

The wide composition of the semi-structured interview especially made up by us to identify the impact of the miscarriage on the subsequent pregnancy, allows a review of pregnancy experiences, starting with the previous pregnancy, the miscarriage, the interval between miscarriage and the next pregnancy, and the current pregnancy. It is a complex approach that aligns in a longitudinal retrospective the pregnancy experiences by facilitating their detailed description and by pregnant women's accessing the behaviours of the current pregnancy.

The results of this research are consistent with those of Côté-Arsenault and Morisson-Beedy (2001), who conducted a qualitative study to describe the experiences of pregnant women with perinatal loss, which highlighted their tendency to retain their emotions, knowing that a new perinatal loss can happen at any time. Also, our results are in line with those obtained by Andersson, Nilsson, Adolfsson

(2011), on how pregnant women with a history of miscarriage experience their feelings during pregnancy.

Our study takes the credit for highlighting the fact that the experiences of pregnant women with a history of spontaneous miscarriage are somewhat complex and dynamic - they are preoccupied with the fear of a new perinatal loss and they experience an increased state of anxiety that determines specific mechanisms and behaviours through which they seek to manage from one trimester of gestation to the next, aspects that clinicians monitor and follow up throughout pregnancy. So, due to the themes identified which show that women who become pregnant again after undergoing a miscarriage experience a high emotional distress, it is important that clinicians collaborate with obstetric-gynecology specialists, evaluate the women's obstetric history, validate previous miscarriages, recognize pregnant women with emotional disorders and low maternal fetal scores, perform interventions focused on improvement of their emotional condition and maternal-fetal relationship.

The fact that the sample of pregnant women was recruited from private clinics / centres in Bucharest is a limiting aspect due to its composition in terms of demographic variables, namely the predominance of pregnant women with higher education and high socio-economic status, a fact which requires the extension of this study on samples with different demographic variables and reveal their specificity.

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