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WOMEN'S EXPERIENCES OF HEALTH CARE IN RELATION TO MISCARRIAGE

Elin Hansson & Jaqueline Niit

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Examinator:	Zahra Ebrahimi

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Preface

We want to thank our mentor Elisabeth Jangsten who has assisted us through the process of writing our Bachelor thesis.

Titel (svensk)	Kvinnors upplevelse av omvårdnad i samband med missfall
Titel (engelsk)	Women's experiences of health care in relation to miscarriage
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Summary:

Background: Miscarriage is relatively common with one in four pregnancies failing to make it to full term. Previous studies show that women consider a miscarriage as a traumatic experience with many women suffering from grief. **Aim:** The aim of this paper is to describe the factors that affect women's experiences of health care provided in relation to miscarriage. **Methodology:** A literature review was carried out resulting in the analysis of 13 articles. Four themes and eight sub themes emerged as a result of analysis. **Result:** The four emerging themes are: *impact of health care providers' management of miscarriage, ineffective communication, women's need for support, and facilitation of the embodiment of grief*. The main findings are that there is a lack of information surrounding miscarriage and a lack of psychological support from health care providers. **Implications for nursing:** A screening of women using scales such as the PGIS and PBGS 6 weeks post-miscarriage are proposed by the authors.

Bakgrund: Missfall är relativt vanligt förekommande med en prevalens av 20 %. Tidigare studier har visat att kvinnor upplever missfallet som en traumatisk upplevelse vilken följs av sorg. **Syfte:** Syftet med denna studie är att beskriva faktorer som påverkar upplevelsen av omvårdnaden i samband med missfall. **Metod:** En litteraturöversikt genomfördes och resulterade i 13 vetenskapliga artiklar. I analysen framträdde fyra teman och åtta subteman. **Result:** De fyra teman som framträdde var: inverkan av hälso- och sjukvårdspersonalens handläggning av missfall, oeffektiv kommunikation, kvinnors behov av stöd, och underlättandet av sorgarbetet. **Implikationer för omvårdnad:** Författarna föreslår att man utför screening enligt PGIS och PBGS sex veckor efter missfallet.

Nyckelord: Spontaneous abortion, experience, grief, follow-up care

Table of contents

Introduction	1
Background	1
Definition.....	1
Demographics	1
Causes of miscarriage	1
Health care during and after a miscarriage	2
Women’s experiences of care while going through a miscarriage.....	3
Physical	3
Psychological	3
Theoretical framework	5
Swanson’s Theory of Caring	5
Problem statement	5
Aim.....	6
Methodology	6
Design.....	6
Selection	6
Analysis	7
Ethical considerations.....	7
Author’s preconceptions.....	8
Result.....	8
Impact of health care providers management of miscarriage.....	8
Quality of health care within the hospital context	8
Availability of follow-up care.....	9
Ineffective communication	10
Quality of information provided	10
Lack of communication	11
Women’s need for support	11
Importance of empathy shown by health care providers	12
Lack of psychological support	13
Facilitation of the embodiment of grief	13
Acknowledgement of grief	13
Enablement of the coping process	14
Discussion	14

Methodology.....	14
Result.....	15
Conclusion.....	19
Implications for nursing care.....	19
Further Research	19
References	20
Appendix	23

Introduction

We have chosen to immerse ourselves in this topic due to personal encounters with women sharing their stories of undergoing miscarriage. We have received the impression that health care providers do not address the emotional needs of these women. The emotional toll of this experience was apparent and we felt the need to identify factors contributing to these negative experiences. Considering the fact that miscarriages occur as often as one in five pregnancies, the need for further research within this field is apparent. Previous studies have well described women's experiences of miscarriage. However there is a lack of studies focusing on the quality of health care and how this affects women's experiences and recovery. The authors intend to focus on care provided in a health care context by nurses and other professional caregivers that women encounter.

Background

Definition

Miscarriage or spontaneous abortion is defined as a pregnancy which has been spontaneously terminated within the first 20 weeks of gestation, where the embryo or fetus and the placenta are expelled from the uterus. The term miscarriage is often used in conversation due to the fact that the word 'abortion' is so negatively charged. Miscarriages are often categorized after the gestational age of the aborted fetus; however they can also be categorized by the nature of the miscarriage. Complete/incomplete abortion, septic abortion, inevitable abortion and blighted ovum are examples of how miscarriage can otherwise be categorized (Janson & Landgren., 2015).

Demographics

The normal length of a pregnancy is 40 weeks. Approximately 15-20% of all detected pregnancies are miscarried with 90% of these happening before the 13th week of pregnancy. Many women who have had an early miscarriage may not even realize that they were pregnant, the miscarriage would have been perceived as an unusually heavy menstrual flow. Because of this fact, it is believed that closer to 50% of all pregnancies are miscarried. The risk of miscarrying is higher as maternal age increases. Women between the ages of 20 and 29 have a 7-15% risk of miscarrying, while women between the ages of 30 and 39 have a 13-20% chance of miscarrying. The risks of miscarrying are as high as 21-46% for women over 40 years old (Janson & Landgren., 2015).

Causes of miscarriage

The length of a pregnancy is often divided into three trimesters, each consisting of three months: the first, second and third trimester. Half of all diagnosed miscarriages that occur within the first trimester are attributed to chromosomal abnormalities. The risk for abortion due to chromosomal abnormalities decreases as the second trimester initiates. During the second trimester the cause of miscarriage is more likely to be of an anatomic nature, suchlike abnormal placentation or maternal systemic disease (Beckmann & American College of obstetricians and gynecologists, 2014). Immunological factors such as genetic disorders of blood coagulation may increase the risk of thrombosis and studies have shown that certain

gene mutations can be frequently linked with recurrent miscarriage. Abortions accredited to infectious factors are rare in the early stages of pregnancy. However, bacterial infections known to induce abortion are chlamydia, listeria and syphilis (Beckmann et al., 2014).

Type 1 diabetes involves higher liability for both congenital malformations and miscarriage due to metabolic effects. Physical factors contributing to the cause of a miscarriage may be uterine factors such as myomas. Uterine leiomyomas occurs frequently and in relation to miscarriage the position of the myoma is more significant than its size. Other uterine factors that may be the cause of pregnancy loss are Asherman syndrome and uterine septum. High BMI (Body Mass Index) also increases the risk of abortion. Environmental factors affecting the risk of abortion are smoking, alcohol, drug use and radiation. The risk of miscarriage increases with the amount of cigarettes smoked each day. Alcohol not only increases the risk of abortion, but also a recurring high consumption of alcohol increases the risk of fetal anomalies. High levels of radiation may increase the risk for miscarriage (Beckmann et al., 2014).

Health care during and after a miscarriage

A miscarriage is both physically and mentally demanding and often takes a great toll on the women and their partners. The most common physical symptoms are vaginal bleeding and painful cramps similar to menstrual cramps. When confirming a miscarriage it is important to eliminate the possibility of an ectopic pregnancy since the symptoms are quite similar. A positive pregnancy test, an ultrasound that shows no visible products of conception, cramps and vaginal bleeding are symptoms of both a miscarriage and an ectopic pregnancy.

If a complete abortion is observed, a woman generally is not in need of further medical intervention. A complete abortion is characterized by the complete expulsion of the pregnancy tissue and the products of conception, and a negative pregnancy test. In the case of an incomplete abortion, one of the three approaches is taken: surgical intervention (curettage), medical intervention or expectant management. Curettage, consisting of vacuum aspiration of the uterus, minimizes the risk for infection and sepsis. Medical intervention implies that the woman is chemically induced, most commonly with the drug misoprostol, which causes the pregnancy tissue to be expelled from the uterus. It is best to medically intervene if the miscarried fetus is less than nine weeks gestation. This option should be given to women who do not wish to undergo invasive surgery and avoid the risk for complications. Expectant management is not interfering with the natural expulsion of pregnancy tissue. Curettage has risk for complications and medical treatment has often unwanted side effects, so expectant management is seen as the best option for some women (Janson & Landgren., 2015).

A study by Kong, Lok, Yiu, Hui, Lai & Chung (2013) compares the three aforementioned approaches: surgical intervention, medical intervention and expectant management. The findings show that surgical intervention is an effective approach with a complete miscarriage rate of 98%. However, surgical intervention is found to have a high incidence of serious complications leading to hospitalization of 8.6% of the participating patients. Expectant management is found to have the least complications with 5% of treated women having to be hospitalized for minor bleeding and abdominal pain but had a 79.3% complete miscarriage rate. The least effective approach was medical intervention (70% complete miscarriage rate) and the participants had on average 15 days of vaginal bleeding.

Women's experiences of care while going through a miscarriage

Physical

The physical symptoms of a miscarriage vary depending on the treatment received. The commonly recurring symptoms across all treatment forms are abdominal pain and vaginal bleeding. A comparison of the three treatment approaches shows that the duration of abdominal pain did not differ. Medical treatment with misoprostol is found to have the longest duration of bleeding with a mean of 15 days while surgical intervention had the shortest, 10 days. A higher incidence of gastrointestinal side effects amongst women who received medical treatment was observed compared to women in the other treatment groups. Women who underwent surgical or medical intervention expressed concerns about the treatment weakening or even damaging their bodies and decreasing their chance of conceiving again. While health care providers often prefer a straightforward approach, the women's preferences should be taken into consideration. Women should be well informed about their treatment options as well as the advantages and disadvantages of each approach. (Kong et al., 2013)

Radford & Hughes (2015) established that a need for open communication with health care providers is paramount in avoiding patients feeling a lack of control, fear and confusion. The study identified a lack of preparedness in a percentage of the study population, women were unexpectant of the amount of blood loss or pain miscarrying would entail. Lack of communication is associated with negative effects on recovery. Detailed information about the practical aspects of a miscarriage should be provided in both verbal and written form since the women may be in a state of shock when receiving information and could therefore find it hard to take in information.

Psychological

Getting pregnant is for the majority of women a significant life event and even more so in case of the first pregnancy. The pregnancy represents a new phase in life, a development of the feminine identity and the measure of evolving as a woman, entering motherhood and parenthood. At this stage of the pregnancy women typically harbor feelings of contentment, success and the anticipation of dreams and plans coming together and becoming a family. Women describe this as an exciting experience filled with elation, optimism and joy. As a result of the miscarriage all of these feelings of optimism and elation are converted into negative sensations both physically and psychologically. Reported feelings experienced by women going through pregnancy loss are sadness, grief, loss, fear and guilt. Some women also reported views of themselves as fertility failures, defect or abnormal and as inadequate wives due to their inability to carry the pregnancy to full term (Radford & Hughes, 2015). The emotional response and experience of a miscarriage is highly individual to every woman (Fernandez, Harris & Leschied, 2011). In some cases the pregnancy is not welcome and the miscarriage is met with a sense of alleviation. However, women generally describe the experience in terms of negative emotions and sensations (Radford et al., 2015).

The needs of women going through a miscarriage are quite complex. The physical symptoms are frightening and the emotional loss felt is crippling. A literature review by Radford & Hughes (2015) shows that women undergoing a miscarriage feel the need to have their physical symptoms as well as their emotional feelings acknowledged and recognized. A grieving couple has expectations of the support offered by health care providers, family, and friends. If these expectations are not realized it may cause women to harbor feelings of

abandonment and isolation (Radford & Hughes, 2015). Fernandez et al. (2011) characterizes health care providers as “task/goal-oriented”, physical recovery and the ability to hold a pregnancy to full term is often the priority. Hence the emotional aspects and the women’s need to cope are often overlooked. Women who have miscarried experience that their loss is not socially accepted as the death of a person and feelings of isolation and abandonment are intensified (Fernandez et al., 2011). This is especially common with early miscarriages, as these fetuses are in the early stages of development and there are no visible signs of pregnancy. This lack of support causes strain on the relationships between friends, family, and even between the parents of the miscarried fetus. Women often feel unsupported by their family, friends and partners (Radford & Hughes, 2015). Two thirds of the women in a study by Gerber-Epstein, Leichtentritt, & Benyamini (2009) felt that their partners were not able to “empathize with the woman’s needs”.

Grief

The experience of loss is depicted as bereavement (Radford & Hughes, 2015). In adherence to the miscarriage, heightened psychological distress and depressive symptoms are prevalent; specifically depressive symptoms and elevated anxiety are more frequent briefly after the miscarriage (Kong et al., 2013). The loss of a pregnancy is commonly followed by intense grief, regardless of the gestational age of the pregnancy, but not all women who share the experience of miscarriage respond with grief. It is therefore imperative for health care providers to focus on the experience of each individual woman in order to be able to meet the specific personal care needs of each individual. Even though it is typical to grieve the loss of a pregnancy, not all women have the desire or need for professional emotional monitoring or intervention (Radford & Hughes, 2015). However the experience is frequently portrayed as deeply painful and some of the women account for the experience as traumatic. Even after a substantial amount of passed time since the incident, women can find it hard to process the experience due to the complex nature of the loss, being that it is difficult to illustrate the loss of what they never knew or had. (Gerber-Epstein et al., 2009). In addition to the loss of a child the miscarriage entails numerous losses, the loss of the pregnancy in itself, expectations and plans for the future and sudden disruption of attachment bonds (Fernandez et al., 2011). The process of attachment develops differently, some women feel an instant bond to the baby as soon as they learn about the pregnancy and for some this bond develops over time. Consequently the gestational age is of importance to the confirmation of the pregnancy, but it differs in the significance of the magnitude of attachment. Hence, the extent of attachment should be considered a more valid predictor to the individual woman’s emotional response and need to grieve. Another important component to the grieving process is providing concrete validation that the fetus is no longer alive. Some women considered the contingency to see the outcome of the pregnancy as a favorable opportunity, while others considered the notion of this to be disheartening and chose to avoid it (Radford & Hughes, 2015). In order to meet the needs of grieving women, an effective measure is to screen for grief intensity. By making use of the PGIS (Perinatal Grief Intensity Scale) health care providers can predict women more likely in need of professional emotional support and monitoring due to intense grief. The PGIS is a 14-item self-report questionnaire; where the higher the score obtained the more intense grief it represents (Lewis, 2014). PBGS (Perinatal Bereavement Grief Scale) is another tool that could be applied to help determine women’s intensity of grief after miscarriage. The PBGS is a scale created to measure grief and longing for the pregnancy loss or the loss of a child. The PBGS consists of fifteen items of statements in conjunction with the pregnancy and with the baby (Ritsher & Neugebauer, 2002).

Theoretical framework

Swanson's Theory of Caring

“Caring is a nurturing way of relating to a valued other toward whom one feels a personal sense of commitment and responsibility”

(Swanson, 1991, p.162)

Kristen M. Swanson, Registered Nurse, PhD, is the originator of the Theory of Caring. The Theory of Caring was formulated through a descriptive phenomenological study which produced two models: The Caring Model and The Human Experience of Miscarriage Model. The original phenomenological study based on the experiences of miscarried women shed light on five core domains which composes the Theory of Caring. Swanson's theory has now been proved applicable in other contexts and is used in a wide range of research, education and clinical practice. The five domains of the Theory of Caring are: *maintaining belief*, *knowing*, *being with*, *doing for* and *enabling*. *Maintaining belief* encompasses the belief or faith one has in another person to be able to endure a demanding situation. It is the ability to offer a patient optimism and hope. *Knowing* is to try to understand what ramifications this situation has for the patient and what it means to them. The caregiver has to be aware and constantly assess the wellbeing of a patient without making presumptions. *Being with* means being present and emotionally available. *Being with* is the ability to share feelings of grief, sorrow and despair without burdening the patient. Fulfilling the health care needs of a patient is *doing for*. This includes help with daily activities, comforting the bereaved and carrying out medical tasks all while preserving the patient's integrity. *Enabling* is to aid patients through life transitions by providing support, information, validation and feedback (Allgood, 2014). Kristen Swanson advocates that in order to have a holistic approach in health care provided during miscarriage, the health care provided should comprise of these five domains to ensure that all the patients' needs are being met.

Problem statement

A miscarriage is an emotionally trying event with both physical and psychological implications. This makes the health care needs of miscarrying women quite complex. A significant amount of grief and psychological impact is identified amongst women who have gone through a miscarriage. The physical symptoms of a miscarriage have been found to be traumatic. Previous studies have indicated that these women's emotional needs are not being met and that their negative experiences can have a long term psychological effect. To achieve an understanding of how to shape health care in relation to miscarriage, factors that positively or negatively affect women's experiences should be identified.

Aim

The aim of this paper is to describe the factors that affect women's experiences of health care provided in relation to miscarriage.

What do women characterize as good health care in relation to miscarriage?

What do women consider to be lacking in health care in relation to miscarriage?

Methodology

Design

In order to give a broad overview of the topic, a review of relevant literature and articles was carried out. Searches were made in the databases Scopus and Cinahl (see Table 1). Articles were selected first by titles relevant, then by relevant abstracts and were then subjected to an initial reading. In accordance to Friberg (2012), reading the relevant abstracts helps with gaining a "helicopter perspective" of the topic and gives the author the ability to see the character of the study. As it is in fact the articles found which determine the character of the study. The articles deemed relevant after the initial reading were audited for quality using Willman, Stoltz & Bahtsevani (2006) audit templates (see Appendix 2. & 3.) for qualitative and quantitative articles. The articles chosen to be included and analyzed in the study were chosen according to quality and relevance to the aim.

Selection

Selection has not been limited to a certain type of research; both qualitative and quantitative studies have been chosen. However, due to the aim of this study focusing on women's experiences it has come naturally that most of the research has a qualitative approach. Search words used were 'spontaneous abortion', 'psychological factors', 'care', 'experience', 'nursing' and 'qualitative'. During the process of the search the specific search terms were not altered, but they were put together in a variety of ways in an aspiration to find the most suitable results. In some cases the same article could be found in the different databases, but these are not accounted for multiple times in the table presenting the results of the search. One article that is not presented in the search table was found through a manual search.

Inclusion criteria for the search are articles published within a time frame of 2000-2016 to ensure the inclusion of relatively modern studies. All of the articles included are peer reviewed. The articles chosen focus on the experiences of women in a health care context, all articles within a health care context were included. Articles about miscarriage, regardless of gestational age were included. Articles which were medically oriented and lacking results about experiences were excluded. The health care context in the articles chosen was a hospital gynecological unit, a specialized miscarriage unit, women who have received ART (Assisted Reproductive Treatment) and an emergency unit. Research with the main focus of examining the experiences of the women's partners was excluded. In addition, in the Scopus search, we chose to exclude the document type review in order to focus on the type of articles relevant for the basis of the analysis. See appendix 1, for a summary of the 13 chosen articles. The chosen scientific articles originated from 6 different countries: Sweden, United Kingdom, Australia, France, Ireland, and Canada.

The chosen articles were subjected to quality auditing in accordance with Willman et al. (2006), the authors audited the articles individually. The authors established that five articles were of medium quality and eight articles were of good quality.

Search Table

Date	Database	Boolean/ Phrase	Limits	Hits	Relevant titles	Relevant abstracts	Viewed articles	Selected articles
160223	Cinahl	MH Abortion, Spontaneous /PF	Peer reviewed, 2005-2016, Full text	98	24	16	11	4
160229	Scopus	spontaneous abortion, care, experience, nursing, qualitative	Peer reviewed 2000-2016 exclude doctype review	271	62	37	26	9

Table 1.

Analysis

An analysis of the results was carried out in accordance to the work of Friberg (2012). The 13 chosen articles were read multiple times and excerpts from each article which was considered significant in relation to the aim were extracted. Assembly of the excerpts into clusters according to similarities and differences was carried out which formed four themes. The quotations under each theme were further divided into sub-themes according to relevance as this was believed to facilitate reading.

Ethical considerations

The authors have implemented an ethical approach throughout this literature study to ensure a fair and ethically sound result. According to Henricson (2012), being ethically considerate in research entails that participants are guaranteed to have their wellbeing, safety and rights preserved. Authors must ensure that participants are not taken advantage of or physically harmed. Therefore, articles that discussed ethical considerations were prioritized. All but one study did not account for their ethical considerations. However, due to the fact that questionnaires were used in the aforementioned study, the authors concluded that respondents have chosen to fill in the questionnaire which makes their participation optional. The articles were chosen and audited objectively to offer an unbiased result. All of the articles presented some form of ethical consideration. Four out of the thirteen articles reported their research approved by ethical committees. Three of the studies did not present any approval from ethical committees, however ethical approval was received from a university in one of the cases, from a senior clinician in another study and the third received approval from two hospitals. Six studies offered no ethical reasoning, however they described ethical considerations regarding their research by accounting for respondents given consent,

recruitment process and in what way they were informed concerning their right to withdraw participation at any point during the process.

Author's preconceptions

The authors have undertaken this literature overview with the preconception that women are not receiving adequate health care in relation to miscarriage. However, all relevant results of acceptable quality were included in this literature review to ensure that the result isn't affected by bias.

Result

Analysis of the chosen articles revealed four themes, each with two respective subthemes:

Impact of health care providers' management of miscarriage

Quality of health care within the hospital context
Availability of follow-up care

Ineffective communication

Quality of information provided
Lack of communication

Women's need for support

Importance of empathy shown by health care providers
Lack of psychological support

Facilitation of the embodiment of grief

Acknowledgement of grief
Enablement of the coping process

The main findings were that women consider there to be a lack of psychological support and a lack of communication in health care.

Impact of health care providers management of miscarriage

Management of miscarriage refers to the context of health care provided during and after a miscarriage. This theme illustrates what ramifications the management of these women has for their experiences of the health care provided.

Quality of health care within the hospital context

Women attach great importance to the health care received during a miscarriage (Harvey, Creedy, & Moyle, 2001). The health care encounters a woman experiences could either have a positive or negative impact on the general experience of health care. A recurring theme confirmed by Smith, Frost, Levitas, Bradley, & Garcia, (2006) and Adolfsson, Larsson, Wijma & Bertero (2003) was uncertainty surrounding duration of the miscarrying process and the long waiting times of which both contributed to lower satisfaction rates. Adolfsson et al. (2004) identified that women experienced great worry while waiting for the sonogram examination to confirm if their child was alive or not. Waiting time for the determining sonogram examination could be from two to four hours. The waiting women's thoughts swayed between hope and dread. This uncertain waiting time provoked feelings of neglect

amongst participants; however, these feelings disappeared when these women were shown sympathy (Adolfsson et al., 2004). A study by Deepa, Oladimeji, & Funlayo (2014) proved that when the time between diagnosis and treatment increased from less than six hours to more than thirteen hours, satisfaction rates decreased from 87% to 67%. Due to the long waiting times, miscarrying women felt that they were considered a lower priority by health care providers (Murphy & Merrell, 2009).

In the cases where women were cared for in a general gynecological ward, women experienced that health care providers focused mainly on the physical symptoms and inadequate attention was paid to the women's psychological needs (Murphy & Merrell, 2009). Ancker, Gebhardt, Andreassen, Botond, & Sophiahemmet Högskola. (2012) found that health care in Sweden caused women to feel that health care providers considered their situation as 'just another miscarriage', another medical case that should be treated hastily and sent home. Harvey et al. (2001) recommends the allocation of a primary care nurse to miscarrying patients to reinforce emotional care with the consideration that these patients have relatively short hospital admission visits. Tsartsara & Johnson (2002) studied the experiences of women that received care at an Early Pregnancy Assessment Unit (EPAU), which provides specialized health care for women going through a miscarriage. Participants in this study accredited the EPAU nurses for providing specialized care, especially concerning the emotional aspects of a miscarriage. Participants felt respected and cared for as caregivers provisioned patients their time and provided them with psycho-social support. In this particular study, patients expressed enduring distress when being referred to an antenatal clinic to receive a sonogram examination. Being surrounded by healthy pregnant women at the antenatal clinic proved to be upsetting because these women were being confronted with the reminders of their loss.

Furthermore, accounts of pain and vaginal bleeding were found to influence women's experiences. More specifically, studies pinpointed the fact that women weren't informed about the amount of vaginal bleeding and pain to be expected. This was proven in the studies undergone by Ancker et al. (2012) and Smith et al. (2006). Significantly higher satisfaction rates were observed in women who received adequate pain relief in conjunction with miscarriage (Deepa et al., 2014). In fact, women would express feelings of irritation and disappointment when receiving insufficient pain relief when pain was adverse (Ancker et al., 2012).

Availability of follow-up care

Planned follow-up care has proven to be helpful for women who have undergone a miscarriage; it reduces feelings of self-blame and offers these women help in overcoming the tragedy (Tsartsara & Johnson, 2002 & Harvey et al., 2001). The most useful interventions concerning aftercare found by Séjourné, Callahan & Chabrol (2010) were in-depth sympathetic discussions with their doctor, accessibility to conversation with a health care professional at any time and group therapy with members of the community who have gone through similar situations. Satisfaction rates of follow-up care was found to be approximately 85% with no difference measured between the form of follow-up care: personal or telephone contact (Deepa et al., 2014). However, Tsartsara & Johnson (2002) found that home visits after the ordeal were greatly appreciated as it helped these women overcome feelings of self-blame. A clear need for follow-up care is identified, it is moreover expected by these women and feelings of neglect arise if follow-up care is not offered.

An element of emotional complexity is observed in the event of a subsequent pregnancy following miscarriage. Participants in a study by Conway, K., & Russell, G. (2000) conveyed that they felt mixed feelings about the subsequent pregnancy; participants were delighted albeit afraid that this pregnancy would also end in miscarriage. These findings were consistent with the findings of studies by Séjourné et al. (2009) and Harris & Daniluk (2010). In the case of infertile women who have achieved a viable fetus via Assisted Reproduction Technology (ART), the emotional exhaustion was evident as women found it hard to emotionally invest in a positive pregnancy in fear that it would eventually miscarry (Harris & Daniluk., 2010).

Ineffective communication

Communication is characterized by information being relayed between health care providers and patients. Health care providers have the responsibility to inform patients about medical procedures and what to expect, this also includes answering patient's questions. Furthermore, patients should let health care providers know how they feel and ask questions if any aspects of their care seem unclear. This theme comprises the importance of communication and how communication affects women's experiences of health care.

Quality of information provided

Women have expressed a need for information and education from health care professionals. One aspect is the need to know the state of the pregnancy, to have confirmation and certainty regarding the fact that it actually is a miscarriage. Women describe the time period of uncertainty, not knowing for sure what the state of the pregnancy is and the tightrope walk with hope on one side and despair on the other as trying and at times even unbearable. At this time the women are in need of adequate information regarding numerous aspects of the process of miscarriage, such as informing the women of what to expect and addressing their questions. The need for information is not only of importance due to practical reasons such as knowing what to expect in regards to health care interventions but it also provides consolation as the women are in a very exposed position (Ancker et al., 2012). In addition, it is crucial for the women to have a sonogram in order to provide an absolute confirmation of the diagnosis (Murphy & Merrell, 2009). Another element to take into consideration is that women (and their partners) are in shock and therefore not able to efficiently take in the information being provided to them due to the situations being of such an emotional character (Adolfsson et al., 2004). One way of providing information in a more effective fashion is to, in addition to verbally communicating information, also providing information in written form (Harvey et al., 2001).

Women experience a lack of information while receiving health care in relation to miscarriage. Séjourné et al. (2010) presents in their study that women generally perceive information as insufficient and specifically feel information regarding the psychological aspects to be lacking. They also felt that their questions were not always answered by the health care providers. Other studies have shown a lack of information about the physical aspects concerning what the women could expect in terms of pain and bleeding while miscarrying, and furthermore women felt inadequately informed about the consequences of different treatment methods. Some women thought there was a lack of information in regards to the medication they received as treatment to be able to evacuate the miscarriage efficiently. They felt it was not thoroughly explained to them how much time it would take for the treatment to work, neither the effect was sufficiently mediated to the women (Smith et al., 2006). A Swedish study by Ancker et al. (2012) report that women felt angry and let down by

the lack of information concerning what to expect physically while miscarrying. According to Harvey et al. (2001) this informational deficiency and uncertainty of what to expect led women to believe it would have a negative effect on their recovery. Several studies have brought to light the consequences of inadequate information regarding the cause of miscarriage. It is helpful for the women (and their partners) to receive an explanation about what has happened in order not to blame themselves or each other, Murphy & Merrell (2009). According to Tsartsara & Johnson (2002) not being provided with an explanation as to why the miscarriage occurred leads to the woman trying to find her own theory as to what the cause was and this can result in self-blame. Conway & Russell (2000) shows in their research that in cases where women have been provided with an explanation of what caused the miscarriage to happen to them, a majority of those women were satisfied or partly satisfied with the explanation they received.

Women look to those around them to provide them with an explanation for what is taking place and women felt disappointed when those they were expecting to cater to these needs were unavailable (Harvey et al., 2001). While miscarrying women need reassurance that the situation they are in will come to an end, they also require information regarding what symptoms to expect and what medical interventions are planned as well as what those interventions will entail (Smith et al., 2006). Health care providers should also be careful about giving conflicting advice. Contradicting information or opinions from health care professionals will make women unsure of what to believe and feel confused about who to turn to for information (Abboud & Liamputtong, 2005).

Lack of communication

There is an observed lack of communication between health care providers and women going through a miscarriage. A lack of communication results in women experiencing the health care encounter as cold and uncaring which leads to feelings of loneliness (Smith et al., 2006). Harvey et al. (2001) suggests that “nursing care should allow provision for women to voice their feelings and concerns, to enable an acknowledgement of their loss.” (p. 13). Good communication provided preoperatively resulted in 87% satisfaction compared to 30% satisfaction without pre-operative information concluded Deepa et al. (2014). It is important that the information that is relayed to the women is correct, Abboud & Liamputtong (2005) write about the distress caused when a woman has been given contradicting information.

According to Adolfson et al. (2004), women have the need to talk about the miscarriage repeatedly and the need to contemplate why it happened. Many women feel comforted as long as someone was present, be it a partner or a health care provider (Ancker et al., 2012). Having the ability to contact a health care professional at any time has been proven to be beneficial in comforting the anxiety of a bereaved mother (Harvey et al., 2001). Even though health care professionals may not understand the grief of a bereaved mother, they are however equipped with skills of communicating with a patient and should be able to listen to the concerns of a couple (McCreight, 2008).

Women’s need for support

Support is a paramount factor in providing satisfactory health care for women during and after miscarriage. In order to satisfy the emotional and psychological needs of these women it is pivotal for health care providers to implement a considerate and empathetic approach.

Importance of empathy shown by health care providers

“I just remember the doctor at the ultrasound was just really warm and sincere because he really held onto my hand, and I just felt the warmth coming through and I thought at the time, when you find out something like that you really need someone to be very sympathetic and warm. You may find people who are really cold and very uncaring. Whereas, he sat down, he actually held my hand and he rubbed ... I remember it ... he rubbed my hand and my head, and he said to me, ‘Don’t worry, you’ve just had a miscarriage. You’re able to have children, you’re fertile’ and that’s all. He didn’t go in depth but what he said was just what you wanted to hear at the time. And that was a good memory out of the whole thing” (Abboud & Liamputtong, 2005).

Health care providers displaying consideration and care were greatly appreciated by women (Harris & Daniluk, 2010). Qualities highly valued in health care providers were their ability to adapt to each woman and her unique experience and providing individualized care (Tsartsara & Johnson, 2002). According to Smith et al. (2006) professional psychological support can affect women’s experience in a profound way, even to the extent where physical symptoms such as pain and bleeding are not perceived as negatively as they would have been in the absence of psychological support. Generally women expressed the need for an empathetic approach, that health care providers acknowledged their feelings and took them seriously (Ancker et al., 2012).

In a study by Harvey et al. (2001), respondents describe their encounters with health care providers lacking in terms of empathy. The women felt that their wellbeing was not the priority of the health care professionals. According to the women health care providers distanced themselves from the women in order to avoid engaging with them and they did not make an effort to understand the situation that the women were in. They also thought that there was too much focus on the physical aspects of the care and that the emotional and psychological aspects were overlooked. Some women perceived a lack of support due to the fact that there was reluctance among health care providers to talk about their experiences. Smith et al. (2006) also speaks about health care providers being cold and not emotionally available. The women also felt abandoned in the sense that they were left alone for long periods of time. According to Ancker et al. (2012) women receiving health care in the emergency department also felt that they had nowhere to go, there was no personal space assigned to them and the hospital staff failed to acknowledge what the women were going through. McCreight (2008) also reports on the lack of sympathy and compassion towards women going through miscarriage and how inconsiderate comments were made by health care professionals, specifically during sonogram examinations.

Another aspect concerning empathetic care was brought up in a study on lesbian women and couples experiencing miscarriage. The research shows that the emotional response or experience of care in regards to miscarriage does not differ due to women’s sexual orientation. However it is expressed by the respondents that it is important to them that health care providers take into account the process of conception for a lesbian couple and realize that this may have an impact on how care is provided (Peel, 2010). Harris & Daniluk (2010) presents similar findings, expressed by women challenged with infertility issues, who received ART (Artificial Reproductive Treatment).

Lack of psychological support

According to McCreight (2008) and Murphy & Merrell (2009), miscarrying women experience that health care providers' focus largely on the physical implications of a miscarriage and there is a lack of concern about the psychological implications. A majority of these women received care after curettage on a surgical gynecological unit alongside women with other gynecological ailments. This was experienced as an unsympathetic hospital environment due to the fact that health care providers lacked the specialties for attending to the psychological needs that arise with miscarriage. Harvey et al. (2001) suggests that psychological care must be 'visible' to ensure that miscarrying women are received with understanding and sympathy from health care providers. Special attention should be paid to lesbian women who have undergone ART to conceive and women who have undergone ART due to infertility issues, since both these groups of women are highly emotionally invested in the pregnancy (Harris & Daniluk, 2010) & (Peel, 2010). Fertility treatments and prolonged planning have most likely been involved with these pregnancies. Harris & Daniluk (2010) has proven that the grief felt by women who have undergone ART is profound and complex due to the built up expectation.

Harris & Daniluk (2010) noted that the majority of the participants in their study considered their partners the most important source of support. In the case of lesbian women, Peel (2010) discovered that sympathy towards lesbian partners was deficient. In fact, in some cases the partners were abstained from being in the room during sonogram examinations and conversations about funeral arrangements. Partners should therefore be included to take part in the care of their loved one.

Studies have shown that lack of choice prompts women who go through a miscarriage to feel a sense of disempowerment (Smith et al., 2006). McCreight (2008) describes the case of a woman who received her dead child in an urn, the hospital cremated the child's remains without consent. In another study by Smith et al. (2006), women voiced dissatisfaction concerning the lack of choice surrounding treatment approach. If given the choice, most women would have chosen expectant management. Giving these patients a choice concerning treatment and their stillborns' body arrangements would be beneficial in avoiding feelings of helplessness and disempowerment.

Facilitation of the embodiment of grief

Grief is a recurring theme in the topic of miscarriage; women grieve over the loss of their unborn child. Health care providers have the responsibility of allowing the embodiment of grief which in turn gives women the possibility to cope. How health care providers approach women's grief and how they manage it is a factor affecting women's experiences with health care.

Acknowledgement of grief

Several studies indicate that women going through miscarriage have the need for acknowledgement. Harvey et al. (2001), Abboud & Liamputtong (2005), McCreight (2008), Adolfsson et al (2004) and Ancker et al. (2012) all share stories of women feeling that their experiences of miscarriage have been reduced to a medical complication of pregnancy where their loss of a child has been trivialized by health care professionals and their bereavement has not been properly acknowledged. The stories shared by these women convey that medical staff fail to provide reassurance and acknowledgement of their emotional experience of losing a desired child. Women also stated feeling a sense of being diminished in regards to their

experience of loss by inconsiderate statement from health care professionals (Harris & Daniluk, 2010). One woman (Susan) shares a short encounter with a doctor stating “Your babies will be born immediately and they will die” after which he exits the room leaving her to deliver her babies in a hallway in the company of a nurse not even acknowledging what is happening in any way (McCreight, 2008).

Enablement of the coping process

Health care professionals should help women by facilitating the process of coping with their loss, both in the hospital context and in follow-up care. Most women appreciate the coping rituals suggested by health care professionals such as naming the child, keeping mementos or holding a funeral (McCreight, 2008). Rituals such as these give women an opportunity to validate their grief and give them a sense of closure. Adolfsson et al. (2004) states that, women find it important that their grief is taken seriously and to be able to talk to competent staff. Being given the opportunity to speak about their unborn child and name their child offered the women a chance to embody their grief (Harris & Daniluk, 2010). According to Tsartsara & Johnson (2002), follow-up care has been proven to be beneficial in helping women overcome the emotional distress of a miscarriage. In some cases women were not made aware of the possibility of follow-up care which procured feelings of dissatisfaction and anger (Harvey et al., 2001). Adolfsson et al. (2004) and Murphy & Merrel (2009) found that women who have gone through miscarriage grieve in different ways and not all women require the same support from health care professionals.

In the hospital contexts women reported feeling it hard to be around other pregnant women which can be the case while waiting for sonogram examinations and on some hospital wards (Tsartsara & Johnson, 2002). Care should be taken since being confronted with reminders of their loss could interfere with the coping process.

Discussion

Methodology

In order to find relevant articles for this literature review, wide searches were made in two databases: Scopus and Cinahl. All relevant articles of acceptable quality were chosen to ensure that there was no bias in the choosing of articles. The decision not to make limitations regarding the context of care or gestational age was made in order to create a broad range in the material analyzed. Articles about miscarriage in relation to ectopic pregnancies and pregnancies conceived with the help of ART in hetero- and nonheterosexual couples were chosen to give a nuanced result. The chosen scientific articles originated from 6 different countries: Sweden, United Kingdom, Australia, France, Ireland, and Canada. Being derived from articles from different countries, the results of this thesis could be a fair illustration of reality. The chosen articles had varying study designs which also increase the reliability of this thesis's results (Henricson, 2012). Both qualitative and quantitative studies were chosen, which gives the result a depth of understanding and general statistics. In the audit of the articles forming the base of the analysis the authors found that in several of the studies the process of selection was not completely described, specifically inclusion criteria and exclusion criteria were not presented in detail. However, being that these articles are entirely aimed to examine women's experiences of miscarriage, the authors made the assessment that this did not have a negative impact on the quality of the articles due to the fact that the respondents for this research entailed that this criteria could only be fulfilled by women who

had been pregnant and miscarried. One study specifically addressed the experiences of women who had received ART (Artificial Reproductive Treatment) in conjunction with conception. Another study focused on lesbian women's experiences of pregnancy loss. In these studies inclusion criteria was based on infertility treatment in the first case and sexual orientation in the latter. These studies were included in the analysis in order to add variation and increase the quality of this thesis (Henricson, 2012). The authors' implication concerning the process of selection in the articles included in the analysis is that inclusion criteria and exclusion criteria was specified and reported if necessary. A few older articles were chosen after assessing that their findings contributed with aspects that were not found in more recent studies. The age factor of these studies were not considered to be of influence to the aim, due to the fact that the health care provided in regards to miscarriage has mainly remained the same during this time frame. Another speculation raised during the review of the articles was the reliability of data collected through online surveys. Two of the articles chosen applied an online approach in collecting their data and concern regarding this was the element of uncertainty this brings in aspects of control, for example if the respondent is truly meeting the selection criteria (Henricson, 2012).

This study's analysis was carried out in accordance with Friberg (2012) which was considered an effective approach. The analysis was initiated by the authors reading each article individually and assigning codes or themes to significant citations or themes. These important citations and results were then discussed which resulted in themes being formed. The authors consider the fact that articles were read and interpreted by each author individually before both the quality check and analysis as a strength. The quality of the articles were checked in accordance to the auditing templates of Willman et al. (2006). There could be a possibility that the authors have misinterpreted the auditing templates and given the articles different levels of quality than others would have. This ensures that the authors did not influence each other's impression of the quality and content of the chosen articles. The fact that the authors are inexperienced in terms of writing thesis's could be considered a back fall in relation to the analysis and presentation of results. The theoretical framework chosen did not affect the analysis due to the fact that the theory was chosen after the analysis and compilation of the results were completed.

Result

The main findings of this study are: that women consider there to be a lack of psychological support, and that women experience a lack of communication and information from health care providers. These findings are discussed and compared to previous research and Swanson's theory of caring. The author's purpose of discussing the findings in this fashion is to strengthen the applicability of the findings by comparing and corroborating them with findings in previous research. While the usage of Swanson's theory of caring as a theoretical framework means to provide insight into how to shape health care so that women's needs are effectively met.

The experience of health care is impacted by the hospital environment patients are being subjected to. Health care providers should take into account that the hospital environment may seem foreign and alienating to most patients, while patients going through a miscarriage are especially vulnerable and require specific care. Findings show a lack of empathy and caring was also shown through inconsiderate comments made by health care providers and long waiting times. These factors contributed to making women feel unimportant and

unacknowledged, leading to lower satisfaction rates. Swanson's domain *knowing* comprises health care providers' ability to understand what ramifications a miscarriage has for these women, inconsiderate comments by health care providers prove that there is a lack of understanding and therefore a lack of *knowing*. Another important consideration is to have awareness regarding the process of conception, due to the fact that women who have struggled with infertility or have undergone ART may be more likely to be highly invested in the pregnancy which leads to complex grief if the pregnancy is lost. Due to the delicacy of the situation, encounters with these women require health care providers to provide care within the domain of *knowing*, by adopting an especially empathetic approach to fulfill the women's empathetic needs.

One of this review's main findings was that women felt there was a lack of information and communication between health care providers and themselves. Communication is essential in the relationship between patient and caregiver. We have identified a lack of information and empathy in relation to health care provided; proper two-way communication could resolve these problems. These findings confirm the outcome of previous research and again establishes the importance of and need for open communication with health care providers. Murphy & Merrell (2009) identified that women find it important to have confirmation that they actually have had a miscarriage. This information should be relayed sensitively but it should also be quite straightforward in the sense that the woman will surely understand that the pregnancy is no longer viable. A recurring theme through the articles was the fact that women experienced a lack of information regarding their treatments and what to expect physically and emotionally during and after the miscarriage. Women feel that their questions were not being answered. Women felt a sense of helplessness and lack of control when not knowing if what they were going through was normal since information was not provided about the duration of bleeding and intensity of the pain. Women should be informed about possible treatment plans, the advantages and disadvantages of the treatment options and they should be given the possibility to make an advised decision about which treatment they prefer. Women should also be given clear information about the side effects of the treatments, what to expect physically and emotionally. Health care providers must be careful not to give contradicting information as this confuses the women and leads to feelings of uncertainty (Liamputtong, 2005).

Health care providers should inform women on what to expect after a miscarriage both physically and mentally, and they should also inform women about the possibility of follow-up care. Harvey et al. (2001) advocates that health care professionals have a responsibility to inform women of the support available within the community and within health care. Feelings of anger and dissatisfaction were observed amongst women who were not given information about follow-up care (Harvey et al., 2001). This shows that women do find follow-up care important and they feel the need to have contact with health care even after the procedure. The health care provider's role in aiding women cope with miscarriage is vital; women with the risk of developing depression need intervention by health care providers. During follow-up care it is important that health care providers apply the principles of the domain *maintaining belief*, which according to Swanson's theory encompasses having faith in someone to overcome a demanding situation. A health care provider *maintaining belief* that a patient can get through this life transition gives the patient hope. Women have experienced that having the possibility of reaching a health care provider at any time is highly beneficial in coping with the loss (Séjourné et al., 2010). Giving women the contact information to health care professionals and allowing them the possibility of contacting them at any time gives

women the chance to get answers to their questions right away, to receive advice and to have somebody to talk to. This is achieved within Swanson's domain *enable* as the health care provider, by informing the women about the supportive resources available, are aiding in their life transition. This also entails providing information regarding access to follow-up care as well as explaining and informing different aspects of follow-up care.

Another main finding, which was a recurring theme amongst the chosen articles was that women felt a lack of empathy and compassion from health care providers. Women reported feeling alone due to the fact that health care providers distanced themselves from the women, which creates an emotionally cold and unsympathetic atmosphere (Smith et al., 2006). A number of the compiled articles presented that women felt health care providers focused mainly on the physical aspects of miscarriage and that there was a lack of concern for the psychological aspects in the care provided. Previous studies have shown that it is important that women have both their physical and psychological needs met, and when these needs are not realized it may cause women to harbor feelings of abandonment and isolation (Radford & Hughes, 2015). This paper's findings confirm that this in fact is the case. Since health care providers focus is on the physical aspects of a miscarriage, they distance themselves and fail to acknowledge the emotional and psychological aspects. Taking Swanson's theory of caring into consideration, these findings show an insufficiency concerning the domain *being with*. Health care providers are failing in being present emotionally which leads to feelings of abandonment and loneliness amongst patients.

Harris & Daniluk (2010) state that women appreciate when health care providers display consideration and care towards them. This is confirmed by the accounts of women in the specialized EPAU where women felt respected and emotionally attended to by health care providers (Tsartsara & Johnson, 2002). This shows that when women's emotional needs are met, their experience of health care provided is relatively positive. These health care providers are educated and experienced in offering individualized care to bereaved mothers and can therefore meet their emotional and psychosocial needs more sufficiently than health care providers in a general gynecological ward. The EPAU is an example of how the domain *being with* could be practiced correctly by health care providers. When Swanson's theory of caring is properly applied concerning the domain *being with*, the emotional needs of women cared for will be met. This is confirmed by the findings of women's high satisfaction with provided care in the EPAU.

Feelings of disempowerment amongst miscarrying women are a direct consequence of lack of choice or say in the events surrounding their miscarriage. Women in this circumstance are already feeling exposed and vulnerable, therefore including them in treatment plans and facilitating them to partake in choices concerning care will counteract them feeling disempowered and could in fact enable them to feel in control. Swanson's domain *enable* encompasses health care providers understanding of the women's circumstances, to take the women's exposed and vulnerable situation into account and to validate their feelings. Other elements of the domain comprises providing information and support throughout this life transition. Findings show that women consider their partners as the most significant source of support; therefore it is paramount to include them in the care. Partners of women going through a miscarriage should be seen as a resource and should be permitted, even invited to contribute to their partners care by providing support.

Caregivers should not reduce the miscarriage to a medical complication or trivialize the loss. It is important to reassure each bereaved woman's individual emotional response to the loss and to accordingly acknowledge the grief in reference to avoid diminishing women and their experience of loss. Dealing with grieving women and their partners entails helping them through the process of bereavement and to facilitate the process of coping with the grief. Health care providers should offer supportive interventions both in a hospital context and in follow-up care. Findings show that women value coping rituals, it is helpful in validating grief and additionally it helps bring closure. Harris & Daniluk (2010) brings up the significance of embodiment of grief as a helpful strategy for health care providers to reinforce women and their partners in coping with the loss through providing them with the opportunity to speak about their unborn child, name the child, keeping mementos or holding a proper funeral. Allowing a woman to embody her grief and to aid her in coping with the loss are good examples of how a health care providers can support a woman within Swanson's domain *enabling*. Therefore, in this context, Swanson's domain *enabling* and the concept of coping go hand in hand. Giving women validation of their grief and allowing women to cope will help them manage their grief and enable them to get through this life transition.

Previous studies have found that gestational age is not a good predictor of grief, and that the level of attachment could be a reasonable predictor. This study's findings show that due to the fact that women grieve in different ways, interventions to help cope with grief need to be individually adjusted and the same supportive intervention cannot be applied effectively to all women.

Neugebauer & Ritsher (2005) find that depression and grief are in fact prevalent in early pregnancy loss, 40.3% of the participating women were observed to be grief-stricken two weeks after having miscarriage, 20.3% after 8 weeks and 19.1% after 6 months. This shows that grief after pregnancy can affect these women in the long term and should be a significant aspect in the follow-up care. However, our findings show that women have experienced health care providers to fail at properly recognizing their grief. This could be due to the fact that health care providers believe grief after an early miscarriage to be less compared to grief after a late miscarriage. This finding relates to a lacking in health care regarding the domain *knowing* in Swanson's theory of caring. Health care providers are not comprehending the ramifications of pregnancy loss has in women's lives. This is proven in the findings of Kong, Lok, Lam, Yip, & Chung (2010). Kong et al, (2010) found that there was contradiction between the perceptions of health care providers and patients concerning the psychological morbidity of miscarriage. Women who went through miscarriage were more aware of the severity of psychological distress a miscarriage could provoke than health care providers were. The same results were observed concerning perceptions of how miscarriage affects women's mental health. Swanson, Connor, Jolley, Pettinato & Wang (2007) researched women's responses to miscarriage during the first year after loss. This study's findings suggest that a woman's feelings of distress six weeks after miscarriage did not differ from the reported feelings after one year. Swanson et al. (2007) advocates that women's distress levels six weeks after a miscarriage is a good indicator of distress levels after a year and that six weeks post-miscarriage should be an appropriate time to do a follow-up.

Conclusion

This literature review's main findings are that women experience a lack of communication and a lack of psychological support. It is important that health care providers are attentive in regards to the women's emotional needs during miscarriage and their need for information, in order to maintain a high quality of care. The negative long term effects of grief, should be considered and if possible avoided.

Implications for nursing care

Health care providers should ensure that women receive enough information regarding the treatment and psychological aspects surrounding their miscarriage. There should also be improvement considering the empathetic approaches of health care providers.

In order to prevent negative long term effects such as grief morbidity, anxiety and PTSD, we suggest that a routine screening of the psychological state of women 6 weeks after a miscarriage should be implemented. The screening should include the usage of scales such as the PGIS and PBGS to measure women's grief responses to the miscarriage and if there is a risk for grief morbidity other long term effects.

Further Research

Further research is needed to determine the most effective follow-up care plan that will allow women to efficiently cope with their grief which is satisfactory in the long term.

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* *Articles analyzed and included in the result*

Appendix

Appendix 1. Article overview

Title	Author(s)	Year/ Country	Study Design	Findings
The experience of spontaneous pregnancy loss for infertile women who have conceived through assisted reproduction technology.	Harris, D. L., & Daniluk, J. C.	2010/ Canada	Qualitative, phenomenological study	9 themes identified: A sense of profound loss and grief; diminished control; a sense of shared loss with their partners; injustice or lack of fairness; ongoing reminders of the loss: social awkwardness; fear of re-investing in the treatment process or a subsequent pregnancy; the need to make sense of their experience; and feelings of personal responsibility for what happened.
Factors that determine patient satisfaction after surgical treatment of ectopic pregnancy: Improving the patient journey.	Deepa, J., Oladimeji, O., & Funlayo, O. (2014)	2014/ United Kingdom	Prospective cohort study	Large amounts of haemoperitoneum and long waiting times resulted in dissatisfaction. While good communication pre-operatively, provision of post-operative leaflets and adequate pain relief resulted in good patient experience. Age, ethnicity and desire for future pregnancy had no effect on satisfaction.
Negotiating the transition: Caring for women through the experience of early miscarriage.	Murphy, F., & Merrell, J.	2009/ United Kingdom	Qualitative, ethnographic study	Three phases emerged in the experiences of miscarrying women: first signs and confirmation, losing the baby and the aftermath. Hospital admission was vital in the early phase, providing the women with sensitive, engaged care and meeting the emotional and physical needs of the women.
Women's experiences	Smith, L.,	2006/ United	Qualitative study	Five major themes were identified: intervention;

of three early miscarriage management options	Frost, J., Levitas, R., Bradley, H., & Garcia, J.	Kingdom		experiences of care; finality; the 'baby'; and pain and bleeding.
Couples' grief and experience of support in the aftermath of miscarriage.	Conway, K., & Russell, G.	2000/ Australia	Prospective study	Miscarriage was found to be a significant event, provoking feelings up to 4 months after the event. Partners scored higher than women on the PGIS. Women tended to receive social support more readily than the partners. Subsequent pregnancies were viewed with anxiety.
When pregnancy fails: Coping strategies, support networks and experiences with health care of ethnic women and their partners	Abboud, L., & Liamputtong, P.	2005/ Australia	Qualitative study	Treatment by medical personnel and family and friends could have a hindering or helping experience. Coping with pregnancy loss is individual. A good support network and positive contacts with health care professionals have a positive effect on coping.
Perinatal loss: A qualitative study in northern Ireland	McCreight, B. S.	2008/ Ireland	Qualitative study	The women's narratives described their experience with health care as negative in that they were subjected to a rationalizing process of medicalization. Their focus was to recover space for their emotions and to seek acceptance and recognition of their grief.
Women's experience of care at a specialised miscarriage unit: An interpretative phenomenological study	Tsartsara, E., & Johnson, M. P.	2002/ United Kingdom	Interpretive phenomenological study	Five themes emerged; at the antenatal clinic: comparing oneself with other pregnant women, EPAU: a special place to go, D&C why am I left on my own?, need for explanation, need for sensitive after care services.
Early bereavement: women's experiences	Ancker, T., Gebhardt, A.,	2012/ Sweden	Phenomenological study	Miscarriage significantly affected the women's lives. The need to

of miscarriage	Andreassen, S., Botond, A., & Sophiahemmet Högskola.			feel unconditionally understood and having people by their side who attentively listen, provide security and respect their loss was identified. These needs were not met by health care, a routine follow-up was proposed.
Guilt and emptiness: Women's experiences of miscarriage	Adolfsson, A., Larsson, P. G., Wijma, B., Bertero, C.	2003/ Sweden	Interpretive phenomenological study	When miscarriage occurs it is not a fetus but a child they are losing. Women feel that they are the cause of the miscarriage, they feel abandoned and they grieve their loss. They are in bereavement.
Women's experiences of early miscarriage: A phenomenological study.	Harvey, J., Moyle, W & Creedy, D.	2001/ Australia	Phenomenological study	Three major themes of loss emerged: the loss of a baby, the loss of the role of motherhood and the loss of the hopes and dreams the women possessed for their baby.
Support following miscarriage: What women want.	Séjourné, N., Callahan, S., & Chabrol, H.	2010/ France	Quantitative study	A majority of women felt that they would appreciate support following the miscarriage. The women felt poorly informed following the miscarriage and had problems with dealing with the emotional impact.
Pregnancy loss in lesbian and bisexual women: An online survey of experiences.	Peel, E. (2010)	2010/ United Kingdom	Qualitative study	Three themes: processes and practices for conception; amplification of loss; and health care and heterosexism. The experience of loss was amplified due to contextual factors. Most felt the losses made a significant impact on their lives. A minority of the participants experienced heterosexism from health professionals.

Appendix 2. Audit templates for quantitative studies according to Willman, Stoltz & Bahtsevani (2006)

Forskningsmetod RCT CCT (ej randomiserad)

Multicenter, antal center.....

Kontrollgrupp/er

Patientkaraktäristika Antal.....

Ålder.....

Man/kvinna.....

Kriterier för exkludering

Adekvata exklusioner Ja... Nej...

Intervention.....

.....

.....

Vad ansåg studien att studera?

Dvs. vad var dess primära resp. sekundära effektmått.....

.....

.....

Urvalsförfarandet beskrivet? Ja... Nej...

Representativt urval? Ja... Nej...

Randomiseringsförfarande

beskrivet? Ja... Nej... Vet ej...

Likvärdiga grupper vid start? Ja... Nej... Vet ej...

Analyserade i den grupp som de

Randomiserades till?

Ja... Nej... Vet ej...

Blindning av patienter? Ja... Nej... Vet ej...

Blindning av vårdare? Ja... Nej... Vet ej...

Blindning av forskare? Ja... Nej... Vet ej...

Bortfall

Bortfallsanalysen beskriven? Ja... Nej...

Bortfallsstorleken beskriven? Ja... Nej...

Adekvat statistisk metod? Ja... Nej...

Etiskt resonemang? Ja... Nej...

Hur tillförlitligt är resultatet?

Är instrumenten valida? Ja... Nej...

Är instrumenten reliabla? Ja... Nej...

Är resultatet generaliserbart? Ja... Nej...

Huvudfynd (hur stor var effekten?, hur beräknas effekten?, NNT, Konfidensintervall, statistisk signifikans, klinisk signifikans, power beräkning)

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Sammanfattande bedömning av kvalitet

Bra... Medel... Dålig...

Kommentar

.....
.....

Granskare (sign.)

Appendix 3 Audit template for qualitative studies according to Willman, Stoltz & Bahtsevani (2006)

Beskrivning av studien

Tydlig begränsning/problemformulering? Ja... Nej... Vet ej...

Patientkaraktäristika Antal..... Ålder..... Man/kvinna.....

Är kontexten presenterad? Ja... Nej... Vet ej...

Etiskt resonemang? Ja... Nej... Vet ej...

Urval

- Relevant? Ja... Nej... Vet ej...

- Strategiskt? Ja... Nej... Vet ej...

Metod för

urvalsförfarande tydligt beskrivet? Ja... Nej... Vet ej...

Datansamling tydligt beskriven? Ja... Nej... Vet ej...

Analys tydligt beskriven? Ja... Nej... Vet ej...

Giltighet

Är resultatet logiskt, begripligt? Ja... Nej... Vet ej...

Råder datamättnad? Ja... Nej... Vet ej...

Råder analysmättnad? Ja... Nej... Vet ej...

Kommunicerbarhet

- Redovisas resultatet klart och tydligt? Ja... Nej... Vet ej...

- Redovisas resultatet i förhållande till en teoretisk referens ram? Ja... Nej... Vet ej...

Genereras teori? Ja... Nej... Vet ej...

Huvudfynd

Vilket/-n fenomen/upplevelse/mening beskrivs? Är beskrivning/analys adekvat?

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Sammanfattande bedömning av kvalitet

Bra... Medel... Dålig