Wright State University
CORE Scholar

Symposium of Student Research, Scholarship, and Creative Activities Materials
Office of the Vice Provost for Research

2014

The Role of the Nurse in Family Coping after Miscarriage

Wesley Hannebaum
Wright State University - Main Campus, hannebaum.2@wright.edu

Follow this and additional works at: https://corescholar.libraries.wright.edu/urop_celebration

Part of the Arts and Humanities Commons, Engineering Commons, Life Sciences Commons, Medicine and Health Sciences Commons, Physical Sciences and Mathematics Commons, and the Social and Behavioral Sciences Commons

Repository Citation

This Article is brought to you for free and open access by the Office of the Vice Provost for Research at CORE Scholar. It has been accepted for inclusion in Symposium of Student Research, Scholarship, and Creative Activities Materials by an authorized administrator of CORE Scholar. For more information, please contact library-corescholar@wright.edu.
The Role of the Nurse in Family Coping After Miscarriage

Wesley Hannebaum

Wright State University – Miami Valley College of Nursing & Health
Abstract

When a miscarriage occurs, it affects the entire family unit, making coping an important part of healing during this time. After miscarriage, women are at increased risk for developing mental disorders such as anxiety and depression. Miscarriage is seldom seen as a concern for the father of the lost child, and thus their feelings are often ignored. It is important for the nurse to know how to best help these men, women, and the rest of the involved family cope after miscarriage so they can move on in a healthy way. The following is a review of the literature to determine effective interventions nurses can use to help families to cope and reduce stress and anxiety after miscarriage.
Table of Contents

I. Introduction ................................................................. Page 4
II. Review of the Literature ................................................ Page 8
III. Description of Project Introduction ............................... Page 29
IV. Project Evaluation ....................................................... Page 31
V. Conclusions and Discussions ....................................... Page 33
VI. References ............................................................... Page 37
Family Coping After Miscarriage

Research has shown that approximately one in five women who are pregnant will miscarry (Rowlands & Lee, 2010). Miscarriage is an overwhelming experience not only for the women who lose their baby, but for their partners as well. Society, oftentimes, does not see miscarriage as a concern to men, and thus their feelings are often ignored (Rinehart and Kiselica, 2010). Miscarriage can also affect other involved family members, such as grandparents and children (Roose and Blanford, 2011). The stress families experience during a miscarriage causes increased risk for the development of mental disorders (Brier, 2004) and relationship issues (Swanson, Chen, Graham, Wojnar, & Petras, 2009). It is important that nurses implement proper interventions to help these families cope with their loss while going through the grieving process. The focus of this paper is a thorough review of the literature to find which interventions nurses can use to best care for women and their families to facilitate coping after miscarriage.

Problem statement

A miscarriage can be devastating not only to the mother, but to everyone involved in that patient's life. Being mindful of patient and family emotions as they experience loss of a baby through miscarriage is important in nursing care because, if left untreated, the patient's grief may lead to depression or other types of mental illness (Brier, 2004).

Significance

One in five women who are pregnant will miscarry (Rowlands and Lee, 2010). It has been found that, oftentimes, couples are not satisfied with the emotional care they receive following a miscarriage (Stratton and Lloyd, 2008). It is important that the lines of communication are kept open between partners and their families during this difficult
time, but oftentimes, this doesn’t take place (Swanson et al., 2009). These patients are at increased risk for troubling their relationship (Swanson et al., 2009) and for developing mental disorders such as depression and anxiety (Rowlands and Lee, 2010). This is significant to nursing practice because research has shown that the care provided in the hospital can have a significant effect on the recovery from and experience of having an unexpected miscarriage (Stratton and Lloyd, 2008). Further research is needed to develop an understanding of best practice interventions nurses can incorporate into their practice for the entire family unit in order to close this gap in patient care.

**Purpose**

The purpose of this research was to conduct a review of the literature to determine effective interventions nurses can use to help families cope after miscarriage.

**Objectives**

The following were the objectives for this project:

1. Conduct a search of the literature about interventions nurses can implement in the family who has experienced miscarriage.

2. Select the best evidence by using information found in the literature review to determine the worth of each study to practice.

3. Link evidence findings to nursing practice by determining how the findings can be used to help families to cope after miscarriage by considering risks and benefits and how feasible the interventions are in the clinical setting.

4. Create and present a clear and concise PowerPoint presentation that discusses effective nursing interventions for patients who have had a miscarriage to present at the Celebration of Research, Scholarship, and Creative Activities and to
nursing students currently taking the Nursing Care of Childbearing Families course.

**Definition of terms**

The following terminology was throughout the project:

1. **Miscarriage:** loss of pregnancy that happens naturally without interference or known cause (Lowdermilk, Perry, & Cashion, 2010).

2. **Family:** the support system of the woman who experiences the miscarriage, everyone who is affected by the miscarriage and whom the woman identifies as family, whether or not there are actual biological or legal ties (Potter, Perry, Stockert, Hall, 2013).

3. **Literature:** articles about a particular subject (Webster, 2012). In this case, articles obtained from internet databases pertaining to the topic of miscarriage and family coping.

4. **Nurses:** a person who is trained to care for sick or injured people and who usually works in a hospital or doctor's office (Webster, 2012). This project will focus on nurses in close contact with families who are experiencing miscarriage and providing their care.

5. **Intervention:** any treatment based on clinical judgment and knowledge performed by a nurse to enhance patient outcomes (Potter et al., 2013). This project will focus on interventions which will help families to cope after experiencing miscarriage.
Summary

Unfortunately, there are many pregnancies that end in miscarriage, and it has been shown the families that go through miscarriage have not been given adequate emotional care (Stratton & Lloyd, 2008). It is important that nurses know how to properly care for these patients and families to ensure they can recover healthily and move on with their lives. The following literature review will summarize some of the current research on this topic.
Chapter II. Review of the Literature

The Importance of Family in the Coping Process

A patient’s family is defined as whoever the patient considers to be included in the family (Potter et al., 2013). Family centered nursing care is important after miscarriage because the loss involves the entire family unit. In times of crisis, it is important that the family unit connects and supports one another to facilitate the coping process (Miscarriage Association, 2013). Communication is especially important after a crisis because it helps families to cope better by sharing their thoughts and feelings related to the event. Oftentimes, this does not occur, because when people are stressed, they tend to withdraw and refuse to talk about their feelings (Potter et al., 2013).

How Women and Men Grieve Differently

According to the American Pregnancy Association (2013), women are usually more open to talking about the miscarriage and seeking support from others while men are quite the opposite. Men often try to keep busy to avoid their feelings (Rinehart and Kiselica, 2010), but are less likely to participate in support groups or share their feelings when compared to their women partners (American Pregnancy Association, 2013). This may be due to the fact that some men believe that strong displays of emotion do not correspond with their role as a husband and father (Rinehart and Kiselica, 2010).

In their study, Rinehart and Kiselica (2010) found that men often blame themselves for failing to notice something was wrong and feel they have failed as a partner, or they may direct their anger toward the medical staff or God. It was also found that men, oftentimes, resort to drugs, alcohol, food, keeping busy, or other forms of acting out such as aggressive or even violent behavior while dealing with the grief of
miscarriage (Rinehart and Kiselica, 2010). These findings suggest that men must be offered socially acceptable ways of coping with the miscarriage to prevent such behavior from occurring and possibly causing more grief.

**Issues that Affect Coping in Women after Miscarriage**

Rowlands and Lee (2010) completed a study in Australia where nine women who had experienced miscarriages were interviewed and a thematic analysis was completed. The study focused on the level and effectiveness of the support experienced by these women who had experienced miscarriage. One theme was extremely evident throughout the interviews, and that was “Engagement by Others”, which was based on the idea that other people have an impact on determining the woman’s miscarriage experience.

Many women said that speaking to and gaining emotional support from other people was crucial, and some stated that support from their friends and family who had also gone through the loss of a pregnancy was the most valuable (Rowlands and Lee, 2010). A study by Rinehart and Kiselica (2010) also supported this idea, because they found that those who have not personally experienced miscarriage themselves are substantially unable to empathize with those who have.

In the study by Rowlands and Lee (2010), one woman stated that she found talking with her family about the miscarriage difficult because she was worried they may not respect her emotions regarding the miscarriage. Two women stated that their husbands were supportive and helped them to cope. Several of the women said that they felt distressed by a lack of support from their family members. Another issue that came up was that some women felt that people could not cope with their grief, and they even
felt alienated or that people were scared of them. Overall, it was important to the women that some sort of validation was received from others.

In relation to healthcare, the majority of women had poor things to say regarding their care from the medical community. Many of the women who were interviewed were upset by the lack of empathy and insensitive comments made by healthcare providers which they felt lessened the significance of the event. Lack of information was also a major concern regarding the medical procedures they were going to undergo, how long they would need to wait for care, and even uncertainty of the diagnosis of a miscarriage itself. However, two women did have positive things to say about the supportive role some of their healthcare providers had during their time of grief. In particular, a few of the women praised their obstetricians, midwives, and gynecologists for their support after their miscarriage had occurred.

One major drawback to this qualitative study was that the sample only included nine women, so the results may be different for a larger and more diverse sample of miscarrying women. However, the women interviewed were described as having a variety of different experiences regarding miscarriage and their responses were still considerably consistent and reflected other research findings associated with miscarriage coping.

The way in which a miscarriage is managed also has an impact on the woman’s experience of a miscarriage. In a study by Smith, Frost, Levitas, Bradley, and Garcia (2006), medical, expectant/natural and surgical management methods were examined to determine if how the method in which the miscarriage is managed affects women’s experience of the miscarriage (Smith et al., 2006). It was hypothesized that if women
have a choice in the way their miscarriage is managed, this will affect their feelings afterward and, therefore, women who miscarry should receive appropriate information about each option and their thoughts about each should be taken into consideration when determining appropriate treatments. Researchers conducted qualitative interviews with women six to twelve months after they had experienced first trimester miscarriage and these interviews were then evaluated to see if any specific themes or significant issues stood out in relation to each treatment. Seventy-two women participated in the study. Five major themes were found: intervention, pain and bleeding, experience of caring, finality, and the “baby.”

With regards to the type of intervention, the major issue found was whether the women thought the intervention they experienced was appropriate or not. Some women were strongly against some interventions compared to others. The majority of the women wished to be allowed to miscarry naturally instead of having to go through an invasive procedure.

Another issue mentioned was that some women felt that the diagnosis could possibly be an error and, if they consented to any type of intervention, they were assisting in the killing of their baby. There was fear in all three groups of each intervention, but fear was especially present in those women whose intervention involved a surgical procedure or hospitalization. A small number of women who were in the medical and surgical intervention groups described the staff as being cold and insensitive.

To have a miscarriage managed naturally, or expectantly, means to let the miscarriage take its natural course where the woman experiences strong periods of cramps and bleeding until the uterus has emptied (The Miscarriage Association, 2013).
Women in the expectant group said that the experience was upsetting, but they were glad they chose to go through the experience in their own home versus at the hospital. The majority of women in all three groups thought it was important that the miscarriage come to a predictable end so they could go on with their normal lives.

The data collected during the study supports the hypothesis that women and their partners need to receive appropriate information about the management options available to them and have their views and ideas taken into consideration when deciding the type of treatment to pursue. It also showed that the how the care is provided to women and their families affects the women’s experiences and feelings of the miscarriage. A limitation to this study is that it consisted mostly of white middle class women and, therefore, many other cultural and socioeconomic groups were not represented. There also may have been a “Hawthorne effect,” because the care givers and participants in the study were aware of the trial and may have changed their normal behavior throughout the process.

**Medical and Psychological Interventions for Women after Miscarriage**

A randomized controlled trial was conducted involving women recruited from the Harris Birthright Research Centre for the intervention groups who had experienced miscarriage to determine the impact medical and psychological interventions have on women’s stress after miscarriage (Nikčević, Kuczmierczyk, & Nicolaides, 2007). The intervention group included sixty-six women who underwent medical investigations to determine their cause of their miscarriage and, five weeks later, had a medical consultation with a healthcare professional to discuss the results. Thirty-three of these women also had further psychological counseling in addition to the medical counseling
(MPC Group), while the other thirty-three did not (MC Group). The control group (CG) consisted of sixty-one women diagnosed with missed miscarriages at the antenatal clinics at King’s College Hospital, Chelsea & Westminster Hospital, and Greenwich District Hospital who did not receive any dedicated miscarriage follow-up care.

The study used questionnaires to determine anxiety, depression, grief, self-blame, and worry at four, seven, and sixteen weeks after miscarriage. The data collected showed that anxiety, depression, and grief decreased significantly with time (P < 0.0001) in all of the participants. The women who received medical counseling had a greater decrease in self-blame over time (On a scale of 3 – 15, with higher scores indicating higher levels of self-blame, MC group self-blame scores = 7.9 at four weeks, 5.5 at seven weeks, 5.6 at 4 months) when compared with the control group (CG self-blame scores = 7.2 at four weeks, 6.7 at seven weeks, 6.5 at four months), regardless of whether they also received psychological counseling (MPC group self-blame scores = 8.7 at four weeks, 6.0 at seven weeks, 5.7 at 4 months). Those women who did receive psychological counseling had the greatest decrease in feelings of grief over time (On a scale of 17- 85 with higher scores indicating higher levels of grief, MPG group grief scores = 52.8 at four weeks, 46.2 at seven weeks, 39.9 at four months) when compared with all the other groups (MG group grief scores = 48.4 at four weeks, 40.9 at seven weeks, 42 at four months; CG grief scores = 46.7 at four weeks, 43.0 at seven weeks, 40.9 at four months). All of the findings in the study showed that medical investigations, medical consultation, and psychological counseling are helpful in reducing women’s distress after miscarriage, and thus supported the hypothesis that women should be offered follow-up care by a health-care provider after miscarriage.
A limitation to this study was that it consisted mostly of Caucasian women, of higher reproductive age, with higher levels of education, stable relationships, and planned pregnancy and, therefore, it underrepresented many other groups of women, mainly younger women, minorities, and women of low socioeconomic status.

The Man’s Experience of Miscarriage

A one-year longitudinal study by Kong, Chung, Lai, and Lok (2010) set out to compare men’s reactions to miscarriage to their female partner’s reactions. This was done by assessing the psychological reaction of eighty-three partners at three, six, and twelve months after their miscarriage, using a twelve-item General Health Questionnaire (GHQ-12) and the Beck Depression Inventory (BDI). The GHQ-12 is a rating scale that has been widely used to determine general psychological distress and is well validated with a high sensitivity and specificity. The BDI is a twenty-one item self-rating scale which is designed to determine the level of depression severity, it has also been used widely in clinical and research settings and a validated version was used in the study. A Dyadic Adjustment Scale (DAS) questionnaire was also used at baseline right after the miscarriage occurred; it is a thirty-two item questionnaire used to assess the person’s perception of the adjustment of their marital relationship. The DAS scores range from 0 – 151 in which a higher score indicates a better relationship and a score of 100 or less is considered to be indicative of marital discordance. There were no specific interventions involved in this study and the couples were instructed to complete these surveys independently of one another.

In women, an initially high GHQ-12 score (greater than or equal to four) was found to be significantly related to a low DAS score, and a both a low DAS score (P = 0.03) and having had an ultrasound showing the living fetus (P = 0.02) were found to be significant
risk factors for an initially high BDI score (greater than or equal to 12). Both of these factors in women remained significant after logistic regression (P = 0.04).

In comparison, men had no significant risk factor found for an initially high GHQ-12 score. The only risk factor determined to be significant after multivariate analysis for initially high BDI scores in men (greater than or equal to 12) were related to pregnancies that were planned (P = 0.008).

It was found that 43.4% of the men scored high in the GHQ-12 and 16.9% scored high in the BDI immediately after miscarriage occurred. These scores then decreased sharply within the following three months (P < 0.001) and reached a plateau. Men scored significantly lower in the GHQ-12 immediately after and 3 months after miscarriage than their women partners. At the one year mark after miscarriage, the statistics between the men and women became more comparable in both the GHQ-12 and BDI. Overall, it was found that, even though the men’s distress scores were not as long lasting as their partners, there was a significant proportion of men who experienced psychological distress immediately after the occurrence of miscarriage. This suggests that in implementing an improvement for the emotional care of couples after miscarriage, emphasis preferably should be placed close to when the miscarriage occurs.

One major limitation of this study was the small sample size. Many of those who agreed to participate in the study had a higher level of education, were more likely to be full-time workers, and more likely to have a planned pregnancy. Therefore, the results of the women involved in this study may not be reflective of the general population. It was not determined if any of the participants had any psychological counseling or other intervention after having their miscarriage; therefore, this may have skewed the results of
the study as well. No baseline psychological information was gathered on the couples who participated prior to their miscarriage; therefore, the results may have been affected by other things going on in the patient’s life, not miscarriage alone.

**Miscarriage Effects and Interventions for Grandparents and Children**

When a miscarriage occurs in a family, the anticipated grandparents are affected as well. During the process of a miscarriage, grandparents are grieving for both their lost grandchild and also for their child who has lost their baby (Roose and Blanford, 2011). This is important to consider in nursing care because healing the grief of the grandparents will help them to better support their children through their grief (Roose and Blanford, 2011).

A study by Roose and Blanford (2011) evaluated the usefulness of a perinatal bereavement program (PBP) for providing support to grandparents and siblings after a miscarriage had occurred in the family. The PBP created a support group for grandparents, allowing them to participate in activities such as hospital visits, holding or caring for the lost child, planning the funeral service, attending the funeral, sharing pictures or mementos, and participating in the PBP memorial service. Grandparents involved themselves in at least one of the PBP’s supportive activities over 62% of the time and the parents found this use to be very useful in their healing 96% - 100% of the time. The grandparents reported that participating in the PBP services was useful to their healing 25% of the time or very useful 75% of the time. This suggests that involving grandparents in the family grieving after a miscarriage is not only helpful to the grandparent, but is also helpful in providing support for the grieving parents of the lost child.
After a miscarriage, signs and symptoms of grief may occur in the deceased baby’s siblings as well (Roose and Blanford, 2011). It is important that these children are considered for emotional support after the occurrence of a miscarriage because, if they are not included in the grieving process, they are more likely to experience feelings of confusion about the event and may feel excluded from the family (Roose and Blanford, 2011).

In the PBP study by Roose and Blanford (2011), less than 25% of families with children at the time of miscarriage included them in the support services offered. It seems that, oftentimes, parents do not want to include their other children in the event of the miscarriage because they felt so overwhelmed with their own grief, they did not want to think about having to also deal with their child’s grief. Parents also said that they felt their child would be too young to understand or be frightened. However, the families who did include their children found the activities to be useful 100% of the time.

Activities offered in the PBP included activities such as visiting the hospital, holding the baby, reading books on grieving, attending the funeral, sharing pictures and mementos, and participating in memorial services. Some parents who said they did not include their children often regretted this decision. Others said they felt they acted strange around their other children, felt they were always trying to hold their grief in, and wondered, if they had included their children, if it would have allowed them to better understand what was happening at that moment in time. Other parents said they intend to educate the child on what happened and share memories and mementos once the child reaches an older age.
Parents who allowed their children to participate in the memorial service found that it helped the child to better understand what had happened and gave the child an opportunity to have their questions answered. This suggests that, although many parents were hesitant in including the siblings of the lost child in the events surrounding the miscarriage, it seems that allowing the children to be a part of the grieving process is helpful not only to the child, but to the family unit as a whole.

A limitation to this study was that it consisted of predominately white participants; therefore, it may not be reflective of the entire population. Also, the number of children and grandparents included in the study was small.

**Couples Focused Interventions**

A randomized controlled trial was conducted to study the effects of couples-focused interventions on the feelings of depression and grief that occur during the first year after miscarriage (Swanson et al., 2009). Couples who had experienced loss of a pregnancy prior to twenty weeks gestation were divided into four groups: nurse caring, self-caring, combined caring, and no treatment. The no treatment group served as the control. The nurse caring group participated in three counseling sessions with a nurse; the self-caring group completed three video and work book modules to be completed by the individual; and the combined caring group participated in one counseling session and three self-caring modules. It was hypothesized that the couples who were placed in the nurse, self, or combined caring groups would have their depression, pure grief, and grief-related emotions decrease faster than those in the control group. It was also hypothesized that the rate of recovery would be the same for everyone who was assigned to an intervention group, regardless of type (nurse, self, or combined caring).
Interventions were developed using Swanson’s Caring Theory and Meaning of Miscarriage Model. This model was developed through phenomenological investigation in women who had recently miscarried, care providers in the newborn intensive care unit, and young mothers who had been receiving a long term public health nursing intervention. This model found that caring consists of five categories: knowing, being with, doing for, enabling, and maintaining belief. The model defined caring as “a nurturing way of relating to a valued other toward whom one feels a personal sense of commitment and responsibility” (Swanson et al., 2009, p. 1247).

A Bayesian framework was used to measure the differences in rate of recovery for each group. Depression was assessed using the Center for Epidemiological Studies-Depression scale, a highly standardized twenty-item questionnaire used in the general population. A score of 16 or higher indicates higher risk for clinical depression. Chronbach’s alpha reliability estimates for men ranged from 0.844 to 0.902 and for women ranged from 0.908 to 0.923. Grief was measured using the Miscarriage Grief Inventory. Two subscales of the inventory were used. The pure grief (PG) subscale focused on thinking about the miscarriage and crying inwardly and outwardly about the lost baby and had a Chronbach’s alpha reliability estimate for men from 0.871 to 0.878 and for women ranged from 0.876 to 0.897. The grief-related emotions (GRE) subscale focused on feelings that indicate distance and distress and had a Chronbach’s alpha reliability estimate for men from 0.803 to 0.854 and for women ranged from 0.761 to 0.853.

The data collected showed that the nurse caring intervention had the most positive effect on resolution of grief and depression as a couple. The intervention most effective
in women was self-caring, and men had the most accelerated grief resolution with the combined caring intervention. A limitation to this study is that the couples were not randomly assigned using a table of generated numbers, but instead were physically randomized. The study sample underrepresented many socioeconomic and cultural groups because it mainly consisted of Caucasian, English-speaking couples in self-proclaimed heterosexual relationships.

**Web-Based Interventions**

Klein, Cumming, Lee, and Bolsover (2012) also did a study on a couples focused intervention. In the study, a web-based intervention aimed to promote mental wellbeing in women and their partners after miscarriage. The study compared web-based interventions with the standard care that normally follows miscarriage. A partially randomized patient preference design was used, in which participants were randomly divided into intervention and control groups. After placement, if the participant wanted to change the group they were assigned to, after the randomization, they could. This was chosen over a randomized controlled trial design to better support patient choice, as the authors brought up that there has been recent controversy with the ethical implications of randomized controlled trials. Two hundred thirty-nine women and their partners were offered participation in the study, and all had experienced miscarriage before twenty-four weeks of gestation. Sixty-seven (28%) of those completed the website registration process and were included in the study. Baseline assessments were collected, as well as follow up assessments, at three months after the start of the study.

The web-based intervention was a website titled ‘Miscarriage Matters’, created based on studies that showed the psychological impact that the loss of a miscarriage has
on women and their partners. The content on the website was produced by clinical experts in obstetrics, gynecology, and trauma and was peer reviewed by the Chair of the Scottish Early Pregnancy Network. Specifically, the following information was included on the website: answers about personal questions related to miscarriage from clinical experts, a ‘forum’ users could use to interact with others to share support and experiences, contact information for agencies who provide support after miscarriage, and definitions of medical terms into lay terms to support users of various levels of education. The site was designed in a ‘frequently asked questions’ format and included links to other parts of the site where appropriate to facilitate navigation.

At the start of the study, the participants in both the intervention and control groups were given log in information for the website and instructions on how to register. The website collected baseline assessments during the registration process using three questionnaires. The questionnaires used were the Hospital Anxiety and Depression Scale (HADS) which measured the prevalence of anxiety and depression, the Medical Outcomes Study thirty-six item Short form (SF-36) which was used to determine overall quality of life, and the Care and Support Questionnaire (CSQ). After completion of the baseline assessments, participants were randomly placed into the intervention group or control group. After placement, if the participant preferred to be in a group other than the one they were randomized to, they were able to change groups. The intervention group included forty-eight participants and the control group had nineteen participants after preference relocation. Most of those who ended up participating in the study were women (60, 89.6%).
The results of the study indicated that the intervention group was significantly less anxious and depressed at the three month follow up when compared to the control group (HADS anxiety, \(P = 0.01\); HADS depression, \(P = 0.02\)). The intervention group also reported higher levels of well-being in regard to the SF-36 questionnaire when compared to the control group (SF-36 vitality, \(P = 0.018\); SF-36 emotional role, \(P = 0.005\); SF-36 mental health, \(P = 0.008\); and SF-36 MCS score, \(P = 0.005\)). In relation to the site and the user’s perception of how helpful it was, 96% (\(n = 30\)) rated the overall helpfulness of the website as ‘helpful’ (\(n = 24\), 77%) or ‘very helpful’ (\(n = 6\), 19%).

The results of this study seem to show that a web-based intervention such as this may be promising in the future of how people are provided with support after miscarriage. However, not all participants found the website to be helpful, which shows that individual differences still need to be acknowledged. Perhaps a web-based intervention could be used as a supplemental tool to other forms of support interventions.

A major limitation to this study was the small amount of people that actually participated, and the fact that many of the male partners did not participate. It was actually suggested by the authors that the thought with this study was that the web-based intervention would be more appealing to men because, when compared to women, they are less likely to openly seek emotional help (Klien et al., 2012). Future studies should include larger population samples and encourage more males or other family members to participate.

**Attribution Retraining**

In a national U.S. survey conducted by Bardos, Friedenthal, and Williams (2013), of women who reported that they had experienced a miscarriage, 40% said they felt they
had done something wrong to cause the miscarriage, 27% said they were ashamed, 40% felt alone and 47% felt guilty. Seventy-eight percent of the women who reported they had experienced miscarriage said they would want to be informed of the cause of their miscarriage even if there was nothing they could have done to prevent it. In contrast, 19% of the women said that if they were informed of a cause, it made them feel as if they had done something wrong. This shows women who experience a loss such as miscarriage often look for an explanation for the event, asking questions about why the miscarriage has occurred, what has happened, and who is responsible. A study by Wing, Burge-Callaway, Rose-Clance, and Armistead (2001) also supports this theme. They found that 97% of couples in their study wanted to know why the miscarriage had occurred and, unfortunately, 37% of those who have experienced miscarriage never are given a cause. This questioning can commonly lead to guilt and self-blame between both the mother and father of the baby (Sharifi, Hajiheidari, Khorvash, & Mirabdollahi, 2013).

Sharifi et al. (2013) defined this type of questioning after the occurrence of a miscarriage as attributive style and examined the effects of attribution retraining interventions on women’s depression and anxiety after miscarriage. The hypothesis for the study was that because evidence has shown there is a relationship between beliefs and attributions about miscarriage and the development of psychological disorders, attributive retraining interventions might be effective in reducing the women’s levels of anxiety and depression. Sharifi et al. (2013) researched this idea by completing a semi-empiric study using a control group and pre- and post-testing. Thirty-two women who had experienced miscarriage within the past three months participated in the study and were randomly divided into case and control groups. Both groups participated in a hospital depression
and anxiety questionnaire before the study, after the study was completed, and then again as a follow up. The case group completed six weekly sessions for attributive retraining interventions while the control group did not.

The results showed that the average post-test and follow-up scores of those in the case group who had gone through the attributive retraining intervention sessions were significantly less than the average post-test scores in the control group (P < 0.0005). This shows that educating women on why miscarriage occurs due to embryo-anomaly or other medical reasons reduces the women’s feelings of depression and anxiety. This appears to be because, after being informed of the cause of miscarriage, they have less feelings of self-blame and have been assured that the miscarriage has not occurred due to something they or someone else has done. One limitation to this study was that it did not look at how attribution training affects the man’s feelings after the miscarriage. However, the results suggest that discussing the cause of miscarriage can help the woman and her significant other or father of the baby to better adapt emotionally to the loss.

Privacy

Miscarriage is something that often first presents in busy areas such as emergency departments. This is oftentimes an issue because lack of privacy can be a concern in this type of care area. Many problems often occur in this busy environment, such as people entering examination rooms during an active exam or providers having to leave the room in the middle of an exam to get more equipment (Bryant, 2008).

A double blind peer reviewed article by Hannah Bryant (2008) discussed interventions that can be used to help better promote privacy for women experiencing miscarriage in emergency departments as indicated by the RCN’s Guidelines for Vaginal
Interventions included ideas such as putting “engaged” signs on the doors to keep unwanted personnel from interrupting an exam and treating these women in areas which have curtains or doors with catches to allow locking. Checklists should be kept in the patient rooms used for vaginal exams to ensure that all equipment is adequately stocked at all times. It was also suggested that because these exams require the removal of most of the woman’s clothing, the patient should be kept in a warm environment to keep them as comfortable as possible. Because these women who present with miscarriage often have a lot of vaginal discharge, it should also be a priority that all women who come to the emergency department with a threatened miscarriage be are provided with hygiene packs containing toiletries such as pads, wipes, and disposal bags to prevent the embarrassment that might occur from having to ask for such items. Bathrooms should also be close by to the patient’s room or examination area, and the patient should be allowed to undress in privacy.

Bryant (2008), also reinforced the ideas discussed earlier in this literature review, such as the need for nurses to provide support to partners, reassuring women that the miscarriage was not their fault, and ensuring that couples are given options and information with regards to the way their miscarriage is managed. Bryant (2008) also expressed the importance of the nurse to treat the patients and their families with respect and empathy. One limitation to this article was that it did not discuss cultural considerations and religious differences, which also could be taken into consideration when discussing privacy needs.
The Emotional Effects of Miscarriage and the Role of the Nurse

Miscarriage is not just the loss of a pregnancy, but a loss of future hopes and expectations (Rinehart and Kiselica, 2010). It has been shown that once the parents view ultrasound images of their baby and the fetus is visually confirmed, the bonding process between the parents and baby has begun (Rinehart and Kiselica, 2010). Parents reported that the most unfortunate things that they experienced throughout the process of their miscarriage were healthcare professionals who were “unfeeling,” those who reacted as if their loss was no big deal, or those who treated the miscarriage in a casual manner (Rinehart and Kiselica, 2010). It has been shown that those who have not personally experienced miscarriage themselves, are substantially unable to empathize with those who have (Rinehart and Kiselica, 2010).

Nurses play an important role in ensuring the patient’s psychological needs are met throughout their treatment of a miscarriage (Bryant, 2008). First, the nurse must establish trust with the patient and it should be made sure that enough time is spent with these patients to allow discussion and show support (Bryant, 2008). The nurse should not avoid discussing the sensitive issue, and most importantly, should acknowledge the patient’s loss (Rowlands and Lee, 2010). The grieving process after a miscarriage may go on for a year or longer (Rinehart and Kiselica, 2010) so nurses should encourage parents to grieve and let them know there is no limit to the grieving process. The nurse should also let the family know that it is okay to feel sad during this time, but not to let these feelings control them. The nurse should encourage the family to do enjoyable things and not to feel guilty about these things. The family should be told that celebrating some joys is not dishonorable to their loss, and that laughter and joy help the healing process.
(American Pregnancy Association, 2013). Follow-up calls were also found to be valuable assets in patient care (Roose and Blanford, 2011) so these should be completed once the patients leave the hospital. Throughout the follow-up call with the patient, the nurse should determine whether the patients have found support groups useful, how they are coping, and the need for further referrals.

**Summary**

A larger amount of high-level quality evidence as opposed to lower-level evidence was used in this literature review (Table 1) which warrants greater validity. However, randomized controlled trials, which are often regarded as the gold standard of clinical research, were difficult to find, indicating an opportunity for more research to be done on this particular topic of family coping after miscarriage.

This literature review shows that more research is needed in regards to nursing care of patients after miscarriage, especially for men, children, and grandparents. It also proves that this is an issue that needs to be brought to attention, as many people are unsatisfied with the care they receive after miscarriage. This is significant since the review shows that miscarriage increases the risk for the development of mental disorders and relationship issues. The following chapter will describe how this information was implemented and its significance to nursing practice.
Table 1: Levels and Types of Evidence

<table>
<thead>
<tr>
<th>Level</th>
<th>Evidence Type</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
<th>13</th>
<th>14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level I</td>
<td>Systematic review or meta-analysis</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Level II</td>
<td>Randomized controlled trial</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level III</td>
<td>Controlled trial without randomization</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level IV</td>
<td>Case-control or cohort study</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level V</td>
<td>Systematic review of qualitative or descriptive studies</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level VI</td>
<td>Qualitative or descriptive study (includes evidence implementation projects)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level VII</td>
<td>Expert opinion or consensus</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Chapter III. Description of Project

The purpose of this project was to determine effective interventions nurses can use to help families cope after miscarriage. The research was completed by conducting a review of the literature to determine how each family member is affected by miscarriage, which interventions are most useful in the coping process, and how nurses can best implement these interventions into practice. Articles were found using the Wright State University library databases and were included if they described or examined support services or interventions to help with coping after miscarriage. The process is discussed in more detail as follows.

Sampling plan

A literature search was conducted using electronic databases including CINAHL, EBSCOhost, and PubMed to identify nursing research articles which discuss nursing interventions for families who have experienced miscarriage. Key words/phrases used include “miscarriage,” “interventions,” “coping,” “trauma,” and “anxiety.” Literature published within the last 5 years was preferred for use in the project. Articles relevant to the topic were identified and included in the literature review. As a Wright State University student, there were no charges accrued for access to research articles and databases.

Population

Scholarly, academic, peer-reviewed articles with a focus on nursing interventions to facilitate coping in women and their families who have experienced unexpected loss of a pregnancy were used in this research project.
Ethical and legal considerations

Copyright laws were followed and no plagiarism has occurred during the creation of this literature review. All information obtained throughout the process of the project has been cited appropriately.

Implementation

After completion of the literature review, the information found to be most useful in determining the ways nurses can help families to cope after miscarriage was put into a clear and concise Power Point presentation. This information was presented to current nursing students in the NUR3440 Nursing Care of Women and Childbearing Families class at Wright State University. This presentation was also given to an audience at the Wright State University Fifth Annual Celebration of Research. After presenting, the project was self-evaluated.

Summary

The overall objective for this project was to complete a review of the literature to determine which nursing interventions are most effective in families who have experienced miscarriage. A Power Point presentation was created, displaying pertinent information to be presented to nursing students in the NUR3440 class and was also presented at the Fifth Annual Celebration of Research. This information will allow nurses to know the best way to promote coping and prevent the development of stress and anxiety disorders after miscarriage. The following chapter will present an evaluation of the current research project.
Chapter IV. Project Evaluation

This project is significant to nursing practice because several of the articles indicated that families are not satisfied with the emotional care they receive after miscarriage. Nurses are the ones who often interact and spend time with these patients the most while they are in the healthcare setting, so nurses have the power to improve this gap in patient care. Overall, the findings showed that all family members are affected by miscarriage and family involvement helps the couple who has miscarried to heal. If nurses are educated on what people that miscarry are going through, it will help them to be more prepared in knowing how to approach these patients and best care for them. The information found in this project was disseminated through oral presentations and use of a PowerPoint that was given to the OB nursing class and at the Wright State University Celebration of Research, Scholarship, and Creative activities.

One of the limitations to this project was the lack of research articles that were available. It was difficult to find articles pertaining to studies that focused on specific nursing interventions used with different family members to assist in coping after miscarriage. Time constraint was another limitation to this project as it had to be completed in two school semesters. Some of the information found was not written in the last 5 years, and therefore, this may have an effect on the reliability of some results found. However, this shows that research on this topic may have not been completed in some time. Many of the studies also had very small sized sample groups and, therefore, they may not be representative of the entire population. It was also difficult to find information regarding the effects of miscarriage on men, grandparents, and children and
helpful interventions for these populations. This suggests that more research needs to be completed on this topic.
Chapter V. Conclusions and Discussions

Conclusion

The information found in this literature review showed that emotional care for patients after miscarriage is a topic that many patients are not satisfied with and this issue needs to be improved upon in the healthcare setting. Inclusion of the family is an important part of the coping process and it was determined that each family member grieves and contributes to the family as a whole in a different way, depending on their role. By having a better understanding of what each person in the family is going through during a loss such as a miscarriage, nurses can better anticipate how to care for these patients and facilitate the grieving process to encourage coping. The lack of information found regarding the nurses’ role in family care after miscarriage suggests that more research needs to be completed on the topic to better improve patient outcomes in this area.

Results of implementation

The hope with the implementation of sharing the information found in this research is that it will further educate nursing students at Wright State University on the sensitive topic of miscarriage and empower them as nurses to help these patients to heal when they come across such situations in their practice. With the presentation at the Wright State University Celebration of Research, this information was given to people not only in the nursing field, but in many other different fields as well. This is significant because miscarriage is something that occurs often, and many people are likely to encounter the issue at some point in their lives, whether it be themselves or someone they know who is going through the loss. The expectation for this presentation is that it will
educate those in the community about miscarriage and the effects it has on each family member, so that when it is encountered by the public, they know how to best support these families, understand what they may be going through, and help them to grieve and ultimately heal in a healthy way.

A longer length of time allotted to complete this research would have allowed for a further in-depth literature review, or perhaps completion of a study or controlled trial to determine the effects of the interventions based on the current research on the patients at a local healthcare facility in the Dayton, Ohio area.

**Discussion**

The research indicates that everyone in the family is affected by miscarriage in some way, and that it is important these people are given appropriate emotional care after miscarriage to prevent further problems with healing such as the development of psychological disorders. It was found that the whole family should be included in the coping process after miscarriage because each person is affected, and communication between these families is crucial in facilitating the coping process by sharing their thoughts and feelings about the event. Oftentimes, this communication may not occur after a crisis so it is important that nurses ensure this communication occurs.

Barriers that seem to be affecting the patient’s experience after miscarriage include unfeeling healthcare providers, lack of information about procedures, and lack of choice for the way miscarriage is managed. It was also found that those who have not personally experienced miscarriage themselves are substantially unable to empathize with those who have, making connecting with these patients difficult for some providers. Having an awareness of these barriers as a nurse can help to improve patient outcomes.
It was found that women are usually more open to talking about the miscarriage and find support from those who have also gone through the loss of a pregnancy as especially helpful. However, some women find reaching out to others difficult during this time because they may be worried that others may not respect their feelings about their miscarriage or they may feel like other people are afraid to talk to them. As a nurse, it is important to let these women know it is okay to seek support from others, and if possible, to educate the family on what this patient is going through to help them to better support the patient during this time.

Men are much the opposite, and tend to keep to themselves or stay busy to avoid talking about their feelings. They may even place blame on themselves or feel they have failed as a partner. It has also been found that society tends to ignore men’s feelings after miscarriage. It is important that men’s feelings are recognized and they are given appropriate ways to cope as they deal with the loss of a baby and help to support their partner.

Research has shown that other family members, such as grandparents and children, should be included in the family coping after miscarriage as well. It was found that, oftentimes, when these people were included, it not only helped in their healing, but to the parents who have miscarried as well. This information further supports the involvement of the entire family after miscarriage.

It was found that patients should be given privacy while in the healthcare setting after a miscarriage, especially since miscarriage often presents in busy places such as emergency departments. It should also be a priority that the nurse takes the time to talk with these patients, and show support. The family should be encouraged to grieve, but
should also be told that joyful things are not dishonorable to their loss and that laughter and joy actually help aid the healing process. Medical counseling to determine the cause of miscarriage was also found to be useful, especially in decreasing feelings of self-blame over time. Follow-up calls should also be completed by the nurse once the patient leaves the health care facility, during which the nurse should determine how the patient is coping and the need for further referrals.

In conclusion, a lot of information was found which can be used to help improve emotional care after miscarriage, but this is a topic which needs to be researched further in regards to nursing care. Few articles were found that focused specifically on interventions that could be used by nurses in their practice, but it was apparent that many people are dissatisfied with the emotional care they receive after miscarriage. Nurses, oftentimes, are the ones who encounter and interact with these patients the most while they are in the hospital and, therefore, have the power to empathize with these families and help them in the healing process to improve their experience. It is important that nurses are educated on this sensitive topic of miscarriage and loss so that they know how to best approach, discuss with, and educate these individuals. Future research projects should use larger sized sample groups and include nursing specific interventions to investigate the issues of miscarriage and anxiety, not only in relation to the mother, but to other involved family members as well.
References

Retrieved from:
http://americanpregnancy.org/pregnancyloss/mcsurvivingemotionally.html

doi:10.1016/j.jpsychores.2007.04.004


*American Psychological Association. Vol. 47, No. 3*


*The Journal of Perinatal & Neonatal Nursing. Vol. 25, No. 1*


controlled clinical trial of couples-focused interventions. *Journal Of Women's Health* (15409996), 18(8), 1245-1257. doi:10.1089/jwh.2008.1202
