Nursing, as a human science and human care, is always threatened and fragile. Because human care and caring requires a personal, social, moral, and spiritual engagement of the nurse and a commitment to oneself and other humans, nursing offers the promise of human preservation in society.

TWENTY married women who experienced miscarriages prior to 16 weeks gestation were the main source of information for this article. Each woman spoke with me on two separate occasions in which permission was obtained to tape-record our conversations. The goal, when qualitatively analyzing the tapes, was to develop categories that succinctly and creatively captured the human experience of miscarriage and the caring needs of women who miscarried.

The author acknowledges the Alpha Kappa Chapter-at-Large of Sigma Theta Tau and Dr. Joseph Butterfield, head of the Denver Children's Hospital Regional Program Planning Committee, for financial support of this research.
This article actually has a dual purpose: (1) to summarize a research study in which I attempted to empirically define and conceptualize caring, and (2) to direct the attention of care providers to some of the common ways in which mothers who miscarried wished to be cared for. The author reviews theoretical perspectives on human loss and caring, briefly explains the Swanson-Kaufman Human Experience of Miscarriage categories, and addresses the caring needs and desires of mothers who miscarried.

HUMAN LOSS

Marris notes that loss events characteristically involve a break from the familiar accompanied by an unexpected, unwelcome venturing into the unknown. He believes that as human beings we have a conservative impulse, "a tendency of adaptive beings to assimilate reality into their existing structures." All have a tendency to find and maintain a structure of meaning in life that makes sense to them. Marris defines this structure of meaning as an "organized structure of understanding and emotional attachments." Unfortunately, when loss or change occurs, humans' conservative impulses are challenged, and they find that what previously had meaning to them may suddenly be rendered useless. As Engel states:

The smooth, more or less automatic, taken-for-granted aspects of living are interrupted. The grieving person suddenly becomes aware of the innumerable ways in which he was dependent, often quite unconsciously, on the lost object [person] as a source of gratification and as an essential influence for his feeling of well-being and effective functioning, his sense of self, so to speak.

Grieving ensues when loss forces people to realize that that which they cling to no longer holds true.

Freud described grieving as a series of attempts on the part of the bereaved to gain proximity to the lost object. Resolution of grieving is said to occur when the energy tied to the lost object is progressively withdrawn or "decathected." Similarly, Lindemann, in a classic study of 101 bereaved individuals, described the following characteristic signs of grief: somatic distress, preoccupation with image of the dead, guilt, hostile reactions, loss of normal behavior patterns, and (less frequently) the appearance of traits of the deceased in the behavior of the bereaved.

The grieving process has been typically described as a series of necessary stages or phases that humans go through in adjusting to loss. Engel describes the following three phases: (1) shock, disbelief, denial; (2) development of awareness (a wide range of emotions is experienced); and (3) restitution (the bereaved learns to deal with the loss and to get on with the business of living). Bowlby, however, cautions that specific types of grieving must be understood in light of the relationship between the individual lost and the person left behind who mourns that loss.

Miscarriage, as a specific form of human loss, had not been systematically studied prior to the research upon which this article is based. The focus of that research study was to describe miscarriage from the mother's perspective. Emphasis was placed on describing not only the impact of a miscarriage on the mother's life, but also
on how she wished to be cared for in her loss. The goal of the analysis was to generate theoretical categories with which to interpret and describe the mother's experience and caring needs. Transcripts of open-ended interviews were analyzed using a constant comparative methodology wherein each informant was compared with herself (within and between interviews) and with every other informant; informants were compared with the emerging categories; categories were compared with categories; and finally all categories were compared with the literature reviewed for the study.

As noted earlier, the categories that evolved were based on the personal witness of 20 women who had spontaneously aborted prior to 16 weeks gestation. While the categories were universal, each woman's actual experience within any given category was unique. As background to help explain the caring categories, which will be elaborated on later, the six Swanson-Kauffman Human Experience of Miscarriage categories will be briefly defined here. They are as follows: (1) Coming to Know (describes the confusing, painful process of balancing mounting evidence of impending loss against hopes for a healthy pregnancy outcome); (2) Losing and Gaining (depicts the multiplicity of perceived losses and gains amongst the informants); (3) Sharing the Loss (summarizes the amount of recognition and support the women received throughout their loss); (4) Going Public (describes the process of letting others know about the loss and the price paid at miscarriage for having [or not having] gone public with the pregnancy); (5) Getting Through It (compares the grieving patterns of the women); (6) Trying

---

The move toward specialized medicine and rapid technological advances have led to a tremendous depersonalization of health care.

Again (discusses the decisions made related to plans for future pregnancies and identifies the related, ongoing fears of future loss).

HUMAN CARING

Caring has been recognized by a number of nursing leaders as a topic of scholarly and practical importance. As Leininger has often said, "Care is the essence and the central, unifying, and dominant domain to characterize nursing." Likewise, Carper notes that given our space-age technology, the need for caring in nursing today is paramount. The move toward specialized medicine and rapid technological advances have led to a tremendous depersonalization of health care. So often nurses and doctors are seduced by the lure of machines, medicines, and procedures. Without caring, the person gets lost in the middle. The person gets reduced to the limited status of patient: one who is viewed as needing a prescribed amount of physical curing interventions.

Watson recognizes that caring is an intentional process that can only be practiced interpersonally. Caring is perceived by the recipient of nursing care when respect for the client's personal worth is demonstrated. Watson states, "Caring calls for a philosophy of moral commitment toward protecting human dignity and preserving human dignity." Likewise, Gaut
relates caring to a family of meanings that include individual attention to and concern for; individual responsibility for or providing for at some level; and individual regard, fondness, or attachment.  

Central to Gaut's and Watson's perception of caring is the recognition of the personal dignity and worth of the person, be the person nurse or nursing care recipient. This theoretical stance on nursing tends to be inherently pleasing to those nurses who value the nurturing aspects of their chosen profession. Caring as a central unifying focus for the profession also serves to set the domain of nursing in a complementary role to the domain of medicine. Caring for humans who are responding to problems of health and illness fulfills a very necessary need for humanity. As a rule, the medical profession responds to the need for disease diagnosis and treatment. It is the role of the profession of nursing to respond to individuals whose very dignity is challenged by their anticipated or actual health deviation. Indeed, Watson values caring as the key to survival of not only the nursing profession but also of the dignity of humankind.

The words care and caring have been used profusely in the nursing as well as common use vernacular; for example, patient care, nursing care plan, caring needs, "I care for you," "Who cares?" This multimeaning use of the word caring presents an indexical dilemma and scholarly challenge for a profession that chooses to use the word as its "essence" and "central, unifying, and dominant domain.  

If caring is to be the driving force behind the survival of the profession, it behooves nurse researchers to study what constitutes the acts or act meanings that may be labeled caring. Furthermore, many questions remain unanswered, such as: What constitutes caring versus noncaring? Who labels an act as caring? Are acts called caring based on intention, perception, or both? Is caring a meaning or an action? Are caring needs universal, disease-specific, person-specific, culture-specific? These are among the questions that motivated my quest to understand the caring needs of women who miscarried.

CARING IN THE INSTANCE OF MISCARTRAGE  

One of the earliest discoveries I made in analyzing the caring needs of women who miscarried was that when looking for acts of caring I discovered a whole "grocery list" of actions: hanging my I.V. [intravenous] bag, hugging me, talking to me, listening, etc. If, however, I examined the transcript data for meanings conveyed by actions, the essence of caring became more evident. Consequently, the research question was clarified: What constitutes caring in the instance of miscarriage? This research question sought to define how professionals and nonprofessionals conveyed caring to women who miscarried. The informants taught me that caring for the woman who experiences miscarriage is conveyed by the following caring categories: knowing, being with, doing for, enabling, and maintaining belief. Knowing, the first caring category, identifies the woman's desire to be understood for the personal meaning of the loss in her life. Each informant wanted to be cared for as a person who was experiencing a loss that had a unique meaning in the context of her own life. Care that was based on knowing came across as personalized, comforting, supportive, and healing. Care
imparted by nonknowing individuals came across as mechanical, routine, impersonal, and often cruel.

Knowing the meaning of loss in each woman’s life involved a desire to understand on the care provider’s part. Knowing is an intentional act and had to come from providers who were willing to see miscarriage through the woman’s eyes and not in terms of the provider’s preconceived ideas about miscarriage. In essence, for professional health care providers it involved a willingness to see the woman as more than just a known diagnostic group category: that is, a threatened or spontaneous abortion. For friends and family, knowing involved a concerted attempt to understand miscarriage as something more than just “nature’s way of cleaning up a mistake.”

One of the study’s informants, Mary, talked about her personal friends and associates who conveyed a desire to not have to know what Mary’s loss meant to her. She described how they protected their own feelings and avoided the topic of her loss:

People that I thought could be supportive, um, people that you think when they found out what had happened would say, you know, “Gee, I’m really sorry about what happened. you know if you need somebody to talk to let me know,” didn’t say anything. . . . I thought, “Gee, I’m really feeling in the pits and why haven’t you bothered to call.” . . . I know everybody is different. But you know, I guess that when somebody has a loss of life, whether it’s a life that they had not seen or bathed or fed or whatever . . . it’s a loss. Whether you don’t know the right thing to say, saying I don’t know what to say is better than saying nothing.

Lisa experienced two miscarriages in less than one year. She described how her obstetrician conveyed caring through knowing the meaning the miscarriages held for her:

He just wanted to talk with me about what had happened, and, I think more to be supportive than anything. To say that he was really upset that it happened again. That he was concerned. That he suggested having chromosome tests done. He said frequently they don’t like to do this until you’ve had three miscarriages, but he said, “You know, I feel like it would be something that would be important for you to go in and have done.”

He’s just so human and down to earth. He doesn’t have this doctor facade. That makes it easier to talk with him and work with him. And it really just makes me feel good that he’s interested.

The next caring category, being with, goes beyond knowing to actually feeling with the woman who miscarried. Being with entails feeling with—not as deeply as she, but with the woman. Knowing and being with are obviously very closely related. In fact, it seems hard to imagine that one could truly know another’s loss without taking some of the pain of that loss onto oneself.

Knowing and being with can be practiced only by a caregiver who is willing to existentially live another human being’s experience. Watson emphasizes that true caring cannot be practiced between two individuals who insist on sticking to their “roles” (i.e., nurse and patient). Rather, caring, she states, must take the form of two persons striving to interrelate:

Human care can be effectively demonstrated and practiced only interpersonally. The intersubjective human process keeps alive a common sense of humanity; it teaches us how to be human by identifying ourselves with others.
whereby the humanity of one is reflected in the humanity of the other.\textsuperscript{13}

For health care professionals this means dropping the professional facade and willingly entering into an emotion-laden, person-to-person relationship. For friends and family it means recognizing and sharing the loss that accompanies miscarriage. Sandra described how she was comforted by her husband’s willingness to be with her in her loss:

His comments really helped. I mean, when he’d tell me that it was just a lot better, that maybe there was something wrong with the baby. And if I was having a hard time, then he’d just—he was really with me through all of this. “Cause you know a lot of husbands could have just said, “Well, I’m getting sick of this.” Because for a long time I did cry…. he’d just— he was really with me through all of this. “Cause you know a lot of husbands could have just said, “Well, I’m getting sick of this.” Because for a long time I did cry…. he’d just— he was really with me through all of this. “Cause you know a lot of husbands could have just said, “Well, I’m getting sick of this.”

An expectation in this category was that care would be delivered in an expert, expedient, and thorough manner. Essentially, the woman wanted the job done as well as she would do it if she had the capacity to do it herself. These expectations extended to the obstetrician who performed the D&C, the nurse who monitored fluid levels, the husband who made the phone calls to let others know of the miscarriage, and the neighbors who offered to babysit.

Sue explained how much she appreciated what her husband did for her:

I felt numb I guess. I wanted him to let my parents know. There were some phone calls… And I asked Chuck in the days to come, also that weekend, to make as many phone calls as he could. That I didn’t want to have to tell people. I felt that I could deal better with people already knowing.

Tanya’s husband’s caring in the form of doing for was quite tender:

I came home and I was just so floopy, you know. And I went upstairs and went to sleep.
And Tim went to the store and got me some sanitary napkins, which I hadn't used in years [laughing]... and he came home with every style that there is out there, it was like every kind in the world. I still have some! All these magazines, flowers... all this stuff. And I was so thirsty. Seven-Up, I came home and ate a box of crackers. I was so hungry. And I went to bed. And he was just real sweet... fixed me poached eggs, brought them upstairs. We didn't even really talk about it. We were both thankful I was okay. He said all I care about is you're all right.

In terms of professional care providers, doing for was conveyed to Michelle when the hospital staff allowed her to "get through the system rapidly." The feeling that rules were being "bent" especially for the informant made her feel extra cared for:

And my husband said "I don't like having to sit around and wait." I said, "Well, the doctor is supposed to be here." So we went looking for him and found him sitting over in the emergency station. And he pushed me through. And the girl said that I made record time getting this stuff done. My doctor said, "Hey, sometimes the patient has to come before the bookwork."

Sandy, like many of the other informants, pointed out how comforting it was to feel that the nurses were anticipating her needs and checking up on her to be sure nothing went wrong:

Well, they seemed to take real good care of me. When you're laying... they didn't leave me laying there. They were always asking, "Well, do you want to sit up?" And they were real attentive. And they'd put those blue pads under me and they fill up with blood and clots. They changed them often, checked my I.V. thing all the time too... I mean lots of times in the past I had nurses that I could, just... I'd rather not have a nurse. But these nurses were right there.

The fourth category, enabling, is caring that facilitates the woman's capacity to grieve and get through her loss. Enabling takes a variety of forms depending on the woman's perception of her loss, her usual coping style, and her specific preferred coping style at the time of her miscarriage. Care providers who are able to successfully enable grieving base their care on a thorough assessment of the meaning of the miscarriage to each woman, and they usually demonstrate a strong background of both knowing and being with.

When asked how physicians and nurses should convey caring to women who miscarry, informants overwhelmingly responded that health care providers should give information to the women. Information was said to be comforting in that it cold women that it was okay to feel badly after a miscarriage; it validated their right to grieve. One informant described how being told what to expect could enable grieving:

If they have information on things that most women go through, similar like to if they tell you that you might go through postpartum depression after a child, that you know, women should look for, that you might feel the same type of symptoms like after you have a baby. That you might be depressed or you might be confused or just that type of thing. If someone could tell you that it's all right, that this is going to happen, or that it might happen—or that it might not. I think that would help more women to realize that.

Another informant added how important it is to include husbands when care is
The final caring category, maintaining belief, focuses on the woman's need to have others believe in her capacity to get through the loss and to ultimately give birth. The mothers needed others to not lose sight of them as fully functional, capable women—even if the informant had a hard time seeing herself that way. As one informant stated, "Even if I couldn't see the light at the end of the tunnel, I didn't want my husband to lose sight of it for me. I wanted him to know that it was still me beneath all this sorrow."

With respect to future pregnancies, this caring category took two forms. If the woman made a permanent decision to cease attempts at childbearing, she needed others to maintain belief in her capacity to make a decision for tubal ligation. If the woman desired to try for another pregnancy, she needed others to not lose sight of her as a childbearing woman. When I asked one informant what would be a comforting thing a physician or nurse could say to a woman who miscarried, she replied:

"Try again. It's not like you can't have a child. I think—if they said "it's o.k., you'll be o.k. You can always have children"—um, that's in case they could, you understand? I think that would really kind of comfort you. The knowing that o.k., although this happened, then six months from now, or a year from now, I can try again to have a baby. Do you know what I'm saying? That has always made me feel a little better.

The risk exists that the maintaining belief category might generate some confusion. So many informants spoke about people who rudely cut them off with the comment "Oh, you can always try again." This comment left the woman feeling like..."
the speaker had no idea of her pain and no desire to be associated with any of her loss. Yet, the same informants stated how essential it was that others (especially husbands, doctors, and nurses) tell the woman that she will be able to have a child. The confusion generated by this category is easily diminished when it is understood that if the care provider speaks from a basis of knowing and being with, then the words "you can try again" are interpreted as an act of belief maintenance and not as a means to dismiss the importance of the mother's loss. Karen thus describes a physician who conveyed caring in the sense of knowing, being with, and maintaining belief:

He came in and talked to me after my D&C, and he was real understanding. He says, "I'm really sorry to hear about this. Can you give me some more details on it?" And he was real, like, had his voice lowered, and you could tell that he just felt something about it. I really like that... He's excellent. And really strong about having my husband come in whenever he could.... The doctor just put his hand on my leg and he was telling me how sorry he was that this happened, and that he knew that I would—that as far as he knew, I wasn't going to have any more problems having kids and he was just real sorry it all happened, and he just patted my leg. I felt he really cared when he came in and did that.

Some of the informants were already pregnant by the time of the second interview, and they drew attention to the fact that the need for others to maintain belief in their childbearing capacity did not cease with the new conception. In fact, having had a previous loss made the newly pregnant woman all the more vulnerable to the ongoing fears of additional loss. Caring for the informants who were pregnant or trying to become pregnant again involved a considerable amount of support, attention to their ongoing fears, and reassurance regarding their capacity to bear healthy children.

The article has focused on the conceptualization of caring in the instance of miscarriage. Support for this focus was empirically derived from a qualitative study of 20 women who miscarried and has been theoretically derived from a limited review of the loss and caring literature. Providers who care for women who have miscarried are advised to draw upon the knowledge provided here as well as other available clinical data for diagnosing specific client needs. The categories are offered as insights, not formulas. They are descriptions and interpretations—not prescriptions—and should be used accordingly.

REFERENCES

7. Ibid., 4.
14. Ibid.