THE SILENT SYMPATHY: A STUDY OF ATTITUDES TOWARD SPONTANEOUS ABORTION

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ABSTRACT

A study of 560 health professionals and students indicated widespread sympathy for miscarriage patients: 83 per cent of respondents rated the emotional support needs of miscarriage patients above the average rating they provided for seventeen other medical conditions. Interestingly, those involved in the delivery of health care were less likely than those not involved to rate emotional support needs of miscarriage patients higher than average. The need to provide strong emotional support systems for these women and training for health care professionals is stressed.

INTRODUCTION

Until not too long ago, certain women's diseases or conditions were not discussed much in public. But in recent years we have heard more about mastectomy, cesarean birth, infertility, abortion and their psychological effects. Of particular concern to this article are the difficulties professionals have discussing these conditions with the patients. For example, *Reach to Recovery*, Lasser, taught us about the intense grief and loss of mastectomy patients [1]; Linda Brid Francke's *The Ambivalence of Abortion* showed us that women who choose to abort often go through severe psychological trauma [2]; and the publicity

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surrounding test-tube "Baby Louise" gave us an indication of the suffering faced by barren couples.

But one area that is now being liberated, as it were, is spontaneous abortion, or miscarriage. Spontaneous abortion is defined by WHO as the expulsion of a fetus before the twenty-eighth week of pregnancy (WHO Report, 1970). Although there exists some dispute about the difference, if any, between the terms; miscarriage becomes a "natural" synonym to describe all spontaneous abortions (as compared to induced abortions), whether occurring relatively early or late in the pregnancy.

According to WHO, over one-fifth of all pregnancies end in miscarriage [3]. This likely would be a startling figure to the public because we do not discuss this subject. Furthermore, women who have aborted spontaneously do not seem to be encouraged to share their feelings of grief and loss [4]. The miscarriage patient generally receives little support or consolation from family, friends or from doctors, nurses, etc. in the hospital. But to these women the loss is all too painful, without the traditional support given in a "real" death – where a funeral serves the purpose of giving a sense of finality to the situation, as well as a formal chance for others to console the loved ones and to grieve with them.

This article will explore attitudes toward miscarriage – of both health care personnel and non-health care persons – regarding immediate medical care needs of patients, as well as emotional support required following the spontaneous abortion.

EARLIER RESEARCH

Most of the work done to date on spontaneous abortion has been on its physiological etiology and prevention.

Javert's classic research was mainly concerned with clinical aspects, i.e., blighted ova, incompetent cervix, etc. [5]. But he did include a section on psycholomatology, where he listed such causes for miscarriage as: conflicts in the marriage, negative attitude of the husband, domineering in-laws and fear of pregnancy. Taussig looked at clinical obstetrics to explain the problem [6]. Kavousi investigated the effect of industrialization on spontaneous abortion rates. Kline, *et al*, correlated smoking with higher abortion risk [7]. Pettersson examined biological and social correlates [8], while James found predictors for spontaneous abortion in birth order [9].

The little work that has been done in the psychological factors of spontaneous abortion tends to look at *causes* rather than *effects* of, e.g., Javert's above-mentioned research [5]. And much of this analyzes the habitual aborter (three or more spontaneous abortions), such as Hertz's study of habitual aborters, who were found to have overly-dependent personalities, develop excess aggressiveness, and have a tendency for exaggerated self-control [10]. Likewise Michel-Wolfromm showed a correlation between spontaneous abortion and neurosis, unstable marriages and conflicting attitudes toward motherhood [11]; while

Kline found the common characteristic of infantile attachment to the husband and hostility toward the mother [12]. Negative mental health was also shown to be a factor by Mann [13] and Malmquist, *et al* [14]. Perhaps one of the most interesting studies was done by Kaij, *et al*, who found an association between spontaneous abortion and girlhood bereavement caused by absence (usually death) of the father [15].

Few studies or articles have focused on the psychological *effects* of spontaneous abortion, i.e., the grief and loss experienced by the parents. Thullen's account of the bereavement of stillbirth parents (with a short description of spontaneous aborters) is a classic [16]. He compares the different grief patterns of mother and father and concludes that one year is the minimum time for sufficient grief. Other works on pregnancy give brief descriptions of expected grief and loss after miscarriage [17].

RATIONALE

Since little research has focused on the psychological effects of spontaneous abortion, there is a need for such work– to analyze parents' grief as well as the support systems in the community which would help resolve their grief and loss. Numerous informal interviews with spontaneous aborters substantiated this need for support [4, 18]. One woman felt "sad, alone and as if no one else had lost or wanted a baby like (she) did." Another one said, "if only my friends would simply say 'I'm sorry,' but no one seems to care," In a study of the emotional effects of miscarriage on thirty-five women [4], women felt that the loss of the fetus was a death and needed solace. Like the women in Franck's analysis of the psychological effects of induced abortion, they too felt unexpected grief and loss [2]. And they longed to be able to talk with someone about it. Yet, little support and comfort was provided.

Based on this information, a study was designed to measure attitudes in the population toward miscarriage. Was the reason people did not offer sympathy because they saw no need for emotional support? Or, as hypothesized, was it because they were just uncertain how to act and what to say? After all, to many of them, the fetus had not yet become an entity or a person, as it may have to many of the mothers.

This study investigates attitudes, in select populations, toward spontaneous abortion, i.e., what are the perceived medical care and emotional support needs, relative to other physical conditions.

METHODOLOGY

Information for this exploratory study on attitudes toward spontaneous abortion was gathered in a questionnaire distributed to several classes of graduate nursing students, faculty in nursing and a group of graduate and undergraduate students from a variety of majors at a large, southwestern U.S. university. In

addition, questionnaires were distributed in several departments in two hospitals. Because the students filled out questionnaires in classrooms, their response rate was nearly 100 per cent. The response rate of the nursing faculty and the hospital employees was about 60 per cent. Table 1 contains a breakdown of the affiliation of the 560 respondents. The major disadvantage of the nonprobability sampling framework (i.e., subjects were not randomly chosen) and the 60 per cent staff response rate is that one has to be cautious about generalizing results to a larger public and that statistical tests for significance of differences among groups are not easily applied. Nevertheless, such study is appropriate for obtaining valuable insights into an important area in maternal and child health care which has received little attention.

Respondents were asked to rate on a scale of zero to 100 how much professional medical care each of eighteen different physical conditions needs. The medical conditions included on the list were chosen on the basis of the criterion of general familiarity to non-medical persons (adapted from the most common discharge diagnoses in U.S. hospitals). (See Appendix A for a list of conditions included.) Respondents also were asked to rate the same medical problems in terms of emotional support needs. (They were asked to evaluate emotional support needs assuming the medical care needs were met.) The actual rating given by a respondent to miscarriage was standardized relative to the mean and standard deviation of each respondent's answers for the list of eighteen conditions to control for individual variations in the use of the scale.[1]

Table 1. Occupational Affiliation of Respondents

Occupation	*N*
Health Care	
Nursing faculty members	21
Nursing graduate students	39
Hospital nurses	21
Other hospital workers	65
Graduate and Undergraduate Students	
Business	218
Liberal Arts	88
Other	108
TOTAL	560

[1] The formula used to standardize the miscarriage rating was $(X_1 - X/SD)$, where X_1 is the rating given to miscarriage, X is the mean rating of each respondent for the eighteen conditions and SD is the standard deviation measure of dispersion around that mean.

FINDINGS

The results indicate widespread sympathy for miscarriage patients. Eighty-three per cent of the respondents rated the emotional support needs of miscarriage patients above the average value they gave to the medical conditions included on the questionnaire. Only 37 per cent rated the medical care needs as above average.

A striking differential emerges when respondents were classified according to whether they are in a health care profession or not (see Table 2). Those directly involved with the delivery of health care (including nursing faculty and nursing students) were much less likely to rate the emotional support needs of miscarriage patients as high as those not involved with the delivery of health care. Ninety per cent of the students compared to only 66 per cent of those in health care rated the emotional support needs of miscarriage patients above average. The students also were somewhat more likely than health care personnel to rate the medical care needs of miscarriage patients higher than average, 40 versus 30 per cent. Additional analysis subdivided health care personnel into nurses, who were generally assumed to have more direct contact with patients, and others in health care professions. No differences were found in either the emotional support rating or the medical care rating given to miscarriage. Similarly no differences of any size emerged when the student respondents were subdivided into major fields.

The overall pattern of response was unambiguous. Those not in a health care profession in our study perceive the need for a great deal of emotional support for miscarriage patients while those who are most likely to be involved with miscarriage patients are less likely to feel a need to give it. Given the size of this attitudinal differential, subsequent differentials control for occupational affiliation.

The other demographic and social characteristics that were examined for possible attitudinal differences included: sex, age, race, religion, past experience with pregnancy of self or spouse, and number of children. We had planned to look at the impact of experience with miscarriage but there were only seven respondents who reported that either they or their spouse had a miscarriage. No differences in attitude about the medical care or emotional support needs of miscarriage patients were found for number of children. However, some differences in attitudes did appear depending on respondent's sex, age, and pregnancy experience.

Males were somewhat more likely to rate the medical care needs of a miscarriage patient higher than females (see Table 3). In fact, the proportion of males rating the medical care needs of a miscarriage patient higher than average was virtually identical for those in a health care profession and those not. However, females in a health care profession were less likely to rate the medical care needs of a miscarriage patient above average than were other females in our

Table 2. Standardized Ratings for Emotional Support and Medical Care Needs of Miscarriage Patients by Occupational Affiliation

Occupational Affiliation	*N*	*Emotional Support Needs*		*Medical Care Needs*	
		Per Cent with Average or Below Average Rating	*Per Cent with Above Average Rating*	*Per Cent with Average or Below Average Rating*	*Per Cent with Above Average Rating*
Health Care	146	34.5	65.5	69.9	30.1
Non-Nursing Students	401	10.5	89.5	60.1	39.9
TOTAL	547[a]	16.9	83.1	62.7	37.3

[a] Respondents who did not give information on the above categories are not included.

Table 3. Standardized Ratings for Emotional Support and Medical Care Needs of Miscarriage Patients by Occupational Affiliation and Sex

Occupational Affiliation	*N*	*Emotional Support Needs*		*Medical Care Needs*	
		Per Cent with Average or Below Average Rating	*Per Cent with Above Average Rating*	*Per Cent with Average or Below Average Rating*	*Per Cent with Above Average Rating*
Health Care					
Male	28	25.0	75.0	57.1	42.9
Female	118	36.7	63.3	72.9	27.1
Other					
Male	234	11.3	88.7	56.4	43.6
Female	162	9.3	90.7	65.4	34.6

study. These data suggest that the sex differential in assessing the medical care needs of miscarriage patients over-rides the previously mentioned occupational differential.

A different pattern emerges for emotional support needs. The occupational differential appears to be stronger than a sex differential in assessing the emotional support needs of miscarriage patients. There was no sex differential on the emotional support ratings among those not in a health profession although a sex differential among those in the health professions can be seen in Table 3. Males in a health profession were more likely to give miscarriage a higher emotional support rating than female health care workers, but were less likely than males not in a health care profession.

As seen in Table 4, there was no consistent pattern by age on assessment of medical care needs of miscarriage patients. Neither was there a consistent pattern by age for emotional support needs among health care workers. The age pattern of response on emotional support needs among those not in a health care profession also fluctuated but there was a tendency for younger respondents, those under twenty-five (especially those not in health care), to rate more frequently the emotional support needs as above average. Perhaps they have had a more open socialization than the older subjects regarding male/female issues and are more sensitive to women's needs.

Finally, past experience with pregnancy among women or among the male respondents' wives appears to diminish the tendency to rate both the medical care and emotional care needs above average (see Table 5). The effect can be seen both among health care workers and others, although the former consistently rate both needs lower than the latter. Only seven of the 158 respondents who reported past experience with pregnancy also experienced a miscarriage. Possibly a successful pregnancy reduces the perception of the medical care needs of problem pregnancies and decreases sensitivity to the psychological impact such an experience may involve.

DISCUSSION

Attitudes toward miscarriage were analyzed with a focus on perceived medical care and emotional support needs. The results indicated that although medical care needs generally were not believed to be higher than average there was much recognition of the psychological impact of a miscarriage. However, a substantial difference in attitude was found between those directly involved with the delivery of health care and the rest of the sample. The former consistently rated both the medical care and emotional support needs of miscarriage patients lower relative to other common medical problems. This finding suggests that in the process of being socialized into health care professions, workers are perhaps made less sensitive to the needs of such patients.

Several explanations for this desensitization seem plausible. First, most miscarriage patients do subsequently bear healthy babies if they have not

Table 4. Standardized Ratings for Emotional Support and Medical Care Needs of Miscarriage Patients by Occupational Affiliation and Age

Occupational Affiliation and Age	*N*	*Emotional Support Needs*		*Medical Care Needs*	
		Per Cent with Average or Below Average Rating	*Per Cent with Above Average Rating*	*Per Cent with Average or Below Average Rating*	*Per Cent with Above Average Rating*
Health Care					
20 – 24	7	37.5	62.5	85.7	14.3
25 – 29	39	28.2	71.8	69.2	30.8
30 – 34	25	40.0	60.0	72.0	28.0
35 – 39	22	26.1	73.9	68.2	31.8
40 +	51	42.0	58.0	68.6	31.4
Other					
18 – 19	37	2.6	97.4	54.1	45.9
20 – 24	240	7.0	93.9	56.7	43.3
25 – 29	62	19.4	80.6	71.0	29.0
30 – 34	26	14.8	85.2	57.7	42.3
35 – 39	17	35.3	64.7	70.6	29.4
40 +	10	20.0	80.0	70.0	30.0

Table 5. Standardized Ratings for Emotional Support and Medical Care Needs of Miscarriage Patients by Occupational Affiliation and Pregnancy Experience

Occupational Affiliation	*N*	*Emotional Support Needs*		*Medical Care Needs*	
		Per Cent with Average or Below Average Rating	*Per Cent with Above Average Rating*	*Per Cent with Average or Below Average Rating*	*Per Cent with Above Average Rating*
Health Care					
Pregnancy of Self or Spouse	88	40.4	59.6	72.7	27.3
None	58	25.4	74.6	65.5	34.5
Other					
Pregnancy of Self or Spouse	70	17.4	82.6	65.7	34.3
None	326	9.0	91.0	58.9	41.1

previously done so, a fact perhaps better realized by health care workers than others. As a result health care workers may view the psychological trauma caused by a miscarriage as a short term problem that will be solved by another pregnancy. Such a complete restitution of previous physical condition is not possible for mastectomy patients, burn victims, amputees or even those who develop ulcers, diabetes or cardiovascular problems. Miscarriage patients commonly are told stories of similar experiences that eventually had a happy ending, the birth of a healthy baby. The moral of these stories is always the same – "keep trying." These stories do not directly address the feelings of inadequacy, guilt and grief a patient may be experiencing.

A second possible explanation for the lessened sensitivity may be that there is little the health care profession can do to prevent miscarriages. Miscarriages are generally the result of genetic or developmental problems for which no medical intervention can rarely compensate. There is no glamorous, sophisticated technology to apply. The role of the health care workers involved tends to be one of monitoring the condition and sometimes hastening the inevitable to reduce the physical strain on the patient.

Finally, the desensitization of health care workers can be related to their general feelings of discomfort with death and dying. Kubler-Ross [19–21] and Thullen [16] maintain that it is the physician and nurse who are the main obstacles in handling of death.

SUGGESTIONS

Because of the apparent need for miscarriage patients to express their grief, to feel emotional and psychological support from those around them, and because this type of sympathy is often "silent," we feel some type of open support system for these women is demanded. One method would be to develop "support groups" for miscarriage patients to discuss their feelings, so that they may be with other women (and possibly husbands) who have been through the same experience and understand the emotional needs to grieve. Others have shown the need to grieve, to do "grief work," which is the psyche's way of coping with the loss, the change. Thullen has organized support groups for stillbirth parents [22]. Groups for cesarean patients are functioning throughout the country.

Another tactic would be to include sensitization toward these issues in continuing education programs for doctors, nurses, and other health care workers. Perhaps this would counteract the apparent desensitization we found in our study. Because the nurse, doctor, and aide are often among the first people to interact with the women after the miscarriage, it is vital for them to understand the psychological dynamics of her experience and help her to cope with the situation.

Finally, we would like to see more publicity on miscarriage, in order to raise the consciousness of society on this issue. Only recently has anything been

written about miscarriage in women's magazines. Even a few more articles in popular publications would go a long way toward turning the "silent sympathy" to "spoken sympathy." As one woman put it, "If only my mother would understand how I feel. Maybe she does, but all she says to me is, 'You'll get over it.' How much it would mean to me if only she would say, 'I know how you feel,' and listen to me. But she doesn't."

APPENDIX A

Medical conditions included in the questionnaire of attitudes toward medical care and emotional support needs:

Broken Leg	Venereal Disease
Breast Cancer	Appendicitis
Heart Attack	Broken Back
Asthma Attack	Skin Cancer
Pregnancy	Epilepsy
Ulcer	Severed Limb
Miscarriage	Knife Wound
Hernia	High Blood Pressure
Burn Victim	Diabetes

REFERENCES

1. T. Lasser, *Reach to Recovery,* American Cancer Society, undated.
2. L. B. Francke, *The Ambivalence of Abortion,* Random House, New York, 1978.
3. *Spontaneous and Induced Abortion,* Techment Report No. 461, World Health Organization, Geneva, 1970.
4. D. M. Hai and M. S. Tong, The Grief of Miscarriage, *Crisis in the Public Sector,* APHA, Washington, D.C., p. 255, 1981.
5. C. T. Javert, *Spontaneous and Habitual Abortion,* McGraw-Hill, New York, 1957.
6. F. Taussig, *Abortion: Spontaneous and Induced,* Mosby, St. Louis, 1936.
7. J. Kline, U. A. Stein, M. Susser, and D. Warburton, Smoking: A Risk Factor for Spontaneous Abortion, *New England Journal of Medicine, 297:*15, pp. 793-797, October 13, 1977.
8. F. Pettersson, *Epidemiology of Early Pregnancy Wastage,* Upsala University, 1968.
9. W. H. James, Spontaneous Abortion and Birth Order, *Journal of Biosocial Science, 6,* pp. 23-41, 1974.
10. D. G. Hertz, Rejection of Motherhood: A Psychosomatic Appraisal of Habitual Abortion, *Psychosomatics, 14:*4, pp. 241-244, July 1973.
11. H. Michel-Wolfrom, The Psychological Factor in Spontaneous Abortion, *Journal of Psychosomatic Research, 12,* pp. 67-71, 1968.

12. C. L. Kline, Emotional Illness Associated with Childbirth, *American Journal of Obstetrics and Gynecology, 69*, p. 748, 1955.
13. E. C. Mann, Spontaneous Abortions and Miscarriage, *Modern Perspectives in Psychological Obstetrics*, J. G. Howeles (ed.), Brunner/Mazel, New York, 1972.
14. A. Malmquist, L. Kaiji, and A. Nilsson, Psychiatric Aspects of Spontaneous Abortion–I. A Matched Control Study of Women with Living Children, *Journal of Psychosomatic Research, 13*, pp. 45-51, 1969.
15. L. Kaiji, A. Malmquist, and A. Nilsson, Psychiatric Aspects of Spontaneous Abortion – II. The Importance of Bereavement, Attachment and Neurosis in Early Life, *Journal of Psychosomatic Research, 13*, pp. 53-59, 1969.
16. J. D. Thullen, When You Can't Cure, Care, *Perinatology*, pp. 31-46, November/December 1977.
17. A. Coleman and L. Coleman, *Pregnancy: The Psychological Experience*, Bantam, Des Plaines, Illinois, 1977.
18. D. M. Hai, The Grief of Miscarriage, unpublished manuscript.
19. E. Kubler-Ross, *Death: The Final Stages of Growth*, MacMillan, New York, 1975.
20. _____, *On Death and Dying*, MacMillan, New York, 1969.
21. _____, *Questions and Answers on Death and Dying*, MacMillan, New York, 1974.
22. J. D. Thullen, personal communication, 1979.

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