

PREGNANCY CONCERNS AND THE FEAR OF MISCARRIAGE: A MISCARRIAGE-SPECIFIC IMPLICATION OR A SOCIAL FEAR OF FAILING IN TERMS OF WOMANHOOD?

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Abstract: Little is understood regarding the sources of women's concerns particularly during a pregnancy subsequent to a miscarriage. The aim of this paper is to elucidate the experience, concerns and meanings that expectant mothers ascribe to an ongoing pregnancy. Semistructured interviews were carried out with 17 British expectant mothers with various past reproductive histories, including that of miscarriage. The resultant verbatim transcripts were analysed using Interpretative Phenomenological Analysis (IPA). Two themes emerged. The first, named "uncertainty of pregnancy", highlights the apprehensions and worries experienced by women regarding their pregnancy's course and their attempts to remain in control of such uncertainties. The second, named "the dual nature of pregnancy" portrays the meanings that women attached to their ongoing pregnancy: this represented a means of establishing their feminine identity and of experiencing an ultimate goal in life, that is, motherhood. IPA revealed that concerns and fears during pregnancy revolve around the fear of miscarrying. This fear and resultant concerns was experienced irrespective of a prior adverse reproductive history, but was more salient amongst women who had previously miscarried or had experienced difficulties with conceiving. It is proposed here that potential sources of pregnancy concerns for expectant mothers, and particularly for those with adverse reproductive histories, stem from fear of miscarriage, which, like infertility, may pose a serious threat to a woman's feelings of femininity and cause considerable frustration.

Key words: Fear of miscarriage, Femininity, Pregnancy concerns.

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INTRODUCTION

Social and medical constructs of controllability of human procreation and pregnancy outcomes (Layne, 1997; Reinharz, 1988), as well as idealised models of motherhood (Lewis & Nicolson, 1998), tend to overemphasise positive images of pregnancy and to ignore the reality of miscarriage among the possible pregnancy outcomes. Yet, miscarriage, which is the spontaneous loss of a pregnancy prior to the 24th week of gestation (Johnson & Puddifoot, 1996), is diagnosed when there has been an expulsion of the foetus from the uterus or the foetus has died in the womb (Chamberlain, 1992). It is a regular gynaecological event which occurs at a rate of between 12% (Everett, 1997) to 22% (Smith, 1988) of all recognised pregnancies and most frequently within the first trimester of gestation (Smith, 1988).

During the last decade there has been a plethora of studies on the emotional impact of miscarriage. These suggest a complex picture of maternal grief confounded by pronounced feelings of guilt and self-blame (Abboud & Liamputtong, 2003; Nikcevic, Kuczmierczyke, & Nicolaides, 1998), combined with elevated rates of depressive symptomatology in the early months following loss (Neugebauer, 2003; Prettyman, Cordle, & Cook, 1993).

Finding that women grieve following the loss of an entity which has never been seen to exist is not inexplicable. Research suggests that, even though a foetus may not qualify as a person, it is often attributed personhood and is invested in emotionally by parents (Hutti, 1992). Children have been found to represent and ensure continuity of their parents' image and identity across time (Woollett, 1994; Worth, 1997). Thus, the loss of a child not yet born may also be interpreted as a loss of part of oneself and invalidate fundamental beliefs about predictability and controllability of life events (Malacrida, 1997). Similarly, since childbearing in contemporary Western societies has been equated with achievement of adult status and with feminine identity (Woollett, 1994), miscarriage may also put in doubt a woman's sense of self-worth (Gittins, 1993) and lead to grief due to loss of a highly emotionally invested child, adult role or even status.

Since the pivotal work of Peppers and Knapp (1980), which indicated that miscarriage produced maternal grief similar to other types of perinatal loss, researchers have, by and large, focused on identifying factors that increase psychological vulnerability in its aftermath. However, attempts that have been made to predict intensity of psychological symptomatology in terms of demographic and reproductive variables, such as gestation age

at the time of loss, have yielded contradictory results (Goldbach, Dunn, Toedter, & Lasker, 1991; Neugebauer et al., 1992; Prettyman et al., 1993). This may be because such approaches disregard contextual factors that may shape women's reactions to the event. For example, the grief responses post-miscarriage may be largely affected by the significance attached to the individual experience of miscarriage and the meaning the specific pregnancy had for a woman (Swanson-Kauffman, 1986; Tsartsara, 2005).

Moreover, literature suggests that grief may be just one aspect of miscarriage's implications. The possibility that miscarriage also increases the risk of anxiety disorders in its aftermath was not acknowledged until very recently (Cordle & Prettyman, 1994; Thapar & Thapar, 1992). In the early months following a miscarriage, women are found to report significantly increased levels of anxiety symptomatology when compared to various control groups of women, such as pregnant women (Geller, Kerns, & Klier, 2004; Thapar & Thapar, 1992) or community controls (Geller et al., 2004; Lee, Slade, & Lygo, 1996). Rates of clinically significant anxiety for women who have experienced a miscarriage may range from approximately 19% (Walker & Davidson, 2001) to 40% (Lee et al., 1996; Prettyman et al., 1993) immediately post-loss. Similarly, there is an indication that clinically significant anxiety may persist up to two years post-loss for a significant proportion (up to 26%) of women who have experienced an early miscarriage (Cordle & Prettyman, 1994).

Notwithstanding, the issue of increased anxiety in the aftermath of miscarriage, research is still in its infancy in attempting to understand the sources of it and, most importantly, its meaning to women. Yet, based on reports of women immediately post-miscarriage that their fears and concerns revolve around the outcome of a subsequent pregnancy (Hamilton, 1989), studies have explored the impact of perinatal loss on women's anxiety during a subsequent pregnancy (Armstrong & Hutti, 1998; Franche & Mikail, 1999).

Indeed, such pregnancies are found to be encompassed by marked feelings of maternal anxiety regarding the pregnancy's outcome (Cote-Aresnault & Marshall, 2000) and increased concerns for the baby's viability and well-being (Cote-Aresnault & Bidlack, 2001; Cote-Arsenault & Mahlangu, 1999). Similarly, studies that have incorporated control groups of pregnant women with no history of perinatal loss, suggest that anxiety symptomatology and levels of reported concerns regarding the pregnancy's outcome, as measured with the Pregnancy Outcome Questionnaire (POQ;

Theut, Pedersen, Zaslow, & Rabinovich, 1988), are significantly increased amongst expectant mothers with a prior loss, than for those who have not experienced pregnancy loss (Armstrong, 2002; Armstrong & Hutti, 1998; Franche & Mikail, 1999; Theut et al., 1988).

With regard to the specific effects of miscarriage on women's concerns longitudinally over the course of a subsequent pregnancy, a recent follow-up survey suggested that having a miscarriage history may only intensify women's pregnancy-specific anxiety and fears of losing an unborn baby up to the start of the third trimester of such a pregnancy (Tsartsara, 2005). In this study, during the 1st trimester of gestation, women with a miscarriage history reported experiencing significantly increased pregnancy-specific anxiety on the POQ, in comparison to their counterparts who did not have a history of miscarriage; however, their anxiety levels had decreased significantly by the 3rd trimester of gestation and had levelled up to those of their counterparts who did not have a history of miscarriage (Tsartsara, 2005; Tsartsara & Johnson, in press). Finding that the 1st trimester of pregnancy is more anxiety provoking for women with a miscarriage history in comparison to those who do not have a history of reproductive loss is justifiable, considering that perceptions of being at risk of losing the baby during this time may be more intense and pragmatic for the former group of women (Tsartsara, 2005). Indeed, the risk for a miscarriage is raised during the first trimester of pregnancy (Krause & Graves, 1999). Conversely, the reduction of mean POQ scores at the 3rd trimester of gestation for the group of women with a miscarriage history, suggests that this may be a time during pregnancy that fears regarding the potential of a pregnancy adversity subside for expectant mothers who have experienced the specific type of perinatal loss.

Again what remains open to investigation is to understand the mechanisms that trigger such increased anxiety symptoms for women who have experienced a miscarriage. Existing research has taken a phenomenological approach and is yet to incorporate a theoretical framework to explain the multiplicity of women's reactions to miscarriage.

What may compound loss from miscarriage, and hence our understanding of women's responses to it, is that miscarriage consists, not only a loss of a pregnancy and a baby, but also of motherhood (Moulder, 1990). However, the extent to which miscarriage is perceived to indicate a failure in terms of ideal feminine images is not yet understood. Also, the social construction of miscarriage and its perceived negative connotations

to a woman's female identity has been largely overlooked. Layne (1997) argues that feminist writers have indirectly contributed to our lack of understanding regarding the social experience of miscarriage and infertility by being more engaged in debates of women's reproductive choices, control of their bodies and alternatives to motherhood roles.

The reality of pregnancy loss clearly violates publicly held expectations regarding the 'natural' sequence of events in the human reproductive cycle. Literature on involuntary childlessness, with a specific focus on infertility, informs us that childlessness is surrounded by negative images. Feeling stigmatised and incomplete (Exley & Letherby, 2001; Letherby, 1999), in despair for not being able to have children (Letherby, 1999, 2002a), and losing one's identity and purpose in life (Daniluk, 2001; Letherby, 1999), are amongst the most prevalent negative discourses of involuntary childless women. Cumulative evidence suggests that involuntary childless women construct a self-concept of 'otherness', of being different or lacking something in comparison to their female counterparts who can reproduce and become mothers (Exley & Letherby, 2001; Woollett, 1994). Such findings are not surprising considering that social constructs of what constitutes the ideal of being a woman overemphasises motherhood as being innate in women's nature (Gillespie, 2000). Women themselves are, in turn, found to appraise motherhood as providing them with a unique status of power and as being an ultimate priority in their lives that qualifies them as mature adult women (Bailey, 2000).

Such findings can be explained under the light of social identity theory (SIT) and gender identity theory. A core axiom in SIT is that people form social identities because of their motive to feel accepted and valued by others, who are perceived to be similar or better than them (Tajfel & Turner, 1979). Social identity formation happens via the process of social comparison with the members of a group. Social comparison, in the theory's language, takes the form of both conforming to the attributes, stereotypes and expectations of an in-group regarding normative behaviours, and of differentiating oneself from the attributes of an out-group (Baker, 1989; Tajfel, 1974; Turner & Oakes, 1986). A consequence of this is that, following miscarriage, women may withdraw from their social networks in a way to avoid possible social embarrassment at the loss resulting in a reduction in their coping resources. Johnson and Baker (2004) identified that following miscarriage the reduction in social support significantly impacted on the coping repertoire of women contributing to

grief intensity. This is in line with the transactional theory of stress which predicts that stress ensues when an individual appraises an event as traumatic and does not have the resources to cope with the situation (Lazarus & Folkman, 1984).

There is some preliminary evidence suggesting that miscarriage may pose a threat to women's feelings of femininity. In a pilot qualitative inquiry conducted between 2-5 months following an early miscarriage, women who had lost a baby up to the 12th week of gestation expressed the fear that their miscarriage indicated a potential of a reproductive deficiency; they also expressed considerable anxiety regarding their ability to reproduce in the future (Tsartsara, 2005). Most interestingly though, and in line with the premises of SIT, women in this study often resorted to upward comparison by expressing feelings of failure and inferiority in comparison to 'all' those women who are able to conceive and carry a pregnancy full-term.

Whether the detected increased levels of pregnancy-outcome anxiety amongst expectant mothers, who have a miscarriage history, are a reflection of an internalised fear of re-experiencing a 'failure', in terms of reproductive capacity and of femininity, remain open to investigation. This may be because no attempt has been made to identify how and why women themselves experience such anxieties in terms of personal and not statistical significance. Moreover, qualitative inquiries that have explored women's concerns during a pregnancy subsequent to perinatal loss have not incorporated the experiential views of pregnant women (Cote-Aresnault & Marshall, 2000; Hense, 1994). In addition, a major difficulty with drawing conclusions from studies that have examined the impact of miscarriage on women's anxiety symptoms during a subsequent pregnancy, either in terms of statistical significance or by exploring qualitatively women's concerns, is that they have incorporated pregnant women whose prior loss ranges from a miscarriage to a neonatal death (Klier, Geller, & Ritsher, 2002). This may have produced misleading results as the content of pregnancy-related anxiety may differ, and its intensity vary with gestation age, depending on the type of loss that has been experienced. Hence, neither the sources of pregnancy-specific anxiety are well understood, nor is it clear whether such pregnancy-related uncertainties are specific to women who have a history of miscarriage, or are also experienced by women with no adverse reproductive histories.

In light of very limited women-centred research in the field, the current paper aimed to explore and elucidate how a past history of miscarriage, as

opposed to no adverse past reproductive history may affect expectant mothers' pregnancy related concerns and the meanings that they attach to an ongoing pregnancy. Incorporating women with diverse reproductive histories was a facet that was of particular interest to explore regarding its potential perceived impact on women's concerns. In this way, the relevance of prior reproductive experiences to self-concepts of femininity could also be explored.

In line with findings of the existing literature regarding the negative effects of miscarriage on women during a subsequent pregnancy, we expected that an adverse past reproductive history of miscarriage would impact on women's stated concerns during pregnancy, which might appear intensified. In addition, in line with the premises of SIT regarding social comparison and identity formation, alongside with the fact that positive pregnancy outcomes and motherhood have been appraised positively within western societies, we expected that women with adverse past reproductive histories, such as a miscarriage, would elucidate more negative feelings regarding their social identity and self-concept as a woman and would also attach greater importance to the ongoing experienced pregnancy.

METHOD

Design

Interpretative Phenomenological Analysis (IPA; Smith, 1995) was employed as the specific qualitative approach for data collection and analysis. Amongst the advantages of utilising IPA in health psychology research is its flexibility as an interviewing technique to allow participants' issues of interest and concerns to be heard, its co-operative nature between interviewer and interviewee in producing interpretations, and, finally, the opportunity that IPA gives for consideration of person-specific contextual factors that are important in meaning-making, have been particularly highlighted (Lemon & Taylor, 1997; Shaw, 2001; Smith, Flowers, & Osborn, 1997).

Data were collected via an open-ended semi-structured interview schedule. In line with recommendations concerning qualitative research, this was produced in advance (Smith, 1995). However, this was not followed blindly, but was rather adapted to the respondents' concerns and

issues of significance to them (Smith, 1995). The schedule explored expectant mothers' personal experience of pregnancy, their related feelings, concerns, and experiences with prenatal screening technology. Some of the key questions that were posed to participants were "What does this pregnancy mean to you?", "How do you feel about your pregnancy now?", "Is there anything in particular that you are concerned/worried about since you have become pregnant?" Any associations that the respondents might draw regarding their prior reproductive experiences were also explored.

Participants

Women with ongoing pregnancies were approached and recruited via local Community Midwife Centres of a General Hospital in the Midlands of UK, which agreed to co-operate. Eligible participants satisfied the following selection criteria:

1. Did not have a sole history of stillbirth (any pregnancy loss following the 24th week of gestation) or neonatal death.
2. Did not have a history of elective termination of pregnancy.
3. Wished the pregnancy to continue.
4. Were 18+ years old.

Seventeen women, who satisfied the aforementioned selection criteria, of whom 3 had a history of miscarriage and 14 no adverse past reproductive experience, were interviewed and comprised the sample for the present qualitative inquiry. This sample size was sufficient in terms of allowing representation of a diversity of past reproductive experiences.

The majority of the participants were married ($n = 12$), 3 women were cohabiting with their partner and the remaining 2 were single. In terms of occupation status, 2 participants were not employed and stated being housewives, 6 women were employed in the private sector as project managers, consultants, selling assistants, or health practitioners (e.g., pharmacists), and the rest ($n = 9$) were civil servants working either as teachers or as nurses.

The age of women ranged from 23-39 years ($M = 30.3$, $SD = 4.6$). As participants' gestation age ranged from 9 to 19 weeks ($M = 13.2$, $SD = 3.3$) the analysis reflects on how certain feelings and concerns evolve throughout the first two, and most risky, in terms of a miscarriage occurrence, trimesters of pregnancy. Thirteen women had planned their

current pregnancy. Those women who had planned their pregnancy had been trying to conceive for a mean of 3.4 months ($SD = 3.0$). Over half of the participants were multigravidae ($n = 10$) and seven women were first-time expectant mothers. In terms of parity, nine participants were childless and the remaining eight had up to 3 children.

Most of the participants ($n = 14$) had no history of miscarriage, the latter being defined as the loss of a baby up to the 24th week of gestation. The remaining three women had experienced one miscarriage in the past and had lost the baby between 6-11 weeks of gestation ($M = 9.3$, $SD = 3.0$). The intervening time since the miscarriage ranged from 4 to 60 months ($M = 23.6$, $SD = 31.5$). Only one of the women who had miscarried had experienced an intervening full-term pregnancy since her loss. The majority of women ($n = 14$) had viewed their unborn baby on the ultrasound scan. Finally, fourteen women responded positively when asked if they had any kind of concern regarding their pregnancy's outcome and baby's well-being.

Procedure

Participants of the present qualitative inquiry were drawn from a larger pregnancy survey which aimed to address the effects of miscarriage history on expectant mothers' psychological responses longitudinally from the 1st to the 3rd trimester of their pregnancy. Following approval of the project from the local Hospital Research Ethics Committee, pregnant women were approached and recruited via Community Midwife Centres of a General Hospital in the Midlands of UK. Participating midwives gave to prospective participants a research information pack that contained an introductory letter, 'patient information leaflet' and a post-paid reply envelope. The letter and information leaflet explained the aims and objectives of the study in addition to details of what participation involved. If individuals wished to participate, they were asked to return the response slip in the prepaid envelope. Pregnant women who responded by returning the confirmatory reply slip were then sent a consent form alongside the survey questionnaire pack. At the end of each questionnaire pack women were asked to state whether they would be interested to be further interviewed by the first author. A total of 61 women consented to participate in the pregnancy survey and returned their questionnaire pack via a freepost envelope. Forty-nine of those women, out of whom 12 had a

history of miscarriage (24%), stated that they would also be available for an interview. There were no significant differences on any measure or demographic between those who volunteered for an interview and those who did not. Out of those 49 volunteers, 17 were randomly selected for an interview and comprised the sample size for the present qualitative inquiry. Those women were further contacted by the researcher to arrange a time and place of convenience to them.

All women were interviewed in their own homes. Interviews lasted between 45 to 60 minutes. Following informants' consent all interviews were tape-recorded. Participants were reminded that they had every right to stop the interview should they feel uncomfortable at any point and that their statements would not affect the standard healthcare provisions that they were entitled to. Verbatim transcripts of resultant tape-recorded interviews were produced. To ensure anonymity, participants' names have been replaced with numbers.

Analytic process and validity

The analytic process followed the sequence that has been suggested by Smith (1995) for researchers applying IPA: each individual transcript was repeatedly read, and statements, which reflected participants' perceptions of personally important aspects of their pregnancy experience, were noted. These statements were then organised coherently into groups of themes. Themes derived from each individual transcript were continuously compared and contrasted in turn against themes derived from previous transcripts. Finally, a list of main themes which reflected the group's shared views and psychological processes taking place during their pregnancy was produced. Internal validity was verified through checking participant's verbatim extracts against the derived corresponding themes (Smith, 1995).

The extent to which derived themes were clearly and adequately supported by corresponding extracts was also verified by the second author, who had read participants' transcripts independently (Osborn & Smith, 1998). When analysing the data the researchers were aware that their own experiences, namely, one being a female and the other male, none of them having experienced parenthood, might have an impact on how the women's experiences were interpreted. To overcome this limitation, only the agreed themes by the two researchers were explored.

RESULTS

Two main themes were derived which specifically explain women's anxieties of an ongoing pregnancy, namely, the *uncertainty of pregnancy*, and the *dual nature of pregnancy*. Each main theme is supported by sub-themes. To preserve participants' anonymity, their names are replaced with pseudonyms during presentation of their supporting extracts.

The uncertainty of pregnancy

The main theme 'uncertainty of pregnancy' reflects the apprehensions and anxieties being experienced by women regarding their pregnancy's course, as well as their attempts to remain in control of such uncertainties. Women's preoccupation mainly revolved around their baby's status and pregnancy's outcome as well as the expected discomfort that participants believed that they would feel at the occurrence of a pregnancy loss. The uncertainty of pregnancy was evident across two themes: the *fear of miscarriage* and the *avoiding announcing the pregnancy to others*.

The fear of miscarriage was explicitly evident in women's discourses of a specific fear of losing their baby or a more vague fear of something 'going wrong' with the pregnancy. Such a fear appeared to accompany feelings of attachment to the baby and was not prescribed necessarily by an adverse prior experience of miscarriage, even though it was far more intense in the latter case.

The fear of something going wrong was frequently expressed by first-time-expectant mothers, particularly those who were in the first trimester of their pregnancy. Mary explained her apprehension in terms of her 'over-anxious' personality in general and of not knowing what to expect with her pregnancy:

It does cross your mind that things may not go as good; you know miscarriage or something like that. I mean, I am an over-anxious person in general, and I always tend to think that nothing is for certain. So, with being pregnant, you never know what will come next. (Mary, 11 weeks)

Being at a more advanced pregnancy stage did not appear to stop first-time expectant mothers from feeling apprehensive. For example, Joanne who was 18 weeks pregnant explained that, despite having passed the most

risky period of the first three months, she was still anxious because she was looking forward for benchmarks that could confirm that her baby was developing normally. Her extract shows that feeling her baby's movements was an important reassuring sign that could ease her concerns:

There is such a lot to worry about in the first few months, because that's the most risky time really for losing the baby, but then, as you get to the latest stages, there are different things to worry about...I think, sort of, you worry when you think that you might feel movements from now onwards but you don't know quite what week it's gonna be. So, again it's something else to worry about, whether it's ok. So, when it does move, I think it's reassuring that you know that it's moving in there. (Joanne, 18 weeks)

The above extract suggests that concerns and apprehensions of negative pregnancy outcomes did not subside; but rather changed content as the pregnancy was progressing. Moreover, for first-time expectant mothers, what seemed to be linked to the fear of losing their baby was a lack of prior pregnancy experiences, which could indicate to them how a normal pregnancy proceeds. On the contrary, specific prior reproductive experiences triggered some of the multiparae women's apprehensions. Women's discourses reflected that 'the quickening' was a strong indicator of normal progression of a pregnancy for multiparae women, yet in a different way than it appeared to be for first-time expectant mothers. Multiparae women compared the onset of the quickening during a prior pregnancy with the current one. This prior experience of quickening served as a benchmark but at the same time as a stressor:

I was expecting it to move, but I felt this baby moving a bit later [than the prior one]. I was thinking *isn't it gonna kick?* In comparison to the other two, this kicked much later. I was expecting it in anguish. (Mandy, 15 weeks)

The above extract reflects that Mandy interpreted her late quickening as an indication of possible complications since she had experienced it at an earlier stage during her previous pregnancy. It therefore appears that prior pregnancy experiences are used as knowledge of what should be expected during the course of a pregnancy. In this sense, they served as the expected norm for women irrespective of whether things were progressing normally.

In comparison, women who had previously miscarried were concerned

that they might lose their current baby due to another miscarriage. Lesley, who was still in the first trimester of her pregnancy, described that she was constantly expecting something to go wrong:

You are just worrying about every little pain, you think, *oh, God, is that it?* It's just little things, you know, you get up in the morning and you go to the toilet and you are just waiting for something to happen. (Lesley, 9 weeks)

Similarly, Brenda, despite having progressed to her 19th week of pregnancy, described experiencing a constant apprehension regarding her ability to carry the pregnancy full-term:

I want to wait until I get a bit bigger before I find out [the baby's sex]. I don't want to know... I think it's perhaps with me losing the one in January. Your mind is sort of *am I gonna carry it full-term?* Do you know what I mean? It's always at the back of my mind *will something go wrong this time?* (Brenda, 19 weeks)

Even though two early first trimester scans had confirmed viability, Brenda was still apprehensive regarding the outcome of her pregnancy. Her statement that, she did not want to discover her baby's gender until after the baby has grown a bit more, suggests that she did not want to raise her hopes out of fear of losing it at some later stage.

Not wanting to announce the pregnancy to others during the early stages appeared to be utilised as a cognitive avoidance mechanism to control pregnancy uncertainty. Women's discourses suggested that this strategy was employed out of a need to avoid the discomfort and upset that would arise if they would have to deal with others' reactions in case of a pregnancy loss. Jane, 10 weeks pregnant, decided that she would not let people know that she was pregnant until after she felt confident that her pregnancy was progressing to full-term. She justified this as a means of not wanting to put herself in the difficult position of having to give explanations to others if something went wrong:

I think I'd like to know that everything is going OK before I told too many people, because if something wasn't right, I wouldn't like to be in a position where I'd have to tell lots and lots of people that something is not right. I don't want to put myself in that position. (Jane, 10 weeks)

Not wanting others to know about the pregnancy was also followed as a policy by women who were at more advanced pregnancy stages. This is articulated in Eve's account; Eve was at her 19th week of pregnancy. She believed that having to explain to lots of people an adverse pregnancy outcome, not only would not help her to cope with her emotions, but would also intensify her grief:

As much as you want to tell people, if you start telling people, and then it goes wrong, you have to tell them it's not happening and that makes your grief harder; dealing with so many people who know. And also they come out in sympathy and perhaps you don't need it or want it. It's so difficult anyway. (Eve, 19 weeks)

In a similar way, women who had a prior miscarriage experience preferred to keep their pregnancy secret from others. For these women, however, withholding the pregnancy's news up to the 12th week scan was employed in a superstitious way, not just as a behaviour that could protect them from losing the baby, but also as a means of avoiding the stigma that another loss would bring forth. As Brenda's extract reflects, by keeping her pregnancy secret she could also protect her partner from the perceived 'embarrassment' that another miscarriage might create:

We left it until I had the twelve weeks scan, in case anything happened, because I told everybody before when I found out. Then, of course, I lost it... I didn't feel that bad about it, but my partner did. He thought differently about it. He didn't want to tell people, he felt embarrassed to tell people that he wasn't gonna be a father anymore. You know, his baby was on its way and then it wasn't. (Brenda, 19 weeks)

Lesley, on the other hand, felt that since she had already been through the grief of a prior miscarriage, she would have felt much better if she had the choice of coping with her emotions on her own first. Her statement suggests that by keeping her pregnancy secret from most of the people around her she was utilising as a mechanism that protected her from the added pressure and raised expectations that others might have regarding her pregnancy's outcome:

I only told a couple of people at work, people that really needed to know,

purely in case anything happened. It was a case of safety really...I suppose with your first one, you just want to say everybody coz you are so excited, but if it has happened to you [a miscarriage] you just want to deal with it [subsequent pregnancy] on your own way first. (Lesley, 9 weeks)

The dual nature of pregnancy

Women's discourses reflected that the pregnancy had a dual meaning for them. On one hand it represented a means of proving their feminine identity and capacity to reproduce, and, on the other hand, a means for experiencing its endpoint, that is, motherhood as a social role. The sub-themes, namely *Conceiving: a matter of success* and *Pregnancy as a means of fulfilling motherhood*, support these two meanings.

Participants perceived conceiving and carrying a baby to term to be an indicator of being a complete woman and hence as a personal success. Their discourses reflected that being fertile evidenced by producing a baby was an important aspect of justifying their feminine identity. For women who were first-time expectant mothers, conceiving was seen as a matter of *getting it right*, and an indicator of being able to reproduce:

It's the one big area in your life that you think you want to get so right. You don't want anything to go wrong. You know, you don't want a miscarriage. (Jenny, 12 weeks)

For most first-time expectant mothers, like Jenny, the need to succeed in being fertile was accompanied by an intense preoccupation of managing to carry their pregnancy to full-term. A miscarriage, or detection of abnormality, would conversely equate to a failure in succeeding in one of the 'biggest' areas of their life. Similarly, women who were already mothers talked about their ability to conceive naturally as a sign of being 'lucky' and of good fortune:

We are very lucky. That's why I said to you I feel so blessed, because with all three of my pregnancies it's been easy [to conceive]. I even know the dates for the first [baby] and for this one. And there are so many women out there that they can't [conceive]. So, I do feel very blessed. (Emma, 15 weeks)

The expectant mother in the above extract stated that she felt 'blessed'

when she was comparing herself to other women who were facing fertility problems and could not experience motherhood. Such a downward comparison towards the 'non-mothers' was a frequently employed cognitive process by expectant mothers, when referring to their success in getting pregnant, and appeared to be utilised as a means of establishing their status of becoming successful adult women.

Many women talked about natural conception as being the most acceptable means of achieving motherhood. Again, downward comparison towards other women with infertility problems was employed in such discourses. For example, Eve stated that she felt particularly lucky for being able to succeed in conceiving without reverting to assisted conception; a state that was perceived to be advantageous to that of women with fertility problems. On the other hand, her discourse reflects that not being able to conceive naturally would be more accepted by her and her partner than reverting to assisted reproduction:

We had friends who had fertility problems and they had to go down IVF. But before we had our son we both sat down and we said "We are not doing that". If we can't have a child naturally, I will have to live with it, we will have to learn and live with it...but we would only follow the natural route...it's been a very happy experience to be able to have children normally. So, I feel very lucky, I mean, I know it doesn't happen to every woman, infertility and things, but we have close friends who have been through this and makes you wonder. (Eve, 19 weeks)

Indeed, women who had experienced difficulties with getting pregnant in the past, talked about the importance of conceiving naturally in their lives. Conceiving was appraised as particularly important by them, not only because they felt frustrated at the idea that there was something 'wrong' with them, as Mary's account reflects, but also because of the fear of being stigmatised by society as infertile, as it is evident in Elizabeth's discourse.

We had been trying for a baby for almost a year now and at some points we were frustrated when nothing would happen. There were times that I was thinking whether there was anything wrong with me or something, but anyway. So, conceiving now was something that I wanted very much. (Mary, 11 weeks)

We didn't want anybody to know that we were trying, it would be easier that way, I think, coz we thought, if we couldn't have children, we as a couple could have accepted it...if we couldn't, we couldn't, you know we wouldn't go into IVF or adoption, but it would be more difficult if we would have to think of the people's reactions as well. (Elizabeth, 12 weeks)

Elizabeth talked about her and her partner's choice to hide from others that they were trying to conceive. As they were not sure whether they could succeed in getting pregnant, keeping secret from others their difficulties with conceiving appeared to be employed as a coping mechanism, which protected them from people's reactions and probably from a perceived stigma of having failed to reproduce.

Similarly, for women who had experienced a prior miscarriage, getting pregnant was appraised as an indicator of personal success. Women's discourses reflected that the realisation of being pregnant following a miscarriage was experienced as a relief and even as a means of compensating for their prior loss as it is evident in the following two accounts:

When I found out I was pregnant in January, well, it was before that, end of November, it was sort of a shock, even though we were trying to have a baby, it was still a great shock when it came back positive. I was like oh, God, you know, it's happened! (Brenda, 19 weeks)

In my mind, I should get pregnant immediately after, to get over my traumatic experience [of a prior pregnancy loss]. And I did within 3 months. It was a relief, my self-medication. (Pat, 18 weeks)

For women, getting pregnant, apart from indicating that they were fertile and were thus becoming successful in terms of producing their own child, also meant that they could experience a new social role, that of motherhood. In this sense pregnancy was also presented by women as a means of fulfilling a major goal in life, that of having children and creating their own family. Being able to reproduce and experience motherhood was presented by participants as an achievement, which would not only give unique meaning to their life, but would also complete their self-image:

While growing up it's all I've ever wanted; I wanted to be happy, to be married, to have a lovely husband and to have a lovely family of my own.

Because that's what I've had. I've had a lovely family life with my mum and dad and my brother. I had an excellent childhood and everything else in my life is so right and I just wanted to be able to do, you know this thing that most women can do fine and don't have to worry about it. (Jenny, 12 weeks)

As the above extract suggests, women's expectation of being able to reproduce was congruent not only with family models that they had been exposed to, but also with perceptions of what 'most women can do fine'; the latter suggesting a cognitive process of upward comparison with women who had already achieved motherhood and who were perceived to be superior in this sense. Hence, getting pregnant appeared to be the first step towards identifying oneself with the image of an ideal adult woman.

Similarly, motherhood was ascribed great significance by women because it was also expected to be self-gratifying and rewarding. More specifically, it could give them the opportunity to be content via experiencing a unique bond with their child. Being nurturing, offering, but also receiving, affection from their child appeared to be the main gratifying element of such a relationship as women clearly stated:

I love children, since I was little I was always playing with dolls; I was never into anything else. I always wanted to be a mum. That's all I wanted to be. And then I used to take other people's children at the park and stuff. I just like being around children. I like it when my son smiles and that smile gives to you so much back. I don't know, making them happy makes me feel happy. (Bettie, 15 weeks)

As the extract above suggests, socialisation into the motherhood role may start from early childhood for little girls. This early training into nurturing and caregiving attitudes may be what makes women ascribe to motherhood such a central role in their lives.

DISCUSSION

Past research reveals that anxiety is an important adverse effect of miscarriage and other types of perinatal loss. When amalgamated, existing evidence indicates an interesting pattern regarding the course of anxiety symptoms in the aftermath of pregnancy loss: women who have experi-

enced a pregnancy loss tend to be more anxious immediately post-loss, in comparison to various control groups of women (Geller et al., 2004). Moreover, women with a miscarriage history in specific, when they embark to a subsequent pregnancy, exhibit increased levels of pregnancy outcome anxiety only in the early months of their gestation, but not during later stages of such a pregnancy, when their levels of pregnancy outcome anxiety are, statistically speaking, comparable to those of expectant mothers with no prior loss (Tsartsara & Johnson, in press).

The present inquiry utilised an Interpretative Phenomenological Approach (IPA), to explore the sources of concerns experienced during the first two trimesters of a pregnancy that may follow a miscarriage. The study does not limit its focus on a specific group of expectant mothers, namely those who have experienced a past reproductive loss. By giving credit to the experiential views of expectant mothers with no history of reproductive loss it brings richer insights and understanding into the issue of pregnancy-related anxiety.

Past qualitative research has shown that expectant mothers who have experienced a prior perinatal loss are particularly apprehensive regarding the outcome of their pregnancy and their baby's well-being (Cote-Arsenault & Bidlack, 2001; Cote-Arsenault & Marshall, 2000). Even though this is, by no means, contradicted here, the findings of the present study support partially our first prediction that increased pregnancy concerns are only evident amongst expectant mothers with a past history of miscarriage. Instead, the results indicated that expectant mothers, irrespective of their past reproductive experiences, are facing uncertainty regarding the outcome of their pregnancy and their baby's well-being. Indeed, the vast majority of participants in this study stated that they had some kind of concern regarding their baby's viability. The IPA clarified that women's pregnancy-related anxiety revolved either around the specific fear of miscarrying or a more generalised fear of 'something going wrong' with the pregnancy.

Both first-time expectant mothers and multiparae women, with no adverse prior reproductive experiences, stated feeling worried regarding their pregnancy's outcome. For first-time expectant mothers such an anxiety appeared to relate to a fear of not knowing what to expect during the course of a 'normal' pregnancy, and hence to a perception that a pregnancy's outcome is a highly uncertain event. On the other hand, for expectant mothers who were multigravidae, pregnancy uncertainty appeared to relate to specific

prior pregnancy experiences, such as the time of quickening, which served as benchmarks and the standard of what should be expected during any subsequent pregnancy. Hence, any sensation or experience that deviated from that anticipated 'standard', served as a stressor producing anxiety regarding the pregnancy's outcome for multiparae women. In comparison, women who had miscarried reported a more specific fear of re-experiencing the same adverse scenario with their ongoing pregnancies. For most women, sensing the baby's quickening appeared to be the strongest indicator that their pregnancy was progressing normally and, hence, a benchmark that could reduce some of their pregnancy-related fears. These findings suggest that prior reproductive experiences, irrespective of whether they are adverse or not, are important in formulating women's pregnancy-specific concerns during the course of an ongoing subsequent pregnancy.

Finding that concerns regarding the pregnancy's outcome and the foetal's well-being are not necessarily prescribed by an adverse history of reproductive loss, as it has been reported elsewhere (Cote-Arsenault & Bidlack, 2001; Cote-Arsenault & Mahlangu, 1999), suggests that such an uncertainty may be a natural response of pregnancy, which, however, might be more intense and pragmatic in the case of women who have experienced a past loss. Indeed, it has been found that pregnant women's reported concerns regarding their baby's viability during early trimesters of their pregnancy are an inseparable part of their emotional investment to the forthcoming baby and of the developing prenatal maternal-foetal attachment (Tsartsara, 2005). However, when pregnancy-related concerns are assessed with the use of standardised questionnaires such as the Pregnancy Outcome Questionnaire (POQ), expectant mothers who have a history of miscarriage and other types of perinatal loss tend to score significantly higher than their counterparts with no adverse reproductive histories (Armstrong, 2002; Armstrong & Hutti, 1998; Franche & Mikail, 1999; Theut et al., 1988; Tsartsara, 2005).

The apparent discrepancy of findings between studies that have utilised structured questionnaires to assess pregnancy-specific anxiety symptoms and the current qualitative inquiry does not necessarily pose a problem of interpretation. The significantly lower levels of pregnancy-specific anxiety which have been detected amongst groups of pregnant women with no history of pregnancy loss in comparison to those who have experienced some type of perinatal loss can be translated in terms of statistical but not necessarily of personal significance. That is, even though the former group

of women may report feeling less anxious, and understandably so, regarding the outcome of their pregnancy, they may still experience fears and concerns that are perceived by them to be of major importance, as IPA findings of the present study suggest.

The present inquiry further brings novel insights regarding the sources of pregnancy anxiety for expectant mothers. Women's discourses suggested that this might relate to a need to succeed in reproducing. Most participants perceived their ability to be fertile as very important in their lives. Their discourses reflected that not managing to carry their pregnancy full-term would equate to a perceived personal failure. The fact that such anxiety was expressed by all women, irrespective of whether they had a prior history of miscarriage, were first time expectant mothers, or had already living children, gives an insight that each pregnancy is experienced as leading to a unique baby, as a unique chance to achieve motherhood, and as a unique indicator of personal success for a woman's identity. This finding is of particular interest considering that most of the women being interviewed had the chance to experience multiple alternative roles as they also had full-time occupations. It is also in line with findings from a recent study with British expectant mothers who were working (Bailey, 2000); in this study, women not only did not experience a conflict between being a mother and employed in a job, but they also talked of the baby as being the ultimate priority in their lives.

It has been argued (Frost, 1980; Rubin, 1984) that feminine identity is actively created by women as a result of their experiences and interaction with the social world they live in. Once a little girl identifies herself with the attributes of her gender group, her identity is confirmed and recognised by others (Andermahr, Lovell, & Wolkowitz, 2000). In discussing women's perceptions of themselves and self-knowledge, both Frost (1980) and Woollett (1994) argue that women, while growing up, start recognising their gender attributes, one of which is their capacity to reproduce. Female children are socialised into the motherhood role, both by observing adult women-mothers and by playing with little dolls, and hence expect to adhere to the norms and expectations that both those whom they perceive as similar (women) and dissimilar (men) impose, once they also reach adulthood (Frost, 1980). Woollett (1994) suggests that this socially normative value of motherhood is what frequently motivates women to equate motherhood with femininity.

This stance may explain why being able to conceive a baby was perceived

by all pregnant women in this study, not only as a sign of personal success and of 'getting it right', but also as a verification of a superior feminine status. The discourse of 'being lucky' in comparison to 'other' women who are facing infertility was particularly employed by expectant mothers who had already achieved motherhood and had never experienced difficulties with conceiving. This discourse is also in line with SIT which proposes that positive identities are formed via both identification with the attributes and characteristics of an in-group that one perceives to belong to, and via differentiation from those characteristics that are not perceived to enhance or verify one's self-image and identity (Baker, 1989; Gurin & Markus, 1989; Tajfel, 1974).

In line with our second prediction regarding the potential negative repercussions of an adverse past reproductive history on women's self-concepts, pregnant women who had lost a baby due to a miscarriage, but also those who had experienced difficulties with conceiving in the past, appraised their ability to conceive naturally at present and to reproduce a child as a unique success in comparison to their prior status which was clearly perceived as an unfavourable and distressing one. The discourses of those women revealed that this was due to their prior fears of being faulty and of being stigmatised as infertile. Moreover, most women talked of their capacity to reproduce naturally, without resorting to assisted reproduction, as the ultimate goal in their lives. These findings suggest that miscarriage, like infertility, may represent not merely a loss of the dream of social motherhood, but also of a taken for granted 'perfect' reproductive system. Such an explanation fits with findings from research in the involuntary childless women who report feeling incomplete as women and pressured from others to produce what is expected from them, a biological child (Daniluk, 2001; Letherby, 2002a, b). In light of these findings, it is not inexplicable why women who cannot have a child often report losing their identity and purpose in life (Daniluk, 2001). Furthermore, results from the present study further verify the premises of SIT that deviating from the perceived desirable attributes and characteristics of an in-group, with which one identify themselves, may lead to feelings of negative self-evaluation and to fear of being evaluated negatively by others (Baker, 1989; Turner & Oakes, 1986).

This in turn may explain two further findings of the present study. The first concerns the reported tendency by expectant mothers who had experienced prior difficulties with conceiving to keep secret from others

their attempts to reproduce. Those women's discourses reflected for once more that this was employed as a means of protecting themselves from people's reactions and possibly from a perceived stigma of being 'infertile'. A similar strategy of hiding not only their feelings, but also keeping secret their experience of involuntary childlessness from others, as a means of controlling stressful encounters and of not increasing their distress has been reported elsewhere (Letherby, 1999). However, this tendency for not disclosing painful feelings has also been found to relate to women's fears of upsetting others, and particularly intimate others (Exley & Letherby, 2001).

In a similar vein, the second finding relates to a certain form of cognitive avoidance that expectant mothers of the present study reported to utilise in their attempts to control their pregnancy uncertainties. This concerned their reported strategy to avoid announcing their pregnancy to others. Avoidance of announcing the pregnancy to others in the early stages was exhibited irrespective of women's prior reproductive experiences, and almost in a superstitious way. This strategy appeared to relate with women's expected distress that they believed they would feel if they had to cope with people's reactions at the possibility of a pregnancy loss.

Indeed, pregnant women with a miscarriage history verified that not wanting to announce the pregnancy to others, particularly in the early stages, was a policy being adopted due to the distress and embarrassment that they had felt when they had to announce their miscarriage to all those people who knew that they were pregnant. Having already experienced the reality of one loss, they preferred not to share their subsequent pregnancy's news with others, until after they felt that the pregnancy was established. Such a 'policy' appears to be in opposition to finding that women want their pregnancy loss acknowledged, particularly by healthcare professionals (Tsartsara & Johnson, 2002). In a study conducted with women who had a recent early miscarriage experience and were treated at a specialised miscarriage centre, participants reported that when the specialised nurses of the centre were sympathetic to their needs for recognition of their grief and offered sensitive and unconditional listening services, women felt valued and stated coping better with their experience (Tsartsara & Johnson, 2002). One possible explanation for those findings is that there is an acknowledgment of their loss and status as 'would have been mothers'. Research on involuntary childlessness suggests that amongst the reasons why women avoid disclosing both their unsuccessful attempts to conceive is not only a lack of understanding that others sometimes exhibit, either by

pretending it hasn't happened to them or by being intrusive and making insensitive comments, but also people's avoidance to bring up and share with them any topic relevant to children (Daniluk, 2001; Letherby, 1999). Due to the difficulty that they are facing to share with others feelings of grief over the loss of their hopes, involuntary childless women many times report feeling as 'outsiders' (Exley & Letherby, 2001). Consequently, not sharing their pregnancy news early on a subsequent pregnancy might be a coping mechanism adopted by expectant mothers with a prior loss experience with the purpose to minimise the anticipated distress that might arise in the face of a negative response by others. Hence, there is a possibility that miscarriage is as much a socially stigmatised experience in our current societies as infertility has been found to be (Exley & Letherby, 2001; Woollett, 1994).

Women's discourses further suggested that socialisation into the motherhood role may start from early childhood via playing with dolls and assuming maternal roles. This early training and familiarization with the role of motherhood may explain why participants of this study perceived motherhood as an inseparable aspect of their femininity and an ultimate goal in life.

These findings would seem to suggest that the reason why women may be psychologically affected by miscarriage or inability to conceive a child is not only an internalisation of stereotypical images of womanhood, but also a life-long investment in motherhood. Of course, not all women are found to invest as highly in the idea of motherhood. In a longitudinal study of Canadian infertile couple's adaptation to biological childlessness, Daniluk (2001) found that those couples with high investment in parenthood and lack of alternative models of living experienced more frustration and greater difficulty in finding a purpose in life or functioning as a family unit. Similarly, Magee, MacLeod, Tata, and Regan (2003) in a study investigating the effects of recurrent miscarriage, detected increased levels of distress amongst women who, in comparison to other goals in life, had invested higher in the motherhood role. This is in line with the premises of the psychosocial transition theory (Parkes, 1988), which predicts that the ability of an individual to cope with a major life transition, including loss, depends on the extent to which the person is called to change their life concepts and assumptions regarding their self-identity and goals in life. This may explain why women who invest highly in their ability to reproduce and experience motherhood are left in confusion when faced with infertility and find it difficult to move on with their lives or to re-construct their

identities as women (Letherby, 2002b).

Considering the contextual nature and the philosophical assumptions underlying qualitative research, no attempt is made here for generalisation of findings. However, the present study has been able to validate why pregnant women with no adverse reproductive histories, as well as those who have experienced a past miscarriage or had faced difficulties with conceiving at some point in their life, appraise their pregnancy as an indication of personal success and as an accomplishment of a major goal in their life, that of experiencing motherhood. At the same time, results of the present study substantiate the expressed concerns, preoccupation and anxiety of expectant mothers, and more specifically of those with a miscarriage history, regarding the outcome of an ongoing pregnancy.

A point of caution should be drawn about the extent to which findings of the present study regarding the sources of women's concerns and apprehensions during pregnancy could be generalised. Considering that participants of this qualitative inquiry were drawn from a survey which examined the impact of miscarriage on a subsequent pregnancy and the differences on various psychological measures between women with, and without, a history of miscarriage, pregnant women with other past reproductive experiences, such as abortion or termination of pregnancy for foetal abnormalities were not included. The decision to exclude pregnant women with a history of elective termination of pregnancy was grounded in light of research evidence suggesting that active decision-making regarding continuation of one's pregnancy may not only relate to different expectations about lifestyle and family planning practices (Kero, Hogberg, Jacobsson, & Lalos, 2001), but also with particularly high levels of guilt and responsibility post-termination (Holmberg & Wahlberg, 2000; Iles & Gath, 1993; Kero et al., 2001). Additionally, it has been found that women following termination of pregnancy for foetal abnormalities experience increased concerns regarding recurrence of foetal abnormalities during a subsequent pregnancy (Elder & Laurence, 1991). In this sense, inclusion of pregnant women in any of the two aforementioned groups might produce confounding effects on the results of any statistical comparison. Future women-centred research in the field could incorporate expectant mothers with more diverse past reproductive experiences and explore both the nature and sources of their concerns and apprehensions during pregnancy.

A number of limitations of the present study should also be mentioned when considering its practical implications. Firstly, this study focuses on the

concerns and worries that women face during pregnancy from an experiential-personal perspective and not from a clinical perspective. Even though it brings novel insights regarding the potential sources of pregnancy-related worries and personal fears of women, it cannot give an estimation of the extent to which such reported fears are confounded by the presence of prenatal psychological disorders such as clinical anxiety or depression. This is of particular importance as pregnancy is recognised to be a period of heightened emotional upheaval for a considerable number of women (Kitamura, Shima, Suguwara, & Toda, 1993). Further the small number of women who had a history of miscarriage in the present study needs consideration. Future research needs to extrapolate how reproductive history interrelates with pregnancy concerns. Identification of those women who are at increased risk antenatally of developing psychological symptoms of clinical significance would give an indication as to who might benefit the most from professional emotional support during the course of their pregnancy.

Future studies should also consider the role of other, potentially mediating, factors not only on women's personally experienced apprehensions concerning their pregnancy's outcome, but also on symptoms of clinical anxiety. One such factor might be the informal support that women receive antenatally. Studies which have examined its role in the immediate aftermath of miscarriage have consistently reported significant associations between perceived support from close others – most frequently a partner or husband – and depressive, grief or anxiety reactions: women reporting satisfaction with this support source seem to be the less affected, whilst those reporting disappointment or conflict within their marital relationship seem to be the most vulnerable (Beutel, Deckardt, von Rad, & Weiner, 1995; Cordle & Prettyman, 1994; Cuisinier, Kuijpers, Hoodguin, de Gravauw, & Janssen, 1993). Past history of psychiatric disorders has also been related with higher risk of antenatal psychological symptomatology (Bernazzani, Saucier, David, & Borgeat, 1997) and would be of major importance to study in such a type of research. Similarly, concurrent bio-medical conditions and pregnancy complications, such as early pregnancy bleeding, might also mediate reported levels of anxiety and the concerns of women antenatally (Reading, 1983).

Finally, considering that the present discourses and themes derived are a reflection of expectant mothers' experiences and meanings ascribed to pregnancy and motherhood during the first two trimesters of gestation, it

would be interesting to explore whether these discourses change in later pregnancy stages or alter following the birth of a live child. Indeed, it is known that motherhood, once experienced, apart from its gratifications, is also appraised by women to entail a number of secondary losses (Oakley, 1980).

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