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Family Planning and Counseling Desires of Women Who Have Experienced Miscarriage

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Abstract

OBJECTIVE: To explore initial pregnancy intentions and postmiscarriage family planning needs and counseling preferences of women experiencing spontaneous abortion.

METHODS: We conducted semistructured qualitative interviews with women who recently experienced spontaneous abortion to explore their feelings about conception, pregnancy, and miscarriage; their future family planning goals; and contraceptive counseling preferences. Two trained coders utilized an inductive, iterative approach to code transcripts and identify themes using Atlas.ti software to organize the analysis.

RESULTS: We interviewed 26 women reporting varied intentions in their recent pregnancies: 54% were trying to conceive, 27% were not trying but not preventing, and 19% were attempting to avoid pregnancy. Participants reported a range of feelings about the pregnancy diagnoses and eventual miscarriages with some relatively unemotional ("a little disappointed…suffering for two months for nothing") and others feeling devastated by their pregnancy losses ("in shock," "for it to be taken away was crushing"). Varying character and intensity of emotional reactions were seen across the range of initial pregnancy intentions. Some participants had consistent childbearing plans before and after miscarriage, whereas others experienced their pregnancies and losses as clarifying events leading to changed goals moving forward ("it was a wake-up call"). Although family planning needs were inconsistently addressed after spontaneous abortion, women were generally receptive to the idea of contraceptive counseling, though they had different preferences regarding timing, ranging from immediately to weeks later.

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CONCLUSION: Women's reproductive goals after spontaneous abortion cannot be inferred based on initial pregnancy intention or emotional reactions to pregnancy loss. Health care providers should offer family planning counseling to all women after spontaneous abortion, remaining responsive to individual patient needs.

Spontaneous abortion is common, accounting for 8–20% of clinically recognized pregnancies.[1] Forty-five percent of U.S. pregnancies ending in spontaneous abortion were initially unintended.[2] How initial pregnancy intention affects subsequent needs for both emotional support and family planning counseling in women experiencing miscarriage remains unclear. Previous studies have shown a desire for contraception in the postpartum and postabortion time periods,[3–7] yet there are no published studies on the need for and acceptability of contraceptive counseling and provision after miscarriage.

With most miscarriages occurring early in pregnancy, often before the initiation of prenatal care,[8,9] women may not have a consistent medical provider caring for them during their pregnancy loss. Because there is a rapid return to fertility after miscarriage,[10] there may be utility in addressing family planning at the time of miscarriage management. However, given the potential emotional distress of women experiencing miscarriage, clinicians may not feel comfortable addressing future childbearing goals and contraceptive needs with women acutely experiencing miscarriage. Additionally, some health care providers may assume that contraception is not needed or that it is only desired by women with unplanned pregnancies, expecting them to have a different experience than women with planned pregnancies.[11] To fulfill our two objectives of exploring patients' contraceptive needs after miscarriage and discovering optimal strategies for addressing patient desires, we conducted a qualitative study of women with recent miscarriages to better understand their family planning needs and counseling preferences after pregnancy loss.

MATERIALS AND METHODS

We enrolled English-speaking women aged 18–45 years in Pittsburgh, Pennsylvania, who had experienced miscarriage in the preceding 12 months. We recruited through medical center and community advertisements and health care provider referrals. Interested women underwent telephone prescreening, which was used to establish their miscarriage history and to ensure diverse representation. We chose a sampling strategy to allow us to capture a diversity of perspectives regarding miscarriage care experiences and preferences guided by prior research of patient characteristics associated with varied pregnancy intentions, including age, race, and insurance status.[2,12,13] Sample size determination in qualitative studies is generally guided by the principle of "thematic saturation" or continuing participant enrollment and data collection until no new themes or findings are noted.[14,15] Other qualitative researchers have suggested that thematic saturation could be reached with as few as 12–15 participants, depending on diversity of the sample.16 We continued participant recruitment and data collection until we reached thematic saturation across experiences with both intended and unintended pregnancies, which we predicted would occur with 25–30 participants. Eligible callers were invited to participate and were scheduled for an appointment at the Magee-Womens Hospital Center for Family Planning Research, with preferential selection given to those with less represented characteristics, to meet our

sampling criteria. At the study visit, participants provided written informed consent and additional demographic information. The principal investigator conducted structured in-depth interviews with each individual participant. We reviewed medical records for those participants who had received care in our hospital system to provide context and corroboration of participant accounts of their pregnancy circumstances and miscarriage care. The study was approved by the University of Pittsburgh institutional review board.

During the study interviews, we used open-ended questions and prompts to steer the conversation toward pertinent topics while allowing for flexibility and space for spontaneous ideas.[13] We asked participants about the context surrounding their pregnancies (including intentions and planning of conception, feelings about discovery of the pregnancy, and the support of partners and family) using the participants' own accounts to explore preconception pregnancy intentions. Based on emerging concepts, we classified pregnancies by each woman's stated preconception intentions and efforts as "trying to conceive," "not trying for but not preventing pregnancy," and "avoiding pregnancy." We asked each participant about her miscarriage experience, including her response to the miscarriage itself, feelings about all medical care received around the miscarriage diagnosis, and any discussions with a health care provider about family planning or contraception during her miscarriage care. We also inquired into future family planning goals after the miscarriage. Finally, we discussed specific preferences for counseling about family planning after miscarriage, including person, place, tone, content, and timing.

Interviews were audio-recorded and transcribed verbatim with original recordings preserved for reference. The principal investigator reviewed all transcripts to ensure that transcribed interviews were consistent with the recalled conversation. We used an editing style of qualitative analysis, described by Crabtree and Miller.[12] This style of analysis does not utilize a predefined codebook, but instead relies on the interaction of coders with the data to generate discrete codes, with the final codebook evolving in an iterative process through constant comparison of ideas. By identifying the patterns and associations of individual codes throughout the analytic process, the coders then collaboratively identify larger themes with eventual development of overarching theory.[13] We started developing a preliminary codebook during the interview process when we began noting discrete elements of the participants' narratives. Completed transcripts were then imported into Atlas.ti 7.5.13 for data management, and two trained coders (R.F.-B. and M.E.H.) individually coded transcripts line by line, guided by the preliminary code-book and developing additional codes using an inductive, iterative approach. The coders met after every three to six transcripts to discuss and adjudicate differences, continually refining the existing codebook. Once the codebook was finalized, all transcripts were recoded using the final version. Themes that emerged during the coding process and after coding was complete were discussed collaboratively by the coders and further developed into an overarching theoretical framework. After analysis was complete, additional analytic validation was provided through "member-checking," whereby interested participants were contacted to discuss findings so they could verify that their perspectives were accurately represented and that suggested practice implications were appropriate and would be beneficial to women experiencing miscarriage.[13]

RESULTS

We prescreened 37 women, all of whom met inclusion criteria, and we enrolled and interviewed 26 women. The median gestational age at miscarriage was 8 weeks (range 3–22 weeks) with miscarriages occurring 1–9 months before the study interview. To provide context for our analysis, participant characteristics are described in Table 1. Briefly, the mean age of our sample was 32.5 years old (range 21–44 years old) with the majority of participants being married and white. Half of the participants had a previous miscarriage and slightly fewer than half had a previous live birth. Fifty-four percent of participants reported they had been trying to conceive, 24% recounted activity that was felt to represent not trying, not preventing, and 19% recalled attempting to avoid pregnancy. Half of the participants reported wanting to become pregnant again right away after their miscarriage. We did not find that gestational age, time elapsed since miscarriage, or subsequent pregnancy affected participants' recounted experiences. Additionally, our participants' recollections of their medical care, including multiple points of contact across emergency departments, clinician offices, and ultra-sound units, were consistent with available medical records. After primary analysis, one third (9/26) of participants took part in validation activities, all of whom expressed concurrence with our findings and suggested practice implications.

We found four major themes in our analysis. First, we found that emotional reactions to miscarriage cannot be predicted by initial pregnancy intentions. Second, childbearing plans often change after a pregnancy loss, so initial pregnancy intentions are not always predictive of future goals. Third, although women vary in when they are ready to consider family planning after miscarriage, they are generally receptive to and feel supported by their health care providers offering it at the time of miscarriage care. Finally, we discovered specific preferences for family planning counseling after miscarriage, which included a sensitive and direct elicitation of a woman's future family planning goals without focus on previous pregnancy intentions, detailed information both discussed in person and provided in writing to review later, and a demonstration of empathy and compassion with a willingness to continue the discussion and provide support after the initial encounter. These themes and illustrative quotes are summarized subsequently.

Women in our study experienced a range of emotional responses to the discovery of their miscarriages, which were often unrelated to intendedness of the pregnancy. Although all participants expressed some negative feelings about their pregnancy losses, some women, including those with intended and strongly desired pregnancies, experienced only mild disappointment or feelings of inconvenience or even relief at ending a process that was uncomfortable and uncertain:

> "I told my friends, they were expecting me to cry maybe or be so upset about it, but I wasn't actually. I don't know why. I was in pain last month because of this miscarriage. I had cramping—maybe it was a relief for me to end it."—Age 39, trying to conceive

Other participants, including some with unplanned pregnancies, reported profound grief that continued to affect their lives months later. Feelings of grief were often accompanied by

self-doubt, shame, or anger toward their medical providers for not identifying the loss sooner or being able to prevent it.

> "But I was just so determined, I wanted to be a mom the second time. So, it was like set in stone for me, and then for it to be taken away was crushing."—Age 23, not trying, not preventing

> "If you would have told me the scenario, I would have thought like ok, this is something you didn't want, and it didn't work out…I think I would have found some sort of peace in it. But I don't…This was clearly not something I was planning, and it was something that I was freaking out about, and when it ended, I wanted it."—Age 30, avoiding pregnancy

Just more than half of the participants (14/26) maintained consistent family planning desires after miscarriage as compared with their initial pregnancy intentions, either desiring another pregnancy or maintaining the desire to not become pregnant. Notably, however, nearly half of participants (12/26) altered their future childbearing plans after miscarriage. For women who lost planned pregnancies, reasons for wanting to delay another pregnancy included wanting time to process, grieve, and achieve closure on the initial pregnancy as well as concerns about the effects of a potential subsequent pregnancy loss on their psyche or their families:

> "So, we decided to take a little break, at least a couple of months, because I was really exhausted after this whole experience. But we might give it another try. Then again, we have two kids at home so if it doesn't work it doesn't work."—Age 37, trying to conceive

For women with unplanned pregnancies who wanted to conceive again immediately, initial uncertainty about the original pregnancy often developed into feelings of attachment and excitement, leaving a feeling of loss or absence after the miscarriage. The process of pregnancy loss was described by one such woman as a "wake-up call," with the experience of miscarriage leading some women to realize their desires and readiness for parenthood:

> "Before this pregnancy I was like it is too late, I'm too old…and so after I got pregnant, it is like I felt like I lost something that I was holding, and I want that feeling of having a baby in my life again."—Age 44, avoiding pregnancy

Almost two thirds of participants reported that they had not received any family planning counseling at the time of their miscarriage care, meaning they were not asked about future childbearing plans or offered a discussion about contraceptive options. Additionally, many of the women who did receive counseling initiated the discussion themselves. Although future family planning was often not a central focus for women at the time of their miscarriage care, all but one participant stated they were or would have been receptive to the offer of family planning counseling and a basic discussion of options at the time of miscarriage. Women appreciated the idea of a health care provider caring about their needs and desires, and they felt it was pertinent to their care and was not inappropriate to address:

> "That wasn't even a thought in my head, so it was nice that (the doctor) had asked…It is something (women) need to think about, but I don't know if they are ready to hear it."—Age 30, trying to conceive

When asked about the ideal timing of family planning counseling after miscarriage, participants were divided. Although all understood the utility and time-sensitive nature of the discussion, just more than half (14/26) felt that they would have been too emotionally distressed to carefully consider their options or to know and articulate their future plans during their immediate miscarriage care. These women expressed that it would be better to discuss these issues at a follow-up appointment:

> "I just felt so overwhelmed that the last thing I felt like talking about was birth control…It was sort of left open to me, like if you want to talk about this, come back…It would almost be helpful to have an appointment set up already for that." —Age 30, avoiding pregnancy

Conversely, nearly half of participants (12/26) felt it was necessary to discuss everything immediately, feeling that not discussing contraception would be a missed opportunity that could present an additional burden to accessing contraception by women who wanted it:

> "First find out if that is something they want, and if it is, then go about and tell them the information…Had you given me the birth control, the prescription for the birth control right there at the end, immediately, I would have taken it…I'm not going to follow-up."—Age 41, avoiding pregnancy

Participants expressed strong opinions about the process of family planning counseling at the time of miscarriage, offering specific advice for clinicians. Women emphasized the importance of health care providers eliciting a woman's future desires and family planning needs in a straightforward way:

> "If you ask me if I want to try or not, it is not bad. It doesn't make me feel like you are intruding, no. At least it is like someone is caring enough to find out what I'm planning to do."—Age 44, avoiding pregnancy

Several participants brought up concerns about health care providers' focus on pregnancy intentions, especially in the initial line of questioning. They felt that pregnancy intentions were not always simple or well-defined and that health care providers' focus on initial pregnancy intentions could feel judgmental or alienating:

> "I see a lot of gray, because like, intentional or not, and then everything in between…That is the question that always kind of startled me. Like if I say it wasn't intentional, you know, what does it mean? Are they going to ask about rape next or are they going to tell me that I messed up on my birth control? I think that question should come up when the woman is already comfortable with the provider, not upfront when you see the person for the first minute, and then they ask you this very personal question."—Age 37, trying to conceive

Participants expressed a strong desire for information, both about their fertility after miscarriage and about different contraceptive options. They wanted to understand the choices available and to have counseling tailored to their individual situations. Many participants specifically wished they had received written information about pregnancy planning and contraception so that they could take time to decide and refer to information later. Overall, participants stressed the importance of being given clear instructions and recommendations so they were not left to wonder what they were supposed to do:

> "She just said don't try this cycle, but generally couples have sex, so I was like, do you mean we need to wear condoms or what's the deal? And she said, yeah, that's fine. And so we didn't get much guidance on it."—Age 28, trying to conceive

Finally, women described the importance of empathy and compassion from their health care providers. They wanted health care providers to recognize their emotional state and offer support and resources in addition to addressing their medical needs. Most women specifically brought up the importance of follow-up, often suggesting a prescheduled appointment to check on recovery from the miscarriage and ensure that their family planning needs had been addressed. In general, participants in our study appreciated when their health care providers inquired about their fertility goals, understanding that inquiry and discussion about family planning was rooted in supporting their needs, while simultaneously being sensitive to the fact that a woman may not yet know their immediate plans:

> "Making it very clear to the person that has experienced this miscarriage…'I don't need your answer right away. We don't have to have this conversation, but I want you to have this (information) to let you know that I care and that there is someone that cares and just wants to help you through this, and wants to let you know that if you are looking to try right away or start back (on birth control), you know, I can help you.'"—Age 30, avoiding pregnancy

DISCUSSION

Regardless of original pregnancy intentions or initial reactions to the pregnancy, all participants expressed some negative feelings about their pregnancy losses. Participants reported varied future childbearing plans after miscarriage, some consistent with plans before miscarriage and some altered based on their experiences with pregnancy loss. Although participants were divided between wishing to have a full discussion at the time of miscarriage management compared with at a follow-up visit, almost all participants were receptive to being asked about future childbearing plans and being offered information about fertility planning or contraception during miscarriage care.

Our thematic analysis revealed that preconception pregnancy intention was not a useful construct to guide care after miscarriage. This discovery is consistent with emerging literature showing the limitations of intendedness as a measure for women's complex thoughts, feelings, and desires about pregnancy.[17–19] Additionally, participants sometimes felt taken aback when asked directly about their pregnancy intentions. Instead of inquiring about pregnancy intendedness as a proxy for attempting to understand patient care needs, participants recommended health care providers ask directly about their patients' future goals and supportively offer contraceptive counseling and options.

There are limited published studies that address women's family planning needs and counseling preferences at the time of care for miscarriage. Wallace et al[11] found that women experiencing miscarriage desired compassion and interpersonal connection with health care providers and were able to consider management options and to identify those that best align with their goals and values. Based on an evaluation of miscarriage management in rural Senegal by Cisse et al,[20] which found that increased postmiscarriage contraceptive

counseling was associated with increased uptake of contraception, there is some evidence that women experiencing miscarriage have an unmet need for contraception and find contraceptive counseling acceptable at the time of miscarriage. To address offering reproductive life planning and contraceptive counseling in a primary care setting, emerging research aims to promote nonjudgmental and patient-centered assessments of family planning needs and goals[21] with unknown transferability to the postmiscarriage timeframe. Our study addresses knowledge gaps in the U.S. population and suggests that patients are likely to be receptive to nonjudgmental, patient-centered assessment of family planning goals and needs at the time of miscarriage care.

As a qualitative research study, this study is not meant to be generalizable.[13] We acknowledge that our findings are based on a small nonrepresentative sample from a single midsized city. Additionally, despite attempts to optimize heterogeneity within our sampling framework, participants were all adult women who were more than twice as likely as the general population to be college graduates and 50% more likely to be married.[22] Based on age, marital status, and income, participants were statistically more likely than the general population to have had intended pregnancies[2]; however, half of them still wanted to delay another pregnancy. Additionally, nearly all participants were receptive to the offer of contraceptive counseling during their miscarriage care, which could suggest an even greater interest in the general population. Finally, although participants did express a wide range of feelings toward their pregnancies, including some who had considered pregnancy termination, no participants admitted actively seeking an abortion before experiencing miscarriage. This may reflect how participants retrospectively processed their losses or could reflect selection or social desirability biases from recruitment relying on self-referral, preventing us from capturing the full range of experiences in our sample. Additional research is needed to explore whether other patient populations have similar experiences and preferences for care.

Our study shows that family planning counseling, approached sensitively and with the aim of helping patients achieve their reproductive goals, is acceptable to and appreciated by women receiving miscarriage care. Based on our thematic analysis and specific message testing, we suggest offering women the option to choose or defer counseling and contraceptive provision by asking all women receiving care for miscarriage, “Is this an okay time to talk about whether or when you might want to become pregnant again?” or “Would you like any information at this time about planning for future pregnancies or about birth control?” This allows women to identify their informational needs and optimal discussion timing while creating an opportunity for education about return to fertility and the availability of family planning resources. We also encourage the development of written educational materials specifically addressing the complicated emotional and medical considerations to family planning after miscarriage. Counseling itself should be guided by direct and compassionate inquiry into patient goals and desires, and the timing and content of the discussion should be individualized to provide support for each woman’s personal needs.

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Table 1.

Participant Characteristics (N=26)*

Characteristic	n (%)
Age (y)	
18–24	2 (8)
25–34	14 (54)
35–45	10 (38)
Relationship status	
Married	19 (73)
Not married	7 (27)
Race	
White	17 (65)
Black	8 (31)
Other	1 (4)
Insurance type	
Private	17 (65)
Public	8 (31)
None	1 (4)
Income (% of federal poverty level)	
Greater than 300	12 (46)
100–300	9 (35)
100 or less	5 (19)
Education level	
Graduate degree	9 (35)
Bachelor’s degree	9 (35)
Some college	5 (19)
High school or general equivalency diploma	3 (12)
Prior live birth	11 (42)
Prior miscarriage	13 (50)
First location of miscarriage care	
Doctor’s office or clinic	15 (58)
Emergency department	11 (42)
Original pregnancy intention	
Trying to conceive	14 (54)
Not trying, not preventing	7 (27)
Avoiding pregnancy	5 (19)
Future childbearing plans	
Conceive again immediately	13 (50)
Postpone a short time	7 (27)
Postpone longer or indefinitely	6 (23)
Received family planning counseling during miscarriage care	
Yes	10 (38)

Characteristic	n (%)
No	16 (62)

* Proportions may not add up to 100% as a result of rounding.