Psychological Experiences of Women Who Had Spontaneous Abortions in Budiriro Suburb, Harare, Zimbabwe

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***Abstract*: The purpose of this study was to explore the psychological experiences of women who had spontaneous abortions in Budiriro suburb in Harare Metropolitan Province. The qualitative approach and phenomenology research design were used to describe the experiences of women who had spontaneous abortions. Data was collected through in-depth interviews and focus group discussions. The collected data showed that women who miscarry experience dysphoria, cognitive disorganization and health deficit. Barriers for timely seeking of counselling after miscarriages were social stigma, treatment fears, anticipated utilities and risks (expected help or lack of help to be obtained from a therapy), social norms and race and ethnicity background. The study recommends that the disclosure of spontaneous abortions can be improved through providing clear pathways, utilizing care networks, eHealth for miscarriage support, community-initiated interventions and use of spiritual intervention. The Ministry of health may also introduce programs which encourage women who have experienced spontaneous abortions to seek mental health counselling.**

Keywords: **Spontaneous abortions, women, psychological, depression, miscarriage**

I. INTRODUCTION

Worldwide, Nfii (2018) asserts that around 12 to 15 percent of pregnancies result in spontaneous abortions. Webb (2017) also alluded that about 30 to 50 percent of women suffer from anxiety with 10 to 15 percent of the survivor's experience depression which could span over a period of four months. Meanwhile, in Africa information and knowledge regarding the miscarriage experiences is still scarce (Evans, 2021). Spontaneous abortion was the most regular negative pregnancy result with frustrating emotional outcome for the survivors and their families (Evans, 2021). As such, lack of adequate information regarding miscarriages or maternal and reproductive health-linked pointers would result in some pregnancies and miscarriages remain unrecorded or reported. In such cases, antenatal care (ANC) services are established from the whole number of women who gave birth in a certain time frame excluding about 30 percent of pregnancies lost through miscarriage or stillbirth (Mark, 2016). As a result of this, data on spontaneous abortions rates in low-income and middle-income nations like Zimbabwe remains scarce (Bauserman et al., 2020; Bearak et al., 2020).

According to Bearak et al (2020), studies carried out in developed nations defines miscarriages through distinguishing pregnancies from five to six gestation weeks' pregnancies that is after the last menstrual period. Consideration of early miscarriages detected by the human chorionic gonadotropin (hCG) or ultrasound before the development of a fetal heart movement, the stated rates were closer to 30 percent (Liamputtong & Abboud, 2003). Some women have risk factors also known as an attribute that escalates prospects of development of a particular condition in women. Shurack (2015) confirmed that miscarriages risk cases vary with 12 to 15 percent in women aged around 20 years and increases to almost 25% in women aged 40. Equally important, Viotti (2020) argued that chromosomal abnormalities lead to age-linked miscarriage risks with almost half of the spontaneous abortions occurring during the first trimester due to some chromosomal defects which could be inherited or found in the male's sperm or female's egg. Thus, genes would define all of a human being's physical components like hair, eye color, sex and type of blood. However, Shurack (2015) argued that majority of chromosomal challenges happen through chance and not linked to the health of the father or the mother.

Van de Akker (2012) also contented that miscarriages could be caused by a number of unknown and known reasons like workplace exposures to an environment like radiation or poisonous substances, infection, hormonal abnormalities, inappropriate insertion of a fertilized egg on the uterus wall and maternal age among others. Viotti (2020) further argued that spontaneous abortion can also be caused by lifestyle factors like alcohol consumption, smoking, drug abuse, immune system ailments like lupus, severe kidney ailment, inherited heart disease, uncontrollable diabetes and medication or drug prescriptions. Shurack (2015) alluded that there was no adequate evidence that stress, sexual encounter or physical activities can result in miscarriage. Alhusen (2008) expressed that miscarriage survivors could react emotionally through strong expressions with majority of the women suffer a sudden decline in their health and mental activity. Major grief expressions among the survivors include sadness, shock, numbness, confusion, insomnia, anger, loneliness, lack of appetite and guiltiness which is also observed through decline in self-esteem and opinions of treating oneself as a biological failure or someone who has failed to conceive (Amato, 2008). According to Amato (2008), some increased intensities of grief can also be experienced by miscarriages and stillbirth survivors

which could also affect the survivors even when they conceive again.

Compared to other forms of child losses, miscarriages were confirmed to not attract sympathy and support like other types of loss with the baby's existence as a real human being only confirmed by the parents who had developed an attachment to the fetus (Jennings, 2011). Consequently, women would feel lonely and unsupported in their grief of their miscarriage given that the society mourns a fully developed and born baby (Brier, 2008) and the author referred the denial for women's bereavement as disenfranchised grief. Brier (2008) added that the feelings of loss by the women would then grow to include shame, guiltiness and discriminated by the society that could not be able to share her grief feelings.

There is insufficient awareness of the psychological problems and discussions concerning women who had suffered miscarriages in Zimbabwe. Besides the miscarriage occurrences and the ensuing psychological distress that occur, inadequate studies have been instigated to explore the psychological impact of the miscarriages on women. Limited clear meanings exist to explain the subject with discrepancy in the conceptual meaning persists which continues to prevent reduction of psychological challenges in women who have suffered miscarriages (Fenstermacher & Hupcey, 2013).

I.1 Aim

To explore the psychological experiences of women who had spontaneous abortions in order to generate strategies that can be adopted by the mental health professionals.

I.2 Objective

The research intended to explore the psychological experiences of women who had spontaneous abortions in order to proffer possible strategies that can be adopted by the mental health professionals.

The specific objectives of the study were to:

i. To explore the different psychological experiences of miscarriages on women.
ii. To identify the barriers affecting women who seek counselling after miscarriages.
iii. To generate evidence informed strategies that can be employed to improve mental health services to women after experiencing a miscarriage.

II. METHODOLOGY

II.1 Population

The target population of this study was women in Budiriro suburbs who once experienced a spontaneous abortion in their life time together with therapists from Budiriro clinic who have an interface with a number of these women.

II.2 Sampling and sampling techniques

Snowball sampling was used to sample the population. According to Parker, Scott and Geddes (2019), snowball sampling is a non-probability sampling technique which mostly relies on social networking and referrals. Due to the sensitive nature of the subject of miscarriage, snowball sampling was used with more thoughtfulness and respect (Portney & Watkins, 2015). The process started with a few first contacts who were requested to become research respondents as they fit the research criteria. Participants who agreed to take part in the study were asked to recommend other people who fit the research criteria, who would be willing to take part in the study. The sample size had ten participants which comprised of eight women who experienced spontaneous abortions and two therapists.

II.3 Data gathering instrument

The researcher used in-depth interviews and focus group discussions to collect data. In-depth interviews were considered relevant since the researcher wanted to gain full insight of the psychological experiences of women who had spontaneous abortions from both the women's perspectives and the therapist' perspective. Furthermore, focus group discussions were utilized to elicit a multiplicity of views and emotional processes. The main purpose of focus group research is to draw upon respondents' attitudes, feelings, beliefs, experiences and reactions in a way in which would not be feasible using other methods. These attitudes, feelings and beliefs were more likely to be revealed via the social gathering and the interaction which being in a focus group entails. Furthermore, spontaneous abortions are a sensitive and complex subject which required the researcher to formulate research questions and investigations in confidential and acceptable manner to the participants so as to fully acquire the required data.

II.4 Procedure

The Budiriro suburb and clinic are under the jurisdiction of the City of Harare who gave the researcher permission to collect data from this geographic area. The clinic's matron and other nurses together with the Friendship Bench members assisted the researcher to locate relevant research participants. This was subject to the availability and willingness of these people as well as the participants. The researcher observed the following ethics: voluntary participation, confidentiality, anonymity and informed consent. The research instrument for both in-depth interviews and focus group discussions were designed in English and translated into Shona. The responses were translated back to English by the assistance of a professional translator. The consent forms were also translated to Shona to enable the participants to fully comprehend the research in which they were participating in.

II.5 Design

A phenomenology research design was used for this study. According to Guerrero-Castaneda et al (2017), a phenomenological research design is used in situation where information about a certain subject is limited or scarce. This research design supported in-depth interviews which enabled the researcher to obtain first-hand information from the participants.

II.6 Data analysis

The data was analyzed thematically (Smith, 2017). The summarized result and transcription were analyzed using thematic analysis. The thematic content analysis of the interview data was done in the following five steps (Sarantakos, 1998), transcription, checking and editing, analysis and interpretation, and verification. The major themes and sub-themes were then given some codes and categorized into similar subjects.

III. RESULTS AND DISCUSSION

The results from this study revealed that majority of women that have suffered spontaneous abortions experience a number of challenges like dysphoria, anxiety, stigma and discrimination from the society. They fear to disclose their experiences and there is limited therapy services to reduce these challenges.

III.1 The psychological experiences of miscarriages in women

Psychological experiences of miscarriages in women were described to result in dysphoria, cognitive disorganization and disrupted social and occupational functioning.

III.1.1 Dysphoria

One participant who suffered from dysphoria stated, *"I was always angry and depressed besides getting comforting words from my husband and relatives. I was mostly affected when seeing other women holding their babies. That was my second miscarriage and I am yet to get hold of a baby after 4 years of marriage".*

III.1.2 Cognitive disorganization

A nurse who frequently assist women who suffer spontaneous abortion confirmed that it is difficult for the women to accept the loss. The nurse stated that,

"A number of women will find it difficult to accept the loss. Some would need company all the time due to some high stress levels."

III.1.3 Social and occupational function disruption

Whilst other focus group participants expressed various opinions, one member expressed that the after effects of the miscarriage affects her work performance. She stated that,

"At work, my workmates were avoiding me saying l had used my pregnancy for rituals so that my husband's business prospers. They did not know that l was married for three years without a baby which is stressing me"

III.2 Barriers that affect women who seek counselling after miscarriages

The participants showed that women fail to seek counselling services after miscarriages due to social stigma, treatment fears, anticipated utilities (expected help or lack of help to be obtained from the therapy) and risks (personal judgment of the possible hazards of communicating their emotions with a professional mental health counsellor), social norms and race and ethnicity.

III.2.1 Social stigma

One woman who is a spontaneous abortions survivor failed to get counseling services due to social stigma as she was taken as insane, crazy or suffering from mental illness. The stated that,

"People fear to seek therapy since they fear to be labeled as suffering from mental challenges"

III.2.2 Treatment fears

Again, spontaneous abortions survivors fail to seek counselling and therapy services due to treatment fears. Some would think that the therapists would not fully understand them and some of the therapists could be inexperienced and of despicable stature. A focus group discussion participant revealed that,

"I feared the process one goes through when receiving counselling. It stresses and reminds one of the horrors you go through when losing pregnancy. I feared to be admitted at the psychiatric center as a patient"

III.2.3 Anticipated utility and risks

Moreover, research respondents described that anticipated utility and risks could also inhibit miscarriage survivors from accessing counselling and therapy services. This is taken as the risk and perception of discussing their feelings with a counselor. A woman during a focus group discussion responded that,

"I chose to be alone than to seek counselling or treatment services. I mistrust counsellors especially that information may leak."

III.2.4 Social Norms

A number of participants stated that social norms also affect how miscarriage survivors access counselling services. One woman who suffered a miscarriage replied that,

"I can confirm that a number of miscarriage survivors tend to be influenced by their peers on whether to or not to seek counselling services. I am one of such persons who took time to seek medical assistance due to peer pressure."

III.2.5 Race and Ethnicity

Some respondents stated that races and ethnicity also determine if a miscarriage victim would seek professional services or not. According to Hunt et al. (2009) a person's cultural norms, beliefs and values could form an obstacle to seek professional mental health services with some societies considering it forbidden and sometimes regarded as a waste of time and money. One focus group participant mentioned that,

"Africans do not value professional counselling. We trust our medicines especially the traditional healers who give herbs to cleanse the womb. For Zimbabweans, most people do not seek professional health or mental care when they suffer miscarriages."

III.3 Strategies to improve mental health services to women after experiencing a miscarriage

Strategies like providing clear pathways, utilizing care networks, eHealth for miscarriage support, community-initiated interventions and use of spiritual intervention can improve mental health services to women who have suffered miscarriages.

III.3.1 Providing clear pathways

Survivors of spontaneous abortions confirmed that there were no clear procedures on how one may get mental support after suffering miscarriage. There is lack of information and advice on where to get the services in the community. One focus group participant responded that,

"Here in Budiriro if one suffers a miscarriage she does not know where to seek help. At the local clinic the staff is not helpful especially on advice on how you can be assisted. I suggest the staff should be equipped with all the information."

III.3.2 Utilizing care networks

Use of social support care networks can assist in improving access to mental health care by miscarriage survivors. It is imperative to rope in the formal and informal care network members to assist in provision of mental health services besides that informal support network is made up of untrained care givers, most participants advocated for its importance. A woman who survived a miscarriage replied that,

"Utilizing care networks can improve access of mental health care by miscarriage survivors. Miscarriage survivors could either choose either to engage formal or informal care network service providers depending on their relationships, costs and sustainability."

3.3.4 eHealth for miscarriage support

Miscarriage survivors confirmed the need for the government and the other private partners to introduce electronic health for miscarriage support. Besides using internet-based programs, women seeking assistance can make use social media platforms or direct calls to their psychosocial-support providers. One focus group discussion participant confirmed that,

"Zimbabwe should move with the developments in the modern world where electronic health services can be offered to miscarriage survivors as an alternative to face to face services".

3.3.5 Community initiated interventions

Mental health services for miscarried women can be improved through implementing the community-initiated interventions. Community initiated interventions are flexible and can be implemented with the use of limited resources. One miscarriage survivor mentioned that,

"It is also important to implement home-made initiatives like the Friendship Bench which is found in Harare City Council health services. Imagine the use of community health care workers have transformed many cases of mental health challenges"

3.3.6 Use of spiritual intervention

Mixed methods of intervention like the use of pastoral care givers can also improve access to mental health services. Some pastors and church personnel have skills to deal with mental challenges which result from spontaneous abortion. One focus group discussion participant mentioned that,

"In my case l got much help from the church. There are some pastors that have trained in counselling and to handle cases of people with different problems."

IV. CONCLUSION

The study revealed that women who had spontaneous abortions experiences various psychological challenges like dysphoria where they will always be angry and depressed when they think of their loss. Again, the women suffered cognitive disorganization when they find it difficult to accept the loss and some would always need company of someone to reduce the stress levels. Spontaneous abortions were discovered to cause social and occupational function disruption particularly in some working females who could not be able to cope up with their work requirements particularly when the work environment can result in some negative stressing factors.

Furthermore, some of the women who suffer spontaneous abortions fails to seek counselling services due to various barriers like social stigma wherein they will be thought to be insane, crazy or suffering from mental illness. Again, the survivors would have treatment fears and some would think that the therapists would not fully understand them and some of the therapists could be inexperienced and of despicable stature. The results also showed that some survivors would suffer from anticipated utility and risks which could be mistrusting the counsellors that their information would leak. Social norms were also considered to influence how the miscarriage survivors would access counselling services especially when peers, relatives and spouses would discourage them from seeking counselling services and encourage them to heal naturally. Race and ethnicity were also considered as a critical barrier for miscarriage survivors to seek counselling services with some choosing to heal naturally or through consulting traditional healers for cleansing.

Finally, there are a number of strategies that can be implemented to improve access to mental health services to women after experiencing a miscarriage. Provision of clear pathways to survivors of spontaneous abortions could improve access to counselling and mental health services. Moreover, survivors can also use social care networks which comprise of formal and informal care network members to assist in provision of mental health services. The Ministry of Health and Child Care and private partners may also introduce an electronic health support service which can be operated in the absence of physical boundaries. Community initiated interventions may also be adopted since they are flexible and can be implemented with the use of limited resources like the

Friendship Bench Initiative. Consequently, the use of spiritual interventions through some trained pastoral care givers can also improve access to mental health services. Some participants expressed that pastors and church personnel have skills to deal with mental challenges which result from spontaneous abortions.

V. RECOMMENDATIONS

i. That the Ministry of Health and Child Care could introduce programs that encourage women who have experienced miscarriages to seek mental health counselling. The community health workers need to be visible and known in their areas of operation which could be useful to guiding the miscarriage survivors to access mental health services. It is also imperative for the Ministry of Health and Child Care to increase the number of personnel trained in counselling services so that they help communities when they come to the health facilities seeking help.

ii. That the Ministry of Health and Child Care is also recommended to work with other partners to assist in solving the psychological challenges faced by women who had spontaneous abortions. Again, workable strategies can be put in place through working with the survivors, community and other partners like Friendship Bench, churches and community leaders.

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