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"My Fruits Never Ripen": Risk Factors of Anxiety among Zimbabwean Married Childless Women with Recurrent Miscarriages

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Abstract:
The study sought to explore risk factors of anxiety among married childless women with recurrent miscarriages. Purposively selected were eleven married childless women (mean age 31; mean number of miscarriages 3) with recurrent miscarriages. Data saturation determined the sample size. A qualitative case study was used with semi-structured interviews, which were conducted in the 4-month period of data collection. Data was narrated then analysed using thematic analysis. Major findings were that anxiety emanated from psychological, social and physical effects encountered following recurrent miscarriages. The effects acted in their individual capacities and in complex interactive ways in causing anxiety. The women expressed feelings of depression, despair, guilt, fear of divorce and of never being mothers, anger, and anticipatory and real grief were respectively experienced before and after miscarrying, self-blame and blame from significant others through questioning their biological make-up. These emotions were compounded by social factors, which included stigma, strained relationships with spouse and with in-laws, and being withdrawn. Physical factors encompassed abdominal pains and cramps, sleeplessness, fatigue, chronic headaches and loss of appetite resulting with weight loss.

Keywords*: Risk factors, anxiety, married, childless, miscarriage*

1. Introduction

In most developing countries, children remain a vital component of the marriage institution since dowry is viewed as a social exchange for child-bearing by married women (McClokey, Williams & Larsen 2005). In this regard, married childless women with recurrent miscarriages are pressured by societal expectations of procreation. Hence, most married women go to great lengths in wanting to fulfill this obligation, not only for them to feel whole, but also mostly to please their husbands and in-laws. They want to quickly get pregnant again and are always stressed out by being vigilant with their life-styles in an attempt to avoid miscarriages, and hence suffer chronic anticipatory anxiety

before, and real anxiety after they lose each of their successive pregnancies (Carr, 2011). Globally, women experience grief on their own following the loss of pregnancy since in most cultures babies lost through miscarriages are not mourned in the same way as those of the death of live ones (Murphy & Philpin, 2010). In Zimbabwe, for example, it is taboo to mourn babies that die before reaching their teething age, and more so those lost through miscarriages. Thus, the women's social networks are not likely to give adequate psychosocial support because they do not fully comprehend the meaning of the loss (Wing, Burge-Callaway, Rose-Clance & Armstead, 2001). Loss of the only expected child is very traumatic as the childless women have no other children to care for (Dyregrov, Nordanger & Dyregrov, 2003).

This is against the background that an unborn child is a psychological extension of the expecting parents (Centre for Disease Control and Prevention, 2012). Shoko (2013) also argues that just because no child was born does not mean a woman did not love, lose or mourn its loss because it was a baby, it was someone, even if the parents never saw the color of its hair or shape of its face, a baby was there just the same. Pregnancy loss is not considered as any big loss yet grief for women, after miscarriage, is similar to that after the death of a loved one and is independent of age or number of losses (Carr, 2011). As such, miscarriages have poor grieving outcomes and have potential trigger for complicated forms of bereavement, which are accompanied by psychotic episodes because there is no public acknowledgement of the loss. Zimbabwe's Own Parenting Magazine (2016) describes such grief as being hidden sorrow, disenfranchised or unprocessed in the sense that the loss is not socially validated because while the loss is real, the women are not accorded the right to grieve.

Globally, approximately 13 to 20% of recognized pregnancies are miscarried, with older women being more likely to miscarry: The risk being 1 in 5 (20%) when a woman is 30, 1 in 2 when she is 40, and 3 in 4 when she is 45 (Oliver-Williams, Heydon, Smith & Wood, 2013). Borg and Lasker (2015) cite a US-based multi-country study whose findings were that out of about 3.7 million recorded pregnancies each year, 900 000 married couples had miscarriages. Within the major industrialized nations of the world, the rate of pregnancy loss has been about 14 to 22 per 1 000 live births since 1980 (Centres for Disease Control and Prevention, 2012). Recurrent miscarriages mean continued loss of the anticipated primary care-giving and parenting roles (Meij, Stroebe, Schut, Stroebe, Bout, Heijden & Dijkstra (2007).

Makaripe (2013) posits that though miscarriages among married childless women are a common problem, little effort has been made and very few studies have considered the resulting effects or shown the severity of the effects on the mental wellbeing of the women, who continue to suffer. Thus, it is in view of the anxiety suffered by married childless women with recurrent miscarriages that the current study aimed to explore the risk factors of anxiety they experience. Knowledge of such factors could enable the designing and implementation of intervention strategies to alleviate the problem.

2. Risk Factors of Anxiety among Married Childless Women with Recurrent Pregnancy Losses

Carr (2011) observed that married childless women with recurrent miscarriages displayed several symptoms in the emotional, social and physical domains, which brought about devastating suffering to the women as well as to their significant others.

2.1. Emotional Risk Factors

Regarding emotional risk factors, among married childless women with recurrent miscarriages, Shreffler, Greil and McQuillan (2012) posit that the women are prone to suicide ideation, stress which affects their decision-making, hopelessness, loss of interest in activities they were normally interested in, and a decreased sense of self-worth. Such emotions are often triggered by environmental factors of coming into contact with babies, hearing a baby cry and/or seeing baby clothes or toys. Consequences of recurrent miscarriages shatter future hopes and dreams of motherhood, and this is exacerbated by loss of self-esteem, and concern over inability to fulfill an obligation they owe to themselves and to their spouses (Lamb, 2002). A common effect of the resulting grief is depression, manifesting itself in sadness, which can be accompanied by crying and staying stuck in anger without one realizing it. And the unpredictable nature of the causes of most miscarriages keeps the women ever fearing during pregnancy.

2.2. Social Risk Factors

Socially, married couple relationships are threatened, and women suffer the most due to being blamed for not fulfilling a role as it is them who are expected to successfully carry the pregnancies (Rosebaun, 1992). Shreffler et al (2012) posit that there is increased strain on marital relationships, which may lead to divorce. Couples may also not connect emotionally, and this strains their relationships, with marriage disharmony, a situation which may further exacerbate chances of future pregnancy losses (Maritz, Poggenpoel & Myburgh, 2008). There can be stigma, sexual dysfunction, reduced intimacy and husbands having extra-marital affairs, which induce fear of separation and/or of contracting HIV/AIDS (Lasker & Toedter, 2000).

Feyisetan and Bankole (2002) posit that in most African societies, children give status to women and their families. In such societies, recurrent miscarriages by married childless women are largely socially-construed because it is not perceived as a result of a medical/biological condition (Shoko, 2013). Rather, it is associated with the women being under a curse or being involved in witchcraft or considered to be possessed with demonic or evil spirits or are accused of having had a history of promiscuity or of having previously terminated pregnancies or accused of being wives of avenging spirits and therefore cannot conceive by other men. Thus, in Nigeria for example, such women suffer from open ridicule, social isolation, stigma, economic deprivation of inheritance, and rejection by in-laws and by society at large (Slobodin, 2014). As a remedy, the women are sometimes subjected to harsh traditional ways of attempting to correct the situation, and remedies include taking concoctions as herbs, and having forced and/or consented sex with traditional healers, which increase chances of them contracting HIV/AIDS. Frustrations may also result with dysfunctional communication between the women and their spouses, a situation which may culminate in various forms of abuse being perpetrated on them.

2.3. Physical Risk Factors

Research evidence shows that most women encounter several physical problems that culminate in them suffering from anxiety post miscarriages (Bedehorst, Riches, Turton & Hughes, 2006), and these include excessive bleeding. The women also undergo surgical redressing procedures to cleanse the uterus of retained products after miscarrying. In cases where the women's personal hygiene is not a priority, there are high chances of cervical cancer (Fraser and Cooper, 2009). This leads to headaches and worry about recovery and whether or not one will be able to conceive and carry the next pregnancy to full term. The resulting anxiety further causes loss of appetite and this results with weight loss, which is a normal way bodies respond to the traumatizing situations (Bongaarts, 1984)

3. Goals of the Study

In view of the given background, the study aimed to explore experiences of anxiety among married childless women with recurrent miscarriages. Knowledge of such experiences could go a long way in improving the wellbeing of the women by playing a decisive role in interventions targeting communities. In this regard, the following objectives guided the study: To

- Explore psychological, social and physical-related experiences of anxiety among married childless women with recurrent miscarriages
- Analyse the women's views on interventions they anticipated to be put in place

4. Scholssberg's 1995 Transition Theory

Scholssberg's transition theory guided the study. According to Evans, Forney and Guido-DiBrito (1998), one's perceptions of a transition are determined by its type, context, and impact. The 3 types of transitions are the anticipated, unanticipated and non-events. In the study, all the 3 types applied to married childless women with recurrent miscarriages: The pregnant women anticipated having live, full-term babies but had unanticipated miscarriages which were unpredictable and were non-events. Secondly, the context of the recurrent miscarriages was that the women were married and childless. Lastly, the impact of the transitions, being miscarriages, was determined by the degree to which recurrent miscarriages altered the women's daily life as individuals and with respect to significant others.

The theory also gives 4 factors that influence one's ability to cope with a transition and these are the situation, self, social support and strategies. In the study, the situation was that of being married, childless and having recurrent pregnancy losses; The self had to do with how the women reacted to miscarriages, which could have varied depending on various factors such as the number of losses they had already had, their ages and how they valued their losses; The presence or absence of social support, be it from intimate-partners, family, friends and communities, also influenced how the women coped; By virtue of their different demographics, the women could have used various coping strategies.

5. Methodology

5.1. Design

A case study design, premised on qualitative research, was used with semi-structured interviews, which had open-ended questions that allowed the married childless women with recurrent miscarriages, to narrate their experiences. The given in-depth data was in the women's own words.

5.2. Participants

The study was conducted at Chitungwiza Central Hospital's female ward for cases of miscarriages. Purposive sampling was used to identify married childless women who had had 2 or more recurrent miscarriages, and were admitted in the female surgical ward post recent miscarriages during the 4 months of data collection. The sample of 11 women was determined by data saturation.

5.3. Data Collection Procedure

Permission to conduct the study was obtained from the Midlands State University and from the Chitungwiza Central Hospital administrator and superintendant. Ethical approval was sought from the Midlands State University's institutional research board. In observation of anonymity, real names were not used, but the women were identified using pseudonyms of their choice. Informed consent, confidentiality and privacy were the other ethics that were observed. To increase validity and reliability of the questions, pre-testing was done.

5.4. Data Analysis Procedure

Data from interviews was narrated after which it was thematically analysed using Zhang and Wildemuth's (2005) stages of familiarization, conceptualization, cataloguing and reviewing concepts, and defining themes. Because interview questions were premised on the study's objectives, the emerging themes revolved around these objectives. The themes that emerged as experiences post recurrent miscarriages were that the married childless women encountered psychological challenges, which were compounded by social and physical problems.

6. Results

All interviews started with questions regarding the women's age, years in marriage, stage of pregnancy at which most miscarriages occurred, and number of miscarriages they had had. This information was deemed important in that the miscarriages and related anxiety was due to variables entailed in answers to respective questions: About age, it could have influenced the degree of anxiety because, in the case of young women, they could have had fewer miscarriages and could have been hopeful of having full-term pregnancies, unlike older women. On the other hand, the number of years in marriage could imply the extent of anxiety as longer marriages might have indicated greater pressure for one to procreate. Regarding stage at which most miscarriages occurred, women who miscarried in early stages of pregnancy could have suffered less anxiety compared to those who miscarried in late pregnancy as other people would have noticed the pregnancy, also that their hopes would have been high for having full-term babies. Lastly, having had more miscarriages could have implied greater chances of anxiety due to loss of hope for having full-term pregnancies.

Table 1 shows the married childless women's demographic data

Name	Age	Years in marriage	Months of most miscarriages	Number of miscarriages
Petty	29	4	3	2
Dheki	24	3	2	2
Lydia	31	6	3	3
Tida	42	15	4	6
Shupikai	35	11	1	4
Tsitsi	22	2	3	2
Chido	27	4	3	2
Farai	38	10	5	4
Carol	33	8	1	3
Wendy	36	10	2	4
Tapiwa	25	2	2	2

Table 1: The women's age, years in marriage, stage of most miscarriages and number of miscarriages

The mean age of the women was 31, and the mean duration in marriage was 7 years. Most miscarriages occurred in the first trimester and the mean number of miscarriages was 3. This could imply that the study's findings were greatly influenced by women aged around 30, and who had been married for a number of years and had had at least 3 miscarriages mostly in the first trimester.
The next section is on experiences encountered by the women and these are narrated guided by themes and respective sub-themes that emerged from the interviews. The experiences are views of the majority of the women expressed in their own words. While psychological experiences mostly pointed at negative emotions, social experiences were indicated by poor inter-personal relationships, and physical experiences were related to physiological problems.

Table 2 shows themes and respective sub-themes that emerged

Themes	Sub-themes
Negative emotions	Depression Grief: Anticipatory and real Fear of future miscarriages and divorce Questioning own womanhood
Poor inter-personal relationships	Strained relationships with spouse and in-laws Stigma Easily irritable Withdrawn
Physiological problems	Chronic headaches Fatigue: Sleeplessness Weight loss

Table 2: Themes and sub-themes

The theme on negative emotions was demonstrated by the women reporting on symptoms of depression, grief, fear of future miscarriages and divorce, and questioning their womanhood. The second theme, which was poor interpersonal relationships was evidenced by the women reporting to have had strained relationships with their spouses and in-laws, having been stigmatized, being easily irritable, and being withdrawn. Lastly, physiological problems were illustrated by reports of chronic headaches, fatigue due to sleeplessness, and weight loss.

- Theme 1: Negative Emotions

Nine of the eleven women reported that they had developed serious emotional instability related to miscarriages they continuously had.

- "I have feelings of despair whenever I look at baby clothes I bought in preparation for my expected first baby. I have kept the clothes hoping that each pregnancy will successfully come to full-term but sadly, the wait has been long and all in vain", said Carol, as she struggled to hold back tears.
- "I worry before I get pregnant, and after I conceive I feel like I'm mourning because I become very painfully vigilant with my lifestyle hoping that I won't do anything that may trigger yet another miscarriage. The problem is I have tried all the medical suggestions and possible solutions but to no avail", reported Wendy, looking at me expectedly as if I could provide answers to her problem.

Tida sadly said

- "I always fear how many more miscarriages I can withstand before I can hold a baby in my arms. I wonder when all this drama will come to an end. I'm fast approaching middle age, and with menopause I will be past the age of fertility, and so, that will be that".

In questioning her womanhood, Lydia retorted

- "What bothers me and what I don't understand is the fact that by virtue of me being able to conceive, it means my reproductive biological make-up is ok. But what is wrong with me? What causes my womb not to hold my babies for 9 months? Imbeuyi isingasviki (My fruits never ripen)"

- Theme 2: Poor inter-personal relationships

Most of the women expressed having uncordial interpersonal relationships with their spouses, in-laws, friends, and with society at large.

Shupikai helplessly said

- "I have been married for long now but I now fear that my husband is losing hope of me ever giving him children. I suspect that he might either divorce me or he might be already having extra-marital affairs, then I will end up infected with HIV/AIDS. My in-laws also ridicule me for having paid dowry for nothing."
- "I no longer feel free to go to church and to attend social gatherings as familiar people always look at me with questioning eyes. Some have even the guts to ask me if I have tried prophetic healing and traditional means. Everyone suggests something, and it's all confusing", reported Chido, while emptily gazing into space.
- "I am very easily irritable even at the slightest provocation. I only sometimes realize this after I will have already over-reacted to people close to me. At least my husband understands and tolerates me," retorted Tsitsi.

Tapiwa reiterated

- "I now prefer my own company as I'm suspicious of even my friends and relatives. I suspect they pretend to have come to console me yet actually want to assess how bad I feel about my situation, and to hear what my next solution is going to be."

- Theme 3: Physiological problems

- "When I first got married I drew up a list of names for boy- and girl-children but my dreams have been shattered. The names and baby clothes I bought for my first pregnancy haunt me and I have developed chronic headaches," responded Lydia, and Tsitsi hopefully said
- "I always wonder why I get pregnant in the first place as it would have been better not to get pregnant at all so that I know I am infertile. Such thoughts give me sleepless nights, and I always feel fatigued due to inadequate rest."

A dejected Petty said

- "I do not feel like eating anything, and I have lost a lot of weight. This could be contributing to me having more recurrent miscarriages, a situation which makes me feel guilty. My friends also complain that I am neglecting myself but there's nothing much I can do about it."

7. Discussion

The study explored risk factors of anxiety among married childless women with recurrent miscarriages. Results indicated a combination of psychological, social and physical risk factors, all of which contributed to anxiety suffered by the women. In concurrence, Kernsa and Klierb (2004) posit that miscarriages often result with increased risk of anxiety due to various factors. This finding is also consistent with Lamb's (2002) USA Virginia State study which found that pregnancy loss presented a significant life crisis. In further support of the findings is Carr (2011), who cites a UK study which explored trauma experienced after miscarriage. The study thematically analysed 26 messages posted on 9 pregnancy fora, and findings showed several symptoms in the behavioural, emotional and physical domains, resulting with anxiety being reported in the early stages following miscarriage.

The current study's findings were that the women experienced negative emotions. In agreement with these findings is Lamb's (2002) USA's Virginia State study, which found that recurrent miscarriages presented a significant life crisis causing several psychological problems, inclusive of depression and failure to concentrate. While the first miscarriage is perceived as a single event, subsequent ones attract ongoing and compounded grieving leading to chronic sorrow. Schwerdtfeger and Shreffler (2009) cite a US study which examined long-term psychological outcomes and reactions to pregnancy loss and infertility among 2 894 women. Distress and trauma were found to be common.

Regarding social risk factors of anxiety, Gold, Sen and Hayward (2010) cite a UK study whose findings were that married childless women with recurrent miscarriages had great hazards of relational dissolution. A South African 2002-2003 quantitative national survey among 7 643 females aged 15 to 44 showed that women with recurrent miscarriages had intimate relationships which were likely to dissolve compared to those of women with live births (Gold et. al. (2010). A qualitative South Australian phenomenological study, in which 15 women aged 31 to 71 responded to semi-structured interviews, showed that friends and family were unconsciously unsupportive after miscarriages (Collins, Riggs and Due (2014). From a quantitative US, longitudinal study, Rosenbaum (1992) reported marital dissatisfaction among couples as indicated by divorce, separation and cheating. An Indian survey of 15 major rural and urban states indicated that there were marital disruptions, domestic violence involving husbands and in-laws (Bedenhorst et al, 2006). A Nigerian study, of 116 married childless women with recurrent miscarriages, showed discrimination and stigmatization (Brody, 2014). However, despite the women in the current study having reported negative relationships, Fraser and Cooper (2009) cite a US study of 185 women attending post-miscarriage treatment at a hospital, and results showed that 70 % had closer relationships with their spouses, 21% reported no change and only 9% reported that their spouses became more distant. Also, in concurrence is Kamau's (2011) Kenyan study whereby some women reported having received exceptional support from their husbands. It was concluded that social risk factors were situational rather than conclusive.

With reference to physical risk factors leading to anxiety, Bedenhorst et. al. (2006) points out that women with recurrent pregnancy losses experience extreme pain, excessive bleeding, sometimes have incomplete miscarriage, weight loss, and in the long-run, become infertile due to likely damages of the uterus, cervical cancer, ectopic pregnancy and, in the worst scenarios, death. In concurrence, Oliver et. al. (2013) add that recurrent miscarriage in itself is associated with later development of coronary artery disease with an increased risk of ovarian cancer, cardiovascular complications, and an increased mortality of 44%, 86%, and 150% for women with a history of 1, 2 or 3 miscarriages, respectively.

8. Implications of the Study

Findings showed various risk factors that predisposed married childless women with recurrent miscarriages to suffer from anxiety. It suggests that there is need for hospital health personnel to not only focus on the women's physical health issues connected to miscarriages but to also put in place counseling services that address the resulting anxiety suffered as this could further compound future pregnancies. There is also need to educate the public about the identified risk factors of anxiety suffered following miscarriage so that they provide the needed psychosocial support. Individual mental wellbeing and support from significant others appears critical in mitigating risk factors of anxiety among married childless women with recurrent miscarriages.

9. Study Limitations

A qualitative case study was used with only 11 women admitted in 1 hospital ward, and this could make the findings not to be generalisable to all women in similar situations. In addition, though structured interviews were expected to yield rich data, the fact that the women were emotionally challenged could have resulted with the women providing minimal information regarding their experiences.

10. Conclusion

Married childless women with recurrent miscarriages, were exposed to a number of risk factors for anxiety. Psychologically, the women had negative emotions indicated by depression, grief, and low self-esteem. The women also reported having had poor inter-personal relationships with their spouses and in-laws, stigma, irritability and withdrawal. Physiologically-related factors were evidenced by reported chronic headaches, fatigue and weight loss. Overall, the women feared never having children and possible divorce.

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