A QUALITATIVE STUDY ON UNDERSTANDING FEAR AND APPREHENSIONS EXPERIENCED BY WOMEN WITH MISCARRIAGES

AIMAN ZAHID

DEPARTMENT OF APPLIED PSYCHOLOGY

KINNAIRD COLLEGE FOR WOMEN, LAHORE, PAKISTAN

2017-2021

A QUALITATIVE STUDY ON UNDERSTANDING FEAR AND APPREHENSIONS EXPERIENCED BY WOMEN WITH MISCARRIAGES

A RESEARCH SUBMITTED ON KINNAIRD COLLEGE FOR WOMEN IN

FULLMENT OF THE REQUIREMENTS OF THE DEGREE OF

BS (HONS)

IN APPLIED PSYCHOLOGY

By: AIMAN ZAHID

F17BPSY041

DEPARTMENT OF APPLIED PSYCHOLOGY

KINNAIRD COLLEGE FOR WOMEN, LAHORE

2017-2021

It is stated that "*All changes suggested by examiners during defense are incorporated in this final copy*"

Student Name: Aiman Zahid **Signature:** 

Supervisor: Ms. Asma Majeed **Signature:** 

Head of Department: Dr. Afsheen Gul **Signature:** 

RESEARCH COMPLETION CERTIFICATE

It is certified that Ms. Aiman Zahid (Session 2017-2021). Department of Applied Psychology has carried out this research work entitled**, "*A qualitative study on understanding fear and apprehensions experienced by women with miscarriages*"** under my supervision**.**

It is assured that this research work is original and not yet been published anywhere else.



Ms. Asma Majeed

Supervisor

Lecturer

Kinnaird College for Women, Lahore



Dr. Afsheen Gul

Head of Department

Department of Applied Psychology

Kinnaird College for Women, Lahore

ANTI PLAGIRISM DECLARATION

I certify that this is my own Research work. The work has not in whole or in part, been presented elsewhere for assessment. Where material has been used from mother sources, it has been properly acknowledged. The similarly index of the report is 17%

If this statement is untrue and I am found guilty of plagiarism, the punitive actions against me should be taken as per Kinnaird Anti plagiarism policy.

Aiman Zahid

F17BPSY041

BS Applied Psychology



Signature of Supervisor



Signature of Head of Department



ACKNOWLEDGEMENTS

First and foremost, thankyou Allah for your blessings. The glory belongs to God for what He has done in, through, and with me on this journey. He is the one who has kept me going and given me the strength to finish this job.

Words cannot adequately express the appreciation for the support give to me by my Supervisor, Ms. Asma Majeed, who was consistent with her tangible advice, affirmation, Encouragement and Support throughout. I am very Grateful for your continuous guidance and assistance.

I sincerely appreciate the whole hearted cooperation and valuable help rendered by the head of Psychology Department Dr. Afseen Gull, who remained a source of motivation throughout.

I am grateful to the women who willingly agreed to speak with me about such a personal and sensitive subject. They were all brave, open, and honest in telling their stories. I appreciate their willingness to share their experiences.

I additionally want to thank my mother and father and loved ones for his or her help and prayers at some stage in my studies. Thanks to all my friends for your help when I need it most. Thank you for the times that you simply permitted me to vent my dissatisfaction almost this extend particularly in covid times and for being there amid those times when working on this thesis was the last thing I needed to do. I see forward to a lifetime of companionship.

Aiman Zahid



ABSTRACT

Pregnancy is an important life experience, and the loss of a pregnancy can have negative psychological consequences. Despite advances in our understanding of grieving following perinatal loss, there has been relatively little research particularly addressing bereavement following miscarriages. The goal of this study was to learn more about a group of Pakistani women's miscarriage experience. Semi-structured interviews with 3 women who had miscarriages, were used to use an interpretive phenomenology technique. In depth interviews and stories helped to gain a better understanding on the care that women received in the hospital. The data was analysed and interpreted using an Interpretative Phenomenological Analysis. Women's miscarriage experiences are characterised by a loss of hope. Three themes were explored in this study: 1) Dealing with the loss of hope, 2) regaining emotional equilibrium, and 3) recognising the need for intervention. Miscarriage is an inevitable event that has to be addressed right away. According to the findings, women gain from support from their husband, family, friends, and health care providers during and after a miscarriage. This study emphasizes the problems that women face as a result of miscarriage. Health practitioners must provide greater in-depth information and empathic treatment to women. The need of better understanding the emotional affects, behaviors, and coping techniques that women find to be significant in the field of social work is important because of the widespread nature of miscarriage. Professionals in the medical field must be trained to provide emotionally sympathetic treatment to these women.

Keywords: Pregnancy, dealing with loss, miscarriages, emotional affects, behaviors, coping, lived experiences

TABLE OF CONTENTS

Contents	Page
Thesis Approval Cetificate	iii
Research completion certificate	iv
Anti-Plagiarism declaration	v
Acknowledgement	vi
Abstract	vii
Table of Content	viii
List of Table	x
List of Figures	xi
List of abbreviation	xii
List of Appendices	xiii
CHAPTER I: INTRODUCTION	1
CHAPTER II: LITERATURE REVIEW	6
2.1 Review of women's miscarriage experiences	6
2.2 Gaps of knowledge	11
2.3 Rationale	12
2.4 Objective	14
2.5 Research Questions	14
CHAPTER III: METHOD	15
3.1 Research paradigm	15
3.2 Research design	15
3.3 Sampling	16

3.4 Data collection 18

3.5 Procedure 19

3.6 Data analysis 19

3.7 Ethical considerations 20

CHAPTER IV: RESULTS & ANALYSIS 21

4.1 Theme 1 29

4.2 Theme 2 35

4.3 Theme 3 38

CHAPTER V: DISCUSSION 43

5.1 Conclusion 49

5.2 Strengths 51

5.3 Limitations 52

5.4 Recommendations 53

REFERENCES

APPENDICES

LIST OF TABLES

Table	Title	Pg. no.
Table 3.1:	Sample Characteristics	17
Table 4.1:	Major themes, subordinate themes, emergent themes and texting	22

LIST OF FIGURES

Table	Title	Pg. no.
Table 4.1:	The figure represent major themes, emergent and sub themes	28

LIST OF ABBREVIATION

Abbreviation	Full Form
DNC	Dilation and Curettage
PTSD	Post-traumatic stress disorder

LIST OF APPENDICES

Appendix No.	Title
Appendix A:	Permission Letter
Appendix B:	Informed Consent
Appendix C:	Demographic Form
Appendix D:	Interview Guide
Appendix E:	Transcribed Interviews
Appendix F:	Plagiarism Report

CHAPTER I

INTRODUCTION

For many women, pregnancy is an exciting time as they prepare for the future. A percent of all pregnancies terminate in miscarriage, unfortunately (Cunningham et al., 2005). Miscarriage or spontaneous abortion, which is defined as "the spontaneous termination of a pregnancy before the foetus has reached viability," used to be the most frequent kind of pregnancy loss. Miscarriage is defined by the World Health Organization as the evacuation of an embryo or foetus from the uterus before 23 weeks of pregnancy and weighing up to 500 grams. Various countries have different definitions of miscarriage. Pregnancy can last up to 28 weeks in poverty stricken places, yet as short as 24 weeks in developed settings (Denzin, 2005).

In recent decades, prenatal detection of chromosomal abnormalities and birth deformities has improved thanks to ultrasonography and chorionic villous sampling. Prenatal diagnosis is given as a regular medical test for high-risk pregnant women who have a higher chance of having a baby with a disease. New Down syndrome screening indicators and approaches have recently been created, like as nuchal translucency assessment and serum markers (Engelhard, 2001).

The traumatic nature of a loss or ectopic pregnancy: four out of ten women exhibited PTSD symptoms within three months after the miscarriage or ectopic pregnancy, according to the study. Nightmares, flashbacks, and re-experiencing sensations related with the loss were among the PTSD symptoms described by the study's participants. Some women

said they tried to stay away from situations that reminded them of their loss, such as pregnant friends or relatives (Cosgrove, 2004).

A Pakistani woman who has had a miscarriage, stillbirth, or neonatal death is frequently barred from participating in rites or events related with any auspicious occasion, such as a wedding or baby shower. The similar "law" applies to women who are having reproductive problems in South Asian culture, in which inability to conceive and bear children is regarded as a bad omen (Brin, 2004).

Stillbirth and newborn deaths have a significant impact on a woman's sense of self. Pregnancy can act as psychological preparation for many women who desire to have children. For many women who wish to have children, the identity of mother begins before conception (Billings, 2003). An identity committed to the function of motherhood, whether consciously or unconsciously, will often develop psychological meaning around the role. The loss of this identification also means the loss of future motherhood status. A life event like this might almost destabilize an individual's identity, causing a shift in self-perception (Laverty, 2003).

According to what I've observed, it appears that Pakistani woman with the narrative of the deceased infant is the victim. Their narrative exemplifies the very real social marginalization that a Pakistani woman faces for failing to meet the traditional depiction of womanhood (carrying a living child), and as a result, she suffers a further assault on her identity, self-esteem, self-worth, and value.

Despite the fact that sadness, dread, and anxiety are common reactions to a sense of loss when a pregnancy has ended, the literature tends to treat pregnancy loss as a single entity rather than distinguishing between miscarriage and stillbirth (Annells, 1996). Women who have experienced a miscarriage owing to congenital deformities show significant

degrees of fear, grief, and mourning, according to the study. Most studies, on the other hand, concentrate simply on the prevalence of psychological distress following a miscarriage, leaving the sensations that occur during the event untouched (Creedy, 2001).

The early stages of a new pregnancy are typically a time of optimism, enthusiasm, and joyous expectation. For women who have had several miscarriages, however, a positive pregnancy test frequently signals the start of a period of worry and mental agony as they wait for proof that their pregnancy is still continuing on. You can understand that if you've had three, five, or ten miscarriages, the joy of a positive pregnancy test is typically eclipsed by concern and fear of miscarrying again, because for these women, a fresh pregnancy does not imply the birth of a child (Burns, 2007).

This period of anxiety and stress had an impact on all parts of life, including physical, emotional, and social well-being. They are really afraid of the upsetting emotions they were experiencing at the time that they were often too afraid to try for a fresh pregnancy and had to summon the strength to do so. Unfortunately, some women opt not to conceive again rather than go through this period of uncertainty (Brier, 2004).

The uncertainty of what would happen made the moment so stressful. Would they miscarry again or will they think this time would be different? We like to know what will happen in a scenario as humans, even when the conclusion may be unfavorable, because it allows us to use our coping strategies to deal with it (Castle, 2003).

Women who experience a recurrent miscarriage, on the other hand, have no way of controlling or correctly predicting the result of their pregnancy; they simply have to wait and see what happens. It is because of this uncertainty that the early stages of a new pregnancy are so tough to deal with (Cosgrove, 2004).

Despite the emotional upheaval that comes with the first few weeks of a new pregnancy, many women who have recurrent miscarriages are left to suffer alone with their anxiety and grief (Alexander, 2007). Many studies have looked into the psychological effects of miscarriage in the aftermath, but only a few have looked into the feelings of women who have had repeated miscarriages, particularly during the early stages of a subsequent pregnancy (Klein, 2007). Due to a lack of evidence, developing supportive treatment to help women with recurrent miscarriage cope with the early stages of a new pregnancy has been difficult.

Women expressed a turmoil of emotions (anxiety, fear, panic, envy, guilt, and betrayal), all of which were exacerbated by the situation's extreme ambiguity (Mazza, 1997). These feelings were frequently overwhelming and had an impact on every part of their lives. Their anguish was exacerbated by the fact that they were unable to foresee whether or not their pregnancy would be successful, thus they constantly ruminated on the outcome. Women, on the other hand, were more concerned with what might happen (Fade, 2004).

The women said they kept their distance from the pregnancy, keeping themselves ‘in control,' since they didn't want to become overly happy about it. They were hesitant to tell their relatives and friends about their pregnancy, and they denied any chance of a healthy conclusion, fully expecting another miscarriage (Moyle, 2001).

Women recounted how they used personal milestones to help them get through the early stages of pregnancy's uncertainty, living day by day and trying not to think too far ahead. It was a lonely moment in the early stages of a new pregnancy (McMahon, 2005). Because they were afraid to tell their friends and family about their pregnancy, many women separated themselves from them. Similarly, there was a widespread avoidance of social

situations and social media for fear of being forced to contact with other pregnant women or those who were announcing a new pregnancy (Cosgrove, 2004).

Because the comprehension of loss caused by miscarriage and pregnancy termination among Pakistani women has not been thoroughly investigated, it is assumed that miscarriage and termination losses are similar to other losses in life (McMahon, 2005). As a result, this circumstance incorporates a mourning process based on the Kübler-Ross, Bowlby, and Parkes models for grief and loss in response to pregnancy loss. Although these models can capture sentiments in response to a sense of loss in general, they are more difficult to apply to miscarriage, which is a spontaneous abortion.

CHAPTER II

LITERATURE REVIEW

Literature review done on sone of the researches based on women's miscarriage experiences is summarised in this chapter. This review covers qualitative research on the subject of recurrent miscarriage. Its goal is to give a broad overview of current knowledge on these areas. Finally, knowledge gaps and the need for more research are discussed.

2.1 Women's Miscarriage Experiences

Women's emotional and psychological reactions following miscarriage were discovered. Grief and despair are the two most prevalent reactions. However, the sorrow reaction can extend up to six months, while the depression reaction might last up to a year following a loss (Paton, 1999). This study, which used a phenomenological approach to investigate women's experiences, was unable to discover conclusive evidence as to why women suffer depression and bereavement. According to the survey, the vast majority of women had unpleasant emotions following a loss. Empathy for women who are grieving was discovered in this study. However, women's sad reactions after miscarriage were caused by observers' displeasure and separation (Chalmers, 1992).

Chalmers. (1992) study looked at post-traumatic stress and discovered that about five women had long-term post-traumatic stress. When a woman suffers from post-traumatic stress disorder, partners feelings are largely neglected. Post-traumatic stress disorder (PTSD) can have a negative impact on many aspects of a person's life, including job, home, and relationships. In this study, awareness aids couples in understanding one other's issues

through pregnancy loss, which is a particularly painful moment in their relationship. The death of a child may have a profound effect on both parents, and this research provides many people who have grieved in silence a voice. In this study, the message is clear: partners with a negative attitude toward their spouses must change (Paton, 1999).

Fertility, pregnancy, loss of pregnancy, parenting, and family dynamics are all themes that social workers deal with. "Reproductive loss experiences are intertwined with usual issues appearing in ordinary social work practice, such as mental health, self-conceptualization, social roles, and future parenthood," according to the study (Price, 2008). Despite this, there is a lot of silence in our culture when it comes to miscarriage (Layne, 1990).

Price. (2008) study looked on the personal experiences of women who have experienced miscarriage distress. They know how women feel after a miscarriage. The in-depth interview looked at both the good and bad elements of women's experiences following miscarriage. This research looks into how women dealt with this terrible situation and overcame their loss. This qualitative research uses a narrative framework to examine themes and findings using category analysis. The findings suggest that some women receive support from their health care providers, husbands, family, friends, and relatives during and after miscarriage. Other women, on the other hand, are subjected to the silence and humiliation associated with miscarriage. The research is significant in terms of discussing experiences and gaining a better understanding of emotional consequences and coping techniques (Maker, 2003).

Meier. (2010) findings looked on the social and emotional experiences of women who had miscarriages. Miscarriage is a very regular occurrence. The study's goal is to learn about the women's emotional and psychological experiences, as well as their changes in

behaviour, and to examine supporting and unsupportive factors. The study is quantitative, but the psychological effects of miscarriage are investigated qualitatively. The participant gave a detailed account of the psychological effects of miscarriage on their lives. The findings demonstrated a lack of understanding of women's health issues during pregnancy. Women gave less information on their physical recovery and attempts to conceive. During a miscarriage, it is critical that women have an open discussion and communicate their concerns with family members (Meier, 2010).

Miscarriage is usually misunderstood by medical professionals as solely a physical event, and as a result, it is rarely acknowledged as a psychologically painful experience (Cosgrove, 2004). It is vital that health care providers should not treat miscarriage as a normal occurrence or process. When women are asked about the medical care they received after a miscarriage, they usually highlight the need of both physical and emotional support (Simmons et al., 2006).

Mann. (2008) research focuses on the social and personal effects of various management methods. A qualitative research was done, with four types of women being interviewed. Participants and health workers from three hospitals took part in a focus group discussion. There were 47 people in all, divided into five groups. All women should participate in the interview. Then, after analysing several topics, discuss each one with the entire team. Following the study, all themes and difficulties related to miscarriages were recognised as a new topic throughout the analytical process. The transcripts were all coded and themes were identified. Themes such as pain, bleeding, caring, and intervention have been recognised. As a result, the study highlights the issues and benefits of women in management, emphasising the importance of professional skill and care (Lindsay, 2005).

The researcher demonstrates the depressive symptoms and anxiety after miscarriage. The women anxiety level is often raised after miscarriage. The literature into whether miscarriage causes anxiety has received much needed attention. One of the literature Cordon and Cook. (1993) argue anxiety is the predominant psychological response rather than depression after miscarriage. After miscarriage is risk of developing anxiety disorder such as panic disorder and obsessive-compulsive disorder. After miscarriage anxiety may influence decision regarding further pregnancies.

The importance of social support in a woman's coping with miscarriage has been discovered. A woman's partner's support is extremely important for her after a miscarriage, and excellent communication between the two is crucial during the grieving process (Hamama-Raz et al., 2010). Many women have found that having other women to talk to about their miscarriages has been beneficial (Rowlands et al., 2010). Interpersonal support, whether from a partner, friends, family, neighbors, religious or cultural organization, or coworkers, is a vital aspect of the coping process (Mann et al., 2008). Support groups offer a unique chance to create environment of support, particularly for women who are not able to share their concerns with others because they feel they will not be able to understand them.

Gender politics, in its broadest sense, is concerned with investigating, comprehending, arguing for, and changing men and women's roles and relationships. Gender politics has a significant impact on family-related issues (Swain & Thornton, 2011). Medical therapy, surgery, and strategy are some of the ways used. The benefits and drawbacks of each approach of miscarriage care have been determined based on the individual circumstances of women. Cordon and Cook. (1993) study highlights the importance of personal beliefs and medical practises. In the treatment of miscarriage, there are a number of medical considerations. Women should have the chance to participate in the decision-making process.

Frost et al. (2007) made a similar point about the loss of options for women's lives and identities. Even though the researchers suggested that participants remark and react to important results to increase their accuracy, just a few women decided to do so. Furthermore, the researchers gave no explanation for how they dealt with the specifics that the participants supplied in their significant discoveries. As a result, the findings' credibility was called into question.

While the most recent study revealed a terrible sense of loss that lingered and resurfaced often in various accounts years following miscarriage. However, because the women in this study had already become moms or were in the early stages of pregnancy, their reactions to the miscarriage could have been impacted. Furthermore, the individuals were interviewed at various dates following their miscarriage, spanning from six months to four years, which may have influenced their perspectives or perceptions of the examined experience (Gerber-Epstein et al., 2009).

Simmons.(2006) research in the United Kingdom looked into recurrent miscarriage stories written by adult women living in the country. It was discovered that the patient's interpretation of miscarriage and ability to cope with their loss were influenced by their quest for a cause of miscarriage and the respondent's reproductive history. Women also reported concerns about inappropriate medicalization and a perceived lack of emotional support from miscarriage care specialists. Despite the fact that these results were derived from 172 narrative replies, it is important to recognize the limitations of employing secondary data. Because the National Women's Health Study (NWHS) in the United Kingdom was not meant to collect qualitative data on miscarriage experiences, data may be incomplete and unspecified. The analysis was confined to the data that was already available.

Unfortunately, few studies have looked at practical day-to-day modes of coping used by women, which is the focus of this research. Examining day-to-day coping methods is useful because it is these seemingly insignificant acts, behaviors, and approaches that assist someone in navigating the process. The participants in this study had a diverse set of coping methods that they used. Some tactics they discovered on their own, through trial and error or naturally, while others came from peer and family recommendations, suggestions, and ideas. Miscarriage appears to be a personal, private, and intimate experience both physically and emotionally, according to various cross-sectional qualitative studies. The most prevalent reaction in women who have had a miscarriage has been shown to be a sense of loss (Rowlands, 2010).

These studies aid in the development of a comprehensive understanding of the recurrent miscarriage experience. Although recent qualitative research had focused solely on miscarriage, they have explored various aspects of the experience and used various designs. As a result, it appears that comparing the findings to those of other studies will be challenging. To acquire a better knowledge of the various facets of miscarriage, further qualitative research based on phenomenology and grounded theory designs is still needed (Figley, 1997).

2.2 Gaps of Knowledge

All current studies have shown that little has been done about woman lived experiences after miscarriage. Some of research has focused exclusively on the domains such as feeling of guilt, health issues and reasons of miscarriage (Denzin, 1994). This research worked on deeper understanding of woman experiences after miscarriage (Chalmers, 1992). This study will increase awareness, knowledge and understanding in their unique perspective. The study is primarily about woman over the age of 26 who have had two or more

miscarriages. This research is mainly about the challenges that women face after losing a child and what other people think about it. In our Pakistani society, it is very difficult to accept a woman who is not becoming a mother after two or more miscarriage.

2.3 Rationale

This study highlights serious mental or emotional issues such as depression, fear, stress, anxiety and any other psychological issues for those who experience miscarriage. This Research highlight serious issues such as societal pressure is most common in Pakistan society. The research is basically needed for long term recognition of the emotional and psychological effects of miscarriage and support for women for family pressure, societal pressure, and martial life issues. In this regard we also need to closely look all women who were experienced with these issues and due to some emotional and psychological issues decided to end their life just because of their never becoming mother again and that they cannot give happiness to their husbands or family members (Burns, 2007). Societal pressure and family issue become major issue when women cannot become mother for several times because of some serious issue. It emphasizes the need to aware the healthcare to assist these women whom are suffering from this problem. (Van den Akker, 2011).

The Rationale of the study is to explore experiences of women after miscarriages and its impact on the psychological and emotional wellbeing, the basic goal is to raise awareness among the people where this discussion regarding miscarriages is often considered negative in our society. There were many studies which were conducted on miscarriages but there is no research conducted which explore the experience faced by women after miscarriage, the basic aim of research is to give insight into how women experience emotional and psychological problem and investigate how they adjust to their family life. The basic aim of

the research is to give insight into how that experience of miscarriage has a considerable emotional and mental illness impact on women (Leff, 1987).

Finally, in hope that these findings will be valuable to social workers to assist women in coping with fear and apprehensions with miscarriages and who can spread this information to other medical professionals involved in women's healthcare.

2.4 Objectives

I. To understand participants' experiences, how they dealt with and overcame their loss, and what impacted and influenced their coping.

II. To listen to their stories in their own words, the meaning of this phenomenon can be grasped.

2.5 Research Questions

I. What are the expeiences of women with miscarriages?

II. What are the coping strategies of these women?

CHAPTER III

METHOD

3.1 Research Paradigm

Interpretivism as a paradigm was used. Because it focuses on individual understanding of the world in which they live and work, which prioritizes discovering the complex interplay of components in any given scenario, and because of its emphasis on learning and understanding the meanings that people hold about experiences (Creswell, 2007). Qualitative researchers "investigate phenomena in their natural environments, aiming to make sense of or interpret occurrences in terms of the meanings that people assign to them" (Denzin & Lincoln). Furthermore, qualitative research is a form of analysis that is thought to hear out participant's opinion and sharing their knowledge with the researcher. This approach establishes an outline for better comprehending the stories and experiences that the participants have lived and shared.

3.2 Research Design

Phenomenological research design was used to study the experiences of women with miscarriages, as well as a culture-based gender dilemma that they encounter. As it stands now, allows researchers to collect important and subjective data. Creswell claims that the phenomenological research explores the everyday life experiences of humans. The phenomenology is the study of how things are. The researcher can use design to interpret the meaning and character of individuals (Creswell, 2018). The goal of phenomenological design was to investigate the lived experience of trauma and to analyse the psychological, emotional, and cultural pressures that women face when they find out they miscarried. The description

of phenomenology includes of phenomena of participant what and how they had an experience. According to phenomenology, researchers aim to understand the world as it is. As humans, we are a part of it. Experiences are the result of an intentional process. When it comes to qualitative research, the goal of phenomenology is to identify and characterise respondents' subjective experiences. It is a question of fact of looking at ordinary life through the eyes of the subject (Schwandt, 2001).

3.3 Sampling

The individuals were chosen through purposive sampling. It's a non-probability sampling approach in which the researcher picks variables for the sample population freely. It aids the researcher in screening out irrelevant replies that don't fit the topic of the study (Glaser, 1991). It is used by researchers to locate potential volunteers in studies when individuals are hard to come by. A total of three women were chosen using this sampling strategy. The women's permission to participate in the study was used to create a sample. The purpose of the study is explained to the participants in detail. Women who suffered more than one miscarriage were included, and data was gathered in the hospital or from other sources (through relatives, social media, research articles).

Table 3.1 *Sample Characteristics*

Sr #	Number of miscarriages	Trimester during which miscarriages occurred	Women's age	Relationship status	Occupation	Husband's occupation	Current children
1	3	1 in first, 2 in second	23, 24, 25	Married	Special Education Teacher	Private job	1
2	2	2 in first	24, 25	Married	Teacher	Private job	2
3	2	2 in first	28, 32	Married	Housewife	Private job	3

Inclusion criteria:

- Women who have suffered from miscarriage, only miscarriage-based women were added.
- Women who are atleast 26 years old or older, and were still suffering from emotional and societal pressure after miscarriage.
- Women who have been suffering from miscarriage without infertility.

Exclusion criteria:

- All data that was unrelated to the study and did not meet the research question and goal had to be removed from the study, as did women under the age of 26. Everything that wasn't connected to the research was eliminated.
- Women who had been labelled as physically or psychologically ill were excluded.

3.4 Data collection

In-depth interviews, field notes, and participant observation were used to gather data. In the interviews, open-ended questions were asked. Attitudes, emotions, and expressions, as well as other actions, are among the data collected for a qualitative research. Three steps are ongoing throughout the qualitative study process: data collection, themes, and data analysis. Qualitative research supports flexibility since the researcher is always gathering new information. In qualitative research, interviews are a typical method of gathering information. The data for the phenomenological investigation was acquired through an in-depth interview, because it is possible to obtain a deeper understanding of the participants' experiences through their own words. Rather of directing what is said, the researcher in this technique directs the questioning process by developing a series of open-ended questions. The researcher gave the participants the opportunity to speak on their topics of interest. The researcher asked probing questions about appropriator and suitable follow-up. The duration of the interview varies between 25 and 30 minutes. All of the interviews took place in person.

Demographic Form

It was used to identify specific features of the participant, such as the particiapnt's age, religion, education, the number of miscarriages and the duration of treatment.

Interview Guide

The interview guide included basic demographic screening questions as well as some factual questions aimed at separating out the participants' basic factual knowledge. The open-ended and less structured questions in the in-depth interviews were used. These inquiries are usually structured around a collection of open-ended questions with probes that emerge from the

interaction between the interviewer and the interviewee. It aided in determining the participants' knowledge, thoughts, and experiences of miscarrying.

3.5 Procedure

With the participant's agreement, all interviews were voice recorded and was discarded soon after the coding. I was able to capture the description and participate in the dialogue while taking notes. However, field notes were gathered after each interview to explain nonverbal information such as physical feelings and gestures that were not audible in the recorded interview (Engelhard, 2001). The nonverbal information was immediately added into the transcript after transcription to help in the interpretation of the data. There was not just new knowledge but also self-reflection after each interview. The duration of the interview was limited between 25 and 30 minutes. I asked participants at the end of each interview if they had any questions regarding the study or the topic matter they wanted to discuss, or if they wanted to talk about how the interviews had influenced their feelings Finally, the interviews were brought to a close by thanking the participants for their time and expressing their insights (Cosgrove, 2004).

3.6 Data Analysis

Thematic analysis was used to analyse data. This method was chosen because it placed an emphasis on identifying, evaluating, and recording patterns in data.

According to Carric et al. (2009) thematic analysis emphasises the commonalities and differences among participant’s major themes. Themes are patterns that can be observed in various data sets, are significant in describing a phenomenon, and are connected to a particular research question. Five stages of thematic analysis were completed.

- Familiarizing oneself with the information and transcribing verbal data was the first stage.
- Initial texting from the data was generalised in the second step.
- After the basic coding, the analyst used more specialised terminology to create the primary themes in the third phase.
- The researcher went over each of the themes one at a time in the fourth phase.
- Themes were adequately established and given names in the fifth step.
- The report's development was the final stage.

The interview was read line by line several times in order to extract experiences from the text and create themes. The same methodology was used to assess each interview. A code list was created from all three interviews once the text had been labelled. Then, after grouping the texts into categories, major themes, minor themes, and emergent themes were suggested.

3.7 Ethical Considerations

At the time of the first meeting, all participants who actively agreed to participate in the study were given written informed consent to protect their privacy, which is the study's top priority. Informed permission was given to the participants, which included details regarding the study's purpose, procedure, and willingness to participate. Verbal knowledge is supplied to the individuals. Verbal information was presented to create goodwill and establish confidence while addressing ethical issues. The participants' privacy and the information they provided were guaranteed. The study's primary aim is to confirm that no damage has occurred, and participants have the option to withdraw at any time. It was entirely up to them whether or not they wanted to participate. Audio recording was done if particpants were cofortable with it. If the person did not agree to answer the question then they weren't obligated to respond.

CHAPTER IV

RESULTS AND ANALYSIS

The transcripts of the interviews acquired from the participants were analysed using thematic analysis. To do so, thematic analysis was used to create themes that took into account the raw data gathered from the interviews. First, the spoken data was gathered, and then the data was transcribed after becoming familiar with it. After generalising the data's original messaging. Following the underlying coding, the data was sorted into themes. More expert materials were used to create the main themes. The topics were then assessed and given names by defining them in the next phase. The final stage was to create the report.

The topics represented the women experince with miscarriages, as well as the coping mechanisms they used to deal with the psychological, social, and emotional issues. The events shared a number of aspects. These encounters are recorded in social and psychological aspects that determine the apprehensions, anxieties, and coping methods that result from the experiences.

The theme that arose from the data had been shown below (see Table.4.1).

Table 4.1 *Summary of major theme and subordinate themes*

Major Theme	Subordinate Themes	Emergent themes	Texting
Facing the loss of hope	**1. the realization of one's hopelessness**	• Denial • Shocked • crying	*My pregnancy had given me a new outlook on life. But the more I listened to what the doctor had to say, the more my hope faded and died. (P1)*
		• difficult to accept the child is no more • unempathethic towards feelings	*I never imagined that the moment I found out I was pregnant, I would be greeted with such joy, only to be followed by such anguish. I felt as if my entire world had come crumbling down in front of me. (P2)*
		• Expectation of first baby is ended	*I prayed to God that we (my husband and I) would not lose the baby. We lost all hope, when the doctor confirmed that I was experiencing a*

		• A personal loss • Feeling helpless	*miscarriage. (P2)* *We had been trying for a child for a long time, and all we had been looking forward to getting pregnant which was taken away from us in a matter of days. (P3)*
	2. Psychological and physical responses	• trouble in sleeping • Difficulty in concentrating • Dreams about unborn baby • Flashback that hurts me so much • feel bad about my self • isolation • anxiousness	*I'm still afraid of miscarrying again. Nobody can tell me whether or not it will happen again. I'm still terrified of having to deal with this issue again. (P1)*
Gaining emotional balance	**3. Developing self motivation**	• Seeking information • self-guilt	*I tried to learn as much as I could about miscarriage by reading books and searching the internet. At*

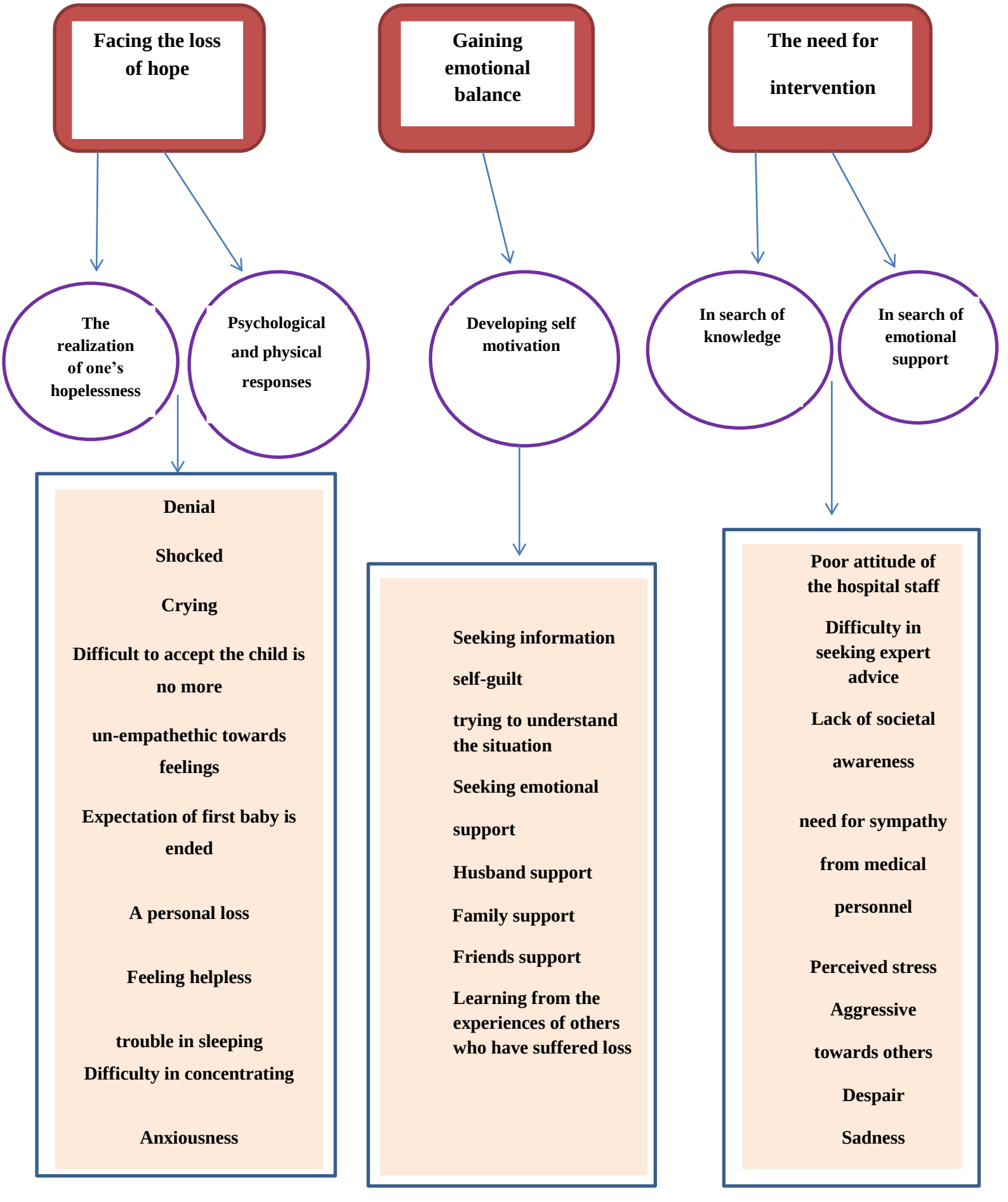
• trying to understand the situation	*the very least, it made me feel relieved that it did not occur as a result of my actions and that it was not my fault in the least. Otherwise, I'd have to live with this guilt for the rest of my life. (P3)*
• Seeking emotional support • Husband support	*If my husband was desperate for a child, I could be under a lot of stress since I thought i was unable to fulfill his wish. But he told me not to worry about it because if we didn't have children, we'd be able to live with just the two of us. It made me feel a lot less stressed. (P2)*
• Family support • Friends support • Learning from the experiences of others who have suffered loss	*It was a fortunate coincidence that I was able to meet and chat with a friend who had a miscarriage. The next*

			month, she was pregnant unexpectedly, and she now has a two-year-old child. Because I had never met somebody who was similar to me before, this friend provided me with new information. I felt a lot better after reading this. (P1)
The need for intervention	**4. In search of knowledge**	• Poor attitude of the hospital staff • Difficulty in seeking expert advice	*I was concerned about the reasons for my miscarriage. It was undoubtedly a natural choice, according to the doctor, because my kid was unhealthy. It was far too broad. I'm interested in learning more about the specific cause. I'd want the doctor to notify me of any precise procedures for discovering the real reason or provide me any suggestions. Or, if there*

		isn't a unique procedure, I'd like to know how to avoid suffering another miscarriage. (P1)
5. In search of emotional support	• Lack of societal awareness • need for sympathy from medical personnel	*I was inconsolably heartbroken and cried excessively. A nurse interrogated me, stating that she needed my information to admit me to the hospital before conducting curettage. At the moment, I wasn't prepared to say anything. (P1)*
	• Perceived stress • Aggressive towards others • Despair • Sadness • Crying	*When I found out the outcome, I was depressed and disappointed... I wanted to be alone with myself and get away from it all... I'm in desperate need of some downtime. To de-stress, I need a secluded spot where For a brief period of time, I*

wanted to be alone or with my spouse. I'm bothered by the hectic atmosphere in the hospital. (P1)

Figure 4.1 *The thematic map showing the major, subordinate and emergent themes*



4.1 THEME 1

FACING THE LOSS OF HOPE

During the transcript analysis, it became evident that all of the participants' initial experience was one of hopelessness. The topic of losing hope was chosen to express the feeling that they had been pushed into an unexpected situation that was drastically different from what they had imagined. This topic is about the importance of having a kid. Although having a child means different things to different individuals depending on their circumstances, being pregnant gives them hope that they will be able to achieve the meanings they wish. They were faced with the reality of losing all hope and dreams for what may have been when their pregnancies ended. P1 summarised her hopes for the future.

I was incredibly excited at the thought of being a mother. It was going to be the end of my family. My happiness was temporary, lasting only two months before dissipating. (P1)

P3's tale is another example of dealing with the loss of hope. She mentioned the following:

We had been trying for a child for a long time, and all we had been looking forward to getting pregnant and that was taken away from us in a matter of days. (P3)

These participants' stories highlighted how they were wrenched from all of their hopes and thrust into an unexpectedly harsh circumstance. Faced with the loss of optimism, participants were forced to analyze their situations in ways they had never considered before. The following section delves into these sub-themes.

- **The realization of one's hopelessness**

The participants in this study became aware of the loss of hope as a result of this perception. A miscarriage meant that the participants' expectations of having a kid were dashed, and they were unable to pursue their dreams as before. As the process of information dissemination

progressed, some people became conscious of their loss of hope. For others, the realization that optimism was vanished came as a shock. P1 felt a sense of loss when she was told she was pregnant and had a miscarriage:

My pregnancy had given me a new outlook on life. But the more I listened to what the doctor had to say, the more my hope faded and died. (P1)

In her story, P2 also stated:

I never imagined that the moment I found out I was preganant, I would be greeted with such joy, only to be followed by such anguish. I felt as if my entire world had come crumbling down in front of me. (P2)

When the findings of the testing were confirmed, the loss of hope became apparent. This happened to P2 right after she was told she had an incomplete miscarriage. She told me,"

My infant had miscarried, he (a doctor) decided. With his remarks, I felt as if my hope, my dream, and whatever desire I had for a child had ended. (P2)

P2 reflected this sentiment as well:

During the repeat ultrasound scan, I prayed to God that we (my husband and I) would not lose the baby. We lost all hope, when the doctor confirmed that I was experiencing a miscarriage. (P2)

The sub-theme of loss awareness was conveyed by the participants in a variety of ways and in response to various stimuli. This sense of loss came on suddenly for some of the participants, whereas it came on slowly and vaguely for others. Some participants, especially those who experienced their first miscarriage with no warning signs, stated that their miscarriage was not a lengthy process that they would be unaware of or could plan for. Instead, all of the participants expressed displeasure with their current situation, which was unexpected.

For instance, P3 acknowledged:

It was absolutely beyond my wildest expectations. I never expected to be confronted with such a situation. (P3)

P1 also expressed her dissatisfaction with her miscarriage, which she described as "unbelievable" and "unacceptable." She described what happened as follows:

Because it was simply spotting and I wasn't bleeding heavily, I didn't think it was a miscarriage. So I decided to keep an eye on things and wait until my prenatal care checkup. I never imagined I'd experience *a miscarriage. I never expected to be confronted with such a situation. (P1)*

Participants when experienced repeated losses, reported that they were continuously anxious that they would have the same experience again and that they thoroughly documented every step of their pregnancy. Their awareness of loss was elevated when they uncovered specific signs that they had felt in a previous miscarriage, which was later confirmed when a miscarriage was identified.

The story of P2 is a great example of this issue. She highlighted how a past miscarriage had altered the awareness of loss in her current pregnancy:

I had more faith throughout my current pregnancy, and it got even stronger when the doctor declared my baby was normal following an ultrasound. I was still worried about miscarriage, though. On the day I found out I was pregnant with a problem. I pictured myself having a miscarriage right away. Then it happened: I was told I was pregnant and had a miscarriage. I gave up hope of ever having another kid since the doctor was confident my pregnancy was coming to an end. (P2)

Another good example is P1's account. She admitted:

On the drive to the hospital, I tried to pray to God for protection for my pregnancy. When a doctor informed me of the ultrasound findings, though, I lost hope and assumed I was having a miscarriage. (P1)

The participants' loss of hope was precipitated by the awareness of loss brought on by the miscarriage. It also elicited a wide spectrum of emotions that may be described as psychological and physical reactions. The psychological and bodily reactions are discussed in the next section.

- **Psychological and physical responses**

When confronted with loss, the subjects went through a variety of physical and psychological reactions. These reactions happened at the diagnosis of miscarriage for some participants who had no signs and symptoms at the start, while they happened at the identification of miscarriage symptoms for others. Some individuals reported a range of bodily manifestations as part of their emotional moods in terms of physical responses.

P3 expressed a similar sentiment in her story:

When the doctor told me my baby's heart had stopped beating, it broke my heart. (P3)

In addition to bodily symptoms, the participants said they were burdened by a range of psychological emotions to the loss. Shock was exhibited in a variety of ways by all of the participants in this research. Some people were shocked when they received their diagnosis, while others were shocked when they recognised the signs of miscarriage and knew what was wrong with their pregnancy.

This feeling is exemplified by P1's story. She said, "I almost couldn't keep it any longer a few days after miscarriage." It just stayed with me. It seemed like I couldn't accept it from the bottom of my heart. I had a strong desire to start a family. (P1)

There was no way for them to delude themselves any further because their symptoms suggested loss. Before accepting the truth, the women stated how they tried to rationalize their understanding. As P1 put it:

I attempted to convince myself that the finding was incorrect and that the bleeding was due to implantation, but my situation had nothing to do with what I had assumed. I couldn't say no any longer. (P1)

P2 also mentioned the following in her story:

A doctor couldn't see my baby at the first ultrasound scan. I was feeling a little tired. It was occurring once more. But I attempted to console myself by reminding myself that my kid might be little and difficult to see. The outcome of the second ultrasound was the same. The doctor inquired as to whether I wanted curettage. However, I wanted to give myself a chance. I asked the doctor to extend my stay for another two weeks. If my baby is unable to develop in my womb, it may miscarry spontaneously, like it did with my last miscarriage. And then I had a spontaneous miscarriage. (P2)

P1 added, *"Our mental states were quite awful that day." Even though I tried to relax, whenever I thought about my miscarriage, tears welled up in my eyes. (P1)*

P1, who had waited and hoped to have a kid, said she was saddened by her third miscarriage. *I was so heartbroken I couldn't find the perfect words to express how I felt. I merely cried and cried with my husband after I got home from the hospital. (P1)*

Although the participants were taken aback and had numerous inquiries, the most pressing was why they had experienced a miscarriage. P1 and P2 described their feelings of doubt in terms of their lifestyles and behaviors throughout pregnancy. As P1 mentioned in her story:

Maybe it was because I didn't look after myself well enough. Or I kept working too hard when pregnant. (P1) And: It was most likely due to stress, or my own fault for not being more cautious for my health... (P2)

Women who had previously miscarried expressed a sense of defeat or betrayal by their bodies. The more miscarriages a woman suffered, the more severe her loss of self and realization of her incapacity to bear a child became.

They were frightened that they would become exhausted and frustrated as a result of the loss, or that they would be on the verge of giving up hope. To put it another way, these women had to choose between battling and submitting to their desire to have a child.

P1, for example, related the following:

Although he (her husband) attempted to persuade me not to overthink things, I couldn't help but feel upset that I wouldn't be capable to give him a kid. (P1)

The lack of self-confidence was not specifically described for the individuals in their first pregnancy. P1, for instance, admitted that:

I'm still afraid of miscarrying again. Nobody can tell me whether or not it will happen again. I'm still terrified of having to deal with this issue again. (P1)

P3 also stated in her story:

I never imagined I'd experienced a miscarriage before. As a result, it's possible that it'll happen to me again. My next pregnancy is a complete mystery to me. (P3)

The participants were either numb from shock or experiencing emotional distress, but they believed they had to deal with their feelings alone because they were at home. The most important source of assistance in supporting them in overcoming this situation without feeling excessive emotional distress was their family members, however healthcare professionals had no role in assisting the participant at this time.

4.2 THEME 2

GAINING EMOTIONAL BALANCE

The recovery of emotional health is the second subject of loss experience to be investigated. The degree of emotional disturbance tends to decrease if people can accept the truth of their position and strive to find peace in living in the now while managing with their emotional responsibilities. Participants talked about how they tried to divert themselves from their grief in order to avoid succumbing to their unpleasant sentiments of loss. Nothing was better than embracing what happened, as P2 reflected in her story.

It appeared to me to be a case of nipping it in the bud. It was I who would get worse from this position if I delayed embracing it and continued to delude myself. (P2)

In her story, P1 mentioned such a problem:

Every loss left me with sadness and grief, but I couldn't do anything because my baby didn't stay with me. At this point, there was only one thing I could do to make myself feel better: leave it. I pretended that the baby wasn't ready to be born next to me. I'm still trying to become a mother. My optimism, at the very least, contributes to the growth of my willpower. (P1)

P2 and P3, divided between battling and giving in to the want to have a child, used their desire to have a baby to cope with their emotional burdens and move on. The following was mentioned by P3:

Although I am still afraid of becoming pregnant, drowning in the past has not helped me reach my goal. Whether it happens again or not, I need to reset my mindset and recover my

body as soon as possible in order to fight it again. (P3)

While the participants expect to achieve mental peace, acknowledging and embracing the loss takes time, and there were a variety of techniques to help the participants cope with their

uncomfortable feelings. P1's story, for example, showed how, despite her thoughts being filled with misery, seeking sympathy from others, even close family, and ignoring her terrible feeling failed to ease her suffering. She appeared to find that experiencing and sharing her grief with her spouse was the most efficient way for her to relieve the agony she was experiencing.

Everyone tried to reassure me and my spouse when I returned home. But when we were alone in my room, no matter how much we tried to comfort and encourage each other, it was futile since we couldn't be happy because our hearts were heavy with sadness. We were both in tears. (P1)

- **Developing self motivation**

Participants said they sought emotional support, sought the truth of the problem, learned from others' experiences, and maintained a good self-image. These appeared to be strategies they actively pursued in trying to recover their emotional peace. All of the participants initially reported a desire for emotional assistance. Because miscarriage left the participants feeling deprived of hope, despair, and melancholy, as well as a loss of self-confidence, they required emotional assistance in order to feel relieved and powerful while they dealt with their grief. The husbands of the participants were the most supportive, calming them down and urging them to keep going.

P2 revealed an inner struggle between wanting a kid to fulfill her ambitions and accepting the fact that they will be a childless family. Despite the stress, she felt relief after deciding to have a relationship without having children.

If my husband was desperate for a child, I could be under a lot of stress since I thought i was unable to fulfill his wish. But he told me not to worry about it because if we didn't have children, we'd be able to live with just the two of us. It made me feel a lot less stressed. (P2)

Some participants wanted to keep their miscarriage quiet because they were worried about the responses of those outside their families. Receiving pity from others, on the other hand, was viewed as unexpected emotional assistance. P2, for example, told me that:

"First and foremost, I don't believe I should inform anyone about what happened." (P2)

During a conversation with a friend who had gone through a similar event, P1 voiced this view.

It was a fortunate coincidence that I was able to meet and chat with a friend who had a miscarriage. The next month, she was pregnant unexpectedly, and she now has a two-year-old child. Because I had never met somebody who was similar to me before, this friend provided me with new information. I felt a lot better after reading this. (P1)

Seeking reassurance was a way for the participants to feel better about themselves and that they could get through their losses.

Some individuals considered learning about the miscarriage to be the same as learning about the reasons of the miscarriage. If they had a greater understanding, they would be able to stop blaming themselves for their miscarriage. The following P3 example serve to highlight this point. P3 related the following:

I tried to learn as much as I could about miscarriage by reading books and searching the internet. At the very least, it made me feel relieved that it did not occur as a result of my actions and that it was not my fault in the least. Otherwise, I'd have to live with this guilt for the rest of my life. (P3)

"I couldn't get away from the knowledge that I had previously miscarried," P2 said in her account of the situation.

If I couldn't be strong, I couldn't accomplish anything. (P2)

As participants are highly emotional about their loss the focus is to first calm them down and help them gain their self motivation back by providing them emotional care and support in which family support and involvement will be crucial.

4.3 THEME 3

THE NEED FOR INTERVENTIONS

The next topic to be explored is the need for interventions. This subject relates to the treatments that participants seek in order to provide support and maintain a sense of emotional normalcy when they are confronting a loss of hope. It is important for the participants to seek hospital services in the diagnosis and treatment of miscarriage as a result of experiencing a miscarriage. As a result, the participant's loss experience is strongly linked to medical and nursing treatments.

"I didn't really understand what happened to me," P3 said.

Before discharge, I was still apprehensive about my loss. Doctors and nurses should assess my condition and fitness before giving me any advise. (P3)

These accounts indicate how health professionals are considered as critical supporters in aiding individuals through their miscarriage losses. The medical and nursing treatments they received, however, were insufficient to meet their requirements. Two sub-themes developed out of the need for interventions. The subsections that follow go deeper into these sub-themes.

- **In search of knowledge**

This theme follows the knowledge that participants require from healthcare experts in order to accept the truth of their miscarriage and plan for future pregnancies.

All participants must have a basic understanding of miscarriage, particularly the reasons of miscarriage. This is due to the fact that all of the individuals had doubt following their miscarriages. The participants' main concern was why they found themselves in this circumstance. This is connected to the issue of self-blame or others' thoughts that the mother did anything to damage the baby. As a result, in order to overcome their worries and plan future pregnancies, the participants will need a strong understanding of the reasons of miscarriage. For example, P3 said in her story,

"What bothers me the most is why it happened to me and whether or not my next pregnancy would end in another loss." I won't be as reckless as I was before if I know what's causing it. Or I'll be able to repair it if I figure out what's causing it. (P3)

The vast majority of participants admitted to learning about miscarriage via textbooks and listening to other people's experiences. Until they had to deal with it personally, they were uninterested. Then they recognised that the most important aspect in preventing miscarriage was education. They needed detailed and clear information from miscarriage professionals, including physicians and nurses. They recognised a need for this information, but also indicated that the physicians and nurses refused to supply it, forcing them to go for it elsewhere. Some of this is related to the fact that the cause of miscarriage is often unclear, especially in the first loss, and even when told, women seek explanations. P1 told the following story:

I was concerned about the reasons for my miscarriage. It was undoubtedly a natural choice, according to the doctor, because my kid was unhealthy. It was far too broad. I'm interested in learning more about the specific cause. I'd want the doctor to notify me of any precise procedures for discovering the real reason or provide me any suggestions. Or, if there isn't a unique procedure, I'd like to know how to avoid suffering another miscarriage. (P1)

As P2 expressed:

The causes of the miscarriage are what I need to know and care about right now. I can take actions to prevent the issue or plan what I should do with my life if I am completely informed of the circumstance. (P2)

It may be concluded from the participants' statements that knowledge from health care professionals is necessary for the participants to overcome painful feelings and emotions of self doubt, depression, stress and trauma.

- **In search of emotional support**

This sub-theme is on the participants' experiences of caring from health-care providers when they are in the hospital. When health professionals demonstrated concern for their patients' feelings, participants said they felt cared for, and they valued health professionals who expressed interest in their feelings.

P2 required empathetic intervention. She showed how relieved she felt after receiving care assistance from a nurse. She remembered,

She remembered, My spouse and I were taken to a small room by a nurse. She assured me that my position was not urgent, and that my husband and I could remain in this room until we were no longer worried. I could call at any time if we needed assistance. This is the type of nursing care I require. (P2)

P1 added to her statement,

When I found out the outcome, I was depressed and disappointed... I wanted to be alone with myself and get away from it all... I'm in desperate need of some downtime. To de-stress, I need a secluded spot where For a brief period of time, I wanted to be alone or with my spouse. I'm bothered by the hectic atmosphere in the hospital. (P1)

P1 also confirmed empathy intervention. She was dissatisfied with the way doctors and nurses treated her, as if they were unconcerned about her sentiments. Not regular intervention, but compassionate intervention was required. She told me the following:

Doctors and nurses didn't appear to care about how I was feeling. Nobody seemed to care about how I was feeling after my miscarriage. They simply inquired about my post-curettage symptoms, such as giddiness and palpitation. No, a nurse questioned about my emotions, but only as part of the admissions process, and that was the end of it. I needed them to be concerned about my feelings and treat me with compassion rather than duties. (P1)

To help participants properly deal with their feelings, flexible intervention is required.

P1 recalled,

I was inconsolably heartbroken and cried excessively. A nurse interrogated me, stating that she needed my information to admit me to the hospital before conducting curettage. At the moment, I wasn't prepared to say anything. (P1)

It's worth noting that the three topics explored in this study are all parts of the same experience. All the components are interconnected to provide a clear view to the reader.

CHAPTER V

DISCUSSION

This study sought to facilitate deeper research on miscarriage women experiences. Interviews considering the lived experiences of informants provided detailed description of personal experiences. This study focuses on women who experience post-trauma such as society stress, family expectations, relationship breakdowns and psychological and emotional issues. In Pakistan most cases go unregistered due to stigma fear of being ostracized by the society (Rowlands, 2010). The present study was conducted to gain in-depth experience of women who undergone trauma of miscarriage. Since data was collected from three participants three superordinate themes emerged.

The results of this qualitative study show that both men and women are significantly impacted by the miscarriage experience. The results of this study confirm previous reports that there is a need for more awareness regarding the prevalence of miscarriage (Orden, 2003). Miscarriage is a frequent occurrence, but as these participants reported, they were not made aware of these high rates until they actually experienced one. This study's participants thought that increased information provision will help people better prepare for the likelihood that their pregnancy would end in miscarriage and, if it does, that there is assistance available (Thorton, 2011).

Dealing with hopelessness, recovering emotional balance, and recognising the need for assistance were the themes that emerged from the data. Each of these areas of life has its own set of issues, and participants claimed that all of the anxiety elements are linked to the development of additional issues (Leff, 1987).Given that a reason is unknown in up to 50% of miscarriages, it was thought that knowing this information beforehand could lessen some of the guilt felt (Swain, 2011). Participants emphasised the need of including physical facts

about miscarriage in such information offering. These results are consistent with those of, who found that spontaneous miscarriages left women feeling unprepared and wondering if their experiences were typical. Miscarriage may be a physically unpleasant experience for women since they may feel intense, unexpected pain, lose blood, and may require hospitalisation. Participants in this study indicated that pregnancy after a miscarriage was stressful (Rowlands, 2010).

The emotional impacts of women lives are that they cannot fully express their feelings after their loss. The most prevalent emotion in the current study was sadness, when the women become depressed and frustrated after this loss then anger comes. Physical effects are the bodily changes in miscarriage women this occurs with repeated miscarriage. Physical changes occur due to weakness and fatigue (Slade, 1994).

The participant reported:

''main problems that are associated with my physical health is sleep deprivation and other was not eating''

Other Participant reported:

''people always say try again and again after a miscarriage. They will not look at our physical condition how we suffer in our lives at this critical time''

A woman who has had a miscarriage has a high level of emotional impact that causes her stress. The stress management model describes the types of stress in experiences because the caregiver shows a negative attitude towards them which make them feel less and it affects them in every aspect of their life. According to the stress process model stressors is directly related to the emotional responses (Meier, 2013).

The psychological effects are the impacts of women mental health which make them unable to relax and perform their tasks efficiently in their daily routine. The participant reported high level of grief and sadness when their love one attitude change towards them. The most common psychological difficulties among woman are stress, anger, grief, and depression. They also have feeling of guilt for having such kind of feeling of anger towards their love one and begin blaming their own self (Lombardo, 2010).

Participant reported:

''*I always blamed myself for what happened''*

It is very common in our society to accept the loss of baby. It is difficult for mother, but people make it more difficult for those who experienced these issues. It is difficult to accept that a child is no more, and women might not become mother in future (Smith, 2006). At that time, all women were anxious about their new-born baby decide their name, gender etc. But all the excitement of the children ended after the loss of the child. They always think about the other people evaluation with her after miscarriage (Slade, 1994). Participant reported that:

''I was very excited when I got the news of my first pregnancy, but I felt GOD only gave me few days for this happiness''

After miscarriage, women experience high level of anxiety which may create greater psychological burden. Because there are some concerns such as waiting for the return of normal life, desire to conceive and risks of recurrent miscarriage and fear about next pregnancy (Price, 2008). In Pakistani society, people may not recognize the importance of the loss of to the women. Traditionally when deaths occur in family everybody can openly mourn their loss and receive support for many months. However, in miscarriage the loss is sudden and often unexpected, and women may not share the fact that they were pregnant, leaving

them to grieve alone, socially isolated (Lee, 1996). Sometimes the psychological effects of miscarriage are also overlooked because miscarriage is very common, and its management is medically straightforward. Most women seek specific follow-up care from their doctors. But our society lacks the comfort and training to diagnose women after a miscarriage. In our society people will start expecting another pregnancy from women. Therefore, patients are at risk for mental healthproblems. State of hopelessness after miscarriage is very common in women (Mann, 2008).

One of the particiapnt said that:

''My husband might be planning for second marriage because I am sure that his family will not accept me knowing that after repeated miscarriage, i will not be a mother again in the future. Some women planned to separate, some later became depressed and say why does God do that? Why did not God not give us this joy?''

Despair is common in women after miscarriage. Due to lack of support from family members, people start ignoring the woman who has frequent miscarriages. Because people think that it is only the fault of those women who did not become mothers (Kvale, 1996).

One particiapnt said:

"*I preferred to sit alone in my room, and no one understood me at that time".*

Previous studies have focused on how women can cope with all these physical condition after a miscarriage, but this current study focuses on challenges women face after repeated miscarriage (Lok, 2007). But there is no research to provide psychological treatment for women after the trauma of miscarriage. This study focuses on the challenges we need to work on in the future. Following this study, it is important to provide psychological education to families about this condition (Layne, 1997). There is great need to work for prevention of social stigma in Pakistan. Educate people on how they can help miscarried women cope with

their trauma. Strategies used by women after repeated miscarriage. It is very difficult to deal with their situation because no one in our society can understand this problem because there is lack of awareness about it. It is only GOD plan. Women don not have their own fault about this problem. Men and women both used commitments as a coping mechanism, particularly caring for the family's other children (Harvey, 2001). Having living children has also been utilised as an indicator for the value connected to the pregnancy in a review of the research on grieving after miscarriage. This notion is based on the belief that a relative increase in desire for children arises when there are no living children. The results also showed how crucial it is for medical practitioners to recognise miscarriage and how grateful the participants were for the support they received (Brier, 2004). Some women said that:

''we were thinking about our husband second marriage because he looked unhappy and this was because of us''

But some women said that:

''women shedding tears all the time and then we always blamed ourselves for, why God does that. Women need love, affection, and care after going through the trauma of miscarriage. But people in our society are showing that it is only women fault''

In our Pakistani society, there is a lack of understanding regarding miscarriage. Family members are in severe need of psychoeducation regarding their situation. There is a lot of cultural pressure that may effect a woman's everyday life following a miscarriage, such as stigma that leads to quiet women being discouraged from announcing pregnancy sooner (Wijma, 2004). Many participants were afraid of humiliation, shame, or failure if they spoke about their miscarriage because of the stigma (Polt, 1999). In our culture, blaming is fairly widespread. In this study, women who were getting closer to childbirth felt more strongly about the perceived insufficiency in service delivery, because maternal age may have an

impact on a person's plans for having children (Simmons, 2006). A woman's increasing maternal age in conjunction with a number of losses she has suffered may have an effect on the length and severity of her grieving (Brier, 2004).

Any elements that might have an impact on the outcomes should be taken into account during the analysis. All of the study's subjects mentioned the specialised early pregnancy loss clinic. The staff at this facility is devoted to the treatment of pregnancy loss. Not many hospitals have such a specialised clinic (Denzin, 1994). Therefore, the existence of such a team at the hospital may have increased other medical staff's understanding of miscarriage and affected how they treated the participants in our study (Frost, 2007).

A Qualitative methodology was found appropriate for this study, it is vital to keep in mind that the results of such investigations are context-specific (Castaneda, 2003). Women's and men's experiences in this study may or may not be representative of those of people who attend other units with different resources and practises. Despite these limitations, it is believed that these data add to our understanding of miscarriage experiences.

5.1 CONCLUSION

The study was conducted to get in-depth knowledge about experiences of women who undergone the trauma of miscarriage. This study highlighted three major themes based on experiences. These were lived experience of miscarriage, emotional experiences and psychological impact, relationship conflicts and societal pressure (Swain, 2011).

The present study shows how societal pressure affects women who go through miscarriage trauma. Social influenced such as social pressure, lack of awareness the critical condition of women that they will face and the emotional burden of the people. The present study elicited the connection and complexity that revolves around the women after miscarriage.

While addressing sensitive subjects carries the potential of causing emotional distress, research indicates that individuals may benefit from the chance to share their experiences (Castle & Phillips, 2003). Participants who are interviewed utilising a qualitative technique can disclose all of their experiences, and frequently people value the chance to have their stories heard honestly and considered seriously. As this can be an empowering experience, knowing that their participation in this research may benefit women experiencing miscarriage in the future.

This study also emphasises that continuity of care during subsequent pregnancies and a thorough assessment of the underlying causes of miscarriage are essential for patients who experience miscarriage. When counselling people who are having a miscarriage, it is crucial to provide both supportive and relevant clinical information. It is important to think about how clinical practise might follow up with women who have other potential miscarriage risk factors but have not had repeated miscarriages.

Women typically control their emotions on their own. They require the support of their close friends and family members as well as the workers at the maternity health care ward because they feel alone with their worries and anxieties. Unfortunately, the staff does not seem to be providing the support the women believe they need, so they are forced to rely on their friends, families, and partners to assist them in controlling their emotions.

However, apart from all distress and anxiety the support from family and friend makes it easy for the survivors to cope with the challenges they face after miscarriage and look toward positive side of life. The results highlight the increased awareness of the importance of women who undergone fear and apprehensions of miscarriage. This study gives information to those who are aware of women's condition and tend to blame them.

Finally, this study clearly demonstrates that women's experiences with the care they received are different. Women in my study who had favourable experiences with medical care were satisfied with the treatment they had gotten. Others, however, had unpleasant experiences and felt unsatisfied with the medical attention they had gotten. The women sought additional in-depth information about their position from medical practitioners who are sensitive to the type of information needed. Additionally, the women require delicate, considerate, and careful medical care. Family members' assistance in assisting women in the workforce can help to lessen feelings of isolation and insecurity.

5. 2 Strengths

- The information offered in this study assisted in identifying the elements that are specific to the experiences of women with miscarriges in Lahore, with the goal of closing the gap that exists in the current literature about this demographic.
- The study actually touched those sensitive parts which women of our country experience when they find out about their first miscarrige. They experience many social, emotional psychological and physical challenges.
- The participants were able to understand the language of interview questions during the interview and that allowed them to provide information rich in experiences.

5. 3 Limitations

- Difficulties were faced during the process of data collection as people were not willing to give interview those who participated had problems with their availability.
- Due to small size of study, the results cannot be generalized in public.
- While all participants were able to converse in English, some indicated that they were more comfortable to speak in Urdu. This affected slightly from their overall fluency in expressing ideas.

5.4 Implications and Recommendations

The findings of this study have led to a number of suggestions. Some of these were expressed by the women who took part in the study, while others are based on my interpretation of the results.

- Educating nurses on how to care for women who have miscarriages
- Providing information to meet the needs of each woman
- Providing emotional stability and support
- Taking into account the various requirements of women and offering compassionate care. The data suggested that they were unsatisfied when care appeared to be regular without regard for individual women's needs. As a result, health providers are advised to give empathic therapies that are attentive to each woman's feelings and needs.

REFERENCES

Adolfsson, A. (2010). Applying Heidegger's interpretive phenomenology to women's miscarriage experience. *Psychology Research and Behavior Management, 3,* 75- 79.

Adolfsson, A., Larsson, P.G., Wijma, B., & BertorÖ, C. (2004). Guilt and emptiness: Women's experiences of miscarriage. *Health Care for Women International, 25*, 543-560.

Annells, M. (1996). Hermeneutic phenomenology: Philosophical perspectives and current use in nursing research. *Journal of Advanced Nursing, 23*, 705-713.

Brier, N. (2004). Anxiety after miscarriage: A review of the empirical literature and implications for clinical practice. *Birth, 31*(2), 138–142.

Brin, D. J. (2004). The use of rituals in grieving for a miscarriage or stillbirth. *Women & Therapy, 27*(3-4), 123-132.

Burns, N. (2007). Critical perspectives. *Politics & Gender, 3*(1), 103-121.

Cacciatore, J., Bushfield, S. (2008). Stillbirth: A sociopolitical issue. *Affilia: Journal of Women and Social Work, 23*(4), 378-387.

Castaneda, X., Billings, D., & Blanco, J. (2003). Abortion beliefs and practices among midwives (Parteras) in a rural Mexican township. *Women & Health, 37*(2), 73-87.

Castle, J., & Phillips, W.L. (2003). Grief rituals: aspects that facilitate adjustment to bereavement. *Journal of Loss and Trauma*, *8*(1), 41-71.

Chalmers, B. (1992). Terminology used in early pregnancy loss. *British Journal of Obstetrics & Gynecology, 99,* 357- 358.

Cosgrove, L. (2004). The aftermath of pregnancy loss: A feminist critique of the literature and implications for treatment. *Women & Therapy, 27*(4), 107-122.

Creswell, J.W. (2007). *Qualitative Inquiry and Research Design: Choosing Among Five Approaches.* (2nd ed.). Thousand Oaks, CA: Sage Publications.

Crist, J.D., & Tanner, C.A. (2003). Interpretation/analysis methods in hermeneutic interpretive phenomenology. *Nursing Research, 52*(3), 202-205.

Cumming, G., Klein, S., Bolsover, D., Lee, A., Alexander, D., Maclean, M. & Jurgens, J. (2007). The emotional burden of miscarriage for women and their partners: trajectories of anxiety and depression over 13 months. *BJOG: An International Journal of Obstetrics & Gynaecology, 114*(9), 1138–1145.

Cunningham, F.G., Leveno, K.J., Bloom, S.L., Hauth, J.C., Gilstrap, L.C., & Wenstrom, K.D., Lindsay, A. (2005). *William obstetrics* (2nd ed.). New York: McGraw-Hill.

Denzin, N.K. & Lincoln,Y.S. (1994). *Handbook of Qualitative Research.* Thousand Oaks, CA: Sage Publications.

Engelhard, I.M., Arntz, A. (2001). Postraumatic stress disorder after pregnancy loss. *General Hospital Psychiatry, 23*(2), 62-66.

Fade, S. (2004). Using interpretative phenomenological analysis for public health nutrition and dietetic research: A practical guide. *Proceedings of the Nutrition Society, 63,* 647–653.

Figley, C.R., Bride, B.E., Mazza, N. (1997). *Death and Trauma: The Traumatology of Grieving.* Washington, DC: Taylor & Francis.

Frost, J., Bradley, H., Levitas, R., Smith, L., & Garcia, J. (2007). The loss of possibility: scientisation of death and the special case of early miscarriage. *Sociology of Health & Illness, 29*(7), 1003-1022.

Gerber-Epstein, P., Leichtentritt, R. D., & Benyamini, Y. (2009). The experience of miscarriage in first pregnancy: *The women's voices. Death Studies, 33*(1), 1-29.

Gerber-Epstein, P., Leichtentritt, R.D., & Benyamini, Y. (2009). The experience of miscarriage in first pregnancy: The women's voices. *Death Studies, 33*, 1-29.

Hamama-Raz, Y., Hemmendinger, S., & Buchbinder, E. (2010). The unifying difference: Dyadic coping with spontaneous abortion among religious Jewish couples. *Qualitative Health Research, 20*(2), 251-261.

Hamama-Raz, Y., Hemmendinger, S., & Buchbinder, E. (2010). The unifying difference: Dyadic coping with spontaneous abortion among religious Jewish couples. *Qualitative Health Research, 20*(2), 251-261.

Harvey, J., Moyle, W., & Creedy, D. (2001). Women's experience of early miscarriage: A phenomenological study. *Australian Journal of Advanced Nursing, 19*(1), 8-14.

Jonas-Simpon, C. & McMahon, E. (2005). The language of loss when a baby dies prior to birth: Cocreating human experience. *Nursing Science Quarterly, 18*(2), 124-130.

Koch, T. (1996). Implementation of a hermeneutic inquiry in nursing: philosophy, rigour and representation. *Journal of Advanced Nursing, 24*(1), 174-184.

Kvale, S. (1996). *Interviews: An introduction to qualitative research.* Thousand Oaks, CA: Sage.

Laverty, S.M. (2003). Hermeneutic phenomenology and phenomenology: A comparison of historical and methodological considerations. *International Journal of Qualitative Methods, 2*(3), 789-889.

Layne, L.L. (1990). Motherhood lost: Cultural dimensions of miscarriage and stillbirth in America. *Women & Health, 16*(3), 69-98.

Layne, L.L. (1997). Breaking the silence: An agenda for a feminist discourse of pregnancy loss. *Feminist Studies, 23*(2), 289-315.

Layne, L.L. (2003). Unhappy endings: a feminist reappraisal of the women's health movement from the vantage of pregnancy loss. *Social Science & Medicine, 56*(9), 1881-1891.

Lee, C., & Slade, P. (1996). Miscarriage as a traumatic event: A review of the literature and new implications for intervention. *Journal of Psychosomatic Research, 40*(3), 235-244.

Lee, C., Slade, P., & Lygo, V. (1996). The influence of psychological debriefing on emotional adaptation in women following early miscarriage: A preliminary study. *British Journal of Medical Psychology, 69*, 47-58.

Leff, P.T. (1987). Here I am, ma: The emotional impact of pregnancy loss on parents and health-care professionals. *Family Systems Medicine, 5*(1), 105-114.

Letherby, G. (1993). The meanings of miscarriage. *Women's Studies International Forum, 16,* 165-180.

Lok, I.H., & Neugebauer, R. (2007). Psychological morbidity following miscarriage. *Best Practice and Research Clinical Obstetrics and Gynaecology, 21*(2), 229–247.

Lombardo, E., Meier, P., & Verloo, M.M.T. (2010). Discursive dynamics in gender equality politics: what about 'feminist taboos'? *European Journal of Women's Studies, 17*(2), 105-123.

Maker, C., & Orden, J. (2003). The miscarriage experience: More than just a trigger to psychological morbidity? *Psychology and Health, 18*(3), 403-415.

Mann, J. R., McKeown, R. E., Bacon, J., Vesselinov, R., & Bush, F. (2008). Predicting depressive symptoms and grief after pregnancy loss. *Journal of Psychosomatic Obstetrics & Gynecology, 29*(4), 274-279.

Meier, P., & Lombardo, E. (2013). Gender quotas, gender mainstreaming, and gender relations in politics. *Political Science, 65*(1),46-62.

Neugebauer, R. (2003). Depressive symptoms at two months after miscarriage: Interpreting study findings from an epidemiological versus clinical perspective. *Depression and Anxiety, 17*(3), 152–161.

Paton, F., Wood, R., Bor, R., & Hitsun, M. (1999). Grief in miscarriage patients and satisfaction with care in a London hospital. *Journal of Reproductive & Infant Psychology, 17*(3), 301-315.

Polt, R.F.H. (1999). *Heidegger: An introduction.* London: UCL Press.

Price, S. (2008). Women and reproductive loss: client-worker dialogues designed to break the silence. *Social Work, 53*(4), 367-376.

Rowlands, I., & Lee, C. (2010). 'The silence was deafening': social and health service support after miscarriage. *Journal of Reproductive & Infant Psychology, 28*(3), 274-286.

Schwerdtfeger, K.L., & Shreffler, K.M. (2009). Trauma of pregnancy loss and infertility among mothers and involuntarily childless women in the United States. *Journal of Loss & Trauma, 14*(3), 211-227.

Simmons, R.K., Singh, G., Maconochie, N., Doyle, P., & Green, J. (2006). Experience of miscarriage in the UK: Qualitative findings from the national women's health study. *Social Science & Medicine, 63*(7), 1934-1946.

Slade, P. (1994). Predicting the psychological impact of miscarriage. *Journal of Reproductive and Infant Psychology, 12*(1), 5-16.

Smith, L.F., Frost, J., Levitas, R., Bradley, H., & Garcia, J. (2006). Women's experiences of three early miscarriage management options: a qualitative study. *British Journal of General Practice, 56*(4), 198-205.

Swain, S., & Thorton, D. (2011). Fault, gender politics and family law reforms. *The Australian Journal of Politics and History, 57*(2), 207-220.

Van den Akker, O.B.A. (2011). The psychological and social consequences of miscarriage. *Expert Reviews of Obstetrics & Gynecology, 6*(3), 295.

Van Manen, M. (1990). *Researching lived experience: human science for an action sensitive pedagogy.* London: The Althouse Press.

APPENDIX

APPENDIX A: PERMISSION LETTER

KINNAIRD COLLEGE FOR WOMEN

Date: _____

PERMISSION LETTER

To,

_____

_____

Our student, _____ of B.Sc. (Hons) Applied Psychology Program, Kinnaird College for Women, Lahore, is conducting her research on:

_____

_____.

She is interested to carry out the study in your institution/organization/hospital with_____. She will be administering her research questionnaire to identify the _____. I request you to grant her permission to conduct research work at your prestigious institute. Your cooperation/help in providing the necessary facilities for collecting data will be highly appreciated. Your support in this respect will also promote research work in Pakistan.

Thanking in anticipation

Afsheen.

Dr. Afsheen Gul
Head, Applied Psychology Department
Kinnaird College for Women, Lahore

KINNAIRD COLLEGE FOR WOMEN 93- Jail Road Lahore.

93, Jail Road, Lahore-54000 Pakistan. Tel: 92-42-99203781-84 Fax: 92-42-99203788 Email: rukhsana.david@kinnaird.edu.pk

APPENDIX B: INFORMED CONSENT



Consent Form for the Participants

I _____ have been informed of the format of the research on the topic "Understanding Fear and Apprehensions Experienced by Women with Miscarriages". I'm willing to participate in this research project and I am aware that the information will be kept confidential and used for research purpose only. I am also aware that I can withdraw from the research at any point if I chose to do so.

I have no further questions regarding the research presently.

Name of the participant _____

Participant Signature _____

اجازت نامہ

مجھے _____

"اسقاط حمل کے شکار خواتین کے ذریعے تجربہ کردہ خوف اور خدشات کو سمجھنا" کے موضوع پر تحقیق کے فارمیٹ سے آگاہ کیا گیا ہے۔ میں اس تحقیقی منصوبے میں حصہ لینے کے لیے تیار ہوں اور مجھے معلوم ہے کہ معلومات کو خفیہ رکھا جائے گا اور صرف تحقیقی مقصد کے لیے استعمال کیا جائے گا۔ میں یہ بھی جانتا ہوں کہ اگر میں نے ایسا کرنے کا انتخاب کیا تو میں کسی بھی وقت تحقیق سے دستبردار ہو سکتا ہوں۔

حصہ لینے والے کا نام _____

حصہ لینے والے کے دستخط _____

APPENDIX C: Demographic form

The information provided here will be kept confidential. Kindly answer the following questions:

First Name: _____

Last Name: _____

Age: _____

Date: _____

Home Address Information

Address: _____

City: _____ State: _____

Nationality/Ethnicity: _____

Country of Birth: _____

Education History

School: _____

College: _____

University: _____

QUESTIONS ON MATERNAL HEALTH SERVICES

- **GENERAL**

Is there a confirmed cause of your repeated miscarriages?

1. Yes
2. No

Do you wish to conceive at this moment in time?

1. Yes
2. No

Are you pregnant at this time?

1. Yes
2. No

Which process did you go through for delivery after miscarriage?

1. Vaginal
2. C-section

After your experience of miscarriage do you still have a fear of pregnancy for conceiving a child?

1. Yes
2. No

How many times have you been pregnant? ___

How many children do you have? ___

How many miscarriages have you had? ___

How many pregnancies have you terminated? ___

The following questions are about:

- **Providing supportive care for the next pregnancy**

1. **During my next pregnancy I would feel supported if I could make a plan with my doctor for the first 12 weeks of pregnancy:**
   Yes
   No
2. **During my next pregnancy I would feel supported if I would receive advice about diet**
   Yes
   No
3. **During my next pregnancy I would feel supported if I would receive advice about what to do and not to do (lifestyle)**
   Yes
   No

4. **During my next pregnancy I would feel supported if I would receive an ultrasound: Directly after a positive pregnancy test**

   Yes

   No

5. **During my next pregnancy I would feel supported if my doctor(s): has knowledge of obstetric history**

   Yes

   No

6. **During my next pregnancy I look for support from: My family**

   Yes

   No

7. **During my next pregnancy I would feel supported if: I would receive counselling from: A specialized nurse**

   Yes

   No

8. **I would feel encouraged during my next pregnancy if my husband would be more interested**

   Yes

   No

9. **If my next pregnancy was to end in a miscarriage I would feel supported if I could talk to someone**

   Yes

   No

Participant's Signature: _____

آبادیاتی فارم

یہاں فراہم کردہ معلومات کو خفیہ رکھا جائے گا۔ براہ کرم سمجھیں کہ اس سوالنامے پر آپ کے جوابات رضاکارانہ ہیں لیکن آپ کچھ سوالات کا جواب نہ دینے کا انتخاب کر سکتے ہیں۔ برائے مہربانی درج ذیل سوالات کا جواب دیں:

پہلا نام: _____

آخری نام: _____

عمر: _____

تاریخ: _____

گھر کے پتے کی معلومات

پتہ: _____

شہر ریاست: _____

قومیت/نسلیت: _____

وطن پیدائش: _____

تعلیمی تاریخ

اسکول: _____

کالج: _____

جامع درس گاہ: _____

زچگی کی صحت کی خدمات سے متعلق سوالات

عمومیϖ

کیا آپ کے بار بار اسقاط حمل کی کوئی تصدیق شدہ وجہ ہے؟

1. ہاں

2. نہیں

کیا آپ اس وقت حاملہ ہونا چاہتے ہیں؟

1. ہاں

2. نہیں

کیا آپ اس وقت حاملہ ہیں؟

1. ہاں

2. نہیں

اسقاط حمل کے بعد ڈلیوری کے لیے آپ کو کس عمل سے گزرنا پڑا؟

1. اندام نہانی

2. سی سیکشن

کیا آپ کے اسقاط حمل کے تجربے کے بعد بھی آپ کو بچہ پیدا کرنے کے لیے حمل کا خوف ہے؟

1. ہاں

2. نہیں

آپ کتنی بار حاملہ ہوئی ہیں؟ ___

آپ کے کتنے بچے ہیں؟ ___

آپ کے کتنے اسقاط حمل ہوئے ہیں؟ ___

آپ نے کتنے حمل ختم کیے ہیں؟ ___

درج ذیل سوالات اس بارے میں ہیں:

ϖ اگلی حمل کے لیے معاون دیکھ بھال فراہم کرنا

1. اپنی اگلی حمل کے دوران اگر میں حمل کے پہلے 12 ہفتوں کے لیے اپنے ڈاکٹر کے ساتھ منصوبہ بنا سکوں تو میں خود کو سہارا محسوس کروں گا:

جی ہاں

نہیں

2. اپنی اگلی حمل کے دوران اگر مجھے خوراک کے بارے میں مشورہ ملے تو میں خود کو سہارا محسوس کروں گا۔

جی ہاں

نہیں

3. اپنی اگلی حمل کے دوران اگر مجھے اس بارے میں مشورہ ملے گا کہ میں کیا کروں اور کیا نہ کروں (طرز زندگی)

جی ہاں

نہیں

4. اپنی اگلی حمل کے دوران اگر مجھے الٹراساؤنڈ ملے گا تو میں خود کو سہارا محسوس کروں گا: براہ راست حمل کے مثبت ٹیسٹ کے بعد

جی ہاں

نہیں

5. اپنی اگلی حمل کے دوران اگر میرے ڈاکٹر (ڈاکٹر) کو زچگی کی تاریخ کا علم ہو تو میں معاون محسوس کروں گا۔

جی ہاں

نہیں

6. اپنی اگلی حمل کے دوران میں اس سے مدد تلاش کرتا ہوں: میرا خاندان

جی ہاں

نہیں

7. اپنی اگلی حمل کے دوران میں خود کو سہارا محسوس کروں گا اگر: مجھے اس سے مشورہ ملے گا: ایک ماہر نرس

جی ہاں

نہیں

8. میں اپنی اگلی حمل کے دوران حوصلہ افزائی محسوس کروں گا اگر میرے شوہر زیادہ ہوں گے۔

دلچسپی

جی ہاں

نہیں

9. اگر میرا اگلا حمل اسقاط حمل میں ختم ہو جائے تو میں اپنے آپ کو سہارا محسوس کروں گا۔

کسی سے بات کریں

جی ہاں

نہیں

شرکت کنندہ کے دستخط: _____

APPENDIX D: INTERVIEW GUIDE

Research Questions	Key Concept	Interview questions	Probing
• What are the expeiences of women with miscarriages ? • What are the coping strategies of these women?	**Introduction**	How are you? Will you introduce yourself? Are your feeling comfortable? Do you need anything? Did you have any problem coming here?	Is there anything you want to add/tell?
	<u>Health:</u>	How did the miscarriage have an effect on you and your health, immediate and long-term?	Is there any other/ anything else related to your fear you want to share?
	• **Psychological**	What were your impressions, both good and negative, following the miscarriage? Can you tell me how you dealt with your feelings after your loss?	can you tell me more about it?
	• **Social**	During your experience, please can you tell me about your support system? If it is your partner, family, friends, group, coworkers, medical team, etc., you can	What do you think that how much social factors can help you during

	list any individuals that contribute to your experience.	this crucial time?
	What was your husband reaction when he came to know about this news?	was it helpful or unhelpful?
• **Level of Self-Efficacy**	How did you feel about people talking about your first miscarriage or finding it out?	How did you react to these feelings? Did you share it with anybody?
Functional Disabilities • **Mental**	Your level of stress related to fear of giving birth after miscarriage from 1 to 10?	How long you have been facing this stress or fear?
• **Physical**	Did this fear affected your daily routine?	How much did this affect/bothers you?
Hope of Recovery	Did you hope you will recover from your fear? Throughout your experience, what did you think was comforting? Were there any strategies that you considered during the experience to be useful?	How much did social support and valid guidance gave you hope? What caused you to smile? What have you considered beneficial in your

			coping activities?
	Progress for Recovery	Do you think this recovered fear helped you (in case) for your child birth?	After this successful recovery how are you feeling?

انٹرویو گائیڈ

تحقیقی سوالات

- اسقاط حمل والی خواتین کے تجربات کیا ہیں؟
- ان خواتین کا مقابلہ کرنے کی حکمت عملی کیا ہے؟

تعارف

آپ کیسے ہو؟

کیا آپ اپنا تعارف کروائیں گے؟

آپ کتنے سال کے ہو؟

آپ کس شہر میں رہتے ہیں؟

کیا آپ کچھ شامل کرنا/ بتانا چاہتے ہیں؟

صحت:

اسقاط حمل کا آپ اور آپ کی صحت پر فوری اور طویل مدتی اثر کیسے پڑا؟

کیا آپ کے خوف سے متعلق کوئی اور/کچھ اور ہے جسے آپ بانٹنا چاہتے ہیں؟

کیا آپ مجھے بتا سکتے ہیں کہ آپ نے اپنے نقصان کے بعد اپنے جذبات سے کیسے نمٹا؟

نفسیاتی

اسقاط حمل کے بعد آپ کے اچھے اور منفی دونوں تاثرات کیا تھے؟

کیا آپ مجھے اس کے بارے میں مزید بتا سکتے ہیں؟

سماجی

اپنے تجربے کے دوران، کیا آپ مجھے اپنے سپورٹ سسٹم کے بارے میں بتا سکتے ہیں؟ اگر یہ آپ کا ساتھی، خاندان، دوست، گروپ، ساتھی کارکنان، طبی ٹیم وغیرہ ہیں، تو آپ ان افراد کی فہرست بنا سکتے ہیں جو آپ کے تجربے میں حصہ ڈالتے ہیں۔

آپ کا کیا خیال ہے کہ اس اہم وقت میں سماجی عوامل آپ کی کتنی مدد کر سکتے ہیں؟

کیا آپ شیئر کر سکتے ہیں اگر آپ کو لگتا ہے کہ آپ کے ساتھی کے ساتھ آپ کا رشتہ متاثر ہوا ہے جب آپ نے اسے یہ خبر سنائی؟

کیا یہ مددگار تھا یا غیر مددگار؟

خود افادیت کی سطح

آپ کو لوگوں کے بارے میں کیسا محسوس ہوا جو آپ کے پہلے اسقاط حمل کے بارے میں بات کر رہے ہیں یا اس کا پتہ لگا رہے ہیں؟ آپ نے ان احساسات پر کیا ردعمل ظاہر کیا؟

کیا آپ نے اسے کسی کے ساتھ شیئر کیا؟

فنکشنل معذوری

ذہنی

آپ کے تناؤ کی سطح 1 سے 10 تک اسقاط حمل کے بعد پیدائش کے خوف سے متعلق ہے؟

آپ کتنے عرصے سے اس تناؤ یا خوف کا سامنا کر رہے ہیں؟

جسمانی

کیا اس خوف نے آپ کے روزمرہ کے معمولات کو متاثر کیا؟

اس نے آپ کو کتنا متاثر/پریشان کیا؟

بحالی کی امید

کیا آپ کو امید تھی کہ آپ اپنے خوف سے صحت یاب ہو جائیں گے؟

اپنے پورے تجربے کے دوران، آپ نے کیا سوچا کہ تسلی بخش تھی؟

سماجی حمایت اور درست رہنمائی نے آپ کو کتنی امید دی؟

کیا ایسی کوئی حکمت عملی تھی جسے آپ نے تجربے کے دوران مفید سمجھا؟

آپ کی مسکراہٹ کی وجہ کیا ہے؟ آپ نے مقابلہ کرنے کی سرگرمیوں میں کس چیز کو فائدہ مند سمجھا ہے؟

بحالی کے لیے پیش رفت

کیا آپ کو لگتا ہے کہ اس دوبارہ پیدا ہونے والے خوف نے آپ کے بچے کی پیدائش میں آپ کی مدد کی؟

اس کامیاب صحت یابی کے بعد آپ کیسا محسوس کر رہے ہیں؟

Appendix E: Transcribed Interviews

Interview #1

Interviewer: Assalamu Alaikum
P-1: Wa Alaikum Salam
Interviewer: kysi hain aap?
P-1: Main bilkul theek hon beta
Interviewer: Apko yahan anay ma koi takleef toh nhi hui?
P-1: Nhi Nhi beta koi masla nhi hoiya
Interviewer: Aur aunty ghar ma sb theek hain apk?
P-1: Ji Alhamdulillah
Interviewer: Aunty phir hm shuru krty hain interview apny bs in sawalon ka jawab dena ha jo apk miscarriage sy related hain
P-1: Theek ha beta
Interviewer: Aunty jb apka phela miscarriage howa toh usk a apki sehat pr kysa asar para fauri aur taweel time tk?
P-1: Mere liye woh boht hi shocking tha mujy toh phely yakeen hi nhi horha tha aur phir issi shock ki waja sy meri tabiyat pr bhi boht-bura asar para rhi baat long term ki toh ab ma kaafi behtr hon.
Interviewer: kya soch thi aapki aunty jb apko apny phly miscarriage ki khabar pta chli (positive

ya negative)?

P-1: Beta mostly negative hi feelings thin meri kuch samajh nhi arha tha k kya horha tha mery sath. All positive ma yehi kh skti thon k Allah ny kuch behtr hi socha hoga mery liye.

Interviewer: Ch aunty bilkul boht mushkil wqt hota ha kisi bhi aurat k liye ye. phir aunty ap ny apny nuqsan k baad apny jazbaat sy kysy deal kiya?

P-1: Beta tha toh boht mushkil pr mery husband ny mujy is situation ma boht support kiya aur mery parents ny bhi mujy boht tasali di k "kuch nhi hota bs tm apna khayal kro".

Interviewer: Ap k is experience k dauran ap kisko sbsy ziada apna support system samjahti hain? Ap k husband, family, friends, medical team ya co-workers

P-1: Jaisey many phly bhi mention kiya mery husband ny mujy boht support kiya unk begair mery liye boht mushkil hota ye sb kuch handle krna.

Interviewer: kya ap shale krskti hain k agr is experience k baad apko lga ho k apk partner ka rawaia ya rishta apk sath mutasir howa ho?

P-1: Ch billkul bhi nhi shukar Alhamdulillah aysa koi bhi masla nhi howa unko mery sath.

Interviewer: Apko kysa mehsoos howa jb jb logon ko apk phly miscarriage k bary ma pta chla?

P-1: Logon ny beta zahir si baat ha baatain toh banani hoti ha lekin unki baaton pr many koshish ki k ziada focus na kron.

Interviewer: Ch aunty boht acha kiya apny..... ..... Acha aunty miscarriages k baad apka birth deny sy related kitna stress ya anxiety thi ap ma (1-10)?

P-1: Beta ma kahon gi 8 kyunk jo aurat 3 dafa is experience sy guzar chuki ha usk liye toh dobara baby conceive krny ka bhi sochna usko khauf deta ha.

Interviewer: kya ye khauf apki daily routine pr bhi affect krta tha? Apko ye kitna taang krta tha

P-1: Haan beta kbhi kbhi krta tha ma is experience k baad boht hi demotivated feel krny

lg gyi thi aur khana peena bhi kaam krdiya tha.

Interviewer: G ma samajh sakti hon..... ..... Aunty kya apko umeed thi k ap is khauf sy recover krskti hain?

P-1: Nhi jb phly mery sath ye experience howa tb toh mujy bilkul bhi umeed nhi thi lekin jb many mery husband aur parents ka support aur unka mujy bar bar motivate krny ny mujy himmat di

Interviewer: Apk is experience k dauran apko kya lga k "tasali Baksh" tha?

P-1: Meri umeed Allah sy k woh meri dua zaroor suny ga aur mujy is mushkil sy bahir jld nikalay ga.

Interviewer: Is experience k dauran koi aysi strategies thi jo apny consider ki jo useful bhi saabit howi apk liye?

P-1: G ma roz subha walk pr nikl jati thi aur many yoga krna bhi shuru krdiya tha jis sy meri attention divert hojati thi.

Interviewer: Aunty kya apko lgta ha k is sb kuch k baad is khauf sy recovered honay ny apko help kiya ha kaafi apki delivery ma?

P-1: G beta jb tk apk paas apki family, husband aur Allah ka support ha toh woh cheez apko kaafi help krti ha aur mayoos nhi hony deti. Sath Sath apki physical health bhi boht matter krti ha isiliye many exercise bhi shuru krdi ha. Aur ma apny phly baby ki successful delivery pr boht hi khush thi mujy boht acha feel howa.

Interviewer: Han g zindagi hmain boht kuch sikhati hai mujy boht acha lga k ap demotivate nhi howi apny hamesha hope rakhi aur phir khuda ny apki dua poori ki ..... acha aunty apka boht boht shukriya is interview k liye time nikalnay k liye aur apni personal information mery sath share krny ma.

P-1: koi baat nhi beta.

Interview #2

Interviewer: Asslamu Alaikum

P-2: Wa Alaikum Salam

Interviewer: kya khaal hai apka?

P-2: main theek hon beta

Interviewer: Apko yahan anay ma koi takleef toh nhi howi

P-2: Nhi beta, haan bs traffic tha kaafi

Interviewer: Ch Aunty traffic bht hogya ha lahore ma ab..... chalain aunty ma ap sy ab kuch sawal poochon gi apk experience sy related.

P-2: Theek ha beta poochlo

Interviewer: Aunty jb apka phela miscalliage howa toh uska apki sehat pr kya asar pala tawi aur taweel time tk ?

P-2: Beta ma toh numb hogyi thi jaisey meny pairon k neechy sy zameen nikal gyi ho. Is news k baad mera khana peena bilkul khtm hogya tha ma kamzoor bhi hogyi thi kaafi. lekin ahista ahista waqt k sath many himmat ki aur ma kaafi behtr hon ab toh.

Interviewer: kya soch thi apki aunty jb apko apny phly miscalliage ki khabar pta chli (positive thi ya negative)?

P-2: Ma toh denial ma chli gyi thi mujy lga tha k shayid insy koi galti howi ha test results ma mujy bilkul bhi yakeen nhi horha tha. meri thinking bilkul negative hogyi thi mujy lga tha k ab kuch nhi hoskta

Interviewer: Aunty phir apny nuqsan k baad apny jazbaat sy kysy deal kiya?

P-2: kaafi mahinon tk mujy kaafi dukh raha is baat ka ma depress feel krny lgi lekin meray husband aur meri mother in law ny meri kaafi help ki mujy tasali di aur kaha k "jo kuch bhi hojay hm tmharay hmesha sath rahengy".

Interviewer: Ch Ch mera apka sawal yehi tha k apko kisny sbsy ziada support kiya tha?

P-2: Haan beta meray husband aur meri mother in law ki ma boht shukr guzar hon.

Interviewer: kya ap shale krskti hain k apr is experience k baad apko lga hok apk partner k rawaia ya rishta apk sath mutasir howa ho?

P-2: Beta ma toh balkay ye kahon gi k hmara rishta toh mazboot hogya ha is experience k baad. Apny phly poocha tha na k positive cheez kya lgi ha apko is dauran mujy lgta ha k yehi ha.

Interviewer: Boht achi baat tha aunty ye toh sunn k acha lga..... Aunty waisey apko kysa mehsoos howa jb logon ko apk phly miscalliage k bary ma pta chla?

P-2: Beta logon ny boht taunt kiya, unka behavior bhi rude hogya mery towards, yahan tak k khin logon ny mery husband ko doosri shaadi krny k liye bhi kaha.

Interviewer: Aysy logon ki baaton py ziado focus nhi krna chahiye ye log bs dusron ka morale hi down krte hain..... Apko aunty birth deny sy related kitna stress ya anxiety thi ap ma (1-10)?

P-2: Mujy lgta ha k 9.5 kyun k logon ki baaton sy meri kuch friends unk experience bhi sun k mery dil ma khauf sa beth gya tha kynk ma phly hi 2 miscalliages sy guzr chuki thi mery ma himmat nhi thi ek aur buri khabar sunnay ki.

Interviewer: kya ye khauf apki daily routine pr bhi affect krta tha? Apko ye baat kitni taang krti thi?

P-2: Haan is experience ny ma kahon gi meri memory py kaafi asar kiya ma khin dafa

bhool jaya krti thi cheezain rakh k ya kya kam mujy krna tha.

Interviewer: Aunty kya apko yakeen tha k ap is khauf sy recover krskti hain?

P-2: Bilkul bhi nhi lekin Allah ka shukr ha k is mushkil wasat ma meey husband meey sath thy aur jo bhi recovery aur support mujy mila ha unki waja sy ha.

Interviewer: Apk is experience k dauran apko kya lga k "Tasali Baksh" tha?

P-2: Meri mother in law ka meri apni maa sy bhi bhar k mujy support krna.

Interviewer: Is experience k dauran koi aysi strategies thi jo apny consider ki useful saabit howi apk liye?

P-2: Mery husband ko jb pta chla k ma is experience k baad depression ma ja rhi hon toh unhon ny psychologist sy contact kiya jo meri counselling kiya krty thy, toh ye meey liye useful saabit howa aur unhon ny mujy is problem k sath deal kruy k liye kaafi coping techniques bhi btain.

Interviewer: Aunty kya apko lgta ha k is sb kuch k baad is khauf sy recovered honay ny apko miscarriage k

help kiya ha kaafi apki delivery ma?

P-2: Beta agr support na hota kisi ka bhi toh shayid ma phly hi give up krdeti kyunk ma kaafi depressed hogyi thi agr meny husband meri counselling na krwaty toh shayid ye fear of miscalleiage mujy zindagi bhar rhta.

Interviewer: Aunty hmari society bhi boht kharab hoti jarhi ha log sochay begair doosron k judge krty hain aur apny sy assumptions bna lety hain lekin inki waja sy hmain agni selfesteem py nhi asar hony dena..... Aunty apka boht boht shukriya time nikalnay k liye.

P-2: koi ayesi baat nhi beta

Interview #3

Interviewer: Assalamu Alaikum

P-3: Wa Alaikum Salam

Interviewer: kysi hain aap aunty? sb theek ha na

P-3: Gr beta sb theek ha koi maslay wali baat hi nhi ha. I'm doing good.

Interviewer: Chalain ye toh boht achi baat ha..... Aunty abhi ma ap sy apk experience sy related kuch sawal poochon gi

P-3: Theek ha beta

Interviewer: Aunty jb apka phela miscarriage howa toh usk apki sehat pr kya asar para fauri aur taweel waqt tk?

P-3: Many toh kbhi socha bhi nhi tha k aysa mery sath hoga mujy aysi takleef bhi sehni pry gi. Ma toh boht depress feel krny lg gyi thi. Aur is waqt k daurain many almost 10kg loose krliya tha kyunk meri diet boht hi disturbed hogyi thi.

Interviewer: kya soch thi apki aunty jb apko apny phly miscarriage ki khabar pta chali (positive thi ya negative)?

P3: Ma toh bilkul hi yaqeen nhi kr pa rhi thi ye kya hogya ha, mujy nausea feel hony lg gya tha aur sir ma dard boht tez shuru hogya tha boht buri khalat thi meri. ma ek dam demotivated feel krny lgi aur us waqt mujy ma kh skti hon suicidal thoughts bhi any lg gye thy, meny liye to jaisey meri duniya hi khtm hogyi ho.

Interviewer: G aunty ma apki takleef samjh skti hon ek maa k liye apni aulaad ko aysy lose krna boht hi mushkil hota ha. Phir aunty ap ny nuqsan k baad apny jazbaat sy kysy deal kiya?

P3: Ma toh yehi kahon gi k mery husband aur mery in laws ny mujy boht support kiya

Interviewer: Ap k is experience k dauran ap apny husband ko sbsy ziad appa support system samjhti hain?

P3: G beta kyunk sbsy ziada is matter ma ussi ka sath sbsy ziad apk important hota ha, ma ye nhi kahon gi k mery parents aur friends ny mujy support nhi kiya pr meny husband ka har bar mujy tasali dena aur is mushkil waqt ma mery sath rhna it says a

lot to me.

Interviewer: kya ap share krskti hain k apr is experience k baad apko lga hok apk partner ka rawaia ya rishta apk sath mutasir howa ho?

P3: Nhi Shukr Allah ka ayisi koi un bun hmaray darmayan nhi howi

Interviewer.. Apko kya mehsoos howa jb jb logon ko apk phly miscalliage k bary ma pta chla?

P3: Jahan tk lgta ha mujy log apk samnay toh bohut apka support kr rhy hoty hain lekin phir jb woh apk samnay nhi hoty toh tarhan tarhan ki baatain bnatay hain

Interviewer: A aunty bilkul ayisa hi ha.....
Aunty miscalliage k baad apka birth deny sy related kitna stress ya anxiety thi ap ma (1-10)?

P3: Ma kahon gi 9 kyunk ma 2 miscalleiges sy guzar chuki hon aur ma hi bta skti hon k us waqt apk dimagh ma kya chl rha hota ha bohut hi overwhelming experience ha

Interviewer: kya ye khauf apki daily routine pr bhi affect krta tha?

P3: Haan bilkul mujy boht intrusive thoughts aty thy ma hr waqt overthinking krti rhti thi aur mujy lgta tha k shayid ma kbhi bhi maa nhi bn skti. Jis ki waja sy ma hamesha distrated rhti thi aur log mala k kanoun ma bhi dehan de pati thi.

Interviewer: Aunty apko umeed thi k ap is khauf sy recover krskti hain?

P3: Bilkul bhi nhi, ma toh boht negative hogyi thi lekin mery husband k support aur care ny mujy ek hope di

Interviewer: Apk is experience k dauran apko kya lga k "tajali Baksh" tha?

P3: Mery husband ki presence

Interviewer: Koi aysi strategies thi jo apny consider ki jo k useful bhi saabit hoyi apk liye?

P3: Mujy painting ka boht shoq ha toh woh mery liye ek theerapy hi hoti thi

Interviewer: Aunty kya apko lgta ha k is sb kuch k baad is khauf sy recovered honay ny apko help kiya ha kaafi apki delivery ma?

P3: Haan beta agr mery pass emotional support na hot toh shayid ma sochti bhi na. Aur jb meri pheli delivery successful gyi toh woh ma ki khushi apni explain nhi krskti.

Interviewer: Aunty apka boht boht shukriya apny mery sath apna expeeience share kiya. Sunn k boht khushi howi k apny himmat nhi chori apny positive rhny ki koshish ki.

P3: Thankyou Beta

Appendix F: Plagiarism Report

Assignments
Students
Grade Book
Libraries
Calendar
Discussion
Preferences

Psychology



About this page

This is your assignment inbox. To view a paper, select the paper's title. To view a Similarity Report, select the paper's Similarity Report icon in the similarity column. A ghosted icon indicates that the Similarity Report has not yet been generated.

BA/BSc January Defense 2023

Inbox | Now Viewing: new papers ▼

Submit File Online Grading Report | Edit assignment settings | Email non-submitters

Delete | Download | move to...

	Author	Title	Similarity	web	publication	student papers	Grade	response	File	Paper ID	Date
☐	Khadija Arfan	EXPLORATION OF ROLE OF FAMILY IN BULLING...	3% 3%	2%	2%	1%			download paper	1965086153	26-Nov-2022
☐	Gopings Zahra	Syeda Khadeeja Imran (Thesis)	11% 11%	8%	6%	6%			download paper	1963477207	26-Nov-2022
☐	Aiman Zahid	Aiman Zahid thesis	17% 17%	16%	2%	5%			download paper	1963200421	25-Nov-2022
☐	Syeda Tayyab Bukhari	HOPE, SELF-ESTEEM, SELF-EFFICACY AND LIF...	62% 62%	12%	12%	60%			download paper	1965084331	26-Nov-2022
☐	Rida Sardar	BA/BSc Defense	75% 75%	13%	8%	72%			download paper	1965083615	26-Nov-2022
☐	Bisma Tanvir	IMPACT OF PERSONALITY TRAITS ON STUDENTS...	75% 75%	70%	26%	59%			download paper	1965083293	26-Nov-2022