Women's Experiences with Coping after Late Pregnancy Loss: A Qualitative Study

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WOMEN'S EXPERIENCES WITH COPING AFTER LATE PREGNANCY LOSS: A QUALITATIVE STUDY

by

Colleen A. Thebert-Wright

A Dissertation
Submitted to the
Faculty of The Graduate College
in partial fulfillment of the
requirements for the
Degree of Doctor of Philosophy
Department of Counselor Education and Counseling Psychology

Western Michigan University
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Pregnancy has been described as a crisis, a developmental period requiring a woman to adapt to profound psychological and somatic change. Resolving the maturational crises related to pregnancy is viewed as a necessary part of achieving maternal identity. Stress may compromise a woman's ability to achieve these developmental tasks. Since a prior pregnancy loss may involve the experience of sudden and unexpected fetal demise, the subsequent pregnancy may be described as high risk and the mother's maternal identity attainment may have been compromised. Relatively little research attention has been directed to the experience of a subsequent pregnancy followed by a late pregnancy loss from the self-reported accounts of the women themselves.

Eight women who experienced a late pregnancy loss, a loss occurring after 20 gestational weeks, and then experienced a subsequent pregnancy and healthy delivery, were interviewed regarding their experiences with coping during their subsequent pregnancy. Interviews with participants were transcribed and data analyzed using the constant comparative method (Marshall & Rossman, 1995). Several themes emerged from the analysis related to women's experiences in coping.
during the subsequent pregnancy. These themes included: (a) contradictory emotions; (b) fear; (c) fearful attachment and persistent vulnerability; (d) obsessive mission, worry, and the wish to hurry the end; (e) awareness that the delivery does not end the worry or the grief; (f) the need for information; (g) differentiating the pregnancy experiences; (h) understanding grief and random events; (i) the decision toward conscious presence and active parenting; (j) provision for the lost child; (k) acceptance of caring for oneself; (l) embrace the experience, the healing aspects of pain; and (m) altered self and worldview. Women's descriptions of what they experienced as helpful and supportive from friends, family, and health care professionals during the subsequent pregnancy are also presented. Findings are discussed in terms of their implications for health care professionals and their possible implications for future research.
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CHAPTER I

INTRODUCTION

Pregnancy has been described as a crisis; a developmental period requiring a woman to adapt to profound psychological and somatic change (Benedek, 1959; Bibring, 1959). Resolving the maturational crises related to pregnancy has been viewed as a necessary part of preparing oneself for motherhood and achieving maternal identity. The developmental tasks discussed by Cohen (1979) are: (a) acceptance of the pregnancy, (b) development of an emotional affiliation with the fetus, and (c) development of an appropriate perception of and response to the neonate as a separate individual.

The experience of stress may compromise a woman’s ability to achieve these developmental tasks. Cohen (1979) concluded a substantial body of evidence was available to support the conclusion that any event perceived by the mother as threatening, depleting or as potentially harmful to herself or her child may seriously compromise the mother’s adaptive behavior toward the pregnancy itself. He stated the existence of any one of several identifiable stress factors are cause for clinical concern and indicate a pregnancy at high risk. In approximate order of importance, the stress factors are: (a) adverse prior experience in childbearing or childrearing, (b) conflicts or defects in the support system, (c) inadequate preparation for childbearing, and (d) maternal health concerns. Since a prior pregnancy loss may
involve nearly all of these factors, the experience of a past pregnancy loss means a
healthy subsequent pregnancy can be described as high risk and the mother’s maternal
identity attainment may have been compromised.

Prevalence of Pregnancy Loss

Approximately 826,000 women may experience a pregnancy loss in the United
States each year. The most common loss is a miscarriage that is estimated to occur in
20% of all recognized pregnancies (Côté-Arsenault & Mahlangu, 1999). Based on the
number of live births in 1995 of 3.9 million (National Center for Health Statistics,
2002), and the 20% estimate of miscarriages, miscarriages may affect as many as
780,000 women in a single year. Of the approximately 3.9 million babies born alive in
1995, over 19,000 died within the first 28 days of life and are considered neonatal
deaths (National Center for Health Statistics, 2002). Approximately another 27,000
(about 1 in every 144 deliveries) were stillborn, dying sometime after 20 gestational
weeks (U.S. Census Bureau, 1999). This translates into the reality that as many as
826,000 women each year are grieving as they attempt to recover from their loss.

Several disputed assumptions regarding the grief parents experience after the
loss have been discussed in the literature, including the length of the pregnancy
influencing the severity of the grief, the gestational age of the fetus determining
whether or not the mother perceived it as an individual separate from herself, and the
nature of parental expectations regarding characteristics of the anticipated child. This
third assumption implied that parental fantasies about the lost child were more
difficult to resolve than the loss of a known person where real memories were allowed to form.

Dyregrov and Matthiesen (1987), Kirkley-Best and Kellner (1982), Lovell (1983), Teel (1991), and Toedter, Lasker and Alhadeff (1988) all contended the later the gestational age of the pregnancy, the more intense was the emotional experience of grief. Laurell-Borulf (1982) and Peppers and Knapp (1980a) asserted the age of the fetus made no difference in the experience of parental grief. Covington (1999), Leon (1986), and Moulder (1994) all described the effects of attachment to, investment in, and individual meaning attributed to the pregnancy as critical factors in parental grief response. They contended the greater the degree of maternal attachment, not the perception of the infant as a separate individual, was a predictor of the intensity of the loss felt.

Of the 826,000 women who experience a pregnancy loss every year, many will attempt to become pregnant again. Increased fertility rates have been demonstrated in women following pregnancy loss in both developing and developed countries (Park, Han, & Choe, 1979; Vogel & Knox, 1975). Rowe et al. (1978) found 54% of their sample became pregnant 10–22 months following their loss. La Roche et al. (1984) found 60% of mothers became pregnant within 2 years after their loss. Oglethorpe (1989) suggested the behavioral response to stillbirth was to have high numbers of pregnancies in the first year following loss, while Côté-Arsenault and Mahlangu (1999) noted despite their intense grief after pregnancy loss, 50–80% of women
became pregnant again. According to Cohen (1979), all of these women would begin subsequent pregnancies influenced by at least one of four major stress factors.

Veiled Distress

While it is clear women achieving pregnancy after an earlier loss experience major health concerns and comprise a vulnerable population, the issue has been given relatively little attention or recognition. Pregnancy is the period of gestation for the child and for the maternal identity of the woman. Any gestational impairment such as infertility, miscarriage, stillbirth, or the birth of an impaired child can engender traumatic misgivings about the competence and worth of the woman’s self. Our culture has recognized the grief associated with death and has established social rituals for its expression. However, neither the recognition of the loss nor the social rituals exist for women who experience and suffer pregnancy losses (McGreal, Evans, & Burrows, 1997; Rajan and Oakley, 1993) and these have been referred to as “non-deaths’ or ‘non-events’ of rarely named ‘non-persons’” (McGreal et al., 1997, p. 160).

Parental grief is exacerbated by the loss of social support. “These parents feel like lepers who are hidden away, out of sight and touch of a healthy society” (DeFrain, Martens, Stork, & Stork, 1986, p. 112). The message they are outcasts was reflected in their birth and recovery experiences. Parents reported being left alone in the hospital with others avoiding them and appearing afraid to mention the baby or to say its name. Practical experience easily validates this contention. With the prevalence of pregnancy loss so common, there is a curious lack of cards in retail stores
addressing this experience. Examination of collections of cards finds very few that specifically acknowledge a pregnancy loss or death of a newborn.

Nature and Characteristics of Pregnancy Loss

In addition to the typical tasks associated with bereavement, women who experience a late pregnancy loss must contend with more than only their grief. A pregnancy loss means the experience of an incomplete rite of passage (Layne, 1990), and the struggle to be a mother without the presence of a child. Women often experience a sense of failure in their role of being a woman or a mother, and blame themselves for the loss of their child (Frost & Condon, 1996; Layne, 1990; Peppers & Knapp, 1980a). Enormous shame, humiliation, guilt, envy of other mothers, and rage against the pervasive sense of inadequacy are additional burdens with which these mothers must contend (Leon, 1986).

The literature has identified psychological complications unique to pregnancy loss that differentiates it from other deaths. Leon (1986) noted that unlike other losses in which grief is retrospective and involves reliving and giving up shared experiences and memories, losing an unborn child is a prospective loss and involves giving up the wishes, hopes, and fantasies of one's ideal family. A death at this time undid the denial of death inherent in the process of giving birth. The shocking coincidence of pregnancy, the process of giving life, with death produced a brutal encounter with human mortality.
The absence of established social support contributes to the lack of closure for and the isolation of those contending with a pregnancy loss. Stringham, Riley, and Ross (1982) found that when pregnancy losses were compared to grieving other losses, a common theme expressed by mothers was “the sense of loneliness and isolation in grieving the loss of someone who was unknown to family and friends” (p. 326), and, as one women in their study stated, “Part of the tragedy of a stillbirth is that many people refuse to recognize you had a child” (p. 326). Often no one other than the parents ever saw the baby, so there is no one with whom to share any recollections that might have been formed. Because their child was not a known person to anyone save themselves, keeping the baby real becomes a major task (Stringham et al., 1982). This need implied an activity directly opposed to relinquishment, an essential component in the established process of grieving.

Effect of Pregnancy Loss on Subsequent Pregnancies

Despite the many complexities these women face, childbearing patterns in the literature identified the strong motivation for and frequent achievement of a subsequent pregnancy following a loss. Many authors cited the presence of ongoing and specific anxiety throughout the pregnancy (Armstrong & Hutti, 1998; Franche & Mikail, 1999; Hunfeld, Taselaar-Kloos, Agterburg, Wladmiroff, & Passchier, 1997; Phipps, 1985; Statham & Green, 1994; Theut, Pederson, Zaslow, & Rabinovich, 1988). Several authors observed the presence of grief for the past loss with symptoms of depression that persisted through the duration of the pregnancy and well into the
postpartum period (Hunfeld, Wladimiroff, & Passchier, 1997; Phipps, 1985). Other researchers reported conflicting findings when attempting to isolate the effects of a past loss on a new pregnancy. A past successful pregnancy was thought to alleviate the grief caused by a future loss should one occur (Statham & Green, 1994); yet findings of later studies contradicted this. Armstrong and Hutti (1998) studied the effect of prenatal anxiety on attachment and found no conclusive relationship between them.

These studies identified varying emotional states women experienced during a subsequent pregnancy, and some attempted to explore conclusions regarding the role of a new pregnancy in the grief resolution of the previous loss. A few authors (Côté-Arsenault & Mahlangu, 1999; Phipps, 1985) attempted to identify and describe the specific emotional experiences observed to occur during a subsequent pregnancy. Little research attention has been directed to the experience of a subsequent pregnancy following a late pregnancy loss from the self-reported accounts of the women themselves. The literature has identified the additional issues that emerged when a subsequent pregnancy was confirmed. High anxiety, specific fears regarding reproductive adequacy and personal competence were commonly presented. Issues of doubt in the medical profession’s ability to ensure a safe delivery and the fear of experiencing any planning or preparation for the new baby were expressed.
Statement of the Problem

Despite the frequent occurrence of pregnancy loss, 826,000 women each year, and the large number of women who experience subsequent pregnancies shortly thereafter, little research or attention has been directed toward the experience of this vulnerable population. Little research has been devoted to the coping approaches and methods these women use, and little is known about what these women experience as helpful and supportive. How do women balance their lived experience with pregnancy loss yet manage the understandable anxiety of a new pregnancy? What coping approaches and methods do they find useful and productive? What support do others provide that is viewed as meaningful and constructive? The present study is intended to help answer these questions and learn more about what women describe as helpful and supportive during these high-risk pregnancies.

The purpose of this qualitative study is to describe the experience of a subsequent pregnancy in the voices of the women who experience them, and to identify the coping approaches and methods they use. A goal is to identify and to describe the coping approaches and methods women state were helpful to them, and to identify the interventions from others they found to be supportive. Additional research concerning women's experience in coping with pregnancy following a late loss may be helpful to women in similar situations and to health care professionals.
Research Questions

1. How do women describe their experience of a subsequent pregnancy following a late pregnancy loss? What is the experience like for them and what meanings do they make of the experience?

2. What approaches to coping do women employ during a subsequent pregnancy after a late pregnancy loss? Which coping methods and approaches are experienced as helpful and which are experienced as counterproductive or stress inducing?

3. What do women experience as helpful and supportive from friends, family and health-care professionals during pregnancy after a previous late pregnancy loss? What do women experience as counterproductive or stress inducing from friends, family and health-care professionals?

4. What would they like to share with other women who may experience pregnancy after a previous late pregnancy loss?

Definition of Terms

*Perinatal loss:* includes miscarriage, stillbirth, late pregnancy loss and neonatal death.

*Miscarriage:* sometimes called a spontaneous abortion, is the loss of a fetus occurring before the 20th week of pregnancy.

*Stillbirth:* the death of a baby after the 20th week of pregnancy but prior to the delivery.
Late pregnancy loss: the death of a baby occurring after the 20th week of the pregnancy.

Spontaneous pregnancy loss: a delivery that occurs for causes other than medical intervention, accident, or trauma.

Early neonatal death: the death of an infant less than 7 days after birth.

Late neonatal death: the death of an infant between 7 and 27 days after birth.

Post neonatal death: the death of an infant between 28 days and 11 months after birth.

Organization of the Dissertation

Chapter I provides the introduction and contextual background information for the present research project. Chapter II provides a review of the related literature and describes the experience of grief responses to pregnancy loss and the complexities specific to late pregnancy losses. Chapter II concludes with a discussion of the need for the present study. Chapter III presents the research methodology of the study. The qualitative and feminist perspectives in which the methodology for this study is grounded are discussed. The in-depth interviewing approach, sample description, data collection, and analysis techniques are described. Chapter IV presents the basic findings and results. Chapter V presents a discussion of the results and their implications, the limitations of the study and directions for future research.
The Human Subjects Institutional Review Board of Western Michigan University approved this study. (Appendix G). The investigator ensured the confidentiality and anonymity of participants.
CHAPTER II

REVIEW OF THE LITERATURE

This chapter reviews the literature relevant to the pregnancy experience and the coping approaches and methods women use that have experienced a previous late pregnancy loss. The first section of this chapter provides an overview of what is known about the prevalence of pregnancy loss and late loss in particular. The nature and characteristics of pregnancy loss are described; the emotional impact and the effects on subsequent pregnancies are delineated. The second section discusses the grief related to the experience of pregnancy loss. Theoretical models of grief are included to contextualize the complex emotional and psychological experiences with which grieving mothers must contend. The third section describes the specific features of late pregnancy loss that present unique difficulties for women in the mourning process. A description of this vulnerable population and their experience of anxiety, stress, and depression during a subsequent pregnancy are included. The fourth section describes the existing research regarding women’s experiences with pregnancies that follow late pregnancy losses. Findings relevant to coping approaches and methods are highlighted. The fifth section describes some of the divergent findings and perspectives in the literature, and the sixth section summarizes the need for research on women’s coping approaches and provides the foundation for the present study.
Pregnancy Loss

Prevalence of Pregnancy Loss

During one year in the United States close to 826,000 women may have experienced a pregnancy loss. The most common loss is a miscarriage that is estimated to occur in 20% of all recognized pregnancies (Côté-Arsenault & Mahlangu, 1999). If the number of miscarriages is estimated based on the known number of births in a single year, 3.9 million live births in 1995 (National Center for Health Statistics, 2002), then as many as 780,000 women may experience miscarriage in a year. Of the 3.9 million babies born alive in 1995, over 19,000 died within the first 28 days of life and are considered neonatal deaths (National Center for Health Statistics, 2002). An additional 27,000 (about 1 in every 144 deliveries) were stillborn, dying sometime after 20 gestational weeks (U.S. Census Bureau, 1999). Overall, these figures indicate that as many as 826,000 women may experience pregnancy loss in a single year. It must be mentioned these totals may represent low estimates because the Census Bureau notes individual state requirements for reporting fetal deaths of greater than 20 gestational weeks vary and not all fetal deaths for which reporting is required are actually reported (U.S. Census Bureau, 1999). Clearly, pregnancy loss is a major loss affecting many parents and families in the United States today.
Nature and Characteristics of Pregnancy Loss

Pregnancy losses are, by their very nature, different than other loss experiences. A pregnancy loss affects the woman's identity and impairs her ability to construct her maternal identity. The losses produce circumstances in grieving that are very different than in other forms of loss. These losses have lingering emotional effects and present issues that time cannot heal; in fact, there are aspects of these losses that are re-presented at every transitional phase in the life of those grieving. Leon (1986) asserts, "The obstacles to resolving perinatal loss are formidable, and one would expect this population of bereaved mothers is at risk for later psychological disturbances" (p. 322). Côté-Arsenault and Mahlangu (1999) contend that a woman's perception of her competency is at stake when she has experienced a pregnancy loss. The physical and emotional pain effectively creates lasting feelings of uncertainty and insecurity in her self. This sense of internal concern regarding one's competency is also mentioned by Theut et al. (1988). Their contention is that pregnancy loss may result in selective concerns focused on the mother's reproductive efficacy and in concerns regarding the course of a new pregnancy because the loss means the mother grieves the loss of herself as a woman of reproductive potential. Phipps (1985) agrees women experience heightened insecurities and anxieties regarding their roles as women and mothers. He alludes to an ongoing future implication of this loss, stating, "Thus, regardless of her personal resources she may perceive herself as inadequately prepared to face the challenges of childbearing" (p. 244). Leon (1990) identifies a pervasive sense of inadequacy felt by these women,
contending that the envy they feel towards mothers with children is a function of a sense of profound inferiority due to the failure to procreate. The loss of a sense of an adequate and competent self despite conscious awareness of known personal resources describes a unique loss dynamic.

Pregnancy losses produce unusual circumstances with which mothers must cope as they grieve. The lack of "concrete evidence of the child's existence" (Leon, 1986, p. 316) forces them to contend with their hopes, dreams, and fantasies of the child instead of any lived realities. Robinson, Stitzinger, Stewart, and Ralevski (1994) wrote about the complications in grief that are produced because no tangible outside child exists. Because it is not possible to develop memories or shared life experiences the loss of a baby may be difficult to resolve. Lockwood and Lewis (1980) state:

> On the one hand the dead baby will always remain a baby and anything to do with babies even years later will remind parents of their loss. On the other hand the child also grows up in a sense. There is what would have been the child's birthday, the first Christmas with the family, the first day of school, and so on. In a very real sense there are two people being simultaneously mourned, making grieving doubly difficult, but more than that, both these people are largely hypothetical, and it is much easier to mourn a reality than a fantasy (p. 311).

A particularly poignant aspect of grieving this loss relates to the destruction of a competent maternal identity and its impact on the grief experience. "How can you be a mother if you don't have a child?" women in this situation have been heard to ask. Additional circumstances unique to pregnancy losses and the lingering emotional effects these losses produce will be more fully discussed later in this literature review.
The powerful future emotional effects of the pregnancy loss experience are not limited to the experience of a subsequent pregnancy. The duration of depressive symptoms and reactions in mothers 4 years after pregnancy losses occurring after 24 gestational weeks was cited by Hunfeld, Taselaar-Kloos, et al. (1997). Even after the healthy delivery of a new baby, increased anxiety, psychological distress, depression, and problems in mother-infant adaptation were more prevalent in women who had experienced late pregnancy losses. DeFrain et al. (1986) also cite the increased duration of stunned disbelief and shock as a complication of the grief after a pregnancy loss and found that 24% of mothers and 18% of fathers reported moving from their home or community after experiencing a stillbirth. Oglethorpe (1989) noted the grief experience after pregnancy loss reflects the theme of multiplicity of loss and Lockwood and Lewis (1980) pointed out that anything to do with babies even years later will remind parents of their loss. Other authors state there will be no real resolution, meaning an end, to the grief of pregnancy loss. They contend during every developmental phase of a family’s life after the loss of a child, grief is revisited. The age the child would have been, the grade in school, the projected physical appearance, etc., are questions that are re-presented. Leon (1986) described this process as a requirement mothers feel. “The mother’s maternal identification ensures her dead child is never forgotten and is always missed. To forget her loss would be a form of abandoning that which was her own” (p. 322).
Effects of Pregnancy Loss on Subsequent Pregnancies

Despite their experience of loss and their acute awareness of risk, many of the 826,000 women who experience pregnancy loss every year will attempt to become pregnant again. Some believe this decision is necessary to allow the woman the opportunity to successfully complete maternal identity development and describe the process of achieving a subsequent pregnancy as marked by ambivalence and emotional pain. Merely considering the decision to attempt a subsequent pregnancy is colored by the strong fear of another loss, which stirs ambivalence about trying again. DeFrain et al. (1986) described trying to become pregnant again as a constant reminder of what might have been. Women experience jealousy and envy at the apparent ease with which others conceive and deliver healthy babies. They also experience anger when issues of abused, abandoned, or neglected children arise. The confirmation of a subsequent pregnancy is often met with ambivalence.

Several authors mention the pervasive fear of another loss that persists for the duration of these pregnancies. The strong sense of dread is described by Phipps (1985) in terms of increased parental awareness and fears concerning all conceivable negative outcomes of the pregnancy. Parents, having had something go wrong, are sensitized that anything can go wrong and nothing is taken for granted. DeFrain et al. (1986) reported similar reactions and noted that being pregnant after a stillbirth is a dreadful experience for many mothers with some mothers reporting worry and fear during the entire pregnancy. As one participant in DeFrain et al.'s study stated: “I did become pregnant, and all I could think of through the whole pregnancy was preparing
myself for its death.” (p.162). Such pregnancies are felt to last forever with time being marked by the passage of gestational weeks, not months, as each successful week means the viability of the baby draws near.

A few authors describe emotional constriction as a typical feature during these pregnancies. DeFrain et al. (1986) noted women’s intolerance of and unwillingness to express the typical emotional ambivalence felt during pregnancy. Such women describe an ongoing sense of fear and blame, thinking had they wanted the previous pregnancy more, their baby might have lived. Kirksey (1987) described women placing very unrealistic expectations upon themselves that are reminiscent of Kubler-Ross’s (1969) stage of grief called bargaining:

“If I get pregnant again, I’ll never complain about anything, even morning sickness” or “If I can have this baby, I’ll be the best parent in the world.” Then with the subsequent pregnancy . . . parents find they cannot always live up to the bargain and feel guilty for “failing.” (p. 258)

Phipps (1985) and Kirksey (1987) both described impairments in prenatal attachment occurring during subsequent pregnancies. This is especially sad when naturally occurring events such as the experience of fetal movement do not provide joy, reassurance, or security. Phipps (1985) relates:

Quickening is seen as a very significant period where the fetus becomes real, and the mother must begin the task of developing an emotional affiliation with this separate, new person. For the mothers in this study, fetal movements were significant only as a sign that the baby was still alive. . . . Quickening is also thought to facilitate development of mental images of the baby for expectant parents, who may begin to attribute personality characteristics to the child. This mental imagery may stimulate mothers to talk to their unborn baby or stroke the baby via the abdomen, and these early forms of interaction are viewed as signs of the developing maternal-fetal attachment. Few parents in this study reported engaging in such behavior. Many purposely avoided such thoughts, while for others, images of the stillborn interfered. Whether

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occurring on a conscious or unconscious level, there was a general hesitancy to look to the future. (p. 249)

Parents view typical obstetrical occurrences such as routine office appointments or laboratory tests as additional evidence of their failure or confirmations of the unspoken conviction their greatest fear will occur again. Neither the increasing gestational age of the child or its actual birth ends these painful emotions. “This fear of failure in a subsequent pregnancy is very real. For this woman, another failure would confirm her suspicion that she cannot achieve that which every other woman can achieve effortlessly” (Kirksey, 1987, p. 255). She contended women focus on the past and feel detached which they prefer to consciously attempt to shield themselves from hurt. This creates isolation from friends and family members who are likely to focus on the future and the new baby. Kirksey states:

For many couples, the first trimester stirs up emotions and unresolved issues regarding the previous pregnancy. Many families say that the father and other family members see a future, while the mother sees her past. During this time, women also report a feeling of detachment, which they claim they prefer to feel toward the new baby. They want to shield themselves from getting hurt, should anything go wrong. As outsiders' and the woman's own attention to the new pregnancy increases, so does her sense of guilt. She has a feeling of betrayal to her previous baby. This occurs more intensely for those women who carried their babies closer to term or who experience neonatal death. (p. 252)

She also reported most mothers report they are unable to begin thinking about the new baby until they reach a gestational age beyond the point the previous loss occurred.

The ongoing experience of grief often becomes more intensely felt once the new birth occurs. Oglethorpe (1989) indicated parents may be unable to commit
themselves to a child who feels like the ghost of the child who died. There is a shared impression among several authors that grief is re-activated by the new birth with an increase of attendant anxiety lasting well into the postpartum period. The emotional constrictions previously described as characteristic of the subsequent pregnancy are thought to continue even after the new baby is medically evaluated and is pronounced well. Normal occurrences, such as the fact siblings often resemble each other, are misconstrued evoking painful emotions in parents. Wilson, Soule, and Fenton (1988) quote one mother in their study as reporting she was afraid to look at her new baby girl saying “I was afraid she would look like a stillborn and I was afraid I would become attached and this one might die” (p. 190) and describe another who reported increased anxiety as she observed her new baby sleeping since “when her baby was asleep, he looked like a stillborn and this made her nervous” (p. 190). Such events are mentioned to briefly illustrate the far-reaching emotional and psychological implications of the experience of a subsequent pregnancy after a loss.

Sadly, families affected by pregnancy losses appear to face an additional developmental task those without a loss history are spared. No matter what type of loss they experienced, even after the subsequent baby is doing well, they will need to determine the place the lost child will hold in their family. A number of authors mention the women’s fear the lost baby will not be remembered, while others discuss the need for and the task of keeping the baby’s memory alive. What may appear to be a philosophical issue takes a very pragmatic form as these families are faced with the reality that their family is different. Casual, social questions such as, how many
children do you have, or, is he your only son, unwittingly dredge up painful memories. Issues such as how to memorialize the lost child, what to tell subsequent children, and how to determine what place the lost baby has in the family history will need to be addressed. Kirksey (1987) describes the additional task in dealing with perinatal death this way: “Ultimately parents have the responsibility to fit the loss of the baby into their family’s life” (p. 266).

Grief and Pregnancy Loss

Theoretical Grief Models

One of the earliest attempts to observe grief reactions in a systematic way was done by Lindemann following the Coconut Grove nightclub fire in 1942. He wrote the classic paper, “The Symptomatology and Management of Acute Grief” (1944) from studies of holocaust survivors and observations made after the fire. Patterns emerged which were described as the pathognomic characteristics of normal or acute grief. They are: (a) somatic or bodily distress, (b) preoccupation with the image of the deceased, (c) guilt relating to the deceased or circumstances of the death, (d) hostile reactions, and (e) inability to function as one did before the loss. Kubler-Ross (1969) conceptualized the process of grief as a series of five stages through which one must work to successfully resolve grief. She believed both the dying person and survivors experience these stages: (1) denial and isolation, (2) anger, (3) bargaining, (4) depression, and (5) acceptance. Similar models of the grief process have been proposed by Parkes (1972) and Bowlby (1980). They identify four stages, which are:
(1) numbing, (2) yearning and searching, (3) disorganization and despair, and (4) reorganization and recovery.

These studies, with the work of Cain and Cain (1964), who highlighted the occurrence of the "replacement child syndrome," serve as the backdrop from which the pregnancy loss literature developed. Based on observations made in child guidance clinics, Cain and Cain described children who they later found had been conceived shortly after the death of a sibling. They identified two prominent etiologic features: the guilt ridden premorbid personalities of mothers who had suffered numerous childhood losses themselves, and the intense parental narcissistic involvement with the child who had previously died. These children were described as "filled with phobias and general fearfulness. . . . All the children were convinced that they were inadequate, vulnerable souls living in a world of constant unpredictable dangers" (p. 449). The parents' replacement child was consumed by the idealized image of the lost child and any apparent resolution of mourning represented nothing more than an ongoing attempt to hold on to the lost object. Poznanski (1972) noted that physicians involved with families of a dying child were in unique positions to prevent development of the "replacement child" syndrome and noted that parents and physicians must recognize the danger in having another child before parents have resolved their grief. This appears to have had an influence on physician recommendations made to mothers following pregnancy loss. Often mothers had been advised to resolve their grief completely and to wait a length of time, as long as a year, before attempting to conceive again.
Prior to 1970 there was little research on the issues of perinatal loss. Zeanah (1989) noted gaps in the literature with a focus on quantitative measurements of depression rather than a deeper understanding of parental grief experiences. Anecdotal data appeared to support the prevalence of pathologic outcomes and parental morbid grief reactions with almost no acknowledgement of normative grief process. Accounts written by care providers regarding patient experiences and personal accounts of grief written by parents are the two primary categories in the perinatal loss literature since 1979 (Rich, 1999).

Anecdotal Reports in the Medical Literature

Anecdotal reports reported in nursing journals describe traumas experienced by women in the hospital. Grubb (1976) describes the experience of a 32-year-old married woman who had three living children and a history of three pregnancy losses. At 34 gestational weeks, an absence of fetal movement was noted and the baby’s death was confirmed. Standard hospital procedure dictated patients wait until labor began spontaneously. The mother carried the baby 3 weeks longer, continued to keep weekly prenatal medical appointments and returned to the hospital in labor. Once born, the baby was removed from the room without being shown to the mother. Three weeks postpartum, the mother asked medical staff if they were certain the baby was completely dead. “It is not known whether or not Mrs. M. achieved a final resolution of the baby’s in-utero death” (Grubb, 1976, p. 37).
Furman (1978) described parental reactions to the deaths of their newborns. She described parental mourning of newborns as special in that mourning is a process that applies to a separate person, and a newborn baby is very little known and loved as a real person since there has been little time to develop strong ties and memories of mutual living. She indicated their mourning process was similar to the experience of persons such as amputees. She also indicated bereaved parents’ experiences were made more difficult because people around the parents are not there to help.

It fills them fear the way an amputee fills many people with fear and anxiety and makes them shun him. It makes them wish he would hide his defect. This is the treatment parents of dead newborns get. They are shunned, and they cannot rely upon the sympathy that is usually afforded the bereaved. (p. 215)

She wrote that there are no funeral services and no support systems in the culture for amputees or for parents who have lost a newborn child.

The apprehension and anxiety with which a physician responds to the delivery of a high-risk pregnancy has been aptly noted by Lewis (1971). He described the case of a doctor’s wife, who with a history of a prior stillbirth, chose to deliver a subsequent pregnancy in their hospital unit. He described such pregnancy and labor as challenging and threatening, and stated, “Not only was the patient under great strain but in choosing our unit she put the obstetricians in an insidious position, a situation pregnant with anxiety. They had to produce a live birth” (p. 324). Lewis stressed the need for physician awareness of the reasons underlying the patient’s anxiety, and concluded it is particularly important doctors understand and recognize the anxiety treating such patients produced in themselves.
Pregnancy Grief Literature

Janssen, Cuisinier, Hoogduin, and de Graauw (1996) reviewed 23 empirical studies published between 1970 and 1993 on pathological grief following pregnancy loss. Based on the general bereavement literature the studies were reviewed from the perspective of four subtypes of pathological grief: chronic, delayed, masked, and exaggerated. Findings indicated that while women may be greatly affected psychologically by pregnancy loss and may show psychiatric symptoms during the first 6 months, most women seem to be able to recover on their own over time. Jansen et al. reported that parents often mourn the loss of the baby for more than 1 year, and 1 in 5 women are unable to accept the loss after 2 years, and delayed grief reactions occurred in about 4% of parents. A concern expressed in the review was that there was no consensus among authors regarding definitions of normal or pathological bereavement. Janssen et al. indicated the studies were based upon an assumed relationship between pregnancy loss and complicated grief, and suggested the development of pathological grief after pregnancy loss may be more uncommon than was previously thought. The belief that parents were at high risk for complicated mourning was assumed to be the result of flaws in empirical research in the area. A substantial majority of women seem to be able to recover from pregnancy loss in time through drawing on their own strength. Janssen et al. concluded when parents continue to show great difficulty accepting the loss after 1½ to 2 years, this might be viewed as a chronic grief response.
Garel, Blondel, LeLong, Bonenfant, and Kaminski (1994) investigated the possible long-term negative reactions of miscarriage on subsequent pregnancy. The study analyzed and described women's physical and psychological health at 8 and 18 months after miscarriages occurring around 14 gestational weeks. At 8 months, 34 of their sample of 50 were pregnant again. The nonpregnant women reported the presence of emotional distress and their use of psychotropic medication was three times higher than the general population of women their age. At 18 months after miscarriage, the proportion of women reporting emotional problems and receiving health care for depressive disorders remained high. The results of their study were inconclusive regarding the association between psychological status after miscarriage and the experience and outcome of subsequent pregnancy. Garel et al. concluded it was necessary for a woman experiencing a miscarriage to receive long-term support.

Friedman (1974) noted physicians should acknowledge grieving is normal, and pregnancy losses represented losses that are significant, not unlike the death of a child from a serious illness. He contended the grief following the loss of a child is intense 2 to 4 months after the death, with more extensive follow-up being required than the typical single meeting with parents to discuss the details of their loss. Members of the medical community acknowledged their lack of training and discomfort when perinatal losses occurred. Woods and Esposito (1987) found little attention was devoted to teaching physicians how to deal with the death of a patient’s baby or with the family’s emotional response. Kirk (1984) stated, “The orientation of the physician toward pain is usually to modify it, obliterate it or remove it. A fourth orientation is to
avoid it. Each of these responses has been tried in the management of perinatal loss” (p. 48). He acknowledged the factors that influenced a physician to become involved in perinatal loss included: his/her own early experience of separation and loss, his/her own degree of attachment to the patient and her pregnancy, and “his willingness to deal with his own sense of failure or responsibility for the loss, or, more startling, the expressed accusations of the patient or her family at his responsibility in the catastrophe” (p. 48). Traditional medical training may have aggravated the problem by regarding fetal or newborn death as deviations from the standard outcome, therefore denying its significance and impact. An obstetrician himself, Kirk (1984) noted the obstetric literature had virtually ignored the issue of perinatal loss, while pediatric and nursing journals had contained relevant material, yet, he noted, only two articles were published in main obstetric journals.

Results of several studies seemed to find the duration of the pregnancy ending in loss was a primary determinant of the degree of material grief (Dyregrov & Mathiesen, 1985; Kirkley-Best & Kellner, 1982; Lovell, 1983; Teel, 1991; Toedter et al., 1988). Therefore, early miscarriages were assumed to be less traumatic and more easily recoverable than later losses or stillbirths. The presence of living children was thought to mitigate the effects of perinatal loss (Oglethorpe, 1989), so mothers with children before a loss were thought to be less affected. There was considerable lack of agreement in the professional literature regarding issues such as whether or not a new baby facilitated or impaired parental grief and whether or not the likelihood of “replacement child syndrome” occurred after the subsequent pregnancy. Medical
professionals had been alerted to the potential hazards facing a “substitute child” by the observations of Cain and Cain (1964) and Poznanski (1972). They identified the replacement child syndrome that highlighted the psychological difficulties of children born after a loss. The researchers believed replacement children were expected to emulate the idealized image of the dead child and would not be allowed to develop a separate identity.

Leon’s Psychoanalytic Perspective

Leon (1986, 1992) discussed the psychodynamics of perinatal loss and identified expected differences in the grief response evoked by perinatal loss, and cited anticipated differences in the experience of subsequent pregnancy. Typical maternal reactions during the early months of grief include shock, sleeplessness, disbelief, crying, sadness, rage, anxiety, somatic distress, and occasional hallucinatory experiences of the dead baby. He reported the grief of perinatal loss was inappropriately compared to the loss of an adult family member. Unlike other losses in which grief is retrospective and involves reliving and giving up shared experiences and memories, losing an unborn child is a prospective loss and involves giving up the wishes, hopes, and fantasies of one’s ideal family. He wrote that perinatal death was also a narcissistic loss for the mother and could be devastating to a woman’s maternal self-worth. Leon observed that mourning a perinatal loss involves the emotional linking by the mother with her own child and not a nameless, anonymous body. Through the identification with her dead child and mourning, the mother gradually is
able to relinquish her attachment to this child and achieve sufficient separation to attempt another pregnancy to form a psychological relationship with another child (Leon, 1986). Leon (1992) also pointed out that perinatal loss often leads to interpersonal exclusion from the activities of childbearing friends and siblings. The childless couple is required to cope with increased isolation due to the loneliness of grief and the additional sense of isolation from a community of families. Leon noted that subsequent pregnancy following a loss would be more difficult to endure because of the greater interference in development and isolation those parents would have to bear in comparison with others who attained parenthood before such a loss.

Specific Features of Late Pregnancy Loss

The literature described unique features of late pregnancy loss that present additional difficulties in the process of mourning. The sudden and unexpected nature of the loss did not allow any anticipation or planning to occur, so shock, emotional numbing, and feelings of unreality are prolonged. This loss had the effect of impairing the process of a woman's maternal identity development and is complicated by intense guilt and self-blame. This grief is described as a loss of part of the self, carrying with it enormous shame and humiliation, and is not unlike the grief reactions experienced with other narcissistic losses involving bodily injury such as amputation (Furman, 1978). The literature noted that following a pregnancy loss; a loss of innocence comes with a loss of trust in medicine's ability to ensure a positive outcome (Kirksey, 1987).
Parents reported being burdened with the discomfort of others as they are offered condolences, and were acutely aware they have become the walking manifestations of other parents' fear. Because many bereaved parents are young the pregnancy loss is often their first encounter with grief. Lacking experience with the turbulent emotions grief produces, they cannot know their seeming emotional instability is normal. Fears of being viewed as unstable and awareness of the discomfort others experience around them, combined with distrust of medical authorities, lead to further isolation. Clearly this group represents a sizeable population with understandable and major mental health concerns.

Subsequent Childbearing Patterns

Follow-up studies revealed the loss of a baby is found to have pronounced effects on subsequent childbearing patterns (Park et al., 1979; Rubin & Ferencz, 1985; Vogel & Knox, 1975). Mothers who experienced loss were significantly more likely than nonbereaved mothers to have at least one more pregnancy (Boyle, 1997). This finding was irrespective of whether the loss was due to SIDS (sudden infant death syndrome), neonatal death, or stillbirth. In a study that compared 194 bereaved mothers with 203 nonbereaved mothers, nearly 40% of bereaved mothers became pregnant within 8 months of the loss compared with 6.9% of nonbereaved mothers. At 15 months after the loss, 57% of the bereaved and 17.5% of the nonbereaved had become pregnant. At 30 months after the loss, 76% and 33% of the bereaved and nonbereaved mothers, respectively, became pregnant (Boyle, 1997).
Few issues in the pregnancy loss literature are more disputed than the timing and the meaning of subsequent pregnancy following perinatal loss. Cain and Cain (1964), Poznanski (1972), and Lewis (1979) suggested conceiving soon after a loss may be equated with replacing the child and not resolving grief. O'Leary and Thorwick (1994) and Lewis and Page (1978) found early conception is equated with the rejection of and negative feelings toward the new baby. Rowe et al. (1978) concluded early conception is correlated with morbid grief reactions. Dyregrov and Matthiesen (1987), Peppers and Knapp (1980a), Stringham et al. (1982), Videka-Sherman (1982), and Woods and Esposito (1987) concluded the birth of a subsequent child assisted in grief work from the previous loss and decreased parental depression. LaRoche et al. (1984) found no difference in depression rates in women having subsequent pregnancies less than 6 months following a loss and those who became pregnant later. Laurell-Borulf (1982) found no differences in how mothers who lost a child prior to, during, or after birth had worked through the crisis resulting from the loss. Hughes, Turton, and Evans (1999) found that vulnerability to depression and anxiety in the next pregnancy was related to time, since stillbirth and women who had conceived within a year after stillbirth were at significantly greater risks than controls. Clearly there seems to be no consensus on recommendations regarding the timing of subsequent pregnancy.
Anxiety, Ambivalence and Stress

The main area of agreement regarding subsequent pregnancy following loss appeared to be in the descriptions of its difficulties. The experience of a subsequent pregnancy in the context of loss was an anxiety-fraught task punctuated by grief. Anxiety was the predominant emotional feature of subsequent pregnancies (Phipps, 1985). Mothers were pessimistic and were known to say, “I’m pregnant but I’m not expecting.” Although many were desperate to be pregnant again, mothers were ambivalent when the pregnancy was confirmed, were hesitant to share their news, and then often attempted to control attachment fantasies and behaviors in an effort to protect themselves emotionally. O’Leary and Thornwick (1994) identified specific emotional stressors including ambivalence with a generalized hesitation to attach to the pregnancy. Parents maintained a sense of hypervigilance because their experience had sensitized them to the probability of every negative outcome. Their innocence destroyed, they were afraid to be optimistic or to look toward the future. They did not purchase clothing, prepare a room, or designate any space at home for the baby (Phipps, 1985). To manage the constant awareness of vulnerability, they avoided baby showers or social occasions where family was the focus. To avoid discussions about the new pregnancy and their hopes, they isolated themselves and unwittingly closed off potential sources of support.

Mothers reported decreased confidence about a positive pregnancy outcome and often cannot be convinced they would deliver a live baby (despite positive diagnostic tests and physician reassurance). As it is in other bereavement situations,
the marital relationship was affected. Having decreased their social support, parents generally relied on each other for reassurance that this pregnancy would be successful, yet were hesitant to discuss their specific anxieties. Aware their partner is grieving, they often attempted to provide emotional protection by restricting the range of communication. This resulted in further isolation (Gilbert, 1989; Phipps, 1985; Rando, 1983).

As the pregnancy progressed, parents reported fear imagining labor and delivery. Past experience had taught them labor did not necessarily produce life (Hense, 1994). In an effort to exert control in the presence of uncertainty, a strategy of creating scenarios was implemented. Parents imagined and discussed a series of negative outcomes along with their ability to cope with them (Phipps, 1985). Using the past experience of loss as a benchmark, they planned the exact steps they would take, including the burial, in the event the new pregnancy ended badly. Leff (1987), a physician who experienced a late pregnancy loss, stated women would grieve for a lost baby as they simultaneously carried a new life. They feared medical intervention; parents viewed all medical procedures with heightened anxiety and alarm. She asserted basic research is needed to identify specific ways of being helpful to parents making this journey.

The literature from the various disciplines identified a high degree of patient needs during subsequent pregnancy yet offered little systematic intervention strategies. Guidelines for support were often based around theoretical suppositions about grieving and the inferred needs of parents (Condon, 1986; Worden, 1983).
Little research had been carried out into the self-reported needs of parents for support; most studies described their evaluations of the services offered and the support received.

Research on Women’s Experience With Pregnancy Following a Loss

The following section describes research that is particularly relevant to an understanding of women’s experiences of subsequent pregnancy following loss. Findings relevant to coping approaches and methods women used during subsequent pregnancy experiences, along with findings relevant to women’s experience of being supported during the subsequent pregnancy are highlighted where appropriate. This section includes a more detailed review of several important research studies concerning women’s experience with subsequent pregnancy after a pregnancy loss.

Parental Stress and Adjustment

In 1985, Sean Phipps published a qualitative exploratory study to identify and to describe the stresses experienced during a subsequent pregnancy following a stillbirth. Until that time, much had been written describing parental grief experiences following pregnancy losses and the frequency of occurrence of subsequent pregnancies, but little was known about the specific emotional aspects of the experience. The study described the entire process, including the decision to enter another pregnancy, the pregnancy itself, parental coping strategies for stress, and
issues related to the early parent-child relationship. Information was gleaned from parents' retrospective self-reports.

Fifteen couples were interviewed in their homes. In 9 couples, a stillbirth had occurred during a first pregnancy; the remaining 6 couples had other children at home. In all cases, the infant never came home from the hospital. All 15 had experienced a pregnancy subsequent to their loss. The ages of children born from these pregnancies ranged from 5 months to 3 years. Parents responded to open-ended questions and were encouraged to make spontaneous comments and to expand on their experiences. The interviews focused around seven broad content areas: pregnancy planning, initial response to pregnancy, social issues, psychological aspects, medical intervention, delivery, and early response to the child. The researcher asked the parents to compare the subsequent pregnancy to their previous pregnancy and to focus on the differences. The interviewer asked specific questions intended to clarify the unique aspects of the subsequent pregnancy.

The results indicated parents were motivated to become pregnant quickly following the loss, and then experienced great ambivalence once the subsequent pregnancy was confirmed. Mourning the lost child continued throughout the pregnancy. Fear and heightened awareness of all potential negative outcomes characterized their experience. Parents protected themselves emotionally by suspending commitment to the pregnancy and avoiding attachment behaviors. They shared expectations with few others and maintained social isolation. The parents viewed the pregnancy as joyless and as a task designed to produce a healthy baby.
Anxiety increased as the pregnancy progressed with frequent hypervigilant states and compulsive, self-protective behaviors. Specialized medical tests provoked anxiety and produced incomplete and transitory reassurance. Parents needed continued reassurance of the baby's health after the baby was born. Parental attachment appeared hesitant until the child's viability was certain. This qualitatively different parental experience with the need for control, self-protection, and sensitivity to negative outcomes with a task orientation to pregnancy was a major finding of the Phipps (1985) study. The identification of coping strategies such as parents imagining worst-case scenarios then planning their response, and the differences in the developmental tasks of these pregnancies due to emotional self-protection were also major findings.

Defrain et al. (1986) studied transcripts of interviews with 22 families and open-ended questionnaire responses of 304 parents from all over the United States who had experienced a stillbirth. As a part of their findings, they reported that 65% of the mothers and 51% of the fathers had irrational thoughts, 24% of the mothers and 18% of the fathers reported moving from their home or community to escape, 9% of the mothers and 7% of the fathers reported seriously considering divorce after the stillbirth, 3% of the mothers and none of the fathers reported family violence, 72% of the mothers and 50% of the fathers reported that they wanted to go to sleep and wake up only after the pain was gone, and 28% of the mothers and 17% of the fathers seriously considered suicide after the stillbirth. In briefly reporting some of the coping techniques mothers and fathers used, they noted that for many parents successfully
coping through a subsequent pregnancy meant that the thoughts [about the stillbirth] would have to be turned off some time. They also noted that sharing stories of pregnancy and childbirth, while a special pleasure for other parents, was not for parents who had a stillbirth, and reported, “Some try bravely not to dampen the enthusiasm of others” (p. 165). They also reported that when the topic of pregnancy arises, parents who have experienced stillbirth will likely experience pain no matter the amount of time that has passed.

The specific ways in which anxiety and depressive symptoms could be moderated in subsequent pregnancy following loss was the focus of the 1999 quantitative study of Franche and Mikail. The first objective was to examine the psychological adjustment of couples with a previous loss during a subsequent pregnancy. The second objective was to identify variables that may moderate couples’ emotional adjustment during subsequent pregnancies. The role of pregnancy-specific locus of control to moderate anxiety and self-criticism, and the role of dependency and gender as moderators of depression, were examined. The participants were comprised of 31 mothers and 28 fathers with a history of at least one perinatal loss in a past pregnancy. The comparison group was comprised of 31 mothers and 23 fathers with no loss history. The groups of mothers were matched for gestational age plus or minus 2 weeks at the time of testing. All women in both groups were pregnant with a mean gestational age of 15.1 weeks.

All participants completed the following instruments: Pregnancy Outcome Questionnaire (POQ), Fetal Health Locus of Control Scale (FHLCS), Beck
Depression Inventory (BDI), Depressive Experiences Questionnaire (DEQ), Abbreviated Didactic Adjustment Scale (ADAS), and the State-Trait Anxiety Inventory (STAI). In addition, all participants described the circumstances of their current pregnancy and, for those having a loss history, the circumstances of their previous loss. The data analysis revealed those participants having a previous loss history had higher depression and pregnancy-specific anxiety scores than participants without a loss history. Women had higher depression scores than men. There were group differences in the presence of pregnancy-specific anxiety with no differences in generalized anxiety. For participants who had a loss history, higher levels of depression were associated with high self-criticism, low dependency, and a higher number of losses. Depression scores for participants without a loss history were associated with low levels of dyadic adjustment.

Franche and Mikail (1999) reported the depression scores were mild in nature, indicative of general distress, not clinical depression placing the subsequent pregnancy at risk. The relationship between anxiety and locus of control differed between the groups of mothers. Mothers with a loss history who experienced a high sense of control over health were more anxious regarding their pregnancies. Mothers without a loss history experienced greater anxiety when they perceived health care providers as having control over fetal health. The authors suggested the mothers with a loss history experience greater anxiety because they assume more personal responsibility for their pregnancy outcome. They also suggested higher levels of dependency in both partners might be adaptive during the early months of a subsequent pregnancy. They
suggested couples having a loss history might benefit from being encouraged to increase their mutual support seeking and activities which facilitate interpersonal connection.

**Anxiety and Depression**

In 1988, Theut et al. conducted a quantitative study to examine the correlation between anxiety and depression in couples experiencing a pregnancy loss compared to those without a loss history. The study intended to identify whether anxiety and depression, if heightened, were generalized or focused. The authors evaluated the internal consistency of the Pregnancy Outcome Questionnaire (POQ) they had designed for the study, and examined its correlation with standardized measures of anxiety and depression.

During the eighth month of pregnancy, the 56 married couples in their sample completed the Beck Depression Inventory (BDI), the Trait Scale (A-Trait) of the Spielberger State–Trait Anxiety Inventory, and the POQ. Twenty-five of the couples had experienced a perinatal loss within the previous 2 years. The other 31 couples were first-time parents. Correlations were performed for the POQ, the BDI, and the A-Trait for the parents within each of the two groups. The mean BDI and A-Trait scores, both measures of generalized depression and anxiety, did not significantly differentiate mothers who had experienced a previous loss from those who had not. The POQ, a measure of pregnancy-specific anxiety, did significantly differentiate the two groups at $t(54) = 3.32, p < .01$ (Theut et al., 1988, p. 290). The results indicated
the POQ was useful in assessing pregnancy-specific anxiety during a subsequent pregnancy. Perinatal loss in a middle-class sample was associated with specific, not generalized, anxiety during a subsequent pregnancy. Intervention by clinicians would appropriately address specific issues concerning the previous loss and worries about carrying the subsequent pregnancy to term, rather than more general issues. In the event generalized anxiety and depression persisted during a subsequent pregnancy, symptoms could reasonably be attributed to other stressors.

Statham and Green (1994) investigated the effects of miscarriage and later reproductive losses and their timing on the influence of feelings in a subsequent pregnancy. Their quantitative study was comprised of 1,356 women who were less than 16 weeks pregnant. Forty-two percent of the sample had experienced a previous pregnancy loss. The purpose of the study was to chart the attitudes, experiences, and anxiety of pregnant women, to answer questions regarding feelings about the current pregnancy, and to test early attachment, whether or not the mother perceived the baby as a person. The Trait Scale of the Spielberger State-Trait Anxiety Inventory was used to assess anxiety as a general personality characteristic. More specific anxiety was measured using the Cambridge Worry Scale. Results indicated a statistically significant difference in trait anxiety scores between women with living children and those without. Women without living children and a history of perinatal loss had a statistically significant ($p < .05$) higher trait anxiety score than those who had not been pregnant before. Seventy-five percent of the women with living children indicated the presence of early attachment and expressed thinking of their baby as a
person, compared to 66% of pregnant women who had no living children ($p < .001$). Women who experienced a previous unsuccessful pregnancy were more anxious both generally and specifically about their pregnancy and the possibility of something being wrong with their baby and about the possibility of losing the baby. Early in pregnancy, women with no living children and a history of unsuccessful pregnancies had the highest trait anxiety. The data analysis suggested the experience of successful pregnancy mitigated some of the effects of previous losses. However, a past successful pregnancy provided a pregnant woman with emotional protection only if it was her most recent past pregnancy experience. If a pregnant woman's most recent past pregnancy experience was a loss, her anxiety would be similar to women who had never experienced a positive pregnancy outcome.

Hughes et al. (1999) compared symptoms of depression and anxiety during pregnancy of 60 women, whose previous pregnancy ended in stillbirth after 18 weeks’ gestation, with 60 match controls. Participants were administered the Edinburgh Postnatal Depression Scale, the Beck Depression Inventory, and the Spielberger State-Trait Anxiety Scale in the third trimester, 6 weeks, 6 months, and 12 months after birth. In the third trimester, women whose prior pregnancy ended in stillbirth were significantly more depressed and had greater state anxiety than women in the control group. Hughes et al. found that the difference was accounted for by those women who conceived less than 12 months after stillbirth, who were also more depressed at 1 year. Findings for those women who conceived 12 months or more after stillbirth were similar to those in the control group at all points and showed
lower trait anxiety 1 year postpartum. For women who had experienced stillbirth, depression in the third trimester was highly predictive of depression 1 year after subsequent birth. Findings indicated that for women who had experienced stillbirth, depression in the third trimester was highly predictive of depression 1 year after the subsequent birth. Hughes et al. found that vulnerability to depression and anxiety in the next pregnancy was related to time since stillbirth, with women who conceived within a year after stillbirth at significantly greater risk than controls. Hughes et al. concluded that since there are problems for both the mother and the infant associated with significant anxiety and depression during subsequent pregnancy, there may be an advantage in women waiting 12 months before the next conception following a stillbirth.

**PTSD and Pregnancy After Loss**

Recently, Turton, Hughes, Evans, and Fainman (2001) investigated PTSD in a cohort group of 66 women whose previous pregnancy had ended in stillbirth. Turton et al. assessed demographic information and measured symptoms of depression, anxiety, and PTSD in the third trimester and at 1 year postpartum. Participants were administered an interviewer-rater demographic questionnaire, the Edinburgh Postnatal Depression Scale, the Beck Depression Inventory (BDI), the Spielberger State-Trade Inventory, and the PTSD-I interview. In the third trimester of the subsequent pregnancy, 21% of women reporting stillbirth as a criterion A stressor had a current
diagnosis of PTSD. Current and lifetime diagnosis rates were 20% and 29%. At 1 year postpartum, current and lifetime rates were 4% and 6%, respectively.

Turton et al. (2001) found a statistically significant relationship for the time interval between stillbirth and the expected delivery date of the current pregnancy and current PTSD. The 13 women meeting PTSD criteria had an average time interval of 23.6 months, and the 49 not meeting PTSD criteria had an average interval of 33.9 months. Perceived social support at the time of the stillbirth was specifically related to current PTSD with perceived insufficient or uncertain support from partner and from family relating to current PTSD. Turton et al. noted that it appeared that having good emotional support after the stillbirth may be a protective factor. Turton et al. noted that significant risk factors for PTSD included conceiving within 1 year of the loss and a felt lack of social support at the time of the loss.

Maternal Adaptation and Attachment

Hunfeld, Taselaar-Kloos, et al. (1997) designed a quantitative study to investigate the mother–infant relationship at 4 and 16 weeks postpartum in women who had experienced a late pregnancy loss compared to mothers without a loss history. The research questions focused on supposed differences in depression, anxiety, psychological distress, and mother–infant adaptation between mothers with and without a loss history. Twenty-seven women who had experienced a previous perinatal loss due to severe fetal anomaly participated in the study. Thirteen of the women had been childless; 14 had one or more living children before the loss.
occurred. The control group was comprised of 29 women with a newborn following an uneventful pregnancy. The Spielberger State-Trait Anxiety Inventory (STAI) measured anxiety. The General Health Questionnaire (GHQ-28) measured general psychological distress. The Edinburg Postnatal Depression Scale (EPDS) assessed depression. The Neonatal Perception Inventory (NPI) measured Mother-Infant Adaptation. The mother rated an ideal baby on various qualities generating an “ideal” score and rated her own baby on the same qualities generating an “own baby” score. The differences between the pair of scores comprised her DIS or Discrepancy Scale. A semistructured interview focused on the details of the past loss, the presence or absence of professional support, and maternal feelings toward the new infant.

Hunfeld, Taselaar-Kloos, et al. (1997) found women who had experienced a past pregnancy loss experienced significantly more anxiety, psychological distress, depression, and difficulties with mother-infant adaptation at 4 weeks postpartum than controls. They observed this may reflect a grieving process still going on or one that has been re-evoked by the birth. These problems decreased across time, and at 16 weeks postpartum, the women with and without previous pregnancy loss were more similar in terms of depression, distress, anxiety, and coping with their new baby. At 16 weeks postpartum, women with a previous normal live birth felt significantly more depressed and anxious than the first-time mothers. Women scoring high on trait anxiety disposition were significantly more depressed, distressed, and anxious, and viewed their infants as less than ideal at 16 weeks postpartum. Women who had experienced a past perinatal loss perceived their babies as significantly less ideal than
controls at 16 weeks postpartum. The affective disturbances experienced by women having a past loss were thought to be caused by ongoing grief for the loss, or grief being re-evoked by the subsequent birth. Women with loss histories viewed the new infant as less than ideal reflected the mother's disappointment in her newborn. The disappointment may have been because lost children behaved like angels; they did not cry, fuss, wake up in the night, and require continual attention (Lewis, 1983). In women having a past loss history, negative emotions and problems in mother–infant adaptation applied to those with and without a previous live birth. This directly conflicted with the notion that a previous normal live birth acts as a protective buffer for negative emotions in subsequent pregnancies.

The effects of grief on a mother during subsequent pregnancy, the relationship of anxiety to concerns about the new pregnancy, and prenatal attachment issues were the focus of the 1998 research of Armstrong and Hutti. The objective of their quantitative study was to determine the difference in levels of pregnancy-specific anxiety and prenatal attachment in pregnant women who had experienced a late pregnancy loss compared to women in a first pregnancy. Thirty-one pregnant women participated in the study. Sixteen had experienced a second trimester loss, a stillbirth, or early neonatal death. Fifteen women in their first pregnancy comprised the comparison group. Subjects in each group were matched for similar gestational age of pregnancy. Participants were mailed the Prenatal Attachment Inventory (PAI) and the Pregnancy Outcome Questionnaire (POQ). The PAI is based on Bowlby's (1980) theory of attachment; the POQ was developed to examine pregnancy-specific anxiety.
Armstrong and Hutti (1998) found statistically significant differences at the .01 level between groups on the POQ and PAI. Women with a history of loss scored significantly higher on anxiety than the comparison group. Women with a previous loss history scored lower on prenatal attachment than the comparison group. The authors concluded women who experienced a previous late pregnancy loss scored higher levels of anxiety related to concerns regarding the current pregnancy and had decreased attachment to the child of the current pregnancy. Women in their first pregnancy were less anxious and more attached to their baby than women in the loss group. The authors suggested women experiencing a normal first pregnancy might have less anxiety related to assuming a maternal role than women in the loss group. Despite these differences, the correlations between the variables of anxiety and attachment were not statistically significant. The authors noted the lack of significance may have been due to the small sample size or that there may be no relationship between anxiety and attachment. The authors warned generalizations could not be made about a relationship between anxiety and attachment.

Qualitative Descriptions of Pregnancy After Loss

The emotional impact of perinatal loss and its effect on maternal role attainment continued to be a research interest as reflected in the 1999 qualitative study of Côté-Arsenault and Mahlangu. The research was a component of a larger quantitative comparison study regarding Rubin's (1984) tasks of pregnancy. The first two tasks, ensuring safe passage and ensuring social acceptance, provided the
conceptual framework for this study. The research questions were designed to identify the specific experiences of women in subsequent pregnancies following loss, and to isolate the effects of the past pregnancy on the current pregnancy. The convenience sample consisted of 72 women who were currently pregnant, had at least one previous pregnancy, and had experienced a past perinatal loss. The participants' progress in accomplishing Rubin's tasks of pregnancy was investigated using a questionnaire including follow-up questions to provide greater detail. Five questions that asked the participant to compare her current pregnancy to her previous pregnancy were included. The participants' written responses were transcribed and major themes were identified. The research team reached agreement on the three dimensions and the seven themes that emerged from the data. A text-based computer program was used for coding. Within the three identified dimensions of past pregnancy, current pregnancy, and self, seven themes emerged. They were: (1) grief and loss, (2) pregnancy anxiety, (3) specific points in time, (4) ways of coping, (5) safe passage, (6) binding in, and (7) social acceptance.

In regard to the ways of coping theme, the authors reported that women coped with their past losses during their subsequent pregnancy in various ways. They noted that women coped by choosing what to do and what to avoid. Some women responded to the news that they were pregnant with excitement, while others chose to remain silent about the subsequent pregnancy. Some women waited to disclose the subsequent pregnancy and were more selective with whom they shared the information. Women varied in their health-care practices during the pregnancy after
the loss. Some altered their diet and exercise, while others gave up any sense that what they did made a difference. Côté-Arsenault and Mahlangu (1999) also noted that references to ways of coping were embedded in the themes of safe passage, social acceptance, and binding-in, and were also noted in descriptions of past pregnancies. These references were often embedded in terms of reflections and comparisons of the current pregnancy with past pregnancies. A finding of the Côté-Arsenault and Mahlangu study was the references women made to change within themselves in areas of biologic competence, maturity, and self-worth.

Although the majority of participants in the Côté-Arsenault and Mahlangu (1999) study had experienced first trimester losses, the themes identified were similar to those described by Hense (1994) with women in subsequent pregnancy following stillbirth. Hense interviewed 11 women who had experienced a stillbirth. Four women, who were the primary informants, were in the last trimester of a subsequent pregnancy. These women were interviewed in the last 6 weeks of the pregnancy, within 2 weeks postpartum and 6 weeks postpartum. Six women, with a history of perinatal loss in their first pregnancy, served as secondary informants and were interviewed one time. Three of these women had successfully delivered since the losses. One woman participated in the study who had experienced a stillbirth 31 years previously. Hense’s study focused on the experiences of the women during pregnancy and birth following stillbirth. Hense identified several themes which seemed prominent in the experiences of these women. These included: disillusionment and feelings of failure, self-blame, fear of recurrence, anxiety, feeling guilty, awareness of significant
dates and time periods, the presence of residual grief with awareness of attempts to replace the lost child as well as efforts to differentiate between the unborn children, resisting attachment to the unborn child, protecting the unborn child, and seeking reassurance. Hence also contributed important information regarding issues of parental acceptance of the live child, continued attachment resistance during the postpartum period, fear of loss of the child, protecting the child, and the need to acknowledge the lost child.

Côte-Arsenault and Marshall (2000) conducted a qualitative study to develop insights into women’s pregnancy after perinatal loss. They conducted focus groups with 11 women and interviewed 2 women individually who experienced pregnancy loss during various trimesters. Eleven of the women interviewed were currently pregnant at various gestational ages and 2 had completed their pregnancies. From these women’s stories, Côte-Arsenault and Marshall observed that a metaphor, One Foot In – One Foot Out, seemed to emerge. They reported that this overall metaphor described the women’s experience with these pregnancies. In the metaphor, one foot was described as tenuously placed in the pregnancy with women fully engaging in activities and behaviors to provide physical safety for themselves and their baby. The other foot was described as being outside the pregnancy in a reality where things do go wrong, where there was a need to protect oneself from disappointments, and where investment was often attenuated in the outcome of a baby.

Côte-Arsenault and Marshall (2000) reported that women found themselves living within four contexts: (1) reliving the past, (2) trying to find a balance in the
present, (3) recognizing their changed reality, and (4) living with wavering expectations. Seven themes were reported to characterize their navigation of the pregnancy: (1) setting the stage, (2) weathering the storm, (3) gauging where I am, (4) honoring each baby, (5) expecting the worst, (6) supporting me where I am, and (7) realizing how I’ve changed. The authors noted that for the women in their study trying to stay balanced was a major challenge in pregnancy after perinatal loss. Côté-Arsenault and Marshall reported that women needed to work hard to maintain their balance between involvement in the pregnancy and protecting themselves from further emotional turmoil, and made it through the pregnancy by maintaining their balance with one foot in “doing” the pregnancy and the other foot out, in a reality where a successful pregnancy with an outcome of a live baby was not guaranteed. They also observed that while the metaphor, One Foot In – One Foot Out, seemed applicable, each woman’s response and situation was very unique.

Social Support

Rajan and Oakley (1993) conducted a randomized controlled trial of social support in pregnancy to study whether or not the provision of social support during a subsequent pregnancy following a loss affected women’s physical and emotional health during the subsequent pregnancy. This study was part of a larger investigation of social support intervention for high-risk pregnancy. In the investigation, 509 women with a history of at least one low birthweight delivery were enrolled in the study. Two hundred and fifty-four women were randomly assigned to the control
group and were not seen again during the study by the research midwives. Two hundred and fifty-five women were assigned to the social support intervention group. Social support intervention consisted of three home visits and two telephone calls between visits by a research midwife. In addition, the midwife provided participants with a radio pager and could be telephoned by the woman at any time of the day or night. Conversations with the woman during the midwives' visits were tape-recorded and an analysis was done of the transcriptions. Two hundred and seventeen of the women in the study (43%) had one or more pregnancy losses. For many of the women who had suffered a previous pregnancy loss, their initial interview with the research midwife was their first opportunity to discuss their feelings about the loss.

Rajan and Oakley (1993) found significant differences in emotional well-being at 6 weeks and 1 year following delivery between supported and unsupported groups. Physical health was not affected by the social support intervention. Qualitative data on the woman’s experiences with pregnancy loss highlighted their need for recognition of the dead baby as a person and the need to legitimize mourning the loss of the baby. Rajan and Oakley noted that the most critical form of social support for many women who lost their babies was being allowed to grieve in an emotionally supportive environment. They noted that often women found this sadly lacking, and observed the unspoken pressure on a woman not to grieve can be very subtle and may reflect internalize beliefs based on conditioning or custom. Factors and beliefs cited as possibly contributing to the stifling of the natural grief process included: the presence of beliefs and attitudes that an unborn child is not a person worth grieving, that there
is a time and place for mourning and once this is past it is no longer appropriate to
grieve, and the existence of other children or the likelihood of additional children in
the future should compensate women for the death of the baby.

The other problem that these women faced was dealing with other people’s
awkwardness and lack of understanding. One of the most frequent complaints
presented by the women in the study was that other women, whom they had
previously regarded as friends, ignored them completely and avoided speaking with
them. Rajan and Oakley observed that isolation after pregnancy loss was exacerbated
by negative social attitudes towards death, the absence of traditional mourning rituals,
low levels of intimacy, and gender differences in grieving. In this study, research
midwives providing nondirective social support were able to improve women’s self-
confidence and feelings of control over their lives.

Divergent Findings and Perspectives

Many authors addressed the emotional aspects of perinatal loss. The effects of
perinatal loss on a woman’s identity and sense of inner self were described by Côté-
Arsenault and Mahlangu (1999); markedly increased anxiety and coping with vigilant
exploration of negative outcomes was found by Phipps (1985), threats to women’s
sense of competence as a biologic women were discussed by Côté-Arsenault and
Mahlangu (1999) and Theut et al. (1988), and a woman’s guilt and belief her body
had failed her was discussed by Theut et al. (1988) as contributing to mother’s
feelings concerning the meaning of perinatal loss. The mother’s grief for lost aspects
of the self was noted by Furman (1978) and Leon (1992). There was general agreement that the confirmation of subsequent pregnancy was met with great ambivalence (Armstrong & Hutti, 1998; Phipps, 1985; Romine-Macbride, 1998; Statham & Green, 1994).

The literature was consistent in the contention subsequent pregnancies were fraught with stress. Côté-Arsenault and Mahlangu (1999) and Statham and Green (1994) cited anxiety as a primary emotional feature of subsequent pregnancy. The presence of pregnancy-specific rather than generalized anxiety was noted by Armstrong and Hutti (1998), Franche and Mikail (1999), Hunfeld, Wladimiroff, et al. (1997), and Theut et al. (1988). Hughes et al. (1999) found women in the third trimester of pregnancy following stillbirth were significantly more depressed and had greater state anxiety. Turton et al. (2001) studied PTSD in a cohort group of women whose previous pregnancy ended in stillbirth and reported current and lifetime rates of 20% and 29% respectively. The combination of anxiety, depression, psychological distress, and hypervigilence was cited by Hunfeld, Wladimiroff, et al. (1997) and Phipps (1985). Women without living children and a history of perinatal losses were thought to experience the highest levels of anxiety (Statham & Green, 1994).

Although nearly all authors acknowledged the existence of prenatal attachment experienced by parents during each pregnancy, there was disagreement regarding its inception and intensity. Armstrong and Hutti (1998) noted lower levels of prenatal attachment occurring in pregnancies following loss. Hunfeld, Wladimiroff, et al. (1997) believed ambivalent feelings on the part of the mother increased
attachment disturbances, yet Statham and Green (1994) contended mothers in subsequent pregnancy are more likely to imagine their baby as a person, which indicated increased attachment. DeFrain et al. (1986), and Phipps (1985) described the avoidance of typical prenatal attachment behaviors, and they all contended the avoidance functioned as parental emotional protection.

Nearly all authors agreed upon the experience of anxiety as a constant factor in subsequent pregnancy, with disagreement regarding the circumstances under which it would be alleviated. The presence of “time markers” during subsequent pregnancy, such as the new pregnancy surpassing the gestational age of the loss, were found to be insufficient to relieve the constant anxiety (Frost & Condon, 1996; Kirksey, 1987; Phipps, 1985), yet Côté-Arsenault and Mahlangu (1999) observed pregnancy specific anxiety decreased as the significant dates of the previous pregnancy are surpassed. Hense (1994), Kirkley-Best and Kellner (1982), and Phipps (1985) described parents’ fear of the future and their reluctance to talk about it, and contended this avoidance served as parental emotional protection against anxiety. Hughes et al. (1999) found that vulnerability to depression and anxiety in the subsequent pregnancy was related to time since stillbirth; women conceiving within a year were at greater risk. Turton et al. (2001) found a significant relationship between the time interval between stillbirth and the expected delivery date of the subsequent pregnancy with PTSD.

There was apparent disagreement in the literature regarding the relationship between grief resolution for the previous loss and the role and timing of a subsequent pregnancy. Some professionals suggest conceiving soon after the loss results in
replacing the lost child and not completing grief work (Cain & Cain, 1964; Lewis, 1979; Poznanski, 1972). One study has concluded an early conception is correlated with morbid grief reactions (Rowe et al., 1978) during the pregnancy. Other researchers believed an early conception will be equated with rejection and negative feelings toward the new baby (Forrest, Standish, & Baum, 1982; Lewis & Page, 1978). Hughes et al. (1999) found that women who conceived within a year after stillbirth were significantly more vulnerable to depression and anxiety during the next pregnancy after stillbirth. Turton et al. (2001) found that women with PTSD in pregnancy after stillbirth had a significantly shorter time interval between the stillbirth and the expected delivery date than women without PTSD.

In contrast to this view, several studies concluded the birth of a subsequent child assisted parents in their grief work (Dyregrov & Matthiesen, 1987; Stringham et al., 1982). One study found parents experiencing less depression (Videka-Sherman, 1982), while others described less intense grief reactions (Peppers & Knapp, 1980a) in parents during a subsequent pregnancy. Others disagreed with those previously mentioned in the contention there was no relationship between the mother's crisis resolution and the new pregnancy (Laurell-Borulf, 1982). There were no differences in depressive symptoms in subsequent pregnancies occurring earlier than 6 months following the loss (LaRoche et al., 1984). A successful pregnancy serving as a protective emotional buffer was discussed by Hunfeld, Wladimiروف, et al. (1997) and by Statham and Green (1994). Both studies concluded that only in the event the successful pregnancy occurred after the loss was their finding true. A woman’s most
recent pregnancy experience determined the anxiety present during the next; thus, a woman with living children who then experienced a miscarriage would be troubled during her subsequent pregnancy. The evidence of her past positive pregnancy outcomes would be insufficient to alleviate the distrust of self her miscarriage evoked.

The descriptions of subsequent pregnancies following losses in the empirical literature are largely congruent with those of clinicians and theoretical authors. There are a few exceptions. Concerns about the replacement child issue described by Cain and Cain (1964) and Poznanski (1972) have not been shared by all researchers in the area. For example, Phipps (1985) observed that, while a major clinical concern is the manner in which the unique stresses of pregnancies after stillbirth impact parent’s attachment to and subsequent relationship with the infant, neither the parent’s task-oriented approach nor the grief response for the stillborn evoked by the new baby in his study appeared to have significant detrimental effects. Some authors described subsequent pregnancy as an attempt to replace the child and the mothering role, yet cited the maternal task of differentiating between the pregnancies as a more primary issue. Other authors documented the desire to become pregnant quickly after loss and did not view it as pathological. Current trends of delaying childbearing until careers are established (thus increasing the numbers of older, first-time mothers), a decrease in family size, and an increased general awareness of the possible negative outcomes of pregnancy tended to support a normative rationale behind rapid subsequent pregnancies.
Relevant questions persist regarding the expected duration of normal bereavement following the loss of a child. The *DSM-IV* (American Psychiatric Association, 1994) manual states the duration and expression of normal bereavement will vary considerably among different cultural groups. The persistence of symptoms beyond 2 months, however, could indicate the presence and appropriate diagnosis of a major depressive disorder. This time frame does not appear to take into account the unique aspects of perinatal loss or its effect on those who experience it. The *DSM-IV* notes certain characteristics not associated with normal bereavement that will assist practitioners in making a differential diagnosis. The symptoms include guilt about things other than actions not taken at the time of death and a morbid preoccupation with worthlessness. Empirical studies conducted with mothers grieving pregnancy losses cited these very characteristics as typical reactions to the loss that may relate to the degree of responsibility a mother assumed for a positive pregnancy outcome.

Need for Research on Women’s Coping Approaches

The preceding literature review has revealed there are studies that identify the difficulties women face during subsequent pregnancies that follow late pregnancy losses. The presence of anxiety, depression and stress that mark these subsequent pregnancies is clearly identified. Issues of anxiety, feelings of sadness and the effect on prenatal attachment are identified and discussed. The experience of pregnancy loss and its potentially deleterious effect on maternal role attainment during subsequent pregnancies has been noted. The literature describes the lack of confidence women
may feel toward physicians; their inability to be reassured by technological confirmation of viability, the difficulty accessing necessary supports due to social and self-imposed isolation, and the belief no one can truly understand their difficulties. All of these factors describe a vulnerable population whose needs may not be met by relying on usual means of support.

The research studies included in the literature review identified several relevant areas for future investigation. Although much has been written about the grief following the loss of a child, Leon (1992) contended that only 20% of the grief response is explained by the absence of the child; the remainder is due to other factors. Little is known about the meaning of the loss; little is known about the adjustment during subsequent pregnancy. Conclusions that the hesitancy to emotionally attach to a subsequent pregnancy may serve as a helpful and protective function for parents challenged the validity of basic assumptions regarding the necessity of prenatal attachment (Armstrong & Hutti, 1998). A different developmental model may be necessary for families facing the challenge of a subsequent pregnancy. Franche and Mikail (1999) contended that because little is known about the impact of subsequent pregnancy adjustment, the interventions of health care providers might not be attuned to meet the needs of families. They asserted the need for researchers to identify the psychological factors thought to moderate couples' emotional distress during subsequent pregnancy.

Several authors agreed research is necessary to determine the best ways to address anxiety during subsequent pregnancy and to investigate what women find
helpful or supportive during such pregnancies (Côté-Arsenault & Mahlangu, 1999; Theut et al., 1988). Steps toward a new pregnancy following late loss are difficult, yet they are often taken quickly. Research is needed to ascertain the impact of the loss in the context of the experience of giving birth to a subsequent child (Geerinck-Vercammen, 1999). The literature identifies increased childbearing patterns in women who experience pregnancy losses; we know this is a sizeable, vulnerable, and underserved population. There has been relatively little research focused on women’s coping approaches and methods to identify what they found to be helpful and supportive during subsequent pregnancies that follow a late loss.

There have been a few qualitative studies that have focused on several important areas necessary for understanding women’s and families’ experiences with pregnancy following a loss. These include: Phipps (1985) study of nature of stress during pregnancy after stillbirth and how parents deal with the stresses, DeFrain et al’s (1986) work on stillbirth, Hense’s (1994) study of the experiences of women in subsequent pregnancy following stillbirth, and Côté-Arsenault and Mahlangu’s (1999) and Côté-Arsenault and Marshall’s (2000) research on the experience of pregnancy after perinatal loss. However, research focusing specifically on women’s experiences with coping during the subsequent pregnancy following a late pregnancy loss is still very limited.

Several studies have had important findings relevant to coping during the subsequent pregnancy after a late pregnancy, including the importance of appropriate support for women experiencing a pregnancy after a loss (Rajan & Oakley, 1993;
Turton et al., 2001). Relatively little research attention, however, has been given to what women experience as helpful in terms of coping during a subsequent pregnancy after a loss and minimal attention has focused on what women themselves experience as supportive and helpful from others, including friends, family, and health care professionals. Studying the coping approaches and methods women use during subsequent pregnancies that follow late pregnancy losses and identifying what they find to be helpful and supportive is important. Given the large numbers of women who experience pregnancy loss annually and who later have a subsequent pregnancy, research to increase our understanding of women's approach to coping and our understanding of what women experience as supportive and helpful to them during subsequent pregnancy after a late pregnancy loss is an important area of research for women and for health care professionals entrusted with their care.
CHAPTER III

METHODOLOGY

Overview

The purpose of this qualitative study was to describe how women experience and cope with a subsequent pregnancy that followed a late pregnancy loss, in particular, a pregnancy loss occurring after 20 gestational weeks. The methodology for this study was grounded in qualitative and feminist research perspectives. Hoshmand (1989) described the discovery orientation of qualitative methods and suggested they can be used to answer questions about the nature, experience, meanings, and perspectives of unfamiliar groups. In this study, women experiencing subsequent pregnancies after late pregnancy losses constituted the unfamiliar group. Qualitative methods were employed to explore the nature, experience, meanings, and perspectives these women related to their subsequent pregnancy experience.

The relationship between the researcher and the participant is characterized by mutual influence and interaction (Lincoln & Guba, 1985). The qualitative methods used in the study rely on the relationship between the researcher and the participant because the focus of the interview was on listening and achieving an in-depth understanding of the voices of the participants. Feminist researchers seek to create researcher–participant relationships that are collaborative and inclusive of the researcher’s and participant’s subjectivity (Cook & Fonow, 1990; DuBois, 1983;
Klein, 1983). Using and understanding women's stories to learn about their experiences of subsequent pregnancy following a late pregnancy loss fits well within the purposes of the qualitative and feminist research traditions. The primary goal of feminist scholarship is to "address women's lives and experiences in their own terms [and] to create theory grounded in the actual language and experience of women." (DuBois, 1983, p. 108). The importance of hearing women's stories and of understanding women's lives within their context is of value to feminist researchers (DuBois, 1983; Klein, 1983).

In this study the researcher elicited stories from women who had experienced subsequent successful pregnancies with healthy deliveries after late pregnancy losses to describe their approaches and methods of coping with the new pregnancy. The design of qualitative interviewing permitted the discovery and exploration of women's coping approaches and methods during subsequent pregnancies to emerge and allowed exploration of what they experienced as helpful from friends, family, and health care professionals. Data analysis allowed the researcher to understand the unique qualities within each woman's experience and the common themes or patterns among all the women's stories.

The researcher conducted in-depth interviews with women to give voice to their experiences and to elicit perspectives regarding the meanings they made. The process of the study was intended to describe how women experienced a subsequent successful pregnancy with a healthy delivery that followed a late pregnancy loss, to identify specific approaches and methods women employed in coping with the
subsequent pregnancy, and also to describe what women found to be helpful and supportive during the pregnancy after an earlier perinatal loss.

The research methodology for this study is discussed in the following sections in this chapter: (a) the conceptual framework for qualitative and feminist research approaches, which describes how the methodology fits the research questions and is appropriate for the study; (b) the research questions, the list of the four research questions the study attempts to explore; (c) sample description, which describes the criteria for participation in the study; (d) instrumentation, which describes the interview approach used; (e) procedures, which provides an exact description of the steps taken with participants; (f) data transcription, which describes the treatment of the interview contents; and (g) processing and analysis of data, which provides a rationale for and discussion about the techniques chosen for the study.

Conceptual Framework for Qualitative and Feminist Research Approach

Qualitative inquiry emphasizes individuals’ lived experiences and is well suited for locating the meanings people place on the events and processes of their lives (VanMaanen, 1977). Qualitative inquiry is an exploratory, naturalistic effort to holistically and inductively understand experience. The methodology is congruent with the study of the subtle aspects of little explored experience. Henwood and Pidgeon (1992) describe the features of qualitative research in this way: (a) it emphasizes description rather than explanations, (b) it represents reality through the eyes of participants, (c) it stresses the importance of viewing the meaning of
experience and behavior in context and in its full complexity, (d) it views the scientific process as generating hypotheses rather than immutable empirical facts, and (e) it stresses the emergence of concepts from data rather than imposing data onto existing theory.

The current study sought to describe the coping approaches and methods women used during a pregnancy after a late pregnancy loss by using the voices of the women who experienced pregnancy after a late loss. In an effort to understand the experience, the meanings women made of their subsequent pregnancies were described within the participants’ own contexts. The nature of this study was exploratory, meant to discover the specific coping approaches and methods women used during their subsequent pregnancy experience and to explore what women experience as helpful and supportive from others. Hoshmand (1989) stressed the discovery orientation of qualitative methods. The current study was designed specifically to understand the experience, meanings, and perspectives of this invisible population of women.

In-depth interviewing intends to capture an individual’s perspective on her experience, to uncover and to describe important dimensions on the questions under study. When interviews are used as the primary method of gathering data, the purpose of the study must have, as its goal, the description of the participants’ perspective (Marshall & Rossman, 1995). As there is relatively little information about women’s experiences during a subsequent pregnancy that follows a late pregnancy loss, the
A qualitative approach seemed appropriate to gain a deeper understanding from the perspectives of the women involved.

Relying on a woman's story as a primary source of data to learn about the coping approaches and methods women used during a subsequent pregnancy fits well within the goals of qualitative and feminist research. The primary goal of feminist scholarship is "to address women's lives and experience in their own terms and to create theory grounded in the actual experience and language of women..." (DuBois, 1983, p. 108). Feminist research aims to generate knowledge that corrects the invisibility of female experience. Lather (1986) and DuBois (1983) state feminist researchers' understanding of women's lives needs to be grounded in the women's language and lived experience. The current study sought to illuminate the knowledge women gained from their experience using their own language. The researcher openly identified the participants as the true experts and requested the opportunity to learn from their experiences. Affirming the client's reality and validating her perceptions are central tenets in the feminist approach (Lather, 1986). The present study sought to accomplish this validation and affirmation by combining both qualitative and feminist traditions in the methodology framework using a developmental approach.

In an attempt to understand the construction of women's coping approaches and methods during a subsequent pregnancy using a developmental approach, the researcher turned to Belenky, Clinchy, Goldberger, and Tarule's (1986) theory. The theory conceptualizes women's approach to knowledge from five positions:

- silence, a position in which women experience themselves as mindless and voiceless and subject to the whims of external authority;
- received knowledge,
a perspective from which women conceive of themselves as capable of receiving, even reproducing, knowledge from the all-knowing external authorities but not capable of creating knowledge on their own; subjective knowledge, a perspective from which truth and knowledge are conceived of as personal, private, and subjectively known or intuited; procedural knowledge, a position in which women are invested in learning and applying objective procedures for obtaining and communicating knowledge; and constructed knowledge, a position in which women view all knowledge as contextual, experience themselves as creators of knowledge, and value both subjective and objective strategies for knowing. (p. 15)

The researcher assumed the coping approaches and methods described by the participants would be a reflection of them having achieved “constructed knowledge.” The participants’ past negative pregnancy outcomes was expected to reduce their reliance upon knowledge given from external, authority figures. The literature supported this contention in its description of women’s distrust of medical professionals following a pregnancy loss (Leon, 1986; Phipps, 1985). Received knowledge, where women experience themselves as capable of receiving knowledge from others was assumed to be insufficient to support the woman during her experience of subsequent pregnancy after a late pregnancy loss. The literature supported this contention in its description of women’s isolation and avoidance of traditionally defined social supports. The contention is further supported by the recognition of the additional supports women need and the call for their development found in the professional literature.

The presence of subjective knowledge, where women experience themselves as having personal, private, and intuitive knowledge is reflected in the nursing and medical literature by the self-report accounts of women contained therein. Changes in routine medical and hospital policy that occurred during the 1980s and after are, in
part, the result of women achieving and giving voice to their subjective knowledge and questioning medical authority regarding their dissatisfaction with standard medical procedures. Procedural knowledge, where women learn and apply procedures from an objective or connected stance with those from whom they learn, is documented by women’s self-reported accounts of their reliance upon the stories of other women who had experienced a healthy pregnancy and delivery following a late pregnancy loss. Constructed knowledge, where women experience themselves as creators of knowledge and integrate their personal and objective knowledge in order to create new knowledge, appeared to describe the position within which participants would construct their own coping approaches and methods. The purpose of this qualitative study was to describe how women experienced and coped with a subsequent pregnancy that followed a late pregnancy loss, a loss occurring after 20 gestational weeks.

Research Questions

1. How do women describe their experience of a subsequent pregnancy following a late pregnancy loss? What is the experience like for them and what meanings do they make of the experience?

2. What approaches to coping do women employ during a subsequent pregnancy after a late pregnancy loss? Which coping methods and approaches are experienced as helpful and which are experienced as counterproductive or stress inducing?
3. What do women experience as helpful and supportive from friends, family and health-care professionals during pregnancy after a previous late pregnancy loss? What do women experience as counterproductive or stress inducing from friends, family and health-care professionals?

4. What would they like to share with other women who may experience pregnancy after a previous late pregnancy loss?

Sample Description

Criterion-based sampling described by Goetz and LeCompte (1984) was used for participant selection. The criteria for the sample were set prior to data collection. The goal was to produce a homogeneous sample in terms of gestational age of the prior fetal loss to allow common themes, if they existed, to emerge. A homogeneous sample addressed one possible limitation of some prior research in which samples were mixed and included losses of various gestational ages.

Participants in this study were limited to women who experienced a spontaneous late pregnancy loss followed by a new pregnancy and healthy delivery. In this study, a late pregnancy loss was defined as a loss occurring later than 20 gestational weeks. The specific medical cause for the loss was not a criterion for participant selection. Women who were currently aware they were pregnant were not considered to be appropriate participants for the study, since it was assumed they were already emotionally vulnerable as a result of the pregnancy and were in the context of the past loss. Appropriate participants were expected to be able to describe...
their thoughts, feelings, emotional reactions, and coping approaches and methods regarding their pregnancy experiences. The timing of the subsequent pregnancy or the amount of time since the late pregnancy loss was not a criterion in participant selection. The woman’s unique experiences, thoughts about and coping approaches and methods used during the subsequent pregnancy following a late pregnancy loss were of interest in this study.

Demographic information including age, race, religion, marital status, years of education, and occupation were recorded. The research questions were focused to describe the experience of women during a pregnancy that followed a late pregnancy loss, and to explore the coping approaches used and describe what they experienced as helpful and supportive from others. The sample consisted of volunteers recruited from posted invitations in physician’s offices, direct suggestions made by health care professionals, or by word-of-mouth from others. This resulted in a self-selected sample comprised of women who had a high personal investment in the topic and the willingness to identify themselves and discuss their personal experiences.

Instrumentation

This study used an in-depth interview approach with a small number of “information rich” cases (Patton, 1990, p. 169). Eight participants were interviewed in the researcher’s office or a private location the participant designated. All interviews were audiotaped for maximum fidelity, and then transcribed. A second tape recorder was used for back-up purposes. Phenomenal interviewing was chosen.
because it is a technique committed to an empathic and joint search for shared understanding (Massarick, 1981). Polkinghorne (1994) suggested that an intensive face-to-face interview produced the most authentic and deep descriptions because a skilled interviewer can establish a climate of trust and openness. In-depth interviewing allowed the participant's perspective of the phenomenon of interest to unfold as the participant viewed it (Marshall & Rossman, 1995). To allow the participant the opportunity to tell her story in her own way, the interview began with a request for the participant to share any information she wished to concerning her prior pregnancy loss. The questions contained in the interview guide were developed using the general interview guide approach described by Patton (1987). The guide contained a list of open-ended questions that were addressed during the interview. In addition to the guide, the researcher followed up with clarifying questions if they were needed to encourage participants to fully disclose their experiences. This approach is appropriate when the researcher "does not know what he or she does not know and must therefore rely on the respondent to tell him or her" (Lincoln & Guba, 1985, p. 269). The interview was guided by the research questions and the topics specified in the interview guide. The researcher was open to discovering concepts and ideas about the topic that were not previously considered. A copy of the interview guide is contained in Appendix K.
Procedures

Participant Recruitment

The researcher sent letters to the offices of local physicians, obstetricians, pediatric offices, the local health department, the Kalamazoo County Medical Society, and the Women, Infant and Children’s Clinic. The letters, presented in Appendices A and B, described the research project and requested the physician post the information in waiting rooms. The researcher asked to be invited to the staff meetings of these practices to explain the project and to provide related recruitment posters and flyers. The recruitment materials are contained in Appendix C. If the physician wished to make appropriate women aware of the project, she/he was invited to do so. The participant invitations described the study, its purpose, and the criteria that needed to be met by all participants. The confidential nature of the interviews and an explanation of how the data would be used were included with a request women call the researcher if they had interest or questions.

Recording Expectations

Rennie (1997) noted qualitative researchers are becoming more aware it is impossible for investigators to totally be aware of and to transcend the influences of their own understanding of the phenomenon. In an effort to recognize bias and to set it aside, before meeting with any participant, the researcher recorded all expectations (bracketing) regarding the anticipated outcomes to protect objectivity during the data
analysis. Expectations are the beliefs the researcher had formed from reading the
literature, developing the research questions or from clinical experience. Hill,
Thompson, and Williams (1998) recommend researchers return to their written
expectations after the study is complete to check whether or not they learned anything
new during the process. The presence of new learning would provide some indication
researchers were informed by the data, not merely substantiating their bias.

Researcher Narrative

The researcher is a 47-year-old Caucasian woman. She has practiced as a
therapist with an interest in women’s issues for more than 20 years. The researcher
identifies herself a feminist therapist, heavily influenced by the following theories:
attachment, developmental, object relations, and the Jungian and psychoanalytic
approaches. The researcher became a mother after years of infertility treatments and
interventions. Several close family members also suffered from infertility, late
pregnancy losses, and/or late neonatal deaths. This combination of personal and
familial experiences later led to the researcher becoming interested in appropriate
treatment methods during the course of providing therapy to a number of women
clients who had suffered traumatic pregnancy losses.

Early in my professional career I worked in a community agency that had, as
its focus, the provision of mental health services to persons and families dealing with a
variety of chronic or terminal medical diagnoses. Providing meaningful mental health
services to the clients necessitated an understanding of the dynamics of grief and loss
as they were applied, were understood, and were experienced in the context of both chronic physical or terminal illness and in the developmental lives of families. I also worked at a local hospice. I sought to understand the integration of the grief experience into an individual’s larger life context. My clients had taught me it was both possible and necessary to grieve the loss of an aspect of oneself or a loss of one’s physical functioning.

Later I began to work almost exclusively with women in a medical setting and in private practice. I worked with women who experienced difficulty with infertility, or who had experienced a pregnancy loss. I had the opportunity to provide counseling to a number of women who had experienced repeated pregnancy losses and infertility. The multiple physical and emotional issues they struggled with as they recovered from their pregnancy losses moved me. Their physical recoveries appeared to be achieved much more quickly than the resolution of their emotional pain, their grief for their lost baby, and the loss of their dreamed of and desired family. I came to understand women experiencing losses of this type often felt a sense of failure, shame, and incompetence. They no longer trusted their bodies, or themselves, to function normally or to protect their unborn. Often these women had been required to subject themselves to repeated, painful, and invasive medical procedures to achieve or to protect their pregnancies. Further, they lost their privacy and any sense of intimacy regarding details of their private lives. These experiences continued to erode the fragile sense of wounded self they experienced after the pregnancy loss. Many women having these experiences reported significant feelings of anxiety and fear. They could
not contemplate the use of medication to manage their anxiety, even at their
physician’s direct suggestion, because they would not consciously choose anything
that might impair the growth, health, or the development of their pregnancy.

Feminist beliefs lead me to honor the experience of individual women and to
view them as the experts of their experiences and of their own lives. Years of practice
as a counselor had informed me individuals, given opportunity and support, can and
do solve their own problems and can construct better solutions than others could
suggest; without a doubt my clients have been some of my best teachers. This
research project developed out of a desire to learn from women who had experienced
late pregnancy losses and subsequent pregnancies. I was also interested in learning
more about how their significant others and health care providers supported them
during their pregnancy experiences. I had always been concerned by the difficulty
grieving people may experience in the “outer world” where others so frequently
cannot understand their experiences or their pain, and, as a result, cannot provide
meaningful support.

I assumed during the project I would hear stories of traumatic loss and
extended grief. I believed women would approach a subsequent pregnancy in a
weakened and vulnerable condition; they would feel both fear and anxiety and would
insist they must manage without medication. I believed it would be difficult for them
to trust themselves, their bodies physically, or any health care professional to protect
either themselves or their babies. I believed the coping strategies they might choose to
share would reflect they were relying on “constructed knowledge,” meaning they
would tend to develop or to construct very unique, personal, and individual coping approaches. I hoped acquiring meaningful information about their variety of coping approaches would be of benefit to other vulnerable women, their supportive others, and health care providers.

Prior to the data collection, the researcher expected participants would describe their subsequent pregnancies that followed a late pregnancy loss as anxiety filled endurance tests. The researcher anticipated participants would describe a sense of emotional detachment from themselves and their pregnancies, with meanings of the experience being constructed sometime after the delivery. The researcher expected women would cope with these pregnancies by imagining various potential scenarios and planning strategies they would use in the event negative outcomes occurred. The researcher expected this would be described as anxiety-producing, but necessary toward feeling a sense of control. The researcher expected usual attaching behaviors to be actively avoided. The researcher expected women would describe supportive responses from others as rather infrequent events. They would feel isolated from significant others and would resist their input because “no one can really understand unless they have been there.” Counterproductive and stress inducing responses would include, “hollow” reassurances from others, “don’t worry, you’ll be fine” or “this baby is so much more special because of what you’ve been through.” Particularly bothersome would be attempts on the part of others to make an interpretation regarding the meaning of the loss, such as, “the baby is your personal angel in heaven.” Any attempt by others to impose a spiritual or religious meaning would be
troublesome to the women. The researcher expected participants to be eager to share their experience in an effort to help other women. They would view themselves as a unique subset of sisters who had bonds to other women few others can appreciate or experience. Some would have found a source of inner resources they were surprised they had, and they would want to share them, especially to impart a belief to other suffering women, these pregnancies were survivable.

Contact With Participants

Initial Telephone Contact

When interested women contacted the researcher, the script in Appendix D was followed. If the woman fulfilled the necessary criteria for the study, she was invited to participate. If she did not, she was thanked for her interest, given the reason her experience did not fit criteria, and was told she could not be interviewed. The participants who met criteria were sent a confirmation letter presented in Appendix E, a demographic questionnaire presented in Appendix F, and an informed consent document presented in Appendices H and I. The informed consent document described the purpose, possible risks, and procedures that were used during the study. In addition, the consent described the procedure for “member checks” (Lincoln & Guba, 1985), allowing the researcher to re-contact the participants during the data analysis.
Interview Process

The participant was greeted and was oriented to the office layout. In the event the interview occurred in another private location selected by the participant, the researcher allowed the participant to orient her to the surroundings. The researcher asked the participant to designate a pseudonym that was used during data transcription to protect her identity. The researcher reviewed the procedures for maintaining confidentiality, then explained and read the informed consent document. She gave the participant the opportunity to ask questions, and the informed consent document was signed. The researcher obtained demographic information and reminded the participant the interview would be audiotaped using two tape recorders for back-up purposes.

The interview began with the researcher stating:

In this interview I will be asking a series of open-ended questions about your experience of a successful pregnancy that followed a previous spontaneous late pregnancy loss. A spontaneous loss occurs naturally. It is not the result of medical intervention, accident or trauma. The main purpose of the interview is for you to talk about your experiences in a way that best describes what the pregnancy was like for you and to describe the approaches and methods that helped you cope with a pregnancy that followed a previous late pregnancy loss. During the interview I will ask questions only as needed to clarify your experiences. Do you have any questions before we begin?

After the researcher felt she understood the participant’s response, she said, “Let’s begin,” and then she turned on the tape recorders. The researcher then said:

It is important for me to understand the context of your pregnancy experiences. I’d like to give you the opportunity to tell me anything you feel comfortable sharing about your pregnancy loss and how it led up to your decision to begin another pregnancy. What went in to your decision to become pregnant again?
From that point the researcher intended to follow the interview guide in Appendix K. The interview guide approach (Patton, 1987) was used where the researcher had the list of topics that needed to be included. In addition to the guide, the researcher used follow-up questions if they were needed to encourage participants to fully disclose their experiences. During the interviews, each participant's story unfolded in a unique way as she described the context of her pregnancy experiences and her experiences coping during the subsequent pregnancy. Some of the participants told extended, rich narratives describing their experiences. The researcher asked questions as necessary to ensure the clarity of her understanding, and used her judgment in applying the interview guide. After each interview the researcher recorded her observational notes (Marshall & Rossman, 1995). The researcher recorded impressions, reactions, self-reflective notes, or any other salient information about the interview for inclusion in a log designated for that purpose. The notes described the researcher's reactions to the presence of the participant and noted questions and reactions to the core meanings of the participant’s responses. The researcher especially noted any particularly illuminating or unique aspects of the participant’s descriptions, looking for the emergence of any new primary ideas and nuances. When reflecting on the interview's overall content, she considered the need to ask deeper or more clarifying questions during the subsequent interviews. The researcher individually listed what she felt she learned in particular from the participant, including how the content of the interview provided direction to inform or to clarify future interviews. This process of interweaving the data collection and analysis from the start of the project is described
by Miles and Huberman (1994). "We strongly recommend early analysis. It helps the
field–worker cycle back and forth between thinking about the existing data and
generating strategies for collecting new, often better, data. It can be the healthy
corrective for built-in blind spots" (p. 50).

The researcher also constructed a summary of each participant's interview for
use in the member checks. The process of preparing the summaries allowed another
opportunity for the researcher to increase her awareness of emerging themes and
commonalities, "employing [the method of] constant comparative data analysis"
(Marshall & Rossman, p. 110). The interview summaries and the researcher's
observational notes were used during the data analysis and in preparing the written
report of the study.

Data Transcription

Within the week after each interview, the tapes were transcribed. After the
transcript had been checked for accuracy and compared with the tapes, the tapes were
placed in a locked box and stored in the researcher's office. The researcher listened to
each tape and read each transcript several times to become immersed in the data.
Each transcript was purged of identifying information and each participant's
pseudonym was inserted into the transcript. All other identifying information was
generalized to protect the confidentiality and identity of participants. Names of
individuals were replaced by pseudonyms or their role or occupation. Any other
identifying information was generalized to maintain participant anonymity.
Participant Thank-You Letter

Following the initial interview each participant was sent a letter thanking her for her participation (see Appendix M). Participants were also reminded the researcher planned to contact them to schedule a second interview. The purpose of the second interview, or “member check,” was to allow the researcher to verify the accuracy of her understanding of the participant’s experience and to share emerging themes or commonalities arising from the data analysis.

The Processing and Analysis of the Data

The researcher read the transcript of each interview several times, then worked with each transcript individually. She extracted the participant’s responses to the research questions directly from each transcript. The participant’s response to each question was recorded by handwriting/copying it from the transcript onto an individual summary list. The researcher followed this procedure with each transcript and every question. This generated a summary that was both individual and cumulative. The researcher developed a list of all participants’ responses relevant to each of the research questions. This allowed the researcher to review, across all subjects, the totality of responses to question one, then question two, and so on.

The researcher re-read all of the participants’ responses to the research questions line by line. Each response to every question was reviewed, and next to the response on the summary list labels were written and a code was assigned. The researcher carefully reflected on the meaning that seemed to be embedded within each
response as the data were questioned to identify recurring ideas, strategies, language, and themes. The researcher attempted to identify similarities of thought among the participants' responses. This process generated approximately 107 codes. Marshall and Rossman (1995) described this "category generation phase of data analysis is [as], the most difficult, complex, ambiguous, creative and fun" (p. 114). They contended, "identifying salient themes, recurring ideas or language, and patterns of belief that link people and settings together is the most intellectually challenging phase of the data analysis and one that can integrate the entire endeavor" (p. 114). The researcher listed all the codes and re-read the labels repeatedly to become sensitized to their similarities and differences. As part of the preliminary development of codes, "in vivo" codes were used as appropriate. These codes were identified by the word or phrases the participants used repeatedly, and they became provisional codes. As the analysis progressed the number of codes was reduced. Some codes did not appear to work as well as others did in describing the data accurately. Other codes decayed; they appeared to become extraneous and were set aside. Some codes were extended (Lincoln & Guba, 1985) as they included the refinement of an earlier theme into which other, less complete codes were collapsed.

The researcher returned to the responses to the research questions. She searched for agreement between the codes and the content of the responses to the research questions. This was largely a matching exercise. The researcher moved repeatedly between the list of codes and the participants' responses to the research questions, using the constant comparative method of data analysis. As she searched
for agreement, the researcher tallied the responses to the research questions against
the list of codes, generating a frequency count. When this process was complete,
approximately 15 codes contained large numbers of tallies. This indicated to the
researcher that these codes potentially represented emerging themes.

The researcher knew the categories should be internally consistent (having
internal convergence), yet should be distinct from each other (having external
divergence). Marshall and Rossman (1995) contended the goal is to identify the
salient, grounded categories of meaning the participants hold. The goal of the study
was to identify the coping approaches and methods the participants found helpful
during their subsequent pregnancies, and, further, to identify what women experience
as helpful and supportive from friends, family, and health care professionals.

**Data Display**

To explore the presence of the emerging themes within and across the
participants’ experience, the researcher constructed a matrix display or summary
table. Bogdan and Biklen (1992) suggested the use of a matrix display to describe a
project bounded with the following: specific acts and behaviors, events, connected
sets of behaviors, strategies, meanings and perspectives, and states and processes.
These categories appeared to be analogous to the areas of investigation in this study,
so the technique appeared to be appropriate. In constructing the data matrix the
numbers 1–6 (representing the research questions) formed the horizontal top margin
or X-axis. The number 1–8 (representing the participants) formed the vertical left
column or Y-axis. Forty-eight cells were formed. Manually the researcher filled in each cell of the matrix with the participant’s verbatim responses contained in her transcript. This time consuming process proved extremely valuable, because the researcher read each participant’s responses again, gaining a deeper understanding of its meaning. The matrix itself allowed similarities and differences among responses to be located on one plane. The matrix display allowed the researcher to visually scan all responses at once and to note patterns of responses within and between individual participants.

The matrix allowed the researcher to see which participant had answered which question(s) more fully, and suggested areas that would require additional focus during the member checks. The visual display the matrix afforded had inestimable value. If a particular cell, or a pattern of cells, appeared to have fewer or less meaningful responses, the direction the member checks needed to take to ensure complete responses was easy to see.

Member Checks

The script for the member check interview is contained in Appendix N. Each participant was provided a summary of her interview, and then was asked to verify its accuracy. The summary contained the individual responses to each research question written in the form of what the researcher understood the participant to say. The participants were invited to correct any inaccuracies or misunderstandings of meaning. Participants were also asked to elaborate, clarify, or provide additional
information to the research questions as necessary. The researcher assured the
participants any corrections they shared were welcome and would provide helpful
assistance, as the additional information would refine the researcher’s understanding
of their experience and would assist in the data analysis. The participants shared a few
corrections and clarifications and assured the researcher they felt she had understood
them; her understanding of their experience appeared to be evident in the summaries.
During two of the member checks, the participants had corrections for the researcher.
In one instance, the participant corrected specific details regarding her medical
treatment and the chronological order of a few events. In the second instance, the
participant requested corrections regarding a few specific words the researcher used
in describing the participant’s experiences. In both cases, the changes or additions
were discussed, were agreed upon, and then were summarized. The researcher then
shared emerging themes or commonalities arising from the early stages of the data
analysis and asked each participant for her comments or additions. This permitted the
participant to comment on the degree to which the analysis was consistent with her
experience. The researcher incorporated participant feedback into the successive
stages of data analysis.

As each member check occurred, it was recorded and then transcribed. The
transcriptionist was instructed to type in bold font the participants’ responses. The
researcher returned to the previously mentioned data matrix method procedure to add
the additional and/or clarified responses to the data matrix. The bold font made the
information collected during member checks readily distinguishable from the
information contained from the first interviews. The researcher returned to constantly comparing and contrasting the codes and the proposed themes with the data matrix.

The researcher returned to the original transcripts and the summaries she had prepared with the additions and clarifications the participants had supplied during the member checks. The researcher believed a good test of the appropriateness and "goodness of fit" for the potential themes was the degree to which they accurately reflected the participant's meanings and descriptions of her experience. Using the constant comparative method described by Marshall and Rossman (1995), the researcher compared and contrasted the potential themes with the content of the transcripts, the summaries, and the participants' member check interview corrections and additions. The researcher was satisfied the emerging themes described the meaning and insight contained in the words of the participants' reported experiences. Additions made after the member checks further refined the researcher's awareness of the importance of certain participants' phrases or descriptions. Particular phrases appeared to be especially vibrant or precisely descriptive; they seemed alive. The researcher listed them and compared them to the entire coding schema to ensure the final list was inclusive.

The process of searching for alternative explanations began. The researcher was aware the patterns and themes that appeared to be apparent had to be challenged. She must search for other, reasonable and plausible explanations for the data and the linkages between them because alternative explanations always exist. The researcher returned to the conceptual framework of the study and the belief the participants were
the true experts of their experience. The researcher understood her role in these ways; she was obliged to create a relationship with the participants that was collaborative and inclusive, and would allow the participants to fully disclose their experiences. She would seek to hear and to understand the participants’ stories within their own contexts, and would use her understanding to identify the helpful coping approaches and experiences women found to be helpful and supportive during subsequent pregnancies that followed late pregnancy losses. She would search for common themes and identify differences. She would carry the voices of the participants with their identified experiences in coping with subsequent pregnancy after a late pregnancy loss. If the analysis was correct, their voices and strategies would be evident and could be heard.

The researcher again employed the constant comparative analysis method. She compared the emergent themes with their definitions she had developed against the matrix display and the original transcripts. The researcher, essentially, was comparing her understanding and summaries against the participants’ described experiences. The researcher reviewed the successive steps of the data analysis. She concluded the process she had followed was consistent with feminist and qualitative research methodologies. The researcher concluded the themes she had developed with their descriptions accurately described the data, and, of utmost importance, had carried forward with integrity, the voices of the participants.
Protection of Participants

Within the week following each interview, the tape was transcribed. After the tape was compared to the transcript to be checked for accuracy, and was heard by the researcher several times for immersion, the tape was destroyed. In transcripts and in any materials included in any report, identifying information was purged and a pseudonym or initial was used. Names of persons or locations were replaced by general descriptors. Each transcript was labeled with a code number and the participant’s pseudonym. The signed informed consent documents were retained in a locked file cabinet in the researcher’s office. The demographic information provided by participants with their code number and pseudonyms were transferred to a master list. The original demographic questionnaire was destroyed. The master list was stored in a locked cabinet separate from the informed consent documents.
CHAPTER IV

RESULTS

In this chapter the results of the study are presented. The chapter is organized in the following main sections: (a) context of the study; (b) participants; (c) description of the subsequent pregnancy; (d) coping approaches; (e) experiences with friends, family, and health care professionals; (f) the relational level of care; and (g) recommendations for other women facing subsequent pregnancies.

Context of the Study

This study represents a collection of interviews with eight women who experienced a spontaneous late pregnancy loss followed by a subsequent pregnancy and healthy delivery. The interviews were conducted from December 2001–April 2002. The interviews occurred in the office of the researcher or in a private location of the participant’s choice. Three women were interviewed in the researcher’s office, four were interviewed in their homes, and one woman requested the researcher meet her in her office at work.

The audiotapes of the interviews included various contextual sounds, a child’s voice, a friend or family member leaving the home, or the distant hum of the clothes dryer. Many participants shared their precious keepsakes and mementoes, such as pictures of their deceased children, the baby clothes in which they had dressed the
child, or the child's blanket. Participants shared their journal entries, poems that had special meaning for them, the condolence letters other had sent that gave them comfort. These linking objects seemed to preserve the individuality and identity of each child as well as the unique aspects of the mother's experiences.

Without exception, the participants mentioned their deceased children by name and wanted their names recognized in the project. This dissertation is dedicated to the participants and their children, and the dedication recognizes the children by their first names. While all of the participants were willing to have their actual names used, pseudonyms for participants were used in transcription and in written reports to protect participant confidentiality. The names and identities of their children, claiming their voices and owning their experiences were very important to the participants.

The participants were interested in the person of the researcher. Several wanted to know if she was a mother, the nature of her loss experiences, and how she had become interested in the topic. The participants were interested to know how the results of the study would be used. They appeared eager to participate and hopeful their efforts could be used to support other women facing subsequent pregnancies. Several participants were committed members of support groups for women who had experienced pregnancy loss and provided active outreach to bereaved mothers. The participants shared rich and detailed illustrations of their lives, their families and their experiences. Everything they shared in addition to the formal interview itself was an important contribution that created a unique ambiance particular to the mother and the life context within which her pregnancy experiences occurred. The cultural affinity
of women may have enhanced the participant's comfort with self-disclosure and their expectation for the experience of being understood.

In the broader historical context, these participants experienced their pregnancies at a time when advanced medical care had reduced maternal deaths and infant mortality rates. Their mother's generation was the first generation of women who expected to raise every child born to them to adulthood free of infectious disease, so none of the participants had a reason to expect she would bury her child. The culture of health, physical fitness, and easily available reliable contraception promoted the belief that women could control the function and performance of their bodies. Childbearing women are usually younger, are healthy, and their life experience supported their belief medical science can protect them. Cultural patterns such as emphasizing education, establishing relational and financial stability while delaying childbearing, often meant family size will be smaller; the children will be carefully planned and long awaited.

Technical advances in reproductive medicine also allowed for the earliest confirmation of conception, causing pregnancy experiences to "last longer" and emotional attachments to occur sooner. Sophisticated gender-conception techniques allow gender choice; ultrasound monitoring of the baby permits gender to be known and the child to be visually observed, allowing development of earlier parental bonds. Early diagnostic procedures can verify fetal health and rule out anomalies. In the event defects are found, intrauterine surgical techniques have been developed to correct them before birth. Advances in neonatology now allow infants born extremely
prematurely, as early as 23 gestational weeks, to survive. The American Academy of Pediatrics, in its 1995 policy statement entitled “Perinatal Care at the Threshold of Viability” states:

The survival of infants born from 23 to 25 weeks of gestation increases with each additional week of gestation. However, the overall neonatal survival rate for infants born during this early gestational period remains less than 40%. Of those who survive, about 40% have moderate or serious disabilities. (p. 1)

The 2001 Obstetric Guidelines of the British Columbia Reproductive Care Program contains information regarding neonatal survival and disability rates. Their data state the survival of infants born at 22 completed gestational weeks is very infrequent. The survival rate of infants born between 23 to 24 completed gestational weeks varies from 10% to 50% (p. 3). Both documents describe the complex medical, social, and ethical decisions that are involved when a child is born prematurely, and the concomitant, extensive, multidisciplinary, and costly care the children need. Despite the complex problems families having premature infants must face, there are medical interventions and planned strategies to deal with them. The challenges are admittedly difficult, yet are not described as being impossible. Solutions do exist in varying degrees of preferability. All of these factors contribute to a cultural context in the lifetime of women today that suggested women can plan, determine, control, and correct the events of their reproductive lives.

Participants

Eight women were interviewed for this study. All were Caucasian ranging in age from 30 to 46 years. Seven of the participants were married, one was divorced.
All identified themselves as having a Christian religious background and belief. All eight participants had earned a bachelor's degree; one had earned her master's degree. Six participants worked outside of their home in professional capacities such as accounting, nursing, social work, massage therapy and engineering. Two of the participants were full time mothers at home. Four participants reported a past medical history of infertility and/or the need for highly technical medical interventions to achieve pregnancies. Four participants described the late loss of her first pregnancy, three her second pregnancy, one her fourth pregnancy. Only two of the participants had living children during their subsequent pregnancies. All of the participants in this study planned their prior pregnancies. Six had waited to complete their educations, and then achieved financial and marital stability before beginning their first pregnancy. Two of the participants already had experienced a normal, uneventful first pregnancy and planned, when they felt the time and circumstances were right, to add another member to their family. When the prior pregnancies were begun, they continued to progress normally, and the participants went on with their regular activities and routines. In all cases these eight pregnancies were considered to be uneventful. There was no evidence of emergent physical symptoms indicating potential problems, and all participants felt they had nothing to be concerned about; they would wait until they delivered on schedule, plan for, and purchase items for the baby in the meantime, celebrate with friends their new arrival, then proceed with the rest of their lives in the context of a new, or larger, family. Tragically, without any prior warning, all eight
pregnancies ended abruptly. The gestational ages at which the losses occurred ranged from 23 to 39 weeks.

Two of the pregnancies ended between 23–25 gestational weeks, two during the 27th week, one during the 29th week, one during the 31st week, one during the 37th week, and finally, one during the 39th gestational week. A few of the participants felt they experienced a decrease in the amount of fetal movement, were worried, and called the doctor. Others, since this was a normal pregnancy, went in for a routine doctor’s appointment. Two of the participants began preterm labor for no apparent cause. Whatever their circumstances, all eight, otherwise healthy women who had planned, waited for and enjoyed their pregnancies, who had made preparations for and prepared a place for their babies, found themselves suddenly experiencing a medical and life crisis. The cause of their pregnancy losses may have differed, but their current circumstance was the same. They, in a matter of hours had experienced an unwanted disruption in their physical, psychological, developmental and maternal status. Their babies were dead, they were in shock and were grieving, they were set apart from their sets of friends, they had become mothers but had no living baby. All of the participants sought out some form of support to help them grieve their loss. Three of the participants attended support groups, four sought out individual counseling or psychotherapy, one used methods of therapeutic bodywork such as Rolfing. Four participants began a subsequent pregnancy within one year after the loss, two were pregnant during the second year after the loss, one during the third year after the loss, one during the fourth year after the loss. The time between the late
pregnancy loss and the subsequent pregnancy may be important because it may imply the degree to which the grief of the earlier loss may influence the new pregnancy. At the time of interview, the length of time since the participants experienced their late pregnancy loss varied from 3 to 14 years with one participant experiencing loss 3 years earlier, one 4 years, one 6 years, two 8 years, one 9 years, one 10 years and one 14 years earlier.

Description of the Subsequent Pregnancy

Contradictory Emotions

For all of the participants the decision to begin a subsequent pregnancy was not made quickly. It was an effortful decision involving multiple factors. The participants needed to investigate the cause of their late pregnancy loss, then assess the possibility of another loss occurring. They needed to carefully assess the physical risks and measure them against their perceived emotional capacity to bear those risks in the event another pregnancy loss occurred. Doing the necessary investigations and reaching conclusions and some closure required time and preparation. This process needed to be fairly complete before a decision to begin another pregnancy could be made.

This assessment was done within the context of the upsetting awareness of the reality that an otherwise healthy woman could be physically incapable of bringing a pregnancy to term despite her best efforts. The participants also knew by then every pregnancy represented a calculated risk and even a trusted physician could not
necessarily predict potential problems, solve them should they occur, or guarantee a positive outcome. The participants keenly felt the pain of their grief with its variable emotional shifts and knew experiencing another pregnancy would add to their existing emotional vulnerability. Within the context of these painful realities, the decision to begin a subsequent pregnancy was made.

Half of the participants in this study reported a prior history of infertility and/or the need for highly technical medical interventions to achieve their pregnancies. Given these histories and the experience of the past loss combined with ongoing difficulties conceiving, the participants experienced conflicting emotions when the subsequent pregnancy was confirmed and throughout its duration. Quotes from several participants illustrate this conflicting experience with mixed emotions:

When we found out we were pregnant the second time it was different than finding out we were pregnant with the first child. With the first we were elated, excited, joyful, thrilled, and anxious. With the second we were all that; however, there was another component of fear.

We were very scared . . . you never put your guard down . . . it just started a long pregnancy of worries.

I was joyful but I was not enjoying it due to the constant worry.

It was a very guarded happiness, a qualified happiness. You are happier pregnant again, but, oh no, now what? Now we have to go through everything again.

The minute I found out I was pregnant and it was a girl and she was healthy I could not believe it. It was too good to be true. You can’t ever have that sense of okay, if I just make it through this part then everything will be okay. I knew better than that.

When their subsequent pregnancy was confirmed participants described experiencing contradictory emotions and described their subsequent pregnancies as filled with
contradictory emotional states, guarded expectations and anticipated future complications.

**Fear**

Seven of the participants described feeling fear as a dominant feature of the subsequent pregnancy. Quite understandably the participants had reasons to feel fear. They each had experienced a late pregnancy loss and were each faced during their subsequent pregnancy with the unbearable prospect of a pregnancy loss occurring again. Their necessary investigations and search for understanding regarding the cause of their loss had also informed them of the many other potential risk factors one faced during all pregnancies. Their fear was experienced as a general lack of safety, a constant emotional vulnerability, and the specific fear of experiencing another fetal loss. The fears of another loss seemed strongly rooted and based on the information the participants acquired as they learned the cause of their loss, weighed the known risks of pregnancy, and their traumatic past experience with pregnancy loss.

Participants described:

- I knew I was worried about it happening again because I remember not wanting to tell anyone [I was pregnant] . . . it was not safe to share it.

- I never felt safe about anything. [There was] always the fear something different would crop up.

- I was already feeling the grips of fear of losing the baby . . . I was constantly checking for blood.

- I lost my innocence, I know the worst that could happen. We have already experienced that worst.
You can only re-live it so many times . . . I don’t want to cry about this again . . . I don’t want to think about it and it is all [self-protective].

Fear entered that pregnancy immediately . . . although I am a person of tremendous faith . . . [I thought] I can’t live through this again.

In essence, participants feared losing their unborn baby again and this fear persisted throughout the subsequent pregnancy.

**Fearful Attachment and Persistent Vulnerability**

Wanting to attach to the new baby yet fearing the formation of emotional bonds represented one aspect of the contradictory emotions experienced by many participants. This contradiction suggested the lingering impact of their loss. Their persistent vulnerability reflected a combination of the participants’ past experiences and their acquired knowledge. They “have already been a statistic”; they now knew the many other statistical probabilities experiencing the new pregnancy caused them to face. Participants reported feeling the internal contradiction of wanting to attach to the pregnancy and the baby, yet fearing it in an effort to protect themselves emotionally.

I attached to the idea of the child immediately but I was afraid. I feel like I never really bonded with her . . . I was guarded in my attachment to her.

I was afraid to attach . . . I was afraid I would never feel emotionally bonded to him. [My] relationship with him formed when he began to kick. It [the attachment] just happened.

I tried to keep an emotional distance in case something happened and the emotional distance almost frightened me at first. I was afraid I would never feel a bond, but I did.
I attached every bit of myself to him, I didn’t hold back but I didn’t feel safe 'til they delivered him.

I don’t remember ever feeling safe about anything. Little did I know how far you can go along and still have problems at the very end. You just never know.

This painful emotional dilemma seemed to demonstrate awareness of the impact of the past loss, the wish to be a good mother to the new baby, and a sense of guilt for needing to protect the self, possibly at the expense of the child. Participants wished to attach to the new baby yet feared attachment at the same time out of the apparent need to protect themselves emotionally from experiencing another very traumatic loss.

**Obsessive Mission, Worry, and the Wish to Hurry the End**

The obsessive mission refers to the single-minded preoccupation the subsequent pregnancy created in the lives of those who experience them. Maintaining the pregnancy had become a task that demanded constant attention and effort. The wish to hurry the end reflected the emotional toll the experience of the subsequent pregnancy has caused the participants to feel. A subsequent pregnancy required more time than merely forty gestational weeks. Choosing to begin a subsequent pregnancy involved a fair amount of investigation and resolution regarding the cause(s) of the past loss, involving mental and emotional effort. Once the pregnancy was confirmed the larger task of monitoring, maintaining and surviving began. Participants reported feeling obsessed with their pregnancies due to constant worry; anticipating the end of the pregnancy is a means to ending their worry:
Having a subsequent pregnancy means being consumed. It literally took every minute of our lives, my husband and I. Our life was me being pregnant and getting through this pregnancy and having a successful end. It was like a job. I was on a mission to bring the pregnancy to term. And it was a success. Plain and simple. That was my life... and my husband's too. It felt like [our job description] whether you wanted it or not and obviously, I signed on for it because I wanted to be pregnant so bad. There was always that fear of losing another one and you're thinking, "Am I just setting myself up? Am I hurting my babies?" But I just did it.

I was just so obsessed by the pregnancy. At 35 weeks I got to get up [from bed rest]. It was scary, I was starting to get excited but... I was still a little guarded so my fear was still there. Okay, let's get her out of there. We know her heart is beating. She is alive... We may really bring a baby home.

That ninth month was just one month too long. [Had it been an option] I would have delivered him early to avoid that [whole] last month.

Maybe three weeks before he was born [I thought] okay, enough is enough. You can be born now. I am tired of... the constant companion... of worry.

One participant also described her experience of the literally felt need to find things to do that would allow her "to rest her mind" from its constant worry about and preoccupation with the details of her subsequent pregnancy. Another participant expressed her fear of being consumed by worries about the pregnancy. As she recalled her subsequent pregnancy, she indicated she had realized, in retrospect, she had subconsciously created other stressors [in my life] because [having] other projects gave me more of a life than just worrying about the pregnancy. You have to have more to your life than just the pregnancy.

Participants described feeling obsessed and consumed by their subsequent pregnancy and experienced continual worry. They seemed to wish to hurry to the end of their pregnancy as a means of finding relief from the discomfort associated with their constant worry. A few participants intentionally tried to find other things to do or took on additional projects as a means of distracting themselves from the worry.
Delivery Does Not End the Worry or the Grief

Delivering a healthy baby did not create pure joy or peace of mind for once-bereaved parents. The information they had previously acquired for their emotional protection ironically now punctuated their experience with the possibility of new future problems and additional, potential losses. As one participant stated:

Towards the end [of the subsequent pregnancy] I looked at him [my husband] and said, “I just want this baby here.” At the same time, going to the support group, I see that there is no finish line . . . there is no safety zone and I think you have to prepare yourself for that. Your kids can die at 21 and it is [they are] still your baby. You’re still going to feel the same. There is no touch down. You are never going to [be able to] say, “Now I don’t have to worry.”

Caring for a living child also evoked memories of what they might have experienced had the previous child lived, so their grief was revisited. The physical resemblance siblings often have, instead of marking kinship, at times provoked painful memories and discomfort:

It scared me to see her sleeping. She looked just like [our baby who died]. I had to be sure she was breathing. I never did the mirror thing though, [it was hard but I tried to] just trust[ed] [she was still alive].

. . . and we all realized after our [subsequent] children were born how much it took us to a new level of grief . . . after my daughter was born how much I thought, “I miss my son more because I never got to see [him in] this [stage of development].”

Even when I had him [subsequent child] . . . hearing about other people getting pregnant, having babies, for awhile there, it really gets to you even when you’ve got your own [baby]. You are still feeling that pain. It goes to show [you] that [having another child] it did not erase it all.
Participants also described an ongoing aspect to their worry that the delivery did not resolve. Having the baby delivered safely did not imply safety for the future or permanence for the family:

I didn’t think she was permanent until she was a year old. Then I knew just because you have a one-year-old does not mean you will have a five-year-old.

You get into giving birth and being home with the baby. [Then] you start to worry about other things.

Although participants seemed to wish to hurry the end of their subsequent pregnancy to find relief from their worry and to obtain reassurance on the safety of their child, once the delivery occurred participants’ worry did not end and they seemed to develop an increased awareness that there were no permanent guarantees for their child’s safety. Also, the physical resemblance siblings may have was a reminder at times of the child who died and sometimes re-evoked grief for the lost child and increased worry that something else might happen to the new baby.

The researcher came to understand the experiences of subsequent pregnancies were filled with contradictory emotions and paradox. After weighing the risks and making a decision to become pregnant after a late pregnancy loss with the knowledge that tragic outcomes might re-occur, participants experienced contradictory emotions on finding out they were pregnant. Happy they were pregnant yet feeling guarded and apprehensive that they may go now through another traumatic pregnancy, the pregnancy was met with contradictory emotions. Fear was described as a primary feature of the subsequent pregnancy that persisted throughout the subsequent pregnancy and the deep-seated fear was of losing their unborn baby again. Wanting to
attach to the new baby yet fearing attachment was one important contradictory emotional experience the women described. Participants experienced a wide range of emotions that were variable and intense and their expectations and hopes were guarded with a wide range of potential problems and complications constantly anticipated. Participants described having varying experiences of being consumed by or obsessed with their subsequent pregnancy, with continual worry and the wish to hurry to the end of the pregnancy. Some distracted themselves with other concerns such as taking on major outside projects in an effort to create the sense of a more balanced life. Worry was a prominent feature of their experiences during the subsequent pregnancy. While during the pregnancy participants experienced the wish to hurry the end of the pregnancy, after the baby was born they realized that the delivery did not end the worry or their grief for their lost child and there were no guarantees for the safety of their child.

Coping Approaches

The Need for Information

The need for information was expressed by all of the participants. This meant they needed to have as much factual information as possible regarding the cause of their late pregnancy loss and needed information that may be relevant to the possibility of recurrence and the chances of success of their subsequent pregnancy. Knowing the cause of the loss sometimes allowed participants to rule out the strong
probability or likelihood of recurrence of that specific loss, which alleviated some of their emotional vulnerability:

I really wasn't afraid it was going to happen to me. It was a cord accident, it’s not as if she had died of a genetic issue. There was no reason to think I was at any higher risk than I had ever been.

I go back to the time I spent with the background and the statistics. I had already hit the probability.

I am just a real logical person and it really helped me in a lot of ways because I was able to reason out the statistics and know there was no reason to think I was any higher risk than I had ever been.

Understanding the cause of the late pregnancy loss and logical understanding of the statistical risks they faced in the subsequent pregnancy also provided some comfort and hope that the subsequent pregnancy might be successful.

For at least one participant knowing the cause of the loss allowed her to request a potentially life-saving procedure that protected her subsequent pregnancy. This participant had a woman physician who, carefully and proactively, studied the progression of events that led up to her late pregnancy loss. The physician believed the participant had a condition known as an "incompetent cervix." This meant the cervix was unable to support the weight of the growing fetus past a certain gestational age, resulting in preterm labor and fetal demise. The participant learned usual medical practice often allowed women to experience at least two such pregnancy losses before the diagnosis of the condition was made and the preventive surgical procedure, the insertion of a cerclage, was performed. She reported:

I need to know we are doing something different this time. I can’t go into it and just be hopeful when we get to that [gestational week] window again we
are just hopeful we will get through it. That is not enough for me. . . . I was just assertive. I learned to be very direct [and ask for what I needed].

The participant felt she could not take the risk of a subsequent pregnancy without the protective cerclage procedure.

Information was also used in an attempt to control the understandable uncertainty these participants faced. Their past loss had been so shocking and unexpected they were afraid to experience the typical "unknowns" most parents enjoy during pregnancies. They did not want to be surprised about anything, even the gender of the new baby.

And we told everybody that it was a boy. We said, "We do not need any surprises. Having a healthy baby will be surprise enough for us at this point." I am happy for those people who can say, "I want to be surprised, I don't want to know" [the gender]. We named him before he was born . . . and that was our surprise for people.

Sometimes I said knowledge was painful because you could catastrophize more but it really gave me a sense of relief because I was able to rule things out. I wasn't going to be surprised.

Minimizing surprises and keeping well informed seemed to provide some reassurance to participants.

Information allowed participants to be more proactive in dealing with physicians. They became much more informed and asked more questions:

I read everything. I am the person who thinks knowledge is power so if you armor yourself with as much knowledge maybe you can prevent something. You don't want to be blindsided by what can happen.

We wanted to know everything we could. I asked everything I could think of. I asked a lot of questions because [by then I'd experienced so much] I knew what questions to ask. We didn't want any surprises.
My doctor would sit with me for the half hour of questions he knew I had to ask.

All participants agreed it was essential to have as much information as they could glean about the cause of their past loss and the probability of experiencing that particular loss again. Coming to some sense of resolution and closure regarding the cause of the past loss was a necessary step as they prepared themselves for a subsequent pregnancy. Participants were very active in taking steps to obtain the information they felt they needed.

It was an ironic reality for participants to learn that the acquisition of information had its negative side. Participants indicated as they attempted to calm themselves and come to some sense of peace regarding their past loss they realized they had learned, perhaps, too much in the sense they had learned of other things that might go wrong. Reading everything they could increased their experience and awareness of vulnerability, as they now knew "all the ways your baby could die":

You start to learn what else can happen. Too many other ways in which a child could die. You know, you learn of all the awful things and that is why I tried to remind myself, okay, this is an isolated population. I could go into a daycare center and see many alive and well kids so I tried to keep that in perspective.

Too much information could also spoil the experience of fetal movement many women anticipate, enjoy, and perceive as calming confirmation their baby is doing well. For those who had experienced a past cord accident resulting in the death of the child, their perceptions of fetal movement could be tainted with painful memories:

Every sensation I second guessed.
Every movement and nonmovement might have meant something [the beginning of another bad outcome].

I was very aware of how much the baby moved and I was grateful she was a big mover. I would occasionally wake her up to make sure she was moving. If for any reason she did not seem to be moving and it seemed like it had been too long, I would check her out.

The reliance on acquired information may also rob a woman of the awareness of her own experience, or her sense of trust in herself. One participant with an extensive background in obstetrics and gynecology found herself unable to trust her own fund of knowledge during her subsequent pregnancy.

The only thing my body did correctly [through the entire] pregnancy was delivery.

I did a lot of reading on my own to make sure I was feeling or growing or whatever like I should.

The participant who related the above-mentioned quote experienced a diminished sense of trust in herself. She had been employed for years in women’s health clinics and had extensive professional training and work experience in obstetrics and gynecology. Another participant expressed the paradox and loss of trust in oneself produced by too much information as follows:

I thought I was helping myself but in the long run what happened was information overload, but I did not realize that until later. You read so many things that are more contradictory and it just got to be too much. When the baby was finally born and I actually had him . . . I did not trust myself. I finally figured out that I had to let it [information] all go [and] just start going with more of my own instincts . . . wanting the mothering intuition to come out in me.

A single participant, however, described a unique effect from having a great deal of acquired information. A health care practitioner herself, she coped with her
grief by attending 18 births where she assisted other women. The participant indicated her decision to attend and assist so many births in her effort to cope with her grief provided an unanticipated and future benefit. During her subsequent pregnancy she came to realize:

When you are [experiencing your] first [occurrence of] pregnant [pregnancy] everything that happens to you God knows never happened [to you or anyone else before] and you are so reactionary, and I came to understand after going to all [of] these births that my first birth, which [at the time] seemed so hard and long, had really been a normal birth with really no problems. It had just been long . . . so I began to understand how broad the term of normalcy [actually] is in birth and I became...[during the subsequent pregnancy] I was just not reacting to the little nuances in the same [anxious] way.

This participant indicated she had a different experience of the result of "too much acquired information" reported by some of the other participants. The additional experience and information she obtained broadened her understanding of the range of normal events during pregnancies, which, for her, produced reassurance.

All of the participants indicated they needed a great deal of information about the cause of their loss and were active in seeking information prior to and throughout the subsequent pregnancy. Reaching some closure on the cause of their loss was necessary in making the decision to risk another pregnancy. They also needed ongoing information as the subsequent pregnancy was confirmed and progressed because they felt vulnerable and needed reassurance, and they also wished to protect their unborn baby and themselves from any other untoward event from happening. The information they acquired, although necessary for some sense of well-being, could also at times increase their perceived sense of vulnerability as they now knew of many other additional risk they faced by taking on a subsequent pregnancy.
The Need to Differentiate the Pregnancy Experiences

A strong theme shared by many participants was the need to differentiate their pregnancy experiences. This meant the pregnancies needed to be contrasted and separated, and for some it meant the subsequent pregnancy needed to be managed differently. This theme seemed to be related to and emerge from the need for information. As participants sought and obtained information about the cause of their loss, this seemed to lead to seeking information that the subsequent pregnancy was likely to be different. Once participants were pregnant again, the actual differentiation of the subsequent pregnancy from the earlier loss became vital. Actually knowing the subsequent pregnancy was different and doing things differently during the subsequent pregnancy became important. As one participant stated: "I need to know we are doing something different this time." This need prompted her to seek out a specific medical procedure that ultimately allowed the subsequent pregnancy to succeed. She describes these differences:

So we did an antibiotic through the first trimester. We did baby aspirin. What she [the doctor] did, though even though we had not determined there was any infection, she was doing all this preventive intervention, which was reassuring to me.

Another participant educated herself about the statistical odds of cord entanglement, the cause of her baby girl's death. The information she gleaned allowed her to differentiate the pregnancies herself:

I was not afraid it was going to happen to me [again]. I really did not think it was going to.
Her independent learning strengthened the participant so markedly she managed her subsequent pregnancy using a very holistic approach and actively rejected her physician’s recommendations for increased fetal monitoring and “nonstress tests.”

The careful use of medical monitoring was found to be very useful in differentiating the pregnancy experiences. One participant described her physician as providing the necessary contrast using ultrasound:

He was actually doing the ultrasound [himself] and pointing everything out. [He could show me what it looked like and could say], “The placenta [the cause of the past fetal demise] looks good.”

The ability to visually scan the placenta and to see, literally, it was healthy reassured the participant this new pregnancy was different; potentially giving rise to the development of an intermittent sense of hope. Ultrasound was used to help another participant differentiate her pregnancies, but at her own request:

I made them ultrasound the baby’s bladder [site of past fetal demise] and my ovaries [site of past complications and infertility] every time.

Because the participant literally saw no physical evidence of the past complications she was reassured. The participant internalized the differentiation and used it to help herself manage her anxiety when it occurred:

It was a different pregnancy and I was able to separate them and say, we are not seeing any of the difficulties we had with the first two [losses]. I knew a lot of the [panic] reactions were coming from my past experience. There was not anything physical there for me to panic [about], it was all mental [memory].

One participant whose baby had died due to cord entanglement had weekly ultrasounds and nonstress tests from 29 gestational weeks until the delivery of her subsequent pregnancy:
This was the doctor's way of helping me know there was no cord entanglement in this pregnancy. The nonstress tests were the doctor's way of identifying [whether] cord entanglement could happen again. I went every week [for the procedure]. The doctor was vigilant.

Differentiating the pregnancies was important to participants as they actively coped during the subsequent pregnancy.

Some participants who were unable to differentiate their pregnancy experiences, however, faced different challenges during their subsequent pregnancies. Several participants had experienced normal, uneventful pregnancies that ended tragically with a cord entanglement, a compression accident, or a placental abruption.

No physical symptoms present themselves in such situations, they are considered unavoidable occurrences. For these participants the normality and the likeness of the subsequent pregnancies seem to make them far more difficult to endure:

The scariest part of the pregnancy was that it was very normal, very uneventful, everything [test] came back the way it was supposed to so you'd think that was a good thing. But that was the scariest part because it was the exact same way with my daughter who died. The fact that everything is going great and well is not a reassurance.

There was nothing [happening] to make you think anything was going wrong and suddenly, she's gone. They believe the reason she died was a cord entanglement. One of the things I found comforting about that was even if I had been hooked up to a machine 24 hours a day, there is nothing they could have done to save her. Yet, one of the things that is really awful about that is there is really nothing you can do to prevent it.

A participant who had experienced a compression accident during an uneventful, supposedly normally occurring first pregnancy helped herself during the subsequent pregnancy by using visual imagery as a critical period, the anniversary date of her first loss, approached. The participant was aware her anxiety increased during the
subsequent pregnancy as the 31st gestational week approached, the week her baby son had died.

I visualized the baby in utero protected by white, healing light [and] me hugging him. The visualization allowed me to survive the anniversary date of my son’s death at 31 weeks. I knew this baby was protected.

This participant seemed to attempt to differentiate the pregnancies with the use of visual imagery around the time of the anniversary date of her first loss to protect her unborn baby. This differentiation seemed to help her cope and protect her baby.

Understanding Grief, and Random Events

Four of the participants lost their first child. All of them were college educated, successful individuals who had established some marital and financial stability before beginning their families. They imagined their lives following a predictable course according to their plans and their wishes. They had no reason to believe they were not in control of the events of their lives. They had made careful plans and good choices for themselves all along. They had no reason to think their reproductive choices would result in any less success than they were accustomed to experiencing. The sudden, unexpected death of their baby also represented the demise of their illusions of control, and their supposedly reliable abilities to plan and to achieve the outcomes they wanted. They found themselves dislocated from their peers, and they experienced a developmental loss. “We are not in the place where we wished, planned, or imagined we would be at this time in our lives.” The events they experienced had the function of removing them from their known culture of young,
healthy, and successful individuals. They were now the unexpected members of a group with others dependent on doctors and on medicine. This created a painful awareness, as they moved throughout their usual activities, they were different; they had experienced a late pregnancy loss and were unable to achieve the successful pregnancies others appeared to obtain effortlessly and independently.

Two of the participants had a past experience of successfully planning a pregnancy, achieving a healthy delivery and then acquiring a normal baby when they wanted one. When they felt the time and their circumstances were right they planned to add another member to their family. Neither had any past experience of infertility or known medical conditions. Their unexpected pregnancy loss brought with it a new sense of their powerlessness. One participant would face repeated pregnancy losses occurring during differing gestational ages, and would later find no medical explanations for any of them. This would come to mean she was unable to protect herself physically or emotionally from another tragedy. Two participants’ babies died as a result of umbilical cord accidents; there is no medical procedure that will prevent this occurrence. Therefore, these participants experienced an ongoing sense of vulnerability in the context of knowing medical science could neither shield them from loss nor protect or ensure any baby’s viability. Two participants’ babies died following preterm labor, two died of genetic anomalies, one as a result of placenta previa. For all of the participants, the pregnancy loss meant a reduction in their sense of control and the beginning of a different life experience.
All of the participants had the experience of being an unsuspecting victim of an apparently random, unpreventable and tragic loss. For most it was their first experience grief, grieving the loss of a loved one, and the loss of a child. The grief literature is consistent in its agreement the loss of one's child is the most painful and difficult loss an adult will ever endure (Gilbert, 1989). The variable, shifting, and intense emotional experience of the expression of grief is known to cause those in its midst to, at times, question their emotional stability or their sanity. The participants typically had little prior knowledge or personal experience with grief. When they did acquire information regarding the process of grief and the reality of the occurrence of random events, the participants reported it was helpful to them. They said:

These things just do happen and I didn't cause it, I did nothing to harm my pregnancy.

These are events that sometimes occur in nature without explanation.

[Women who have had this experience] just need to keep going over and over and reassuring them[elves] . . . it was not their fault . . . it is not anything they should be feeling guilty about.

Participants indicated they needed to have the reality of random occurrences acknowledged and needed support in understanding that they did not cause their earlier pregnancy loss. Most people's experience, including their own, had taught them caution, planning and attention to detail could actually protect them; they were not aware of the reality of their constant vulnerability. It was difficult for many to accept there can be devastating effects without known, preventable causes.
The Decision Toward Conscious Presence and Active Parenting

While still fearful and vulnerable about attaching to and then possibly losing the baby, several participants made a conscious, active effort to engage in parenting. This choice meant they maintained their conscious awareness of the pregnancy, they chose to be present to it, and they did not distract themselves with other tasks. They focused their attention on the baby. These parents had experienced the loss of their baby before, so they knew the pain they would experience if another loss occurred. However, they decided to actively parent the baby and make parenting decisions during the pregnancy. Instead of avoiding attaching behaviors for their own emotional protection, they actively facilitated and developed the mother–child dyad. They created a place for the child in their emotional and cognitive experiences as well as a physical space for the child at home. They developed an emotional relationship with the baby:

There is not a safety net at any point in time so instead of focusing on that and letting fear dictate how you are going to try protecting yourself or minimize your loss, just go the opposite and dive into it and savor it for what it is now . . . so you really do have . . . a sense of being cheated a little bit less because at least you know you had that, at that moment [you had] that baby during the pregnancy. I had a lot of feelings to just really live in the present and that is why there was this real strong sense of making sure I was her Mom . . . a strong feeling of being her Mom right then.

This participant described not letting the fear interfere with her pregnancy, choosing to live in the present and actively making a choice to be her daughter’s mother during the pregnancy. She went on to describe:

You look at your typical woman who goes through her first pregnancy and doesn’t have a clue a miscarriage could ever happen. [She] is thinking of the
pregnancy as a journey [to] get from here to [a] destination, which is motherhood. When you are not sure that is going to happen, for me anyway, I just focused on, if I am her Mom right now, and if I buy her outfits right now, and if I paint her bedroom right now, and if I talk to her right now, and if I rock her right now then if this is all that I have I have still gained. I have still been her Mom. Even if she never stays in this bedroom it is her bedroom now. If she never gets to see it, well, I still did it for her. I have a daughter now. It kind of made the fear more controllable by saying; I am her Mom right now. If she is not born and I don’t have her then, then all of this time that I had her [I would have given up]. So right now was when I could enjoy every minute of it and not focus on the fear part. You [can choose] to be the baby’s parent right this minute because this minute may be the only chance you have to parent the baby . . . so do it!

She realized there were no guarantees concerning what would happen in the future and she made a conscious choice to be her daughter’s mother in the present moment.

This choice and decision seemed to reduce the fear and provide comfort in the knowledge that she was acting on and was enjoying motherhood in the present.

Another participant echoed the importance of choosing to maintain a conscious focus on the subsequent pregnancy, and suggested she learned this value as a result of her previous loss:

I was determined to embrace it and really enjoy it and one of the things I had taken away from my daughter’s [pregnancy] is I did not regret the times I had been present to being pregnant. Those are the times that I had with her and so I wanted even more time like that with the new baby. I would be damned if I was going to go through it and feel like I was not present every second of it!

Another participant described using yoga and meditation as tools to help her maintain her conscious presence during her subsequent pregnancy.

Yoga is the thing that helps you center and helps keep you in the now with this baby. It is the only thing I have ever found that helps physically, emotionally, and spiritually.
The participants that indicated they made the active decision to maintain a conscious presence to their subsequent pregnancy viewed the choice as a positive coping mechanism. Realizing they were mothers in the day-to-day moments during their pregnancies supported their sense of maternal competence, and seemed to be helpful. The understanding that while there were no guarantees of a successful delivery in the future, they were a mother in the present, and the awareness seemed to help. Some participants appeared to realize that the lack of guarantees about the safety of their unborn children are no different than the lack of safety and health of any children at any other point in life. This is evidence of the changed life perspective the awareness of the presence of death can provide.

Several participants described their awareness of the presence of the expected baby helped them cope with the subsequent pregnancy. One of the participants was confined to bedrest for more than 3 months during her subsequent pregnancy. Usually very active and employed full time, she found the inactivity very challenging to maintain:

You feel this baby growing inside of you so that is the part that is so motivating. It helped me maintain my discipline.

A participant who had experienced a stillbirth alluded to a sense of partnership with the baby during the subsequent pregnancy where she felt the baby helped her during times she worried:

The baby knew when I needed him to kick, we seemed to have this bond, he never let me worry.
Two participants described experiences when their own unconscious process helped them. One participant had a very strong sense the babies she had lost were around her. During her meditation, she described:

... seeing an angel coming into the room holding a baby. She [the angel] had the essence of communicating, “Don’t [you] worry, I’m just taking care of her. She will be here.”

The participant understood this meant her child was being well cared for and was waiting for her. The participant continued:

... it felt like someone was babysitting your kid and you would be able to pick her up later. [Then] I was confident I would have the baby because [I felt, all right] okay, as long as I know I can have her back I guess I don’t have to feel that [devastation]. For me the worst thing was the knowledge I may never get the baby back [but] I knew she was okay. I could [tell myself], “she’s okay, she’s being taken care of and you are still a Mom.”

The participant quoted above indicated she could still preserve and maintain her maternal identity as she waited for the physical presence of her [successfully delivered] child. During a subsequent pregnancy another participant described a dream where her unborn child understood, assisted and supported her in her reluctance to attach to the pregnancy. She stated:

I had some profound dreams... at one point in my dream I was so hesitant to attach to her and in my dream she is this infant [who] can talk and communicate and [she] gave me permission to be guarded. It was so powerful and she finally said, “but now I need you.” I wasn’t wanting to attach at a deeper level... but this dream was the turning point. I said, “I just need to do this and it went fine but I was so afraid.”

The participant quoted above indicated her awareness of the supportive sense of partnership provided by the child helped her contend with her fear. The participants who maintained a conscious presence during the subsequent pregnancy that was
inclusive of the baby despite their understandable fear viewed this as a positive coping mechanism that became a source of strength.

**Provision for the Lost Child**

Several participants described the need to make provisions for the deceased child during and after the subsequent pregnancy. This need seemed to relate to maintaining and preserving the place of the lost child while the family was in the process of adding another member. The need also appeared to include preserving the mother’s maternal role to the lost child. The participants who described this need appeared to meet it in differing ways. The next participant’s description of her efforts to provide the place for her lost child appears to be similar to comments mothers of a living child might make as they anticipate the birth of their second baby. They are aware of the depth of love they feel for the first child, and question their capacity to attach to and to love another child as deeply:

You’re afraid going on with another child is disloyal to the baby you lost. How can I be a good mother to my son [who died]? Being a good mother to him is accomplished by being a good mother to the new baby. I did everything I could for my first child up to the point of losing him. I did everything I could [to nurture him]. It was not my fault that he died and I know that. So I did everything that was required of me up to that point of being a mother, nurturing him and now, in his memory, or what we would have had with him, I am having with [my second son so there is consistency in me there]. I am loyal to my son [who died] by being a good mother to my son [who lives].

Anticipating the imminent delivery of her subsequent pregnancy, one participant needed to make provisions for her son, her baby who died. Before going to the hospital she attended mass, went to the cemetery, and made a trip into town to
ensure his memorial information would be included in her support group newsletter by the date of his first birthday (had he lived) and before his sister was born:

I wanted him to know we were thinking of him. I did not want to become so distracted and busy with the new baby I would not include him.

One participant who stated, “You parent the lost child too,” described including the lost child into her awareness on a daily basis:

I’ve still got that concrete statue and I look at it every day . . . the statue in my yard of my little girl. I would talk to her, it was kind of a way of feeling she was here. You need to have the reality you were that baby’s Mom even after it’s over. It’s really important.

Another participant expressed her need to preserve the place of the child she lost and make him real to his brother. She said:

I want to make sure he knows about his brother, I want to make sure of all of that. It is not going to be like it never happened . . . I have my keepsakes for him but they are just not out [in the house]. I keep them in a box where they are always near me . . .

Another participant felt the need to remain the parent to her daughter who died before beginning a subsequent pregnancy. She said:

I really really do not want to get pregnant for the first two years [after my daughter died]. And part of it was to give her her time. I needed to grieve her and I felt like I needed to get to know her and a lot of what I did during that time [were] things I felt on some level were allowing me to get to know her and I just felt like if I had another baby too soon, I just wouldn’t ever get to know her [in] the same way. There was some awareness that I was still her mother and that there was still [remained] some level of [my maternal] responsibility.

Two of the participants each had one child at home during their loss(es). Both children were older, elementary school aged children. These children, obviously, were both aware of and affected by both the loss(es) and the subsequent pregnancy(ies).
Their mothers then had to contend with the issue of the alterations in their family composition to allow the preservation of the place of the lost child. Since these participants wished to preserve the memory of the lost child, they had to make decisions regarding how and what to share with the children they had. All participants would ultimately face the dilemma of what they would say and when they would tell subsequent children about their deceased sibling(s). One participant described how she addressed both issues.

I had to make the children [I lost] real to my son [first child], and to my daughter [fourth child] too. The babies are real and we will all grieve them. Of course I told my son I was pregnant! What if something happened [to threaten the pregnancy] and he saw me crying? He had to know the baby was real and was worth grieving about. My son knows he was never the only child. He knows what the statue and the garden are for. He helped me paint the walls [in her room] before my daughter was born. He is their brother... The new child is a mirror, not a replacement.

The provision for the lost child included maintaining the place of that child in the family constellation, maintaining the original order of siblings, and protecting and conveying the reality of the child’s existence to the future family members.

Acceptance of Caring for Oneself

Participants recognized that it was acceptable, advisable and necessary for women during subsequent pregnancies to put their physical and mental health first. For many participants this was the first time in their lives they felt it was appropriate to prioritize themselves and their needs, to say “no” to requests or to assert themselves instead of taking care of others. The participants’ awareness of their ongoing grief for the lost child and the emotional demands the subsequent pregnancy
required of them assisted them in accepting the need to protect and to care for themselves. The lack of understanding they reportedly received from most others seemed to accentuate their awareness of the necessity for self-care. This appeared to give rise to the formation of stronger self-other boundaries, and seemed to serve as a foundation for the substantive alterations in the self that will be discussed later.

Participants who had typically been self-sacrificing mentioned a new method of self-protection as a feature of their subsequent pregnancy:

[You can decide it is acceptable to protect yourself emotionally and] you might not want to put yourself through that [baby shower].

I need to do what is best for my unborn baby. My unborn baby is to [receive] the best [medical care] so I achieved that and sought it out.

[Self-care] it is like you are re-prioritizing and you are giving yourself, maybe for some women the first time in their life[lives] permission to say, “I have something going on that is more important.”

When you can’t do it [decide to take care of yourself] for yourself you can do it [decide to take care of yourself] for the baby. If you can’t do something for yourself you can do it for your kids.

The researcher observed some participants appeared to become more self-honoring:

It is okay to say, “No, I am not going to the baby shower, no, I am not going to hold that baby.” For me it was very important that I try to allow myself to listen [to myself] and not feel like I had to do the right thing or the nice thing [in the opinion of other people]. But this [meeting my own needs] was the right thing and the nice thing for myself. It was for my [unborn] daughter too at that point. I was not going to do the right thing for the other people. I kept thinking, I’ve got to stay calm. I’ve got to stay as calm as I can during this pregnancy because I owe that to myself and to her.

Now that you mention it, I think I am even more so in terms of getting what [I] you want and not burying feelings, not in a horribly bitchy way or anything. I am not destructively mean now or anything, but definitely, I have no fear of saying to a doctor or somebody, “Hey, no.” I have definitely learned that through this whole experience. No more would I go in and say, “Well, I don’t
feel like the baby is kicking,” and they [would say] said, “It is just in your mind.” [Now] I would be like, “Let’s do a stress test.”

One participant described experiencing an identity-altering impact by accepting, learning and practicing caring for herself:

I set a lot of boundaries that I had never set before. Before I had my daughter who died, I was a pleaser always. I would please even when it was not good for me. Well, I just was not willing to do that especially during the pregnancy. I decided that this over-giving, always doing so much for everybody else was not really working for me. So, being more receiving, more receptive... not being so focused on being a doer was a big task for me. I really had to learn [another way] to be in the world. I really focused on this baby and I told myself not only could I receive but I should receive. Anybody or anything that was stressful or unhealthy I just removed myself from it and did it without a second of guilt which was very different behavior for me. What was important was that I have a good pregnancy. That was very utmost.

This appropriate form of self-protection often challenged a participant’s internalized socialization. Many women are socialized to protect their relationships and other’s feelings often at their own expense. Many women feel they are expected to practice self-sacrifice and fear being perceived as selfish. Several women after their loss became more aware of the need to care for themselves. The role of mother itself implies one who is very giving and caring for others, caring for oneself goes contrary to those traditions. In coping with the subsequent pregnancy after the loss, some participants acknowledged the importance of the necessary distinction between self-care and selfishness.

I really just did not care what other people thought. I was going to do what was right for me so it was really empowering to set boundaries like that. I can take care of myself and not be selfish because I am just taking care of my baby. It felt even more important to me having gone through a lot, but I really put myself and my own health and what was good for me first and avoided situations or circumstances that were not supportive.
I did not have to justify myself, explain myself, or explain what I had been through time after time [to every nurse who worked me up during every appointment before I saw the doctor] because emotionally, that was more than I was willing to do . . . I did not feel the need or desire to explain myself more than I had to.

When women experience a pregnancy loss they learn they must take care of themselves; to take care of their unborn baby also means taking care of themselves.

**Embrace the Experience, the Healing Aspects of Pain**

Two participants in this study described very unique ways in which they approached handling the grief of their lost child. These participants described making a conscious decision to face and to experience all aspects of their grief. They believed facing, even embracing their emotional pain could assist them in developing the ability to maintain a conscious presence to the subsequent pregnancy, to focus their attention on the expected baby, to actively parent their unborn, and further, to experience moments of true happiness, even joy, in the midst of the conflicted emotions all participants reported feeling, during the subsequent pregnancy. One participant described her subsequent pregnancy as, “the best time of my life.”

It was really good. I was really happy, I felt beautiful, I felt strong. It was a very different choice oriented experience and as a result I think I felt really good. I was not afraid it was going to happen to me [again]. I just knew I was going to be fine. . . . During the other pregnancy I had worked in a smoky bar, so I avoided [being in smoke filled environments during the subsequent pregnancy] I was cautious, but not obsessively so.

She attributed the actual joy of her experience to her willingness to embrace the pain of her loss and to allow the pain to change her. The participant described in great
detail the ways in which she embraced her grief. Portions of the journal entries she wrote to her daughter are poignant and compelling, and are noted here:

I miss you and will always miss you. I wanted to share my life with you, to love with you, grow with you, challenge you and be challenged by you. Somehow we can still do this, my daughter. I believe our love is stronger than death, so feel me loving you and help me to feel you. Help me open up even more so our connection won't be lost. Help me to remember the time we had together and help me to know you. I cannot accept that your dying was good but now that you have died I will try to make something good come of it. So help me through your death to give birth to myself and let this pain be my teacher and my baby transformed.

The participant related she began to live her life differently following her daughter's death:

And then I began to make choices in my life... I decided I wanted to go to some births. What was happening was whenever I would see pregnant women with babies it really hurt. It was like salt in the wound. I hated that. I had always loved pregnant women and babies and I did not want to feel like that. I had so much love stored up for a little baby and she was not there for me to give it to her, and of course I was trying to give it to my husband and my son but there was some need to do something with it. And it felt like giving it to women who were having babies was a great thing to do, plus it really helped because I would never have gone to those births if she had lived. Every birth I went to and every person I met and every experience [I had] became something that was coming to me only out of grace. I began to call these things that would happen in my life “my daughter’s grace.” I really felt like a way I got to know her was [through] what came to me through [my choice to honor] her. I was really incredibly sad but just working early on in coming to a peace and getting myself into a space where I felt very peaceful and integrated... I just needed to get over it and live my life with the kind of grace she had shown me... I was the only one who really knew her... and [I felt] that basically her impact on the world would be how I responded [to my loss of her]. The more I could honor her by doing positive works through that energy and by living my own life with grace and dignity that that would be honoring. At the same time I have never wanted to deny my grief, my sadness, or to think it was okay that this happened or that I would choose... I will never say any of that and I still think that she could have lived and we would have just had a great life that way.

The participant did not become pregnant again until:
...we felt really clear that, no, we would never be over it [the grief], we will never be over it. We still grieve her and think about her but we had celebrated four years [after our loss]. We were feeling fairly peaceful, fairly calm, like she was part of our lives and I know she is.

She added:

...if you get pregnant before you heal, or at least come to some sense of peace with what happened, not only do you not get to enjoy the subsequent pregnancy and maybe not be as present to that baby because you are still in grief, but you also miss out on the subtle opportunities to get to know the child you lost.

The participant maintained her attachment and facilitated the relationship with her lost child and did not deny any aspect of her loss. She indicated she had learned doing anything less would have caused her to incur additional losses; the loss of presence to the next child and the loss of possible relationship to the child who died. She believed her willingness to integrate her pain healed her. She clearly experienced that the work of grief is never completely done; it had to become integrated into her life and re-experienced at different life stages. She stated:

The reason the subsequent pregnancy was pleasant, fulfilling and healing was because I did the grief work for my daughter and that work is never done. It was important to fully experience and fully honor her and find ways to turn and twist the experience so that it was an experience I could live with. By fully integrating her into my life I could go on.

This participant stated she was aware that doing the conscious work of grief was a necessity. She had observed others dealing with their losses in less conscious ways and it worried her. She related:

Maybe I am wrong but when I talk to other people my sense is that I do not come across people that are very healed from their loss. What I see and what I noticed was people either acted like it did not happen and they do a lot of pushing it under the rug, denying its existence or denying its impact... or they were so devastated that they pretty much lost a few years of their mind...
or went crazy in some way or had their marriage fall apart or whatever it was they did to cope. I am not going to act like this isn’t huge, unbelievable, more than anyone should bear . . .

The participant described her gradual awareness that the more she actively embraced her grief, instead of it weakening or separating her from herself and others, it increased her capacity to experience presence and relationship:

I began to recognize this awareness that when I denied her death and kind of tried not to feel that I cut off the lows but I cut the highs off and I became to feel like I was sort of the living dead where we were sort of half alive but that . . . when I was really facing and accepting and looking at her death, which in so many ways was so close to my own death because she was inside me when she died, that I became more aware of how much more alive, how much more joy I got out of things and how much I laughed more. So I became [began] to see that really [by feeling my pain] I could be more present. I could be a better mother to my son.

Another participant described the difficulty she experienced while she tried to be emotionally present to the experience of her emotional pain and her grief. She said:

And being present is one of the hardest things in getting through . . . the grief, because we are so taught in this society to run from it, to take drugs, take mood altering substances, whatever, rather than feel the pain . . . don’t get me wrong, [I don’t want to hurt and] I am all for epidurals. I am talking emotional [pain] not physical, because there are some things I think [we must feel]. I do think there is pain . . . you need to feel . . . [to be] human for [your own] growth. You can learn from it, and I certainly let myself feel it. It is hard being present. That pain is hard for . . . other people to share, but then, [those people] . . . are really not your friend[s] . . . if they can’t [share your pain].

She further described her experience of the integration of her emotional pain into the larger, evolving context of her life, and how the integration continued to occur after the birth of her subsequent child. She said:

I think that letting your soul feel your emotions [and] working through them, not blocking them [helps]. I do think that is important because I do think it gives you a healing. It gives you a healing from your past pregnancy, which helps you with this [subsequent] one. Do you know what I mean? This is the
whole important thing depending on how fast you get pregnant again. You are still hurting from the lost pregnancy while trying to cope with another pregnancy which is so difficult. There is just no time limit on healing . . . you will always feel that pain. That pain never goes away. It doesn’t lessen. It doesn’t, but what happens, I feel, is that you become familiar with it. It becomes a part of you. Yes, that pain is familiar. So, it doesn’t feel quite as sharp as it did when we first lost [my first son], but it has in no way diminished. It . . . has just . . . become a part of me and it is familiar.

The participant described the process of embracing her pain and not fighting against emotionally experiencing it. She said:

The faster you can do that, the faster you can recognize it, face the pain, feel the pain, let it become part of you, the easier . . . it is going to be for you. When you try to fight the pain, try to fight the whole experience . . . it is not helpful.

The participant also alluded to a belief that suggested one’s denial of pain might be a form of attempting to deny the reality or the impact of the significance of death. She concurred with the belief that by fully experiencing the range of all painful emotions, one could achieve healing. She described:

You will get a healing from the past pregnancy by feeling your emotions so don’t block them. You will always feel the pain; it doesn’t lessen, you become familiar with it as it becomes a part of you. The faster you can face your pain, feel it and let it become a part of you the easier it will be. [I] let him [my lost child] have his place in my heart . . . [I] integrate[d] it and the pain . . . then there is [was] room for the new baby [my subsequent child]. Pain becomes a part of you just like breathing. My first son [who died] is there [in my heart] and his influence is there . . . always there but you don’t have to think about it all the time like you don’t think about [your] breathing all the time.

This participant indicated dealing with her pain in a direct way also prepared her to live the rest of her life differently and from a more centered position. She stated:

I will never be afraid again. I was in a place where I felt insanity, where I felt the depths of despair and this horridness and everything evil and yucky grabbing at my ankles. I was there and I was at its brink. And then, on my own . . . and not without the help of others . . . I came through it and [now] I
see the beauty and I survived it all! It is so freeing and now I feel like I could fly... there is something about it... because any sort of earth shattering experience is so freeing... my whole perspective has changed. I know my place in the universe and it makes sense.

Both participants demonstrated their belief that grief needs to be integrated; it will never be erased. The reality of the lost child can also be integrated; creating increased capacity for the loving acceptance of one’s self and others. Their coping approaches suggested embracing one’s pain and choosing to feel the full emotional impact of one’s losses can create health and strength, not destruction and a painful, ongoing sense of emptiness.

Approaches Which Created Stress

In telling their stories, the participants primarily focused on the coping approaches that they experienced as helping them. However, a few described coping approaches that were experienced as not helpful. These participants appeared to have experienced some intrapersonal conflicts in their attempts to manage the stress of the subsequent pregnancy. Being on a fetal monitor on a daily basis offered some comfort that their baby was alive and well. Removing the monitor, even when the doctor recommended it, was frightening. The participants experienced fear for the baby when they were away from the monitor. Their anticipated emotional support was conflicted; following a trusted doctor’s recommendations should be anxiety-relieving, not anxiety-producing. The desire and the attempt of a person of faith to relinquish the child of the subsequent pregnancy to God’s care could be experienced as stress-inducing. Some participants commented they felt conflicted because their faith was
important to them and provided them strength and hope. The conflict was experienced when they simultaneously thought about their faith in the context of their loss experience and their grief. The struggle, to integrate their experience of pain and tragedy, and to connect it to the concept of a loving God who had their best interest at heart and would, indeed, preserve and protect their unborn, was difficult. One participant expressed experiencing the conflict in this way:

The need to surrender the child to the will of God made me feel powerless. How could I be sure God’s will was for the baby to live? How could I know it wouldn’t happen again if it was allowed to happen once?

The researcher understood these intrapersonal conflicts to indicate the participants’ uncomfortable awareness the moments of lack of faith or trust caused them to feel. It was personally uncomfortable, if one viewed herself as a person of faith or a patient who trusted her doctor, to have even a momentary lapse of faith or trust. The understandable conflicted and contradictory emotions of subsequent pregnancy, in these moments of experience, appeared to produce a loss in the perceived sense of the mother’s view of herself as a person of faith.

Several participants indicated the search for information regarding the cause of their pregnancy losses could result in producing greater stress and anxiety. This occurred when the individual research a participant made would end with the discovery that no medical reason was known and no medical explanation was available to explain the cause for the pregnancy loss. This meant no reassurance would be available either; a similar loss could occur again without any mechanism to
identify it or to prevent it. This also challenged the participant’s ability to have confidence in the medical profession’s capacity to protect her or her pregnancy.

A few participants were under the care of more than one physician during their pregnancies. When multiple physicians offered them several and differing treatment options additional stress for the mothers was produced. Issues of which physician to trust, which information would be more reliable and which treatment option would best protect the pregnancy raised anxiety. Participants responded to this circumstance by increased, independent searches for additional information. The researcher had the impression their need for more, independently gleaned information at times may have harmed the partnership the mother needed with her physician.

Altered Self and Worldview

The researcher understood some participants to describe substantive changes in their sense of self and their worldview as a result of their loss and subsequent pregnancy. Several participants described significant changes in their sense of themselves as a result of their loss and subsequent pregnancy and in their outlook. These changes in self varied among participants but included changes in their sense of personal control over life events, changes in their sense of control over their body and physical functioning, changes in their sense of the certainty and continuity of life, a stronger sense of self, a greater sense of inner strength, the experience of integrating the loss as a part of who they were and their new sense of self. Several participants described themselves, prior to their pregnancy loss, as assertive, take charge
individuals who were successful in their lives. They were accustomed to making plans and carrying them out. Feeling secure in their lives, they had no real knowledge of the presence of random events or their impact. The fact of their own vulnerability and the vulnerability of all they loved to the experience of physical danger was not yet a part of their reality. They had a sense they maintained control over the events in their lives, and had not encountered situations or circumstances their efforts could not remedy. The experience of their child dying directly attacked their perception of being in control. As they reflected upon the ways in which their loss experience changed them, many participants acknowledged a shift in their worldview and in their perception regarding the role of control in their lives. Their previously held beliefs in their ability to control events or their physical functions were examined and re-worked.

One participant described a changed perspective on the role of control in her life. Her descriptions of herself before her daughter's death suggested a person who coped by exerting control on herself and on her circumstances. Her experience of her daughter's death taught her that despite her best efforts, "there is no guarantee." She described this . . . as a life changing realization with regard to all attachments. You must appreciate what you have everyday you have it because you cannot appreciate [today] what you had yesterday. Just because you have a one year old does not mean you will have a ten year old.

This seemed to indicate the participant had integrated a changed perspective on control and certainty into her reality. Another participant described substantial alterations in her perspective of reality and of her own vulnerability as a result of her pregnancy losses:
People assumed I was more injured by the final [late pregnancy] loss, when in reality the first one that was only six weeks was much more traumatic to me and much more painful. I had no context to put it in, I had no possible [perspective of] reality that a [pregnancy loss] would be anything I would [ever] experience. I was healthy.

This participant alluded to a previously held belief she could control her physical body and its functions:

You are led to believe you [actually] have this control. If you eat too much you gain weight, if you starve yourself you’ll lose weight, if you exercise and are disciplined you’ll be the size you want. I used to feel [that] maybe if I wasn’t so punishing in my head to my own body, that maybe I wouldn’t have had to go through so many of them [losses] . . . I had to learn not [to punish and blame myself for a failed effort of control because] to say it had anything to do with my body betraying me, because it [my body] didn’t [and my body was never subject to my control anyway].

The researcher understood this participant to mean she had punished [blamed] her body for its betrayal of her [for not supporting her pregnancies] until she learned and fully understood her perceived sense of control had always, and only, been an illusion.

Several participants described a stronger sense of self as a result of their pregnancy losses. They appeared to describe intrapersonal alterations in their internal wisdom and perceptions regarding the reliability of their own strength:

I felt like I had been through the fire with my daughter’s death . . . it had just changed me to where I could accept things because I had accepted that loss and had gotten through it and so God knew that I could accept something else. I think I was able to be more in that surrender space pregnancy requires of you [because of that acceptance].

Another participant reported:

. . . my whole experience made me who I am. I have become a strong person, a spiritual person.

Another participant described multiple self-changes as a result of her multiple losses:
Any loss of this type is a life-changing event, it is not something you get through and [just] go on. It changes a lot of aspects of your life and it changes how you function. It changes how you perceive things and how you cope.

Another participant described changing her views on relationships as a result of her pregnancy loss and subsequent pregnancy. She initially described herself as a logical, rational person focused on achieving outcomes. She busied herself with tasks and took on major outside projects during the subsequent pregnancy, as so not to be distracted by emotions she feared would interfere with her planned outcome [the healthy delivery of her child]. She related she subconsciously created other areas of focus so her life would not be consumed with preoccupations about her subsequent pregnancy. She initially believed that the presence of children, “would be an adjunct to my life, I would strive to keep them from interfering with my own plans.” She stated:

losing my daughter taught me you have a baby because you want to share [your] life, to be with that child. Now I know I need to be emotionally attached [in all of my relationships].

This suggested the participant had achieved a new value for presence versus activity/accomplishments; alluding to an altered sense of self. Now the participant valued a relationship characterized by mutuality and reciprocity, where she shared herself, instead of relationships where others were expected to join her.

One participant’s medically unexplained; multiple losses caused her to lose faith in the medical profession’s ability to protect her. Initially she felt alienated and isolated; later she described becoming increasingly relational and felt part of a larger sisterhood:
You go to where the literature is and where the women who have gone through it and written about it and are talking about it and that is the only place left to go because you cannot turn to the people who are supposed to have the answers because they don't know about why [the losses] happened or anything. I know I am a part of [a larger] sisterhood. I feel a real strong sisterhood to all the women . . . even those I will never meet who have been silent and have suffered and who have felt shame because they have not spoken up when someone said something so stupid to them about “Oh, you can have more babies” because they don’t understand, because no one is talking about it. I am a part of this and to me it is like a badge of honor. [It is] something that is female that has been silent. I am not silent. I have a big mouth and [now] no fear. [If it ever comes up] I mean, if someone says [anything about pregnancy loss], “Have you lost a baby?” I will talk to you about it because it is part of who I am. I don’t care if I have known you for five minutes I will tell you because it is part of who I am and it is an out loud thing, damn it!

The experience of having one’s child die is shattering and disrupting to one’s perception of the natural order of the chronology of life. This traumatic experience may conflict, challenge and threaten existing worldviews. Participants became very aware that they did not have the personal control over life events they once believed they had. With this realization participants seemed to experience an altered sense of self and worldview as they attempted to cope as best as they could. While they realized they did not have the control and certainty in life they once experienced they made every effort to understand and to take responsibility whenever they could when it came to the subsequent pregnancy. They became active in seeking out all information relevant to their pregnancy loss and the status and progress of their subsequent pregnancy to understand and to exert as much control as they could over their own and their child’s destiny. They recognized that it was important that they accept taking care of themselves during the subsequent pregnancy and not be as concerned about pleasing other people. For some this seemed to be a change in the
traditional cultural role often ascribed to women as protecting relationships and others feelings at their own expense. They became active and assertive in relating to health care professionals in asking for information and in requesting specific medical tests and procedure. Several participants reported experiencing a strengthening of themselves as a result of the experience they had been through and described the loss of their child in the earlier pregnancy as a life-changing event.

Experiences With Friends, Family and Health Care Professionals

Approaches From Friends and Family Experienced as Helpful

Listen Without Judgment or Offering Explanations

All participants agreed that the willingness of friends and family to listen without judgment or offering explanations for their loss gave them comfort. They agreed this was unfortunately a rare experience because their sudden, tragic losses caused others to feel uncomfortable, vulnerable and inadequate. The participants would inevitably feel a wide range of strong and painful affect and those willing to listen and to stay present would be difficult to find. One participant reported:

You find your [real] friends fast after you lose a child. People don’t want to see or know your reality. It is hard enough for me to feel the pain I’m in . . . we’re taught to run from grief . . . It’s hard enough for me to stay present in my pain. Can you [or anyone] sit with pain, mine or your own, and not run away?

[Your friends are the ones who] actually truly listen to you when they ask how you are doing and you say, “I am having a bad time, I am thinking about . . .” [my lost baby and my grief]. They would actually listen to the story rather than [you overhearing them] typing in the background on their computer . . .

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The participants reported their supportive friends and family were those “who listened without offering explanations for events they hadn’t experienced themselves anyway.” One participant mentioned the chaplain who sat with her at home and said:

I have no answers for you. [When I get to heaven] the first thing I’m going to ask God is why this happened to you twice.

The Shared Journey

The participants mentioned friends and family helped them by sharing the journey of the subsequent pregnancy. Sharing the journey implied the willingness on the part of others to demonstrate they were emotionally available to listening to and accepting the range of affect the participants would experience and need to discuss during the subsequent pregnancy. The participant would need to remember and would inevitably mention the baby she lost and the grief she continued to feel in the context of her tentative future hopes. These conflicted feelings and the pain of ongoing grief would be difficult for others to hear about, but only those who could hear and respond appropriately could actually share her journey and decrease the mother’s moments of sadness and isolation.

People were thrilled that I was pregnant again. I had been so upfront about my grief. It was so present that people knew. People knew I lost a baby. People knew that it had hurt and they were so excited for me and it was really clear that the community was thrilled that I was pregnant and I felt that from family. I felt that from friends. I felt that from acquaintances . . .

The girlfriends who took me out to breakfast, [who were so excited for and supportive to me] who made the pregnancy really special by sharing it with me.
[I had] having a lot of people I could call on [when I needed to talk] helped, knowing I wouldn't burden one or two with the same story.

A participant who felt she had been positively supported by attending a support group described feeling her struggle and her journey was shared. She said;

... because in a support group you usually have varying stages of people that have had their subsequent pregnancies and come through [them] it, and women who are [currently] going through them. It is very helpful, I think ... just knowing you are not alone is a big thing because I think we as humans, especially, tend to feel very isolated in our pain ... [and that] is ridiculous because there are so many of us [who contend with subsequent pregnancies] ... [in a support group] you have the mutual commiseration with the women going through it with you and then [you are] ... able to see people who have come through it [there is someone in the present that is going through it with you that can share the journey and you can actually see a future].

Another participant described her fond recollections of how her friends protected her emotionally during her subsequent pregnancy. She described it thus:

My friends were just supportive yet they didn’t patronize you, as far as that is concerned. [They didn’t make statements like] “Oh, you must be so worried. You must be so” ... they were very good about just being very supportive of [the] pregnancy and not like, “are you crazy? How could you” [do this again] ... there was no coddling or ...”everything is going to be fine,” things like that ... they did not create unnecessary worry. You know how people can do?

Her friends did not patronize her, did not give false reassurance, did not create unnecessary worry, and were simply experienced as present and available to her in a supportive manner.

Medical professionals could also share the journey of the subsequent pregnancy. When their actions allowed the participant to maintain herself within the context of whatever coping approach or method she needed to withstand the pressures she faced; the journey was shared. One of the participants had experienced
several pregnancy losses at different gestational ages; no medical reason for any of her losses had been provided. Her experience had taught her there was never a “safe” time to emotionally attach to a baby during any pregnancy because medically it was impossible to guarantee the baby’s safety or viability. The participant approached her fourth, subsequent pregnancy with a coping approach described by the choice to actively parent her unborn. This meant, despite her emotional vulnerability and fear of yet another loss, she coped by maintaining a mindset in which she chose to “be a mother” to her baby every opportunity she had. The participant actively parented, nurtured, planned for, and made a physical place for her unborn during the pregnancy. She described her most difficult and fear filled moments occurring when there were medical issues to confront, such as appointments or procedures. During an appointment the baby’s heartbeat was not readily detected, and, of course, she was afraid. Her understandable fear in those moments challenged her established coping approach. She described how she managed herself emotionally as medical staff searched for evidence of her baby’s heartbeat.

[During] like the doctor appointment when they couldn’t find the heartbeat right away and it was kind of like, “Do I go back [inside myself] or do I stay here?” And that was what was really in my mind. It was a huge time when I thought, “Okay, I can either feel [as if I am on] a [an emotional] roller coaster again or I can just stay real calm and stay [in the place where I am able to allow myself] to know what I know to be true right now and that is what I did.” I said to the nurse who was there, “Okay, I am not getting scared until you tell me that I need to be. I am really going to stay calm here.” I remember I was not crying but there were tears coming down my face but I wasn’t sobbing, crying. It was taking just everything in me to stay right there in the moment, stay calm. Not get stupid and not get crazy.
This participant indicated to the researcher she, during those moments, allowed the nurse to emotionally hold her fear for her baby's life. She trusted the nurse to tell her when and if there was a valid reason for her to feel that fear. Until the nurse literally told her it was time to set aside her emotional place of calmness and feel fear instead, the participant maintained her presence and her choice to believe her baby daughter was alive, was well, and she was mothering her. This illustrates the sharing of the journey. During an emotionally terrifying medical procedure, the nurse knew the participant was afraid, was aware of her chosen coping approach, and she respected it. The nurse allowed the participant to maintain the coping approach she needed to hold onto to endure the fear filled moments. The participant’s willingness to trust the nurse allowed her to momentarily suspend her awareness of the events that were occurring around her; she was being allowed to maintain the mental and emotional presence she knew she needed. Her ability to trust the nurse allowed even the most terrifying aspects of her journey to be shared.

Another participant described a terrifying experience during her subsequent pregnancy when she had not felt the baby moving for awhile and feared another cord accident, the cause of her first loss, had happened to her again.

I had one [time] during my subsequent pregnancy where I was just so positive the baby was dead. I hadn’t felt him kick and I freaked out. It was the one time I really freaked out. So I call up that doctor and get that lady that is the phone person... and she is like... “Let me give her [a nurse] a note and she will call you back”... and I was just freaking out. I was crying. [The nurse got on the phone] and said, “Calm down. First of all, I’m so surprised you can feel the baby [kicking at only 18 weeks]. It [kicking] is not going to be regular at first. I want you to relax, drink some water, and if you don’t feel that baby kicking come in and we will do what we have to do. We are not going to let
anything happen to you. We are not going to let anything happen to that baby.”

The participant’s description of the nurse’s response to her indicated the nurse understood and validated the reason for the terror. The nurse gave the participant necessary information regarding reasonable expectations of fetal movement during the gestational age of the subsequent pregnancy. Further, the nurse instructed the participant, kindly told her what steps she might take to assess the viability of the baby, then offered to be available and accessible, if the participant continued to be concerned. The nurse’s behavior illustrated the sharing of the journey and the nurse’s use of the word “we” suggested collaboration and joining, a partnering in the relationship.

Willingness to Know About and to Include the Lost Baby

Others who were willing to know about and to include the baby who died offered a rare and precious means of support. The willingness to know implied an active interest in hearing and talking about the baby who died. When a friend initiated the mention of the lost child and intentionally included the child into a regular conversation the mother was joined in her grief, her past and present experiences could be connected. The inclusion meant the lost child’s reality, her importance to the mother and her place in the family’s constellation were preserved. One participant reported:

The people that let my daughter who died into their lives helped me because I was not the only one who remembered her. I had people that let it be important to them [too].
As the participant said this, she pointed out a crystal angel on her windowsill. It was placed among other, similar angels. A friend had given her an angel gift for each member of the family and had included one for the lost child. The friend’s willingness to include the lost child as a family member had great meaning for the participant.

Another participant reported the following story concerning a nurse who she saw infrequently:

The nurse we had [during a procedure occurring in the subsequent pregnancy] was the same nurse we had when our son who died, was born. We [had] never kept in touch. I only knew her name. [At that time] I knew her first name and took her a gift, and she was not working when I took it in. So, I never talked to her, so when she saw our name on the board [at labor and delivery in the hospital] she remembered and that just touched . . . [she] remembered and [came to talk to me and she] used my little son’s name. It was so touching [and it] . . . was so meaningful to me.

While her family was still in the hospital, the friends of a participant went out and bought the baby who died an outfit. They altered it on the spot, and brought it to the mother so she could hold and dress the baby in clothes that fit him. The participant described:

. . . that was probably my first sense of how you could be a mother without a baby. They helped make my [motherhood] real.

The willingness of others to recognize, know about and include the lost child in conversation, special occasions, and remembrances was deeply appreciated by the participants.
Approaches of Family and Friends Experienced as Stressful

Participants indicated, both implicitly and explicitly, that they experienced stress from the responses of others that were the opposite from the previously mentioned responses they described as helpful. In addition, participants also described certain statements and behaviors of others as stressful. Many participants reported they were upset and alienated when others attempted to explain to them why their baby had died. Being told, "God had a reason for this and one day [we will all know] why," and "God will never give you any more than you can handle," was experienced as stress-inducing. Participants reacted to such statements in these ways:

You get all sorts of answers from people. "Well, God does not give you anymore than He thinks you can handle, and everything has a purpose." I cannot believe that. I do not want to say it is a bunch of crap because people do believe it and I don't. I cannot find any purpose why I would lose three children. I do not see any purpose or reason for that and that attitude gives me no comfort whatsoever. To this day I cannot find a reason for it.

People keep saying to me, "Oh, God does not give you anything that you cannot handle," which is of course the last thing you want to hear when you are in that position.

If there is a reason for this [my baby's death] then what is the reason God gave children to people who abuse and neglect them? . . . Does that mean God thinks I'm not good enough [to be a parent]?

Participants agreed that being told, "You can have another baby" or "You can try again" was not helpful. Participants responded to such statements in these ways:

Well, don't tell me that . . . It is not okay that I lost my baby so don’t belittle me with your reassurances . . . I loved my baby . . . Don't tell me it was meant to be or they are with God.

I found it very insulting when people would say things like, "So are you going to try again?" I got real sharp with people and I can remember saying a couple
of times, "There is no trying again. My one daughter died and I will never get another one of her"... like try again, like she was a failed attempt.

Several of the participants reported any comments made to them by others that heightened their ongoing sense of anxiety or comments they experienced as fear inducing were extremely difficult to bear. Here are some of their examples:

I found it really stress-inducing when people would sort of project their fears upon me and then wonder why I was not in their fear space. I got a lot of... about wanting to have a home birth. I had not had an issue with the birth. It was [a cord accident] not like I had a birth problem and the baby had died... that is what the doctor was trying to say to me, "[I] couldn’t have a home birth"... [but I told him], "but I had her [and she was dead] in the hospital... the birth had nothing to do with it" [the loss].

Some participants experienced stress when others tried to comfort them with blindly reassuring responses indicating they (the participants) really should not be so worried.

This was reported as insulting and denying of their past, painful experiences.

That quote, "Everything is going to be fine," and "fine" for me at that time was identified as, "The baby is born healthy." I said, "How can you guarantee that?" It was very unhelpful... don’t ever say that to me. They mean well... and I can not attack them... but you know in the big picture, yeah, everything is going to be okay no matter what happens but it was not the time or place to say it... they couldn’t guarantee that [everything was going to be fine] because, you know, I kept thinking, "If it happened once, why couldn’t it [a loss] happen again?"

The only thing that was not helpful was when people would come up [to me] and say, "Oh, everything is going to be fine with this baby," and I think some people thought I was being pessimistic but I was not pessimistic. It is being real and you have to keep that [awareness of your own reality]. You don’t want to be blindsided by what can happen.

It was also difficult for participants when others wanted them to feel and to act demonstrably excited about the subsequent pregnancy or the expected baby. It appeared unreasonable to participants that anyone could expect they would react with...
pure enthusiasm to any aspect of pregnancy, their own or anyone else's pregnancy.

This expectation meant the anxiety and fear they experienced repeatedly regarding attachment was disregarded and misunderstood. It also meant the full extent and the lingering impact of their grief for the child(ren) that died, and their need to preserve the place for that child, was being invalidated:

Finally during the 36th week [of the subsequent pregnancy] I started saying, "We may really bring a baby home." I wouldn't let anyone touch the nursery, I didn't want any gifts . . . my neighbors wanted to [have a baby] shower . . . and I didn't know how to tell them "no" but I really didn't want it . . . my sister-in-law finally came to stay with me [and it helped me deal with the pressure because] . . . it was just really hard for me, how to be excited about gifts when I don't want them. She [my sister-in-law] was here and it went fine, but I was very clear about "Let's not get overly excited."

I was clear I did not want a shower until after the baby was born. . . . My neighbors . . . we have several women in the neighborhood pregnant so they wanted to do a neighborhood shower or something like that, and I did not know how to tell them "no" but I really didn't want it. So I was on bed rest and I couldn't go . . . [but] they ended up coming over afterwards . . . it was just really hard on me, how to be excited about gifts [they felt they had to give me] when I don't want them.

These participants' experienced these situations in terms of feeling that others treated them with a sense of presumption of expectations. They were being expected to join in and celebrate and feel excited at a time they had difficulty allowing themselves to feel this way given their prior loss and their fear and worries. This was experienced as stress-inducing. Other pregnant women with uncomplicated histories and no lost children may easily and legitimately feel excited about their impending deliveries. They may easily imagine bringing a baby home so they could enthusiastically prepare a place for one. Several participants with a history of pregnancy loss felt it was unreasonable for other women to expect them to join them in their feelings of pure
happiness and unguarded expectations. When this type of situation happened
participants often experienced the expectations and implicit demands they join in the
celebration as stress-inducing.

Approaches of Health Care Professionals Experienced as Helpful

The participants used a variety of health care professionals during their
subsequent pregnancies, including medical doctors, midwives, nurses, massage
therapists, counselors, and psychologists. The helpful approaches and methods these
professionals offered are described in this section and are later summarized in list of
“helpful medical professional characteristics.” The list of “helpful medical professional
characteristics” was developed from the combined descriptions of the participants of
helpful health care professionals who cared for them. The researcher shared the
“helpful medical professional characteristics” with each participant as part of the
member check procedure during the data analysis. All of the participants agreed the
researcher’s summary accurately described the approaches and methods of
professionals they described as helpful during the subsequent experience.

The helpful relationships provided by these professionals appeared to share the
following characteristics. The health care professional provided information to the
participant regarding the cause of the late pregnancy loss and offered information
throughout the subsequent pregnancy. It was important to the participant to
understand the cause of her loss so she could make informed decisions regarding
meaningful, future care. Information about the loss informed the participant
specifically how the subsequent pregnancy might be managed differently. The 
information that was conveyed needed to be presented in a fashion the participant 
found meaningful and needed to make sense to be useful. This appeared to be 
essential because the information could later be used to assist the participant and the 
health care professional to differentiate and to contrast the pregnancy experiences. 
The process of differentiation appeared to be critically important to the formation of 
hope for the participant. If she could have reliable information to support the 
possibility her subsequent pregnancy could end differently and well, her anxiety could 
be eased.

The health care professionals needed to respect and to honor the knowledge 
base the participant had gained from her past experience, her knowledge of her body 
and its reactions while pregnant, and the information she would continue to collect 
throughout her subsequent pregnancy. The most helpful relationships were those in 
which the participant and the health care professional formed a collaborative 
partnership characterized by their mutual respect. Participants reported they 
appreciated receiving individualized and personalized care with attention to 
differentiating the pregnancies.

I remember my doctor telling me [reassuring me] from the beginning [of the 
new pregnancy] . . . I knew it was a healthy girl and that it [this pregnancy] 
would be different and okay . . . [I also knew if I was worried] anytime I 
wanted ultrasounds I could have [them]. It helps you stay with, “here is my 
baby right now” . . . it affirmed my right-now-ness.

My whole thing was, hey, the more ultrasounds the better. Give me all the 
procedures you can give . . . in fact I had nonstress tests done from 29 weeks 
on until almost the end. . . . maybe it was not necessary completely but the 
doctor was doing it for me . . . I think it was his [the doctor’s] way of letting
me know he was being vigilant. If there was a cord entanglement or whatever, a repeat of that, we would be able to find it. At least we would be able to see the baby was in distress.

... and the fact that I just saw him, [one doctor] nobody else. He is with a group [with other doctors] but I only had to see him [because he did not require me to see the others].

He [the doctor] actually listened [and paid attention] to me. He was not looking at his watch.

Participants reported when the medical professionals with whom they were dealing demonstrated personal initiative and investigation, volunteered necessary medical information and proactive solutions, presented procedures and care in an understandable form, used collaborative language while communicating, differentiated their pregnancies, and willingly and unhurriedly attended to and responded to the emotional aspects of the subsequent pregnancy, they felt supported and helped.

The Relational Level of Care

The helpful health care professionals offered a relationship within which the participant felt cared about as a person, in the context of her pregnancy. It was especially meaningful when the professional offered to provide an exclusive relationship. For example, a medical doctor who practiced in a group offered to care for the participant and acted as a sole provider. This meant the participant would have her own doctor and would not be required to rotate through the group of doctors during her scheduled appointments. The willingness to alter the routine office procedures protected the participant from needing to create additional relationships when she was already stressed and experiencing difficulty in trusting outcomes.
Participants expressed they felt this honored their loss experience, acknowledged and validated their emotional vulnerability, and protected them from having to explain their history repeatedly. This meant their need for information would be more readily accepted; their need to ask many questions or to verbally challenge a professional would be understood.

When a professional initiated and offered such a relationship, they communicated an understanding of the importance of the loss experience and the participant’s emotional isolation could be decreased. The shared understanding allowed the participant to feel preferred and less painfully different than her loss experience had caused her to feel. The professional would find she had opportunities to help to lift her patient’s sense of stigma and shame, and her sense of compromised maternal identity, by her willing attention and her helpful and supportive responses. This allowed a participant to begin to believe her experience of a subsequent pregnancy could be a “shared journey” with a health care professional; someone else who was aware of her painful history would choose to accompany her.

The participants described the relational level of care in these ways:

My obstetrician, who was part of the group offered to be the sole doctor that I saw, that I did not need to go make the rounds through the group. And that she would deliver the baby and that was helpful for me in that she knew what we had been through. She had been part of it and she knew the reasons I was asking the questions I was asking or seeking out the things I was seeking. I did not have to justify myself, or explain what I had been through.

Primarily, I think that he took care of me. I felt he had a true interest in me and our situation. I was not just another patient and another case situation. He became a person to me too instead of just my doctor . . . he let me get to know him too. I have found for me, with someone in a situation like that [a
subsequent pregnancy] that I do better if I [am allowed to] connect with that person.

I think the most helpful thing was my doctor. She was a much better doctor for the type of person that I am that needs to have complete answers to questions and not [say] “Oh, don’t worry about it.” Because I would ask the questions and I trusted her. [I would ask] “Is that something to be concerned about?” and [she would respond] “This isn’t [something to be concerned about] and this is why.”

I always saw her every month and it was a big practice. You are supposed to rotate through the doctors but I didn’t, I just saw her . . . it added that stability that you need at that time, that consistency . . . that with everything else crazy . . . there is one thing that is at least consistent.

What helps is have[ing] a good doctor to go to . . . that is going to be sensitive to your needs and not just focus on the OB part or the uterus and the baby but focus on [your] emotional situation as well.

My trust in him and my confidence in him alleviated a lot of fear . . . if I had a fear, a thought, I could call him. I could come in . . . if I needed to. He would make his rounds and check on me but then when he was all done with his day he would come back. We would sit there and just talk. We had dinner together. My husband brought in dinner from a restaurant.

I tried to have the same caregivers. It was really comforting for me to have the same midwife. I used some of the same health professionals that had helped with the grieving . . . the people I had gotten the most support [from] when I was going through the worst part of my grief . . . so they were the same people I went back [to] . . . so we were all celebrating this journey . . . I think the level of tears at my bed that I and my midwife shed when she [my new baby] was here and she was a girl did speak to the loss. I think in some ways it didn’t color it. It just added to the joy.

When a health care professional provided accessibility or offered to make herself available outside of office hours the participant felt her physical and emotional vulnerability were honored and she was being offered security and protection. Her legitimate need for additional support was understood and validated. The fact she
would experience moments of real fear during the subsequent pregnancy was legitimized; the true difficulties of her experience were being accepted.

The participants described their reactions to this additional level of care in the following examples.

I remember going home that day and telling my husband, "My God, let me tell you what the doctor said today!" I wanted to ask but I did not know if I could and she told me that every once in awhile, that it is not their normal procedure, but they are allowed to have special patients they do that with. She gave me her home phone number so that if I went into labor and she was not on call, she told me to call her at home . . . I could get to her.

He gave me his pager [number] . . . he was phenomenal . . . it was phenomenal coping because the lines of communication were always open.

When a health care provider allowed herself to remain emotionally present to the participant, and was willing to discuss the emotional aspects of the subsequent pregnancy, perhaps initiating such discussions herself, a relational level of care was created.

If a health care provider allowed the lost child to be mentioned or used the child's name it was a significant and constructive event for the participant. The mention of the name acknowledged and confirmed the existence of the participant's maternal identity separate from the viability of the child. The reality and the significance of the lost child's life were acknowledged. The provider's confirmation of the participant's status as a mother potentially engendered hope she might become a mother again, and this was experienced as hope producing and experienced as an aspect of relational care. This approach contrasts markedly with the experiences many of the participants' described when others actively avoided their grief or any mention
of their baby, and thus increased their perceived sense of isolation and of shame and impaired their established relationships.

When a health care provider remained physically present as diagnostic procedures were being performed, or chose to perform the procedures herself, the participant felt she was not alone in her experience. Behaviorally, the provider was stating to the participant she would not be asked or required to view or to experience frightening images alone. A trusted other would look at those images with her; a terrifying event would not necessarily separate the participant from her perception of her bodily integrity or her relationship with her provider. Further, the physical presence of the provider helped emotionally shield the participant from re-experiencing a reminder of the trauma alone that had occurred when identical procedures had been performed in the past. Several participants first learned their baby was dead during routine office visits or routine procedures. Obviously undergoing the same procedures during subsequent pregnancies were not routine events; they presented significant emotional tests for the participants and were, by their nature, fear engendering.

These moments of the provider’s physical and emotional presence, in the context of the participant’s past loss experiences, meant the participant was no longer alone. One participant who reported she had experienced a relational level of care with a health care professional during a subsequent pregnancy described the helpful relationship in which she, with her helper, relationally shared her journey. She said, “I looked to [the health care professional] during those times . . . when I could not [find
Stressful Relationships With Health Care Professionals

Relationships with health care professionals that were described as less helpful and stress inducing had the opposite characteristics than those this section previously described. Relationships characterized by a lack of necessary collaboration, the absence of active and attentive listening, the dismissal or minimization of fear, the perception one was viewed as emotionally reactive or hysterical, the unwillingness to discuss the previous loss or the emotional difficulties inherent in the subsequent pregnancy, or the perceived lack of compassionate response to the pain of others were all viewed as stress-inducing. Any response from a provider that indicated the presence of these attitudes alienated the participants, and the participants often reacted to them by changing health care providers. They would choose to take on the added work of establishing a new relationship and informing the new provider about their painful histories rather than stay with a known provider who was perceived to be insensitive and unable to meet their needs. The participants described less helpful relationships in these ways:

I honestly did not trust them [the obstetric group]. I felt none of them took me seriously. From day one I always said [to the doctors], “It felt like that baby didn’t move enough,” and they forced me to see a different doctor every time . . . maybe they would have taken me more seriously if I would have seen the same doctor and I was saying the same things to the same doctor. [Had I been taken seriously] a nonstress test would have shown them [I was right and] the baby was in distress. [After he was dead they saw] the cord was [wrapped] twice around his neck, once around his body. The baby was in distress.
I do think they pooh-poohed me because I did have a miscarriage prior to that pregnancy [the late loss]. I think they kind of thought, "She is being a little hysterical" . . . I am [usually] a proactive person but I think I did trust them . . . more than I should.

[When] I went to see my . . . doctor [after experiencing the loss] he was just being so weird with me and so different and he wanted me to take stress tests and do all these things. I thought it was very strange because he himself had told me there was no reason to think I was at any higher risk than anyone else for this to happen again. He was totally scaring me. . . . the next doctor I found was fabulous and did not give me any of that _____.

I really felt [stressed] when I went in to talk to the doctor and he is talking to his foot. He is looking at his foot the whole time I am with him, like 20 minutes and here I am, [also a health care professional]. I did not really mean this [to be a] smart ass, but I really thought something was wrong with his foot, and I said, "Is your foot bothering you?" He said, "No, why do you ask?" I said, "You have been staring at your foot the whole time" [and giving me no eye contact].

And I will guarantee you my doctor never spent time talking to me about that [the emotional aspects of the past loss or the current pregnancy]. I am sure I would have remembered . . . if we would have had those conversations . . . Most women have certain fears about going into labor . . . don't we all think we are going to die? I wondered if I would come out of this [subsequent pregnancy] alive. I can remember thinking that too. He was in [the room to examine me] and out [of the room].

. . . and then [during my appointment while I was with the doctor] I realized they had a woman lose a baby or they could not find the heartbeat and they were having her stand out in the hall . . . I was like, "No, you need to go deal with that woman." The way they made her stand out in the hall . . . I just realized . . . this guy is not going to be the way I wanted. So I got out of there and I was just sobbing.

Participants experienced the lack of collaboration, the absence of adequate attention and listening to the participant, reluctance to acknowledge or discuss the previous loss, the dismissal or minimization of fear, and the perceived lack of compassion to the participant herself or to others as stress-inducing.
Helpful Medical Professional Characteristics

The researcher compiled a list of medical professional characteristics as the interviews occurred. Every participant had experiences she described as especially helpful, compassionate, and caring by medical professionals provided during the subsequent pregnancy. Participants were cared for by physicians of both genders; participants did not express a gender preference. However, the degree of compassion, the willingness to share power, the facilitation of an exclusive and egalitarian relationship were aspects of care all participants felt were essential. The literature sometime suggests findings women want to change doctors after they lose their baby. This finding was not supported in this study. Most of the participants wanted very much to remain with the doctor that knew her and understood her history. This provided the participant necessary continuity and stability, as well as the freedom from needing to explain or to justify her concerns. Each participant evaluated and endorsed the list of the medical professional characteristics as part of her member check.

The participants agreed these were the necessary characteristics and behaviors medical professionals needed to practice if they were to provide compassionate care to women during a subsequent pregnancy after a loss. The doctor should be understood to imply a general, and not exclusively, medical role. The term is not meant to imply either gender. Professional is not meant to be understood or to imply "exclusionary" criteria or the membership in any profession. However, for the ease of reading, both terms are used here. The characteristics are meant to provide
descriptions of any person, in any role or capacity, who is willing to and is capable of providing the relational levels of care the participants described as helpful, supportive, and necessary.

1. The doctor was always available and facilitated the creation of an exclusive relationship. He provided access to his services not limited by established office hours, giving a pager number, and/or home phone numbers. The availability meant the mother was not alone in her concerns regarding the pregnancy; the doctor was available in the event of an emergency. Both chose to participate in a "shared journey."

2. The doctor actively provided information, and contrasted the pregnancy experiences by literally and visually demonstrating how past problems were not recurring in the subsequent pregnancy. A mother was allowed to have additional diagnostic procedures such as ultrasounds to alleviate her anxiety upon her request. It was understood there would be critical moments during the subsequent pregnancy when the mother's emotional burdens were expected to increase. The anniversary dates of past losses are one example of a critical time period when such requests were likely to occur.

3. The doctor behaviorally demonstrated that he knew and cared about the mother as an individual. He demonstrated sensitivity to and an understanding of her past pregnancy losses, and he was willing to initiate discussions about those experiences. He focused on the physical and emotional needs of the mother, not just the progression and status of the pregnancy and the baby.
4. The doctor was present during interventions and procedures himself. This is a contrast of past experiences where a technician or a nurse was present and reported the results to the doctor. His or her physical presence was emotionally supportive and shielded the mother from re-experiencing reminders of the past emotional trauma alone, if the knowledge or confirmation of fetal demise occurred during similar procedure in the past. The doctor willingly altered the usual office practices such as rotation through all physicians and allowed the mother the option of having him/her be her sole caregiver. This protected the mother from needing to share her history with multiple professionals in the practice. It protected her from needing to establish multiple relationships and from receiving varying information and/or treatment options, which could be unsettling or stress-inducing.

5. The doctor needed to demonstrate a consistent spirit of compassion and was willing to discuss the emotional aspects of the subsequent pregnancy any time he/she or the mother appeared to need to do so. The willingness to initiate these discussions was understood to be as important as his medical knowledge or skill.

6. The doctor and patient needed to form a team of equal status, a reciprocal relationship in which the mother’s input is viewed creditably. The doctor respected the patient’s knowledge and the ways in which her loss experience educated her regarding current needs. The test of the efficacy of the doctor’s respect for the patient was made evident by her ability to report she felt she was treated as his peer when their appointments or their discussions occurred.
Support Groups

One important point participants made during the member checks and the review of helpful health care professional characteristics was that their pregnancy experiences made them inappropriate candidates for usual birthing classes. Special birthing, Lamaze, or Bradley classes are needed by these women if their needs are to be met. The participants thought health care professionals should refer women considering or experiencing subsequent pregnancies after a late pregnancy loss to a support group comprised only of women who have survived such pregnancies. The usual Lamaze, Bradley, or other prenatal birthing classes were experienced as inappropriate and unequipped to meet their needs. These usual groups were experienced as constraining and isolating to women experiencing subsequent pregnancies. Their past loss made it difficult for women to relate to the “naiveté” of those having a first pregnancy. Women who had experienced a loss and were grieving experienced contradictory emotions, they were not necessarily joyful and happy; therefore, they could not share the optimistic mindset of the group. The optimism of the others created worry for them; these women had learned through experience pregnancy does not necessarily mean viability for their baby. They worried about the other women who innocently presumed well-being and safety. They were constrained about sharing their loss experience, knowing others would feel saddened, perhaps doubtful regarding the viability of their own unguarded expectations. The shattering experience of “the loss of innocence” would occur to others if women in subsequent pregnancies after losses did share openly. None of the participants in this study could
ever imagine permitting herself to make such a self-disclosure despite her emotional isolation and perceived need to share her experience. Women who have experienced a loss are very aware of the potential deleterious effects of anxiety during a pregnancy, and were very unlikely to openly participate in a traditional support group due to their reluctance to create worry for others. A participant who attended both groups, first Bradley then a support group specific to parents who experienced losses stated, "I felt a greater sense of kinship with women who had lost a baby, especially if they were experiencing their first subsequent pregnancy." Another participant, agreed with the need for their own support group commented, "If such a group [of women experiencing subsequent pregnancies had] existed I could have actually talked!"

Participants' Recommendations to Women Experiencing Subsequent Pregnancies

Some participants clearly stated and others implied during their interviews or member checks, other women could be assisted during their subsequent pregnancies by using the coping approaches and methods the participants experienced as helpful to them. A brief list of the coping approaches follows here, written in a manner the researcher believes is consistent with the strength and intensity of the voices the participants used during their interviews and member checks. If their experiences are to be honored, their voices must be carried forward with their integrity. Women who have experienced late pregnancy loss and a subsequent pregnancy would tell other women going through the same experience:
1. Gain the necessary information about the cause of your loss and acquire any additional information you feel you need to answer your many questions and to support yourself during the subsequent pregnancy.

2. You may find it helpful to differentiate and contrast the pregnancy experiences to reassure yourself the current pregnancy is specifically different and could potentially have a different and positive outcome.

3. Understand the experience of grief and the reality of the occurrence of random events. This knowledge may assist you in normalizing your experience of strong and variable, shifting emotions and alleviate any feelings of guilt or feelings of responsibility regarding the cause of the loss.

4. Understand it is possible to decide and to choose to remain emotionally present to the new pregnancy despite your understandable fears of attachment. This choice may potentially allow you to actively parent your unborn child, help you maintain a present focus and preserve a sense of maternal identity and maternal competence.

5. Understand the need to preserve and to protect the place of your lost child in your own mind and heart and in the constellation of your family. This decision will honor the reality and importance of your baby's life, and will acknowledge the impact of your loss.

6. Accept the need to care for yourself and prioritize your own needs during the subsequent pregnancy. The decision to care for yourself actually means a decision to be a good mother to your unborn child. Setting appropriate limits for unhelpful
others and stress-inducing situations is a manifestation of self-care, and is, by extension, taking care of your unborn child.

7. Understand the loss of one's child is the harshest possible grief experience. Choosing to actively face, feel, experience, and hopefully to integrate the resulting grief means the likelihood of the occurrence of substantial changes within your perception of yourself and the role of control in your life. If the impact of your loss is fully experienced and is integrated, you are likely to find yourself changed and strengthened.

8. Recognize your need to be cared for by health care professionals who are capable of providing a relational level of care. Seek out those people who will honor your experience and who will treat you with respect. Form a partnership with them and expect they will willingly provide their active, ongoing attention and compassionate care to you as a mother, and to all of your children. This attention will include the mention of your past history, the baby you lost, and your range of conflicting and variable, strong emotions. If the people with whom you are working, for whatever reason, are unable to provide this level of care, understand it is appropriate to discontinue the relationship and seek out others who will join you during the journey of your subsequent pregnancy. The courage you are demonstrating by undertaking this journey appropriately demands the best efforts others can give you.

9. Recognize your need for support by those who understand you and what you have experienced. Attend support groups where participants have had similar
experiences of prior pregnancy loss so you may talk openly and freely and receive the support you need.
CHAPTER V

DISCUSSION

In this chapter, results of this study, which were described in Chapter IV, are discussed. This chapter is organized into five main sections. First, an overview of women's experience with coping during a subsequent pregnancy after a late pregnancy loss is presented. This section highlights and provides an overview of the coping process during the subsequent pregnancy experienced and described by women participants in this study. This overview attempts to integrate the findings across the main themes reported in Chapter IV. The second section discusses and compares current findings with some of the earlier findings in the research literature to consider possible similarities and differences, and to bring attention to possible new findings in the present study. The third section discusses implications for clinicians. The fourth section discusses limitations of the study, and the final section discusses implications for future research.

Overview of Women's Experience Coping During a Subsequent Pregnancy Following a Late Pregnancy Loss

All of the women in this study experienced a late pregnancy loss and subsequent successful pregnancy and delivery. The death of one's child may be one of the harshest loss experiences an adult will ever face. Following their late pregnancy loss, all women participants experienced grief and distress. For these
women participants, the losses happened without any warning. Prior warning, such as the emergence of a physical difficulty with the pregnancy, might have given the women time to adjust to the prospect of a potential loss with the potential possibility to prepare themselves. Several of the women went alone to, what had always been in the past, a routine and uneventful doctor's appointment, only to have the death of their baby suspected or confirmed. The unexpected loss of their baby was a traumatic and life-altering event.

Following their loss, all of the women began to engage in the search for information, an important theme in this study. They needed a cause for the loss to resolve, as best one could, the death of their baby. They also needed to assess the future risks a new pregnancy would bring into their experience, and decide whether or not they felt capable, physically and emotionally, to be able to manage a subsequent pregnancy. While obtaining information and learning the cause of the death of their lost child helped achieve some understanding, the acquisition of information also brought with it the new awareness of another level of vulnerability. As they obtained information they also learned about many previously unknown pregnancy risks. They experienced increased awareness that they and their children were facing the threat of the loss of life on a daily basis, and they would experience this increased awareness during future pregnancies. This "loss of innocence" also refers to the theme, understanding grief and random events. The women were painfully learning their previous perceptions of control were, in part, illusions. Neither their efforts nor the efforts of any doctor could necessarily completely
protect them or their child from physical danger. Following their experience of late pregnancy loss, they realized no one could guarantee they would deliver a healthy baby despite their best efforts. Whether they were consciously aware of it at the time or not, the women seemed to be in the process of significant internal change. They would later realize and report they had become different people with altered perspectives on life and its possibilities. They would later describe significant changes in their sense of self and in their personal outlook toward the extent to which they could control events, which in this study has been described as the theme of altered self and worldview.

As the women continued to acquire information, all of them would ultimately decide to begin a subsequent pregnancy. The need for information would continue, however, throughout the subsequent pregnancy and persist past the postpartum period. When their subsequent pregnancies were confirmed, they were characterized by contradicting, variable, and intense emotional states. The past loss had changed and limited women participants' capacity to hold unguarded, future expectations. Their awareness of the many risks they faced caused them to think, to ask about, and to anticipate future complications. They would, very literally, need to cope with their memory and the fear of another fetal death. Feeling the fear of losing their unborn baby was experienced as a dominant feature of the subsequent pregnancy. Their traumatic loss experience and knowledge would not easily permit them to attach to the pregnancy emotionally or to form emotional bonds with the unborn. Women described wanting to attach to the new baby yet fearing the
formation of emotional bonds out of the apparent need to protect themselves from another devastating loss. Their future expectations were guarded, not only about the pregnancy and the baby, but also about the future of their family. Some of the women reported they had become aware that their child could die at any age, the certainty of viability could never be guaranteed given the reality of living in an unpredictable world where events could not be controlled with certainty.

The women approached the subsequent pregnancy with very distinct needs. Their need for information was continuous, and they would actively question any medical professional who cared for them because they continued to feel vulnerable to the experience of another loss. Questions that superficially appeared to be requests for information regarding specific details would be, if examined more closely, questions regarding the baby's future viability and safety. Knowing the baby was alive one minute, while providing immediate assurance in the present moment, did not provide long-term reassurance the baby would be alive in future weeks; such was the level of fear and anxiety participants felt. Fear of the loss of their unborn baby continued throughout the subsequent pregnancy. Some of the women described their subsequent pregnancy as an obsessive mission, and were obsessed, worried, and preoccupied by its every detail. Obviously this obsession could be exhausting and emotionally draining, and it was also being experienced in the context of their variable and intense emotional state. Women described this experience of obsessive mission and worry as such an intense experience, many
wished they could "hurry the end" and deliver the subsequent pregnancy to end their constant worry.

Women reported the successful delivery of the new baby did not end their worry; their worries changed in form and became concerns about the permanent viability of their child. For several women, the baby did not “feel permanent” for months, for one woman, not for the entire first year. The knowledge of their vulnerability to random events and to danger would persist. They would find they might experience a re-awakening of the grief for the lost baby, because parenting the new baby increased the reality of the lost child and the grief for their loss.

Women reported that it helped to have their pregnancy experiences differentiated. They appreciated and found helpful knowing specifically how and in what ways the new pregnancy was physically or medically different, and how the subsequent pregnancy could be managed differently. Specific medical tests, procedures, and the knowledge that the subsequent pregnancy was a distinctly different pregnancy and actually doing things differently or knowing the pregnancy was being medically managed in a different manner, if appropriate, was reassuring. If women could not differentiate the subsequent pregnancy, as in the case of the circumstances described in Chapter IV, then the subsequent pregnancy seemed to be more difficult to cope with since there were no indications that the subsequent pregnancy was different.

The women appreciated having health care professionals who would patiently and tolerantly answer all of their questions and respect their need for a
great deal of information. Professionals were perceived as helpful if information and proactive potential solutions were volunteered and were discussed collaboratively. Women also appreciated when professionals would individualize the approaches used and the medical procedures provided according to the woman's indications of her needs. The women valued being treated and respected as a knowledgeable peer; one who would be expected to remain actively involved in the medical management of her pregnancy. Women also appreciated when their active, challenging, and inquisitive presence was accepted and welcomed. They also valued when health care and medical professionals participated in the subsequent pregnancy as a shared journey and provided a relational level of care. This meant that women appreciated receiving individualized and personalized care, in which they felt cared about as a person. Women felt it was especially meaningful if professionals offered to provide an exclusive relationship in which they were able to see a single provider they knew and trusted. Women found it very supportive when health care professionals were personally present during tests and procedures, especially when specific tests or procedures were previously associated with women learning their lost baby was deceased. They also appreciated it when providers altered routine procedures and made themselves more directly accessible to women throughout the pregnancy by making home phone numbers and pager numbers directly available to participants if there was an emergency.

Friends, family, and others were experienced as being helpful when they were able to willingly and unhurriedly attend to all the aspects of the variable
emotions the participants needed to express. If they could continue to maintain an awareness of the woman’s ongoing feelings of fear, especially the fear of experiencing another loss, and if they could listen without judgment or offering explanations or providing false reassurance women experienced comfort and support. Women also deeply appreciated it and experienced support when others were willing to know about and to include the lost baby in conversation, special occasions, and remembrances. Women experienced stress when others attempted to explain why their baby had died, when others tried to comfort them with blind reassurance, and when others expected them to join in traditional predelivery baby celebration activities such as baby showers and did not understand participants’ hesitancy to join in these activities.

All of the women experienced grief following the loss of their baby. While each woman coped with her grief in her own way, a few women described their awareness of choosing to face directly, head-on, all of the emotional aspects of their grief. They described this coping approach and stated it assisted them in facing, integrating, then moving on emotionally into a subsequent pregnancy that was for them, at times, even enjoyable. The theme, embrace the experience, healing aspects of pain, describes their coping approach.

Despite the awareness of their persistent vulnerability and the fears of attachment, a few of the women also described another unique, active coping approach that they seemed to uniquely articulate. These women decided to actively develop, to maintain, and to try to keep a conscious awareness of their pregnancy
and their unborn. They focused on the baby and formed a relationship with their child. This coping approach seemed to represent an attempt to actively move beyond the earlier described feelings of fearful attachment commonly experienced by women in a subsequent pregnancy following a late pregnancy loss, and seemed to emphasize how one could experience being a mother without a child yet born, and appeared to allow women to experience the active parenting of their unborn. Several women described using this approach and stated it helped them stay focused in the present, and it allowed them to experience being a mother to their baby before the birth. Some women described this active parenting as helpful in assisting them in soothing their fears of another loss, especially in specific situations they experienced as fear engendering. They chose to think of themselves as mothering the baby during every moment and, if another loss occurred, they could feel they had protected the baby and had facilitated their relationship in every way possible for as long as they were allowed to and, in essence, had been good mothers.

All of the women described the need to make some sort of provision for the child they had lost, and they made provisions in various ways. All of the women wished others would talk to them and would share memories and thoughts about the lost child. Any person in any role or capacity who was willing to know about and to include the lost baby was experienced as providing a very important type of support the women valued highly. Friends, family, and medical professionals who willingly provided support of this type were described by the women as those who shared the
journey of their subsequent pregnancy. The sharing of the journey and the relational level of care are described by the participants as most meaningful support.

At times and in response to the stressful experiences women had with certain others, some of them became increasingly aware of the need to accept greater responsibility for their own self-care. This decision is described by the theme, acceptance of caring for oneself. The participants acknowledged that very few others could fully understand their experience; it was necessary they learn to meet their own needs. Further, some came to understand caring for themselves was also a means of caring for their unborn baby. For some, this seemed to be a change in the traditional cultural role often ascribed to women as protecting relationships and others' feelings of their own expense. They became active and assertive in relating to health-care professionals in requesting specific medical tests and procedures. In reflecting on their late pregnancy loss and subsequent pregnancy, women reported that they had also changed in other significant ways as a part of their experience. They became very aware that they did not have the personal control of life events they once believed they had. Several reported experiencing a strengthening of themselves as result of the experience they had been through and described the loss of their child in their earlier pregnancy and the experience of the subsequent pregnancy as a life-changing event.
Current Findings and Earlier Research

Several main themes emerged from the participants’ descriptions of their experiences with coping during subsequent pregnancies that followed a late pregnancy loss. In particular, the themes which seemed to emerge from participants’ descriptions of their experiences with subsequent pregnancies included (a) contradicting emotions; (b) fear; (c) fearful attachment and persistent vulnerability; (d) obsessive mission, worry, and the wish to hurry the end; (e) awareness that the delivery does not end the worry or the grief; (f) the need for information; (g) differentiating the pregnancy experiences; (h) understanding grief and random events; (i) the decision toward conscious presence and active parenting; (j) provision for the lost child; (k) acceptance of caring for oneself; (l) embracing the experience, the healing aspects of pain; and (m) altered self and worldview.

It is interesting to consider and compare the themes, which emerged from the stories of the women in the current study with observations and findings noted in the literature, and to consider possible similarities and differences. In considering the themes noted in the present study and earlier findings, there appear to be several areas of consistency, and a few areas of possible new findings. First, in terms of similarity with findings from earlier investigations, several of the themes found in the current study appear consistent with other research findings and reports. In particular, the theme of contradictory emotions, guarded expectations, and anticipated complications seems similar to reports by other investigators of researchers concerning ambivalence toward the subsequent pregnancy (DeFrain
et al., 1986; Côté-Arsenault & Mahlangu, 1999). The presence of anxiety and fear
was reported by several researchers including Phipps (1985), DeFrain et al., (1986),
Hense (1994), Armstrong and Hutti (1998), and Hughes et al. (1999). Fearful
attachment seems similar to reports by Phipps (1985), and Kirksey (1987). They
described impaired prenatal attachment during the subsequent pregnancies, where
the naturally occurring events, such as fetal movement, failed to provide either
lasting happiness or emotional security for once-bereaved parents. Also, Wilson
et al. (1988), Côté-Arsenault and Mahlangu (1999), Kirkley-Best and Kellner
ambivalence toward attachment and the pregnancy. The theme of obsessive mission,
worry, and the wish to hurry the end seems consistent with findings by several
investigators concerning anxiety during the subsequent pregnancy. These include
and Stringham et al. (1982). The awareness that the delivery does not end the worry
or the grief appears similar to observations by Oglethorpe (1989), Wilson et al.
(1988), and Hunfeld, Taselaar-Kloos, et al. (1997) that worry and anxiety does
continue beyond the birth of the baby and that parents continue to worry. The theme
of provision for the lost child appears consistent with observations by Leon (1986)
and Helmrath and Steinitz (1978), in which the importance of the lost child is
acknowledged, and the theme of honoring each baby noted by Côté-Arsenault and
Marshall (2000). Also, the theme of altered self and worldview appears similar to
Côté-Arsenault and Marshall’s theme of “Realizing how I’ve changed.”
Several authors, most recently Hughes et al. (1999), described women experiencing significant levels of depression during subsequent pregnancies that followed later pregnancy losses. They found depression during the third trimester of the subsequent pregnancy was highly predictive of depression one year after the subsequent child was born. The women participating in the present study did not describe themselves as experiencing depression during or after their subsequent pregnancies, although nearly all of them experienced anxiety and grief. Since current observations are based on retrospective qualitative reports some years after the experience, it may be difficult to say whether or not any of the participants experienced depression at the time of the subsequent pregnancy since it may be difficult to distinguish between grief and depression retrospectively. Future clarification of the nature of grief versus clinical depression in women who experience subsequent pregnancy after a late pregnancy loss may also be helpful.

As noted in Chapter II, there has been concern in the literature regarding the concept of the "replacement child" (Cain & Cain, 1964; Poznanski, 1972) concerning children born to parents following another child's death. In a study of subsequent pregnancy following stillbirth Hense (1994) reported one of the themes identified was the presence of residual grief with awareness of attempts to replace the loss child as well as efforts to differentiate between the unborn children. The women in the present study, however, were consistent in reporting they viewed each of their children as individuals. They grieved and mourned the loss of the individual child who died, and reported they were angry and offended when others might
suggest they could “try again” or “have another baby.” The women reported these suggestions were offensive to them because they were aware the lost child could never be replaced. Further, the themes that emerged from the study, the need to differentiate the pregnancies, and the need to provide for the lost child, seemed to support their reported recollections. The women needed their pregnancies differentiated, in part, because each pregnancy was about a separate individual; the provisions made were intended to preserve the place of a loved child who would maintain her individual place, forever.

Several of the themes and coping approaches identified in the current study seem to be new and do not seem to have been clearly pointed out in the literature. First, the need for information. While it seems obvious from a common sense point of view that the need for information would be important to women who have experienced a late pregnancy loss and who were contemplating or actually were experiencing a subsequent pregnancy, this point apparently has not been emphasized in the literature. Rajan and Oakley (1993), in their study of social support interventions for women with high-risk pregnancy, did note that the need mentioned most by women who had previously suffered pregnancy loss was for more information from doctors. However, the question on need for information was not repeated during their study and not included in the overall ranking of women’s perceived needs during pregnancy. Reports from women in the current study indicate women clearly value and need information after their loss and during the
subsequent pregnancy. This is a means by which they attempt to have knowledge to make informed decisions and to care for themselves and their baby.

The theme of differentiating the pregnancies also seems to be a new finding and has not been clearly emphasized or highlighted in the literature. Differentiating the pregnancies was important to women in the study because they needed to know the likelihood of another fetal death might be decreased in the future. The presence of anxiety, fear, guarded expectations, and fearful attachment are characteristics of most subsequent pregnancies. Women who chose to take the risk of another pregnancy may be able to more effectively manage these understandable emotions if they literally could be reassured the new pregnancy was healthy and past problems were not reoccurring. Helping differentiate the pregnancies may assist the woman in formulating hope for a healthy outcome for the subsequent pregnancy.

The theme of active parenting and conscious presence as a means of coping also appears to be a new finding. While, as noted above, several investigators have noted that women experiencing subsequent pregnancy are likely to experience fearful attachment to the infant during the subsequent pregnancy, how women cope with these mixed feelings of attachment and descriptions of women’s efforts to actively parent in spite of feelings of fear, anxiety, and the need to protect themselves has not apparently been described or emphasized in the literature. The approach of active parenting as noted by two women in the current study may be an important new finding.
Implications for Clinicians

Clinicians who wish to provide effective care for women who have experienced traumatic pregnancy losses and/or subsequent pregnancies may find it helpful to be aware of the experiences with coping of the women in this study. Women having a pregnancy loss history appreciate being given as much information as they ask for regarding their loss, their current medical status, and the development and progression of their pregnancy. Information regarding the cause of their loss is also experienced as very helpful in the context of making decisions regarding and during the subsequent pregnancy. Clinicians need to understand that women who have had losses will be weighing all known risks in their own minds at every step during the pregnancy and then will be assessing the development and health of the baby once she or he has been born. Women need to know they and their babies are receiving the best levels of medical care possible. Clinicians who are willing to share information and to discuss with women who have experienced a late pregnancy loss the widest range of appropriate interventions will help empower them to make those provisions.

The information women gain may also be helpful in assisting them in differentiating their pregnancy experiences. Women in this study found it very helpful to know specifically how the subsequent pregnancy was different, and the ways in which it could be managed differently. In helping make this differentiation, it may also be helpful to include discussions with the mother herself in terms of any changes she anticipates making during the subsequent pregnancy. The ways in which
each individual woman will be helped in terms of having her pregnancy experiences
differentiated will be unique to her and need to be congruent with the specifics of
her pregnancy loss, her learning style, and her remembered experience of trauma.
Clinicians who are able to hear what the woman asks for regarding differentiation of
the pregnancies; who are sensitive to this issue; who respect the woman’s ideas,
expressed thoughts, and statements concerning differentiation; and who, when
possible, help in differentiating the pregnancies, are likely to be experienced as
helpful and supportive.

Two of the central experiences described by women in their relationships
with health care providers described as helpful were the themes of the shared
journey and the relational level of care. Women really appreciated being in an
egalitarian relationship with providers who clearly cared about them and their baby,
who appreciated the nature and extent of their loss, and who provided relational
care and demonstrated mutuality and shared responsibility during the journey of
managing the subsequent pregnancy. Women seemed to especially value when
providers make special efforts to establish continuity and stability of care, such as
making arrangements for one provider to see the women throughout the subsequent
pregnancy. Women also deeply appreciated it when providers made themselves
directly available in case of emergencies during the subsequent pregnancy by giving
their pager numbers or home phone numbers directly to the women. Women going
through a subsequent pregnancy after a loss especially need to feel they and their
baby are cared for as unique and valued persons. This appears to be so basic it
seems this might not need to be stated; however, the literature indicates and the
women participants in this study suggest, the rarity of the presence of willing others
who would volunteer to know and to hear about the tragic events these women
experienced.

Clinicians need to be sensitive to the fact that, as women go through the
subsequent pregnancy experience, the women will experience many reminders of the
loss of their baby. These reminders, which health care providers may think are
routine events of the pregnancy such as office visits, tests, and procedures, may be
for the women reminders of earlier traumatic events and experiences when women
learned they had lost their child. Women describe really appreciating when doctors
or their health care providers where physically present during the tests and
procedures during which the women had earlier learned they had lost their child.

Clinicians may also find it helpful to note during history taking the significant
dates and anniversaries which may occur during the subsequent pregnancy. The date
and the circumstances under which the woman first became aware there were
problems in the prior pregnancy, the baby’s death date, the baby’s birth date, and the
baby’s full name are critically important and should be considered to be significant
demographic intake information for women who have experienced a late pregnancy
loss. The clinician needs to be aware of all of these dates, despite the passage of
time since the loss occurred. The woman will certainly be remembering them, and
will be privately wishing a trusted other will make mention of them and initiate a
discussion regarding their continued significance.
When a clinician uses the lost baby's name, it may also be appropriate to ask the origin of the name, to ask why the woman chose the particular name. The clinician is inviting the woman to inform her about the hopes, dreams, and characteristics imbued by the mother to the child by the gift of this specially chosen name. In a sense, the mother is telling the clinician who she thought her child would be, whom she wished, wanted, and dreamed the person of the child would become.

In initiating and making mention of the events that occurred in the context of remembered yet ongoing grief and loss, the clinician indicates to the mother her child may have died, but her memory and her place have not been lost, and the mother and all the mother's children are important to the clinician. In the women's experience in this study, most others hesitate to initiate these discussions and recollections, incorrectly assuming the mention of past events or the baby would add to the mother's pain. In actuality, the mother carries her pain and her memories within her, invisibly, all of the time. Asking to be allowed to discuss the memories together conveys to the mother her pain and her lost child are always relevant and important.

The clinician may ask the mother to bring with her, to her appointments, whatever linking objects she treasures may be a very important and honoring gesture toward the grieving mother experiencing a subsequent pregnancy since it will be experienced as both inclusive and honoring. The clinician can always appropriately ask the mother, "If you want to, please bring whatever pictures or objects you are keeping that you would like to show me. I would like to see whatever you have so I
can know the baby. Please help make her real to me too.” The clinician’s willingness to see, to touch, and to actually hold in her hands the objects the mother has treasured and has saved conveys her willingness to know and “to hold” the lost child. One of the saddest and most isolating aspects of grieving an infant is the lost ability and opportunity for the mother to proudly show her baby to loving and accepting others. When the clinician asks to “hold the baby” in this way, she is in effect, repairing this aspect of the mother’s loss, the inability to proudly present her live baby to the welcoming world. The clinician is, in effect, requesting the privilege of being introduced to the baby by her mother in a “public” setting. This gesture and practices of this nature capture the heart of what is intended and is meant by the relational level of care and the shared journey.

Strengths and Limitations of the Study

One of the strengths of this study was the use of qualitative methodology, which generated richly descriptive data about the participants’ subsequent pregnancy experiences. The use of the semistructured interviews, the member checks, and the on-going and early data analysis procedures that included the participants’ comments, corrections and validations, allowed the complexities of their experience to emerge. Three of the main themes identified in the study, the need for information, differentiating the pregnancy experiences, and the decision toward conscious presence and active parenting have not apparently been previously emphasized in the professional literature. Also, the participants’ description of their
experiences with health care providers appears to be an area not previously emphasized in the literature. The results appear to yield potentially useful information for women experiencing subsequent pregnancies and for health care professionals and others who wish to provide them support.

There are limitations in this study, which need to be acknowledged. The sample size is small with eight participants. It is entirely comprised of middle class, well-educated, financially stable Caucasian women, all of whom volunteered to be participants. Since participants volunteered and were involved in support groups and in other outreach activities to assist women experiencing pregnancy losses, it is possible they may be more verbal and more articulate concerning their experiences than other women might be. Also, the fact that they volunteered for the study may be a reflection that they had successfully resolved and integrated their earlier loss experience to the extent that they were able to talk about and discuss their experiences as part of a research study.

The participants in this study also had the benefit of the passage of some time since their loss experiences, and the interviews were comprised of their retrospective accounts. For each participant, several years had passed since the experience of the subsequent pregnancy after the late pregnancy loss. The passage of time with additional maturation and life experiences may have influenced their descriptions of their coping experiences some years before. The descriptions of other women who may be currently experiencing subsequent pregnancies or those who are currently in acute grief may be different. The sample was also very
homogeneous with regard to socioeconomic, religious, race, and cultural background. The experiences and descriptions of the coping experiences of women from different socioeconomic, ethnic, and cultural backgrounds may be different. Therefore, the transferability of the results to other groups may need to be explored with future research.

Implications for Future Research

Further research is needed on helping women cope during the subsequent pregnancy following a late pregnancy loss. Specific attention to what is helpful to women coping during these challenging pregnancies is still very limited. More work is needed to understand what may be done to help support these women and to help them cope appropriately. Additional research focusing on exploring some of the important issues and themes noted in the current investigation, that apparently have not received a lot of attention in the literature to date, may be beneficial. These include the need for information following the loss and during the subsequent pregnancy, differentiating the pregnancies, and active parenting during the subsequent pregnancy.

The need for information was very prominently mentioned by women in this study as helpful in the process of coping with their loss and with coping during the subsequent pregnancy. However, investigation of the nature, type, and process of providing information to women experiencing subsequent pregnancy after a loss may be helpful and could be studied more in-depth and more systematically. Study
of the process of differentiating the pregnancies may also be helpful. More needs to be known in terms of how women themselves attempt to differentiate the subsequent pregnancies and more needs to be understood about health care providers attitudes and behaviors in helping women differentiate the pregnancies following a loss. Also, the theme of the relational level of care and the shared journey with a single trusted provider seemed crucial to these women as a source of support during the subsequent pregnancy. More research is needed concerning provider attitudes, behaviors, and willingness to modify current group practice approaches often seen in contemporary health care practice to implement a more relational, personalized care approach with women who have experienced a late loss and are being seen for a subsequent pregnancy. Research on the training and education of health care providers in helping women during subsequent pregnancies after pregnancy loss may be a very important area of research. Additionally, research on support groups, especially programs and support groups for women who have experienced pregnancy loss and are experiencing a subsequent pregnancy may also be beneficial. Similar studies using qualitative methodology, but comprised of women with differing demographic and ethnicities are also needed. Comparing the coping experiences of women having subsequent pregnancies after late pregnancy losses in the context of cultural differences would be especially interesting.

The issue of the relationship with the lost child and the relationship with the new baby during the subsequent pregnancy seemed to be very important issues to women in the current study. More research on the relationships women develop and
maintain with their lost children may be helpful to other women and the clinicians who care for them. This seems to be a relatively invisible aspect of the experience of a subsequent pregnancy following a late pregnancy loss, and additional information on this process would seem to be beneficial to women and clinicians. Also, additional research on the process of developing an attachment and relationship to the new baby after a late pregnancy loss may be very useful. The active parenting approach to coping described by a few participants in the current study seems important as a coping approach that may be of value to other women and understanding this approach may be important to clinicians. The active parenting approach described by these participants appeared related to the resolution of the fearful attachment to the new baby in the subsequent pregnancy. While the literature has clearly suggested the presence of fearful attachment exists during the subsequent pregnancy, less seems to be known regarding how women resolve and deal with this understandable response during the course of the subsequent pregnancy after a loss. The area of mother–infant attachment after a late pregnancy loss could benefit from more research attention and understanding and seems to be a very crucial issue for women experiencing subsequent pregnancy after a loss and a very important area of future inquiry.
Appendix A

Physician Letter
Physician Letter

Dear Dr. ________________,

I am a doctoral student in counseling psychology with a professional interest in women's pregnancy issues. I am especially interested in women's experiences of a subsequent pregnancy that follows a spontaneous later-term pregnancy loss. As you may know, approximately 955,000 women experience a pregnancy loss each year. Of these, 27,000 families experience a fetal or infant death. There has been very little research directed toward understanding women’s experiences with pregnancies that follow a spontaneous later-term loss. I am studying women’s coping approaches and methods during these subsequent pregnancies.

My dissertation research focuses on identifying the specific coping approaches and methods women rely on during a subsequent pregnancy. To participate in this project a woman must have experienced a spontaneous past pregnancy loss occurring at 20 gestational weeks or later. In this study a spontaneous pregnancy loss is described as a loss that occurs naturally, and is not the result of medical intervention, accident or trauma. Potential participants must also have experienced a pregnancy and healthy delivery subsequent to the loss, must not be currently pregnant, and must be able to describe her feelings about and reactions to her pregnancies in depth and in detail. Women will be asked to participate in one confidential interview lasting about 1 1/4 hours scheduled at her convenience. The interview will be audio taped then transcribed. The data will be analyzed to identify themes and commonalities. A second meeting will then be scheduled for the purpose of sharing the themes and commonalities that emerge during the data analysis. Women will be asked for their comments and corrections to ensure the findings accurately incorporate their experience. The second meeting is anticipated to require approximately 45 minutes of time.

A woman's commitment to this project will include only the scheduled interview appointment time and the second meeting to verify the themes found during the data analysis. There are few anticipated risks to participants. There may be some emotional discomfort such as stress, anxiety or sadness related to the recall of painful past experiences.

I would appreciate your support in this project. I am requesting you allow the enclosed poster, invitation, and flyers to be posted in your office waiting room. Also, if you have patients who meet the study criteria, I respectfully ask you to personally request they consider contacting me. All identifying information about a patient, her experience and her responses will be kept confidential. The Human Subjects Institutional Review Board of Western Michigan University has approved the protocol for this project. Dr. Patrick Munley is the principal researcher and is supervising this project. If you have questions regarding the study please do not hesitate to contact me at 373-1101, Dr. Munley at 387-5100, or the Human Subjects Review Board of Western Michigan University at 387-8293.

Sincerely,

Colleen A. Thebert-Wright
Appendix B

Participant Invitation
Participant Invitation

I am a doctoral student with a professional and personal interest in women's pregnancy experiences. My dissertation research is an attempt to more fully understand how women cope with a subsequent pregnancy that follows a spontaneous late pregnancy loss. A spontaneous loss occurs naturally and is not the result of medical intervention, accident or trauma.

Women who have this experience have a great deal of important information to share with other women. If you have experienced a spontaneous late pregnancy loss and then had another pregnancy and healthy delivery, please consider participating in this research.

I would like to hear about your pregnancy experiences one-on-one, in a comfortable, private place. We could meet at my office in Kalamazoo, or in another private place that is convenient for you. My intent is to listen and to understand your pregnancy experiences, especially how you coped during the pregnancy that followed the loss.

Your privacy will be respected and all identifying information about you is strictly confidential. I will be audiotaping our discussion, and then transcribing it so I can study it in detail. When I study the interviews, I am hoping to identify major themes and commonalities about women's experiences during pregnancies that follow spontaneous late losses. After I have studied all of the interviews, I will call you to schedule a second meeting. I want to check whether or not my findings accurately describe and incorporate your experience. I want to hear your comments and corrections to verify my understanding of your experience and to make sure I have captured its meaning.

The basic goal for this project is to obtain information that may be helpful to other women during pregnancies after they have had a spontaneous late pregnancy loss. Your experience and the experience of other women in the study may offer information that would be helpful to women and the health care professionals taking care of them.

Please consider adding your voice to this project. To help, you should meet the following criteria:

A. You are able to talk about and describe your thoughts, feelings, and emotional reactions about your pregnancy experiences.
B. You experienced a spontaneous past pregnancy loss (for any reason) at 20 or more gestational weeks (5 months of pregnancy).
C. You then experienced a new pregnancy and healthy delivery some time after the loss.
D. I am asking women who know they are pregnant not to participate. I simply do not wish them to experience any additional discomfort such as unnecessary stress, anxiety or sadness that may arise from discussing a pregnancy loss during a new pregnancy.

I would appreciate the opportunity to learn from your experience. If you might be interested in participating or you have questions, please call me at 373-1101. Thank you already for your interest and your help.

Sincerely yours,

Colleen A. Thebert-Wright MS LPC
Appendix C

Recruitment Materials
If you have had a late pregnancy loss then a new pregnancy and healthy delivery please consider participating in a research project at Western Michigan University.

Women who lose a baby late in a pregnancy may find their next pregnancy difficult and stressful. Very little is known about how they cope, little is known about what really helps them.

I want to learn what helps women get through this difficult situation. If you decide you want to share your experience, your participation will involve filling out a questionnaire, a 90-minute interview and a 45-minute interview at the end of the project. If you have had a late pregnancy loss and then had a healthy pregnancy and delivery please consider helping in this project.

The information I learn from you will be used to help other women manage a pregnancy that follows a loss. Your experience may help not only the women, it can also teach health care professionals how to give support and care that is truly meaningful.

If you would like to find out more about this study please call Colleen at (616) 373-1101.

Thank you.
Appendix D

Telephone Screening
Telephone Screening Interview

Thank you so much for calling about the research project. Let me describe it for you, and you can see if your experience fits the needs of the study. I would like to talk to women who have had a spontaneous late pregnancy loss and then, later, had a healthy pregnancy and delivery. A spontaneous loss occurs naturally and is not the result of medical intervention, accident or trauma. We know that losing a baby and then managing another pregnancy can be very stressful. What we want to know more about is how women cope with the pregnancy after the loss. Does this sound like something you would be interested in discussing in detail?

Have you experienced a spontaneous late pregnancy loss? How far along was the pregnancy when the loss occurred? Did you have a healthy new pregnancy and delivery after the loss? Do you think you would be interested in meeting with me to learn more about a study about pregnancy and loss and to decide if you would like to participate? Do you have any questions or concerns about participating in this project, or about being contacted for follow-up? When can we schedule a meeting and where would you like to meet? I have a private, comfortable office in Kalamazoo, or is there another place you would prefer? As we make this decision, the location of the interview needs to be private and free from potential interruptions. To protect your confidentiality no partners and/or children are permitted to attend the interview. How and where would you like to be contacted? By telephone, e-mail or surface mail? May I have your address and phone number so I can send you a confirmation letter of the date, time and place of our meeting?

If the participant does not meet the criteria for the study, the researcher will say, I'm sorry. I'm really glad you called but it won't be possible to schedule a meeting. All of the participants need to _______________ (name missing criteria). Your situation doesn't fit the study's criteria in this way _______________ (describe). Thank you so much for your interest.
Appendix E

Confirmation Letter
Dear ____________________,

Thank you for talking with me on the phone. As we discussed, you do meet the criteria for participation in the study. I am writing to confirm our appointment on __________________________ at _______________________. I am looking forward to meeting with you so you can learn more about the study and decide if you would like to participate.

If you have any questions or concerns about participating, please do not hesitate to call me at 373-1101.

Thank you again.

Sincerely,

Colleen A. Thebert-Wright
Appendix F

Demographic Information
Demographic Information

<table>
<thead>
<tr>
<th>Code #</th>
<th>Age</th>
<th>Race</th>
<th>Religion</th>
<th>Marital status</th>
<th>Length of relationship</th>
<th>Years of education</th>
<th>Occupation</th>
<th>Are there children at home? Yes</th>
<th>No</th>
<th>Ages of those children</th>
</tr>
</thead>
</table>

For each confirmed pregnancy you have had, please supply the following information:

<table>
<thead>
<tr>
<th>Your Age</th>
<th>Length of Pregnancy</th>
<th>Outcome of Pregnancy*</th>
</tr>
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<tbody>
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*healthy delivery, complicated delivery, miscarriage, abortion, late pregnancy loss, or stillbirth
10. The pregnancy loss I will be discussing occurred (date)___________________.
   This was my (first, second, etc.)__________ pregnancy. The gestational age of
   the baby was________________. My age at the time was________________.

11. The successful pregnancy and healthy delivery occurred_______(date). This
   was my (second, third, etc.)__________ pregnancy. My age at the time was
   __________.

12. Did you seek out special support to help you deal with the pregnancy loss?
   Yes__ No__

13. If yes, what type of support? (Individual counseling, support group, etc.)
   ________________________________________________________________.

14. Have you experienced fertility problems or treatment for infertility?
   Yes__ No__

15. If you have, what were those problems or treatments?
   ________________________________________________________________.

16. Do you feel you have experienced any other traumas (very upsetting emotional
   experiences) in your life? Yes__ No__

17. What were those experiences?
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

18. Do you have any concerns or questions about the interview or the research
   project? Yes __ No__

19. If yes, please describe them:_______________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

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Appendix G

Human Subjects Institutional Review Board
Letters of Approval
Date: December 10, 2001

To: Patrick Munley, Principal Investigator
    Colleen Thebert-Wright, Student Investigator for dissertation

From: Mary Lagerwey, Chair

Re: HSIRB Project Number 01-11-11

This letter will serve as confirmation that your research project entitled “Women’s Coping Approaches During Subsequent Pregnancies That Follow Later-Term Pregnancy Loss: A Qualitative Study” has been approved under the full category of review by the Human Subjects Institutional Review Board. The conditions and duration of this approval are specified in the Policies of Western Michigan University. You may now begin to implement the research as described in the application.

Please note that you may only conduct this research exactly in the form it was approved. You must seek specific board approval for any changes in this project. You must also seek reapproval if the project extends beyond the termination date noted below. In addition if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: November 21, 2002
Date: April 11, 2002

To: Patrick Munley, Principal Investigator
    Colleen Thebert-Wright, Student Investigator for thesis

From: Mary Lagerwey, Chair

Re: Changes to HSIRB Project Number: 01-11-11

This letter will serve as confirmation that the change to your research project “Women’s Coping Approaches During Subsequent Pregnancies that Follow Later-Term Pregnancy Loss: A Qualitative Study” requested in your memo dated April 9, 2002 (follow-up interviews will be taped if subjects agree and sign a second consent document) have been approved by the Human Subjects Institutional Review Board.

The conditions and the duration of this approval are specified in the Policies of Western Michigan University.

Please note that you may only conduct this research exactly in the form it was approved. You must seek specific board approval for any changes in this project. You must also seek reapproval if the project extends beyond the termination date noted below. In addition if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: November 21, 2002
Appendix H

Informed Consent 1
I have been asked to participate in the research project "A Qualitative Analysis of Women's Experience of Subsequent Pregnancy Following a Late-Term Pregnancy Loss". The project will study how women cope during pregnancies that follow a spontaneous later-term pregnancy loss. A spontaneous pregnancy loss occurs naturally and is not the result of medical intervention, accident or trauma. This project is the dissertation research of Colleen Thebert-Wright supervised by Dr. Patrick Munley.

I agree to be confidentially interviewed for approximately 45-90 minutes. The interview will be about my experience of the pregnancy that followed a later-term pregnancy loss. The interview will be audio taped and then transcribed. Two tape recorders will be used for back up purposes. The researcher will take great care to maintain my confidentiality as explained in this document. I will also provide information about myself, including my age, level of education, employment status, and my pregnancy history. At the end of the interview I will be asked permission for the researcher to contact me again at a later date. If I do not wish to be contacted again I may say no.

The researcher will analyze interviews with a number of women. Then she will contact me to schedule a second meeting to share what she has learned so I can make comments or corrections to be sure my experience has been accurately described. The second meeting will last about 45 minutes. During this meeting the researcher will make handwritten notes of my comments or corrections, and will include them in the project. If I want it, I will receive a written summary of the information the researcher has learned from the interviews.

As in all research there may be unforeseen risks to the participant. If an accidental injury occurs, appropriate emergency measures will be taken; however, no compensation or additional treatment will be made available to the subject as otherwise stated in this consent form. The researcher anticipates minimal risk with my participation in this research. There is the possibility I may experience some feelings of stress, anxiety or sadness that may come from discussing my pregnancy experiences. I can ask for the interview process to be stopped or ended at any time if
I am uncomfortable or I choose not to continue. In the event I experience a strong emotional response during the interview, the researcher is skilled in the techniques of crisis counseling and she will provide support as appropriate. She will make the names of appropriate professionals available at my request if I desire to discuss my pregnancy experiences further. I will be responsible for the cost of therapy if I choose to pursue it.

One way I may benefit personally from the interview is by having the opportunity to describe my experience of a successful subsequent pregnancy that followed a spontaneous later-term loss, in the context of knowing my experience may be helpful to other pregnant women. The information will be used to increase understanding of women's experiences during these pregnancies and to identify the coping strategies they find helpful. In the future this understanding may help both women and professionals.

All of the information collected from me is confidential. Strict confidentiality will be maintained except as required by Michigan law in the event of abuse, neglect or knowledge of an individual's expressed intent to harm themselves or others. Confidentiality means my name will not appear on any papers on which this information is recorded. My privacy will be further protected by the following measures. I will choose a false name at the end of the interview that will be used in the transcription. The forms will all be coded, and the researcher will keep a separate master list with the names of the participants and the corresponding codes. Once the data is analyzed the master list will be destroyed. The signed informed consent documents and the original transcripts will be retained for at least three years in a locked file in Dr. Munley's office. The tapes of the interview will be destroyed immediately after the transcription is checked for accuracy. All names will be deleted from the transcripts and will be replaced by false names. All other identifying information will be made unidentifiable. For example, a reference to a person will be described by their role, a reference to a specific location will be described as a general location. In this way no written information could be traced to any individual. Also, any reports that are published or presented will be carefully checked and steps similar to those mentioned above will be taken to minimize the possibility that any information can identify individuals.

I may refuse to participate, or withdraw from this study at any time during my participation, without any prejudice, penalty, or the risk of loss of any service I might otherwise have. If I have any questions or concerns, I can feel free to contact the researcher: Colleen Thebert-Wright M.S. at 373-1101, or Dr. Patrick Munley, Dissertation Chair, at 3102 Sangren Hall, Western Michigan University, Kalamazoo, MI, 49008 (616) 387-5100. I may also contact the Chair, Human Subject Institution Review Board at (616) 387-8293 or the Vice President of Research at Western Michigan University at (616) 387-8298 if questions or problems arise during the course of my participation in the study.
This consent document has been approved for use for one year by the Human Subjects Institutional Review Board as indicated by the stamped date and signature of the board chair in the upper right corner. Subjects should not sign this document if the corner does not have a stamped date and signature. My signature below means that I have read and/or had explained to me the purpose and requirements of the study and that I agree to participate.

Signature: ____________________________ Date: _______________

Consent obtained by: ___________________ Date: _______________

initials of researcher

If I agree to participate, I will sign both copies of this form. The interview cannot take place until the researcher receives this form.
Appendix I

Informed Consent 2
Western Michigan University
Department of Counselor Education and Counseling Psychology
Colleen A. Thebert-Wright, M.S. Doctoral Student, Department of Counselor Education and Counseling Psychology
Women's Coping Approaches During Subsequent Pregnancies That Follow A Later-Term Pregnancy Loss: A Qualitative Study
Supervised by Dr. Patrick H. Munley, Associate Professor, Department of Counselor Education and Counseling Psychology

I have asked to participate in the research project “A Qualitative Analysis of Women’s Experience of Subsequent Pregnancy Following a Later-Term Pregnancy Loss”. The project will study how women cope during pregnancies that follow a spontaneous later-term pregnancy loss. A spontaneous pregnancy loss occurs naturally and is not the result of medical intervention, accident or trauma. This project is the dissertation research of Colleen Thebert-Wright supervised by Dr. Patrick Munley.

I agree to be confidentially interviewed for approximately 45-90 minutes. The interview will be about my experience of the pregnancy that followed a later-term pregnancy loss. The interview will be audio taped and then transcribed. Two tape recorders will be used for back up purposes. The researcher will take great care to maintain my confidentiality as explained in this document. I will also provide information about myself, including my age, level of education, employment status, and my pregnancy history. At the end of the interview I will be asked permission for the researcher to contact me again at a later date. If I do not wish to be contacted again I may say no.

I have already participated in the first interview. The researcher will contact me to schedule a second interview to share what she has learned so I can make comments or corrections to be sure my experience has been accurately described. The second interview will last 30-45 minutes. The researcher will audiotape the interview and will include my comments or corrections in the project. If I want it, I will receive a written summary of the information the researcher has learned from the interviews. I realize I have already signed a similar consent document. This amended document merely allows the
researcher to audiotape the second interview instead of handwriting her notes.

As in all research there may be unforeseen risks to the participant. If an accidental injury occurs, appropriate emergency measures will be taken; however, no compensation or additional treatment will be made available to the subject as otherwise stated in this consent form. The researcher anticipates minimal discomfort with my participation in this research. There is the possibility I may experience some feelings of stress, anxiety or sadness that may come from discussing my pregnancy experiences. I can ask for the interview process to be stopped or ended at any time if I am uncomfortable or I choose not to continue. In the event I experience a strong emotional response during the interview, the researcher is skilled in the techniques of crisis counseling and she will provide support as appropriate. She will make the names of appropriate professionals available at my request if I desire to discuss my pregnancy experiences further. I will be responsible for the cost of therapy if I choose to pursue it.

One way I may benefit personally from the interview is by having the opportunity to describe my experience of a successful subsequent pregnancy that followed a spontaneous later-term loss, in the context of knowing my experience may be helpful to other pregnant women. The information will be used to increase understanding of women’s experiences during these pregnancies and to identify the coping strategies they find helpful. In the future this understanding may help both women and professionals.

All of the information collected from me is confidential. Strict confidentiality will be maintained except as required by Michigan law in the event of abuse, neglect or knowledge of an individual’s expressed intent to harm themselves or others. Confidentiality means my name will not appear on any papers on which this information is recorded. My privacy will be further protected by the following measures. I will choose a false name at the end of the interview that will be used in the transcription. The forms will all be coded, and the researcher will keep a separate master list with the names of the participants and the corresponding codes. Once the data is analyzed the master list will be destroyed. The signed informed consent documents and the original transcripts will be retained for at least three years in a locked file in Dr. Munley’s office. The tapes of the interview will be destroyed immediately after the transcription is checked for accuracy. All names will be deleted from the transcripts and will be replaced by false names. All other identifying information will be made unidentifiable. For example, a reference to a person will be described by their role, a reference to a specific location will be described as a general location. In this way no written information could be traced to any individual. Also, any reports that are published or presented will be carefully checked and steps similar
to those mentioned above will be taken to minimize the possibility that any information can identify individuals.

I may refuse to participate, or withdraw from this study at any time during my participation, without any prejudice, penalty, or the risk of loss of any service I might otherwise have. If I have any questions or concerns, I can feel free to contact the researcher: Colleen Thebert-Wright M.S. at 373-1101, or Dr. Patrick Munley, Dissertation Chair, at 3102 Sangren Hall, Western Michigan University, Kalamazoo, MI, 49008 (616) 387-5100. I may also contact the Chair, Human Subject Institution Review Board at (616) 387-8293 or the Vice President of Research at Western Michigan University at (616) 387-8298 If questions or problems arise during the course of my participation in the study. This consent document has been approved for use for one year by the Human Subjects Institutional Review Board as indicated by the stamped date and signature of the board chair in the upper right corner. Subjects should not sign this document if the corner does not have a stamped date and signature. My signature below means that I have read and/or had explained to me the purpose and requirements of the study and that I agree to participate.

Signature: ___________________________ Date: ______________________
Consent obtained by: __________________ Date: ______________________
initials of researcher

If I agree to participate, I will sign both copies of this form. The interview cannot take place until the researcher receives this form.
Appendix J

Research Questions
Research Questions

1. How do women describe their experience of a subsequent pregnancy following a late pregnancy loss? What is the experience like for them and what meanings do they make of the experience?

2. What approaches to coping do women employ during a subsequent pregnancy after a late pregnancy loss? Which coping methods and approaches are experienced as helpful and which are experienced as counterproductive or stress inducing?

3. What do women experience as helpful and supportive from friends, family and health-care professionals during pregnancy after a previous late pregnancy loss? What do women experience as counterproductive or stress inducing from friends, family and health-care professionals?

4. What would they like to share with other women who may experience pregnancy after a previous late pregnancy loss?
Interview Guide

Note: Italics indicate approximate wording that will be used by the researcher. The interview questions are focused to obtain descriptions of the participants' experiences of coping with a subsequent pregnancy following a spontaneous late pregnancy loss. In addition to the guide the researcher will use follow up questions as may be needed to encourage participants to fully disclose their experiences. If the participant tells one long narrative the researcher will use follow up questions as necessary to ensure topics are covered and to identify what needs to be asked before the interview ends. The researcher, based on the context of the individual interview, may modify the wording of the questions. As each interview is conducted there may be questions added which represent emerging issues. Interviews will last approximately 45-90 minutes but no more than two hours.

1. Greet the participant, orient her to the office layout. Review informed consent document and obtain informed consent and signature. If the interview takes place in another location, greet the participant; allow her to orient the researcher to the space selected for the interview, and obtain informed consent.

2. Review the Purpose: In this interview I will be asking a series of open-ended questions about your experience of a successful pregnancy that followed an earlier pregnancy loss. The main purpose of the interview is for you to talk about your experiences in a way that best describes what the pregnancy was like for you and to

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describe the approaches and methods that helped you cope with a pregnancy that followed an earlier pregnancy loss. During the interview I will ask questions only as needed to clarify your experiences. Do you have any questions before we begin?

Let the participant know the tape recorders have been turned on. Let's begin.

Opening question: It is important for me to understand the context of your pregnancy experiences. I'd like to give you the opportunity to tell me anything you feel comfortable sharing about your pregnancy loss and how it led up to your decision to begin another pregnancy. What went into your decision to become pregnant again?

Question 1: Compared to your other pregnancy experiences, how would you describe your experience of the pregnancy that followed the loss? What was the experience of the pregnancy like for you? What meanings did you make of the experience?

Question 2: What approaches to coping did you use during the subsequent pregnancy after the loss? What coping approaches and methods did you experience as helpful? Which coping approaches and methods were experienced as stress inducing or counterproductive?

Question 3: What did you experience as helpful and supportive from friends, family and health-care professionals during the pregnancy after the loss? What did you experience as stress inducing from friends, family and health-care professionals?
Question 4: What would you like to share with other women who may experience another pregnancy after a spontaneous late pregnancy loss?

Question 5: If another woman facing the same situation asked you, “What does it take to successfully manage and to survive this type of pregnancy?” what would you tell her? What do you feel is the most important advice you could give her?

Question 6: Is there anything else you think is important for me to know about the approaches and methods you used to cope with this pregnancy? To really understand your experience what is the most important thing I should focus on?

The interviewer may probe for clarification but allow the participant to freely describe her experience. When the time is up or the participant has nothing more to say, I will say: We have come to the end of the interview. I need to review some information with you and then we will have some time for you to ask any additional questions or make comments you would like to add. As stated before, the content of the interview is confidential. I will be the only person who will be able to match your name with the interview. I will keep that information absolutely confidential. Your confidentiality will be protected by the following measures. The tape of this interview will be kept in a locked box until it is transcribed. The tape will be destroyed immediately after checking the transcription of the interview for accuracy. All names and identifying information will be removed or changed from the transcript. The transcript of your interview will identify you only by the pseudonym you choose. What pseudonym would you like to use? Any reports or
presentations that are made from this data will undergo scrutiny to ensure no 
information is present that would identify any participant. I will need to contact 
you again during my data analysis to schedule a second meeting. I will need about 
45 minutes of your time. During the second meeting I will describe the way I am 
categorizing and conceptualizing the data, and I will ask for your comments or 
additions to make sure it accurately represents your experience. The focus of the 
meeting would not be to obtain additional information from you, but to get 
feedback to make sure my descriptions of your experiences are correct. I might ask 
you to clarify information you have shared if I have questions. The goal would be 
to provide clarity. Is it OK to call you for your input or clarification? Would you 
like to receive a summary of the research findings at the conclusion of the study? If 
yes, note this for future reference on the master list.

In concluding, I would like to give you the opportunity to add any comments or ask 
any questions you may have had along the way.

The interviewer concludes the interview by thanking the participant. Procedures for 
handling the tape and providing a transcript are to be carried out in the manner that 
was described to the participant above. Transcripts that have had all identifying 
information removed from them will then be ready for data analysis.
Appendix L

Master List
Master List

The master list contains the following information for each participant: code number, name, address, telephone number, selected pseudonym, indication of participation in scheduled member checks, and a reminder to send the research findings if they were requested. To protect the confidentiality of the participants, the master list will be stored separately from the interview transcripts and signed informed consent documents. The master list will be destroyed three years after the end of the research project.

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Appendix M

Thank You Letter
Dear ____________,

Thank you for taking the time to meet with me. Your help is appreciated as I work to learn more about the pregnancy experience after a spontaneous late pregnancy loss. As we discussed, I will be studying the transcripts of all of the interviews in great detail. After I have analyzed all the interviews and identified themes and commonalities I will call you to schedule a second meeting. I will need approximately 45 minutes of your time. I want to share what I have learned to make sure I have accurately described your experiences. I will ask for any corrections or comments you may have to be sure I have captured the meanings of your experience.

Please know I will always appreciate your help. If you have questions about any aspect of the process, please do not hesitate to call me at 373-1101. If you do not wish to be contacted in the future please let me know. Whatever you decide, I am thankful for your help and interest in the project.

Sincerely yours,

Colleen A. Thebert-Wright, MS LPC
Appendix N

Member Check Procedures and Script
Before beginning, the researcher obtained signatures for the revised Consent Document.

You have the summary of your interview. Please review it carefully. I want to know about any areas that need clarification or any inaccuracies that need correction. My goal is to make sure your experience has been accurately described and is fully understood.

1. Please review the summary of Question #1. Does it accurately describe your pregnancy experience with ____________, how the experience was different and the meanings you made of it?

2. Please review the summary of Question #2. Does it accurately describe the coping approaches you used that were helpful/not helpful during ____________’s pregnancy?

3. Please review the summary of Question #3. Does it accurately describe the helpful/not helpful coping approaches of your family, friends and medical professionals during ____________’s pregnancy?

4. Please review the summary of Question #4. Does it accurately describe what you would like to share with other women?

5. Please review the summary of Question #5. Does it accurately describe the most important advice you would like to give another woman?

6. Please review the summary of Question #6. Does it accurately describe the most important aspects of your experience?

7. Are there any other comments or corrections I need to include to make sure your experience is accurately described and fully understood?

Please review the medical professional characteristics. Does it describe medical care you would consider helpful and supportive during a pregnancy that followed a later-term loss? Are there any corrections or additions you would like to make?


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