Women's Experience of Pregnancy After Pregnancy Loss

by

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A Master's Research Project

presented to
Oregon Health Sciences University
School of Nursing
on partial fulfillment of
the requirements of the degree of
Master of Science

19 September 1997

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Abstract

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A grounded theory method known as dimensional analysis was used to describe the experience of seven women experiencing pregnancy subsequent to pregnancy loss. Much of the research done in the area of maternal-fetal attachment after pregnancy loss has focused upon women's physical health and marital relationships during these pregnancies. Research hypotheses focus upon the presence or absence of presumed adaptations, and the prevailing opinion is that subsequent pregnancies are healing unless a "morbid grief reaction" has occurred. Little research has been done to describe women's actual experiences during such subsequent pregnancies, and none that arises from a naturalistic perspective. Two research objectives guided the study:

(1) To identify and describe the experiences, both positive and negative, of pregnancy subsequent to perinatal loss, from the perspectives of the women who have undergone pregnancy after a perinatal loss; and

(2) To identify and categorize the factors having the greatest influence on the positive and negative experiences of subsequent pregnancies.

Seven categories of experience arose from the dimensional analysis of interview data. These categories were:

(1) Changes in internal, "spiritual" relationships, including dreams, visions, shrines to their dead children, and changes in their own ways of knowing the universe;

(2) Changes in ways of relating to others, including relationships with their children, their partners, their own mothers, medical providers, God, and other "expert" who have experienced perinatal losses;

(3) Changes in perceptions of the state of pregnancy, including before the lost pregnancy, after the lost pregnancy, deciding to attempt pregnancy again, and perceptions of the current pregnancy;

(4) Changes in self-perception and awareness, including loss of faith in God, self and body;

(5) Redefinition of motherhood and life expectations;

(6) A sense of the price paid for experience, and

(7) Learning to be the mother of a dead baby.

Additional research findings were that women experiencing pregnancy subsequent to pregnancy loss reported attachment processes that are different from commonly accepted or expected processes. Normally happy occurrences such as the presence of audible fetal heart tones and quickening were perceived as anxiety producing rather than anxiety relieving. Relationships with significant others were often tense, and the predominant emotions expressed by women experiencing subsequent pregnancies were anger, anxiety, and hope. Feelings of depression were frequently described, although triggering factors were not always appreciated. Spiritual belief systems and friends were the most commonly identified support systems. Women experienced relationships with prenatal providers as good when they included acknowledgement of previous losses, individualized management of the prenatal period , and planning for anticipated periods of increased anxiety, grief, anger, or depression.

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CHAPTER 1

Introduction

The concept of prenatal attachment is addressed frequently in both professional and lay literature. By definition, the concept of prenatal attachment is an attempt to observe the unseeable and to measure the unknowable. It is used as an assessment of a woman's mental health during childbearing and of her adaptation to her pregnancy. It is used to predict a woman's behavior toward her child after birth. It is also used in a more insidious manner. As the theorists attempt to explain dark, feminine mysteries, they define societally expected behaviors as much as actual phenomena. Our culture holds a pregnant woman to a rigid standard of behavior. She may not smoke cigarettes, drink alcohol, contact potentially hazardous substances or engage in personally dangerous behaviors without facing public opprobrium. Her decisions are expected to display an appropriate consideration for the welfare of her fetus; in fact, she may be expected to value her fetus's well-being more than her own, and to submit to invasive procedures, prolonged bed rest and even major surgery for the benefit of her child. While many women do hold their fetuses in such regard, it is perhaps faulty reasoning to assume that all women do, or should, value so highly someone whom they have never met.

Not all women do welcome pregnancy, nor do they feel unconflicted about even a desired pregnancy. Even a woman who is experiencing a desired pregnancy may not choose to act in her baby's best interests. Some have overriding habits or concerns of their own, and some may have deep, unresolved conflicts about the circumstances of this pregnancy or previous pregnancies. These conflicts may be most prevalent in situations of pregnancy subsequent to previous perinatal losses,

i.e., pregnancy loss, stillbirth, or neonatal death. Women in these circumstances have reason to associate pregnancy with deep emotional and even physical pain, yet they are pregnant once again.

Differences between societal expectations, theoretical expectations and women's actual circumstances suggest that much is unknown about the perspectives of the women themselves. Therefore, the purpose of this research was to examine women's own experiences of pregnancy subsequent to pregnancy loss in a naturalistic manner.

CHAPTER 2

Background and Significance

Relationships Between Concepts in the Literature

Early attempts to define the concept of maternal attachment arose from psychoanalytic theories of women's psychology, and, in fact, from psychiatric patients. Deutsch (1944) described a psychology of women based upon the idea that although becoming a mother was essential to a woman's achieving emotional maturity,the experience of being pregnant brings up a woman's old emotional conflicts, especially conflicts with the pregnant woman's own mother. Other psychoanalysts, Benedek (1956) and Bibring (1959) described pregnancy as a period of psychological disequilibrium and emotional crisis. Benedek focused on "women's essential passivity", believing that if a woman could not remain passive during pregnancy, her essential motherliness might be lost. Bibring claimed that the emotional crisis of pregnancy affected all mothers and could be resolved "with appropriate psychological care as part of the prenatal program". Rubin (1970, 1975) attempted to describe the nature of the pregnant woman's interactions with a then unknown fetus. Rubin's work was formative in describing the "binding-in" process that defines a mother's early relationship with her fetus, and that continues long after the fetus becomes a child.

Developmental theory provided the background for later studies of attachment. Mercer (1986) describes attachment as a progressive process, an affectional and emotional commitment to an individual. Mercer found that women's emotional maturity and personality integration were correlated more to the woman's developmental stage than to her status as mother. While developmental theory does recognize pregnancy as a normal, rather than a pathologic state, it assumes that all women go through linear stages of

development. This creates a possibility that women's own lived process will be overlooked, misjudged, or worse, judged as pathologic because it does not fit a preconceived time line.

The concept of prenatal attachment is also closely linked to general attachment theory. Early researchers used animal models of bonding to describe human processes. Klaus and Kennel (1984) adapted these models to study the origins of maternal-infant attachment, theorizing that for a brief period after birth, maternal physical conditions create a period of heightened sensitivity and responsiveness that facilitates the development of maternal-infant attachment. Thus was born the concept of post-delivery "bonding," a magical period perceived to be essential to the development of a healthy, loving relationship between mother and baby.

Attempts To Measure The Concept

Cranley (1981) attempted to measure maternal attachment during pregnancy. Defining maternal-fetal attachment as "the extent to which women engage in behaviors that represent an affiliation and interaction with their unborn child", Cranley consulted with clinicians and Lamaze teachers to develop a list of statements mothers make about their babies. These statements were reviewed with other professionals to determine content validity, and items referring to the fetus in negative terms were eliminated, as it was assumed that women would be reluctant to admit annoyance from their fetuses. Pregnant women were then asked whether or not these statements applied to them, and their agreement or disagreement used to determine the extent of their attachment to their pregnancies. Cranley found attachment levels to be positively related to mother's perceived social support and negatively related to mother's perceived stress levels. In attempting to define maternal attachment, Cranley used external observations and parameters of

appropriate behavior, then further restricted the realm of normal by deleting all negative topics from her assessment tool.

Curry (1987),using Cranley's Maternal-Fetal Attachment Scale as a measure, describes the three components of maternal behavior as maternal acceptance of pregnancy, identification with a motherhood role and maternal-fetal attachment . She defines maternal attachment as emotional affiliation with the fetus unrelated to threats to maternal or fetal health or well-being.

Cranley's MFAS has been used in numerous studies of the dimensions of prenatal attachment, but only recently has its validity been examined (Muller, 1992, and Muller & Ferketich, 1992). In a secondary analysis of content, Muller examined women's statements concerning current pregnancies, categorized responses, then submitted the resulting categories to expert nurses to determine their appropriateness. While Muller's research did not support the dimensions of the MFAS, she still examined women's perceptions and experiences through an external, "expert" lens.

Stainton (1985, 1990), in a grounded theory study conducted with expectant couples, has described attachment as a "constructed relationship" arising from interactions between parents and their unborn infant, and developing as sequential levels of increased awareness of their infant's interactive ability.

Most of the above research was done with primiparous women; and most of that was done with healthy women in healthy, desired pregnancies. There has been very little work exploring the attachment process in healthy multiparous women, and even less with multiparous women after perinatal losses. The existing literature on perinatal loss is primarily from the realms of high-risk maternal nursing and psychology and focuses on five areas: maternal grief after perinatal loss, women's physical and psychological health after pregnancy loss, changes in

significant relationships after pregnancy loss, appropriate levels of professional intervention after pregnancy loss, and attachment to subsequent pregnancies.

Maternal Grief

Grief has been characterized as a phemonon of universal and predictable phases or stages. (Kubler-Ross, 1974). While this characterization is useful didactically in terms of organizing and communicating the major affects, behaviors and reactions of grief and mourning, in life, the stages of grief may not be clearly delineated. Bowlby (1980) describes grief as an emotion associated with the loss of attachment bonds, and resolved by a process of detachment from the lost loved one. This model of maternal grief is marked by paradoxes of relationship and transformation of cognitive structure. In reality, maternal grief may be a multi-layered, non-heirarchical web of inter-related phenomena. (Brice, 1991). Brice describes the "ur-paradox" as the desire to mourn and not to mourn the lost child. This paradox leads to ambivalence in establishing relationships with others, and, presumably, to ambivalence in considering another pregnancy.

Women's Health After Pregnancy Loss

Acute grief threatens a mother's physical and psychological health, with such psychic and physical manifestations as

(1)Overactivity without a sense of loss;

(2)Acquisition of the symptoms of the illness of the deceased;

(3) Development of psychosomatic diseases such as ulcerative colitis, asthma, and rheumatoid arthritis;

(4) Irritability and social withdrawal;

(5) Furious hostility;

(6) Mannerisms representing schizophrenia, due to repressed hostility;

(7) Lost patterns of social interaction, involving inhibition of initiative and

decision-making making abilities;

(8) Activities detrimental to one's own social and economic existence;

(9) Agitated depression, including insomnia, tension, agitation, low self-esteem, self-accusation, and even suicidal tendencies (Ney, et. al., 1994) . The acute phase of grief generally lasts from six to twelve months, while "morbid grief reactions" can last as long as two years. These prolonged reactions are characterized by preoccupation with the dead infant, the inability to function in a daily routine, loss of appetite, feelings of guilt, and a sense of failure. Psychological conflicts after pregnancy loss may negatively affect women's health by consuming physical and psychic energy, thus leaving the woman less able do deal with life stressors. There is also evidence that depression resulting from unmourned losses can interfere with immune system function (Ney, et. al, 1994.)

Changes In Significant Relationships After Perinatal Loss

While it is postulated that the stresses associated with perinatal loss can lead to changes in marital and other significant relationships, little research has been done to examine the idea. A longitudinal study of 934 parents who had lost a child to stillbirth, neonatal death or sudden infant death syndrome found that parents of a child who died were more likely to experience a marital breakup and more likely to express dissatisfaction with a marital relationship than parents of a child who survived (Najman, et. al., 1993). Changes in a woman's mental and physical health and preoccupation with her grief can lead her to "think less rationally about the other aspects of her life, including personal relationships" (Ney, et. al., 1994). Conversely, in a study of eight families who were currently experiencing pregnancy following stillbirth, five families reported that the loss of a pregnancy made them feel "closer" to each other. They reported fewer arguments than before the loss, as well as less anger, distance and depression (Wilson, Soule, & Fenton 1988).

Appropriate Levels of Professional Intervention

The literature focuses on determining appropriate and inappropriate types of professional interventions for women who have experienced pregnancy loss. Often, advice is influenced by the age and parity of the woman experiencing a loss, with increased parity being as reason for increased emotional support (Reed,1990). Much professional intervention is intended to provide cognitive structure, with physicians and nurses instructed to "establish the meaning of the loss to the woman," "identify specific fears," "explain the anticipated course of events," "encourage the use of a support network," and "identify maternal attachment and bonding behaviors" (Brost & Kenney, 1992), thereby attempting to provide resolution to the situation for the mother. Medical literature is even more directive, providing protocols for advice concerning the timing of subsequent pregnancies (Davis, Stewart & Harmon, 1989). While physicians, midwives and nurses no longer cope with the grief of pregnancy loss by denial or by insensitive suggestions to "get on with your life," their response is often determined by protocols fashioned after Kubler-Ross's stages of grief (Ilse & Furrh, 1988). Women's own perceptions of the processes of grieving and accepting losses are not addressed in these protocols and studies; again, individual responses may be judged as pathologic if they do not fit preordained patterns of grieving.

Attachment To Subsequent Pregnancy

There is similar dissonance in the literature of attachment in pregnancies subsequent to perinatal loss. Women are often advised to wait approximately six months after a loss before attempting another pregnancy, in the belief that a six-month period will allow resolution of grief (Davis, Stewart & Harmon, 1989). Pregnancies begun before this six-month period of resolution are thought to be "replacement" pregnancies, while those conceived beyond one year following a loss

are seen to be "tentative" and are thought to lead to overconcern and over protection of the pregnancy and the child (Theut, et.al, 1988; Zeanah, 1989, Rando, 1993). At the same time, various authors have defined the attachment process in such pregnancies as characterized by such states as cautious optimism (Brost & Kenney, 1992); detachment (Van der Zahlm, 1995); depression and anxiety (Theut, et al, 1988); denial and "conscious unreadiness"(Woods & Esposito, 1987); overconcern, over protectiveness, and over-attachment (Peppers & Knapp, 1980); and morbid grief (Brice, 1991). Once again, women's own perceptions have not been sought, and their experiences are frequently judged as pathologic when they do not fit preconceived patterns.

Statement of the Problem

Much of the research done in the area of maternal-fetal attachment is focused upon women's physical health and marital relationships during these pregnancies. Research hypotheses focus upon the presence or absence of presumed adaptations, and the prevailing opinion is that subsequent pregnancies are healing unless a "morbid grief reaction" has occurred (Ney, et. al., 1994). Exactly how a woman might be healing, or might have already healed, has not been explored.

Specific Aims of the Research

The specific aims of the research are:

1. To identify and describe the experiences , both positive and negative, of pregnancy subsequent to perinatal loss from the perspectives of women who have undergone pregnancy after a perinatal loss.

2. To identify and categorize the factors having the greatest influence on the positive and negative experiences of subsequent pregnancies.

Women's experiences will be used to reveal the relative importance of

interrelationships, social and professional support, therapeutic interventions and other less understood elements in the decision to attempt pregnancy once again, as well as elements in women's healing processes following pregnancy loss. Women's perspectives will be used to illuminate those elements or categories of importance that may not be appreciated by researchers or health care professionals.

Summary

There is a significant body of nursing and psychological literature related to the concept of maternal or prenatal attachment. Much of the literature assumes the presence of maternal attachment, then attempts to define or measure that which is assumed. I have not encountered literature suggesting that a prenatal relationship between mother and fetus does not exist, or that the relationship is other than beneficial to both parties. Prenatal attachment is also a common topic in the popular media. Much attention is directed to monitoring and changing pregnant women's behavior in order to optimize pregnancy outcomes. Less attention is paid to women's internal adaptations to pregnancy, or to causal factors other than women's behavior as explanations for undesirable pregnancy outcomes.

The existing literature on the subject of pregnancy after perinatal loss is even more presumptive, as it is based upon the idea that subsequent pregnancies are desired and healing experiences; and if they are not so, then the woman's response is pathologic. No where are women's experiences validated or even sought. The literature does not reflect my own experience with pregnancy after perinatal loss, nor does it reflect the experiences of friends and clients I have encountered in my years of perinatal nursing. I have come to suspect that the literature on prenatal attachment does not necessarily reflect women's experience. I have chosen to

examine the process of attachment after perinatal loss as a pilot study in a long-term examination of the prenatal attachment process in contemporary women.

A thorough understanding of women's psychology and development is one of the tenets of midwifery care, and one of the primary ways in which midwifery care differs from obstetrical care (Kennedy, 1995). An understanding of a woman's relationship to her growing fetus is basic to understanding the choices she will make concerning labor, birth, and mothering. At the same time, it is essential that the midwife listen to the woman's own story, and not approach each individual woman with a preconceived scale of appropriate behaviors.

The essence of midwifery care lies in listening to women, and in providing care that is safe, satisfying, respectful, informative, and meets each woman's individual need (Kennedy, 1995). It may be that our current models do not address the needs of women undergoing such stressful and potentially painful challenges in what is recognized as a life-changing event. If so,we must change our models to meet our client's needs.

CHAPTER 3

Methodology

Design

As the focus of this study was the natural description of women's experiences of pregnancy subsequent to pregnancy loss, a grounded theory method known as dimensional analysis was selected as the research design. Grounded theory is a methodology for developing theory that is grounded in data that is simultaneously gathered and analyzed. Theory evolves through this continuous interplay between analysis and data collection (Glazer & Strauss, 1967). Dimensional analysis, as described by Schatzman (1991), is a refinement of grounded theory technique involving "natural analysis;" the natural cognitive process used by people to interpret and understand problematic experiences or phenomena. The process of dimensional analysis entails the designation, or naming, of data bits and the expansion of those data into their various attributes including dimensions and their properties (Kools, et. al., in press.)

Sample and Setting

Women who have experienced pregnancy following a perinatal loss were sought by referral from local agencies and midwifery practices. The following criteria were used for selection of the participants: (a) experienced a second or third trimester or perinatal loss in a previous pregnancy; (b) experienced a successful pregnancy following the perinatal loss; (c) English speaking; (d) 19 years of age or older; and (e) willing to participate in an interview one to three hours in length. The sample consisted of seven women who all met the above criteria. The initial three participants were recruited from local midwifery practices. The last four were recruited from an advertisement placed in a newsletter published by a local support group for parents of subsequent pregnancies. Two of the women were in the last

weeks of a subsequent pregnancy, while five had delivered a healthy child following a pregnancy loss from ninemonths to four years earlier. Five of the women had experienced more than one pregnancy loss. All of the women were married or partnered. They ranged from 24 to 39 years of age.

Data Collection

Instrument

Data collection was accomplished by a semi-structured interview of participants. The open-ended questions (see Appendix B) were developed through review of the relevant literature. This interview guide was developed by the researcher for this study and was reviewed by experts in maternal child nursing to assure that its content was representative of literature regarding the phenomena. The purpose of the interview was to allow the woman's story of her child-bearing experiences and the factors that were most influential on these experiences to unfold so that novel factors and concepts of importance to her perspective could surface. The interview guide was generated for use in the early interviews and was modified as new concepts emerged from data analysis.

Procedure

Initial contact with prospective participants was made by means of a brief descriptive letter sent to local midwifery practices (see Appendix B). Women meeting the participant criteria were given a letter (see Appendix C) which asked them to contact the researcher by means of a response card. One of the initial participants volunteered to place a notice in a newsletter published by a local support group. In either case, interested women responded to that notice by direct telephone calls to the researcher. The research project was explained in detail over the telephone. After the initial contact, an appointment was set up for the interview

at a location of the woman's choice. Five of the women were interviewed in their home. One was interviewed in her hospital room where she was undergoing a prolonged period of bed rest for preterm labor; the other woman chose to be interviewed at a local skating rink, as her immediate family members did not know of her pregnancy losses. All interviews were tape recorded, were conducted by the researcher, and lasted one to three hours.

Protection of Human Subjects

Approval for the project was received from the Committee on Human Research at Oregon Health Sciences University. All participants were notified both at the initial contact telephone call and at the interview that their participation was strictly voluntary, would not jeopardize their care in any way and could be terminated at any time. All participants signed a consent form (see Appendix A) approved by the Committee on Human Research. Additionally, participants were informed that transcriptions of the interviews would not be identified by name; they were free to use a fictitious name, and that code numbers would be used to organize data. All data transcriptions were kept in a locked cabinet, and demographic data were kept separate from interview data to further ensure confidentiality. No names or other personally identifying information were used in written reports of the study. At the end of this research, all tapes, transcriptions, and other material were destroyed. The investigator made every effort to attend to the participant's emotional state and offered at the beginning of each interview to postpone or terminate the interview at any sign of emotional distress. None of the participants requested to delay or terminate the interview because of emotional distress, although interviews were frequently delayed for child care. The participants were offered the option of a follow-up telephone call to provide opportunity for expression of feelings or closure. None of them chose to follow up

with a telephone call, although three did request to see the final version of the research report.

Data Analysis

The interview process was guided by the principles of theoretical sampling although the intent of this pilot project is to identify major concepts, not to formulate a theoretical explanation of the phenomenon. Data collection and analysis are understood to represent parts of the same process in dimensional analysis. The following steps in the analysis process were followed: (1) transcription of data; (2) dimensionalization of data; (3) designation of categories. Each interview was immediately transcribed by the researcher. Transcriptions of the interviews were analyzed according to the operations of dimensional analysis to the point of category identification. During the early phase of dimensional analysis, the data are expanded as each dimension within the area of inquiry is recognized, listed, and grouped (Schatzman, 1991). This process is analogous to the open coding techniques described by Strauss (1987). Words of particular importance are retained, and others of apparent similar meaning are grouped into tentative categories. These dimensional categories are named (designated) so the analyst can recognize these new abstract categories, and grouped categories are further analyzed to determine the dimensions of each. In the process of dimensional analysis, when no new categories are forthcoming, no more data are collected. For the purposes of this pilot study, sampling stopped at seven interviews.

The goal of this small pilot project was not the formulation of theoretical statements. Rather, the goal was to discover tentative, novel categories salient to the experiences of women.

CHAPTER 4

Findings

Description of Participants

The seven women interviewed gave candid and intimate accounts of their lost babies, their griefs, and the changes in their lives. Their names and certain other identifying characteristics have been changed for the purposes of this paper.

Anne is 38 years old, and works as a mental health therapist. She has been married for eight years. At the time of our interview, Anne was 37 weeks pregnant, one year after the full-term stillbirth of her first child, Michael.

Belinda is 24 years old, and is at home with her daughter. She has been with her partner for one year. At the time of our interview, Belinda's daughter, Lisa, was three months old. Lisa was born following losses at 18, 19, and 22 weeks.

Corinne is 36 years old, and works as an accountant. She was interviewed in her hospital room, where she was on bed rest. Corinne has been married twice, most recently for five years. She in currently 36 weeks pregnant following losses at 12, 16, 18 and 34 weeks, and most recently the full term loss of her daughter, Amanda, one year ago. Corinne has four living children.

Donna is 39 years old, and works as a registered nurse in a local school system. She has been married for twenty years. At the time of our interview, Donna's youngest daughter was a year old, born two years after the loss of her son, Abram at 26 weeks and her daughter, Michelle, at 38 weeks. Donna has four living children.

Elizabeth is 31 years old, and works as a free-lance writer. She has been married for seven years. At the time of our interview, Elizabeth's son, Sky, was two years old. He was born four years after the loss of her son, Timothy, at 27 weeks.

Faith is 38 years old, and works as a registered nurse in the post-partum unit of a local hospital. Faith has been married for 12 years. At the time of our interview, Faith's daughter, Beatrice, was 7 months old. Beatrice was born less than one year following losses at 13 and 20 weeks. Faith has five living children.

Georgia is 33 years old, and owns her own service business. Georgia has been married for 15 years. Georgia's daughter, Carla, is 11 months old, and was born two years after her mother's most recent loss. Georgia has had four pregnancy losses at 12, 12, and 13 weeks, and most recently, her daughter, Charity, at 27 weeks. Georgia has four living children.

Categories Identified

There were seven categories identified from dimensional analysis of the interview data:

(1) Changes in internal, "spiritual" relationships, including dreams, visions, shrines to their dead children, and changes in their own ways of knowing the universe;

(2) Changes in ways of relating to others, including relationships with their children, their partners, their own mothers, medical providers, God, and other, "expert" women who have experienced perinatal losses:

(3) Changes in perceptions of the state of pregnancy, including before the lost pregnancy, after the lost pregnancy, deciding to attempt pregnancy again, and perceptions of the current pregnancy;

(4) Changes in self-perception and awareness, including loss of faith in (God),self and body;

(5) Redefinition of motherhood and life expectations;

(6) A sense of the price paid for experience, and

(7) Learning to be the mother of a dead baby.

Changes in Internal Relationships

Internal changes occurred simultaneously with changes in relationships with others. Changes in internal relationships involved a reordering of each woman's ways of understanding and knowing the world, and attempts to integrate her losses with her belief systems.

Dreams

Disturbing dreams following the lost pregnancy were a universal experience. These dreams involved lost babies, dead babies, crime scenes, and disturbing news delivered in a variety of ways. None of the women reported that these dreams created any great distress, only that they were a part of the immediate post-partum experience.

Anne-" At first, I had dead baby dreams, reliving labor dreams. At first all I had were dead baby dreams. Then I had a few dreams that were about a live baby, I was nursing a live baby, but it wasn't mine. It wasn't my baby. ."

Donna-"Yes. It's funny you should say that. I had one just a little while ago. In fact, right after Michelle's death- it was during that two week period , when inside I thought, "My baby's coming back. God's gonna bring me my baby back. They're going to call me from the hospital."It's just that somebody made a mistake. Also, I had this very vivid dream of being in my hospital bed in the same room. I could see the wallpaper, everything, all the details. And I looked on the floor, and on the floor were a bunch of dead babies. And they all had bruise marks and blood coming out of their nose. And they were all crawling towards the bed trying to come up to me. The floor was covered with them. Whoa!! That was such a vivid dream. I woke up crying, that's only happened to me a couple of times. I was actually weeping in my dream. I woke up, I couldn't sleep the rest of the night. And then, through the whole first year of Michelle's death, I had dreams of crime scenes, when you see that yellow tape. I had dreams of my other kids dying. I had dreams of trying to find her."

Several women reported a single, significant image or dream. While the images varied from revisiting scenes past to angels to reassurances from strangers , these dreams all indicated to the women that it was time to go on, that they had unfinished work to do, and that everything would be all right.

Anne-"And, I had this just a few days ago. I dreamed that I had to go back to a university town in the Midwest- either Champaign, Illinois, or maybe Iowa City, because I went to school in those towns- those were the towns I got my degrees in. But, I had to go back, because I had left some things there, you see, I had left some things undone, because I wanted to work on this other thing- this pregnancy, but my baby had died, so now I had to go back to do this. And my friend, one of my friends from work who was so great after the baby died, came with me, and a childhood friend, and that friend's mother- it's so weird- and we went back to this dorm room, where I had been staying, and then everyone said, why don't you just leave all of this, you don't have to do this, but I said, "I have to do this." So, I opened the door of the room, and there was this Christmas tree, and it had been there for a year in that room, but it was still alive, still green and the lights were still burning- they were red lights, and I thought, "That's amazing. They should have burned out by now." And there were all these presents, baby things, like a portable crib, and blankets, and toys, and some of them were wrapped, and some half unwrapped, and some were still in the paper, and I couldn't see what they were. And I left my friends, so I could take care of all these baby things, the things that had been waiting for a year. I just had that dream a few days ago.

Corinne- "Of course, the angels came to visit me, and told me that everything's going to be okay. It must have been Monday or Tuesday of last week. And I've felt good ever since then. They come and visit me all the time. They're in my dreams. I used to not pay attention to them, but now I do. The day that Amanda died they came to visit me, too. Little baby angels. The angels that came to visit me here were just looking down at me, and they told me everything will be okay. So, I think I feel, it's been a whole week now, and I feel better. I feel comfortable, I have a feeling of peace. I don't know if that has to do with my faith in God, that's why I feel this way, but I just feel like everything will be okay."

Donna- "Then I had one really significant dream that changed me. That was about ten months after her death. I dreamed that we were in a car. And this is how I knew that I was going to have other kids. There was my husband and myself, there was my son, and my daughter, , and then there was like three other people in this car. And we stopped at this store, and we went into the store, and we asked for directions. and we had this map and everything. And we got the directions and we got back in the car, and we drove down this road. And there was a hill- in a very beautiful place- with beautiful trees and flowers, kind of like our place here in the summertime. It was a combination of the most beautiful parts of all the places I've ever lived. And we were driving up this hill to this house- it was a Colonial house- I'm from back east, originally. And it was just perfect. It was just what I'd love to live in someday. So we drove up, and we got of the car. All my kids were with me, and there were some other kids there that I didn't even know. And we walked into the house, and there was this woman there. And she said, "Oh, it's the Freesons. Oh, and Donna, I have something for you, something very special. I know you've

been waiting for it a long time." She took our family back to another room, with this beautiful view- mountains, valleys, flowers, and the inside of this home was hard to describe, it just shone. A lot of white light, and lush, vivid colors. So she took me back to this room, and there was this baby. It was my baby. She helped me find my baby."

Creation of Shrines

All but one of the women reported creating some sort of shrine to the lost baby. The shrines consisted of pictures of the lost baby, clothes, blankets, objects related to the birth experience and other significant objects in some way related to the lost baby, as well as family pictures and objects of artistic and religious significance. Several of the women talked about the significance of natural items; and stones, shells, feathers and crystals were frequently seen in the shrines, even shrines created by women with more orthodox religious belief systems. Placement of the shrines was significant - in one case, the shrine was placed in the room originally intended for the lost baby, and moved to a shelf just above eye level when the room was redecorated in anticipation of the subsequent baby. In the other cases, shrines occupied spaces within common family rooms, but outside of open sight- usually on a shelf or in a cabinet just above eye level. The shrines served to create a place for the lost baby within the family- a place that would remain constant even as the family changed.

Anne-" At first, I set up a shrine to Michael, with his things, and his pictures... It's gotten smaller now... but it's still there. I know people- have friends- who just left everything right where it was, sort of a permanent tomb, a permanent shrine."

Corinne-"I went home and packed a diaper bag for her, which no child will ever use again. I put the few things that we saved from her in it, and called it her memory bag."

Elizabeth- "I have a little (shrine)-yes. I guess I do. Up there on the shelf. I can't give up the box, even though we threw the ashes out. And I have his pictures,

and that little Teddy bear we bought the Christmas I was pregnant. A few things like that."

Donna-" I have both their pictures up on my picture wall in the hallway, and... So how my husband and I coped with it is as the pregnancy progressed, we started writing down lists of what we were going to do to celebrate this baby's life. So, towards the end of this pregnancy, I guess I had a philosophical change, and I realized that this is the gift of life, and I'm going to celebrate even if the life is very, very short."

The one woman who had not created a shrine to her three lost babies had never discussed her pregnancy losses with her family or with her current partner, as the losses occurred during a period in her her life when she used drugs heavily and lived on the street- a period in her life that she, herself, did not wish to remember.

Changes in Ways of Knowing the Universe

All of the women talked about their changed perceptions of the orderliness and predictability of the universe. They all talked about no longer believing that things would turn out well, or that they would have any control over their lives. Four spoke of their fears that other family members would be lost to them, and of becoming what even they themselves determined to be overprotective toward their remaining children. All of them could articulate the basis for their over protectiveness, and all of them felt justified in their fears. No one spoke about wanting to change these behaviors. Although friends and other family members sometimes called these fears irrational, they all spoke of having developed a greater understanding of the unpredictable nature and the fragility of life.

Belinda-"Like you always think of the worst. You think of the worst thing that can possibly go wrong. I was just thinking, my kid's gonna end up with problems, and I didn't even know what the hell it would be."

Donna-"And I took things a lot more serious, and I 'd get really weird about my other children leaving my presence, I was afraid, I... I... I... I didn't trust God any more. So, I really didn't like God. (laughs) I was really mad at him. I thought, well, he took my child. What"s gonna stop him from taking another child? Or my

husband? Or somebody else in my life? And so I became very protective."

Elizabeth- "I think that the real outfall for me happened after Timmy was born. Because I was a maniac. I lived in morbid fear on a daily basis. I was terrified the entire first year. He..well, as you notice, we still don't have him (Sky) out of our bed. And people go, 'Oh, you wait. You're gonna want a husband again, and that baby's not gonna want to leave.' Well, I don't care. I know that its a little more difficult now, but the thought of having him that far away, at at the end...Forget it.

And I had a real fear of going out of the house for awhile. Nobody knew this about me. I looked highly functional. But I kept thinking, 'I can't take the baby to Washington Square- I'm going to get abducted. We're going to have a gun or a knife put in our side when I go out to the car.'

I am just now starting to ease up on that aspect. One thing I have always told people, and I believe it, but it does me no good in allaying my fears, is that all of these possibilities existed in the universe before you started worrying about them so all your worrying isn't going to make it happen,. and all your not worrying isn't going to prevent it from happening. I know this, but...I always have to have my eye on him at every moment. And one of my friends laid into me- she said that I was traumatized, and therefore I was over protective. I felt like her thinking was such a slap in the face to anybody who's ever lost a child. I no longer associate with her. I wanted to say to her that the only difference between the traumatized and the untraumatized is the traumatized know it can and does happen. I mean, trauma is just another word for experience. So, I don't know what kind of mother I'd be like if he wasn't my second. But I only have the experience that I have. And it's been very hard to relax. Ever since I was first pregnant, It's just been very difficult to believe that anything will be normal, that anything will be okay. The sense of vulnerability almost drove me out of my mind. I still have this sense of waiting for IT to happen, in one form or another. It's a struggle between wanting to present this normal face to the world and also getting your needs met. And my needs are, I am a hysterical parent. I am waiting every breath of my life for the bad news."

But I never go away without telling him I love him, and I never go away without thinking I might not see him again. Because every time could be the last time. I wish that there could be a way that I could stop thinking like that all the time. But I haven't found it yet."

Faith-" Because I had realized after that first miscarriage that I could lose this baby. The first time, I didn't know that could happen to me. I just didn't have any, any... because I had had only one doctor's visit the whole time. It was like it was...It's not that it didn't affect me, I mean I was very depressed, and...But it kind of had a cumulative affect, I guess. When the second one happened, I just started thinking that anything could happen. I mean, my kids could be here and then be gone a minute later. You know, you just start thinking that way, that life is more fragile. I guess before that, I just kept thinking things are just more stable. And after that happened, I understood that life really isn't that stable, that predictable. We really

don't know what will happen to us. "

Georgia- "I think I'm on the high end of overly protective with the children I do have.My kids are not left with teenage babysitters. There's just no way I can leave her- she's too precious.... Because I think, what if one of them gets hit by a car, or snatched? What if some horrible freak thing happens and I wasn't there? I think fears that are normal for parents are somewhat heightened for parents who have ever had some kind- something happen to one of their children And sometimes I think, Gosh, I've only got eighteen, twenty years with them to be with me. I want to spend the most time I can with them. I don't ever see leaving her with a sitter- that's just too uncomfortable. I'm just not willing to risk it."

Changes in Relationships With Others

In general, all of the women's relationships with others shifted from a dependent to nondependent status as they grew more able to articulate their own beliefs and needs.

Faith- " And I guess losing the pregnancies has kind of solidified that I can figure out what's best for me. I don't need somebody else to tell me what I need. I can figure that out. And if I feel that I don't want to do something, I should listen to that. And having the miscarriages, and the last seven months, have really solidified to me that I have to listen to myself. I don't have to say yes to everything."

Relationships with Partners

Women reported a range of changes in their relationships with their partners, ranging from strengthening to distancing. There was no apparent correlation between the direction of change in the relationship and the length or perceived stability of the relationship, marital status, whether there were previous children, or any other variable explored. Women reported their relationships with their partners were strengthened to the extent their partners were willing and able to communicate with them about the woman's reactions to the loss, and weakened by their perceptions of their partner's unwillingness or inability to attempt to understand the woman's reaction. They also discussed conflict over different coping

styles.

Anne-"It's good, I mean, this has made us strong, really connected. He likes to talk, he's a communicator. I'm the one who doesn't like to talk, who has to be drawn out. But it's been good, and he's really wonderful. I can't imagine life without him anymore. "

Donna-"My husband was not very helpful. He couldn't understand why I was so upset all the time."

Faith-"My husband is very- and maybe all men are like this, I don't know- but he's very task-oriented. It's like, I had the miscarriage, and medically it's all taken care of, you know. So cry for a couple of days, you know, and then move on with it. He never, he never has understood how deeply it has affected me.And it's caused some difficulties on our relationship, because I found that, initially, I was just crying, and telling him how I'm feeling. But after a few weeks, its like he was tired of hearing that and he didn't want to hear that, and maybe that was just my perception. So I just took it into myself. But that has made me less trustful of my feelings with him..."

Belinda-" I had a resentment towards him because I was pregnant- again- "

Corinne- "Oh, my husband's so mad, I mean my husband's so good. I have the most wonderful husband in the whole world. And he will do anything to appease me."

Subsequent pregnancies were often perceived as stressful times in the partner relationship, especially if the woman was unable to keep up her responsibilities as wife and mother due to pregnancy difficulties, or found it necessary to redirect her emotional energy into the well-being of the pregnancy rather than the family. Women reported conflicts concerning perceptions in role changes - their role as protector of their baby's wellbeing as opposed to their role as wife and lover for their husband's well-being.

Corinne"Because I'm on bed rest, a lot of things spill over onto him. We live in a thirty three foot trailer... And my husband would get embarrassed, and that would put pressure on me, for someone to see our house a mess. And so, it's better that (people) not come over. Because he doesn't want to put pressure on me. He's just now getting used to the mess."

Georgia"That was one of the most stressful times of our marriage, when I was

pregnant with (my subsequent baby). Because I certainly did not want to have sex when I was pregnant. That was like totally off limits. I don't know if I ever made that as clear to my husband as he would have liked. It was just,"We're not going to be having sex." That was totally off limits. And, I was irritable- I was on Terbutaline, which makes you irritable and jittery. And so, here he looked at me as laying on the couch all day with a nurse in here taking care of me and the children, and I should be happy, you know, and full of life when he got home.... And, to a degree, he understood that, because he wanted this baby as much as I did. But I don't think it was quite the same for him. I really felt that happened to us after (the loss), that we just were there for each other, even though he may have been grieving on different levels. We were still there for each other. But when I got pregnant again, I totally pulled back emotionally from my whole family to some degree. I wasn't there for him. I didn't feel like I needed to be there, like I should have to be there for him, you know what I mean?"

Relationships with Mother

Several women discussed their relationships with their own mothers. Some reported a degree of empathic response from their mothers, or reported discovering shared experiences with their mothers of which they may not have been aware before their own losses.

Anne-"Michael died just about a year after my father died. My mother's had a hard time - that's been hard for my mother."

Belinda- "My mom thought my pregnancy was the coolest thing in the whole world. From the time I turned eighteen she's been asking me 'When are you gonna have a baby? When are you gonna have a baby?' She said that most women, when they, when they have, or do, lose a child, they can get kinda iffy about the next one. My mom had five kids and lost one at five months old. My mom has had adversity, so... she knew."

For others, their experiences created a need to redefine the basis of their relationships with their mothers. These women described their relationships with their mothers prior to the lost pregnancy as ranging from strained to estranged - both of these women described feeling unsupported by their mothers during their experience of loss and subsequent pregnancy. The estrangement and the women's

need to process their experiences led in one case to further estrangement, and in another to a renegotiation of the mother-daughter relationship in order to meet the woman's needs.

Faith-"I don't have a very good relationship with my mother anyway. She had had two miscarriages herself, and maybe it's...I don't know if she ever grieved...When I had mine, I called her to tell her about it, and I didn't like talking to her and telling her about it, because she didn't hear my grief. She went on and on about what happened to her. It changed my relationship with her. I just found I couldn't talk to her about it. I don't really mention the miscarriages because I found that her going on and on about her losses was counterproductive to me feeling better, so I decided I would just let myself feel better, and if she wants to work on her grief, she can do it. Because I needed to take care of myself."

One woman described discovering that her initial pregnancy loss and subsequent pregnancy created a desire to reaffirm traditional family roles with her own family of origin.

Elizabeth-"My mom left me when I was a little girl. And the relationship was on again, off again contact with her, and I definitely didn't want any contact with her when I was pregnant with (my son). When he died, I had an overwhelming need to have anybody who could be be there for me. And I did have a need to let my mother know. A cousin called her on my behalf. And my mom did call, and she was pretty -mean- and she wanted to know what was the difference between my baby's death and the abortion I had.

So, it was obvious to me that I'm definitely not going to get anywhere with this mind. But It was interesting.... I have since created a relationship with my mother because it was something missing- when I was pregnant with (my subsequent pregnancy), I felt that if something happened to this pregnancy, nobody will know, again. The last time nobody knew because I didn't tell anybody that I was pregnant until after the fact. Now, I want people to know. And even though I wasn't up for the rejection, my need to have a mother in my life was pretty strong.... I realized how desperately I wanted to have a grandmother for him. The generational thread that had been pulled was very interesting. And that's something else that's very hard to explain to people who haven't been there, who don't have an estranged parent. So, anyway, things are pretty cool in that area now, but it was because of my profound experiences that I was even able to negotiate a different way of accepting my mother, and negotiate getting what I need from her, understanding what I'm going to get from her and what I'm not going to get from her. It works pretty well."

Relationships with Providers

All of the women spoke at great length about their relationships with medical providers. They all reported changed relationships with medical providers, including a redefinition of a competent provider. Some of the women chose to stay with the medical providers who had been with them for the lost pregnancies.

Corinne- "He's good, because he informs me in specific detail about how things work. It's not, 'We're going to try this, and we're going to try that, and see how it works.' He says, 'This here is a blocker for this and this here, and this here, and this is why it works.' And that makes (me) feel confident... When is doesn't work, he'll say, 'We'll simply have to use more effort toward it.' He's never iffy-anny. And he follows through with everything he says. He'd never say we're going to do something then not do it. He follows through. That makes me feel safe. Not all the doctors do that."

Donna- "I understand now how doctors function. It was pretty normal- even if their patient is having a difficult time. They, they, you know, it's delegated to somebody else. I chose the same OB for two reasons. Number one, was that she knew me, and I knew her, and her and I could communicate. I felt that that was very,very important."

Others managed subsequent pregnancies in ways designed to maximize their chances for a good outcome.

Anne- "Since this pregnancy, I've been doing things I wouldn't usually do-things that are quite unusual for me. I've been going to an acupuncturist, to, you know, to keep my energy in balance, and I've been taking these Chinese herbs. To keep my energy in balance. (This time) I had tests, AFP, the triple screening, and ultrasound for nuchal translucency, because I wanted to KNOW, if anything was wrong, I wanted to know about it. But, I didn't have amnio, even with my age, because it's invasive, there's a risk. I told them, 'Only if you really think there's a problem,- I don't want you to cause a problem, if there isn't a problem.'

The choice to stay with a provider or to change providers or management plans was dependent upon their trust in the provider's judgment and their ability to communicate with the provider. The woman's perception of her ability to communicate with her provider was seemingly more important in her decision.

Belinda- "I guess in a way they should have let me know that I was gonna be

okay if just...I don't know, let me know positive things instead of all the worst things that come, you know. Which I already know that, you know. They could have said positive things about pregnancy, about watching her grow, all that stuff."

Faith- "Uhm, I'm probably supposed to think he's like God-he brought me this baby, but I think maybe it's just his personality, ... he's very task oriented, and I would go in and I wanted somebody who would listen to me, whereas he wanted my urine, he wanted my blood pressure, the baby's heart is beating, and you're out of here. It was very much a conveyor belt type of office. I've been to offices like that, and I really wanted to change my doctor, but he's a personal friend, so that's been a little difficult to change. My doctor got me through it , and I'm very grateful and happy to have this little baby, and I feel he helped me do that, but he wasn't very understanding. And (after my losses), what I felt like should have been a half an hour visit, going over all this stuff, was like, five-ten minutes. 'Okay, your uterus is back to size, your vagina is okay...' Those are the only parts of you that matter. You're fine. Now go away. And that's where I felt this mistrust of him. And I just...I guess I've become more consumer conscious, but now I know I have to take care of myself. I can't rely on some doctor to tell me what to do."

Georgia- "We talked to a genetics counselor because of the genetic thing, but everything we talked about, everything was always medical. It was never, 'How are you doing as a person? How are you doing? This has got to have affected your life Can you talk to me about it?' I never felt like they really wanted to know how I was. I think they all wanted me to say, 'Oh, I'll be fine.' Because they would say 'oh, the chances of this happening again are so slim da da da da.' It was just like the doctors want you to have a subsequent pregnancy so they feel better, so they're okay. Somehow your failure to have a live birth, to have a live baby has something to do with them."

Relationships with Other Children

Three of the women interviewed expressed a need to shield their other children from the experience of pregnancy loss. They talked about wanting to protect the other children from their own grief, even if it meant they could not talk about their grief with the other children,and even if their own grief was intensified because of their inability to share it.

Faith- "My kids would come in and ask, "What's wrong, mommy?" I didn't know if I did this a bad way, or... My kids didn't know I was pregnant. My kids don't know that I lost these babies. And so, I'm kind of...I hid it from them, which has made it difficult. I haven't been able to openly grieve about it as I wanted to."

Two women actively included their children in the processes of grief, especially in planning memorial services and creating shrines, in the belief that including the other children would help ensure a place for the lost babies within the family.

Donna-"All of my children participated. My oldest child is sixteen, and he participated, he read something he had written for his brother. So it turned out to be a real family bonding experience. I went back to school on Tuesday, the day after we buried him. It hit my daughter the hardest, my eight year old. Since we'd already been through this once before, we knew what to do in terms of our own grief, so that was very helpful. We set up candles, we had a little memorial place for the whole week until his little funeral, we'd go out an buy things. We'd just walk through Target, or Fred Meyer, Meir & Franks- whatever caught our eye that was Abram, that was something we would buy, and we would put into his casket.

I don't want to leave the impression that all we ever talk about is dead babies. Our lives are very full. But we're very open about them in our home. And the older children do talk about the babies, what they'd be like if they'd lived. And we say that that's not the reality, the reality is that they died. I feel we've had a very good death dialogue in our home."

Additionally, the child born subsequent to the pregnancy loss was often perceived as the "other" child, differentiated from those born before the loss. Subsequent babies were often perceived as more fragile and vulnerable than those born before the pregnancy loss, in keeping with the general perception of life and well-being being less predictable.

Relationships with Expert Women

Four of the women discussed changes in their relationships with other women, especially with women who had experienced pregnancy loss. They described shared experience as a shared knowledge, and as a bonding experience that crossed social and cultural lines.

Anne-"The other thing that's been most beneficial, most helpful during this time has been the support group. I've been several times, actually, we've both been, even though it's mostly women. It's good to know other people have been through

this, (that) other people think this way. It's good to know, to be able to say things I can't say to anyone, no matter how close or supportive they've been. All kinds of women go, from different social groups. It's interesting, really, in a detached way... to see what's the same across lines."

Donna-"(With my subsequent birth),they gave me a very good nurse, who had lost a baby to SIDS. So she kind of understood that I was feeling two things at the same time. I was feeling anxious that the baby was going to die in labor, but at the same time, I was feeling ambivalent about this child, because I really hadn't bonded. But she was very helpful. It was good to have a nurse who had had a loss, and who could discuss it. Because she, she kinda knew."

Elizabeth" I was appreciating more and more the situations of other women, what they went through. There were a lot of things that didn't happen to me. I was grateful for. It wasn't really that I was counting my blessings, but I don't know."

Faith-" But there isn't anybody close to me who's had a miscarriage to talk to, and when I talk to somebody who hasn't had a miscarriage, their eyes, I mean, they just don't understand. And I know the feeling, because I didn't understand before I HAD a miscarriage. I mean, I thought, "Oh, you lost a baby. Well, go have another one." That's how I felt before. ... But I think I'll always have..I mean, I really have gained compassion for people who have lost children. Right after Beatrice was born, my friend's sixteen year old died from sniffing butane, and I just can't even imagine how she can go on. "

However, one of the women described a feeling of separation between herself, the survivor of an involuntary loss, and women who had terminated their pregnancies for medical reasons. These women were perceived as having chosen their loss, and their experience was perceived as having different qualities.

Georgia- "(T)hat's a hard thing in our support group, so hard that we've now separated out. We now have a medical termination group, you know, we put to a separate group. Because there was so many of these feelings of women like me. I didn't have a choice. It wasn't something that I chose to go through. I still haven't gotten it. They chose to do that. Their grief was a chosen grief, over mine. And granted, they would have grieved when their babies were born over the loss of a healthy life and all that, and the loss of the healthy baby, or the baby who didn't survive. I have a really hard time with that, to be honest."

Relationships with God

All of the women talked about their relationships with God- some were

prompted to talk about it, while others talked without prompting. The women described their relationships with God as encompassing faith and understanding. Two women found their relationships with God as having been strengthened by their experiences.

Corinne - "And I had a realization last year that just because you want something doesn't mean that God's gonna give it to you. Because we prayed, we prayed our little hearts out for Amanda to live. My reverend said, "When you're praying, you always don't get what you're praying for. You need to pray for God's will to be done, not what you want." I think God has a reason for everything. And we don't know what it is. We're not allowed to know. We might not ever know what it is."

Georgia- "I never, I never was angry at God. I, I didn't go through that. I think I've actually become closer to God because he was merciful to us. But if she would have made it to term, she would not have lived more than a couple of hours, at most. And I believe she would have suffered in those couple of hours. So, I look at my God as being merciful to her, because he took her home before she had to go through that. Yet, I also don't believe that it was God's will that she was handicapped, I don't believe that God said, 'You guys are going to have a handicapped child.' My religious basis is that we live in a world that fell when Adam and Eve sinned, and in a sinful world, bad things happen both to good and bad people. I believe God does the best he can to make a bad situation tolerable. And I believe God won't give you anything you can't handle. He won't let you go through it alone. And I really believe that my faith - is what made me come though this. Because I've never looked at God as being an angry or a mean person. And I know some people have this image of God as playing with them, like toys. I don't look at him that way. He created us in his image. I think he suffers when we suffer. He never created us to be fallen from him in the first place. No. I'd say my faith- has only gotten stronger through this. God suffers right along with me. He sent his son- he lost his own son. So he's got to know what I've been through."

One woman talked about not depending on God to solve her problems and that this had strengthened her relationship with God.

Faith- "It's been...I guess my relationship with God probably got stronger. I felt more, during the miscarriages and during the pregnancy, I felt like I had to rely... there weren't any answers out there for me as to why this was happening, and I guess I kind of relied on, I guess one thing was I kind of relied on God to help me get through it, you know, by praying about it. But now that I've, I guess it's just because I'm so busy, but since I've had the baby, I've kind of gone down as far as spirituality. And part of that is I just don't have time to sit ant ponder it any more. I've got other

things to do. But I spent so much time...I had to have an hour every day just to sit and think about stuff, after the miscarriages, and when I was pregnant. I just needed to sit and be quiet for an hour and think about stuff."

Another woman described her relationship with God as confused by her experiences.

Belinda- "I guess maybe I was confused about why God makes the decisions to let a woman get pregnant and then take that child away, or whatever, for whatever reason. I don't know. I don't know. I mean, with me, it's probably best explained that God could ever make more than he has to. It's scary, confusing, and frustrating all at the same time."

Changes in Feelings About Pregnancy

The seven women interviewed reported that their feelings about pregnancy were changed by their experience of pregnancy loss. The women who had experienced pregnancies prior to their losses reported that their feelings about pregnancy did not change with each successful pregnancy, but were changed with their lost pregnancies.

Donna- "Very much wanted, very much loved. It's almost like you fall in love with your babies before you have them. You know, that contemplation of getting pregnant, I think women go through feeling when they fall in love with the idea of pregnancy, then they fall in love with their pregnancy, but there's always moment, in the first three months, when you wonder, 'What did I do?' (Laughs)"

Georgia- "I guess for me, especially with my first losses, (at 11, 12, and 13 weeks) I never had ultrasound- it wasn't routinely done, especially at my age. I never felt pregnant, because I was young, and I never got to the stage of needing maternity clothes. So, in my head, it was -especially with the first two early losses - it was always,'We're gonna have a baby.' It was like telling somebody, you know, 'We have this' or 'We're going to do that'- part of that was my immaturity."

<u>Before Pregnancy Loss</u>

All but one of the women reported that the lost pregnancy was a wanted pregnancy. Several of the women had planned the pregnancies they lost, and some

had waited years to become pregnant. In three cases (Donna, Faith, and Georgia), the lost baby was planned as the last baby in the family. All but one of the women reported being happy with their lost pregnancies. They used words like "happy", "ready to be a mother", "strong", "powerful","womanly", "loved", and "cool" to describe their pregnancies. While only two of the women described motherhood as their major life goal, all of the women described it as an important part of their life plans.

Anne-"I was 36. I was so happy- I mean, I was ready to be a mother. My husband was happy, too. If anything, he was more ready than I was. I was a little nervous, also- because of my age, I had bought into all that high-risk thinking. I had the whole works, the MSAFP, the amniocentesis, the ultrasound. And all the tests showed he was okay. I mean, he was okay... My pregnancy was a good one- I wasn't sick, didn't get very tried, I felt great. I read all the books. Everything was going the way it was supposed to go."

Corinne-"I'm one of those women that, when I was six years old, I wanted a hundred kids because I didn't know you couldn't have a hundred kids. I was like, 16, when I had my first miscarriage. And I remember the nurses coming in and saying things like, 'Well you're too young to be mother anyway.' You know, babies having babies. Well, I was married, and my husband and I got married because we wanted a baby. You know, you can't have children if you're not married, so we got married. Matter of fact, we had to go through changes to get married."

Donna- "My husband and I wanted to have six children in our family, I know that sounds like a lot, but that was what we wanted. So we got pregnant again soon after the birth of our second child, and that was my daughter Michelle and that pregnancy was uneventful. I had no problems with the pregnancy, or with getting pregnant after that period of infertility.... Very much wanted, very much loved.

Elizabeth- "I remember when I was pregnant, one day saying to my husband, 'You know what's so cool about this? I have no idea what to expect.' I have no idea what this baby's going to look like. It's just such a cornucopia of fantasies. Wow."

Faith- "I loved being pregnant. I know some people hate it, but I just loved being pregnant. I've always felt stronger, and bigger, and more powerful, just feeling that life within me.... My husband- we used to enjoy watching the baby move, even with the third and fourth kids.... I was kind of surprised when I got pregnant. We had kind of planned to have another baby, but it seems like with Catherine, it took me a little longer to conceive, because I was thirty-two at the time. It seems like as I

get older, it takes a longer time to get pregnant. But, I got pregnant right away, which shocked me. I didn't go into the doctor's right away because I thought, 'Oh, I've done this four times. I don't need to.' "

After Pregnancy Loss

All of the women interviewed reported feeling a betrayal or loss of faith in their bodies following their pregnancy loss. The sense of betrayal stemmed from a belief that pregnancy and birth were "simple, basic biologic functions" that any female could do, but they could not. Their bodies could not do this simple, basic thing.

Anne-"My feelings about myself (changed). Oh, definitely. I felt absolutely betrayed by my body. And I've always been a very active, very physical person. I've always been able to do what I wanted to do. But my body couldn't do this simple, basic thing."

The women also talked about their beliefs that they had "done everything right"- they had followed all the conventional prescriptions to ensure a healthy baby, including diet and lifestyle changes. Several of the women expressed their feelings that pregnancy is an experience different from the birth of a child. They gave equal weight to the experiences of pregnancy, birth and mothering the unknown child.

Elizabeth- "I wanted the experience .... I wanted something normal- and I couldn't have anything, it seemed.... None of the peak birthing experiences would be mine."

Some described a lag in time between grief over the lost pregnancy and the realization of and grief over the lost baby.

Donna- "I remember it took two weeks, till the numbness wore totally, wore off enough till I actually realized I lost a child. And I remember that. I remember crumbling to the floor, in agony, and moaning, and just crying out to my child two weeks later at home, and realizing that had I lost everything- my pregnancy, my baby, this part of my future, my belief. You know. It was just, just, just incredible to me."

Deciding to Attempt Pregnancy Again

The change in perception of pregnancy as an experience affected their plans for other pregnancies. They talked about deciding (or not deciding) about another pregnancy in various terms, of why, when, and whether to attempt another pregnancy. Some did not make active decisions, instead allowing themselves to become pregnant if it happened. Others waited for various periods of time for various reasons; some on the advice of others, some on their own council. Others did not wait at all.

Anne- "I just wanted to be pregnant again, like there was this great, unfinished thing I had to do. I mean, I liked being pregnant, but there was something I just had to finish. I got some advice, from friends, from some doctors, to wait six months, so I did, but I was ready to get pregnant soon afterwards, really soon after Michael died. I didn't really do anything to prepare, other than wait. No rituals, no medicines. I didn't really think about how it would be to be pregnant again. I didn't have any ideas. I just felt, I'm 36. I want to do this now. Especially since we want to have more than one child- I never wanted to raise an only child. So I wanted to keep going onward."

Belinda- "Well, I had three (losses) before her- she was my fourth. So, when it came to her, I was, like, oh right on. Then after awhile it was, Oh, God, why me, then it was a while before I was, like, Please, let this one come out all right."

Corinne-" (I hoped) that there would be another child, always that there would be another child."

Donna- "And then I remember just being emotionally numb for six months, and not being able to think about anything except for, number one thing I thought about was getting pregnant again. Soon as you lose that baby, when you get the message that baby is gone, you become a sex fiend, you look at your cycle, you look for mucus, you say, 'I've gotta have a baby, I've gotta fill my arms up, I've gotta have something.' Because you think having another baby, having a another pregnancy is going to do it.... And,so, I lived through that. I told my husband, I said, 'We can't do that.' Because to me, my daughter Michelle, my full term stillbirth, deserved the space in the family. I don't know what it is, but to me, I wanted to allow her the space in the family that I'd normally would put there if she was alive. I didn't want to fill in my time, my time with her in grieving, in adjusting to the loss, with another baby. On one hand I wanted to, on the other hand I didn't. So, I wanted to

respect her as a person. Does that make sense? So, we purposely did not, we said a year.... But, I had enough faith, and we wanted to have more children, that we, that I was willing to try again."

Faith- "It was, you know, I was just devastated. I couldn't stop crying. But then I, I guess I thought, "Oh, this will never happen to me again, I've had my one. Everybody has one miscarriage. It'll be over with " So, that was September that I had the miscarriage. I got pregnant again in January. And then I, I just thought, "Okay, I'll just recover from this, and go on and have another baby. And that didn't happen. But I knew I wanted to have a another baby. It was as soon as I knew that baby was dead. And I read a lot of books, and some books would say, you know, don't rush right into it. Wait until you're ready. I didn't listen. I didn't want to listen to that. I wanted to...I guess because of my age, too. I didn't want to wait a long time.

I don't know- I guess I just kept on trying to figure out what these books would want me to feel, so I would know I was ready. I couldn't figure that out, and I just knew I wanted to have another baby. And part of that was a replacement for these babies I lost. All the books said don't have another baby as a replacement, but I know that's how it felt. I still wanted a baby, even though I'd lost those. The losses didn't wipe out my desire to have a baby. And even after the second one, I wanted to have a baby right away. And maybe that's partially just to help me feel better.

I was very anxious to become pregnant again. I was, I mean, it was probably part of grieving, but I was almost desperate to become pregnant. I just felt like, "I have to do this." It became an obsession."

Georgia- " It was just like, don't get attached, don't get emotional about it. Just get on with the task of getting pregnant. Have another baby. So, I got pregnant three months later."

Feelings about Subsequent Pregnancy

Most of the women reported feelings of anxiety during their subsequent pregnancies. These periods of anxiety were especially strong during the traditional peak moments of prenatal attachment, including quickening and hearing fetal heart tones. Three of the women had borrowed Doppler ultrasound monitors from their prenatal care providers. One woman described this technical intervention as beneficial, while two described it as increasing their anxiety.

Additionally, all the women reported anxiety over the issue of whether to

wear maternity clothes. Four of the women said they never wore them during the subsequent pregnancy. They saw wearing maternity clothes as a public declaration of their pregnancy and their attachment to their baby.

Corinne- "I don't wear maternity clothes. I don't even get my baby things out. They stay in a box, in the closet, until the baby comes home from the hospital"

Donna- "I refused to wear maternity clothes. I wore two pairs of my husband's sweatpants until I delivered"

Faith- "And I just, I remember I did not wear maternity clothes. I was four months along, and I was wearing my jeans. They were practically unzipped, because I couldn't fit my belly in, but I was not going to wear maternity clothes. And, in fact, I never bought any maternity clothes. I know it was the miscarriages that made me not want to even think about being pregnant. I guess I kept thinking, 'I'll wait another week and then get some clothes. Oh, we'll just see how the next doctor visit goes.' By the time I got to eight months, I thought maybe she'd get here, but by that time I thought it was stupid to go buy something I'd wear for only a month or two. So I wore sweatpants and my husband's T-Shirts and scrubs at work."

Georgia- "I refused to wear maternity clothes. I was too afraid. I tried not to hear her heartbeat at my doctor's appointments"

The women reported a great deal of anxiety , anger, and ambivalence about the early pregnancy period during their subsequent pregnancies. The ambivalence was related to fear that the baby would not survive.

Anne- "I must have driven everybody crazy. I remember one time, there was a time I was supposed to wait six weeks in between visits at the Birth Center. I just couldn't. I just couldn't. There was a time I was calling there every other day or so. I felt foolish calling all the time, but they said it was okay- it was just a part of this pregnancy, like a medical condition might be part of someone else's pregnancy.
So, I went in every two weeks, even if just to hear the baby's heart beat. I felt better hearing the heart beat, like it was still real.We got a Doppler from a midwife at the birth center-I used it a lot when I was freaking out in the first and second trimester. I just gave it to one of my friends, because she's there now."

Corinne- "I've developed this 'I'm not going to fall in love with my baby' feeling....What did I feel (during my pregnancy)? I felt angry. I had hate. I wasn't really sure who I was angry at. If you asked me then, I couldn't tell you who I was angry at. And I couldn't even tell you why I was angry. I just didn't know. I just knew that inside I felt uhm.. I was angry at my husband, I was angry at my children,

you know. And there was no reason for me to be angry, because they all bent over backwards to appease me....To me, I just felt like I was angry at the whole world., and I couldn't pinpoint it. "

Faith- "I can't pick out one or two...I mean, just from the very beginning. I went in at six weeks, and they did a vaginal ultrasound. And I was just super-aware of anything that was going on. I was in there in the office every two- as a matter of fact, I think I had appointments every two weeks until well into the second trimester. And the doctor gave me a fetal monitor so I could monitor the heart beat at home. It was good..and yet it was difficult. I think he gave it to me around ten weeks, and it was very difficult to find the heart beat, and so I remember in March of last year we were going to drive up to Seattle, and I just all of a sudden had this...I mean, it would come in waves. I'd be okay, and then all of a sudden I'd get this panic, like I was sure there was something wrong. We were getting ready to leave, and I just couldn't leave until I knew if the baby was okay. So I got the Doppler out, and I couldn't find the heart beat . And this was on a Sunday. So I told my husband that we had to wait until I went to the doctors Monday morning and they found it. The panicky feelings went away after awhile. I mean, I just decided. I mean, not that I didn't still have those panicky days. But I decided I was not going to stress myself so much about it."

Georgia- " And all I did for the first four months was cry and worry that she was going to die. I didn't attach, because I became, I had to, I put up walls. I mean, I was attached- I know that looking back, I would have been just as upset to lose her. But we put up walls to protect ourselves. I had no guarantees that this baby was going to make it, and I was just scared. I just wanted to get to six months. All I could think was, 'Get me to six months, tell me there's no anomalies, tell me that she's a healthy baby, you know, and maybe I can attach at that point.' There was no way I was going to get all psyched up to have a live baby and have her die."

There were new and different sources of anxiety as pregnancy progresses.

Anne- "The anxiety has calmed down a lot. I still have my moments, but there's mostly around the thought of labor, now. I can't imagine that, can't picture it. My labor with Michael was so easy, so fulfilling, I don't know what it will be this time. I'm afraid.... I'm afraid it will be hard to let go, hard to give in, hard to let my body go. I haven't talked with anyone about it yet, I don't have any plans. Well, a few plans. This baby will be born in a hospital. The perinatologist I talked to said no, there wasn't a problem, per se, I'm more at risk because of my age than any other reason. He recommended I labor and give birth in a hospital, just because of what happened last time. It isn't what I really wanted, but what I really want is a live baby.

Donna- "As the pregnancy continued, and I continued to grow in centimeters, I got more anxious. I quit my job sooner, I sat around more. I was more cautious, I did more kick counts. I chose not to have a Doppler- some people choose to have a Doppler at home for their subsequent pregnancy. Well, I chose not to. I used one for a couple weeks, and I was a mess. I was crying every day. I'd sit there with the Doppler, and if I couldn't hear the heart beat right away, I would just freak out. And I'd be hysterical- no, not hysterical. I'd just hyperventilate. And I realized, I just can't do this. This is not good. I think it raised my blood pressure. So, I said 'No Doppler.' "

Faith- "But when I was in labor, when I finally gave birth to her, it was always on my mind that there could be something wrong. I wanted to do no drugs, and I had done that before, and it was just a very satisfying experience for me. And the labor had lasted all evening, and it was midnight, and I remember thinking, 'I don't want to go through all this pain, and what if there is something wrong, and I have to go through all that pain.' So I said, 'Give me the epidural. I can only deal with one stress at a time.' "

The women also described difficulty thinking about the baby as a real or potential person. Instead, they focused upon becoming pregnant, being pregnant, and maintaining the state of pregnancy. In many cases, achieving and maintaining the state of pregnancy was more real to the women than the imagined or potential baby, even to women who had other children. The inward focus on being and maintaining pregnancy often precluded sharing the pregnancy with the outside world. Outward denial of the pregnancy allowed protection from hurt.

Anne-"So I didn't really think about it. Because I'd already thought about it- already thought through having a baby. But at the same time, I wasn't thinking about having a baby- I was thinking about being pregnant. Early in the pregnancy, I had a really, really hard time focusing... I haven't had any dreams about my own baby. I don't know what she looks like."

Faith- "I guess that thought is what I was thinking about with the pregnancy. I mean, I was in total denial about being pregnant when I was pregnant. Here I was obsessed to become pregnant, but I didn't tell people until I was almost five months along. I didn't ever get the baby clothes out. When we brought her home from the hospital, that was the day my husband said, 'We'd better get the baby clothes out. She's going to need some clothes.' I didn't get out any baby clothes. I didn't put up the crib.... She was five months old when I put the crib up."

"And it's just now that I'm realizing what a state of denial I was in. I was completely- I guess I was protecting myself. I wasn't allowing myself to really accept

that I was pregnant because I was thinking subconsciously that it would somehow protect me- even though it wouldn't. I know I would have been completely devastated if I'd lost it. But it just felt like a protection, like I would maybe not feel all the pain. Maybe it would feel less painful if I lost her. So, it was a very strange pregnancy, whereas with my four other kids, I just celebrated my pregnancy. But with this pregnancy, I didn't at all enjoy it. I mean, there were moments when I liked it, but I was never able to sit back and relax and say, "I'm pregnant." and feel this baby move and kick. My husband- we used to enjoy watching the baby move, even with the third and fourth kids, but not with this baby. We never just watched her. He hardly ever touched my stomach to feel the baby kicking or anything. We were very,very hesitant. We didn't even want to think about it. We'd hope that she would get here, but until that time, you know, we couldn't even allow our minds to feel she existed."

Donna-"It was a textbook pregnancy- the only thing was that I had difficulty bonding. I didn't want to bond with this baby. I felt like I was just going through the motions, and I had a difficult time bonding with this baby. It was different because I felt like I was walking to a death. I was getting pregnant to give birth to a death. And, there was just no way I could see my body producing a live baby."

This inward focus had another dimension for some of the women, who described a somatic memory of the more powerful moments of their lost pregnancies.

Donna- "Because, my last experience of my dead baby emerging from my body, and being there dead and lifeless, is so imprinted on my brain. Even now, when I'm talking to you, I can see her. I can see her. I can see her."

Elizabeth- "And certainly your body remembers. And this is the other thing, too. This isn't even a theory. This is just something I have observed over and over again in action. You can say, 'Oh, I'm over IT,' or 'Oh, I won't think of IT today.' But your body, has a cellular memory of those anniversary times. It's just wild. And I've heard from plenty of other women, and certainly myself, 'Why am I feeling so crazy today?' or 'Why am I feeling...?' and I'll realize, 'Oh, this is my LMP, or this is the date I found out I was pregnant. You know.' Some of them are pretty obvious. I know his birthday. I know my due date. But I'm not always cognizant of the date of the day I went and had the ultrasound. But if one realizes that we have that type of cellular memory, then think of how many other things in our lives we're storing up, that could have been looked at, or bear looking at now."

Changes in Feelings About Self

The period of time after the lost pregnancy and during the subsequent pregnancy was marked by a lowered sense of self-feeling and self-esteem. Some of the women differentiated between a loss of faith in their bodies and a loss of faith in themselves. This was sometimes articulated as a loss of faith in their ability to be a good mother or as a loss of their sense of self-worth, and two, Corrine and Faith, experienced periods of marked depression. Some felt the subsequent baby to be unsafe in their body, and safer in the hands of medical experts.

Corinne- "(I)t makes me feel like I want to give up. it's not worth keeping the baby inside of me. They can do it better than I can, anyway. They, the doctors and nurses. The ones in the nursery."

Donna- "When you have had a baby die in utero, you feel like your womb is a death chamber, especially for stillbirths. When you've had a full term stillbirth, you feel like your womb is like a death chamber, and this baby is at risk for dying. You get really strange toward the end of your pregnancy, like, "Get this kid out. I don't trust my body anymore.... Uhm, I hated myself. I hated my body. Because, not only had I gone through the infertility, lost all those years as a young person, by now I'm in my thirties, and , so, look what happened. So, my body just can't be trusted.... And, I was scared, because I felt my womb was a tomb, and that I was just asking for another baby to die."

The Price Paid for Knowing

All of the women talked about paying a price for their experiences. Some of the women talked about their losses as maturing experiences, as somehow having learned something from all this. Others described achieving an enlightenment from their losses. They described a need to get ready for life, a need to be prepared for the unknowable. They learned that to understand the unknowable, they must somehow make it meaningful. To make it meaningful, they must go thorough it. At the same time, the women interviewed spoke about their willingness to exchange their enlightenment for a chance to have the lost baby, and their profound

understanding that this could never be.

Anne- "There's nothing I wish were different, except, of course, I wish he had lived. But then, I wouldn't have this baby. So, what can I say. What can be different? Nothing can."

Belinda- "Because at the time (when I was pregnant), you know, I didn't think I was ready for it. I still wasn't ready for it when she came. I guess in a way it kinda teaches you how to get ready for it."

Donna- "People think they have everything planned, everything under control. But this is life. Life throws you stuff. You've got to learn to deal with it. You've got to be resilient. If you don't learn it now, you're going to learn it sometime. Some people don't learn it until they're old, and it makes them sick, and then they die. I wouldn't wish anybody's baby dying, and its sad when it happens, and its tragic, it's not something you ever want to have happen. But in order to make it a meaningful experience, I think you have to go through the grief process, deal with it, and make something out of it.

Elizabeth- "I hate to say the word, but it's helped me to mature. There's an enormous freedom to be had in that understanding. Don't get me wrong. I mean,I would trade all of that understanding back if I could be ignorant and have that baby. But, I can't have that baby....

I have to assume that God was in that room, putting those nurses and doctors there, making that decision. Because I could have easily died. In another place, or day, or age, I would have definitely died.... And the thing is, I could have said, 'NO, this is an abortion, and I refuse it. I don't believe in it, and I'm religious, and therefore...' But then I would have been dead, and I wouldn't have been around to rethink my decisions, and I wouldn't have been around to give birth to Sky. Or to any of the other children I hope to have. So it adds another very interesting dimension to these arguments. Where does God stop? Where does a decision stop, or a cause and effect? Yes. Timothy died because he was going to die anyway. Then the question is, do I die with him or not? So, I didn't. And I got Sky. So... And I got Sky with that experience. The good news is, I got that experience, I did it in the modern era, where even in a world filled with all this prejudice and ignorance, it's still a lot better than it used to be. And therefore, I was able to really heal, and really come out of it evolved. So maybe all of this has nothing to do with any of us, except it was Sky's destiny to have a mom who had a stillbirth so that she could be enlightened, so she could know how important he was. To know that loving him is the most important thing, and that everything else will pass."

Faith-"When I think about the miscarriages, the thing that comes to mind, that really hurts is that empty feeling I had laying on the gurney in the hospital, and that empty feeling that I had when I came home to my house and it was all cleaned.

I remember coming home from the hospital and thinking that if the price of coming home to a clean house is to not have this baby, it's not worth it. It was just so empty feeling. And I don't know if that will ever go away. I imagine in time that it will lessen... But I feel I've really learned something, really grown.

Redefining Expectations

The women talked about a period of internal reflection and refinement of their expectations of the process of pregnancy and birth. Even though they had definite desires about their pregnancies and births, these desires became redefined. This redefinition was frequently expressed as the wish for a live baby, at the expense of any desired birthing experiences. They came to realize that the baby was the significant factor in the experience of pregnancy and birth, and while they valued all of their previous experiences and plans, the experiences themselves were not more significant than the baby.

Anne-"I feel like I had such a perfect birth last time, such a perfect labor, anyway, that I don't know what I want this time. I , well, what I want is a baby, a live baby I can take home with me. That's what I want. I hope it happens the way I want it to, but what I want is a baby."

Elizabeth"I wanted that experience of seeing his head come out. I wanted that experience. I asked my doctor, 'Can I do this the other way?' She was really hesitant about (a vaginal birth). And I really wanted to defer to her. Because if something went wrong, then how was I ever going to forgive myself? Then it was going to be a lot more in my hands. And I figured, whatever it took, that's fine."

Redefining Motherhood

For many women, the process of redefining expectations also encompasses the redefinition of motherhood. They had (or had not) dealt with their own inability to give birth to a live baby, and for many, that experience also changed their perceptions of themselves as mothers.

Belinda-"What does it mean to be a mother? You mean me? I don't know, I just started. I don't know. I guess it means paying attention to her, giving to her, giving her what she needs. I think being a good parent is just being there when your kid needs you, being someone that your kid can talk to about whatever. When

I was pregnant, it meant giving her all the stuff that I never had when I was a kid. I was angry about that, too, I was afraid I couldn't do that.

Donna-"Well, you know, in a way I feel very grateful- my concept of myself as a woman. Because, I think to be really human, sometime in our lives, all of us will experience deep sorrow and great joy. It's just part of being human, of being a person, of being a soul. And I feel very fortunate that I've experienced both of those. And they've all been centered around my children. So I feel very fortunate in that regard from other women. I've had some real highs and some real lows. And other people I talk to have their lives, their storybook kind of lives. I feel sorry for them sometimes, because they aren't really getting into the depths of life.

Elizabeth- "It doesn't mean that I don't have a positive outlook. I understand that he's not here because I deserve it. He's here because he's here. I expect that things will be okay because I don't have any other evidence. One of the things this experience has taught me, and that I have to keep reminding myself about, is that good things can happen too. And that really got me through a lot."

Learning To Be The Mother Of A Dead Baby

Three of the women interviewed volunteered they had achieved some sort of resolution concerning their losses. These women all talked about their process of finding a place for the dead baby within the family, just as one would make a place for a live baby in the family.

Elizabeth- "Grief will either sit dormant or it will work through. That's why women who had miscarriages forty years ago and finally are given permission to think about that as a loss, and they break into tears. My husband's aunt lost a baby forty years ago- FORTY YEARS AGO- and she never talked about it. I find it interesting that no one in my husband's family talks about it. I asked one of the aunts, "What was this baby's name?" And she didn't remember. She was a live baby who was a baby, who wore dresses and was googly, and no one remembers her at all. She has no place. No wonder my husband's aunt drank herself to death."

Georgia- "We didn't wait long enough. We should have waited a year. I now understand why they recommend a year. You need to parent, you need to give to that child you lost. You wouldn't recommend someone go out and get pregnant right after a live birth.

This place making was accomplished by allowing the lost baby physical and temporal space - physical space in the form of photographs and shrines, temporal

space by consciously or unconsciously allowing the dead baby the same amount of spacing as one would allow a live baby within the family.

Donna- "And on the one hand, you just want to fill your arms up with another baby, but, intellectually, I knew needed to give her that space. Now, everybody's different. I find, I talk to people in our group, and they want to have another baby, they're ready in like, two months. They have their own reasons. And for me, I wanted to give her space and time. I wanted to respect the grieving process.. And I'm really glad I did. During those two years, that we didn't pursue another pregnancy, as a family, we were able to communicate. I felt like I was, in a way, mothering Michelle. Because her anniversary, holidays that came up, we would do special things. We took a lot of time and got a really nice headstone, and put it on her grave. We instigated rituals in the family, that are around her. I think if I'd been preoccupied with another pregnancy, she wouldn't have had that time. I wouldn't have given her that time and energy that I felt she deserved. So, I'm really glad that I did that."

Elizabeth- "But what makes having a baby so special? If a woman were to give birth, and just get up from the hospital and go, "OH. I forgot the baby. I'm just not used to this yet. I don't have any concept of this person. I've never met him before. So why would I immediately think of this in my life?" You'd be appalled. You'd call the police. Why do we have baby showers? Do you bring cute little clothes and do cute little games for dead babies? No. You expect something. Something. And whatever makes that moment special with a live baby is exactly what makes it grievous with a dead one. And exactly what you can't think about with another baby. There's no separation. I couldn't think of one example of a live baby that you wouldn't grieve over a dead baby. It doesn't go away. It's right there. You learn how to be a parent to a dead baby. I'm understanding that dead is really dead. I mean, it's so final. There's just no ...But I move on. I can be a mother to a live baby."

For these three women, accepting that "dead is really dead", and moving on to become the mother of a live baby involves learning to live with grief and joy together, and to give place to the dead baby while maintaining faith in the possibilities of the unknown. They were then able to give a place to the subsequent baby.

Donna-" So how my husband and I coped with it is as the (subsequent) pregnancy progressed, we started writing down lists of what we were going to do to celebrate this baby's life. So, towards the end of this pregnancy, I guess I housed a philosophical change, and I realized that this is the gift of life, and I'm going to celebrate even if the life is very, very short."

Conclusion

For all seven women, the experience of pregnancy after pregnancy loss was marked by feelings of anger, anxiety, loss of faith and trust and a redefinition of expectations of self, others, and the experiences of giving birth and being a parent.

For Belinda, Corinne, and Faith, the experience of pregnancy subsequent to pregnancy loss was marked by anger, anxiety, ambivalence and depression. For Anne, Donna, Elizabeth, and Georgia, the experience was marked by the same experiences. However, for these four women, transition from those experiences was marked by finding a place for the lost baby within their own selves and their families, redefining relationships with others, especially medical professionals and their own parents. Spiritual changes in the transition included learning to live in a world where anything can happen, and learning to be the mother of a dead baby. All of the women experienced dreams of lost babies and violent scenes. Some women also had dreams of finding a new home, returning to unfinished work, and angels reassuring them that everything would be okay. These positive dreams appeared to be linked with the transition period to finding place for the baby within self and family.

The Importance of Provider Relationships

Additionally, the women interviewed all expressed a need to discuss their experiences with their prenatal care providers, and for their prenatal providers to understand their need for what they perceived to be a greater need for reassurance. Common interventions designed to reduce anxiety, such as the loan of portable fetal monitoring units during pregnancy, were reported to increase anxiety for some women due to the technical difficulty of obtaining accurate fetal heart tones in the first trimester. In no case did women report their anxiety was decreased more by portable monitoring devices than by simply talking frequently with an

understanding provider. Most of the women interviewed were active to a greater or lesser degree in support groups for women pregnant after pregnancy loss. These groups, while experienced as important sources of support, were not the same as providers who took the time to listen.

Chapter Five

Discussion of Findings

The study uncovered seven dimensions of the experience of pregnancy subsequent to pregnancy loss. As expected, some of the dimensions uncovered in the research were supported by the literature, some of the dimensions were not supported by the literature, and many of the dimensions were not discussed in the literature. For the most part, findings concerning attachment in pregnancy after pregnancy loss were congruent with other findings in the literature, while findings concerning the resolution of grief were incongruent. The dimension best supported by the literature seems to be the changes in relationships with others, including women's relationships with partners, their own mothers, medical providers, God, and other, "expert" women who have experienced perinatal losses. These changes in relationships with others are accompanied by changes in internal cognitive structures.

Changes in Relationships with Others

As Garner (1991) reported, incongruities within a couple's grieving processes or communication styles can cause strain in the relationship. One woman reported that her relationship with her husband was strengthened by his ability to communicate with her during the period after the loss of their baby, reflecting the findings of Wilson, Soule, and Fenton (1988) that pregnancy loss drew couples closer to each other. The other women reported arguments, anger and distancing within their relationships. Two women experienced the ending of relationships during their experiences of multiple pregnancy losses, and both reported that conflict over communication styles contributed to the breakup of their relationships, reflecting the findings of Najman,et. al., (1993) that parents of a child who died were more

likely to experience marital dissatisfaction or breakup. Other women reported periods of distance within the relationship, most commonly related to incongruities of grief processes or communication styles. They frequently stated, "We just didn't see things the same way" and "He didn't understand what I was going through, and eventually, I couldn't talk to him about it."

All of the women reported some conflict with their mothers, or with other, older, women close to them. While some conflict may be congruent with observations of irritability, social withdrawal, and "the inability to think rationally about all other aspects of life" that Ney, et. al. (1994) observed as acute grief reactions, it is interesting that women did not report similar conflict with fathers or men (other than husbands) close to them. While supposition is difficult and risky, it is possible that the women either had no male relationships as close or powerful as the mother-daughter relationship, or that something within the mother daughter relationship is especially vulnerable to stress at this time. It may be that the women had differing expectations of fathers and mothers. This finding fits with the psychology of women described by Deutsch (1944), in which the experience of pregnancy brings up old emotional conflicts, especially conflicts with the pregnant woman's own mother. At the same time as they were reliving conflicts with their mothers, the women reported a heightened sense of connection with women who had experienced similar losses, suggesting that emotional support is drawn more from shared experience than familial ties.

Changes in Internal Relationships

All of the women reported changes in internal, spiritual relationships, including dreams, visions, shrines to their dead children, and changes in their own ways of knowing the world. These changes in internal relationships have not been addressed specifically in the literature, although Ney, et. al. (1994) have described

similar alterations in behavior as "mannerisms representing schizophrenia due to repressed hostility." None of the women in this sample reported concern over their internal changes, including visions and dreams, and none reported feeling that she might be developing symptoms of a mental illness. Instead, these dreams and visions seemed to the women to serve as markers in their resolution of grief. The women often reported "knowing that everything would be okay" from the presence of these dreams.

The women also all reported changes in their perceptions of the orderliness and predictability of the universe including feelings of vulnerability and a loss of sense of control over their lives. The self-reported changes in women's ways of knowing the world mirror the transformation of cognitive structure described by Brice (1991) as part of the "ur-paradox"- the desire both to mourn and not to mourn the lost child. Much of the women's self-described over-protectiveness concerning their remaining children is linked to this heightened sense of vulnerability. While this sense of vulnerability and over-vigilance resembles grief reactions described by Peppers and Knapp (1980) and Brice (1991), the women described their attentions toward their surviving children as reasonable and understandable. They were not willing to lose another child.

The creation of shrines to the lost baby serves to create a place for the lost baby within the family - a place that would remain constant even as the family changed. This is reminiscent of Stainton's "constructed relationship." Although Stainton (1990) specifically refers to a relationship arising from interactions between the parents and their infant, the shrine serves to construct a permanent relationship between the family and the dead infant by assuring the infant's place in the family.

Changes in Perceptions of the State of Pregnancy

When discussing their reactions to their losses, all but one of the women

differentiated between the loss of the baby and the loss of the pregnancy. Even as they grieved over their babies, even if they were not yet ready to have another baby, they wanted to be pregnant still. The use of such strong descriptors as "powerful", "womanly", and "cool" demonstrates their understanding of the power of the state of pregnancy, a status that they wanted back. This is in direct contradiction to Benedek's description of the "essential passivity" of pregnant women. Two of the women had experienced multiple losses. For them, the ability to maintain a pregnancy became the objective. They spent months on bed rest to maintain their pregnancies, despite resulting conflicts within their marital and familial relationships. While willingness to endure bed rest may appear to an example of passivity, in fact, extended periods of bed rest are very disruptive to self-image and family routine, and require extreme determination and will power to be successful.

Perceptions of the current pregnancy were also altered. Feelings of anger, ambivalence and anxiety were much more commonly described than feelings of happiness or anticipation. Common markers of attachment to pregnancy, including joy at hearing the baby's heartbeat, wearing maternity clothes, or preparing the home for the baby were delayed or absent. These reactions mirror the detachment reported by Van der Zalm (1995), the depression and anxiety reported by Theut, et. al. (1988), and the conscious unreadiness reported by Woods and Esposito (1987).

Changes in Self-perception and Awareness

In the same way that achieving pregnancy made them feel powerful, all of the women related that losing a pregnancy caused them to feel as if they had failed at a fundamental task. Three of the women described a loss of faith in their bodies, and in their ability to believe in the naturalness of pregnancy. Four of the women reported emotional trauma and depression related to their inability to give birth to a live baby following successful previous pregnancies. The four multiparous women

had achieved Mercer's developmental task of motherhood; and while their grief was intense, it may have been very different from the nulliparous women's grief (Mercer, 1986).

Choosing to Try Again

The choice to attempt pregnancy again was an individual one, made without consultation with medical providers, and certainly without respect to providers's protocols (Davis, Stewart & Harmon, 1989). Providers were, however, frequently consulted (and changed) in order to maximize the chances of a good outcome, and to fit in with the woman's changed perceptions of pregnancy.

Redefinition of Motherhood and Life Expectations.

For all of the women, beliefs about pregnancy and birth were redefined. This redefinition was frequently expressed as the wish for a live baby, at the expense of any desired birthing experiences. They came to realize that the baby was the significant factor in the experience of pregnancy and birth, and while they valued any of their previous experiences, the experiences themselves were not more significant than the baby. This differentiation between experience and outcome is understandable, but has not been examined in the literature.

A Sense of the Price Paid for Experience

These changes in perception and awareness led at first to a spiritual crisis, and then to an enlightenment. While Bibring (1959) discusses the emotional crisis of pregnancy brought on by the disruption of somatic and psychological equilibrium, and Bowlby (1980) discusses transformations of cognitive structure caused by pregnancy loss, neither of these authors truly describes the crises relayed by these seven women. All of the women talked in terms of paying a spiritual price for their enlightenment, and of having reached some kind of maturity. While the women interviewed did in fact realize the potential offered by their pregnancy for great

psychological growth (Bibring, 1959), all affirmed their willingness to exchange their enlightenment for a chance to have the lost baby back.

Learning to be the Mother of a Dead Baby

Four of the women interviewed volunteered they had achieved some sort of resolution concerning their losses. These women all talked about their process of finding a place for the dead baby within the family, just as one would make a place for a live baby in the family. This place making was accomplished by allowing the lost baby physical and temporal space- physical space in the form of photographs and shrines, temporal space by consciously or unconsciously allowing the dead baby the same amount of spacing as one would allow a live baby within the family. For these four women, accepting that "dead is really dead," and moving on to become the mother of a live baby involved learning to live with grief and joy together, and to give place to the dead baby while maintaining faith in the possibilities of the unknown. They were then able to give a place to the subsequent baby. Accomplishing these tasks may be interpreted as a progressive, developmental process, along the lines of Mercer's (1986) progressive process of attachment. There is some correlation between the process of resolution with the women's levels of emotional maturity and personality integration, but the process of giving place to the lost baby is not linear. Rubin (1984) describes the process as "a spiraling, a widening in scope of capacities and experience at advancing points of the life stream for increased hierarchical forms of mentation and behavior. ...(T)here is articulation, transformation, and consolidation into the personality structure and then progression to the next stage."

Limitations of the Research

The limitations of this research are primarily methodological. One

methodological issue is that the seven women interviewed may not be representative of all American women who have experienced pregnancy after pregnancy loss. First, all the women are Caucasian English speakers, and may not be representative of other ethnic groups. Second, they live in the Portland, Oregon metropolitan area. The population of the Portland metropolitan area, an urban, industrialized area with much in-migration in the past few years may not be representative of women who live in Eastern, Southern, or rural regions. Additionally, six out of the seven women interviewed were employed outside of the home; only one was an at-home mother. It may not be possible to generalize these results to all women who are at-home mothers. Finally, the women were recruited primarily by word-of-mouth from support groups for women who are pregnant following pregnancy loss. These self-selected women may have a very different process of resolution, and can in no way be presumed to be representative of all women who are pregnant following pregnancy loss.

Another factor limiting the research is that the researcher's biases may have influenced the coding of data and the generation of concepts. Prior knowledge of the literature of maternal attachment as well as previously discussed beliefs about the limitations of the literature may have sensitized the researcher to find certain concepts in the data and to overlook other concepts present. A strategy employed to reduce the potential impact of researcher bias was to request frequent review of the analysis by experts in maternal-child and family nursing.

Yet another limitation is the potential for bias introduced by the researcher's personal experience of pregnancy following pregnancy loss. The researcher was explicit concerning her personal experience at all steps of the research process, and frequently sought review from experts in maternal-child nursing to identify any bias. The potential exists, however, for undetermined influence in coding,

generation of concepts, or interpretation of the analysis.

It is recommended that further research on this topic focus on findings from this study, taking into account the above mentioned limitations. For instance, this study could be repeated by a researcher without the above-mentioned personal experiences to determine the extent of personal bias present in this work. Additional work could be done with women of other ethnic, geographical, and and socioeconomic groups to determine the applicability of these findings. Further work could be done defining changes in self-definition and awareness in multiparous women with and without living children. Another area of study would be to further define the differentiation between desired experience and desired outcome.

Application of the Research

As previously stated, a thorough understanding of women's psychology and development is one of the tenets of midwifery care and one of the primary ways in which midwifery care differs from obstetrical care (Kennedy, 1995). A thorough understanding of a woman's relationship to her growing fetus is basic to understanding the choices she will make concerning labor, birth, and mothering. At the same time, it is essential that the midwife listen to the woman's own story, and not approach pregnant women with a preconceived array of appropriate behaviors.

All of the women interviewed clearly described a need for frequent visits with providers, both as follow up to the lost pregnancy and during the course of the subsequent pregnancy. The fifteen minute post-partum physical and pap test is not appropriate for these women, nor is care that is limited to monthly fifteen minute prenatal visits accompanied by take-home Doppler monitors and referrals to support groups. These women strongly articulated their need for a provider who listened to their concerns and took their reactions to these losses seriously.

The essence of midwifery care lies in listening to women, and in providing care that is safe, satisfying, respectful, informative, and meets each woman's individual need (Kennedy, 1995). While it may not be realistic or appropriate for midwives to attempt psychotherapy on women experiencing pregnancy after pregnancy loss, it is certainly appropriate for them to be respectful of women's needs to process their losses and redefine their lives in their own ways.

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Appendix A

Consent Form

IRB # 4204
APPROVAL DATE 11/8/96

Oregon Health Sciences University
Participant Consent Form

TITLE Maternal Attachment in Pregnancy Subsequent to Perinatal Loss

PRINCIPAL INVESTIGATOR Bonnie L. McLellan, RN, SNM, (503) 234-0141
FACULTY ADVISOR Linda C. Robrecht, CNM, DNSc, 494-3832

PURPOSE

The purpose of this investigation is to gain understanding of how women who have experienced the loss of a pregnancy or baby perceive a subsequent pregnancy. Your point of view about what things were most significant in your own experience is of great importance. You will be asked to give your opinion about certain things that may or may not have happened to you during these times, and what things were most important to you. This information will be used to provide a framework of knowledge for future study of the processes a mother uses to bond with her unborn baby.

PROCEDURES

If you agree to participate in this study, you will be asked to give information about where you live, who you live with, how many pregnancies and children you have had, the ages of your children, how much education you have received, and what kind of job you hold. This information will not include your name. After the demographic record has been completed, it will be placed in an envelope that has a code number on it. This number will be known only to the investigator. You may choose to use a fictitious name instead of your real name. Next, you will be asked to participate in one interview that will last from one to three hours. At the interview, you will be asked to describe your feelings about the loss of your baby and what influence they had on your following pregnancies. You also will be asked to give your opinion about what were the most important and significant things that your health care providers did for you at that time. The interview will be conducted anywhere that is convenient for you. The interview will be tape recorded. Like the demographic record, the tape will be stored in a locked file until it is transcribed. The tapes will be erased following transcription at the end of the research study. Transcriptions will be kept in a locked file and will be identified by a code number.

RISKS AND DISCOMFORTS

It might be uncomfortable, embarrassing, or otherwise emotionally distressing to discuss your pregnancies and losses. If the interviewer sees that you

are in distress, she will ask you if you want to stop responding to the questions. You may stop the interview at any time. The investigator can assist you to obtain counseling about these issues if it is needed.

BENEFITS

You may or may not personally benefit from participating in this study. However, by serving as a subject, you may contribute new information which may benefit patients in the future. Knowledge gained from this research project may help broaden understanding of the effects of pregnancy and pregnancy loss on women's lives. Any findings of this research will be shared with researchers, nurses, midwives, doctors, and others who care for pregnant women.

CONFIDENTIALITY

Your information will be kept confidential. Your name will not be used in any publication or presentation of the study results. The name on your forms or other identifying qualities will never be available to anyone but the investigator. This record and all other information collected in the course of the research will be kept in a locked file drawer. The investigator may request to be able to contact the participant briefly for clarification of issues during analysis. Participants may request a brief description of the study's findings if they desire. According to Oregon law, the investigator must report any suspected child, elder, or partner abuse to appropriate authorities.

COSTS

There will be no cost to you for participating in this study.

LIABILITY

The Oregon Health Sciences University, as a public institution, is subject to the Oregon Tort Claims Act, and is self-insured for liability claims. If you suffer any injury as a result of the research project, compensation would be available to you only if you established that the injury occurred through the fault of the University, its officers, or employers. If you have further questions, please call the Medical Services Director at (503) 494-8014.

PARTICIPATION

If you have any questions regarding your rights as a research subject, you may contact the Oregon Health Sciences University Institutional Review Board at (503) 494-7887. Bonnie McLellan, (503) 234-0141, has offered to answer any other questions you may have about this study. You may decline to take part in this investigation, or you may stop participation at any time without affecting your care at Oregon Health Sciences University or your relationship with the persons or groups referring you to the project. If you decide to stop, the information that you have already given will be destroyed. Your signature below indicates that you have read the form and you

agree to participate in the study. You will be given a copy of the consent form for your records.

Participant's Signature **Date**

Principle Investigator **Date**

Appendix B

Interview Guide

I. Introductory Scenario

The purpose of this interview is to have you tell the story of how you managed to survive your loss and the ways you made your decision to have another child. You may be coached by me to talk about specific topics such as, who was most helpful to you during your loss, what happened after your loss, and how you came to the decision to have another child. I would like you to begin the interview by telling me about yourself. (Tell me something about who and what you are.)

II. Topic Areas

The following areas will not be addressed verbatim. They will only be used as probes if a topic area does not emerge in the course of the woman's story telling.

Topic 1.

Tell me about your pregnancies

How old were you when you were first pregnant?
How many pregnancies have you had?
How was your relationship with the baby's father(s)/your partner(s)
How did you feel about your pregnancies?
What do you wish were different?

Topic 2.

Tell me about the pregnancy /baby you lost

How did you feel about the pregnancy at first
How did you feel after you knew you would loose the pregnancy
How was you relationship with the baby's father/your partner?
What did (s)he say
How did (s)he act?
How were your other relationships?
-parents
-friends
-work
What do you wish were different?

Topic 3.
Tell me about your life after you lost your baby

What changed for you after you lost your baby?
-feelings
-health
-relationships
What did you friends and family members say to you?
What did they do?
What do you wish they had said or done?
What did your medical care givers say to you?
What did they do?
What do you wish they had said or done?
What do you wish were different?

Topic 4.

Tell me about how you thought about having another baby

How long did you wait?
What happened in between your pregnancies?
Did you decide to have another baby?
How did you think it would be?

Topic 5.

Tell me about your more recent pregnancy

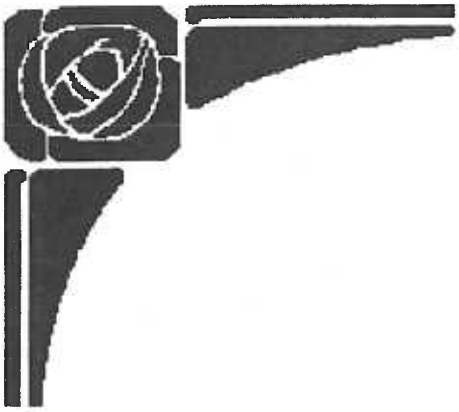
How did you think about your baby
-fears
-concerns
-joys
What do you remember about this time?
How will you know this baby is okay?
How is your relationship with your baby's father/your partner?
How is your health?
-physical
-emotional
-mental
What else has happened around this time?
Was it anything like the first time?
What things were helpful? Not helpful?
What do you wish were different?

Topic 6.

Is there any thing else you would like to tell me?

Appendix C

Contact Letters



Dear colleague,

I am a second year nurse-midwifery student at Oregon Health Sciences University conducting a grounded theory research project about the process of prenatal attachment in pregnancies subsequent to pregnancy loss. Part of this research involves interviews with women who either are currently experiencing or have experienced a successful pregnancy after a second or third trimester loss. If you know of any women in your practice who fit these criteria, I would be eternally grateful to you for sharing the enclosed contact letter and response card with them.

If you have any questions about this research, please to not hesitate to contact me by phone at 234-0141 or by e-mail at mclellan@ohsu.years old.

Thank you for your time and support

Bonnie L. McLellan

Hello

I am a nurse-midwifery student at Oregon Health Sciences University. My interest in women, pregnancy, and birth has lead me to a long term study of the process of bonding between a pregnant woman and her unborn baby.

I am currently studying this bonding process in women who are now pregnant or who have given birth after losing a pregnancy. I find that I need to talk with women who have had this experience in order to gain understanding of how women who have experienced the loss of a pregnancy or baby think about a subsequent pregnancy. Your point of view about what things were most significant in your own experience is of great importance. I believe health care workers must listen to women's own stories to know what is most meaningful to them, and to know what parts or their care they must change.

If you agree to participate in this study, I will ask you to give information about where you live, who you live with, how many pregnancies and children you have had, the ages of your children, how much education you have received, and what kind of job you hold. None of the records will include your name, and you may choose to use a fictitious name with me instead of your real name. The interview itself will last from one to three hours. At the interview, I will ask you to describe your feelings about the loss of your baby and what influence they had on your following pregnancies. I will ask you to give your opinion about what were the most important and significant things that your health care providers did for you at that time. The interview can be conducted anywhere that is convenient for you, and it will be tape recorded. Your privacy will be protected at all times, and all tape recordings will be destroyed after this project is completed.

I plan to share the findings of this research with other nurses, midwives and physicians, in the hope that understanding women's actual lived experiences will influence care for other pregnant women in the future.

If this sounds like something you would like to do, please contact me using the enclosed card. Let me know the best way and time to contact you.

Bonnie L McLellan, Student Nurse-Midwife