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# PERINATAL LOSS AND THE REPLACEMENT CHILD:

# THE EMOTIONAL LIMITS OF REPRODUCTIVE TECHNOLOGY

by

PEGGY A. MORTON

A dissertation submitted to the Graduate Faculty in Social Welfare in partial fulfillment of the requirements for the degree of Doctor of Social Welfare, The City University of New York.

1996

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9/5/96
Date

Chair of Examining Committee

9/5/96
Date

Executive Officer

Dr. Andrea Savage

Virginia Walther
Supervisory Committee

THE CITY UNIVERSITY OF NEW YORK

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Abstract

PERINATAL LOSS AND THE REPLACEMENT CHILD:

THE EMOTIONAL LIMITS OF REPRODUCTIVE TECHNOLOGY

by

Peggy Morton

ADVISOR: Dr. Irwin Epstein

While perinatal loss (defined as miscarriage, stillbirth and neonatal death) has been acknowledged as a significant psychological trauma over the past twenty years, the literature on its psychological effects highlights the problem of pathological symptomatology, particularly in the early bereavement period. Though a well-documented phenomenon, minimal attention has been paid to the lingering impact of perinatal loss; that grief which may extend over time. Additionally, while mourning has been noted (with some contradiction) to be resolved by subsequent pregnancy and parenthood and conversely, to be detrimentally interrupted by it, the actual relationship between grief and subsequent pregnancy and parenthood has been underresearched.

This is the study of thirty-two women who share the experience of attaining biological motherhood subsequent to

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perinatal loss. Using qualitative research methods (in-depth interviewing and a grounded theory approach to data analysis) the study yielded a comprehensive understanding of the meaning of perinatal loss in women's lives and its implications over time, including how it resonates throughout the experiences of subsequent pregnancy and parenthood.

Qualitative data analysis resulted in findings in four basic areas of women's experiences: perinatal loss, subsequent pregnancy, subsequent parenthood and life issues beyond the subsequent child. The thirty-two respondents described the ways in which perinatal loss continued to reverberate in their experiences subsequent to loss and even resonate within their current lives. The findings strongly suggest that this group of women did not experience the normal, predictable trajectories of pregnancy and childbearing that most women traverse.

As continuing advances in reproductive technology enable increasing numbers of women to biologically bear children after loss, health and mental health professionals will need to strongly consider the emotional uniquenesses of their experiences in their caregiving approaches.

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ACKNOWLEDGEMENTS

In executing a project of this magnitude, there are many people to be thanked for their contributions made in a variety of different ways. It gives me great pleasure to have the opportunity to thank them all within this manuscript.

In a grounded theory approach to research, the data lies in the powerful narratives of the respondents' stories. The 32 women interviewed were more forthcoming than I could have ever imagined them to be. They openly shared the memories of their innermost pain associated with their pregnancy losses, the gripping fears and anxieties of their subsequent pregnancies, and the joys and sorrows currently experienced in parenting their subsequent children. I wish to thank them for their time, their openness, their courage to come forward and for allowing me to tell the story of perinatal loss and its aftermath in the following pages.

In retrospect, having completed a dissertation, particularly one that concerns itself with highly-charged emotional content, it is difficult to ascertain which was more valuable and needed, ongoing academic support or emotional support.

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I feel extremely fortunate to have had a project advisor and committee chair who has the rare ability to provide both. Irwin Epstein always conveyed genuine excitement and support for the academic value of this project, while never losing sight of its personal meaning to me. Through various discussions of potential dissertation topics, Irwin always encouraged me to pursue my most heartfelt interests and also understood fully the emotional complexities of doing so. I thank him for his unwavering support throughout my doctoral career, for his unusual capacity to be interested in an extremely wide array of topics and for suggesting the title for this study. His enthusiasm always fueled my own.

I would also like to thank the other two members of my dissertation committee: Dr. Andrea Savage of Hunter College and Virginia Walther from Mount Sinai Medical Center who exhibited interest and support of this project and provided insightful recommendations.

I am grateful to George Ziskind, at Hunter, for his technical assistance with the execution of this paper.

On a more personal note, there have been several people who have lived almost daily with this dissertation and they

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certainly warrant mention, although words seem inadequate to describe my gratitude: My loving husband, Jonathan, who has sustained many years of my academic endeavors and for the first time in 10 years of marriage will know me as a "non-student." He has not only been a staunch supporter of my academic pursuits, but also walked the rocky roads of pregnancy loss and subsequent pregnancy with me until the birth of our son almost three years ago. My son, Benjamin whose very being precipitated the idea for this research project; had there been no "subsequent child" this clearly would have been a different study. I wish to thank him for being the light of my life and for tolerating both my physical absences and the total emotional absorption required to complete this project. My mother and sister too must be acknowledged for their lifelong admiration and support of my ambitions.

My father, dead twenty years, must be remembered for his academic interests and belief in continued learning, the forerunners of my own ambitions.

I need also to thank my many devoted and wonderful friends who stood by me through the completion of this project and were always there for me during the times of

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pregnancy loss as well. My doctoral "buddy," Dr. Richard Joelson deserves special thanks for cheering me on from the finish line.

Finally, there are two people to be acknowledged, who were not directly involved in the writing of the dissertation, but without whom it could not have occurred: First, since the idea for this project was predicated on the birth of my son, I would like to thank Dr. Jonathan Scher and his associates for their medical wisdom, compassion and hopefulness, all of which I believe enabled the birth of my "subsequent" child. Secondly, my utmost gratitude goes to my therapist, Dr. Harriette Podhoretz, who, through her infinite empathy and incredible analytic ability, made it psychically possible for me to produce both: a child and a dissertation.

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# PREFACE

If Freud's principle of psychic determinism is true, that each psychic event is determined by the ones which preceded it and mental phenomena are causally connected, than the seeds of this project were sown long before my own personal odyssey into the worlds of pregnancy loss, subsequent pregnancy and parenthood.

As the child of a Holocaust survivor, I spent much of my life preoccupied with the psychological effects of massive trauma and its aftermath. How, I wondered, could people endure and survive such horrors and want to go on and rebuild new lives? What happened to their traumatic memories in the continuing courses of their lives? And what impact did it all have on the next generation - that group of children that represented an opportunity for restoration and restitution of all that was lost?

With this interest long in mind, when it came time to decide on a dissertation topic it followed rather naturally that I would focus on some topic related to Holocaust survivors, or their children, preferably one that reflected

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on their strengths and coping capacities, since their psychopathologies had been all too well-documented.

Just prior to beginning my research, I gave birth to my first child subsequent to 5 years of pregnancy losses, infertility and ultimately a highly problematic pregnancy, throughout which the final outcome, my son's live birth, was questionable. Much to my surprise what awaited me at the end was not the blissful excitement of new motherhood, but an emotional state more akin to posttraumatic stress disorder. Clearly, the scars of my past losses had not been healed; the tensions and tentativeness of a dubious subsequent pregnancy were not forgotten; the past resonated powerfully within a present of joy, comingled with anxiety and depression. Others simply could not understand how I could be anything but jubilant - for after all, "Hadn't it all been worth it to get this outcome?" It was clear that the common assumption was that attaining the goal, producing a child, would automatically overshadow the traumatic, arduous, and uncertain path to get there. I felt greatly misunderstood in regard to the many complex and mixed feelings aroused by the birth of my subsequent child and

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believing I was probably not alone, wanted to better understand and study these phenomena systematically.

My dissertation advisor, always supportive of my ever-changing ideas, enthusiastically embraced the idea for a research project and astutely pointed out that actually this was not totally removed from my original idea. In essence, I would still be studying the impact of traumatic loss and its long-term aftermath: in this case, pregnancy loss and its sequelae of subsequent pregnancy and parenthood. Wisely he added that the topic was perhaps more progressive, current (both in the social climate of advanced reproductive technology and personally, to my life) and more "future-focused."

And so I embarked on the study of perinatal loss and its effects on subsequent pregnancy and parenthood. It was a journey painfully difficult to continue at times. Respondents' stories revived for me the devastating sadness and disappointment of fetal loss, the anxiety of a tentative subsequent pregnancy with the accompanying fear of never attaining motherhood, the disbelief of a live birth and the many joys and sorrows of parenting the subsequent child. I felt my own past reverberate through their stories which

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were incredibly frank, detailed and affect-laden. Yet, there emerged for me ultimately a "silver lining" from the sometimes dark clouds. Their stories were courageous, inspirational and I felt a oneness and kinship with them borne out of the understanding of a common experience. My "personal Holocaust" became a shared trauma and somehow, something was put to rest for me.

I hope that the 32 women interviewed for this project felt a little less alone, slightly more acknowledged in the opportunity to tell their stories, and that other women who have had similar experiences and read this study might feel the same. Finally, my greatest wish is that these highly personal, emotional and moving narratives written in the voices of those affected, are eye-opening, mind-opening and educative for all those who encounter women who have experienced perinatal loss, subsequent pregnancy and parenthood.

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# CHAPTER ONE

## INTRODUCTION: STATEMENT OF THE PROBLEM

Perinatal loss (defined as miscarriage, stillbirth and neonatal death) has received increasing attention in the literature over the past twenty years and has been acknowledged as a significant psychological trauma for parents.

The literature on the psychological effects of perinatal loss highlights the problem of affective symptomatology (psychological morbidity, i.e. pathological grief, disordered mourning) particularly in the early bereavement period (acute grief, one to two years duration). Though a well-documented phenomenon, minimal attention has been paid to the lingering impact of "shadow grief" (Peppers & Knapp, 1980); that grief which may extend over time.

Additionally, while mourning has been noted (with some contradiction) to be resolved by subsequent parenthood and conversely, to be detrimentally interrupted by it, the actual relationship between grief and subsequent pregnancy and parenthood has been underresearched (Theut, et. al., 1990).

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The limited amount of literature on pregnancy subsequent to loss focuses on quantitatively measurable affective states (anxiety, depression, fear) with less attention paid to the qualitative meaning of the experience and how it compares to the "normative" developmental process of pregnancy. An even smaller body of literature addresses the effects of perinatal death on subsequent parenting and family issues. Much of the literature highlights the pathogenic effects of loss and is based on speculation, rather than actual interviews with parents which would allow exploration of the experience in a deeper way.

In addition to a general need to examine and further understand the psychological effects of pregnancy loss and its longer-term reverberations, including the impact on subsequent pregnancy and parenting, there are currently compelling reasons to study such phenomena in light of certain converging social trends: 1. While the 1960s was a time when feminists promoted alternatives to motherhood, the 1990s has been described as a "pronatal" decade, one in which older baby boomers are sentimentalizing parenthood (Thurer, 1994, xxiii) and to be child<u>less</u> is not "in vogue." Women may therefore feel a resurgence of sentiment about

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motherhood as *intrinsic* to female identity and consequent pressure not to remain childless. 2. Many of the aforementioned "pro-child" baby boomers, who did not want children but changed their minds in striking numbers in their 30s and 40s (New York Times, February 12, 1995) constitute part of the (more than) 25% of the general population experiencing perinatal loss, since their decisions to delay childbearing were more likely to have resulted in reproductive problems, including losses. At the same time, however, remarkable advances in reproductive medicine are enabling increasing numbers of them to biologically bear children, even after repeated failures.

It may therefore be timely and instructive to understand the effects of perinatal loss over time, including the impact on a subsequent pregnancy and on parenting; in essence, to study the experiences of a group of people who share similar stressful histories in relation to childbearing with the ultimate goal of developing recommendations for professionals who work with such people.

This is the study of thirty-two women who share the experience of attaining biological motherhood subsequent to perinatal loss. In-depth interviewing yielded a

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comprehensive understanding of the meaning of perinatal loss in women's lives and its implications over time, including how it resounds throughout the experiences of subsequent pregnancy and parenthood.

Through exploration of the experiences of pregnancy loss, subsequent pregnancy and parenthood, this study addressed the following areas:

1. THE EXPERIENCE OF PERINATAL LOSS: a) Recollections of the affects and events associated with the loss; b) Efforts to cope with pregnancy loss, including the use of subsequent pregnancy as a coping strategy; c) Longer-term effects: ways in which pregnancy loss might have continued to resonate throughout the experiences of subsequent pregnancy and parenthood and in the present lives of women.

2. THE EXPERIENCE OF THE SUBSEQUENT PREGNANCY: a) The decision to pursue another pregnancy in the face of increased uncertainty; b) The emotional experience of a subsequent pregnancy, and the ways in which a history of loss remains alive; c) Coping mechanisms employed throughout the subsequent pregnancy.

3. THE EXPERIENCE OF SUBSEQUENT PARENTHOOD: a) Delivery and the early postpartum period; b) Mother-Infant

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bonding; c) The subsequent child in relation to the lost child; d) The relationship between the subsequent child and perinatal grief; d) Positive and negative aspects of parenting the subsequent child.

4. LIFE BEYOND THE SUBSEQUENT CHILD: a) Ways in which pregnancy loss altered the anticipated course of women's lives; b) Continuing resonance of loss; c) Future considerations.

OUTLINE OF CHAPTERS

This study begins with a comprehensive review of the related literature in Chapter two; Chapter three describes in detail the methodology used for the research project. Chapters four, five, six and seven present the findings of the study: chapter four focuses on the experiences of perinatal loss, chapter five explores the subsequent pregnancy; chapter six examines the experience of subsequent parenting and chapter seven addresses issues related to perinatal loss that go beyond subsequent pregnancy and parenting. The culmination of the study is chapter eight, a summary of findings and the emerging implications and recommendations for practice.

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# CHAPTER TWO

## REVIEW OF THE LITERATURE

In preparation for this project, literature was reviewed in the following areas: 1. Perinatal loss, including long-term grief; 2. Pregnancy subsequent to perinatal loss; 3. "Normative" pregnancy as a developmental process; 4. Post-loss pregnancy and high-risk pregnancy as developmental processes; pregnancy after infertility; 5. The early postpartum period of parenthood; 6. Transition to parenthood subsequent to loss: the early post-partum period; 7. Parenting the "subsequent child." 8. Parenthood after loss of an older child to illness or massive trauma, like the Holocaust; 9. Long-term sequelae for the parent-child relationship of other early infant crises, such as severe illness, prematurity, etc.

### EFFECTS OF PERINATAL LOSS

The psychological effects of pregnancy loss, both early and late have been well documented (Kirkley-Best & Kellner, 1982; Greenfield & Walther, 1991; Leon, 1986; Theut, et. al., 1990; Zeanah, 1989, etc.). The emphasis in the literature has been on quantitative measurement of perinatal grief, manifested in specific affective symptomatology

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(Lasker & Toedter, 1991) rather than examination of the comprehensive process of mourning (Hunfeld, et. al., 1993; Zeanah, 1989) with the goal of ascertaining normal vs. pathological grief reactions (Turco, 1981). The focus has been largely on pathological outcomes, with minimal attention paid to some of the noted positive aspects of surviving loss such as a change in values to less materialistic, less career or personal goal oriented to valuing interpersonal relationships; increased capacity for empathy, intimacy and a tendency to become more present-oriented (Sherman, 1987).

THE EMOTIONS OF LOSS

The intense anguish and despair following perinatal loss are well-documented (Kirkley-Best & Kellner, 1982; Lewis & Page, 1978; Peppers & Knapp, 1980; Theut, et. al., 1989). Sadness and confusion are often accompanied by anger, bitterness and resentment, disbelief, feelings of guilt, shame and self blame (Zeanah, 1988). Additionally, Herz (1993) notes the prevalence of surprise and shock when the expectation of a healthy child results in an unanticipated and sudden negative outcome; where the "joy" of birth, results in death (Kirkley-Best & Kellner, 1982)

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after pregnancy has proceeded without incident (Covington & Theut, 1993). Other commonly felt emotions are jealousy and envy of other pregnant women and those with babies (Leon, 1986).

Studies have examined the effects on perinatal grief of gestational age at the time of loss, yielding controversial results from no differences noted between early and late pregnancy; i.e., the quality of the relationship to the fetus is not associated with the time invested in it, (Peppers & Knapp, 1980) to later loss resulting in more intense grief symptoms (Toedter, et. al., 1988). Additionally, studies have begun to address gender differences in styles of grieving, noting that the intensity of perinatal grief in mothers exceeds that of fathers (Zeanah, 1988) and that females tend toward a more ongoing, expressive grieving style than males (Black, 1991; Lister, 1991; Stinson, 1992), creating conflict between couples.

## THE CIRCUMSTANCES AND EVENTS OF LOSS

It appears that the details of events surrounding the experience of perinatal loss are remembered with great accuracy even many years after the loss. Peppers & Knapp (1980) noted that specific circumstances of the loss,

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including memories of the emotional climate, were retained as much as ten years past the event. Memories of the tensions of delivery, i.e., hours of stressful labor with "no reward" and of returning home "empty-handed" are imprinted strongly. Women experience the full range of postpartum physical effects accompanied by feelings of grief (Herz, 1993).

ROLE OF THE PHYSICIAN AND HOSPITAL STAFF

The salience of caregivers' compassion in the emotional recovery of women experiencing perinatal loss is documented in the literature (Herz, 1993). Unfortunately, most women report experiences with medical/hospital staff that intensify, rather than diminish grief (Peppers & Knapp, 1980). The tendency of physicians to avoid discussions of loss, reject the grieving family, withhold expressions of concern and "say all the wrong things" is documented repeatedly in the literature (Covington & Theut, 1993; Herz, 1993, Kirkley-Best & Kellner, 1982; Leon, 1986; Peppers & Knapp, 1980). Such emotional insensitivity on the part of physicians to the experience of perinatal loss has been attributed to medical training, which does not prepare the the obstetrician to deal with death and to the physician's

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response to his/her own feelings of failure and helplessness with guilt, anger, resentment and avoidance (Kirkley-Best & Kellner, 1982; Peppers & Knapp, 1980).

Treatment by hospital staff has a great impact on the mother's well-being as well. Great strides have been made in the hospital's response to the event of perinatal loss in the last twenty years. Whereas before hospital rules were inflexible and many grieving mothers were returned to regular maternity wards, and not informed of the options of seeing, holding or taking pictures of their babies, nowadays, comprehensive protocols for grieving are offered by most hospitals. These include encouraging opportunities for viewing, holding, naming, picture taking, saving mementoes (footprints, i.d. bracelets, etc.) and planning funeral services and burial ceremonies (Zeanah, 1988). It is now believed that such procedures offer concrete reminders and evidence of the loss which will facilitate the mourning process of the lost child with whom there has been no actual interaction (Condon, 1986; Greenfield & Walther, 1991; Kirkley-Best & Kellner, 1982; Leon, 1986).

While Herz (1993) notes that perinatal bereavement practices have become greatly humanized and sensitized over

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the last twenty years, Leon (1992) cautions against the institutionalization of bereavement; the "grief counselor's" encouragement of the appropriate way to mourn. He emphasizes the importance of providing genuine empathy to the grieving parent rather than "canned lines" which may represent a defense against the caretaker's grief (Ibid).

MECHANISMS FOR COPING WITH LOSS

ENCOURAGING MOTHER'S ACKNOWLEDGEMENT

As noted above, it is now common practice to encourage mothers to see and touch their dead babies so that grief may be rooted in reality and mourning may proceed more readily with the availability of a concrete representation. While in the past, mothers were often excluded from funeral arrangements which were handled by fathers and or/grandparents, current practice dictates that where possible, both parents should participate in decisions about disposition of the child (Peppers & Knapp, 1980). Mothers should be given the opportunity to participate in rituals, and to acknowledge the child's identity, as a prerequisite to mourning (Leon, 1986), however, she should feel free (and not pressured) to make decisions about the ways in which she chooses to participate in acknowledgement of the child.

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THE ROLE OF OTHERS

The "conspiracy of silence" that surrounds fetal death (Lewis & Page, 1978) results in a devastating sense of loneliness for the grieving mother. Peppers & Knapp (1980) note the lack of understanding demonstrated by friends and relatives of the mourner; the ways in which communication about the loss is curtailed, as mothers are urged to forget. Appropriate support is often not provided, as most people have difficulty acknowledging the "life not yet born" (Herz, 1993) and tend to see the loss as a replaceable one. Mothers describe a highly lonely period of mourning, with grief experienced in isolation, because no one wants to listen. Some mothers have reported that self-help groups have been the most helpful in dealing with their losses, (Leon, 1986) while in other instances, they are noted to be poorly attended (Rosenblatt & Burns, 1986).

ROLE OF THE SPOUSE

Peppers & Knapp (1980) highlighted the incongruent bonding, and consequently incongruent grieving patterns experienced by mothers and fathers. While some mothers report the ability to talk with their spouses after perinatal loss, most experience minimal support and lack of

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empathy and seek the support of peers instead (Rosenblatt & Burns, 1986). Due to differences in the ways in which mourning is experienced (Herz, 1993), marital relationships may become strained in the areas of communication and sexuality.

## THE IMPORTANCE OF AN EXPLANATION FOR LOSS

Finding the explanation or medical cause for perinatal loss is important to the emotional healing process in mitigating feelings of guilt and helplessnes (Leon, 1986). Indeed, in the case of stillbirth, 70% of all instances proceed with unknown cause (Kirkley-Best & Kellner, 1982) resulting in unresolved questions that may "haunt" the mourner for an extended period of time. Where medicine offers no answer, women tend to ascribe blame to themselves, their physicians, or to existential forces.

Self-blame for inadequate care during the pregnancy, or for immoral acts of the past can heighten feelings of guilt and failure, or alternately aid in a sense of control, if one feels she can do things differently next time (Herz, 1993). Where blame is directed outward, it may exist as anger at the physician who minimized or ignored concernsprior to the loss and/or did not do enough to

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prevent it (Covington & Theut, 1993; Leon, 1986; Rosenblatt & Burns, 1986). Finally, the existential question of "Why me?" is frequently posed by women in the search for an answer to their devastating pain (Covington & Theut, 1993; Herz, 1993).

Most of the clinical reporting on perinatal grief has centered on the immediate grief reaction to loss; the intense pain and suffering of the early bereavement period. Most of the work with mothers has been acute grief management in the hospital or two to three months post-partum (Kirkley-Best, 1982). Yet, it is not uncommon for women to present themselves for treatment of grief decades later (Condon, 1986; Davis, 1991), evidence that symptoms may persist for a longer period than the one-year predicted by many theories of grief (Rosenblatt & Hammer, 1986; Rowe, 1978; Sherman, 1987; Theut, 1992). In fact, data indicate that for some, perinatal loss may bring incomplete, long-term, even lifetime grieving (Rosenblatt & Hammer, 1986), manifested in a "shadow grief" (Peppers & Knapp, 1980) persisting in the form of lingering sadness, depression, anger, etc. (Leon, 1986; Peppers & Knapp, 1980). As with a usual postmourning response, such loss may be re-awakened

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recurrently but in the case of perinatal grief, inability to complete mourning may relate to the unique and complex nature of the fetus: the challenge of mourning a person for whom it is impossible to evoke a mental representation, with memories based on actual interactions; i.e., there is no reality-based concept of the lost child (Greenfield & Walther, 1991; Leon, 1986). Additionally, the retention of grief may relate to the desire never to forget the loss, as resolution is seen as betrayal. The need to remember must be kept alive and becomes paramount when other accepted avenues of expression are hard to find (Leon, 1986), as is unfortunately the case with perinatal loss.

In spite of the acknowledgement of the phenomenon of unresolved mourning, little is known about the long term implications of perinatal grief reactions, particularly the relationship of such "shadow grief" to a subsequent pregnancy and on parenthood. Does it precipitate pregnancy or interfere with it? Is grief mitigated or exacerbated by parenthood? Finally, while recovery has been defined as renewed vitality in activities and pleasures without preoccupation with the loss and by the capacity to maintain and develop other significant relationships (Leon, 1990),

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little research has been done to understand the relationship between grief and the decision for subsequent pregnancy and parenthood.

SUBSEQUENT PREGNANCY

THE DECISION-MAKING PROCESS

Given the availability of reproductive technology, couples are increasingly called upon to make decisions and choices in areas that previously offered no alternative (Black, 1981). Such decisions often require thinking rationally in the face of uncertainty and prior failure. In the case of couples experiencing previous losses, any objective notion of high or low risk becomes meaningless because they have already experienced events said to be rare and can already anticipate that which might happen again. The uncertainty and ambiguity of the situation provides free rein for the imagination, as couples can anticipate the worst that can happen in spite of medical information. An approach to understanding risk taking behavior might help improve decision making in the face of uncertainty for people facing medical risks and choices (Ibid.).

Relatively little is known about how couples make the decision to face the uncertainty of a pregnancy following

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loss. The relationship between doctors' advice and decision-making appears insignificant (Davis, 1989). Medical opinion has been divided about how soon after loss to attempt conception (Condon, 1986; Peppers & Knapp, 1980; Phipps, 1985) and mothers have valued doctors' faith in their ability to make the right decision (Davis, 1981) rather than prescriptions for the "right" amount of time to wait.

Pregnancy has been viewed as the fulfillment of woman's deepest yearnings and as occupying the fantasies of girls' psychic lives since childhood (Deutsch, 1945) while motherhood has been assumed to be intrinsic to female identity (Ireland, 1993). Clearly, the biological, psychological and social motivations for pregnancy and parenthood are many. These may underlie and fuel some additional unique factors in the decision to pursue pregnancy after loss.

Some of the factors contributing specifically to the pursuit of a pregnancy after loss are: mothers' overwhelming feelings of emptiness, fears of advancing maternal age and infertility (Phipps, 1985); concerns about spacing of children, feelings of impatience; feeling that

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another loss cannot be worse; the emotional inability to use birth control; the wish to move on to a joyful time; the need to overcome failure and prove that one can successfully have a livebirth (Davis, 1989); the wish to repair intense narcissistic damage created by the loss of part of one's self (Leon, 1990).

The factor precipitating pregnancy most cited in the literature (and of most concern) is the wish to replace the loss; to restore through parenting (Ornstein, 1980).

In general, the desire for pregnancy tends to be preceded by significant life experiences, often those consisting of earlier object losses and separations (Greenberg, et. al., 1959). The motivation may be replacement or reinternalization of the object, including the death of a fetus in a recent pregnancy (Ibid.). Studies of adolescents who became pregnant following pregnancy loss revealed that unresolved feelings of loss contributed to the second pregnancy as most stated that they became pregnant again as a replacement for the previous loss (Horowitz, 1978). The subsequent pregnancy tended to cut off further expression of mourning (Ibid.). In the past, mothers were encouraged to get pregnant quickly and become busy with

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another child to fill the emptiness and forget the loss; to "cure" their grief (Brost & Kenney, 1992; Peppers & Knapp, 1980). A quick pregnancy that yielded a "replacement" baby was seen as a way to avoid the pain of mourning or as a means to resolve it (Lewis & Page, 1978; Zeanah, 1989). Working through a loss can be difficult, while becoming pregnant again may seem to be a simple solution (Bourne & Lewis, 1984).

The idea of "replacement" however is unique to perinatal loss (Peppers & Knapp, 1980) and recently a subsequent pregnancy within a year (Kirkley-Best, 1982) has been increasingly viewed as manifesting delayed or absent grief, an indicator of disordered mourning (Zeanah, 1989); a reflection of severity of grief and an inhibitor of the mourning process (Bourne & Lewis, 1984; Phipps, 1985). A cycle may exist whereby: 1. mourning is inhibited by pregnancy because maternal self absorption during pregnancy conflicts with the preoccupation with the deceased necessary for mourning (Peppers & Knapp, 1980; Phipps, 1985). Once the new life arrives, psychological preoccupation may continue to preclude mourning or it may return too soon after birth, leading to pathologic influences on mother-

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infant bonding and relationship (Bourne & Lewis, 1984; Brost & Kenney, 1992; Davis, 1989; Phipps, 1985). 2. adaptation to pregnancy (and parenthood) are inhibited by mourning (Phipps, 1985) when unresolved grief accumulates creating dysphoria and uncertainty related to a sense of impending loss (Greenfield & Walther, 1991).

Studies reveal that mothers pregnant less than five months after a perinatal death or who have a new infant closely following a death or who have a surviving twin are subject to prolonged grieving (Goldberg, 1986; Rowe, 1978; Wilson, et. al., 1982; Zeanah, 1989). Women with unresolved grief who attempt to conceive quickly appear to have higher rates of infertility and spontaneous abortion in the first year after loss (Mandell, 1980).

Becoming pregnant then, to resolve a loss appears to be a pseudo-resolution, detrimental to all involved (Kirkley-Best, 1982) while waiting is seen to be advantageous in providing more time to heal physically and emotionally thus enabling greater enjoyment of the new baby (Davis, 1991). Grief resolution would mean a decision to become pregnant again not to replace a lost child but because mourning has been fully expressed and a new child can be accepted in its

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own right; the new baby is a different baby (Condon, 1986; Lewis, 1979; Peppers & Knapp, 1980; Phipps, 1985); couples can appreciate the individuality of their babies and keep them psychologically separate (Davis, 1991).

While recently subsequent pregnancy has not been recommended as an antidote to grief, at the same time there has been evidence that less bereavement is registered after the birth of a viable child, therefore providing a corrective experience that helps parents attain a degree of grief resolution (Peppers & Knapp, 1980; Theut, et. al., 1989;1992). While most mothers feel they can never fully resolve a prior loss (Phipps, 1985) most women who succesfully give birth to another child feel that they have "made it;" that they could then deal successfully with whatever manifestations of grief remained. Giving birth to a healthy baby was seen as the most joyous moment of their lives. If mourning is achieved sufficiently, a healthy pregnancy outcome may restore a sense of maternal self-worth (Leon, 1986), repair narcissistic damage (Leon, 1990) and offer consolation and fulfillment (Bourne & Lewis, 1984). The definition of sufficiency is vague, however and the

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relationship between grief and a subsequent successful birth has not been fully explored.

It appears that the "optimal time" for a subsequent pregnancy will depend on the mother's emotional health and how to best meet her needs, including the ability to grieve and cope with the loss; her personality, past experiences and losses, current life, desire to parent, and support factors. The most important determining factor may be whether or not she feels ready to move forward with her life.

Little is known about the cumulative effects of pregnancy loss on motivations for subsequent pregnancy and parenthood, i.e. does the struggle for a child become a symbol of a unique goal in life (Deutsch, 1945) whose attainment becomes more important than the actual object of success? Deutsch (1945) wrote that a woman can enjoy motherliness even if she has not conceived, borne and given birth to a child and that maternal feelings can find indirect gratification elsewhere. If this is indeed the case, what propels mothers to persistently pursue pregnancy after loss rather than opt for adoption or childlessness?

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## SUBSEQUENT PREGNANCY

## THE EMOTIONAL PROCESS

Regardless of differences in time spent waiting to conceive, the literature confirms that intense anxiety is experienced in the subsequent pregnancy (Davis, 1981; Phipps, 1985; Theut, 1988; Zeanah, 1988). The trauma of losing an infant during the perinatal period creates a strong sense of emotional disequilibrium (Brost & Kenney, 1992); reticence and fear (Peppers & Knapp, 1980) of repetition of the loss of the child now that the knowledge that it can happen is no longer just abstract (Davis, 1991; Penticuff, 1982).

Depression too, is more evident in post-loss pregnancy (Penticuff, 1982; Theut, et. al., 1988) and may lead to a sense of fatalism, helplessness and vulnerability resulting from feeling a lack of control over the environment (Davis, 1991; Penticuff, 1982). Some couples attempt to cope with the anxiety by projecting and imagining worst case scenarios and how they would deal with them (Black, 1982; Leon, 1990; Phipps, 1985); others maintain a subdued, detached, hypervigilant response during pregnancy with an excessive focus on a negative outcome, again, bracing themselves for

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the worst (Hense, 1994; Phipps, 1985; Zeanah, 1989). Field & Marck (1994) outlined a process used by women as they appraised and coped with the threat of uncertain motherhood. Once the threat was identified, they used various strategies to protect themselves through affect control: blaming self/blaming others; connecting/disconnecting; telling/not telling; seeking information/blocking information. The effectiveness of these (and the use of other) coping strategies has not been adequately studied.

Often couples experience anger and disappointment that the experience of pregnancy cannot be blissful (Davis, 1991). Anger may be felt around the stress of the pregnancy; the anxiety around the possibility of further tragedy; the ease with which others attain pregnancy and the lack of empathy for the difficulty of the situation, especially since people tend to view a new pregnancy as resolution to the grief of past loss (Kirksey, 1987).

At best, the experience of the subsequent pregnancy may be characterized by great ambivalence of emotions (Phipps, 1985). The fear of not becoming pregnant is offset by the fear of becoming pregnant (Kirksey, 1987) and news of pregnancy is met with joy and anxiety, hope and fear (Kohn &

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Moffitt, 1992); fear of recurrence vs. occurrence. Confirmation of pregnancy provides something concrete to be lost (Hense, 1994) and the fear of another failure seems overwhelming (Brost & Kenney, 1992). Sometimes relief is experienced when the point at which the previous loss occurred is passed, (Kirksey, 1987) but generally anxiety persists and pervades, even after the birth of a healthy baby.

ATTITUDES TOWARD SUBSEQUENT PREGNANCY: GENDER DIFFERENCES

Differences have been noted between mothers' and fathers' experiences in regard to the subsequent pregnancy.

Women tend to verbalize a tremendous fear of the subsequent pregnancy and remain preoccupied with the loss. (Black, 1991; Lister, 1991). Fathers are noted to express less fear and anxiety (Schweibert & Kirk, 1986). This is felt to be related to later attachment to the fetus since it is not invested as a part of the (physical) self and thus a new pregnancy is seen as a new endeavor, unencumbered by the previous loss. The predominant focus is the urgency to have another child as soon as possible (Mandell, 1980) in an attempt to regain the lost child and also prove evidence of virility. Men want to put the experience of loss behind

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them and look to the future, while for women, the idea of another pregnancy is frightening and consuming (Kirksey, 1987). One study did find that to the contrary, women wanted to get started on a pregnancy sooner than men (Phipps, 1985). The issue of another pregnancy may become a source of conflict for couples, as they attempt to protect each other, anticipate each others' needs and reassure one another (Phipps, 1985).

Much less is known of the experiences and behaviors of expectant fathers than of mothers, especially in regard to the stresses of high-risk situations (Penticuff, 1982). Is the event of the prior loss really less meaningful or is there a tradition of inhibition of sadness, tenderness and vulnerability that precludes expression of these feelings? (Penticuff, 1982). Fathers may have difficulty acknowledging insecurity about their competence as men and providers of a safe environment for mother and child and while continuing uncertainty is stressful for men as well as women, it may be more difficult to admit. The tendency may be to exhibit protective feelings toward one's partner in fear of the physical vulnerability of mother and child (Penticuff, 1982).

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PREGNANCY AS A DEVELOPMENTAL PROCESS

Pregnancy is considered to be a normal developmental crisis (Taylor & Hall, 1979). In the "low-risk" pregnancy, expectant parents have confirming physiological signs that the pregnancy is proceeding normally and is on an "expected" course, a progressing trajectory between conception and delivery which can be predicted (Snyder, 1982).

Additionally, pregnancy involves relatively predictable psychological processes for expectant parents in preparation for the arrival of a new child. Such processes and changes are felt to have profound effects on the mother-child relationship (Bibring, 1959) and the mastery of certain developmental tasks are thought to predict subsequent adaptation to future parental roles (Leifer, 1980; Phipps, 1985; Valentine, 1982).

Several frameworks exist for looking at the developmental tasks to be negotiated in the normal adaptation to pregnancy (Leifer, 1980; Mercer, 1985; Rubin, 1984; Phipps, 1985; Stainton, 1985; Taylor and Hall, 1979, Valentine, 1982). While detailed explication of each is not possible here, stages basically relate to the following areas:

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1. Resolution of ambivalence towards the pregnancy, resulting in binding-in to the pregnancy (Rubin, 1984): acceptance of and investment in the fact of pregnancy and idea of parenthood, including developing affections and emotional affiliation for the unborn infant (Phipps, 1985; Taylor & Hall, 1979).

2. Incorporation of fetus into body image, part of self and emotional life (Leifer, 1980; Taylor & Hall, 1979).

3. Attachment to the fetus: prenatal attachment is the extent to which the pregnant woman engages in behaviors that represent interaction and affiliation with the unborn fetus and is generally established by the latter part of pregnancy (Leifer, 1980). Emotional attachment is characterized by increased introversion and narcissistic investment in the self, then preoccupation with the fetus, anxiety about the health of the fetus, and ascription of personal characteristics to the fetus; i.e., appearance, temperament, behaviors with meaning, etc. (Valentine, 1982; Taylor & Hall, 1979). Expectant parents form a relationship with the unborn child and construct a perception of the fetus as a separate other, interacting with it as an individual family member (Stainton, 1985).

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Prenatal attachment has been thought to be a crucial developmental task for women (Cranley, 1981; Kemp & Page, 1987); Muller & Ferketich, 1992; Phipps, 1985) due to the belief that the degree of affective involvement with the fetus by a pregnant woman is an accurate predictor of later maternal feelings toward the new infant (Davis, 1987; Penticuff, 1982; Valentine, 1982). The woman's future relationship with the infant is thought to have its roots in the emotional work of pregnancy (Snyder, 1979). Findings have been conflicting regarding the relationship between a woman and fetus before birth as positively correlated with perception after birth. Cranley (1981) found no correlation, while Davis (1987) found that prenatal attachment interventions appear to affect postnatal attachment and recommended facilitation of such to enhance successful mother-infant relationships (Davis, 1987; Valentine, 1982).

4. Preparation for separation from fetus and for the parenting role. In normal pregnancy, parents fantasize and dream about the fetus, wonder what it looks like and develop hopes and expectations for the child in preparation of letting go of the fetus (Taylor & Hall, 1979). Parents may

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be filled with joyful expectation, or with sadness at the prospect of separation (Deutsch, 1945).

All psychological tasks of pregnancy lead from investment in the self and fetus to letting go of the fetus with the goal of assuming the maternal (paternal) role (Phipps, 1985; Snyder, 1982).

POST-LOSS PREGNANCY AS A DEVELOPMENTAL PROCESS

In the case of pregnancy after perinatal loss, the "normal" trajectory of pregnancy may no longer be predictable or applicable (Snyder, 1982) and traditional models may not apply (Phipps, 1985). Little research has been done on the effect of having high-risk status on a woman's psychological process through pregnancy (Kemp & Page, 1986).

The high risk mother (in this case, the "post-loss" mother) may be in a special situation, coping with a complex network of psychological, physiological and societal problems. Her prior adverse experience in childbearing creates a stress factor that may interfere with the pregnancy process. Essentially, she deals with two distinct crisis situations: the normal developmental crisis of childbearing and in addition, the recognition and fear that

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the pregnancy may not progress along expected lines (Phipps, 1985; Snyder, 1979). Her experience may involve a number of unique psychological situations:

1. The normal task of resolution of the ambivalence around pregnancy and childbearing (thought to occur by the end of the 1st trimester) may not occur (Mercer, 1990). Doubts and negative feelings may be exaggerated due to the prior adverse experience and happiness about the pregnancy is less evident (Penticuff, 1982). There is a need to accept the fact of pregnancy while acknowledging problems that might be faced. Rather than fantasize about enjoying motherhood, the woman after loss may wonder whether she will be a mother at all (Penticuff, 1982): the experience is characterized by pervasive uncertainty (Ibid.).

2. Pregnancy after perinatal loss requires combining two theoretical and emotional frameworks: grief/loss and attachment (Lewis, 1979). Couples may simultaneously grieve prior losses while attempting to attach to the unborn child (Lewis & Page, 1978); they attempt to detach and attach at the same time (Moses, 1990). This may seem extremely difficult due to the incompatability of emotions (Brost & Kenney, 1992) and is evidenced as such in studies of grief

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reactions of parents of twins where one has died and couples are faced with the duality of mourning the loss of one while attaching to the surviving baby (Goldberg, et. al., 1986; Wilson, et. al., 1982). It is challenging for a woman to think through mixed feelings toward the dead baby and feelings for the new baby whose safety is of immediate concern (Bourne & Lewis, 1984).

3. Heightened anxiety and depression can interfere with the parents' ability to focus on the pregnancy and the developing fetus, impeding the psychological process of attachment (Theut, 1988). While temporary and low levels of anxiety are seen as mobilizing psychic energy to form a new attachment and as complementary to the attachment process (Gaffney, 1986), a positive relationship has been suggested between high anxiety during pregnancy and low attachment (Avant, 1981).

The proposition that prenatal attachment is indeed inhibited in parents after loss has been debated. One side of the argument has been that high risk women score similarly to low risk women in fetal attachment and that both groups develop feelings of attachment during the pregnancy (Kemp & Page, 1987; Mercer, 1990). Women in high

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risk groups are seen to be very involved with their fetuses (when studied in the third trimester) and seem to accomplish maternal affiliation whether the pregnancy is threatened or not (Kemp & Page, 1987). It is thought that all women ultimately connect with their babies, though the process may be slower to develop for some. In fact, it has been suggested that some who have experienced prior loss may even bond more quickly and intensely to experience the unborn baby as much as possible (Kohn & Moffitt, 1992).

A larger part of the literature supports the notion that couples have more difficulty attaching after loss; that continued ambivalence and denial about the pregnancy will interfere with the bonding process (Kirksey, 1987; Penticuff, 1982).

The process of guarding (McGeary, 1994) describes a defense used to avoid the pain of loss. A kind of "cover-up" operation, (Phipps, 1985, p.248) it is mobilized in response to perceived uncertainty and enables the woman to guard her self and her baby. Feelings of concern and affection for the fetus are avoided in case it does not survive (Kemp & Page, 1987) and a conscious effort is made to hold back from connecting. Raising and lowering one's

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guard represent a circular process, setting perimeters around the nature of connecting. One's guard may be lowered when reassured through reaching a significant turning point, then raised again when feeling cautious or mistrustful of being able to carry to term (McGeary, 1994).

Guarding is of concern if it in fact precludes prenatal bonding and if in fact prenatal attachment (the "binding-in" process") is associated with positive overall adaptation to pregnancy and early motherhood (Penticuff, 1982). As has been suggested, if the woman's future relationship and enduring affectional attachment (Ibid., 1982) with her infant is thought to have its roots in the emotional work of pregnancy (Snyder, 1979), then it would be critical to further understand problems that might be specific to the prenatal affiliative process of post-loss parents as a way to anticipate insufficient parental bonding.

4. Joy and excitement about the pregnancy are tempered due to fear of loss. Couples are reluctant to believe in the pregnancy or the outcome (Kohn & Moffitt, 1992), do not share the news with others, or anticipate the future (Ibid.; Phipps, 1985). In the latter stages when most couples are preparing for a new member of the family, (Stainton, 1985)

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such parents stay "consciously unready" for the birth (Kirksey, 1987) focusing on the uncertainty of the outcome (Penticuff, 1982); there is inadequate preparation for childbearing (Phipps, 1985): they don't fantasize with elation about the baby but rather, worry about its future survival and health. The fetus is denied personhood and antenatal knowledge is avoided. (Davis, 1991). Parents may not exhibit nesting behaviors, such as preparation of the nursery, or choosing names (Davis, 1991; Hense, 1994;) or show recognition of the coming baby as a separate individual (Valentine, 1982). While "normal" couples are getting eager for the delivery, parents after loss may want to keep the baby inside for protection if their previous experience was of giving birth to death (McGeary, 1994).

While guarding and the need to hold back from attachment to the unborn may be viewed as maladaptation to pregnancy, (Cohen, 1979), this concept needs to be explored given the circumstances (Phipps, 1985). Maladaptation to pregnancy has been defined by faulty nonacceptance of the pregnancy; rejection beyond quickening and inability to develop an emotional affiliation with the fetus or neonate (Cohen, 1979). These may be manifest in absence of response

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to fetal movement, absent nest-building preparatory activity, which is considered adaptive in preparing for the upcoming separation from the fetus (Leifer, 1980) or a lack of ability to describe distinguishing characteristics of the newborn (Penticuff, 1982). Such states are seen as representing developmental failures or arrests, yet in situations after loss these may not be unhealthy, but rather means of attempting to cope with uncertainty. After loss, parents may be motivated by self-protection and increased vulnerability and this may lead to a kind of hypervigilance (Cohen, 1979). They may in fact be preparing for parenthood but preparation is masked by preparation for a negative outcome, (death) thus giving the appearance of inadequate or maladaptive preparation (Phipps, 1985). A seemingly detached response may in fact be normal, when life hangs in the balance (Moses, 1990).

Whether such defensive maneuvers effectively facilitate self-protection is questionable particularly given the increased use of ultrasonography, amniocentesis and fetal monitoring in high risk situations which may enhance attachment to the fetus. Fletcher & Evans (1983) reported on three cases in which women reported early enhanced

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prenatal bonding during ultrasound examination and Rothman (1986) noted that the mother's developing relationship with her fetus is altered by reproductive technology; particularly that amniocentesis (even with a good diagnosis) changes the experience of pregnancy, placing women into a state of "tentative pregnancy," where they can neither ignore nor accept the pregnancy until the amniocentesis results. While waiting, Rothman (1986) found that women attempted to control their anxiety partially by remaining in a state of "suspended animation," maintaining distance from the fetus which they knew might ultimately be aborted because of bad prenatal diagnosis.

TRANSITION TO PARENTHOOD

THE EARLY POST-PARTUM PERIOD

Studies of normal and pathological responses to the experience of childbirth suggest that the early postpartum period has major psychological significance for all mothers (Blumberg, 1980). Postpartum adjustment and binding-in to the child (Leifer, 1980; Rubin, 1984) appear to be facilitated by positive attitudes toward pregnancy and childbirth. Antenatal attachment has been found to be predictive of attachment in the first few days and as much

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as two months postpartum (Leifer, 1980); those emotionally attached to the unborn child (fantasy baby) transfer attachment to the reality baby and the association between positive antenatal feelings and corresponding components of first impression of the neonate is highly significant (Condon, 1988). The fantasy baby is a composite of previous experiences, expectations, hopes and fears and the crucial event at birth is the confrontation between the fantasy and reality babies (Ibid.). Some degree of congruence between the fantasy baby and reality baby seems necessary for parents' attitudes to be smoothly transferred to the reality baby.

Negative attitudes toward pregnancy and childbirth are associated with higher levels of depression and anxiety and more negative perceptions of the newborn (Ibid.). It is not known whether these abate or have an enduring effect on the mother-infant relationship (Ibid.; Blumberg, 1980); whether events occurring in the immediate postpartum period can substantially influence parental behavior and subsequent child development (Lamb, 1982). It is felt that individual differences in the quality of mother-infant attachment will

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forecast the degree of secure attachment over the first year (Belsky, 1984).

Klaus and Kennell, et. al. (1972) postulated a "maternal sensitive" (immediate) bonding period during which certain experiences are more likely to produce affective attachment or bonds to infants than at any other times. They suggest that when this early period is interrupted, for example, by a baby's placement in NICU, various forms of aberrant parental behavior are likely to occur and that long term consequences are likely. Though supported by some, the claim that early contact and bonding has enduring effects on maternal attachment has not been well supported (Chess & Thomas, 1982; Lamb, 1982; Svejda & Campos, 1980); in fact recent studies have shown that bonding between birth mothers and infants may be more gradual than thought (Leifer, 1980) and might even take up to eighteen months without a negative impact on the relationship.

## PARENTING SUBSEQUENT TO LOSS

### THE EARLY POST PARTUM PERIOD

Little is known about postpartum adjustment for parents who have had prior losses; whether or not there are special needs and problems resulting from the previous loss; whether

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or not the transition to the parental role is different and whether there are implications for the subsequent child. While abundant information exists on the emotional effects of perinatal loss, little has been written on how specific issues of parenting relate to prior loss (Bernstein, 1990).

Upon delivery, the post loss (or post-infertility) mother is put in the difficult and paradoxical situation of changing the coping mechanisms that allowed distancing during pregnancy into emotional openness and attachment (Bernstein, 1988) and of developing a positive self-concept and feelings of competency in the parenting role after suffering lowered self esteem due to the failures of prior pregnancy losses (Ibid.).

After delivery, women with a history of prior loss are at higher risk for postpartum depression (Garner, 1985; Lewis & Page, 1978) and mild depression has been noted to persist in such women or those who give birth to vulnerable (high-risk) infants for up to one year (Bernstein, 1988). This is of obvious concern since heightened states of anxiety and depression are thought to interfere with maternal responsiveness and the postnatal attachment process (Brost & Kenney, 1992) and long term, maternal depression

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(including postpartum) has been strongly associated with later problems in children (Zuckerman & Beardless, 1987) and has been correlated with increased incidences of child abuse (Ibid.).

Mourning of a previous loss may be observed to be intense during the first few days postpartum with a new baby who may open unhealed wounds created by the previous death; losses that have been repressed in the service of coping with pregnancy (Kohn & Moffitt, 1992). Women may experience negative initial impressions of the newborn. Grief after birth seems to be more intense for parents who experience late loss than those who experience early loss (Theut, 1992). Infrequently, serious and bizarre reactions can occur after the birth of a subsequent healthy baby (Bourne & Lewis, 1984). At the same time that grief is noted to interfere with bonding ability (Kohn & Moffitt, 1992) some mothers report that it is secondary to the elation and excitement experienced after birth (Phipps, 1985).

Parents may compare babies, pregnancies and childbirth experiences; they may not desire close contact with the new infant (Brost & Kenney, 1992) and exhibit a hesitancy to attach to the child (Phipps, 1985) born out of disbelief

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that there is a real child belonging to them (Bernstein, 1990); they may require continued reassurance about the child's health and safety and feel anxious, overprotective and vulnerable (Phipps, 1985). The latter may all be of concern as potentially interfering with the maternal bonding period which is believed to be uniquely important for mother-infant attachment and therefore to affect long-term parent-child relationships. However, it has also been suggested that these mothers' early detachment is normal and should be respected out of self-protection; once comfortable with viability of the child, mothering will be initiated (Ibid.). In fact, contrary to the notion that bonding is impeded, some mothers state the prior loss facilitates attachment and their gratitude for a live birth increases their tolerance of some of the difficulties and stresses of the early months of motherhood (Phipps, 1985).

The importance of reconciling the fantasy baby with the real baby for postpartum adjustment has been noted above. Parents who have had loss may not allow themselves to develop a fantasy baby as part of the protective process of guarding. Alternately, if they do, they may have difficulty reconciling the fantasy baby with the real baby, as there

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are such high stakes riding on parenthood for the couple after loss (Menning, 1980) and the experience has become highly idealized and romanticized. Such parents may expect love and bonding and the perfect relationship to develop instantly in the postpartum period. If the child seems less than perfect, they may feel vulnerable to a previous sense of failure. Parents need to mourn and let go of the fantasy of the perfect newborn. If they cannot let go of the ideal child then bonding with the real child may be difficult (Bernstein, 1990; Kohn & Moffitt, 1992).

PARENTHOOD AFTER LOSS

EXPECTATIONS OF PARENT AND CHILD: FANTASY VS. REALITY

Deutsch (1945, wrote that (in the "normal" pregnancy) many a woman admits that the amount of happiness experienced during a wished for pregnancy often far exceeds the joys of real motherhood. Leifer (1980) found in her study that the drive toward motherhood is great and accompanied by expectations of fulfillment, satisfaction and a sense of accomplishment, which do not necessarily occur. Many mothers found that the realities dissipated the romance and that at best, ambivalence characterized the experience.

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To some degree then, parents after loss may be even more disappointed, since no pregnancy or parenting experience can live up to their expectations; no infant can make up for the years of trial and anguish; in fact, the baby gives nothing at all for a long time, but makes constant demands (Menning, 1980). Parents may need the child to conform to their standards and fulfill all their hopes and dreams and they may be overinvolved in their achievements and failures. Unrealistic expectations may result in parental frustration and disappointment (Garner, 1985) and in extreme cases in severe outcomes like child abuse (Sommerfield & Hughes, 1987).

At the same time that expectations for the child and the experience of parenthood are high, parents' expectations for themselves may be unrealistic as well: parents who suffer so much to achieve parenthood must be perfect parents (Davis, 1991). When a child (fetus) dies, the event threatens the image of self as a "good" mother thereby creating the need to become a "supermother" with the next child (Cain & Cain, 1964). This phenomenon may be further exacerbated by the current social environment, noted by Thurer (1994) to have reinvented the "mythology of the good

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mother." She wrote about the current emphasis on the ideal of the perfect mother, adding that to be in conflict about mothering is equivalent to betrayal of the child. Parents who have experienced prior pregnancy losses may be even more surprised and disappointed by their ambivalence about parenthood (Bourne & Lewis, 1984) and unable to express it or any negativity because the child is so special. Ambivalent feelings may create a state of cognitive dissonance if parenthood turns out to be less gratifying than imagined, especially after so much pain and effort. Parents may feel pressure to be selfless and never resentful (Davis, 1991) and as though they have no right to complain. They may overvalue the child (Sigal, et al, 1973) and accord special status to the child as she comes to represent two children, the lost one and the real one (Krell & Rabkin, 1979). The fantasy of a "magical child" (Wilson, 1988) may be put upon the child at birth. Later, parents may have difficulty setting limits and disciplining because of their childs' specialness. They may vow that there is nothing they will not tolerate in another child (Kohn & Moffitt, 1992; Solnit & Green, 1964; Szybist, 1973) and make few demands other than that the child stay alive (Blinder,

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1972). Difficulty in tolerating childrens' hurts and disappointments may result in overindulgence, favoritism and entitlement (Cain, et. al., 1963; Davis, 1991; Sigal, et. al., 1973).

SEPARATION/OVERPROTECTION

Parents who successfully give birth after loss have been found to have difficulties with separation and tend to be overprotective (Bernstein, 1990; Cain et. al., 1963; Davis, 1991; Menning, 1980; Phipps, 1985; Solnit & Green, 1964; Theut, 1990).

Maternal overprotection is exhibited in excessive contact, infantilization, prevention of independent behavior and a lack or excess of maternal control (Levy, 1943). Any experience that thwarts or threatens the possibility of a successful outcome of pregnancy is a potent source of increased maternal longing. In such situations, the mother may be more apprehensive and protective in her attitude toward her offspring (Ibid.). The child is seen as irreplaceable and normal concerns intensify to extreme proportions, leading to restrictiveness, infantalization and hypervigilance. Parental phobias may result in the child becoming fearful, passive-dependent and vulnerable.

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Overprotective feelings can continue for years accompanied by feelings of lack of control (Davis, 1991). In fact one study verified long term maternal overconcern with the child's health and with differentiation (Theut, 1992). Though limited in extent, this study revealed concerns with separation as particularly salient at around sixteen months, the typical developmental time of separation-individuation. This time may recall the separation that occurred at the time of earlier loss (Theut, 1990). The steps toward independence that occur at or before the age of two may be difficult for parents who waited so long for a child that it seems impossible to begin to let go.

Theut (1990) suggests the need to follow up on mothers in terms of behaviors exhibited toward children as they become more autonomous, since the very limited number of studies have been confined to the very earliest developmental stages. It would be useful to know what happens to such parent-child relationships through later developmental milestones.

THE "VULNERABLE" CHILD

Parental concern and overprotection may spring from (or result in) a perpetual view of a child as a "vulnerable

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child." Solnit & Green (1964) coined this term to describe the well child whose family is constantly worried that some disaster might strike. Usually either the child had a serious illness in the past (was destined to die, and is now seen as "on loan") had a sibling who died, or was born amidst an unresolved grief reaction after perinatal loss (Phipps, 1985) and considered a premium baby because the couple had resigned themselves to childlessness (Levy, 1943; Solnit & Green, 1964). Parents may develop phobic concerns about illness, accidents and safety and develop fantasies of this child dying too. This may lead to severe parental overprotection and restrictiveness (Cain & Cain, 1964; Costanza, et. al., 1968) which may result in the child's becoming filled with phobias and fearfulness (Perrin, et. al., 1989; Solnit & Green, 1964;) and in experiencing the world as too dangerous a place to explore. Such children may remain immature, with passive-dependent relationships and widespread ego restrictions (Cain & Cain, 1964).

The view of a child as vulnerable may persist and affect parent-child interactions over time. Some of the literature on the emotional effects of prematurity suggests that in the case of the birth of a premature infant, an

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emotional crisis may persist in the mother which will have long-term effects on child rearing practices (Scheiner, 1985). Mothers may fear severe problems will continue even though they are reassured of health, and early complications have been resolved, leaving them objectively, not vulnerable. It appears that more negative perceptions and anxiety about the experience of the preterm child may color ongoing perceptions (Perrin, et. al., 1989; Phillips, 1983). Such children may be perceived years later to be more vulnerable and the enduring stereotype of morbidity carries with it lower expectations for the child (Scheiner et.al., 1986, Stern & Hildebrandt, 1986;). These children then may be at risk for living out this self-fulfilling prophecy of vulnerability and underachievement (McCormick, et. al., 1982; Solnit & Green, 1964).

Alternately, the vulnerable child syndrome has been questioned (Costanza, et. al., 1968). Some studies have indicated no significant differences between mothers of preterm vs. full term infants; no emotional sequelae (Scheiner, et. al., 1986) and it is consequently hypothesized that some of the problems seen with premature

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infants relate more to first time motherhood. (Busch-Rossnagel, et. al., 1984).

UNRESOLVED ANGER

Parents with prior loss may experience unresolved anger from previous loss or infertility which can be displaced onto the child who then becomes the focus of this preexisting anger or failed mourning (Bibring, 1959; Lewis, 1979). Parents may unconsciously encourage children to further display aggression to express what they cannot because of their guilt due to death (Sigal, et. al., 1973). Anger may help them to avoid attachment and they may continue to guard against attachment by thinking negatively about the new baby to ensure that it will live and anticipating how they will react if another child will die. They may defensively avoid feeling too much.

THE "REPLACEMENT" CHILD

Many children are conceived shortly after the death of another child or fetus with the intention to have the child as a replacement or substitute for the one who died (Bourne & Lewis, 1984; Cain, et. al., 1963; Davis, 1991; Poznanski, 1980; Theut, 1992). The new child is brought into existence as part of an attempt to regain the lost object and is a

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pseudo resolution of mourning, whereby the illusion is of redirection toward the living; in experiencing oneself as capable of creating new life (Ornstein, 1980). The parents' new substitute image is consumed by the idealized image of the lost child (Poznanski, 1980). The apparent resolution of mourning represents little more than continued bondage to the lost object (Cain & Cain, 1964). These circumstances may cloud the child's upbringing and present potentially pathological consequences upon the child's development, since attempts to replace the dead child are fraught with danger; when parents use a child to replace an original family member, this indicates a failure in empathy detrimental to the child (Ornstein, 1980). The replacement child contends with an unseen, but always present, powerful double (Wilson, 1988).

The replacement baby born after a stillbirth may even be born on the anniversary of the death, one year to the date of the loss, making its separation from the dead baby more difficult (Lewis & Page, 1978), especially if it is the same gender. The child may be named for the dead child whose identity is imposed upon the new baby. Comparisons may be made and expectations of the new child may be based upon

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a hyperidealized and grossly unrealistic image of the dead child and upon excessive narcissistic investment in the new one (Ornstein, 1980). Hopeless competition builds resentment and is damaging as the new child is hemmed in by conscious and unconscious expectations as a reincarnation of the dead child (Cain & Cain, 1964; Krell & Rabkin, 1979).

Based upon a very limited study, Krell & Rabkin (1979) noted that the replacement child may fall into three categories reflecting family (in)ability to handle grief: 1.The haunted child: whose life is enveloped in the mystery of a shameful secret; a conspiracy of silence; 2. The bound child: who is overprotected from exploring the world; 3. The resurrected child: whose parents attempt to restore the missing child in denial of the reality of death; restoration attempts occur when parents have experienced an earlier traumatic loss in their families of origin. The new infant is destined to live a dual life: its own and that of the missing sibling (Krell & Rabkin, 1979; Lewis, 1980). Parents are enabled to complete a piece of unfinished business by continuing relationships previously begun with the other child. The new child's sense of identity is

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undermined by the ascription of two personalities: real and illusory (Krell & Rabkin, 1979).

The replacement phenomenon generally occurs in situations where the parents could not work through their mourning or grief. The new child may be born into a world of (preoccupation with) mourning (Sigal, et. al., 1973); where apathetic, withdrawn parents are focused on the past and unable to provide love and attention (Cain & Cain, 1964). The home may have a funereal atmosphere of depression and yearning (Ibid.).

The replacement phenomenon appears supported in the literature, but what is less fully addressed is how children born are affected by it (Zeanah, 1988).

Additionally, the replacement phenomenon has been discussed in relation to the child born after a loss in latency or adolescence; how it might occur subsequent to perinatal loss has not been explored. Yet, Krell & Rabkin (1979) noted that the loss of a child (fetus) may affect those yet unborn. The child may be born into an atmosphere surrounded by mystery, puzzlement, fear and guilt over the loss of the first child (fetus) and subject to impossible expectations to make up for the loss.

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POSITIVE ASPECTS OF PARENTING AFTER LOSS

Very little has been written about the potential positive effects of raising a child subsequent to loss. In discussing children of Holocaust survivors, (many of whom were born subsequent to parents' devastating losses), Ornstein (1980) noted that while some experience the special position they hold in their parents' lives as a burden, others view it as a challenge. They grow up with a sense of importance as children whose existence affirms their parents' capacity to create a new generation. Indeed, after prior loss, some parents feel predominantly elated and excited (Schweibert & Kirk, 1986) with the birth of a new child. Such parents might bring maturity and stability to the parenting situation and this child may be loved and appreciated (Davis, 1991) and truly wanted and welcomed, engendering a sense of positive self-esteem and self-worth. Additionally, the birth of a child may have positive effects for parents' self esteem (Menning, 1980) which has been damaged by prior (infertility and) loss. Since these babies may be treasured and viewed as special, parents may find a tolerance of the demands of infancy in the early months that they otherwise might not have had. (Phipps, 1985).

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ECHOES OF LOSS

Peppers & Knapp (1980, p.48) note that the "resolution of sadness and grief may never arrive" for some who have experienced perinatal loss; a lingering, transient sadness may be felt years after the loss. Indeed, occasional feelings of grief may be felt decades after the loss and are set off by fresh reminders: anniversary dates, random conversations, news, visits to the gynecologist, seeing the pregnancies of others, and seeing children of the same age as the lost child would be (Rosenblatt & Burns, 1986). What may be grieved are: the child, subsequent childlessness, absence of desired additional children, unpleasant medical and marital experiences, a loss of innocence, an end to feelings of invulnerability and a loss of faith that life is fair (Rosenblatt & Burns, 1986).

Leon (1986) comments on the difficulty of resolving a perinatal loss in that it means relinquishing the wishes, hopes and fantasies about one who never was. In addition, maternal grief keeps the deceased child alive (Condon, 1986) and insures that he/she will never be forgotten, for as Kaplan (1995, p. 118) notes, when a child dies, the "palpable presence of grief is all that is left for the

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parent; a dead child can only be memorialized in the parent's grief."

CONCLUSIONS

In sum, while significant attention has been paid to the psychological effects of perinatal loss and some of its longer-term effects, based upon the review of the literature, a number of areas were identified for further qualitative exploration:

1. The experience of perinatal loss, including its lingering effects over time; the relationships between perinatal grief and subsequent pregnancy and parenthood.

2. The decision making process for couples considering pregnancy after loss and motivations for parenthood including the influences of certain social phenomena: reproductive technologies and the current renewed popularity of motherhood.

3. The experience of pregnancy after perinatal loss as a developmental process distinct from the "normative" process of pregnancy; how emotions of each trimester are coped with and the effects of such coping mechanisms and of reproductive/diagnostic technologies on prenatal attachment;

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the relationship between past perinatal loss and the experience of pregnancy.

4. The transition to parenthood after prior loss; the experience of the postpartum period particularly around bonding;

5. Positive and negative aspects of parenting the child born subsequent to perinatal loss and the ways in which prior loss may resonate throughout parenthood.

6. The experience of perinatal loss beyond the subsequent pregnancy and parenthood; continuing manifestations of grief and the possible implications of perinatal loss for the larger context of the anticipated course of one's life.

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# CHAPTER THREE

# METHODOLOGY

## INTRODUCTION: TIMELINESS AND APPROPRIATENESS OF RESEARCH

Presently, perinatal loss affects more than 25% of the general population (Davis, 1991). The high numbers may partially be due to the social trend to defer parenthood until the mid to late thirties, even forties and also to the capability for extremely early detection of pregnancy, which enables identification of early miscarriage. At the same time that advanced maternal age may increase the risk of pregnancy complications (infertility, loss, etc.), high-tech reproductive therapies make it possible (and perhaps create added pressure) for couples to attempt repeatedly to have children (where previously they might have relinquished their efforts).

Additionally, while in the 1960s, women fought the assumption that motherhood was intrinsic to female identity and were promoting alternatives to it (Ireland, 1993), in the 90s, as Thurer (1994, p.xxiii) notes, our society has become "unabashedly pronatal," resulting in an increased sentimentality for motherhood and a mythology of idealized,

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perfect parenting among older, educated baby boomer circles. The internal desire to have a child may be strengthened by the external social and scientific pressures, encouraging some women to be "driven" to achieve successful childbearing.

In the years to come, due to technological advances, it is likely that increasing numbers of children will be born subsequent to repeated failures (including multiple pregnancy losses). In the short run, these children are considered scientific success stories, but in the long run it is possible that the total psychological picture will be more complex. What might the lingering emotional effects of pregnancy loss be, even once subsequent pregnancy and parenthood have "successfully" been attained?

This study sought to generate new concepts and theories about a specific group of people who share certain unique common experiences in relation to childbearing and parenthood. Pregnancy and parenthood are generally treated as normative developmental crises - times of growth and change for individuals and couples. Advances in reproductive medicine and nontraditional family lifestyles are effecting more diverse and complex experiences of these

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"typical" life cycle phases. Special attention may need to be paid to the more atypical circumstances of childbearing and parenting, including birth after one or many pregnancy losses.

GOAL AND OBJECTIVES OF THE PROJECT:

The primary, overall goal of this project was to more fully understand the experiences of pregnancy and parenthood after perinatal loss (both for theoretical and clinical implications). In light of the gaps in the literature and this researcher's interests, more specific objectives of the study were:

1. To understand more about the long term effects of perinatal grief, including its (longer-term) relationship to the subsequent pregnancy and child;

2. To understand more about couples' decision making processes when pursuing pregnancy after loss and the effects of various psychological and social factors on motivations for childbearing;

3. To understand more about the actual process of subsequent pregnancy and how (if at all) it alters the low-risk developmental course; how mothers cope during subsequent pregnancy; how pre-natal attachment is affected;

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4. To understand more about the impacts of reproductive and diagnostic technologies on pre-natal attachment and the emotional process of subsequent pregnancy;

5. To understand more about the experience of parenthood after perinatal loss including the personal meaning of the child (ren);

6. To understand more about how perinatal loss impacts upon parenting practices and the parent-child relationship;

7. To understand more about the effects of perinatal loss on the larger course of life. The study included:

-accessing the literature on the psychological effects of perinatal loss, including "shadow" grief, subsequent pregnancy, normative pregnancy and parenthood as developmental processes, high-risk pregnancy, parenthood after infertility, perinatal loss or an older child's death to illness or trauma, later sequelae of other early emotional crises (serious illness, prematurity, etc.).

-interviewing those who have successfully had children after loss to better understand the emotional processes of long term grief, subsequent pregnancy and parenthood. The latter can be related to the normative processes of

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pregnancy and parenthood as discussed in the literature to better assess the impact of these special circumstances and whether or not these parents need to be treated as a special group.

-identification of existing commonalities and differences among people undergoing this experience and the role of various background variables (gestational age at time of loss, time since loss, gender of subsequent child, etc).

-exploration of the potential positive effects of the experience.

-examination of psychological and sociological implications in the hope of generating new constructs related to pregnancy, parenting, parent-child relationships and child development that are relevant to some of the unique circumstances of childbearing and rearing borne out of the advent of reproductive technologies and the social trend toward childbearing.

SCOPE

This study encompassed two general areas: 1. assessment of the experiences of perinatal loss, pregnancy and parenting after loss with the goal of generating new

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psychological and social constructs and theories; 2. the possible clinical/practical application of this knowledge for those working with individuals affected by this situation.

REVIEW OF EXISTING METHODOLOGIES

Methodologies utilized in studies relevant to this research project have been reviewed in the following areas: 1. Perinatal loss including long-term grief; 2. Subsequent pregnancy. 3. Normative pregnancy as a developmental process; 4. Post-loss and high risk pregnancy as developmental processes; 5. Transition to parenthood; 6. Parenthood after perinatal loss or after the death of an older child through illness or extreme trauma like the Holocaust: Effects on the subsequent child; 7. Later sequelae of early phenomena affecting the parent-child relationship such as prematurity, illness at birth, low birthweight, etc. Of note is that the overwhelming majority of all research reviewed was conducted with white, middle-class, highly-educated, and married female subjects. Very little information exists in any of the abovementioned areas pertaining to other ethnic, cultural and socioeconomic groups or males.

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PERINATAL LOSS/LONG-TERM GRIEF

As Zeanah (1989) indicates in a comprehensive critical review, the literature on perinatal loss is extensive. Studies utilize a combination of close-ended quantitative measures as well as more open ended, semi-structured interview approaches or a combination of both and are both retrospective and prospective in nature (Zeanah, 1989). Individual case studies have also been described in the literature (Leon, 1986;Lewis & Page, 1980). Most of the studies on the effects of perinatal loss have been conducted short-term, one to two years following the death.

The longest term follow-up study was conducted 12-14 years after the loss (Zeanah, 1989). Rosenblatt & Burns (1986) conducted a small scale, random sample (not purposively chosen) interview study in which one incident of ongoing grief was still reported as much as 44 years later; this study consisted of reported "stories of loss" including how they affected relationships with other children, but did not relate specifically to the effects on the subsequent child. Covington & Theut (1993) did conduct a qualitative analysis of the 1988 National Maternal and Infant Health

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Survey. An open-ended question added to the survey yielded responses identifying major themes in reactions to loss.

Zeanah (1989) comments on the gaps in the literature on perinatal loss, noting the lack of longer-term follow-up studies and the focus on quantitative measurement of affective symptomatology (depression) rather than exploration of the deeper experience of grief, per se; the "experience behind the numbers" (Black, 1991). The focus is on pathologic outcomes, with much anecdotal data provided to evidence disordered mourning. However he notes that certain quantitative instruments and their use in research studies have made important contributions to the literature: for example, The Perinatal Grief Scale (Toedter, 1988) is specific to perinatal grief and attempts to characterize the unique components of perinatal grief vs. other types, such as the absence (often) of a visible, publicly acknowledged object to mourn; heightened feelings of guilt; unwillingness of people to discuss it, causing isolation; often unknown cause of death; perceived need for each partner to remain strong for the other; feelings of betrayal by one's body, anger at the occurrence of a trauma rather than a joyous event; envy of others; feelings of vulnerability; feelings

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of having let down one's husband and the possibility of multiple anniversary reactions (date of conception, due date, date of loss, etc.) Very little literature exists on the relationship between grief and the subsequent pregnancy/child: only one study located (Theut, et. al., 1990), utilizing the Perinatal Bereavement Scale, examined the grief reactions of parents during the pregnancy subsequent to loss and during the subsequent child's early development. Though the literature notes the importance of working through the grief of perinatal loss prior to attempting subsequent pregnancy and the failure of many people to do so, no studies have attempted to assess how people determine that mourning is complete; how individuals define that grief resolution is sufficient enough to pursue another pregnancy.

SUBSEQUENT PREGNANCY: DECISION MAKING/EMOTIONAL PROCESS

Studies on the experience of pregnancy subsequent to loss utilize both quantitative and qualitative methodologies. Only one study systematically evaluated decision making after loss: Davis et. al., (1989) examined effects of doctor's advice on subsequent pregnancy, utilizing a self-report, structured open ended interview,

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the Perinatal Loss Interview. This is an open ended instrument used to explore mother's perceptions of feelings, thoughts and behaviors in regard to pregnancy loss including the subsequent pregnancy and child. Very little is known about the processes of decision making around health issues, particularly in the area of reproductive medicine yet this will be an increasingly expanding and important area to understand (Black, 1982; Walther, 1991).

Some studies of the emotional experience of subsequent pregnancy have utilized standardized measures of affects (depression, anxiety) that were not necessarily constructed to measure the unique situations of pregnancy after perinatal loss or infertility. For example, Bernstein (1988) used the Hopkins Symptom Checklist to examine affects such as depression, hostility, and interpersonal sensitivity in infertile couples after successful pregnancy; other studies are strictly statistical in nature, measuring rates of fertility subsequent to loss (Mandell, 1975).

Conversely, Theut, et. al., (1988) designed the Pregnancy Outcome Questionnaire to measure parental anxiety specific to pregnancy after loss. This measure is unique to the post-loss situation and was used to compare this

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specific anxiety to the more generalized anxiety of low-risk pregnancy. Such an instrument appears most valuable in terms of exploring and differentiating the quality of anxiety, not just measuring its prevalence or intensity. Leifer (1980) noted that while many researchers have studied the intensity of anxiety as a characteristic emotion of pregnancy, its content and meaning have been ignored. This is true also of the anxiety specific to the post-loss pregnancy situation.

Few studies have examined how people cope with the stress of pregnancy after loss. Phipps (1985) conducted an extensive qualitative study of stresses and adaptation to pregnancy after stillbirth. He interviewed 15 couples with children ranging in age from 5 mos to 3 years, regarding the unique aspects of subsequent pregnancy in seven different areas: pregnancy planning, initial responses to pregnancy, social issues, psychological aspects, response to medical intervention, delivery, early response to child. Parents' perceptions were elicited by reliance on retrospective, self-reported interviews which were then reviewed and coded for categories and themes to define parameters and generate hypotheses (analysis applied qualitative methods of Glaser &

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Strauss) (Phipps, 1985). Field & Marck (1994) used the theoretical insights derived from a collection of qualitative studies on uncertain motherhood to propose a model for coping when the outcome of motherhood is uncertain. They noted that the women interviewed in these studies appeared to identify the threat to motherhood, appraise its severity, and then employ strategies to protect themselves from hurt (guarding, self-protection, affect control, connecting/disconnecting from the event, telling others/not telling, seeking information, blocking information). How well these strategies work, and their long-term implications (post-birth) have not been fully addressed.

SUBSEQUENT PREGNANCY: EFFECTS OF TECHNOLOGY

A minimal literature exists on the effects of reproductive technologies and the increased use of diagnostic technologies on the process of pregnancy. Fletcher & Evans (1983) described enhanced maternal-fetal bonding in patients during early ultrasound examinations, however their reporting is based upon only three examples. Rothman (1986) conducted an extensive qualitative study on the emotional impact of both positive and negative

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amniocentesis results, including the effects on prenatal attachment.

PREGNANCY AS A DEVELOPMENTAL PROCESS

Studies that have been conducted on the psychological aspects of the developmental process of pregnancy have focused mostly on women in low-risk situations, generally either in the third trimester or longitudinally over time, into the postpartum period. Developmental tasks of pregnancy have been described in detail by Leifer (1980) who utilized mothers' reporting of involvement with their fetuses. Leifer's extensive longitudinal study (published as a book, The Psychological Effects of Motherhood) is exploratory, descriptive, and hypothesis generating. She used a small sample (19) of women pregnant for the first time to study the experiences of pregnancy and early parenthood. Leifer used the principle of selecting strategic cases for investigation (theoretical sampling) not to represent the population at large, but rather to learn more about certain theoretical concepts. In-depth interviews were conducted which were guided by theoretical concepts, common sense observations about pregnancy and parenthood and suggestions from women in a pilot study. In

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addition to in-depth interviews, six research instruments were used as a data source. Analysis was conducted using systematic coding and rating using qualitative approaches. Leifer (1980) derived a descriptive typology of pregnancy and early motherhood by analyzing the themes that emerged in examining women's attitudes to pregnancy and motherhood over time. The theoretical views about maternity were then applied to arrive at specific interventions and changes that might enhance the experience of parenthood.

The categories Leifer (1980) explored in her study included motivations for/responses to pregnancy, emotional changes during pregnancy and early parenthood and the development of maternal feelings including the process of attachment.

Additionally, Leifer (1980) approached pregnancy and parenthood not necessarily as crises, noting that most studies have measured psychological variables predictive of "adjustment," correlating antecedent with postpartum conditions, rather than exploring women's subjective reactions to pregnancy; the meaning of the events is ignored. She noted further that psychoanalysts such as Bibring and Benedek studied pregnancy in samples of

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populations in psychotherapy, focusing on the resurgence of intrapsychic conflicts at this time and importantly, ignoring the broad social forces impacting upon the processes of pregnancy and parenthood.

PRENATAL ATTACHMENT: MOTHERS

Many of the studies of the psychological processes of pregnancy center on the task of prenatal attachment, thought to be crucial to postpartum adjustment. The process of prenatal attachment has been measured primarily with quantitative instruments. Cranley (1981) designed the widely utilized Maternal Fetal Attachment Scale (MFAS), a 24 item scale with 6 subscales (differentiation of self from fetus; interaction with the fetus; attributing characteristics and intentions to the fetus; giving of self; roletaking, nesting) developed to measure the construct of maternal fetal attachment during pregnancy. Maternal fetal attachment was defined as the extent to which women engage in behaviors that represent an affiliation and interaction with their unborn child (Cranley, 1981, p.282). These categories, deductively generated by speaking with professionals about statements mothers make, supported the notion that prenatal attachment is multidimensional, but

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only three of the subscales were actually supported in an evaluation of the scale by Muller and Ferketich (1987) which used content analysis of parental remarks to assess accuracy of the dimensions of the MFAS. The authors concluded that Cranley's MFAS needs to be expanded to fully represent dimensions of maternal fetal attachment and indeed, speaking with mothers directly seems valuable in this effort. Leifer (1980) noted that what is missing from studies of motherhood has been a focus on how women themselves respond to changes in pregnancy and motherhood. Ribbens (1994) adds that expert ideas and theories have largely dominated the area of parenthood with a failure to listen to what women themselves have to say.

Another major limitation of existing quantitative measurements is that they reflect prenatal attachment to the fetus, but only continued use and correlation with later parental attachment behaviors would support or contradict their validity of parental statements as a measure of attachment. (This supports the case for looking at the developing parent-child relationship over time, particularly in relation to the antenatal experience). Correlational studies linked with the post-birth period are limited:

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Cranley, studying women only 3 days postpartum found no correlation between prenatal and postnatal attachment using the Neonatal Perception Inventory, but this contradicts other findings based on studies using pre (MFAS) and post (Avant's maternal attachment assessment scale) test measures with interventions between to promote intrauterine attachment and foster maternal awareness and response to fetal cues (Davis, 1987).

Overall, little has been written about the extent to which pregnant women develop an emotional attachment to the fetus and more so and perhaps more importantly, whether this attachment is significantly related to the attitude toward the baby, especially over time. The association between attitudes toward pregnancy and subsequent adaptation to the maternal role is not clear cut (Leifer, 1980). In general, studies show that women who are more accepting of their pregnancies relate more positively to their babies, while those who are more anxious have children with more difficulties; the strength of the emotional bond with the fetus is predictive of psychological preparedness for parenthood (Leifer, 1980) but it seems that much more could be learned about this through asking mothers directly about

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their experiences. Gaffney (1986) explored the relationship between maternal fetal attachment and self concept and anxiety, again using quantitative measurements in the third trimester. Stainton (1985) conducted an exploratory study of perceptions and interpretations of fetal behavior to differentiate the dreamed about baby from the actual, using questions such as "what do you know about the baby? She developed categories from an analysis of themes rather than starting with predetermined subscales to measure attachment. Certainly in the case of high risk pregnancy, the concepts of pre-natal attachment and anxiety and the long term implications of both need to be viewed in a broader context.

SUBSEQUENT PREGNANCY AND HIGH RISK PREGNANCY AS DEVELOPMENTAL PROCESSES

While little research has been conducted on subjective experiences of normal pregnancy, even less has been done on how high risk status affects woman's psychological experience of pregnancy (Kemp & Page, 1987). Will the traditional models of pregnancy and parenthood apply?

A number of comparative studies have been done between low and high risk groups: Kemp & Page (1987) looked at maternal self esteem and prenatal attachment in the high and

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low risk situation. Using the Rosenberg self-esteem scale and the Rees prenatal attachment scale, they found no significant differences in attachment between the two groups. However, one wonders about the more subtle differences perhaps not measurable quantitatively since much of the literature based upon interview (and hypothesis) indicates the high risk woman's difficulty with prenatal attachment and her use of coping/defense mechanisms such as denial and guarding for protection from attachment (Davis, 1991; Hense, 1994; Kirksey, 1987; McGeary, 1994; Penticuff, 1982; Valentine, 1982). It appears that such a controversial area could use more qualitative assessment of the actual process of prenatal attachment for people in a high risk situation. What is lacking in the literature as well is some linkage between the experience of pregnancy (in this case, post-loss) and premorbid personality; the experience is treated outside of context and this detracts from understanding the personal meaning of it as well as any ability to differentiate responses to pregnancy from more generalized or characteristic responses.

Snyder (1979) presented a high risk mother trajectory of pregnancy but how it is derived is unclear from her paper

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which does not present a study. Stainton et. al., (1992), in her paper Maternal Tasks of Uncertain Motherhood and Field and Marck's (1994) book Uncertain Motherhood present phenomenological studies conducted by nurses using unstructured interviews to assess the experience of uncertain pregnancy and motherhood. The latter book is a collection of six research studies utilizing a phenomenological method of inquiry, a grounded theory approach that explored from different perspectives the experiences of women faced with uncertainty during their childbearing years. These studies analyzed the "stories" of women experiencing uncertain outcomes in relation to pregnancy, basically by asking "What is it like for you?" Studies examined the circumstances of infertility, unexpected pregnancy, uncertain health of mother or child, livebirth following stillbirth, premature birth and birth defects. Through analysis of themes that resurfaced throughout the women's stories the researchers theorized about commonalities and differences that speak to the experience of uncertain motherhood. These studies were designed to examine these experiences through a phenomenological approach because the researchers felt they

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did not understand the high risk perinatal situation and they wanted to be able to provide informed, accurate, and appropriate nursing care.

Further, Stainton et. al., (1992) interviewed high risk mothers during pregnancy and then through 6 mos postbirth, asking "what has the situation been like for you?" and also examined diaries, journals and self interpretation of stories. Out of her analysis came developmental tasks of uncertain motherhood which were then related to Rubin's (1984) stages of attainment of maternal identity (in the normative pregnancy). Stainton's research supported Rubin's (1984) original theory of developmental tasks identified and described in the process of maternal role attainment: seeking safe passage; seeking acceptance of the child; seeking acceptance of self as mother to the child, the "binding-in;" and exploration of the meaning of giving of self to another, with some shades added to the original theory.

TRANSITION TO PARENTHOOD

Many of the studies regarding the process of postpartum attachment originate in the developmental psychology and nursing literatures. The early postpartum period was

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studied by Leifer (1980) and extensively by Rubin (1984), who conducted a systematic, descriptive analysis of the subjective maternal experience. Rubin (1984) utilized the qualitative method of the "naturalist in the field" to discover and generate hypotheses. To explore attainment of the maternal role, subjects were observed for behavior in hospitals and interviewed. The primary question was "How does this woman feel about herself in this situation at this time (Rubin, 1984, viii)?" A very large sample (6,000 women, representing a wide variety of demographic background and experience) were observed and interviewed from the beginning of pregnancy through 6 weeks postpartum regarding their experiences. Content of the data was recorded, analyzed and presented in book form, with chapter headings derived from the central themes relevant to the subjective experience of chilbearing. Rubin (1984) identified four tasks of maternal roletaking: safe passage, acceptance by others, binding in to the child and giving of oneself and earlier had investigated the various processes, models and referrants used in attainment of the maternal role (1967).

Mercer (1984) studied the process of maternal role attainment in three age groups over the first year of

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motherhood using quantitative and qualitative methods and a longitudinal design. Mercer (1986, p. 6) defined maternal role attainment as a process that has been observed to occur over a 3-10 month period with major components including attahment to the infant through identifying, claiming and interacting with the infant, gaining competence in mothering behaviors, and expressing gratification in the mother-infant interactions. She operationalized maternal role attainment using four measures that use scales: feelings of love for the baby; gratification in the mothering role; observed maternal behaviors and ways of handling irritating child behaviors and then completed interviews with mothers in the hospital and then at home regarding maternal role attainment.

One seminal study on maternal attachment was done by Klaus & Kennell, et. al. (1972). Using comparison groups, they studied the differences in bonding between two groups of mothers, one which had more early contact time with the newborn than the other. Three- question interviews and observations were used to determine that a "maternal sensitive period" exists early on postpartum and has a powerful effect on a mother's interaction with her infant as

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well as later development. Studies have attempted to look at early bonding as it relates to prenatal attachment, but fewer prospectively, as a predictor of the later relationship (Lamb, 1982). Though studies such as Condon (1988) look at the correlation between the (prenatal) fantasy baby and first impression of the neonate (reality baby) using self report questionnaires and interviews, a great discontinuity exists in the literature in terms of what happens to the first impression of the neonate over time and the lasting effects on the parent-child relationship.

PARENTHOOD AFTER LOSS-THE SUBSEQUENT CHILD

A very small amount of literature exists on the effects of perinatal loss on the subsequent child, particularly over time. The most extensive treatment of the subject is by Davis (1991) who qualitatively studied the experiences of perinatal loss, subsequent pregnancy and subsequent child using the Perinatal Loss Interview. She noted the spontaneous discussion of 24 mothers about overprotective and replacement feelings toward the subsequent child, regardless of the time since birth. What is lacking in this study is follow up over a longer period of time.

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Theut, et. al., (1992) studied perinatal loss and the maternal attitude toward the subsequent child. Measures (Maternal Attitude Questionnaire; Maternal Separation Anxiety Scale) specific to the situation were derived from pilot interviews that yielded concern with the subsequent child's health and with separation/psychological differentiation. The researchers wanted to evaluate the degree of investment in the child and chose parents with children at 16 months of age, particularly because this corresponds with the time of psychological separation/individuation.

To this researcher's knowledge, no formal studies have been conducted of parental experience beyond 16 months, though Glazer (1990) in her book The Long Awaited Stork: A Guide to Parenting After Infertility, (culled from letters and anecdotes) has chapters on issues specific to preschool, latency and adolescent years.

Other related bodies of literature were reviewed assessing long term attitudes, stereotyping effects (Stern, 1986) and effects on the parent-child relationship of special situations such as early neonatal risk, (Blumberg, 1980) prematurity or early illness and vulnerability to

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assess whether parents' early feelings and attitudes are distinct or prevail long-term. A study by Sigal et. al., (1973) regarding later sequelae of early illness is the only study that asked children to rate their parents' attitudes toward them compared to siblings. Most studies of the effects of parental experience on children tend to be from the parents' perspective. At some point it would be useful and novel to study subsequent children's experiences over time and assess feelings and attitudes from their, not their parents' perspective. This was however, beyond the scope of this project.

Those studies measuring later sequelae of early phenomena used predominantly quantitative measures: mother child relationship inventory, personal assessment inventory (Scheiner, et al, 1985); low birthweight-child behavior checklist (Philipp, 1983); parent-child relationship after NICU (Kratochvil, et al, 1991); correlates of vulnerability (Perrin, et. al., 1989); child vulnerability scale (McCormick, et al, 1982; Busch-Nossnagel, et. al., 1984). Many of these measures are derived from child development or child psychology research and again, measure less content

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and meaning of experience than qualitative exploration might.

Studies that look at the effects of sibling death in childhood on the remaining child (Blinder, 1972; Cain & Cain, 1963; Poznanski, 1972) tend to rely on case reports of children seen in child guidance clinics, and therefore suggest a population with pathology. As few as two to three cases (Krell & Rabkin, 1979) are illustrated to derive various labels for categories to form a typology of children who are born subsequent to death of another child.

It is from a clinic population that the concept of the "replacement child" was derived, and from looking at children born after a death in latency or adolescence not infancy, or even earlier, perhaps subsequent to a fetal death or miscarriage. This phenomenon has also been studied in the literature on children of Holocaust survivors, also culled generally from clinic populations (Davidson, 1980; Sigal, et. al., 1973) to assess the effects of homogeneous parental trauma on the second generation. Zeanah (1989) noted that only indirect empirical support is available for the replacement phenomenon after perinatal loss (fast conception), but more direct evidence is unavailable as is

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how this relates to subsequent children. This is an area for further exploration.

Solnit & Green (1964) relied on 6 years of observations of pediatric patients (with early difficulties) and interviews to determine the concept of the "vulnerable child syndrome." Articles on the replacement child and the vulnerable child syndromes provided little information regarding the details of questions asked that resulted in these derived categories. Again, this literature neglects discussion of the premorbid personalities of the subjects studied so as to treat these perceptions as unintegrated into the context of the larger parent-child relationship or other parental attitudes.

Only one study located (Priel & Kantor, 1988) compared high risk pregnancy mothers' perceptions of their infants with low risk mothers at 3 months; this study used the Broussards Neonatal Perception Inventories to evaluate maternal perception of one's own vs. an average baby.

METHODOLOGY FOR THIS RESEARCH PROJECT

This project utilized a qualitative approach to research with the semi-structured, in-depth interview as the research instrument. Using a grounded theory approach, the

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researcher explored the experiences of perinatal loss and its effects on subsequent pregnancy and parenting from the vantage point of the individual mothers who had experienced the losses.

QUALITATIVE RESEARCH APPROACH

Qualitative inquiry is an exploratory, naturalistic effort to inductively and holistically understand the experiences of a group of people, rather than test theoretically derived hypotheses (Patton, 1990). This methodology lends itself to the study of the more subtle dimensions of new and little explored phenomena. In-depth inquiry captures people's experiences and perspectives and uncovers and yields important dimensions of the phenomena being studied. Since there is little information available concerning the meaning or special significance of perinatal loss once subsequent pregnancy and parenthood are attained (i.e., the longer-term effects), the qualitative approach appears appropriate to gain new and beginning understanding; to explore what it is actually like to live through these events (Field & Marck, 1994) from the perspective of those involved; to look at the phenomenological and subjective experiences of women who have experienced perinatal loss and

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then eventually become parents (Rubin, 1984). This method seems particularly relevant to this area since while medicine is providing the technology of advances, understanding of the emotional and psychological complexities has not kept pace (Field & Marck, 1994; Walther, 1991). A comprehensive exploration of the latter seems pragmatic and crucial to the planning and implementation of social health and mental health services.

GROUNDED THEORY

Since "shadow grief," subsequent pregnancy and parenthood after loss are areas of minimal empirical exploration, the overarching goal of this project was to generate new concepts or constructs that would integrate the psychological and social dimensions of these experiences, enabling deeper understanding of women's experiences that would ultimately enhance and facilitate the delivery of health and mental health services. This project used a grounded theory approach, an inductive process, whereby the complex realities of a given social setting were explored and discovered, in order to generate theory grounded in the reality of the social system (Field & Marck, 1994). As an inductive method, theoretical concepts are derived through

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observation from the data, rather than the data testing previous hypotheses. Complicated social realities are not fully and deeply explicated in quantitative measurements which tend to use closed-ended rating scales and are limited to exploring independent/dependent relationships; the goal of this study was to capture the patterns of feelings and rich emotional experiences of the processes of perinatal loss and pregnancy and parenthood after loss, new and little explored phenomena. The subject matter suggested a research process in which the meaning and lived experiences of participants are important. Leifer (1980) notes that most accounts of what pregnancy and motherhood mean have come not from the professional literature, but from the women's health movement and descriptive accounts. While the nursing profession (and psychology to a lesser extent) has recognized the value of more subjective and phenomenonological exploration in these areas, (and in high-risk pregnancy situations), little research has been done by social workers, who most certainly come into contact with people affected by these experiences.

A literature review was conducted to identify existing relevant studies and concepts and any gaps that

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suggestedinitial directions for research. As new concepts emerged, a return to the literature was useful in linking emerging theories with those already identified, noting any congruencies or disparities.

SAMPLING PROCEDURES

In a grounded theory approach, it is important to recruit participants who meet the information needs of the study; theoretical sampling yields information-rich cases (Patton, 1990). For in-depth interviews, the researcher sought mothers who had suffered prior perinatal loss and aimed to select participants who had three qualities of a good informant: knowledge of the topic, ability to reflect on personal experience, and willingness to share that experience (Field & Marck, 1994).

Since it was difficult to locate respondents with this specific experience in one setting, social networking, snowball sampling and advertising were used to yield a purposive sample. Social networking refers to both "word-of-mouth" referrals made to the researcher by peers who knew of the study as well as a contact made with the director of a high-risk pregnancy support organization who was able to recruit participants. In regard to advertising, subjects

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were recruited both through the newsletters of two organizations that deal specifically with reproductive problems, as well as three general, parent-oriented newspapers serving the metropolitan area. It was felt that the latter strategy (reaching the more general population of parents) would broaden the search for respondents who did not necessarily identify themselves as members of a group specifically designated for people with problems of pregnancy. An effort was made to diversify the sample racially and ethnically by advertising in newspapers circulating in neighborhoods of predominantly non-white composition, however these yielded no viable respondents.

The study was initially advertised as one of the effects of pregnancy loss on *first-time* pregnancy and parenthood, however when interest in the project was expressed by several women who had a child prior to their losses, in addition to subsequent children, it was decided that the criterion of first-time parenthood would be eliminated and that the effects of having prior children could serve as a variable for consideration in the study.

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PROTECTION OF RESPONDENTS

This research was conducted in accordance with guidelines established by the Hunter College Committee for Protection of Human Subjects for Research Risks Institutional Review Board. All participants were assured of confidentiality and anonymity. The researcher introduced herself personally, with a letter of introduction (see Appendix A - attached Letter of Introduction), described the purpose of the project, informed respondents of the time commitment needed for participation, and guaranteed the right to withdraw at any time, stop at any time during the interview and also to get feedback about results. Instructions, purpose, process and expectations were made clear.

Respondents' emotional protection was considered by the researcher's offer to respondents to stop whenever material felt too difficult to discuss and her availability to respondents subsequent to the interview process should any difficult emotional issues have arisen that required follow-up contact. The researcher's professional training as a psychotherapist and awareness of the emotional potency of

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the subject matter served as an asset in the support and encouragement of respondents as needed.

SAMPLE CHARACTERISTICS

A total of 32 respondents were recruited and interviewed for this study. Sixteen respondents were generated from advertisements in parent-oriented newspapers, 10 through social networking, 4 from newsletters specific to women with reproductive problems and 2 through "snowballing." All women who responded to advertisements and met the criteria of achieving pregnancy and parenthood after loss were interviewed. The interview process was assessed as complete once theoretical saturation occurred; i.e., no new data emerged, categories were densely developed, and the relationship between categories was well established and validated (Strauss & Corbin, 1990, p. 188).

The sample was predominantly white (29); two respondents were Black and one was Hispanic.

At the time of the interview, 25 of the women were over 35 years of age, (35 determining the point of high-risk pregnancy); (14 were over 40, the eldest being 50) while only 7 were under 35 (the youngest being 24).

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This sample group was middle-class, all were at least college-educated, with 16 possessing advanced degrees and 3 pursuing such. At the time of the interview, 9 worked full-time, 11 worked part-time, 9 were full-time mothers (all had worked prior to having a child) and 3 were full-time students (11 of the 32 are in the mental health profession).

Six women had a child prior to loss while 26 had become first-time parents subsequent to loss. Of the 32 respondents, 16 had one child, 12 had two children, 3 had more than two and one was expecting her first (subsequent) child. (A total of four women were pregnant with subsequent children at the time of the interview). Of the 32 respondents, 11 had suffered one loss only; 11 had two losses, 4 had three, 5 had four losses, and 1 had five. Eleven women had first trimester losses only (of these, 10 had multiple miscarriages); 11 had later losses only and 10 had a combination of early and late loss. Five women experienced voluntary (therapeutic) 2nd trimester terminations, either solely, or in addition to other, spontaneous losses. The length of time since the last loss ranged from as recently as 4 weeks prior to the interview to as much as eleven years ago.

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Twenty-seven women attempted subsequent pregnancy 3-4 months after the loss while only 5 waited up to a year and a half before pursuing pregnancy again.

REPRESENTATIVENESS OF THE SAMPLE

In quantitative research, the aim of sampling is to achieve representativeness of the sample; to select a part of a population to represent the entire population to which one wants to generalize. Alternately, in qualitative research and grounded theory, the concern is with representativeness of concepts; events that are indicative of phenomena. (Strauss & Corbin, 1990). Such an approach generally utilizes purposive sampling which does not use probability estimates to approximate population representation. Rather it seeks representativeness by "purposefully" choosing a sample that typifies the phenomena to be studied. Therefore, this approach does not sanction statements to be made about the general population from this particular sample, but enables comprehensive learning about the conceptual structure of the phenomena of study. (McMahon, 1995).

In this research project, the sample was a self-selected one with the goal of studying the characteristic

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phenomena relevant to the experiences of perinatal loss, subsequent pregnancy and parenting, and does not necessarily represent the general population. Interestingly however, while perinatal mortality rates are highest among poor, nonwhite and uneducated women, (and thus not reflected in this sample), the composition of the sample probably resembled closely the general demographics of a different group of women who are currently experiencing perinatal loss and subsequent parenthood in increasing numbers: those women of the "baby boomer generation" who did not want children but then changed their minds in large numbers in their 30's and 40s (New York Times, February 12, 1995). Unlike the larger population, these women suffered perinatal loss and then pursued superior medical care, facilitating the births of their subsequent children. However, access to high-quality medical care alone did not appear to insulate against the psychological effects of their experiences, thus hinting perhaps at the emotional limits of reproductive technologies.

Similarly, while nearly one-third (11) of respondents were in the mental health professions, 15 had discussed their experiences in individual therapy or a loss support

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group, 3 had pastoral counseling and four counseled women with pregnancy problems, the women appeared to continue to be strongly emotionally cathected to the experiences, displaying intensity of sadness and anger. Indeed, some who answered the advertisement commented on the interviews' cathartic and therapeutic potential, in that they had not shared their "stories" with anyone genuinely interested in their experiences. Many of the respondents urged the researcher to use the findings to educate others, particularly those in the medical professions, about the emotional impacts of perinatal loss.

DATA COLLECTION

Data was collected for this study from late April through early September, 1995. The primary source for data collection was a semi-structured, tape recorded in-depth interview, of approximately 1 1/2 to 2 hours in length (see Appendix B-attached Interview Guide). This data-gathering instrument included both informal conversational interview and general interview guide questions (Patton, 1988). Taperecording, rather than note taking was used to capture interviews verbatim so as not to divert the researcher's attention from the respondents who shared sensitive subject

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matter. Descriptions of any other observations made while interviewing respondents (nonverbal communication, etc.) were noted as well. For the sake of convenience, respondents were given the option to be interviewed either at home, in their workplace or in the researcher's office. Six interviews were conducted by telephone because geographic location or respondents' personal obligations precluded time for face-to-face contact. All respondents were voluntary candidates who signed consent to participate in the study. While some emotional resistance had been anticipated since material sought was often of a charged and painful nature, respondents did not evidence difficulty with remembering or disclosing the minutest details of their experiences.

## MEASUREMENT AND QUESTIONNAIRE CONSTRUCTION

Thirty-two qualitative interviews were conducted using a standardized, open-ended format, asking the same questions of each person interviewed. The open-ended format permits identification of more precise shades of meaning than can be expressed in the close-ended format of quantitative instruments (Pridham, 1987). The interview questions were written out in the way they were asked during the interview and probing questions were placed in the interview as needed

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(Patton, 1990). The semi-structured, standardized interview was appropriate to this study given the wish to minimize interviewer effects and judgment; such a format also makes data analysis easier (Ibid.). Questions were primarily aimed at eliciting descriptions of experiences, behaviors, actions, feelings and thoughts, present and past. Components of the following existing instruments relevant to the study of subsequent pregnancy and parenthood were utilized: The Perinatal Loss Interview (Davis & Stewart, 1984); What Being The Parent of a New Baby is Like (Pridham & Chang, 1985); Qualitative Interview of The Subsequent Pregnancy after Stillbirth (Phipps, 1985); Maternal Attitude Questionnaire (Theut, 1990). The questionnaire was introduced by a statement of the researcher's wish to understand more about the long term ramifications of perinatal loss including how it affects the experiences of subsequent pregnancy and parenting (see Appendix A -Letter of Introduction to Interview Guide and Signed Consent Form). The study examined a process of development over time and respondents were asked to think retrospectively about their experiences. This was a "trace-back analysis" from the loss through to the pregnancy, then parenthood to the present.

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Questions were sequenced so as to render a process over time which culminated in the respondents' current experiences.

ACCURACY

From the standpoint of accuracy, ideally, a longitudinal, prospective study would have been most appropriate to the study of pregnancy loss, subsequent pregnancy and parenthood since these could be conceptualized as (developmental) processes occurring and perhaps changing, over time (Leifer, 1980). However, practical considerations of time and access prohibited this as a possibility for this research project.

Therefore, this interview process required recollection and retrospection and relied on memory. These processes may raise concerns regarding accuracy of the material reported, as retrospection and memory may be subject to distortions of recall. With specific regard to memories of pregnancy loss, Condon (1986) noted the added possibility that sedation at the time of trauma could impair recollection of real events, though memories of the emotional climate appear to be clearly retained. The researcher also considered that accurate memories of past (traumatic) events might have been repressed, or clouded and overshadowed by the more positive

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present experience of having attained parenthood, given the proposition by Loewald (1975), that ways of reliving the past are influenced by novel present experience; certain past experiences are seen in a different light and felt differently. Thus it was of concern that the past, and potent descriptions of the past might be diminished by the (more joyous) present, however this did not appear to be borne out judging by the incredible detail and intensity of the sense of loss with which respondents' histories were narrated.

In fact it is possible that respondents' memories were particularly acute and reliable given the role they play in serving as a connection to the past. The past is "irretrievably lost" without memory (Loewald, 1976, p. 148) and in the particular circumstance of death, memory maintains an attachment to to the people one has lost (Hogman, 1985). The respondents might then, cling tenaciously and precisely to their memories as a way of remembering their dead children, the way some clung to their grief as a similar means of connection.

The issue of reliability of memory may be raised in regard to the lack of standardized amount of time since the

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losses of the respondents interviewed. Can a loss that occurred eleven years ago be reported with the same accuracy as a loss that occurred one month ago? Langer (1991, p.xv) (writing of the reliability of memory of Holocaust survivors providing testimonies) responds to the question of "How credible can a reawakened memory be that tries to revive events so many decades after they occurred?" with the statement that "there is no need to revive what has never died." Ultimately, for the respondents interviewed, it appeared that in spite of how long ago the loss occurred, the details and affects were recalled with great clarity, emotion and precision. Rosenblatt & Burns (1986) concluded that the availability of detailed memory indicates that perinatal loss is too unusual, and too significant to be easily forgotten.

EXTERNAL VALIDITY

In regard to the external validity (generalizability) of a study, Patton (1980) wrote that qualitative methods produce detailed information about a smaller number of cases, increasing understanding but reducing generalizability. Straus & Corbin (1990) noted that in grounded theory, we seek not to make generalizations to a

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larger population, but rather to specify the elements of their experience. Field & Marck (1994, p.295) noted that while commonalities of experience need to be understood, there is also "weakness to generalizing experiences that are not generalizable." Yin (1984) wrote of the difficulty in ensuring external validity when doing qualitative (case) studies because they rely on analytical generalizations in which the researcher seeks to generalize a set of results to some broader theory.

The generalizability of this study is limited since it included a small sample of people, whose representativeness of the general population is not certain (see Representativeness of the Sample). Since this study was an exploratory and preliminary one, theoretical constructs generated by this study, should be tested further in studies with other individuals who have undergone the same experience before results can be generalized. As an added measure of external validity, findings were related back to the small amount of existing literature to assess how well they correspond.

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INTERNAL VALIDITY

Yin (1984) stated that the concern over validity for qualitative (case) research may be extended to the broader problem of making inferences. Investigators infer that a particular event resulted from an earlier occurrence based on interview and documentation. To insure validity of the inference one has to consider that rival explanations have been considered. In the case of this study it was important to know that the questions asked accurately reflected the phenomena of study (perinatal loss, pregnancy and parenting after loss) and that wording did not force respondents to answer in a particular way. Additionally, inferences had to be made cautiously, as it is hard to know whether these parents would have described the same experiences around pregnancy and parenting had they not undergone loss (since this is not a direct cause and effect phenomenon and not a comparative study with a control group). Those instances in which respondents were able to make distinctions and ascertain which dimensions of their experiences of subsequent pregnancy and parenthood felt uniquely correlated with loss were documented. Some astutely noted the possible

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contributions to their experiences of confounding and competing variables such as their own premorbid personalities, "normative" feelings of first-time parents, etc. and these are reported. Such elements of respondents lives must be considered, rather than treating their experiences of subsequent pregnancy and parenthood in isolation if some determination is to be made regarding what is specific to the particular circumstances of loss (vs. what might occur normatively).

RELIABILITY

Reliability insures that this or another researcher could repeat this study with the same set of respondents and get the same results. For this to happen, instructions had to be clear and unambiguous and the process clear enough that it could be documented and replicated. The inclusion of some standardized questions assisted with reliability in that it provided some insurance that all interviewees responded to the same questions asked and that they could be repeated. The researcher was extremely careful about conducting herself in a similar manner with all interviewees to somehow standardize their responses and also about being internally consistent in coding the qualitative data, making

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certain that themes were rendered reliably and that judgment about such was consistent. This was difficult at times since the researcher's own immersion in the experience and lack of detachment from it at times affected the way in which responses were heard. However, the researcher's self-awareness, awareness of her identifications with clients' experiences and emotional vulnerability during the process, professional discipline and self-monitoring facilitated objective listening and reliable rendering of material. Moreover, it was felt that the researcher's professional training as a psychotherapist facilitated the emergence of highly sensitive and emotionally charged content and the ability to draw on her own heuristic experiences (Moustakis, 1990) as a mother who experienced prior perinatal losses assisted with relating sensitively to respondents, eliciting and hearing material and identifying themes.

DATA ANALYSIS

Qualitative analysis involves description and interpretation of data (Patton, 1990); bringing "experience to language" (Field & Marck, 1994). The first step in analyzing the data obtained from this study was to present "thick description" of the answers to the major questions

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asked; the second was to explain the findings, highlighting significant themes and patterns. While the latter implies interpretation of the material, in essence the data is presented primarily in such a way as to allow respondents to "speak for themselves." Both of these steps (presenting descriptions and elucidating patterns and themes) were done keeping the initial goals of the project in mind so that the presentation of findings cohered with the original purpose and focus of the study.

All interviews were conducted, tape-recorded and then transcribed using WordPerfect 5.1 by the researcher. Interviews were read several times and the content of interviews was then analyzed manually and with utilization of Martin software with the goals of identifying, coding and categorizing the primary patterns in the data (Patton, 1990). Careful attention was paid to respondents' significant words, phrases and metaphors which so richly and aptly reflected their experiences. The women's metaphors, those "figures of speech in which a word is applied to an object that it does not literally denote in order to imply a resemblance" (Barker, 1985, p. 5) communicated strong, inexpressible feelings that were hard to convey in any other

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way and were basic to their constructions of the world through perceptions and categories of thought (Siegelman, 1990).

This was an inductive analysis, meaning that the themes, patterns and categories emerged from the data (Patton, 1990) and natural variations were observed. Categories emerged from the respondents studied (indigenous categories) or the researcher's articulation of that which respondents could not name (analyst-generated categories) and contained "recurring regularities" in the data (Ibid.).

Once descriptions were complete, interpretation was used to offer explanations, draw conclusions, make inferences, build linkages, etc. in a speculative, hypothesizing way (not in a linear, cause and effect way). Descriptions and interpretations were reported to yield some answers to the original research questions posed.

## CONCLUSIONS

The long-term effects of perinatal loss have only just begun to be explored and understood. Further exploration of the psychological and social aspects of pregnancy loss and of subsequent pregnancy and parenting seems timely and warranted given the increasing numbers of people

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experiencing live births after loss (and infertility) made possible by reproductive technologies. The tendency may be to view such cases as "success stories" without fuller consideration of the special situations of such parents which may involve more complex sets of feelings and needs. It will be important to further understand their experiences so that proper medical and mental health care and intervention can be provided.

This study aimed to add to a growing body of knowledge of the phenomena of long term grief, pregnancy and parenting after perinatal loss. It appeared appropriate to utilize a qualitative approach to research these areas; a collaborative search between the researcher and respondents (Moustakis, 1990) that elicited the voices of the mothers themselves who have lived through these experiences and could illuminate their rich emotional and social complexities. Through a grounded theory approach, women participated in the process of discovery and used their own words and language to construct highly personal scenarios which were analyzed and assessed for commonalities and differences of experience.

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# CHAPTER FOUR

# STORIES OF PERINATAL LOSS RETOLD

As noted earlier, most of the clinical reporting on perinatal grief has centered on the immediate grief reaction to loss; the intense pain and suffering of the early bereavement period. While a longer-term, "shadow grief" (Peppers & Knapp, 1980) has been acknowledged, little is known about the lingering implications of perinatal loss. How does the experience resonate in the ongoing life of an individual, particularly once successful pregnancy and parenthood have been achieved?

As a preface to understanding the possible continuing reverberations of loss, the 32 respondents were simply asked to relate their experiences of failed pregnancy and how they coped with such. Regardless of whether the loss occurred as recently as one month, or as long as twelve years prior to the interview their stories were told with great emotional intensity.

## THE FEELINGS REMEMBERED

The experience of perinatal loss often results in sustained feelings of sadness and despair, confusion, anger,

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bitterness, resentment, guilt, loneliness and a sense of failure (Peppers & Knapp, 1980). For the women in this sample the predominant feelings recalled after loss were sadness and depression; surprise and shock; powerlessness and loss of control and anger, accompanied by envy of pregnant women, or women with children.

Sadness and Depression

The great majority of respondents related in great detail and with much affect the experience of loss from the moment of the initial discovery of fetal death or impending fetal loss. Congruent with the literature which documents that intense sadness and depression are the primary psychological responses to perinatal loss (Peppers & Knapp, 1980), most women characterized that period as one of varying degrees of "devastation and sadness."

At one end of the spectrum, respondents used extreme descriptions such as "the most grief ever experienced;" "the worst trauma ever;" "unbearable and infinite pain." Four respondents illuminated the paradoxical nature of the feelings associated with their losses; they went from "the greatest feelings of joy, optimism and hope..to total disappointment;" "complete elation to devastation;"

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"fullness to emptiness;" "feeling this living thing to finding out it's not living at all..." Another two compared this loss to that of losing their mothers, stating this was far worse.

Several of the respondents commented on the onset of depression after the loss, noting the special situation of dealing with "the physical postpartum, hormonal" feelings, exacerbated by the sadness of loss:

> It's not like you've lost a baby, your labor is induced and it's over. You come home and you still have the whole breast thing, swelling and leaking and going through all that, like your body thinks you had a baby and you're left with the same discomforts only you don't have the baby as a reward.

One woman noted the pervasive effect it had on her life:

> It (the loss) affected my whole life; my doctorate, the work I was doing...I couldn't concentrate, I was just so depressed...a depressed mess.

Premorbid Factors

Three respondents elaborated upon the impact of premorbid personality on their responses to loss, noting:

> ...it was made worse by the fact that I have a predisposition..I mean I am characterologically depressed, low level dysthymia..."

> I felt I had a personal history that was contributing to my problem with the losses, because I was an abused child and never worked that

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> through. So there was a lot of connection between that whole lack of control, not being in charge, somatic things that were triggered by the pregnancies.
>
> As a teenager I suffered from depression so I knew I would get into a funk, I mean biochemically I had the predisposition.

Yet another commented on the loss as profoundly affecting her previous outlook and mood:

> My past self was cheerful and competent. The loss increased my pessimism tremendously. Your optimism is lost when a rare trauma occurs. I can never see the glass as half full anymore. I'm fearful of everything.

Planned vs. Unplanned Pregnancy

Only two of the respondents denied any recollection of significant feelings of sadness subsequent to their losses. Both suffered very early first trimester losses. One attributed her lack of a strong emotional response to the fact that her pregnancies were in fact unanticipated and unplanned and so she was not terribly disappointed by the losses:

> I didn't really want to be pregnant and even contemplated terminating it because at the time I was not emotionally ready to deal with it. And then I lost the baby. It wasn't too intense because I wasn't happy about the idea at that moment anyhow.

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Retrospective Redefinition of Loss

Interestingly enough, when this same woman later desired conception and encountered difficulties, she then reinterpreted those earlier losses as having a more profound effect than she had realized, an indication that the context of the loss impacts significantly upon its meaning.

Gestational Age

The other woman, who suffered three early losses, introduced the variable of gestational age as possibly impacting upon feelings of loss, stating:

> There was mild disappointment, but these were not real people; there are no concrete signs of life in the first trimester.

This same woman also shared that her perspective on her early losses was shaped considerably by the subsequent unrelated loss of a 15 month old child which she found to be much more traumatic. The impact of her early miscarriages felt negligible when compared with the more recent loss of her older infant.

The importance of gestational age as a factor in the intensity of a grief reaction has been debated in the literature. While typically the assumption has been that later losses promote more intense grief, it appears that the

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degree of attachment to the fetus may more significantly impact upon severity of grief than gestational age (Ilse, 1982) and is not necessarily correlated with it.

Indeed, the former sentiment of this respondent which minimizes the effect of early pregnancy loss was not commonly shared by the eleven women who experienced _first trimester losses only_. For these women, gestational age had no bearing on the magnitude of their losses, as this respondent remarked:

> From the moment you find out you're pregnant, you're already in a "pregnancy point of a view." It feels like a child and the fantasy is already created...the loss is the end of a dream, because you create such magic in your mind, it's just such magic.

However, the latter feeling expressed by the above-mentioned respondent was universal among those who suffered either late losses only, or both early and late. The 22 women who suffered late loss only, or in combination with an earlier loss, viewed first trimester loss as simply incomparable to late gestation loss. It was placed into a different context; considered insignificant; as "barely a loss" which a number almost failed to mention in their interviews, having described their later losses in great

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detail. Two women were angered that the two episodes could even be considered as related events and made the following distinctions:

> A miscarriage is not a premature birth where a baby is born early and it dies...a miscarriage is the hypothetical loss of a potential child..the other is the loss of a specific child. You've seen the baby, felt the movement, it's a whole other thing.
>
> I had a living child that was snatched away from me. I saw this baby, I carried this baby, this baby breathed our air. There's a bit of difference. People would say I had a miscarriage and I'm not meaning to put miscarriages down but I don't think you can compare a 3-month miscarriage to a 24 week loss. I would get the same reaction as a 3 month miscarriage and this is such a different thing.

While emotions may vary and expressions of grief may be different depending upon the type of loss (Peppers & Knapp, 1980), it was clear that most mothers suffered some degree of grief, regardless of the stage of pregnancy.

Surprise and Shock

Another common emotion described by all but two of the respondents was that of extreme surprise or shock about the loss. Of the two who claimed they were not surprised by their experiences, one attributed her feelings to a history of infertility which she felt had made her pessimistic about

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childbearing in general and "prepared her for the worst." The other considered herself generally "gloomy" and never surprised by misfortune.

The great majority (93%) however, related a general lack of expectation or anticipation that anything could go wrong in a pregnancy. The element of "surprise" appeared to exacerbate the reaction to loss, as this woman (pregnant at the time of the interview) suggested:

> I never thought this would happen to me...even if you can't control the outcome...it's always better to know the possibility of a problem exists..than to be surprised. Now at least, if something happens, I have the idea. I'm in a high risk category, there are these factors, I've had warnings. So if something were to go wrong, not that it would make a big difference, but I would have had some kind of foresight that something even can go wrong, may be going wrong.

Many of the women acknowledged a prior "innocence" about pregnancy, a "naivete" which was dispelled by their experiences, as this one remarked:

> I never thought twice about pregnancy problems. I was completely unprepared, naive, innocent about pregnancy and the possibility of adverse events.

Impact of Multiple Losses

The feeling of surprise was mitigated in some instances where respondents suffered multiple losses. Some of these

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women described loss as "becoming routine" however they traded feelings of surprise for fears of future reproductive problems and growing disbelief that they would ever successfully have children, as this woman described:

> By the second and third (miscarriages) it was no longer a shock but it started to affect my perception, my definition of the situation. It went from "one of those things" to this is a problem.

Another one added:

> There is a difference between the first incident and this is the "start of something."

These women were commenting on the different meanings ascribed to one vs. multiple losses. Interestingly, in this particular sample, 10 of the 11 respondents who experienced first trimester loss only, suffered more than one loss. Perhaps they responded to the advertisement because they felt stronger emotional effects than those who suffer a lone loss. It might be hypothesized then, that while surprise may be diminished, as losses multiply, other emotional impacts may be strongly felt. For example, an added sense of failure and deficiency accompanied repeat loss; a feeling that one's body "couldn't get it right:"

> My psychological nature until then was I was always good in everything - good in school, I worked in a

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> top flight lab, I had a Ph.D., I was used to being a perfectionist and an expert. And to no longer feel that way, it damaged my self esteem.

Lack of Safety Markers

The feeling of surprise that a pregnancy could proceed in any way but "normally" was often compounded by the shock of a problem occurring in the respondents' specific pregnancy, particularly when the pregnancy had progressed unproblematically to what was thought to be a "safe" gestational age. Five women noted the phenomenon of reaching certain pregnancy "milestones;" feeling "out of the woods" with no hint of an impending problem, only to then suffer an unexpected late loss. Three women, all experiencing stillbirth noted their pregnancies had been "model and perfect" up to the point of fetal death; one had been told her pregnancy was "disgustingly normal." Most of these women acknowledged an awareness and "semi-preparedness" for the possibility of miscarriage in the first trimester, but grew increasingly secure about the probability of a live birth as their pregnancies advanced successfully.

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Due to advanced maternal age, most of these women also used all the available medical technology in an effort to assure a safe, healthy outcome, but to no avail. Three women commented on the illusion of assurance that technology can offer:

> After learning from my amnio result that everything was O.K., I finally let myself "settle in" to the pregnancy, and begin to prepare. I started to feel great, and then suddenly, with no foreshadowing ...the irony of this terrible loss.

> Up until a certain point you can expect disaster (1st trimester). Then you get to a certain point where you pass that and you figure, O.K., now I am getting a baby. It might be a preemie, but nowadays that's still getting a baby. You just don't ever expect this.

> There is sort of a notion out there that if you get out of the first trimester, babies don't die. You know that's the middle class, American notion, because they don't that much. It's very rare. And so you get much more invested in the assumption that you're having a baby.

Powerlessness and Loss of Control

Feelings of surprise and shock were often accompanied by feelings of powerlessness and loss of control. These seemed to exist both on the concrete level, as women noted a "lack of control over what was happening internally;" "a sense of betrayal by my body;" as well as on the more philosophical level as women described the

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feelings of fragility and vulnerability that reigned; a sense of life's transience, randomness and unpredictability, as these respondents asserted:

> This experience totally challenged my "myth" of how much control I have; my sense of control was assaulted. It taught me how things just change overnight without any sign or warning; they go from perfection to imperfection in a moment. In one minute..it can all be taken away. In that way, it's a "life lesson," about the meaninglessness of planning.

> All it means is that these things can happen...life can be that capricious and there are no guarantees about anything. Nature can be that capricious.

Cognitive Reaction to Powerlessness

While one respondent derived comfort from the knowledge that certain things were "larger than life" and beyond her control, and stated "I can worry only about what's preventable," all others (31) expressed discomfort with how helpless; how lacking in control, this experience made them feel.

Limits of Science

Just as advanced medical technologies had not guarded against their misfortune, respondents additionally expressed how impotent the loss rendered them in spite of how very medically informed, well-read and knowledgeable they were

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about pregnancy. Two respondents (the first a physician) stated:

> Medical knowledge and awareness only provide the illusion of protection. In the end, intellectual mastery doesn't guarantee the outcome. The things you rely on - your knowledge, your profession and medical compliance...don't prevent losses.
>
> ...I mean my father is an obstetrician, my mother is an obstetrician, my sister-in-law is an obstetrician, you would think I was pretty well informed!

In fact, two respondents (the first a neuroscientist) spoke of loss as precipitating a kind of disillusionment or faithlessness in the sciences of medicine and statistics:

> Once this happens to you, the "it's so rare" no longer holds true. Theoretical rarities no longer feel that way. The odds mean little when you fall into the nonprobability group and you're the exception repeatedly. Nothing is reassuring when you've been the statistic.
>
> There's a whole yuppie library of books out there that exists to make you feel as though you can do scientifically proven things. You can not smoke, you can take folic acid, you can not go in the sauna, there is all this literature. But I did all those things and it still didn't work, so there must be something you can't articulate, because even with all the equipment they have, all the advances in technology and even your own prayers...it just doesn't work.

Existential Responses

Another commented on the ensuing feeling of vulnerability:

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> What's important about all this is that you become a statistic in your life. You are, in some event or another, one of the random - Oklahoma City, etc... there are just too many examples of it. But when you feel like you've become the victim of a random event, I think you lose your denial a little bit and you lose the blind faith that you need to live in this world.

Additionally, the best prenatal care and strict adherence to medical regimens and advice were not foolproof either, as this respondent lamented:

> In spite of all the care I took, all my caution, my lack of risk taking behavior...I couldn't prevent the loss. Even "doing all the right things" didn't result in the birth of a healthy baby.

Another noted:

> This challenges the idea that all you have to do is be a good girl and follow the doctor's orders and it will all turn out alright. It didn't work.

Anger and Envy

The above-noted inability to control the outcome of situations in spite of their efforts, resulted in an expressed sense of anger and injustice at life's unfairness. Many cited instances in which individuals they knew had been less meticulous about their prenatal care and had had better outcomes. Envy of those women with "perfect pregnancies" (and anger at all others who could have smooth and

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uncomplicated pregnancies) was an additional feeling these women had to grapple with:

> I had such envy and rage that if I was in a mall and saw a pregnant woman I wanted to punch her. I didn't act on it...but that is how much emotion I felt.
>
> I was so angry because two of my colleagues were pregnant at the time and I had to watch them go through their whole pregnancies. It's a fertility zoo there (at work). I became attunely aware of wherever there was a pregnant woman, I just zeroed in on it. There were pregnant people everywhere...
>
> There was tremendous jealousy, a jealousy in terms of why we had to struggle. And why do some people have areas of their lives that seem so perfect, so easy?

This was further complicated by accompanying feelings of guilt for feeling envy, an emotion that most of them were not well acquainted with.

## THE CIRCUMSTANCES AND EVENTS RECALLED

In their study of perinatal grief, Peppers & Knapp (1980) reported that each mother interviewed demonstrated an acute remembrance of the events surrounding their losses; a keen ability to recollect specific circumstances of pregnancy and loss.

Similarly, respondents in this study recalled quite vividly and with striking detail, the events associated with

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their losses from the moment of discovery, for as one woman noted, "The affects get repressed in favor of the facts and events."

In fact only one respondent of 32 felt that the details of her experiences had become unclear, and both she and her husband had suffered serious illnesses since her pregnancy losses.

> Over time...the experience recedes...mostly because other traumatic circumstances have intervened to mitigate it.

The other thirty one women continued to remember and almost relive in the retelling, the powerful and traumatic events that occurred. Indeed, it often seemed that these had a greater impact upon their emotional pain than the mere event of loss itself. Such circumstances and events recalled include time of the loss, the actual process of loss and treatment by physicians and hospital staff.

<u>The Contextual Significance of Dates</u>

Universally, the date and time of year of the loss was recalled with no hesitation, as was the date the pregnancy was confirmed, the date a problem might have started and the due date of the lost pregnancy. A surprisingly high number of respondents (greater than 50%) reported losses occurring

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around major holidays, or birthdays, adding a poignancy and sadness to the experience and a heightened anniversary reaction, making that time of year feel "forever bittersweet:"

> It was cold and right after the holidays. And I'm off to the hospital. I'm a big holiday person, big Christmas person. A Martha Stewart. I'm into it the whole nine yards, and there I was.

Premonitions of Loss

Six respondents recalled feelings or experiences preceding the loss to which they retrospectively assigned meaning as symbolic of looming misfortune:

> For some reason, I just had a feeling I was going to miscarry. I started adjusting to this idea that there is always this cloud, a black cloud I call it that tells me.

> We lost him that week. He did well, but I just knew. The day he was in trouble at the hospital, I knew it.

> (stillbirth) We drove in the car, to the hospital, kind of silent. And it was weird, almost like an omen. The car broke down two blocks from the highway, on the exit ramp. Broke down. Just stopped. Such a weird thing.

> I went to a psychic right after I had seen the doctor, two days before the miscarriage. She said very sweetly and gently about the baby, "It's an angel." And she knew. I think that's what she was saying.

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> (while pregnant). I dreamed I was being pursued by two men and I was trying to get away from them and I couldn't get away fast enough and they caught up with me and said, "We really have to tell you something, the baby died." And I said, "It can't be that the baby's dead." And they said, "No, no, no, the baby's dead." And I said, "Oh, I guess I'll have to live with that." And I knew, I knew, the baby died that night.

> I had this dream where I had a baby except it was born much too early. I was going to the gym but I had this baby so I wrapped it in a baby blanket and put it in a locker and went to gym class. But it wasn't a whole baby, just a head with a fishbone body. I remember so vividly, the sounds, the smell, the whole thing, because that was the end.

The Process of Loss

A Sense of Unreality

Two respondents used the term "surreal" to characterize the moment of awareness of loss or of threatened loss. They reported a sense of disassociation from what was happening, a "numbness" and psychic distancing from the event that inhibited their hearing and comprehending what was being told to them:

> (at full-term) They told me there was no heartbeat and it felt like I was just an onlooker, instead of this was happening to me. I was out of my body and I was watching, like I was in a movie, that's the only way I can describe it. I did not understand how this could be happening to me.

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> At that particular point, I don't think it actually set in what he was saying. I knew what he was saying, but I was saying to myself, "He's saying this, isn't he?" It still just had not hit me. When he took me to his office and we had this whole conversation about fetal demise...and this is like 5 minutes after he told me what he just told me so this wasn't sinking in either.

Undoubtedly the actual experience of passing a fetus or delivering a dead or very premature infant was the most painful event described. All the women interviewed who had experienced 2nd or 3rd trimester loss had to endure a regular delivery even when it was known that the baby was dead or would not survive and commented on the inhumanity of the procedure:

> When the wish is just to end the pregnancy quickly and painlessly...you're then faced with the trauma of going through the pain of a regular delivery.
>
> So first you lose the baby and unfortunately there are no breaks in this life... you still have to deliver it.
>
> The most devastating part to me was that I had to birth the fetus...it was part of the whole process of feeling like it was adding insult to injury and punishment. It was a nightmare, a total nightmare and it is what is so imprinted in my experience.
>
> A part of me just wanted to say, "Take a sledge hammer and take this baby out, I don't want to know anything about it. Just please....if it has to happen, O.K., but please don't make me go through this."

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Another commented on this ironic aspect of the loss, stating:

> It's all the pain and no gain, only a dead baby...and no reward.

It appeared that this experience added to the trauma of the loss, and a number of women questioned whether there might not have been a more medically "humane" way to end their pregnancies. Poignantly, two recalled the excruciating paradox of a "silent" birth:

> One of the hardest things is when delivering that child, you don't realize that if a child is not born alive, it's not gonna cry. And that silence wrecked me. The whole silence thing. And I don't know if realistically I didn't expect the baby to cry coming out, but I hadn't thought about it I guess. When it happened to me, this is the silence. That was very hard.

> We all know, you deliver a baby, they tap the baby, it cries. But here there's no sound, no sound, it's a totally silent birth. I thought I died. That's how it felt.

<u>The Agony of Carrying a Dead Fetus</u>

A number of respondents were in the particular position of learning of the death or imminent loss of a baby and then having to wait to deliver it. The period of waiting was an extremely difficult time emotionally:

> I had a sonogram at 8 months and the doctor called us in and told us that this was a disaster and this child would never be able to be cared for by

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> us and that I needed to wait..and in two to three weeks this child would die inside of me. It sounded barbaric and we were lost...confused...In fact the child did die, maybe two or three weeks later..I didn't feel any more kicking. I called the doctor and said I do think this baby has died and from his exam he could tell it was then a stillborn...it was already dead. We thought he would then do a c-section and they'd take the fetus from me, but no I had to carry it another two weeks until I went into labor. I was a head case!

Another respondent who chose to voluntarily terminate an 18 week old fetus after learning of genetic abnormalities said:

> I had to wait from Thursday night till Monday for the doctor to terminate the pregnancy. That weekend was awful. Here I am still pregnant and knowing... and you're just waiting for the end result to occur.

This rather ambiguous position of still being pregnant, yet knowing it would end imminently was noted to be an impediment to beginning the grieving process. Respondents in this predicament felt they could not begin mourning until the actual termination occurred.

This was also true for women who experienced the uncertainty and anxiety of "holding on" to a threatened loss, waiting desperately for resolution of the threat or

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for confirmation of the loss so that they could then begin mourning and move on, as one woman described:

> I was just short of 24 weeks and hemorraghing and went into labor. First I was optimistic that they would stop the contractions and I'd go on with the pregnancy. I was hanging upside down in the bed on the labor and delivery floor and I was in labor over 24 hours..I was panicking and hemorraghing and it was horrendous, but still thinking the drugs should work. Then when I realized the baby was really coming...I just wanted it over...just end the nightmare.

This woman, and four others were in the unique position of suffering late second trimester losses, which seemed to present greater ambiguity in terms of outcome because the babies were just short of a viable gestational age. They had delivered their babies alive, albeit very premature, at great risk and knowing that death was most likely inevitable due to their previability or borderline-viable gestational age. They were then placed in the very difficult situation of making a decision about the use of extraordinary measures to save their fetuses. Three opted not to, but all lost their babies shortly after birth. The two women who chose aggressive measures to save their neonates both described the ensuing period as a "rollercoaster ride" during which they were alternately encouraged and discouraged about their

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babies' prognoses. They recalled this time as one of "acute neonatal distress" and experienced their babies' suffering in the NICU until their deaths as exacerbating their own pain. One woman commented on the trauma:

> That month was like being in the inner circle of hell; it's like combat, the whole experience. She kept dying but they kept bringing her back to life, 3 or 4 times until there wasn't anything they could do...there is a limit. And even my husband was traumatized...and that surprised me because he suffered 9 years of labor camp in the Soviet Union and had a lot of bad experiences...but neonatal intensive care beat everything...even labor camp.

Maternal Risk

Another factor contributing to traumatic recollection was the added possibility of maternal risk involved in some of the respondents' experiences. Not only was fetal loss a pressing condition, but in a couple of cases women feared losing their own lives due to unexpected excessive bleeding. This realization did not hit until the fetal loss had been acknowledged and managed somehow:

> I just figured that the worst possible consequence would be that I would lose the baby. Later the doctor told me that the worst consequence would've been that I wouldn't have made it. But that didn't really sink in. I didn't realize until a full year later that they were very scared of losing me because I was hemorraghing.

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Insensitive Treatment by Physicians and Hospital Staff

Repeatedly respondents commented on the significant impact that medical personnel and practices had on their experiences and these were angrily recounted as predominantly negative. In most instances, the encounter with medical staff intensified rather than diminished grief. One woman commented (eleven years later) "I still have nightmares of poor medical practice, of total neglect in the hospital."

The difficulty that many physicians have in dealing with death and the resulting unsatisfactory relationship that many women have with their physicians during the traumatic time of loss has been documented by Peppers & Knapp (1980).

Most respondents felt that discussion of their experiences was avoided or minimized by attending medical personnel and even their own physicians. Two respondents felt for the most part that they were treated impersonally as doctors focused only on medical facts and procedures:

> They focus in on the estrogen, blah, blah, blah and they say, "If you don't get pregnant soon on your own, start your next cycle (of medication) and just go on like that." Instead of "I'm sorry

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> that what you thought was gonna happen hasn't..." And like that.
>
> My analogy was I was like a bubble in this practice. They were so busy and such a big practice and I would float in and out, a nameless, faceless person, and they had absolutely no regard for me or my emotions.

Two women alluded to their doctors' discomfort in the "clinicalized" manner in which they addressed the deaths:

> I kept saying "the baby died," and he kept saying "you had a stillbirth." They have it all down those doctors...the language of loss.
>
> They use a lot of different words. Like the doctor said things like the "high probability of morbidity" or something and I was there like, MORBIDITY - gee, that's sort of a crossword puzzle word, but what does that mean again? That she's gonna die? So they don't really talk straight to you...

Another added:

> And you know people use the word miscarriage, it's like a medical condition, they don't think about a baby being there, they don't want to think of it. And so they dismiss what the woman has been through...

Most felt their losses went unacknowledged and the reality of their experiences was denied as two women expressed:

> The doctor never even said he was sorry. He came to the hospital and you'd think he would at least say he was sorry or hug me or something but he just shrugged his shoulders..literally..and said "what

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> can I say?" And walked out. He never called, nothing.
>
> I kept saying I was in pain and the nurses kept telling me I was just upset, but I'd had lots of bouts of preterm labor...and it's NOT just that you're upset, it's painful. So it was a very devaluing, denying of your experience sort of thing.

Three women had the experience of arriving at the hospital for surgical procedures either for spontaneous loss or voluntary termination for a genetic defect only to be confronted by a team of medical personnel who diminished their experiences and perhaps due to poor communication with other medical staff, assumed they were having voluntary abortions:

> I had to go to the hospital for a D&C, I was pretty far along so they had to do an extraction. I got put on the schedule late at night and I remember lying on the stretcher outside the OR and the anesthesiologist, he said "What are you crying for?" And I said "I'm sad." And he said, "Well you're just having an abortion." And I said "No, I've had a miscarriage and I'm having a D&C." And he just said "Oh." I was so in need of reassurance and he was so cold.

In other instances, doctors simply were physically unavailable during the time of crisis and remained emotionally distant:

> I paged the doctor anywhere from 5 to 10 times over 3 hours and he would not return my calls. I

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> decided I couldn't wait anymore and I went to the hospital. Still, my doctor was unable to be reached. I was in the hospital for three days including being induced. I was very upset because I could not get in touch with my doctor, didn't know then what I was supposed to do, how to handle the situation...

> He (the doctor) was a nightmare. He never once came to see me in two days and two nights, just called in every three hours to find out how I was doing. He insisted that he stayed away because the family always tries to get him to do something (to speed the process of delivery) and its best off not to do something. Obviously he did what was safe at that point but it was a bullshit excuse. I think it was his inability to deal with the pain. So for me, it was not just about losing the baby...it was a feeling of being TOTALLY ABANDONED.

Hospital Practices

Other respondents commented on hospital practices and policies which served to heighten their psychological pain during the time of loss. While the literature reports generally improved and more sensitive hospital practices regarding perinatal loss, a number of these women reported experiences of being on the same floor or in the same rooms as maternity patients, witnessing labor and the delivery of live babies, while they were having their births:

> After my baby had been delivered (dead), I was next door to the overflow from the delivery room and every night I would hear these thump, thump, thump (monitored hearbeats) from the babies, and fathers

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> making the phone calls from outside my room. It was nightmarish. Really really surreal.

In one hospital, a respondent reported having to visit her very ill premature (twin) babies in the NICU which was located adjacent to the well baby nursery. This juxtaposition of death and birth; extreme sickness and wellness was more than she felt she could bear at that very vulnerable moment.

A number of respondents also felt they were on "medical exhibition," delivering in rooms that were extremely crowded and brimming with curious medical and nursing staffs, eager to learn from their unfortunate experiences. In these instances, rage was apparent as women discussed their circumstances.

> We were just a case to them...a statistic. We were always the center of all this attention because she was the smallest one that had ever been born in that hospital and lived this long. So all day long they used to just parade doctors and nurses and interns by us all the time. I felt like we were a circus show after a while.

> (ironically) Let me tell you..a premature birth..it's a joy. Not only do you deliver with the staff delivering your baby, you deliver with the whole NICU emergency unit. So in your delivery room you have a group of people who are gonna grab your baby with an incubator, work on your baby and as you're in labor they're telling you, you know

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> YOUR BABY WILL BE BORN DEAD. It's quite a lovely (sarcastic) experience...

Surprisingly, only 7 of the 32 respondents reported contact with a social worker in the hospital and only one reported feeling it was helpful. In one case, the patient felt the visit was not done in a timely manner; she waited too long when in crisis. In two of the instances the respondents felt that the social workers were imposing their ideas about "how to grieve" on them, as though there were a defined protocol, supporting Leon's (1992) proposition that perinatal grief practices may be becoming choreographed and ritualized:

> This social worker came to see me and she said, "I just saw another patient of your doctor and you don't need to feel guilty, you don't need to feel guilty, but I never told her I felt guilty, so I felt like, how could she tell me how I feel?

> I was very much against seeing the (dead) baby and I didn't want to know about taking pictures. I was upset they even came to ask me instead of my husband. The social worker came and was hellbent on convincing me that I wasn't experiencing my grief properly and wasn't ever going to have closure if I didn't look at these pictures and go with whatever the current program is. I eventually had to just throw her out of my room. I have my memories and I feel I mourned sufficiently, whatever that is. If there's ever sufficient. I don't think I ignored it by not looking at pictures or having mementoes, so it confuses me, the way the hospital trend goes.

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In the remaining four situations, the respondents felt that the social workers were inappropriate in their responses and simply could not understand what the mothers had just experienced. However, in a moment of self-reflection, a Jewish respondent noted that an element of inconsolability might have factored into her feelings:

> She (the social worker) was well intentioned. She walked in and started telling me some supposedly consoling story about little angels flying around in the sky - my little baby angel looking down on me...which A) isn't Jewish theology...and B) isn't me. She was inappropriate but she wasn't malicious or anything, or even unsympathetic. It failed to help...BUT NOTHING WOULD'VE HELPED ANYWAY.

Grief Protocols

As one respondent noted above, currently, hospitals encourage grieving parents to view, hold, name, take pictures and retrieve mementoes of their dead babies with the hope that concrete representations of their children will facilitate the mourning process. Decisions about partaking in these processes, as well as those about disposition of the child often have to be made rapidly, creating added stress as this respondent noted:

> I wanted to request that the child be baptized before anything else, but it was like I had no

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> time. I was given all these options for burial, and I was completely overloaded because they want you make these decisions as fast as possible.

Such decisions are felt to be important later in the healing of grief and therefore should be given adequate and thoughtful consideration.

In this study, respondents were divided in their preferences for contact with the dead child. Some felt that seeing the child made it easier to mourn and put the experience behind them. They chose to view, hold, rock, name or take pictures of the child in the hospital, while others were fearful of doing so, as this woman explained:

> I never saw the baby...I didn't want to be left with memories of the dead baby. It would've dispelled my own fantasies and romantic illusions (of baby's appearance).

Two women accepted their needs to distance themselves from their babies. One who lost twins at 24 weeks gestation noted:

> I did not hold the babies. I was afraid I'd see some likeness to me or my husband...and that would make them too real.

And the other:

> I did not want to see the baby. I distanced from him, denied he was mine. I never identified this child as my "son."

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Only one respondent mentioned feeling remorse about her decision:

> I didn't hold the baby and that is one of the things I regret. I felt guiltier sooner after the birth than later. So I only saw her that one time.

Impact of Caring Experiences

On the other hand, respondents acknowledged that good treatment by hospital staff made all the difference in easing the trauma of loss. One woman who suffered four miscarriages highlighted the impact of her doctor's compassion on her emotional recovery:

> The doctor's compassion and the good care by hospital personnel completely made the difference in how I recovered from this loss because this last loss was the worst and yet it's the only one I fully recovered from. The difference was a caring, supportive doctor; he was a "kindred spirit."

Others echoed the importance of an empathic, sensitive and well-related doctor who would tend to the patient's emotional pain, in spite of how busy he was. When respondents experienced this they were grateful for it and felt it to be "out of the ordinary." Critical too was any acknowledgement of loss displayed by hospital staff, particularly nurses who assisted in termination procedures.

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The comfort provided by even a lone orderly was long remembered by this woman:

> There was no overt acknowledgement in the hospital, but when we lost our daughter I remember an orderly came into my room, the only one who acknowledged what had happened and she was so sorry and she heard of a (perinatal bereavement) group in San Diego and it was really very sweet of her but we were living in New York at the time.

## ATTEMPTS TO COPE WITH LOSS

Memories of the hospital experience ended with the sorrow of returning home "empty-handed" and efforts to "pick up the pieces and go on with life." Only one woman sought solace in a return to religion and began attending church regularly to help manage her feelings of powerlessness and pain. Two women noted the need to just get through "one day at a time."

### Suppression of Loss

Only a handful of respondents reported the wish to quickly suppress the experience by engaging in some activity that would distract them from the pain of loss. These included going on vacation, immersion in work, return for further study or simply "keeping busy with anything." All concurred that these efforts at denial of their experiences were largely ineffective.

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Acknowledging the Loss

The majority of women attempted to cope with their losses through some form of their own acknowledgement; seeking the acknowledgement of others, including professional or peer support; finding an explanation for their trauma; framing the loss as positive and most prevalent, pursuing the subsequent pregnancy.

Allowing For Self-Acknowledgement

The large majority (80%) of respondents recognized that they had to allow for their grief somehow and for many acknowledgement came through their use of various rituals or memorials designed to remember the lost child. Most of the Christian women who suffered late losses chose to have their children baptized, and Jewish women their sons circumcised, then buried or cremated. While in the past mothers often were excluded from their babies' funerals, in this sample only three did not attend the burial; two for prohibiting cultural or religious customs; one out of personal choice. Some went to great lengths to assure that the burial properly and fully acknowledged the lost child, as this woman elaborated:

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> I told the funeral director it was very important to me that she (stillbirth) had a soft pink pillow in there (the casket), a cushion. We had a whole outfit for her with a sweater and we actually put in pictures of us and I wrote her a letter, the hardest letter I ever wrote in my life. We put pictures of us in so she would remember her mother and father. And for the unveiling, we got a special stone made. We designed the stone; we attributed teddy bears to her so we had them engrave a teddy bear on it because we wanted that. We wanted to make it very special. We felt we owed it to her and that it was the very least we could do for her. And we have a special plaque dedicated to her that hangs in our house and trees that we planted in Israel in her memory.

Other respondents found creative ways to recognize or memorialize their children, without formal burial procedures, as the following Black respondent described:

> I chose not to have a funeral because I didn't want her life to signify her death. But I needed some kind of memento, something to mark the moment that I could go back to, because she was part of my life. So I had this shaker kind of wooden box and I never did anything with it. When I found out she was a girl, I bought some wonderful stuff..and I had the sonogram picture, and a baby girl shoe and my sister gave me a teddy bear. My sister is an artist...I told her I had these things, to put them in the box for me and decorate it. She painted it and stenciled it and quilted inside it and it's the most beautiful thing. It was perfect to capture the moment.

> (she continued) The other thing is..I like to collect from flea markets and one day I was looking for nothing in particular and came across a picture of a folkloric little black girl with braids. For $3 I bought it. I took it home and hung it on the

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> kitchen wall. I never said anything to anybody. When I saw the picture I felt it perfect, I felt it was meant to be. I hung it on the wall and I felt like Ok now she has a place, she's part of the family, not hidden in the box somewhere, its there and it made me feel better for whatever reason.

In the case of women who had miscarriages, where actual burial was not an option, other interesting ways were found to mark their losses. One dedicated a song to her lost baby, while another planted flowers to symbolize regeneration. It appeared that rituals, some act of remembering, aided in the process of emotional healing. As one respondent said, "Once I realized I did something to signify that she was committed to memory...I was able to move on."

Seeking the Acknowledgement of Others

The public acknowledgement of trauma has been noted to be important to the victim's healing. Kaplan (1995, p.220) wrote of Holocaust survivors who recalled a common dream: "they had returned home and with passion and relief were describing their past sufferings to a loved one, and were not believed, indeed were not even listened to." The silence that greets grieving mothers has been documented, as

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family, friends, colleagues and even husbands avoid or discourage discussion of the loss (Peppers & Knapp, 1980).

Accordingly, respondents recalled the pain of "re-entry" into the world they left prior to their experiences. Universally, they remembered feeling totally alone, outcast and avoided. Two described feeling like "lepers;" one a pariah, like there's "something contagious about you" and one felt as though people treated her like she "had a cancer." One who lost twins noted the difficulty of coming home and "going public;" having to recount and explain the loss to others:

> What made it very bad was since I was pregnant with twins I looked very big and everyone I saw from the supermarket clerk to the doormen to the dry cleaner...all thought I had a baby. I had to explain over and over to people what happened. I came in the next morning, limping from being in labor and that whole ...and I'm coming into the building carrying a plant from where my husband worked and they're all looking at me.."What happened to you and where are the babies?" And it was a nightmare.

Lack of empathy in the hospital was mirrored by very little understanding and recognition of the loss by family, friends and work colleagues. Respondents commented on the "taboo" they felt about discussing their losses and the silence of others that was understood to be protective, yet

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resulted in their feelings of loneliness. Many noted that they responded to the lack of support by withdrawing further from family and friends, not wanting to burden them with their sadness:

> You feel like you're part of a secret club. Nobody wants to talk about it after it happens. Because people don't want to know all the terrible things that can happen. They want to remain perfectly innocent or whatever. So then when it happens to you you feel like you are the only person in the whole world that this has happened to.

Impact on Marital Relationship

In many instances, sometimes in an effort to protect their wives, spouses did not wish to communicate about the loss. Respondents commented on their husband's "different" grieving styles: they were generally less expressive of their sadness, angrier, and wished to deny the loss and simply "move on," returning to work and going on with the activities of life:

> I don't think my husband understood at all. He may have been experiencing the exact thing I was, but there was no chance he was gonna let on to himself.

> I cried a lot and was very upset that my husband did not cry a lot, which I'm sure you hear a lot, that the men don't do it the same way.

> My husband was supportive but I think men in general and my husband in particular have a hard

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> time expressing their feelings and so to him he acted more like it was just a slap in the face.
>
> The day after the (therapeutic) abortion, he (husband) went back to work and I was crying and he said, "What are you crying for? Everything is just the way it used to be." And I said, "It'll never be the way it used to be again." And he said, "You're being so dramatic." But men do deal with it differently than women - men tend to do more and women deal more with the feelings.
>
> My husband is Asian and in that culture you don't ever talk about these things once they occur. You just put them behind you. I'm Hispanic and in that culture you can talk about it and you don't put it behind you...so it was very different and that was very stressful.
>
> You know all the groups are women and men go through these things too. They feel funny coming to groups especially when it ends up being a bunch of women sitting around crying. So the husbands who do show up don't last very long...

In spite of the differences in responses to grief, four respondents reported that loss had a strengthening effect on their relationships:

> I discovered throughout this whole thing that my relationship with my husband got a lot stronger. I never realized how really sensitive he was, he never expressed it as much.
>
> Before all this happened, I was the strong, tough one who never needed anybody. All of a sudden, I needed my husband and he was there. That was the only positive thing.

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> My husband and I were able to cry together which is unusual for my husband, he's not a particularly emotional person. Before this happened I always had this joke with him that we were not really related, just married. That day he said "Now we're related, because we lost this baby together."
>
> My husband was really wonderful. If it wasn't for him I would never have pulled through this. He was really there, encouraged me, gave me a chance to talk about everything I was feeling, the whole gamut from sad to mad, every conceivable emotion.

Unempathic Responses

Repeatedly, respondents described remarks made to them by others as unempathic and "stupid" and as evidencing that people simply "do not know what to say." Such remarks tended to deny the existence of the fetus as a child, thereby disavowing the sense of loss:

> People were so unconnected. Part of it was they never had the experience. They make believe you don't connect when you get pregnant, that it wasn't a baby. That whole notion...that it wasn't a baby. But it was a dream, that's what it was.

With the hope and expectation that grief would be short lived, others encouraged the mother to forget and focus optimistically on the future, and reassured her that she could "have another one," as though that would eradicate the pain of this loss.

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> So everybody says..."you'll have another one," because people really want you to get over it. They don't want you to talk about it because you've got this great sorrow clinging to you and even if you're trying to cope with it...they want you to move on...and have another one, because then _they'll_ feel better. "Go on, have another one," they say, just like they're telling you to go have another potato chip.

The ubiquitous difficulty people have allowing for feelings of grief without offering hope or focusing on something positive was clear. One woman, who worked for a large social service agency commented on the irony of her colleagues' need for her to "move on:"

> A psychiatrist there, a woman doctor who specializes in bereavement said..and I was very upset, because it was a totally stupid, ignorant remark especially coming from someone...something like "oh don't worry, you just gotta get the strength to forget about it and have another baby."

Two women who had children prior to their losses felt that their experiences were minimized by others because they already had a child. Just as the subsequent child was frequently implied to be a replacement for the loss, the existing child too was seen as an adequately comforting and fulfilling substitution.

Those remarks implying that the loss was for the better provoked tremendous anger as evidenced by three women, the

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first of whom delivered a premature baby who subsequently died:

> It's as if nobody cared. You've just been stepped on by the fates you know. And then people get all jumbled up because they don't know what to say exactly..."It's God's will she died..It's God's will she was born but only had a short stay on this earth." You know people write you all sorts of garbage and they get all muddled up because what's their philosophy exactly...?
>
> People are very, you know, very heartless. They say things like, "Oh, there must've been something wrong with the baby. This is God's way, you're young, you'll have more," all that stuff.
>
> The priest told me, "Well, you know, she (dead fetus) won't have to go through all the turmoil in life that we will..."

Respondents expressed anger that such comments were made to them with the "illusion" of mitigating their suffering; to shield them from their pain, when in effect these were experienced as cutting off expression of their pain; as being largely self-serving and protective only of those who could not bear their grief. Unresolved hostility was palpable in their interviews, manifested in intense affects and sarcasm.

Alternately, only six respondents noted the positive effects of friends, colleagues and relatives (other than spouses) who were supportive and encouraged them to talk

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about their losses. In particular, three of the women's mothers provided support where possible and (as noted prior) in a few instances spouses were mentioned as being extremely willing to acknowledge and openly share their wives' grief, resulting in the strengthening and solidifying of marriages. Friends who had shared the experience of a perinatal loss were felt to be particularly amenable to providing support:

> The only person I could talk to was someone else who went through it. I have a good friend here (at work) and she went through a number of miscarriages and she was very supportive.

> I never went to a bereavement group but I did find comfort in talking to other women friends who had losses. If people haven't been through it, they don't know what you are talking about. Yet miscarriages really are very prevalent, once you start talking to people.

> I had a friend at work and before I came back she would call me and she was very supportive and even if I got very upset at work I could go up to her office and talk and she was very helpful and I think I couldn't have got through it without her too.

Use of Formal Support

Undoubtedly the greatest sources of recognition and comfort were "other women who had been through it," and these were readily found in perinatal bereavement support groups. Six respondents had joined support groups only,

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feeling that others who had not been through the experience, even mental health professionals, could not possibly understand how they felt. The understanding and empathy they felt in a group enabled them to openly discuss their own losses without feeling burdensome and alone:

> The thing that helped me the most was this group of women. I had gone to this group and we were to each other what we needed to be, which was a place to be able to discuss that we'd lost these babies. I was living in a world where nobody got it, except these few women in the group.

Three women were in groups and in individual therapy and nine were in individual psychotherapy alone after their losses. Of these, most expressed disastisfaction, feeling that the therapist was not "close enough to the loss:"

> I decided to go two or three times to talk and see and after the 3rd time I said, "I'm not doing this again." I was paying someone to listen to me and she hadn't lost a child and there's no way she can understand what I'm going through, this is a major waste of time. And it's like I'm talking to someone who can imagine what I'm feeling but hasn't experienced what I'm feeling, so therefore basically cannot tell me that it's so difficult to move forward...I mean she could say that because she's trained to say that, theoretically and trained to be sensitive and understanding, but it wasn't coming from the gut.

Interestingly enough, the three respondents that found individual treatment most helpful had already been in long-

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term therapy at the time of loss and their satisfaction may have been attributable to an established relationship with someone they already felt understood by. Three respondents sought counseling from a member of the clergy.

The Need For Explanation

One common approach to coping was to seek some explanation for the loss; some understanding of what happened. Most women expressed needing to have a reason, anything, in order to feel they could move forward. The first explanation sought was generally a medical one. Where none existed, women sought to place blame either on themselves for somehow precipitating or contributing to the loss, or on their physicians for some form of negligence. The hardest losses to accept appeared to be those where neither medicine offered the explanation, nor where blame was suitable. In these instances, other interesting, more "philosophical" reasons were suggested.

Seeking Solace in Medicine

Interestingly, while many respondents ultimately lost faith in medical knowledge and science after their losses, it was clear that initially, most had turned to medicine with the hope that some medical problem would be detected,

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for as one simply stated, "If there's a problem...there's hope for correction." Alternately, "Knowing helps, not knowing means you can't know what to do the next time." The need to know was apparent. In fact, even where a problem was detected with no prevention possible (for example, a predisposition to a genetic defect), there still seemed to be relief in the knowledge. One woman who suffered three early losses due to a genetic abnormality explained:

> Even if you're helpless to do anything, knowledge gives you mastery...I learned a lot about genetics fast. What that meant though emotionally was that I had a place where I could put my fears. I knew there was nothing I could do that was gonna change my odds, all of a sudden I was playing the game of statistics. And I understood it...I didn't understand the WHY but I understood the HOW and that made accepting it much easier. Knowledge is power. It enables you to control your thoughts...if not the events.

Another effort to seek a medical/biological explanation for loss was to attribute it to heredity. A number of respondents mentioned that their own mothers (and sometimes grandmothers) had had miscarriages and stillbirths and they wondered about loss as an inheritable condition. This mutuality of experience seemed to enhance their identifications with their mothers and made them more compassionate toward their losses.

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The attempt to cope through finding a medical explanation for loss resulted in many of these respondents becoming expert in the science of reproductive medicine. Even where the doctor could offer no explanation, many sought information on their own and read obsessively for hours in medical libraries. Respondents felt that knowledge enabled them to become better advocates for their own medical care, rather than handing their treatment over to the "experts" and this helped them manage feelings of helplessness and loss of control. A couple of respondents also recognized that the fervor with which they approached "scientific study;" the intellectualization of what had happened to them, served as a defense against the pain of loss.

Interestingly, only one respondent turned away from medicine, becoming more non-interventionist in her subsequent approaches to pregnancy. Rather than researching high risk obstetricians, this woman elected involvement with a birthing center, becoming disillusioned with advanced reproductive technologies:

> After dealing with hospitals, I decided I wanted to give birth in a birthing center. I've become very noninterventionist. I've come to the conclusion

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> that a lot of things, even if I had a repeat performance of the same symptoms (preterm labor), I feel I'd be getting better care in a noninterventionist environment because with all the intervention I didn't get the care I needed and even a high risk doctor couldn't stop the labor. I don't think I could consider anymore, delivering in a very medical environment.

Self-blame/Guilt

Guilt has been acknowledged as a common phase of the grieving process (Peppers & Knapp, 1980) and can facilitate or impede the coping process. Where a medical explanation was unavailable, some respondents found consolation in thinking that somehow they contributed to their losses. Taking responsibility at least offered the possibility of prevention of further loss by doing things differently the next time, as this woman noted:

> Self-blame is easier than accepting total helplessness and lack of control.

Remorse was often felt for the way life was lived earlier - "too much drinking, smoking, self-neglect;" responsibility was felt for not acting sooner when loss was threatened; for compliance with medical personnel who minimized symptoms even when respondents felt they were at risk; for making certain decisions about treatment to prolong life or for not making those decisions and for choosing to have certain

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diagnostic procedures that entailed some risk of loss (like chorionic villi sampling).

Two respondents who placed blame on themselves had a history of prior elective abortion. In these instances, a sense of responsibility did not aid coping but rather engendered feelings of self-recrimination, as abortion was used as an explanation for later involuntary losses. The latter was viewed either as God's punishment for earlier voluntary terminations, or as a result (medically) of prior abortions. For these women, abortion appeared to take on more salient psychological meanings after their losses, as this one stated:

> It was only after my miscarriages that I started to feel remorse about the lost babies. They were children too that I chose not to have and now I feel cheated of more chances.

Feelings of guilt also complicated the reactions to loss of the five women in the sample who chose to voluntarily terminate pregnancies (therapeutic abortion) upon finding out that their amniocenteses results yielded genetic defects. The loss of a fetus was exacerbated by the "guilt of killing," and this was viewed as in some ways more

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difficult than an involuntary loss as noted by these respondents:

> I had to weigh all the genetic factors and make the difficult decision to terminate. I'm left with the guilt of playing God. Spontaneous loss at least is guilt free.
>
> The guilt is tremendous. In my own mind I've used the word kill.

Another commented:

> It was a nightmare...just a nightmare. It was the pain of feeling that after all, you've lost this baby that you were so excited about. Some of the most painful memory of that is just the injection which started that process...which at that moment I knew, I was ending her life. It was horrible, just horrible.

Anger at the Physician

Five respondents felt strongly about the possibility that medical negligence resulted in their perinatal losses. The women felt that doctors minimized their complaints, did not detect an apparent problem or did not respond to signs of threatened loss soon enough:

> Having a first time pregnancy, I didn't know what was occurring, and when I would call the doctor and say I didn't feel right, but couldn't give a specific symptom, they talked me off as being neurotic and overly concerned and as though there was not reason to feel like this. The night I went into labor (at 24 weeks gestation) I had been in contact with my doctor up till then but he never

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> thought any symptom I had was worthy of note...and then I went into labor.
>
> I kept asking, "Is there anything I should be doing? Am I losing the baby?" And he kept saying, "Just let things take their course." And I really didn't know about miscarriage then so I was doing my regular activities, lifting, traveling, and apparently the baby was dying.

In these five instances, the women were able to direct their rage at what they believed to be medical mishandling compounded further by the doctor's lack of acknowledgement of wrongdoing. Whether this was helpful or not seemed to relate to their ability to translate anger into some satisfying action. One woman who suffered from gestational diabetes and had a stillbirth felt the doctor had waited too long to deliver her. She was left feeling unresolved by the "what ifs" and this was exacerbated by her inability to confront the doctor:

> My baby died and it was a TOTAL WASTE. There was nothing wrong with her. And that's something I've never been able to accept. And I feel like somebody should be punished for this. It's not a closed chapter, and it's never gonna be because there was nothing wrong, no blood clot or anything, there was nothing wrong with her. She was perfect. It still haunts me because I feel I want revenge, not just because I lost a baby, but because there was absolutely no reason to lose this baby. And it was because this doctor didn't know what he was doing..and he still doesn't. And I never told him how I feel.

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Another lost a baby at 38 weeks gestation due to a genetic problem that went undiagnosed through amniocentesis. She lamented the suffering she might have been spared had the problem been detected sooner, but also felt somewhat vindicated by her pursuit of legal action against the doctor:

> What I went through the past year will be for the rest of my life, and I didn't have to go through this. Had they found out...not that having an abortion is pleasant but that's the whole point of having amnio. So I had an amnio...and this (with anger and disbelief) was something they should've caught right then. Not that an abortion would've been pleasant, but it would've been a lot different at 15 weeks than it was at 38. I've seen a lawyer and I have to keep fighting my case.

Anger at God

Only one respondent mentioned directing her anger towards God:

> I remember being very angry at God and thinking How can I ask for forgiveness on Yom Kippur when I'm so pissed? I was very depressed and confused because I felt I didn't have a right to be angry at God. And the rabbi said I could be, which helped me.

Seeking Explanation Where There's None

Perhaps the hardest losses to reconcile were those that could not be attributed to any clear medical problem, or responsibility of the respondent or her doctor. Only one

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woman seemed truly accepting of the notion that her losses were "just bad luck." Most women described feeling that without sufficient explanation, the loss remained a "mystery," one that continued to haunt them. Eleven years post-loss, one respondent was still searching for an explanation, and still considering retrieving all her past medical records to see what they might reveal. One woman admitted that she would have believed any explanation, just to have an explanation while another explicated the complete feeling of helplessness induced by an inexplicable loss:

> The randomness of it is really frightening. If there was a reason, if I ate something that I shouldn't have eaten, well, that would be great, because then I would know if I don't eat that thing again, this won't happen again. It gives you some control back.

Most unsettling to women were the various terms used repeatedly by physicians to efficiently explain the unexplainable. Many women were told their losses were "just a fluke;" a "fluke of nature", a "freak" thing; an "aberration," or just a "case of fetal demise." Another was told that her loss was a case of "lightning striking once."

Of interest, was the way in which these terms were interpreted by respondents. One woman noted that while

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initially she found comfort in a "fluke," because a fluke is an isolated event, that ultimately she felt rendered powerless and helpless by the idea that a fluke can happen anytime. Likewise, another one noted with disbelief, "If lightning can strike once, it can strike twice;" one loss does not guarantee immunity from another. It was therefore difficult for these women to be optimistic about the allegedly isolated instance of their unexplained losses. As noted earlier, statistics and probabilities of occurrence held little comfort.

Some women then, attempted to cope with unexplainable loss by soothing themselves with more "philosophical" or spiritual explanations. These took the form of "things happen for a reason;" "we were meant to have a loss;" "it was fate;" "you go down a rough road for a reason;" "this was an act of God;" "God gives you only what you can deal with;" "some higher power had another plan for us." In some instances, an element of "magical thinking" appeared in the respondents' need to find a reason for what happened to them. One woman felt that her optimism about her pregnancy led to its loss; another believed that an earlier "wish" of her husband's resulted in the "deed" of loss:

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> We felt a tremendous amount of guilt...because once while G (her husband) was stationed in California up on a mountain and they were supposed to be rapelling down and a typical 17 year old boy at that point in the Marine Corps he said, "Get me the hell out of here and I'll give you back my first born!" This was just a stupid 18 year old crack, but it came back to haunt us. He made the crack...and then it happened.

Clearly, seeking an explanation was a way for respondents to console themselves as an alternative to simply feeling the pain of loss, feeling rage with no one to direct it at, or feeling totally helpless and unable to control the outcome should there be a next time. Quite poignantly, many of them comforted themselves with the notion that had it not been for the loss, the subsequent child would not have been born, and so the loss was necessary to make that child's existence possible.

Deriving Positives from the Experience

In spite of their grief, a number of respondents mentioned ways in which their losses changed their lives in positive ways. These changes occurred in the areas of basic outlook on life or their identities, priorities, careers and interpersonal relationships.

As an outgrowth of the painful realization that much of

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life is beyond one's control, a number of respondents noted that where once they had been extremely perfectionistic and in need of control, they had begun to relinquish some of those ideals. They felt humbled by the transience and fragility of life and in some instances increased their tolerance for the unexpected and unpredictable; that which was beyond their realm of power. Additionally, while formerly some aspired to the "superwoman" ideal, the experience of loss enabled them to see themselves as less strong, heroic and invincible and more human and vulnerable.

The losses encouraged them to re-examine the meaning of priorities in their lives. For a number this meant a shift in emphasis away from their careers and the pursuit of material things. Several left work entirely to pursue pregnancy and parenthood full-time; a couple changed careers and entered a helping profession with the expressed purpose of counseling women who experienced pregnancy loss. Creating a family became more important than work and as one woman commented, "Bringing a live baby into the world was all that mattered."

The increased ability to relate to others on a deeper, more meaningful level was noted. Respondents reported

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heightened empathy for others, both generally and specifically in relation to the experience of pregnancy loss, as well as an increased awareness of the importance of acknowledgement of feelings and of being more altruistic.

The Impact of an Existing Child On Coping Capacity

Findings regarding whether the perinatal grieving process is made easier or more difficult by having an existing child have been mixed (Toedter, et. al., 1988). Most of the women interviewed had experienced pregnancy loss before the birth of their first child. A small number (five) already had a child at the time of the loss. While the former group believed that the situation of loss before parenthood was most difficult, the latter group did not appear to feel that the presence of a child either sufficed to mitigate their feelings of loss or diminish their desire for a (second) child. On the contrary, having attained parenthood they felt they knew more intensely "what they had lost," and the desire to provide a sibling to the existing child was a powerful one. An existing child introduced other emotional complexities that had to be confronted and coped with by these respondents.

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Most importantly, they reported the added strain of explaining the loss to their children at a cognitive level they could understand, a difficult task given that the oldest of these children was seven at the time of the loss, while the others were young toddlers. Appropriate to their stage of development, their concerns were largely egocentric, as the following woman described:

> One of the hardest parts was explaining to my daughter. I explained to her that you know, sometimes things happen that we're not exactly happy about, we don't know why and that I wouldn't be having a baby in the house. And her response was that she wasn't gonna be a big sister. And I explained to her that she was still a big sister, only that her sister wouldn't be living in the house with us.
>
> I did try to tell her that after a while people do die and its a part of life as much as anything else and sometimes you sort of become creative when you have to explain things to kids. So she asked me if I had put the child in the same kind of box her grandma is in and I did explain to her that it does happen that way. Then she wanted to know, well what is the purpose of the casket? I told her it is something like a jewelry box and I don't know where this came from...and that just like she puts her things in there to save them and protect them.... After that...I was wasted, but she was O.K.

Some of these children faced not only the loss of a potential sibling, but had also endured a painful separation

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prior to the loss if their mothers had been hospitalized in an effort to prevent it.

These particular mothers then, had to attend to not only their own feelings of grief, but their childrens' feelings as well; their children's pain added to their suffering:

> I was trying to prepare her, so I told her the babies are trying to come out too soon and the doctor will try to keep them inside but if it doesn't work, they're too little to live outside me. It was horrible. Her whole face fell, it just wrenched at my heart. I felt worse about what it was doing to her than to me at that moment.

Additionally, the burden of maternal responsibility after the loss was illuminated:

> I returned home totally debilitated physically and emotionally. And it was not enough I had to deal with what just happened to me...I then had to try to be a mother to this child through all my depression. I couldn't even get up the energy to walk her up the hill to the park. It was awful.
>
> J (existing child) didn't have her mother the whole summer. I was very depressed. I sort of meandered through the whole house in a vague, ethereal kind of way and J floated in and out around me.

Yet another, however, highlighted the potentially positive function of motherhood as a distraction:

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> You just can't indulge your emotions fully with a child. You have a child, so you must bounce back. The live child forces you to go on...it absorbs your energy.

Subsequent Pregnancy: Coping Mechanism or Grief Inhibitor?

Controversy exists as to whether immediate efforts at subsequent pregnancy after loss aid in grief resolution or alternately, inhibit it. It has been the general recommendation that women wait at least six months before pursuing pregnancy again so as to allow themselves adequate time to mourn their losses and distinguish between children, rather than risk viewing the subsequent child as a replacement for the lost one.

In spite of such recommendations, as soon as medical clearance was granted, the great majority (27) of the respondents in this study turned their attention to the pursuit of another pregnancy. Though most recognized that the drive for the subsequent child was partially a displacement of grief, and certainly not a remedy for it, the overriding feeling was that a subsequent pregnancy would help them cope with their losses.

Conclusion

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This chapter conveyed in depth, respondents' experiences of perinatal loss. Specifically, their feelings at the time of loss, the circumstances and events recalled and their efforts to cope with pregnancy loss were reported in detail. Specific findings related to the issue of pursuing subsequent pregnancy will be discussed in the following chapter, including the decision-making process involved in pursuing the subsequent pregnancy and motivations for motherhood, the actual experience, strategies for coping with the subsequent pregnancy and the impact of the prior loss as it echoed throughout.

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# CHAPTER FIVE

## SUBSEQUENT PREGNANCY

The use of subsequent pregnancy as a mechanism for coping with perinatal loss is controversial. As noted earlier, after pregnancy loss, mothers had been advised to seek a "replacement" pregnancy quickly and distract themselves with another child to diminish their sense of pain; to "resolve" their grief (Brost & Kenney, 1992; Lewis & Page, 1978; Peppers & Knapp, 1980; Zeanah, 1989). More recently, however, greater concern has been voiced that a rapid subsequent pregnancy (within a year) may be an indicator of disordered mourning (Zeanah, 1989). Pregnancy might inhibit mourning or delay it until the time of birth, at which point it may interfere with the relationship between the mother and subsequent child. Current thinking dictates that waiting to pursue pregnancy is an asset to the healing process (physically and emotionally), facilitating greater enjoyment of a subsequent baby (Davis, 1991). At the same time, however, the birth of a viable, healthy child has been seen to aid in grief resolution (Peppers & Knapp, 1980; Theut, et. al., 1989; 1992).

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The second part of this study explored women's attitudes toward a subsequent pregnancy. Respondents were asked how they approached the decision to pursue subsequent pregnancy, including their motivations for such; how the process was experienced and how they coped throughout the pregnancy until the birth of the subsequent child. (In the case of multiple loss, some respondents had more than one subsequent pregnancy before motherhood was achieved. Generally, the most detail was provided about the pregnancy that resulted in the birth of a viable child).

THE DECISION FOR SUBSEQUENT PREGNANCY:
NOT WHETHER BUT WHEN?

In an exploration of motives for motherhood, McMahon (1995, p. 51) noted that becoming a mother did not have the "character of choice" in the lives of many of her research participants, in that they did not reflect on options nor weigh the costs, benefits and consequences of having children; rather, they had difficulty giving reasons for why they wanted to have children.

Likewise, for all the respondents in this study (32), subsequent pregnancy and parenthood were discussed almost as "non-choices;" the question was never WHETHER, but rather

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WHEN (McMahon, 1995, p.62) they would attempt another pregnancy.

Three women were clear about their need to wait, two did not feel strongly either way and the rest (27) wished to attempt subsequent pregnancy immediately and did so as soon as medical clearance was granted, usually 3-4 months after the loss.

Of the three women who waited a full year, one felt her "body needed to heal," while the other two felt they needed time for "emotional readiness," as this one commented:

> My girlfriend insisted I ask the doctor when it would be possible for me to get pregnant again. I said "No, I never want to get pregnant again." I was adamant, I mean this was not radical thinking, the pain of it was just too great. I thought it just wasn't meant to be. I'm not fooling around with this again..if something goes wrong, I just can never exist again. A year later...I was ready to try.

Two respondents exhibited ambivalence about moving forward with the subsequent pregnancy. While they attempted to protect themselves by assuming a "noncommittal" stance, their behaviors ultimately evidenced the wish for pregnancy that accompanied the fear, as this woman indicated:

> I did not "try" to get pregnant, but I did not use contraception either. I figured if it was "meant

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> to be" it would happen. But I know I was depressed every month that I got my period, and I was joyous when I got the news I was pregnant.

The remaining 27 respondents turned their thoughts to seeking subsequent pregnancy immediately, with a couple already having thoughts in the delivery room about going on to have another baby. Twenty-five of them acknowledged their fears but commented that simultaneously, the thought of an instant subsequent pregnancy helped them face the loss, and combat their feelings of emptiness and grief, as this woman noted, "Only another pregnancy would assuage the feeling of empty arms."

Two respondents "intellectually" considered the possibility of waiting, but ultimately felt that this would not be beneficial, as they described:

> Time doesn't help; waiting doesn't help your grief. I decided I was just gonna try to get pregnant again because I'm not gonna feel too much better about this than I'm feeling now.

> I needed to get back on the horse...so I got pregnant again. Time would not have helped me...in fact the longer I refrained, the more time I had to talk myself out of trying again and I would be sitting here today having never had a child.

Another noted the therapeutic effects of attempting conception immediately on regaining a sense of control:

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> Most people thought forget it, we shouldn't try, ever again. And we were aware that the conventional wisdom was it was not a good idea to try again so soon, (6 weeks post-loss), but meanwhile, time was passing and for me it was better to try right away, it gave me something to do with the frustration and powerlessness.

The Desire For A Child vs. Grief Resolution

Most impressive about those women who attempted subsequent pregnancy right away was their awareness of the distinction between their desire for a child and their wish to heal the pain of loss. While the literature cautions that a subsequent child may interfere with the grief process and take on the role of a replacement child, (one that is treated as a substitute for the lost child, not as an individual and distinct child, in its own right and might distract from the mourning process), only two respondents admitted that they wanted to replace the lost pregnancy and hoped that a healthy baby would heal them, while another acknowledged that her obsessive pursuit of a subsequent pregnancy, "aggression and tenacity about it... became a substitute for the grief."

The remaining 29 respondents, however, appeared to distinguish clearly between attempting conception and resolving the loss; they did not view the subsequent

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pregnancy as synonymous with healing grief, as this woman noted:

> The pregnancy mitigates the sense of despair, the disbelief and envy that there's no baby. It also mitigates the sadness of there not being more than one child because there is more than one child; it in no way mitigates the loss of that child and that's important to understand, because that's confusing.

At the same time, though, the acknowledgement of the need to mourn did not eradicate the desire for a child and mourning and attempting pregnancy were not necessarily conceptualized as having to proceed as serial events, as this woman clearly articulated:

> Basically I decided I could just as well mourn while trying to get pregnant. It's not my nature to seal things over, in other words to say "Oh good, I'm pregnant, now I've got a new baby so I don't miss the old ones." I knew I wouldn't do that. I mean...you get pregnant because you want a kid and you can't fix the loss but mourning doesn't change the fact that you don't have a kid and if you want a kid, that doesn't go away.

Focusing on a subsequent pregnancy was also "something to do" that was future-oriented. One's emotional energy could be shifted away from the loss onto the wish for the next child:

> ...You do feel that it's not that it's going to fix the loss or replace the loss, I was very clear on that. But its something else to do, its like a project. Its a different project, like you could go to college or go on a trip. So it was like a

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> project to do, but I didn't think of it as being a remedy to grief because no one was gonna replace...that was my baby. Nothing else can replace it.

SUSTAINING MOTIVATIONS FOR PREGNANCY AND MOTHERHOOD

In spite of the trauma sustained and the fear of another loss, respondents demonstrated tremendous motivation to pursue pregnancy and motherhood. Many years ago Deutsch (1945) noted that pregnancy represented the fulfillment of a woman's deepest yearnings and occupied the fantasies of girls' psychic lives since childhood. More recently, Ireland (1993) in writing of childlessness acknowledged a resurgence of sentiment about motherhood as intrinsic to female identity. Indeed, the women interviewed felt that the strongest desire they had was to be a mother and this wish superseded any fear of further fetal loss or even maternal risk, in a subsequent pregnancy as these respondents stated:

> How could I continue? And why do it? Because I wanted to and I had no reason not to. And I put myself at great risk. I put myself at risk with the heparin, the aspirin, the risk of multiple pregnancy, all of those things. I insisted on pursuing this, as fast as I could. I wasn't gonna take no for an answer.

> The doctor told me, you'll have some new options if you get pregnant. You'll have to take aspirin

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> every day and inject yourself with heparin. And I said ILL DO ANYTHING TO HAVE A CHILD. I WILL DO ANYTHING.
>
> At that point, we were ready to do anything including sell our souls to the devil...to have a child.

When asked to articulate what motivated them so strongly toward the rapid attainment of motherhood, respondents' were able to offer a number of reasons, and these seemed to be both practical and psychological in nature. Practical factors included concerns with maternal age, desired family configuration and the ease with which women were able to conceive, while psychological components included feelings and attitudes about "achieving" motherhood, family history, and the impact of an explanation (or none) for the loss.

## Practical Motivating Factors

### Fear of the "Biological Clock" Running Out

One interesting propelling factor perhaps intrinsic to the unique group of women studied was that of advanced maternal age, since 75% of respondents were at least 35 at the time of loss. Even if they were still grieving, many felt that they had "no time to wait" because advancing age

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created increased risks of infertility and loss, as they clearly described:

> Here I was at that point, 38 years old and I really had this feeling that I could not affort to wait. I didn't want to wait another year or two till everything was in order and I had gotten over it. I just felt like this was LIKE AN HOURGLASS WITH THE SAND RUNNING OUT AND I JUST DIDN'T HAVE A SECOND TO WASTE. I didn't know if it would take me a year or something to conceive and I felt I could not afford to waste any time.
>
> I knew the longer I waited, the less chance I'd have of getting pregnant again given my age and my history and that I would rather have a harder time emotionally and physically by having another pregnancy too soon than not get pregnant and always wonder about "if I had tried sooner...would I have gotten pregnant." I decided that I could live with the first better than the second. And so we started trying seven weeks after the twins were born and died.

Thus, while the literature recommends allowing sufficient time to grieve before attempting pregnancy, for these older respondents, the ideal of emotional readiness had to be compromised in the service of containing further potential risks. The fear of the "biological clock running out" was even greater where respondents had hoped for more than one child as these two noted:

> I'm 39 now and it took me a while to get pregnant when I was first trying. I didn't have a lot of time and I just always assumed I was gonna have children, not one...but a couple of them.

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> Once I lost the child I wanted immediately to try for another one and there were a lot of things going into that decision. One is I always wanted at least two children...I didn't want my child to feel that she is an only child.

Spacing Between Children

Another practical matter that affected the wish for another pregnancy quickly was the desired spacing of children. All five respondents who had a child prior to the loss mentioned the concern that their children would have too many years between them if they waited to attempt pregnancy:

> I already had a child and I wanted her to have a sibling, and she was already 3; they would already be further apart than I wanted them.

> We needed time to mourn, but it was frustrating and I was so worried about my age and I was so worried about J's (daughter's) age and having such a big gap between kids which was never what I wanted. I never was one of those women who wanted them 18 months apart - for me the ideal spacing was 2 1/2 years apart and I was already long long past that.

Nonproblematic Fertility

Another practical factor that enhanced motivation for pregnancy was ease of fertility. Eight respondents who were quick to conceive mentioned that the capacity for fast

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conception was a key factor in their hopefulness and persistence:

> With easy conception you at least eliminate the stress of infertility. It balances the discouragement, because the question of whether you "can or not" is at least resolved.
>
> Our fertility was not a problem, which of all the little silver linings I appreciate. Because if you have trouble getting pregnant in addition to having the heightened risk of loss, than it just becomes even more emotionally charged. It's enough as it is...if you had fought for that pregnancy and then found it wasn't working, then you have an even extra SENSE OF LOSS.
>
> I already had a child so I knew I could get pregnant and it was up to medicine..to medical science to make sure that I kept it. And I was willing to do whatever I had to do to keep a pregnancy. Now I suppose if I had been infertile...seriously infertile... I might have felt differently.

## Psychological Motivations

### Motherhood as a "Mission"

The urge toward pregnancy and biological motherhood has been noted to be extremely powerful in these women. As mentioned earlier, the difficulties and pain they endured did not serve to deter them in their pursuit of motherhood. In fact, on the contrary, half (16) commented that loss

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fueled their zeal for motherhood and increased motivation to attempt subsequent pregnancy:

> It was like having blinders on. I was not focusing on having lost a baby, it was I had this ABSOLUTE DRIVE now to have another child. People would tell me I was brave and I would say you don't understand...it's not being brave, it's just kind of this crazy drive, it's almost as though I don't have a choice. That was how I felt about it. I wanted another child so desperately now I felt I would do whatever was necessary.

Three referred to their efforts as a "quest," noting a quality of obsessiveness about getting pregnant, or as one woman described, "I became totally singular in my pursuit." Another added, "My motivation increased, because I felt like something got taken away from me that was mine." In a couple of instances respondents were surprised by their own passion:

> As far as the determination goes, I don't remember wanting a baby so badly. There was a determination, but it was instinctual...thats the word I should use. I couldn't explain WHY. Somehow I was afraid of getting pregnant again, I was afraid of something going wrong, I was already 41. So I was kind of surprised where it came from. I'm mystified that I could think of doing it again.

> The loss...it brought me in touch with my maternal feelings, because all this desire to get pregnant...When there was an actual fetus that was viable for a while, the things that I started feeling I had never felt, so I began to realize that this is something about myself that is very

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> big...but it was only a dress rehearsal. And then it was O.K., I really want it now.

Motherhood As An Achievement

Deutsch (1945) commented that the struggle for a child may become a symbol of a unique goal in life whose attainment becomes more important than the actual object of success. Indeed, 1/3 of respondents commented that the desire to achieve motherhood became increasingly powerful the more unattainable or unlikely it seemed, taking on the flavor of an accomplishment. They were determined to prove that they could "do it" and would not be defeated in their efforts:

> That became the whole issue. I wanted to know if I could really have a baby...can I really do this? I functioned on pure determination...it was like I'm gonna have a baby...I'm gonna have a baby, godammit! To me this is the female equivalent of the "macho thing" - I was "superwoman" you don't quit, because no obstacle is too large. I needed to prove I could do it, like all the other women I knew. It was pure determination at all costs.

This respondent astutely noted the possible impact of social attitudes on furthering the desperate striving for motherhood as she reflected on the use of language:

> I got obssessed with trying to get it right and do every element right. The next pregnancy won't have any problems...I'll do it right! You feel it's some sort of scale you have to master which is really silly but people make you feel that

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> way..."SHE CARRIED TO TERM," they say, "THIS ONE WAS A SUCCESSFUL DELIVERY, SHE CARRIED IT TO TERM," as though she was carrying an egg and she got it to the finish line.

In a number of cases, the struggle possessed an element of rivalry, as women discussed the pain of wanting to secure what their peers had:

> Did the loss discourage me? Au contraire. It was partly some competetive instinct in me, some kind of drive to get this. I had begun to doubt my body's capacity to come out with something at all, like having a baby was not gonna happen to me. I definitely decided I was not capable of it..so there was an added pride if I could. I actually was seeing it as an achievement, rather than just a natural, biological thing.

Impact of Family History

Family history was another psychological factor that figured into some respondents' wishes for motherhood in a variety of ways.

Wish for Disidentification with Mother

Six respondents commented on the loss as provoking an undesired identification with some part of their mothers, and the attainment of motherhood then represented a potential separation or disidentification with that feared part of them. Five women referred to some parallel with

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their mothers' own reproductive difficulties, as elaborated by the following:

> You know I thought this is it. My mom...tried for seven years to have me until it happened. And she had all these really weird treatments and stuff...and then I had in my head that that was gonna happen to me, and then I started thinking I'm gonna be just like my mother thought she was gonna be... I may not have any kids...
>
> The other thing I was aware of was that my mother had entered menopause at the age of 40 and I was worried that I would also enter menopause very early like her, so I didn't want to wait another year or two years till everything was in order...
>
> There is an interesting twist to all of this. Which is my mother had a baby girl that died too. Before me, making me the second girl. So this loss made me more like her which is something I've always struggled not to be. Even though I always hoped for a girl, when I had a boy, I thought, at least I wasn't following in her footsteps...

One respondent expressed the fear of approximating her mother's depression after loss and viewed her persistence as an antidote:

> I insisted in pursuing pregnancy. I wanted to pursue it as fast as I could because after having the endogenous depression after the second pregnancy loss, and it was a real depression, all I could think of was my mother on antidepressants and her whole life is a mess and all I could think of is I've inherited it, I think this is it, my lot in life, I'm gonna become my mother, never get out of bed, and my strength of will is the only thing that's gonna prevent this and damn it, I'm gonna do it!

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Reworking Old Conflicts

Family history was also a motivator toward pregnancy for three respondents who viewed the value of motherhood in a "compensatory" fashion:

> I come from a home where my father beat my mother, no family life whatsoever, just a total disaster. I basically have no family so I want to create this ideal thing. I wanted six kids - through all this, I still haven't lost that. I don't think I have much choice. I have no one else and one of my biggest fears is that if something happens to my husband and child I'm all alone in the world. The more kids you have, the more you insulate yourself against that.

> My mother admitted she was an abusive mother to me. I think a lot of my wish to be a mother has to do with making it up to myself. You know, heal your own inner child...

Impact of Personal Interpretation of Loss

The question of whether an identifiable (and generally treatable) problem was found after the loss significantly influenced the relative degree of optimism or pessimism that mothers felt about pursuing subsequent pregnancy. Clearly, if a problem was detected and treated, particularly early on in pregnancy, respondents felt more hopeful about a successful outcome. While those who felt they were "victims" of vague arbitrary events all attempted pregnancy again, motivation was impacted upon by the way "randomness"

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was interpreted; a characterological predisposition perhaps to optimism or pessimism. In the following situation it was enhanced:

> I was ready immediately. Getting pregnant again as soon as possible was my thought. I was convinced and I had been told this was an aberration; it wouldn't happen again. It was not genetic, genetically I was fine...so that put the decision making there.

In most instances, the notion that a "fluke" occurred did not aid belief in a positive outcome:

> The doctor kept telling me there's a 99% chance it's all gonna be alright next time, the chance is so slim of this happening to you again. Maybe 1%...but to me that was a lot. It's 100% that it happened to me and he didn't realize that. That all that rational thinking didn't mean a thing. I was already the statistic. There would be times I'd do research at the library, close the book and say this means absolutely nothing.

> Well, the first time it happened I could say, "O.K., once you've been struck by lightning you won't be struck again." So I thought I was safe for life. Nothing bad was ever gonna happen to me or anybody I love. One tragedy, and that's it. But the most of an explanation I got from the doctor was that it was a fluke...which being trained as a scientist didn't sit very well with me. Fluke? I mean flukes..I didn't feel I had any control over flukes. But that was the best I had so I went into the next pregnancy thinking I was safe only as a result of having lived through it once...CAUSE A FLUKE COULD HIT AT ANY TIME.

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Impact of Others on Motivation for Pregnancy

Medical opinion has been divided about the "optimum" waiting time for attempting conception after loss and doctors' opinions have not heavily influenced women in the decision-making process.

Only five respondents mentioned doctors' input into the decision for subsequent pregnancy and it appeared that the common recommendation was to wait three months before trying again, making no distinction between physical recovery and psychological readiness:

> I would go to the doctor and he would tell me at the six week check-up that I could try again. And I would say, "But I can't, I'm not ready." And it took me a year emotionally each time before I felt I could take the chance and do it again. I knew this was not for me, trying 6 weeks later, not my temperament.

In the one instance where the latter was considered at all, this respondent felt that her doctor had a different "take" on emotional preparedness:

> (after full-term stillbirth) He wanted me to wait one complete cycle before trying, that was it. In terms of emotional processing, he was sensitive to it, but didn't...(take it that seriously, since) we were functioning just fine to the outside world, that was what mattered...but being in the field (psychology) I knew I had some things to work through.

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This respondent was commenting perhaps on the dichotomy between how loss is experienced internally and assessed externally, the latter often resulting in the suggestion that the bereaved must "move on." This respondent expressed surprise at the advice of a mental health professional in this regard:

> I went to a psychologist for a year after that, once a month and I don't think it was very helpful. I never did quite get the point of it, because it seemed from the beginning the fellow said to me, "The only way you'll get over this is to have another one." I can't believe...this was the bottom line in his mind and he was someone who was a specialist in working with parents in the NICU. It blew me away...a therapist - he said it like it was a scientific fact!

One Orthodox Jewish respondent sought the advice of her rabbi in regard to parameters for proceeding with subsequent pregnancy which she found comforting:

> I spoke with the rabbi and he said if I felt not ready, I could still wait 6 months, but not longer than that, since medically I was O.K. But deep down I wanted another baby at that point so I started trying right away.

## CONSIDERATION OF OPTIONS OTHER THAN BIOLOGICAL MOTHERHOOD

In spite of Deutsch's (1945) assertion that a woman can enjoy motherliness even if she has not conceived, borne, and given birth to a child; that maternal feelings can find

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gratification elsewhere, the drive toward pregnancy and biological motherhood was extremely strong in this sample of women. The options of childlessness or adoption were not considered favorably.

Childlessness

For the women in this sample, the prospect of a childless life was a grim one. When questioned about consideration of alternatives to biological motherhood, only two women, (after five losses each) in a tone of "resigned" acceptance, mentioned that the possibility of childlessness had begun to occur to them. In fact, in both cases, the pregnancy that resulted in a successful outcome was to be the last attempt:

> We finally had a talk about it. We tried to say, "We have a nice life, we have a lot of free time, we both play tennis, we go to the gym, stuff like that. So we tried to convince ourselves. Life will be nice, it'll be O.K." I don't think I really believed it, but the stress was getting to be more than I could take. I decided I had enough. I couldn't take it anymore. Let's just close the book and forget it...and that's when I got pregnant with my daughter...

Even a successful career was not an adequate substitute, as this physician-respondent remarked:

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> I felt I should cherish every moment of that subsequent pregnancy, even though it was so difficult. Because you can't duplicate that experience. No accomplishment in a career will ever equal the accomplishment of a pregnancy and having a baby.

Adoption

Without any enthusiasm, nine women had considered adoption as a "next best option," but only one had actually begun the process while she continued to pursue reproductive treatments. Of the nine, three mentioned husbands who were adamantly opposed to adoption and in favor of continued efforts at genetic childbearing; two women felt daunted by the whole adoption process and one felt her known fertility and wish for a biological child continued to overshadow her desire for and efforts toward adoption. Once biological motherhood was attained, thoughts of adoption totally ceased; it was clearly viewed as a "last resort."

SUBSEQUENT PREGNANCY: THE EXPERIENCE

Whether immediately, or within a period of a year, all respondents were able to hold their fears in abeyance enough to attempt and (eventually) achieve a subsequent pregnancy. In preparation for such, all but four of the respondents

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sought out a new physician with whom to pursue the next effort with one changing physicians five times!

The Role of the Physician in the Subsequent Pregnancy

Of the four respondents who remained with their doctors, three cited as reasons their belief in the physician's medical expertise; only one of these three emphasized her doctor's emotional support in addition to his knowledge.

The reasons given for seeking a change of physician fell into three categories: first and foremost, the wish for a more supportive, compassionate doctor; secondly, the need for a high-risk specialist, an "expert" who would make every effort to locate the problem; and finally, the hope that use of a different physician, preferably affiliated with a different hospital would facilitate an emotional separation from traumatic memories of the prior experience.

The Search for Compassion

While good medical management was important to these women, it was surpassed in salience by the need for an emotionally available, empathic doctor; one who would consider and understand the psychological impact of the previous pregnancy; would be sensitive and responsive to the

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patient's anxiety and fear and stay with it, rather than simply appealing to reason and optimism as this respondent appreciated:

> He (the doctor) was able to hold my anxiety without getting caught up in it. Anytime I had any kind of pain, I was on the phone to him. At one point he told me that he was not gonna convince me I wasn't gonna lose the baby and he understands that and he understood my anxiety and if I wanted to come in an extra time or whatever, I could. But he knew...(and he was right) THAT THERE WAS NOTHING HE COULD TELL ME THAT WAS GONNA TOTALLY HELP ME.

Another poignantly recounted how understood she felt by her doctor who appreciated her inability to acknowledge and enjoy her pregnancy out of fear:

> I really needed to be in maternity pants, I was showing early and I couldn't button my jeans but I had a lot of superstitions about everything and I walk into the doctor's office and happen to tell her I'm wearing regular clothes and she said, "I know this isn't scientific, but I don't want to see you in maternity pants till you're 34 weeks." I said, "I thought I was bad, but you're worse!" And she said, "I know...but you've been through so much...let's not even play with the clothes." It helped me to relax, knowing that she felt the way I felt.

Fortunately, those respondents who switched doctors in search of greater warmth and relatedness expressed much greater satisfaction with the doctor during the subsequent

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pregnancy. They felt that treatment was more personalized, comforting and reassuring:

> Just to let you know...I had the greatest doctor. A new doctor in the practice and I just hung with him. He was so understanding. Finally I found someone who had compassion and could really relate. He was a lot younger than everyone else in the practice but he gave them a lot to learn.
>
> I was a nervous wreck, paranoid. I needed someone to hold my hand, a therapist-doctor. I went to see this doctor who told me he believed I could have a child. And i asked, "Can you handle me? I ask questions, I'm very nervous", I went on and on and he said, "If you can handle me, I can handle you. And I have to say I've been in love with him since. He's wonderful, he's given me two children...I mean GOd's given me two children, be he supported, helped that process. He's been there for me and when I'd see him, he always joked, relaxed me, made things lighter than they were, and seeing him always put a relief in me.

Unfortunately, two of the four respondents who remained with their physicians reported unempathic comments made to them at some point during the subsequent pregnancy:

> I was very sick, vomiting constantly during the pregnancy, losing weight. I couldn't even stand up and I thought for sure this guy (doctor) would hospitalize me. But his attitude was, "As long as that baby is healthy and I see a beating heart, I don't care what shape you're in." And I'm sitting there, you know you go to the doctor for salvation and he's like, "Tough, you'll live."
>
> (during hospitalization for preterm labor). The doctor came in and asked how I was doing and I started to cry. And he said, "Just stop crying

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> now, because if you get down now, it's gonna be a mighty long couple of months." He never saw me cry again.

Importance of Medical Expertise

Six respondents mentioned a change in physician for "medical reasons;" i.e., they sought the expertise of a specialist, or desired a physician with a compatible treatment philosophy:

> One of the things I had done was shop around to find the best doctor I could find. I wrote the only woman in the country who writes textbooks on diabetic pregnancy in California and asked for her recommendation.

> One of the things that became clear to me about medical stuff which became relevant in terms of my subsequent pregnancy was that there are enormous differences in the ways doctors handle cases. Maybe not a strep throat, but in complicated cases...And this notion we have that there's a "way to do it" is really untrue. And that when you pick a doctor, you're picking a whole personality style and medical philosophy. Not just how they deal with you as a patient, the interpersonal piece, but how aggressive they are and stuff. And you really don't know what you're picking when you pick a doctor, unless you've been through some big thing.

The Wish to Differentiate the Pregnancies

Two respondents changed doctors and hospitals in an attempt to separate themselves emotionally from the last experience. Unfortunately, one ultimately had to deliver her baby in the same hospital, but noted, "It was a totally

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different experience, delivering a live, healthy baby," suggesting perhaps that it was less the physical setting and more the actual successful outcome that helped her distinguish the two pregnancies.

Access to Medical Care

Of note is that the high cost of advanced reproductive medicine was never mentioned by 30 out of 32 respondents; rather it was almost implied that access to the best choices in medical care was never an issue. Respondents simply "shopped around for the best doctor." However, two women did introduce the importance of availability of superior care to a successful outcome as this one commented:

> I truly believe if I lived somewhere else, did not have the means, did not have a "rolls royce" obstetrician, did not get to a high risk guy...I mean the genius and technology was there. I was completely in the right place.

The other respondent in turn, described how she lacked the option to seek out quality care. A clinic patient, she lost a baby at 20 weeks gestation. Though deeply disatisfied with the care recieved, she remained a clinic patient during the subsequent pregnancy due to inadequate funds and medical insurance. This patient stated she relied on "faith, rather than technology," but it was clearly not by choice. As

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noted earlier, the very specific socioeconomic group studied presents a limitation in the scope of the research and the situations of women like the above-mentioned respondent need to be further understood.

## THE EMOTIONAL PROCESS

As noted extensively in the literature review, the emotional experience of pregnancy following loss often does not follow the "normal" psychological course of pregnancy. It is frequently characterized by intense anxiety and fear, rather than the bliss and excitement felt in a "normal" pregnancy. Joy is consciously tempered due to the fear of another loss.

### Prevalence of Anxiety and Fear

The women in this sample supported previous research findings, as only three reported enjoyment of the pregnancy, five had "mixed feelings" throughout, while 75% described the worry and terror that pervaded the entire experience.

Of the three respondents who were able to enjoy the pregnancy, one felt anxiety was useless, as she could not control the outcome; one "put her faith in reason" rather than believe that one loss necessarily implied more, and

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this woman made a "conscious" decision to enjoy the pregnancy at all cost:

> I have to say I had the happiest pregnancy anyone could've possibly had because I told myself, "nothing lasts forever...this might not last, but enjoy it while you have it. Every day. Like someone who's been told they had a terminal disease almost. It sounds morbid, but everyday I woke up I was pregnant I was the happiest woman in the world.

Five respondents described the duality of emotions throughout the pregnancy: excitement coupled with fear, as this woman commented:

> I never felt such a dichotomy. I was so unhappy and so happy at the same exact time.

For most, the pregnancy was permeated by constant anxiety, panic, uncertainty and fear of another loss. Respondents used descriptions like "unprecedented fear...a tense, anxious scary time," "inconsolable, endless fear and worry," which for most of them, lasted the entire nine months of pregnancy. It was as though "worry" could mystically ward off danger, for as one woman noted, "If I just don't relax, then maybe the bottom won't drop out."

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Fragility of Pregnancy

The subsequent pregnancy was commonly referred to as having a "tentative" quality; an all-consuming experience whose successful outcome never felt assured:

> I was totally anxious all the time, completely and utterly anxious about it. It (the pregnancy) became my world...my focus. And I thought every single day, every step of the way, every single hour, I thought, this could go sour. This could all be over tomorrow. I never lost that fear...never.

> It was a "tightrope" existence, every day, every hour, guarding and protecting that pregnancy. It was like being pregnant 24 hours a day and SITTING ON YOUR EGG IN A NEST.

Marking Time

This total absorption in the pregnancy resulted in an acute awareness of time and marked consciousness of its passage, as the pregnancy became defined by the achievement of certain "milestones." These typically coincided with seeing a fetal heartbeat on ultrasound, the end of the precarious first trimester, the receipt of a good amniocentesis result, the inception of fetal movement, the point of viability and perhaps most critically, passing the gestational point at which the prior loss occurred. While each milestone represented a "marker of success,"

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particularly passing the "danger zone," (point of loss) only two respondents expressed feeling a true sense of increased confidence and diminished anxiety as the pregnancy progressed and both had losses due to genetic problems. Once it was ascertained through testing that the fetuses were normal, these women had greater emotional ease during the rest of the pregnancy:

> Once I got my good news, life was really pretty golden. And I had no fears that I might I lose the baby. Which, when I think about all those stories...you might lose it. I didn't need to keep anything in reserve at that point. I harbored all my emotions at the beginning, and then I could let go. In all this, I count my blessings...

For the most part, however, even as the pregnancy advanced, intense anxiety remained and as one respondent noted, "one worry just replaced another," and occasionally began to extend into worry beyond the pregnancy as this woman described: "I became terrified of pregnancy and everything beyond it; I felt I prepared for a lifetime of worries." "Unrelievable" anxiety was particularly prominent for women who suffered unexplained losses and feared the unexpected and inexplicable could happen again. Moreover, for those who sustained late losses, anxiety

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seemed to increase, rather than decrease as they approached the third trimester:

> Nothing seemed to matter...only "how far could I get to?" Was the baby healthy, and how long I could get to. But I remember, even towards the end...I just kept thinking what if the baby strangles on the cord? You NEVER give yourself the option just to say...now it will be fine.

> After 24 weeks (loss point), we were counting down the weeks. Instead of eager anticipation, I'm doing all these things most pregnant people never do; calculating the birth weight, calculating the odds of survival, figuring out what organs had developed at each point...I was weighing all the factors most people probably don't ever consider.

The Mixed Effects of Fetal Movement

Even more than mention of exceeding the loss point, references to the powerful significance of fetal movement in the subsequent pregnancy were common. Ten respondents noted the extreme amount of attention paid to their bodies during pregnancy, especially a hypervigilance to fetal movement once it began to occur. Interestingly enough, while movement was generally felt to be reassuring, given a history of loss, it had other connotations as well.

For those women "overly-attuned" to their bodies, one noted that "waiting for movement took on the quality of an

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addiction," while another added that "daily monitoring of movement became the normative focus, not having the baby." Three respondents jokingly told of their efforts to force movement to occur:

> That baby had to move...I would wake up at night and if it took a half hour, I was not going back to sleep if I didn't feel the baby move. Everytime I got up to go to the bathroom, if there was no movement, we were going to the hospital. I woke up that baby every nite, two or three times a night, so I never slept, I didn't sleep and I was waking up this baby all the time (laughing). I don't know, I had to. I had to do it.

> I would spend my time counting the movement. Five..six times an hour and if I didn't feel movement I'd call my husband to bring me an Entenmann's cake because I have to count for the baby. Because I knew this child needed a sugar rush to move. Sometimes she would move and I would watch to see the form of her. And because she was mellow, I would watch for everything...when she moved, when she rolled over, when she got hiccups...

At the same time, all the focus on movement did not seem to diminish anxiety significantly, for it rendered the baby and the accompanying threat of impending loss, that much more real. For as one respondent noted, while it was "normally reassuring...this time it was loaded with the fear of loss; it was excitement and magic mixed with terror." Another compared feelings elicited by movement in the

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subsequent pregnancy to her prior pregnancy before the baby died:

> It was definitely different. Hard to describe. I remember with the first, with K, when she started moving, I could feel it. IT WAS A THRILL. It was fun and exciting and it was happy. But when E started moving in there it was terror in the beginning, terror in the middle and terror in the end. I never felt optimistic, I had a sonogram and I had an amnio and everything was O.K. Didn't matter.

Emotional Effects of Complicated Subsequent Pregnancy

The emotional experience of the subsequent pregnancy was clearly complicated by problems that arose throughout its course. After their traumatic losses, 50% of respondents went on to endure pregnancies that became problematic. Such complications affected the experience significantly, in at least three essential ways: anxiety was heightened as the possibility of another loss became more real; the threat of loss introduced by problems, the "high risk ordeal," revived potent memories of the process of the prior loss and made the two events harder to separate psychologically; in fact, during her interview, one woman noted that "the trauma of the subsequent pregnancy not only reawakened the earlier loss, but nearly eclipsed it in memory;" and finally, where bedrest was prescribed,

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respondents experienced anger, depression, boredom and loss of independence in addition to anxiety.

Memories Reawakened

Memories of loss were most clearly revived in situations that presented the same threat anew, such as preterm labor:

> At 29 weeks it was like we had hit a great big stumbling block. Here I go into labor again. I became a basket case. It was a deja vu of the prior fear we both still had such fear of losing this baby as well.
>
> At that point...I hemorraghed and thought I was losing the baby. It was just a recurring vision of what happened with the other miscarriage. I went on bedrest after that.

Even where no immediate threat existed, another pregnancy and the mere thought of a potential problem, evoked strong feelings in this respondent who lost twins:

> I was not puking my guts out which was in some ways worrisome to me. So I had an ultrasound and there was the fetus...and only one in there which was a tremendous relief. And they found a heartbeat and for me well I was really partially excited and partially sad. It made me miss G and L (previous pregnancies) more. I had to work hard to separate the "mother of the subsequent pregnancy" from the "mother of the loss."

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Added Stress of Bedrest Pregnancy

One-third of all respondents reported following prescriptions for total bedrest and tocolytic medications (for prevention of premature delivery) during at least part of the subsequent pregnancy. Most described feeling angry, bored and as though they had relinquished their "prior life and functioning," with two adding that the restrictions imposed made "pregnancy feel more like an illness." The three "bedresters" who already had children highlighted the logistical problems of being confined while having a young child. Additionally, they presented two significant emotional factors specific to having a child: sadness and guilt about being less available to the existing child and concerns about the child's fears of maternal absence and/or another loss:

> I told her..I spoke to her and explained that as scary as it may be, that it may happen again. And if it does, I'll be O.K., and we'll be O.K. And as much as it was a lie, I told her I would be fine because I know I have her. And that did it for her. And I guess it's terrible to say...but you have to lie to be a parent...or alter the truth a little.

Yet in spite of their complaints, respondents were simultaneously unambivalent about their commitments to

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sacrifice all to protect the pregnancy, even if it meant possible significant maternal risk:

> They told me you have to go straight to bed for the rest of the pregnancy and you have to sign to take this medication. This medication could make you die or have a stroke or heart attack, but if you don't take it, this baby will be born now and die. And I said O.K., I pick, I DIE. And I went to bed on this medicine because no matter what they told me I had to do, no matter how dangerous this medication was they were gonna give me, what was gonna happen, I didn't care. If you can make the baby live, fine, if it means that I don't...I don't care.

## COPING WITH THE SUBSEQUENT PREGNANCY

Respondents were asked how they managed to cope with the stress of the subsequent pregnancy. Strategies included channeling anxiety and fear into some sort of action; utilizing available support from others and employing numerous psychological mechanisms to get through the nine months of pregnancy.

### Active Strategies

Nine respondents (all of whom were not physically restricted) discussed "active" coping strategies which helped distract them from their anxiety and enabled them to combat feelings of helplessness during the subsequent pregnancy. These included working hard, keeping busy and

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attending church regularly. Five women mentioned taking steps that might somehow foster a greater sense of control of the outcome of the subsequent pregnancy. These included taking even better care of themselves; exercising even more caution and in three instances where full-term loss occurred, convincing the doctors to schedule a delivery date prior to the due date to avoid another loss:

> I was full of remorse about my loose living in the past and I became pretty puritanical. I started to see my body as a big garbage dump that I created that was barely capable of taking care of itself. I was ready to give up everything for this kid. I wanted to do it right the second time around. I got much more serious. I developed an obsession about the correlation between my body and creation. I gave up coffee in my second pregnancy. The first pregnancy I did drink a little. The second one, nothing. I became a total health nut. This kid wasn't gonna be just a sideline, a sidekick. He was like a little hot house flower.

> I told the doctor...there is no way I'm going to 40 weeks again, (point of stillbirth) you know that. I'm not going to 40 weeks, that was my biggest fear. I knew that if I went to 40 weeks, I would not have that baby. That's how I felt. Even if they told me every thing was fine, if I had to jump up and down to get that baby out, I told the doctor there was no way I was going 40 weeks because to me 40 weeks meant death. That's how I felt.

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In spite of efforts made to be meticulous about the pregnancy, this respondent astutely acknowledged, however, that control was at least partially an illusion.

The Role of Support by Others

Seventeen respondents mentioned seeking the support of others during the subsequent pregnancy. A couple mentioned the value of friends, one sought the comfort of a priest and eight mentioned the role of their spouses during the subsequent pregnancy. Of the latter group, only two mentioned positive support provided by their husbands, while six described marriages strained by the subsequent pregnancy. Generally spousal anxiety and fear at least equalled if not surpassed the respondent's:

> My husband was extremely anxious. I think in some ways, more affected than me. Maybe because it wasn't his body. He wasn't in control of it. Or..even less in control than me, I should say!

> My husband was an anxious wreck. When our daughter would crawl into my lap and I was uncomfortable, he would say, "Don't do this, don't do that, you want this pregnancy to go sour too? You want to lose this one too?" I mean, he was not being too supportive.

And at the most extreme:

> My husband wanted me to terminate the next pregnancy. He couldn't deal with it...I don't know if he was afraid he'd lose it again, or never

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> wanted the responsibility and had a chance to think about it now, but he left me. When the baby was 6 weeks old, he left me.

Finally, six respondents sought the support of either individual therapists or self-help groups to help them through the subsequent pregnancy and these contacts were noted to be useful.

Psychological Coping Mechanisms

Respondents discussed a variety of interesting ways in which they attempted to cope psychologically with anxiety and fear during the subsequent pregnancy. These included: appealing to their rational sides; displacing anxiety; projecting the occurrence of a negative scenario; and most prevalently, using denial either of another potential loss; or more significantly, of any investment in the pregnancy, or attachment to the fetus.

Appealing to Reason

Three respondents managed anxiety by soothing themselves through "reason," as this woman who was pregnant at the time of the interview, described:

> I definitely am more anxious and conscious of it. So I am trying to tell myself when I start to feel myself getting more anxious, not to worry about it, to calm down, not to stress myself, because it's not gonna do anything for me to be stressed out

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> this way. I go back and forth trying not to worry about it, saying it's not gonna happen again, to it could happen again.

Displacement of Anxiety

Two respondents used displacement to cope with anxiety. After 5 miscarriages, one respondent described quite an elaborate defensive response which consisted essentially of a displacement of anxiety and fear coupled with a fantasy that would somehow enable her to control a negative outcome:

> I developed an unbelievable AIDS phobia that lasted throughout the whole pregnancy. I was convinced I had AIDS, convinced. That and toxioplasmosis, those were my two things and I drove everybody nuts with them. I had seven tests for toxio...that was the only way to manage my anxiety, was to keep having bloods drawn. It was completely psychotic, but it was like very bit of my anxiety about the pregnancy went into this. I decided that I was gonna kill this baby with AIDS. I was insane, crazed. I was 13 weeks pregnant and wanted to have an abortion. People told me there were other things I should be worried about and I knew what they were getting at...but I couldn't go there.

Control Through Anticipation of Disaster

Like the foregoing respondent, four others attempted to exercise some control and protect themselves from the "surprise" of another loss by anticipating or planning out subsequent misfortune:

> Once everybody knew, I started thinking how if I lose this one, and then they ask me, "So, did you

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> have the baby?" How was I gonna respond? I was already planning out what I would say to people, how I would tell them.
>
> I was so worried and I had already gone through such hell...I reached a point where "whatever is gonna happen, is gonna happen." Because I've already been to the lowest depths there are and it can't get any worse. So I got into that kind of dialogue with myself; I just told myself: "This baby will die and it won't be as bad as the first one dying."It can never be that bad again.
>
> (4 losses and currently pregnant) I developed this fatalistic attitude. I can't say I worry. I just know something bad is gonna happen and I'm just waiting to see what it is and how bad it's gonna be. Then if nothing goes wrong, I will be shocked.

Uses of Denial

The psychological mechanism most widely used during the subsequent pregnancy was undoubtedly the defense of denial and interestingly, it was used in almost diametrically opposed ways.

Denial of the Possibility of Repeat Loss

A much smaller group of respondents (5) used denial as a kind of "wishful thinking;" they attempted to convince themselves that tragedy could not happen again:

> When I think about it, I just decided it had to work out. I just did not allow myself to consider that it would not work out. I really didn't. I just believed that it had to be O.K. and fortunately, it was.

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> (after 5 miscarriages and in the midst of hospitalization for preterm labor) I was totally convinced that everything was gonna be alright. I was getting all this feedback about how serious it was, how brave I was...truthfully, it was not out of nobleness. It speaks to the denial I was in. I thought, "Oh, premature baby?" That's alright, a preemie is just really little. I didn't know about brain bleeds, I didn't know about those things till afterwards. Which is totally unlike me because I tend to research things heavily. But I needed to do this. And it worked for me.
>
> I decided at some point I'm gonna throw over all this stuff...no bedrest support groups, no newsletters, no books, I'm not gonna read. I'm just gonna pretend I'm not on bedrest and I actually did jobs for people and no one knew I was lying in bed. I had a manuscript to do and I rigged up my computer on a hospital table lying on my back and worked and pretended...

Denial of Pregnancy

As discussed earlier, the process of guarding (McGeary, 1994) has been defined in the literature as a defense used to avoid the pain of loss. It is mobilized in reaction to uncertainty and enables the woman to protect her self and her baby.

More than 75% of respondents (27) relied on the use of denial, not of possible repeat loss, but of pregnancy and attachment to the pregnancy, to ward off the terror and potential pain of another loss. Repeatedly and in great detail they discussed ways in which they "totally detached"

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themselves from the pregnancy; left themselves in (emotional) "neutral" and lived in "disbelief" of a successful outcome for nine months. This denial ("or guarding") occurred in various forms.

Concrete Manifestations of Guarding

On a concrete, or behavioral level, many women spoke of their inability to acknowledge the pregnancy or plan and prepare for the birth of the baby. They avoided buying maternity clothes, reading about pregnancy, viewing videos they had in their possession, decorating a room for the baby, subscribing to parenting magazines, having baby showers and choosing names. For many, this constrasted with their behavior during the prior pregnancy:

> We were extremely cautious this time. Never talked about a name for the baby till we were in the hospital delivering. I made no preparations. Last time I had gone for the layettes and it was really exciting. We were making preparations, we went shopping for a crib, a carriage, a car seat. This time I never got down all the clothing and linens I saved. They had to be washed because they were sitting in boxes. So when I walked into the apartment with this new baby, there were boxes all over and nothing was ready. Talk about not planning...not dealing with it...not coping.

> We wanted that child but we weren't sure that second child wouldn't end like the first one and I think that's reflected in our not planning. Our not doing all the things we did before and loved

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> doing so much...because we were so scared. Could we deal with choosing a name and then having the disappointment of that baby not being born? Or not surviving again? Could I face getting out all this baby clothing at 25 weeks (time of last loss) and then washing it and having it sit in the drawers and then losing a baby again? I couldn't deal with it. So there were a lot of things that waited till the very last minute and it's a reflection of where we were at and where I was at emotionally in that next pregnancy.
>
> I didn't get anything ready for him, no showers, no cribs, nothing was prepared and so we scampered around and came home and there was nothing ready. It was really stupid. I should've gotten over my pessimism and gotten things ready for the baby so I wouldn't be making extra work for myself!

Keeping Pregnancy A Secret

Another common manifestation of "guarding" was to withhold the news of pregnancy from others. It was as though the respondent led a "double" life: she possessed an internal intense awareness of the pregnancy while denying its existence to the outside world:

> I was in denial to others, total denial. No one knew but me, my husband, mother and mother-in-law. My mother would come and say, "How's the wee one today?" and I didn't want to hear any reference to the wee one. Just say "how are things?" I was in bed and a friend called who I hadn't spoken to in a while and said "what's new?" And I said, "What do you mean what's new?" There was no way in hell I would tell her I was pregnant. Finally, at 26 weeks gestation I started to tell people. A good friend of mine, even, I told very late. She didn't

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> take it too well when I told her because at that point I was 28 weeks!

And somehow, magically...this would be protective:

> At that point it got to be a game with me. I didn't tell anyone and nothing's happened so far...so how long can I hold out? To 28 weeks? Viability? 29? I played all these tricks...mind games. I swore my family to secrecy and when I did tell people I was pregnant they would say congratulations and I would say "Don't congratulate me- it's not good news I'm pregnant. The good news will be when you hear I have a child." And I'm saying this even 8 months pregnant!

Those women, who, in self-protection withheld or hid the pregnancy from others, recognized a different kind of acknowledgement, even to themselves; a greater inability to "deny" once they "went public:"

> The last two weeks of my pregnancy even strangers said things about me being pregnant so I thought...I really am pregnant. Someone gave me a seat on the subway and I said "Oh, I guess everybody knows now" and it felt more real.It made it much more real when people noticed I was pregnant. I couldn't deny it anymore. You know, it's like if people didn't know, then it wasn't real.

Unfortunately, keeping the pregnancy a secret made it further impossible to get the social support these women so badly needed.

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Emotional Detachment from the Pregnancy/Child

Sadly, the greatest effect of respondents' denial of pregnancy was that in many cases, it precluded enjoyment of the pregnancy, excitement and eager anticipation and preliminary feelings of attachment to the fetus/child. In a couple of instances, rather than begin to cathect to the new pregnancy, women maintained their energies thinking about and "holding on" to the lost child.

Indeed, many of these women discussed a delayed attachment to their fetuses; a distance maintained from their babies. Even subsequent to passing certain critical "milestones," while they "knew intellectually they could be more optimistic...emotionally, they could not get there." The thought of allowing for closeness and encountering death and disappointment yet again was more than some respondents could bear. Rather than risk connection and then possible severance, many adopted a "wait and see" attitude, in accordance with the flavor of uncertainty that pervaded the whole experience:

> Even though the first trimester was very uncomplicated, I was extremely anxious and guarded about getting attached to this pregnancy. I was very, "I'm not getting invested in this, I need to protect myself, we'll see what happens." And

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> that's not like me, I'm somebody who gets invested very fast...at least I used to get invested very fast. And so I was very tentative with myself and then of course worrying how that would affect my capacity to attach to the baby, assuming of course, the baby got born. But I really felt like I needed to be just very arms length about the whole thing...

<u>The Limits of Denial/Guarding</u>

While efforts were made to remain emotionally detached, some of these women recognized the "fallacy" of their own magical thinking that they could in fact avoid attachment, and that this would, in fact diminish the pain and disappointment they would feel if they had another loss. For some this was a conscious realization that was articulated as such in the interview:

> Eventually I came to the realization that if you don't bond, if you detach from the fetus that it's illusory. And all that does is deprive you of the experience of prenatal bonding. And that's illusory of protection too. My therapist helped me to see that, that if I avoided attachment it probably wouldn't hurt any less if I lost the baby and if everything turned out I would've missed the pregnancy completely - the bonding, talking to the baby, feeling movement.

> I knew all the time, though that I got attached to all of them (pregnancies), from the day I knew I was pregnant. I don't know if you can not do that. I think when you find out you're pregnant you automatically begin to wonder what this baby will be like.

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> I think I was definitely guarded, but I still did things like touch my belly and communicate with the fetus. Maybe it was just more like a praying communication, than a confident communication...

Others remained unaware until the time of the interview that while conscious efforts were made to ward off investment and belief in the actual birth of the baby, that in fact, unconsciously they were making plans for the baby's arrival:

> Now that I think about it I was in disbelief she would ever be born. But you know after the amnio I found out she was a girl and I finished the room for a girl and I picked girls names. Maybe somehow I really did believe it was gonna be O.K. I think actually that you get attached from the day you know you're pregnant. I don't know if you can not do that. I think when you find out you automatically begin to wonder what this baby will be like...

> I got nothing, absolutely nothing. I read no child books, did nothing, no stroller. I didn't find out the sex because I was convinced it was a boy. And then she was a girl and I was in complete shock because come to think of it...I already the bris (circumcision) planned! In fact I told my father not to buy me flowers for my 35th birthday because I wanted him to buy food for the bris!

> We were careful. I delayed any rejoicing. I delayed any acceptance that this was really going to happen. Yet I wanted to know the gender because I thought I would bond better. And she was in fact very much a part of our lives from the first heartbeat we heard. We called her "bean," she was always a bean and we talked to her and touched her all the time.

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Attempts at Denial and Complicated Pregnancy

A couple of factors emerged as interfering in respondents' best efforts at self protection: one was the circumstance of a complicated pregnancy that required daily vigilance and attention. In a highly monitored situation, attempts to deny the pregnancy were made virtually impossible:

> It was like an out of body experience. I didn't want to, didn't let myself connect to the baby in any way. I had just been so hurt by how I had connected the first and second time and there was no chance I was ever gonna do that again. But then there was a heartbeat, and there was a baby, and then a baby that was moving and I was injecting, injecting, injecting daily and so I had to give magical powers to this medication, while all the while I treated it like an out of body experience.

Emotional Impact of Medical Technology

The other was the often frequent use of high-tech monitoring equipment (especially ultrasound and fetal monitoring devices) which had a number of impacts, including making the pregnancy more concrete and real. Interestingly, reactions to the availability and use of advanced reproductive interventions were mixed. Respondents felt that sonograms of the baby were at times very reassuring:

> The first sonogram they did, they couldn't find the heartbeat and I was looking at T (husband) and his face had fallen and I was trying to figure out how I was gonna comfort him. Then they did it again

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> and lo and behold there it is. And they turn on the noise and there's this heart going thump thump thump and it felt like being pulled from the edge of a cliff. It's like you lost your dreams and all of a sudden they're back. For me getting to that point was the most extraordinary feeling in the world.

In making the baby more real, denial of the pregnancy was inhibited and respondents were faced with the dilemma of trying to ward off attachment to the fetus at the same time that its reality became more pronounced by seeing an image of the baby on a screen:

> I tried so hard not to attach but I remember when I had that sonogram and it was so clear I was having a baby. I thought, I really am having a baby. Still, I never bought maternity clothes. I wore the same thing everyday. I was too afraid. And then around the last month it got very clear I was having a baby. I remember a sonogram later on and seeing a face and saying "Oh my God, that's my husband's face." It looked just like his bone structure. There's really somebody in there. Until that point, it never really occurred to me that I was having a kid.

At the same time that technology offered some women reassurance, more expressed disatisfaction or disillusionment with high tech interventions for a number of reasons. Four felt that technology turned the pregnancy into a "too scientific" experience providing almost "too much" knowledge, too much to worry about:

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> I've had so many screenings...I had to get up and go to lab here, lab there, I was constantly somewhere, and always discussing if everything was O.K. I was more aware of everything being tested. Now I know they do this, they do that, alphafetal protein test, nothing's just for risk, now it's all routine. I mean I never had a sono with my first child. I was consumed with medical appointments, at the doctor every day. Cardiograms, fetal echo, where they focus on the baby's heart...it was very nervewracking.

Six respondents expressed the feeling that technology was confirming only "momentarily," and could not offer much consolation in light of what had happened to them; there were no guarantees. In fact, three noted with anger that it provided an illusion of ability to control and avoid tragedy which then raised expectations:

> (pregnant at interview) I've had all the testing. High risk everything. Echocardiogram, every time I go to the office low resolution sonograms, 3 or 4 high resolution sonograms already, stress tests. Last time I had no tests, now it's like I'm hooked up permanently to things. It's reassuring at the time. When you see the baby kick you know it's O.K. When the kid is active, it makes me feel better. But even the reassuring is not without...stuff still happens. So the baby will kick too hard and strangle itself on the cord... Even though they'll tell you the technology is so much better now. Things happen anyway, because nature is always gonna be bigger than technology.

> For one thing...reproductive technology gives you tremendously high expectations. Even though they tell you the failure rate is blah, blah, blah and it's written down that your chances of being

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> successful are 20%, you don't hear it. They don't want you to hear it. I really believed that with all they know, all the technology they have, it's gonna insure the pregnancy.
>
> I had been through all those tests and still lost the baby. So it didn't mean anything. I'd been through all the genetic counseling, it didn't guarantee, it didn't have a reassuring effect. So there were the little milestone, so far so good. But I knew I couldn't bank on it because I'd been through all that. It had been a perfect pregnancy till that moment (of death at 24 weeks gestation).

Finally, two women commented upon how the technology used, particularly sonography, reawakened the prior loss in rather painful ways:

> They sent me for extra sonograms because of the diabetes. They were upsetting to me because they only reminded me that if they had done this the time before maybe I would've been alright. It was upsetting because there I was, I could look at this moving baby and wish more that I could have one, knowing that hoping for it doesn't work. So there were all sorts of memories of the pregnancy before and thoughts of "if only they had done this then, I wouldn't be here now."
>
> Every single time I went for a sonogram, every single time they would put me on the machine and the doctor wouldn't say anything and I would say do you hear a heartbeat? Do you see a heartbeat? All the time, is everything O.K.? I would panic everytime because that's how I had found out she had died. With that sonogram. So for me the sonogram was always very mixed.

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Loss of the Experience of "Normal" Pregnancy

Sadly, a number of respondents commented that the process of "guarding," of remaining detached, engendered a sense of loss that they could not enjoy the pregnancy. Five described feeling "cheated" of a normative experience:

> Pregnancy was an illness...much more medical than it was magical. I never allowed myself any pleasure around the pregnancy and I got totally beat up just by the process. I felt I had already lived this life with her, but not a happy one - an intense, intrauterine life with no excitement. I still remember feeling jealous of all the pregnant women in the waiting room...After her birth, I mourned that I never enjoyed my pregnancy because it was never a sure thing. And I had to hold back from my baby because of that.

And one, pregnant at the time of the interview, felt empathy that her baby would lose out:

> Not only do we not talk about the baby, but I feel like this baby is sort of getting cheated. Last time I had a shower, I'm not doing that now. I don't want anybody to buy anything till the baby's born. O.K. So I'm not gonna have shower pictures, and I refuse to buy her anything. This kid is getting cheated, but I just can't help it.

Conclusion

This chapter explored in-depth, the experiences of pregnancy subsequent to perinatal loss. It explored the decision-making process involved in the pursuit of

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subsequent pregnancy, motivations for pregnancy, and the emotions and events of the experience. Finally, it described respondents' strategies for coping with a subsequent pregnancy, including ways of experiencing the prenatal period. As noted, the role of guarding in inhibiting prenatal attachment and consequently, postnatal bonding and adaptation to motherhood has been debated in the literature. Indeed, respondents had expressed that while pregnant, they felt concerned about the psychological impact of prenatal guarding on subsequent postnatal attachment and bonding.

The following chapter explores in depth their actual reactions to delivery and the early postnatal period, followed by a detailed account of their experiences parenting the subsequent child.

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# CHAPTER SIX

# THE SUBSEQUENT CHILD

The third section of this study centered on the experience of motherhood subsequent to loss. Respondents discussed their experiences of delivery, the early postpartum period (including the impact of perinatal loss on bonding) and their feelings about their subsequent children, including the possible effects of their losses on parenting.

## BIRTH OF THE SUBSEQUENT CHILD

As noted earlier, for most respondents pervasive fear and worry typified the subsequent pregnancy. A small number of women (4) reported that delivery brought with it some let-up from anxiety, as they recalled pleasant memories of their experiences:

> The delivery with M...it was a totally thrilling birth. He (the doctor) was so positive and optimistic about my strength and my pregnancy that he encouraged me to have a birthing room that overlooked the river and he set up a mirror for me and I had an epidural but I totally watched the birth. And that was incredible, totally incredible.

### Tensions around Delivery

The remaining respondents (28) described less joyful memories of delivery that were characterized by feelings of

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fear and apprehension, exhaustion, disappointment, uncertainty, disorientation and "anticlimax."

As they approached their due dates, six women (five of whom had suffered a stillbirth previously) became increasingly concerned about being "overdue." As noted earlier, three of these women attempted to cope with anxiety and achieve some sense of control by getting the doctor to induce labor. In fact, one woman described defying doctor's orders, in order to precipitate labor:

> I was told to stay on my left side, in bed and one day I just got bored. It was around my due date and I got up and took a walk because I was bored and I was probably looking to throw myself into labor because I couldn't take one more day of waiting...lying in bed and waiting, waiting. I walked and walked and it worked, I went into labor. My method of madness worked.

Other respondents commented on the fear and uncertainty experienced:

> It was terribly frightening. I woke up in the middle of the night...When I got to the delivery room, I had to take off my clothes, put on a gown so they could put a monitor on me. Getting through that moment which would confirm the baby was alive was torture.

> (subsequent to fullterm stillbirth) I didn't realize till after the delivery how frightened I was. Because during the entire time I was in the delivery room I could not open my eyes. I did not open my eyes until I heard my son shriek...which

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> was the most wonderful sound I had ever heard. It was this loud bellow and he just sounded really strong...

or the exhaustion and let down:

> I wasn't even excited after he got born. It was anticlimactic and that bothers me and I don't understand why...because I'm very emotional. But I think a lot was exhaustion...all the fear that had been brought up the whole pregnancy. I thought I would've just cried with happiness. But I think I was just too exhausted, physically, emotionally.

Impact of A Problematic Delivery

Fear of loss turned to terror with the addition of any complications that arose during the delivery, for either the baby or mother:

> I was hysterical during labor and delivery. I didn't end up having a C-section, but almost. The baby was in distress and they were giving me oxygen and turn on your left side and I just started praying, and I was hysterical. I didn't shut up for one second. And then he came out and he was blue and I was yelling, "suction him," and telling them what to do. And the nurse said all babies are blue, give him a minute and it seemed like an eternity till he looked good...

> So here I was delivering these babies (twin gestation) but then I got so sick. The babies got whisked off to infant ICU because they were considered high risk because I was considered high risk. I got to see them briefly in the nursery all hooked up and then my pressure kept rising and I kept bleeding...My blood had stopped clotting but instead of bleeding out it coagulated in one giant hematoma. I was totally out of it, the first 24 hours after delivery. They made me get up and

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> walk, I fainted, hit my head and needed stitches. I had a tantrum. And at the same time, I was totally hit with postpartum blues.

Role of the Physician and Hospital Staff:

Supportive Treatment

Only one third of respondents reported that their physicians were quite supportive during the delivery and recalled this as critical to their anxiety tolerance, particularly when the prior delivery (of loss) had been traumatic:

> The doctor stayed with me during my whole labor, from 7:00 till when he was born at 11:25 the next day. He was with me the whole time. And he said that he had seen this pregnancy through to this point and he was gonna see the baby totally through...he didn't even do that when his nurse gave birth. He said he had gone too far with the pregnancy. And he was going away for the weekend and said if I didn't naturally go into labor by Friday he was gonna induce because he wanted to be the one who saw the whole pregnancy through...he didn't want to take a chance that anybody else would deliver me. I can't say enough good things about him...

> The doctor was so supportive...I needed to know that he would give me an epidural if it weren't contraindicated, if it were at all within his power. What he said was that the minute he smells a dentist's office he wants an injection...so I thought that was great. I didn't want to feel I was gonna be denied it, because they couldn't give me one for the first birth (loss) - it was 36 hours without pain medication. So I wanted to have that straight, and he was very supportive.

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Lack of Support During Delivery

Alternately, three respondents complained that hospital staff were insensitive to their concerns during delivery and the early postpartum period and attributed this to lack of knowledge of their prior losses or worse, to a lack of understanding of the significance of loss as it impacted upon the emotional tone of the subsequent birth:

> One of the problems with having a baby after a loss like that (stillbirth) is the attention you get in the labor room...or lack of it. It is very scary, happenstance. My doctor didn't show up right away. So the resident came in and he asked how many pregnancies I had and I practically blew up in his face--READ THE CHART! And I said, "Look, I'm worried" and he said, "What do you have to be worried about?" And I thought...YOU ARE FROM MARS! God, was I furious. So furious, what a jerk. I swore if there ever was a next time I would tell the doctor I wanted people in the delivery room who could help out and protect me from the residents and med students and everyone else who walked through the door...

> My son had jaundice and so I had to leave him in the hospital. I was discharged and coming back and forth around the clock to nurse him because I could not leave him. Every time before I was going home I would stand at the nursery...tears rolling down my face and the nurses were so busy, they would just look at me. I think some communication is important in terms of the prior history so there is some understanding. What a feeling, to be going home without the baby a second time...to have all those feelings of loss restimulated...and they certainly were!

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> My son had jaundice and a feeding problem, tongue retraction. And that was another interesting thing because when people know your first baby died, they also kind of peg you as "Baron Von Munchhausen Syndrome" possibility, or whatever. Some little note goes in this chart, like "This lady..." because when I had a lot of questions about breastfeeding him the first nurse said to the other nurse, "Well, she lost her first one," instead of just answering my questions. They acted like my questions were from outerspace.

This respondent was quite disappointed in her doctor's insensitive suggestion during delivery:

> The obstetrician said, "So, we're gonna tie your tubes, right?" And I was completely unprepared for that. He said, "As long as we're here, we'll tie your tubes." And I said, "you men...what is this? Like going to the coffee shop and as long as you're at the coffee shop buy me a cup too? This is not the same thing. As long as we're there we're gonna tie your tubes???" My reaction was partly due to the pregnancy losses. This (the subsequent birth) should be a time of celebration. I did not want to be put in the situation of experiencing what I had already experienced so many times...I didn't want to feel that I had lost something at the same time that I was supposed to be celebrating bringing home this baby. The doctor was upset...

Disbelief

Feelings of disbelief were also common during the birth:

> Here I am, in labor and the heart was still beating and everyone was taking bets its gonna be a boy. And for me it was an out of body experience, because I just couldn't believe I was finally really having a baby.

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> Even though he was coming...I was afraid to make it a reality yet. I didn't believe it. I wanted them to check him out first, to say, "He's yours, really yours, he's O.K. and you can take him home." Because the first time (after stillbirth) it was horrible going home.
>
> The baby was born, and I said, "You mean it's mine? I get to keep it?" It was all so unreal.

## THE EARLY POSTPARTUM PERIOD

### Postpartum Recovery

A handful of respondents acknowledged a difficult postpartum recovery, either physically or emotionally. All of the five had complicated pregnancies and the following four described some of the unique difficulties encountered postpartum as a result:

> I don't think I ever really believed that everything was gonna be allright till I was mobile again, because I spent another two weeks in bed at home after that. I was afraid to pick them (twins) up because I had an enormous incision.
>
> I remember reading in a pregnancy bedrest manual about your "after feelings" - that it's like post traumatic war syndrome, or whatever. And it's true, that you just have held on so much to that pregnancy, that then to let it go is kind of a strange thing. And even detaching myself from the practice and the doctors and nurses was awkward. I almost missed them. They were my only source of contact with the outside world for all those weeks...
>
> Well...then I had this baby now. And that was the worst. I did not know what I was doing. I had

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> never thought about having a baby. M (her husband) had brought me books to read when I was in the hospital (for preterm labor) but I couldn't read them, because if the baby died...I just couldn't. So here I am, I had the baby and during the pregnancy, I had someone taking care of me 24 hours a day, 7 days a week. I was the center of attention of big medical dramas...and then here I am in the lobby of (hospital) and the nurse is like "See ya." I was so depressed I should've taken prozac. I went into such a funk...and I didn't know what the hell I was doing. I just cried and cried and if someone had come in the first week and said, "A, we'll take the baby," I would've done it then.
>
> I really suffered postpartum depression during that which I also think now is not some vague thing. It's an actual thing, with a beginning, a middle and an end. And symptoms. Cause you know when you don't have it. I cried uncontrollably for no reason. Here I had this new baby, but it all seemed so awkward...

Reflections on an "Imperfect" Delivery

Six respondents noted in retrospect that a live birth after a loss had changed the meaning to them of a "successful" delivery. Having experienced loss, their ideals and priorities had been scaled-down in terms of the birth experience:

> One thing that was very different...I had a Caeserean. Nine hours of labor and a Caeserean. There are a lot of people who get very upset about having caesereans. They feel they had a failure. And I really didn't care. I was so happy to have seen this come to be, I didn't care how they got this baby out. It has never mattered to me that my

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> pregnancies were delivered by C-section because what mattered to me - when they say, "It doesn't matter, as long as they're healthy..." - that's what mattered to me.
>
> With this baby, I had a V-BAC (vaginal birth after caeserean) and I was very frightened having a V-BAC. I remember thinking...I don't care if they deliver the baby through the top of my head - I don't care. I didn't care how the baby came out as long as it was safe and they could guarantee me that that was gonna be safe...

EARLY MOTHER-INFANT BONDING: DELAYED OR "NORMAL?"

As noted earlier, the quality of antenatal attachment has been thought possibly to be predictive of early postnatal attachment, with negative feelings toward pregnancy and childbirth associated with a more difficult postpartum adjustment (Condon, 1988; Leifer, 1980). Similarly, it has been suggested that the early postpartum period can substantially influence the subsequent parent-child relationship.

As mentioned earlier, the literature documents the highly paradoxical situation of (post-loss and post-infertility) mothers who must move from a position of self-protective distancing during pregnancy into one of attachment during the postpartum period (Bernstein, 1988).

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How successfully this is accomplished has not been systematically explored, however.

Respondents were asked to comment on their experiences of the early postpartum period in relation to bonding or "binding-in" to the child. These were of especial interest given the large number of respondents who felt they "guarded" against attachment in the antenatal period (as discussed in the prior section on subsequent pregnancy). Would there be remnant effects of warding off connection prenatally?

The Subsequent Child: Transient or Permanent?

Respondents generally reported continued feelings of "numbness;" "disbelief and mistrust" of the fact that they actually had successfully given birth. One woman recalled asking repeatedly, "Is he really mine?" "Do I really get to keep him?" Another echoed this, describing her continued anxiety about the impermanence of her daughter:

> I was freaked out. I was freaked out about is she really gonna stay? Is she here for real? I just kept looking at her. Is she mine? It was such a depersonalized...not at all what I imagined. It wasn't this loving, grabbing feeling. It was will she leave? Will she leave? And that has set the precedent for me as a mother. That is the key factor. (Five years later) It never feels

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> permanent. It never feels permanent. She never feels permanent to me.

Joy related to the birth of a child was often held in abeyance:

> I had totally mentally detached during the pregnancy and even when he was born, even after a positive result, I could not, would not believe the reality. When he was three weeks old, I could first look at baby things with any excitement. But I still could not buy into it...because I was so afraid.

Significance of Complications After Birth on Feelings of Transience: The Resonance of Loss

Probably the single most significant factor influencing security about the baby's permanence was the (perceived) health status of the neonate during the postpartum period. Just as problematic pregnancies and deliveries induced anxiety about repeat loss, complications following birth, however minor or "routine" set off waves of panic in respondents. This birth now harkened back to the previous one, and felt like a foreshadowing of another impending loss. One third of respondents projected past experiences of terror onto the current situation, upon learning their infants had any kind of problem:

> I remember feeling very, very concerned about the health of my baby, which was my loss talking. They had to keep her longer than average to check her

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blood sugar because there's danger when the mom is diabetic. So they have to look 1/2 hour, 1 hour, 2 hours and I kept saying "where's the baby?" I was just avid to see her because then I began to worry again that something was the matter. Another little flashback to the pregnancy before...

The last night we were feeding her, she spit up blood. My husband went into convulsions and the baby went to the ICU just overnight. It was nothing but we were petrified and having not known that problem happens, psychologically, it added to our nervousness...

That night, she hadn't urinated after 2 days. So they mentioned it as a passing concern...and I'm like "Oh my God, now what?" I remember we were supposed to go home the next day and my husband and son were there and the doctor came and said, "We're really concerned, and if she doesn't urinate, we'll have to put a tube in..." I thought, I don't believe this. I don't have the strength. If something was gonna go wrong, why would I be allowed to get pregnant again? I can't go through this all over again. I just can't have anything happen to her. Then in the morning she was wet. So then they said "Everything's fine." For those moments...everything just flashed through my eyes.

What happened was...his lungs filled with fluid and they had to keep pumping them out. They put him, not in the NICU but a special unit...not heavy duty, but still, I couldn't believe this was happening. Then they let me have him in my room and he started choking. And I had been so intent, looking at him to turn blue, I could not take my eyes off him because the first baby (born prematurely, 25 weeks) turned blue and that was a sign you should do stuff. So I kept waiting, waiting to see him turn blue, and it didn't occur to me that he might turn red, bright red, that that would mean anything. So it turns out he's red and choking and a nurse saw he was in trouble, put him

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> on a crash cart, oxygen, suction, and they whisked him away and I was running after and I started to think HOW CAN THIS HAPPEN TWICE, ITS NOT FAIR HOW CAN THIS BE? But this was just a routine thing. They kept him another day and I refused to leave the hospital without him. I parked myself there and I said "I don't care what you do I am not leaving this hospital.."

Placement in NICU

Additional stress was felt by mothers whose infants' medical complications resulted in their placement for any period of time in the NICU (Neonatal Intensive Care Unit). Such separation not only furthered anxiety and fear of loss, it physically precluded maternal-infant closeness and psychologically hindered beginning investment in the relationship:

> I was on antibiotics for endometritis and they come to me and told me my daughter had a synotic episode. Synotic is a term when lips get bluish. They were feeding her (I couldn't) and she spit up the formula and turned blue. I was hysterical at this point. They put her in the NICU and I told them we have a big milk allergy in the family. Meanwhile, they made her undergo a barium swallow. I had vowed my child would not be in an NICU. I vowed I would hold out long enough this pregnancy...and here we went through all this and she couldn't come home till she was two weeks old. I thought I can't go through this again. I did not bond with my daughter. I was so afraid. I loved her, but I would not bond. I remember I'm riding in the car and this is how much I would not let myself bond with this child, I remember saying, "If

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> anything happens now and this child does not make it, at least I know I can have a baby."

Even where the subsequent birth was uneventful (in reality), (and most were), this woman alluded to the lingering anxiety and fear elicited even by mere association, thus attesting to the power of the past:

> I was in the hospital, very happy. And one night my husband had left, the babies were back in the nursery and I heard them saying, "Code Blue in the nursery, Code Blue." I remember feeling that I could not go back to bed if that was my child and I don't know know for sure...I hobbled down to the nursery, my room wasn't anywhere near. No one was in the hall. The nurses asked me where I was going. I told them and they told me it wasn't her.

Mother-Infant Bonding

Only a handful of respondents felt that their wariness during pregnancy did not impede early bonding, however, in most instances, respondents acknowledged that prenatal feelings of fear and guarded attachment continued into the early postpartum period. Feelings of disbelief and a sense of the child's transiency then, evolved into a "reserved" postnatal attachment/bonding process.

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Immediate Bonding

Five respondents felt that in spite of their anxieties during pregnancy, they were able to bond quickly and intensely to their infants:

> I was worried about that (ability to bond), how I would be if I ever finally did have that baby. But as soon as I saw him, saw the face and then they gave him to me, I did a total turn around. I felt like Oh My God...I really am a mother. I knew immediately and I was very surprised about that because I kept worrying...but right away I felt the attachment. Really big. I'm cognizant of that cause I was so surprised.

> I was scared to death when he was born, of a new baby. But totally happy. And I felt totally joined to him. I was totally in the moment. All I had gone through with the pregnancy and childbirth...I don't think I took a moment to reflect. Just totally consumed, attached.

Two of the five noted the possible impact of uncomplicated pregnancy and delivery on their postnatal feelings, identifying the importance of these two factors in helping to differentiate past from present experience:

> Not in the least did I feel like I had to protect myself when she was born. But then again...I had such a successful pregnancy and even when she was late I knew I had this big healthy placenta, and fluid and she had all this room to move around. She was in no distress, she was happy where she was.

> The delay in attachment (during pregnancy) really didn't have any effect once he was born. One would

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> expect it. But I don't feel I had a delay in bonding to him. Once I got through the birth easily, that is. As soon as he came out we started attaching. I had a name for him and he was this person already.

Delayed Bonding

For the remaining respondents (27) bonding to their infants was neither immediate nor uncomplicated. It was not the "unbounded" joy that might be anticipated normally:

> It took me a while to really sort of bond with her and I thought I would have that overall sense of "this is the baby girl I wanted all my life." I think it had to do with...it took a while. I was very reserved. I was sitting back, saying "let's just see." I didn't feel it overtly, but inside somewhere...

What became apparent, however, was that it was sometimes difficult to assess reasons for delayed attachment in that, according to respondents, it could have been correlated with factors beyond prenatal guarding (and a history of perinatal loss). These variables need to be considered before reaching a conclusion about a definite causal connection between prenatal detachment and problematic postnatal attachment.

Additional Explanations for Hesitant Bonding

Sometimes, respondents' reactions seemed non-specific in nature:

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> I had a very strange reaction, I think. Strange, as other people have said. They showed me the baby, all squiggly, wet and gooey and asked me if I wanted to hold her. I saw this squiggly thing and I said please take her from me and just do...whatever...You think this just happens, the bonding. It does not.
>
> I think I was a little distant from the baby. I think my attachment, my real attachment, its hard to say because it's hard to become attached to something that's non-verbal but I think there was a great deal of standoffishness.

At other times, feelings were elicited by perceptions of the child as difficult:

> There was a bonding with him, but it was delayed and it was very ambivalent because this was not what I had bargained for. I was overwhelmed, depressed, I didn't understand his demands. I can't imagine that bonding would ever be smooth. I remember trying to love this little thing but I also remember he was difficult. I didn't know what to do with the crying. I remember it wasn't until about 6 months that I remember being totally in love with him.

The trauma of maternal or fetal risk during the pregnancy could also factor into the immediacy of attachment:

> (subsequent twins) I had seen the babies only once (in two weeks) and I couldn't nurse them at all because I had so many transfusions, no. It wasn't until they were two weeks old that I could actually walk down to the nursery and see them. With C (pre-loss daughter) it (bonding) was immediate. There was this baby, beautiful, pink and gorgeous. These babies...who are they? The private duty nurse gave me the baby, gave me the bottle and I just started crying...who is this baby? Baby A and

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> Baby B - "you almost didn't make it here, you almost killed me, I don't know who you are!" With C I had an immediate bond to her before she was born because I knew everything was fine. These guys, I almost lost every single minute of eight and a half months, I didn't get my hands on them till they were almost two weeks old and my reactions was, "Who the hell are you and how am I gonna love you both?"

Another respondent attributed her delayed attachment to a characterological pattern:

> Looking back on it...it takes me a really long time to warm up to people. My good friends are my good friends after I've known them for ten years...and that's like not that long really. It takes me a long time till I know somebody well. It's not a surprise I married a guy I knew since I was eleven. It takes me a long time to feel close, to feel any kind of attachment. So put that in the context of my kid. And everybody's saying but bonding and all that...

This respondent appeared able to clearly distinguish between what was attributable to prenatal guarding, vs. an alternate explanation, based upon her knowledge of her experience with her "pre-loss" child:

> I felt it took me longer to attach to her (vs. the child she had before the losses). I think so. I worried whether the prenatal guardedness would really make a problem. I mean the way I was with her in the beginning is the way a lot of women say they are anyway. You hear a lot, "Oh it took me a couple of weeks to fall in love with my baby..." But it's not how I am. Or at least how I used to be. So I know it was because of what happened with

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> G and L (lost twins). I didn't really spend the pregnancy symbiosing and exciting and doing that stuff you should be doing. And I was more guarded after the birth. I became real attached to her, but it did take a couple of weeks.

## Feelings about Breastfeeding

In the discussion of postpartum bonding, seven respondents commented on the importance (or lack thereof) of breastfeeding.

Three women highly valued breastfeeding and were avid in their commitment to it, in spite of self-sacrifice or even possible risk to the child:

> My breasts were hurting all the time and I couldn't feed him even when I thought he might be hungry. Sometimes his cry would last so long it would turn into a hunger cry and I would nurse him. My breasts were killing me, killing me and I kept thinking of all those women who say it's so blissful to nurse. But how could I stop? He would look at me with this beautiful, grateful smile...it was like heaven.

> He had a feeding problem...tongue retraction. He didn't gain weight, didn't thrive as fast as he was supposed to and they thought of putting him on formula, but I wanted to keep breast feeding him and I kept going to the clinic and doing exercises with him and I lived from one doctor's appointment to the next. The first place I ever went was to a La Leche meeting and that was disappointing because they're not used to the thing he suffered from or the whole history I had. I came in and felt like a war wounded person and everyone else was oblivious.

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> They were crying for cracked nipples and I was worried about starving him, and obsessed about things like his blood saturation level and the oxygen level in his blood stream...

This respondent commented on the meaning of breastfeeding as it related specifically to her feelings about loss and the subsequent pregnancy:

> I had this irrational thing about nursing her. The milk was the magical thing that would keep her alive, so I was obsessed. I would not give her a bottle. Her lips never touched anything but breast milk till she was nine months old. It was total magical thinking. I remember it was as if breastfeeding was a continuation of the pregnancy stage...the nursing was again my responsibility - to nourish her and keep her alive and was my way of holding onto her, just keeping her attached. Breastfeeding affirmed that my body worked. I was even upset when I was nursing, everyone else had so much milk and I had to work so hard at it...

Alternately, four respondents chose not to breastfeed. Almost indignantly, three asserted that they felt they had sacrificed enough for the baby:

> (after 5 losses and complicated pregnancy). I didn't want to breastfeed. I had done my bit for nature here and I refused to have a kid hanging on my tit. And people were kind of like -- what??? A white, (neighborhood) mother and you're not gonna breastfeed?

> I opted not to breastfeed. I was not up for it and I knew by having the bottle my husband could do half of it with me. We weren't getting a baby nurse and I thought, "We're gonna get through this together. It's gonna be a sleep deprivation

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> nightmare and we can both suffer." I had been a physical pin cushion for the last two years (from reproductive testing) and I decided...there was no more martyr left in me.
>
> At this point (daughter was in NICU) I decided I'm not gonna nurse anymore, I had had it. I don't care about these mothers that say they nursed forever...I would never say this to my daughter, but not too many people have done what I did; I've done this end already. I just couldn't handle it.

## EARLY IMPRESSIONS OF THE SUBSEQUENT CHILD - A DISTINCT OR REPLACEMENT CHILD?

As noted extensively in the literature review, concern exists that a child conceived quickly subsequent to perinatal loss may be viewed as a replacement or substitute for the one who died. While many acknowledged the wish not to compare nor confuse their two children, respondents alluded to a number of factors related to the birth of the subsequent child, (some more concrete than others), that stimulated thoughts of the lost child and occasionally resulted in comparisons between the two.

### In Utero Comparisons

Only three respondents commented that comparisons were made of their babies beginning in utero and these related to differences in the way they carried (large or small) or activity level.

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Impact of Due Date

The baby born after a stillbirth (or other loss) may be born on or close to the anniversary of the death, one year to the date of the loss, making it difficult to separate from the dead baby (Lewis & Page, 1978). Indeed, five respondents acknowledged their awareness of the subsequent child's birthdate as coinciding with the date of the loss; for two, the dates were only one day apart. One respondent hoped for an early delivery to both hasten the confirmation of the child's existence and separate its birth in time from the loss:

> A month before my due date I thought, "Let's just get that baby born." It was May and coming up to the anniversary of their (twins) deaths. On the one hand I wanted her born prematurely because I wasn't gonna believe I was getting a live baby till it showed up and I wanted that before the anniversary because I thought I would feel less upset or something. On the other hand, I realized I didn't want her birthday to coincide with the anniversary of their deaths. I wanted to be able to mourn that at that time and to have her birthday relatively uncontaminated...

This respondent commented sadly on how her efforts to keep the two children distinct, in spite of the coincidence of their birth/death dates (one day apart) were undermined by

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others who emotionally needed to see the subsequent child as a replacement for the dead one:

> The worst thing was that by having her born, everyone wanted to wipe out the memory of the other. Every year I buy flowers for my first daughter who died. And that table there is where we keep her pictures and everything that had to do with her. So I put the flowers there and I came home from the hospital (with new baby) and someone had taken...I had roses in there and someone took some carnations that came for the new baby and jammed them into the same vase. And it made me so sad to see the vase with the two sets of flowers in it because I wanted them separate. To have the day to mark her death and the next day would be the birthday of the second daughter. And not the flowers jammed together. But there was no sensitivity. No one commented that they were so close together in time. They were afraid to.

Impact of Gender of Subsequent Child

It has been noted that where the gender of the subsequent child is the same as that of the lost child, distinctions between the two may be harder to make. Respondents in this sample discussed how gender impacted upon their feelings about the subsequent child beyond just serving as a feature that distinguished this child from the dead child.

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Indifference to Gender

Subsequent to loss, seven respondents reported feeling indifferent to the gender of the child, with their only wishes being for good health and survival of the child:

> I didn't want to know, didn't care about the gender. I just wanted to know it was a healthy baby. I was so eager, so open, so happy to be having a healthy baby, it really didn't matter a hoot...

As concerns for health were primary, most chose not to learn the gender prior to the birth, as they felt that focusing on "what it was" would help distract them from the anxiety of the delivery. A couple of respondents admitted an original preference for a girl, which became secondary to the health of the child after the experience of loss:

> The first time we really wanted a girl and that's what it was. This time I didn't care, as long as it was alive.

> I didn't care at that point (about gender). I just wanted a healthy baby. When I found out it was a girl I wasn't as surprised or excited as the first time. I remember being glad, but not too excited. I guess just reserved is the best way to describe it.

Birthing A "Same Gender" Child

While the literature notes the potential problem of making a psychic distinction between subsequent children and

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lost children where they are of the same gender, respondents did not appear to express this as a concern:

> (boy subsequent to boy) The child I lost...I always call it the baby, but I never call it the boy, or the son. And before N was born, I was speaking to a friend and she said something about "your son" and I said, "Son? I don't have a son." I mean, is that denial? I did have a son who died before N was born. I can say it now. I couldn't say it then. So I don't think the fact he was a boy, that there was a connection with the baby that I lost because I never identified the baby that was lost as a son.

At the same time however, while differentiation of children was not an issue, an interesting phenomenon arose uniquely where the birth of a female followed the loss of a female: respondents openly conveyed great joy and enthusiasm about the outcome, thus identifying a gender preference. In the following instances, the respondents harbored guilt that they could even entertain desires beyond that of wishing for a healthy baby:

> I knew from the sonograms that this was probably gonna be a girl. I prayed for a girl. I had lost a girl and I felt I was due a girl. Which is an obnoxious, uneducated and dumb thing to say because what I really intended was for a healthy baby. But deep down inside, I felt they had taken...I am also an only child and a girl who grew up with my mom, so there were many reasons coming into why I just kind of wanted a girl.

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> I feel guilty saying this, but I really wanted a girl having lost a girl and I wanted to be able to be the mother to a girl. Even though I kind of figured either way I would have feelings of grief at the knowledge. If it was a boy I might feel distraught that I had lost a girl and might never have one. If it was a girl, I might be reminded that K was a girl and it might bring back feelings from the last pregnancy...But having the doctor say it was a girl in delivery was wonderful. Given that outcome, it was all worth waiting for...

Having the "Opposite-Gender" Child

For those nine respondents who gave birth to an opposite gender child, again, only three mentioned gender as facilitating the psychological separation of the subsequent child from the lost one. One of the three had "predicted" the outcome with the expressed (psychological) aim of helping her separate the two babies:

> (boy after girl) I just knew this was a boy. I'm intuitive, a little psychic too. I really felt it was a boy, this time. I had a lot of boys names picked out. I think it was a kind of survival thing - that I had to think it's a different, the opposite sex, but I definitely felt like it was a boy. This helped me to accept it or something, because I was still very hung up on A (lost girl).

Significantly, only one respondent expressed joy that she was having a boy subsequent to losing a girl because there were "no boys in the family," while eight of the nine expressed feelings of disappointment when they gave birth to

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male children subsequent to losing females, revealing perhaps a strong maternal wish for the opportunity for identification with the same-gender child; the perpetuation of the mother-daughter relationship:

> (two boys subsequent to loss) I feel sad, a definite sadness about missing the opportunity to have a girl. I even went through a major thing about a third child with my husband who really didn't want to go to three; he felt like "don't tempt fate, you can't assure a girl and you have two beautiful kids." For me, it's a self-involved feeling, that when you're older, somehow boys will be more separate from you and a daughter will hang out and I'm sure that's somewhat true...
>
> I really wanted a girl. I was afraid to have a boy because I don't have brothers or sisters and I felt I wouldn't know how to take care of a boy...my only knowledge was of a girl, cause I am a girl, you know what I'm saying. I felt I really wouldn't know anything about taking care of a little boy, so that's why I wanted a girl too.
>
> When she was born (then died) I was thrilled I wouldn't have to do a briss. Also now my sister and I could go out and get them (her daughter and niece) matching dresses for my nephew's bar mitzvah. And now my son, he always wants to use my nail polish and I put blue and green on him so he looks like a boy playing with nail polish, rather than a girl. Because I can't stand to think...that's another thing. You see all these girls doing all these things and it's so sad to see...I wanted N (lost daughter) to do all those things too. I didn't say it but when she was born, I really wanted a girl..
>
> I was disappointed he was a boy. I was not elated, but disappointed it was a boy. Disappointed I

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> didn't have a girl, for my husband, not for myself. Well, maybe. I mean when the first one happened to be a girl, I was so disappointed. I was already 42, I wasn't gonna do this again. So I remember feeling disappointed because this "last time around" wasn't gonna be a girl.

The wish for a girl was likewise confirmed by this respondent who gave birth to one after losing male twins:

> When they said she was a girl I was in complete shock. I thought it was a boy again because there are all these theories about when you get inseminated...I figured since when I got inseminated I had two boys, that this would be another boy. I thought, "I'll be happy with a boy," and I had the bris planned. But when it was a girl...we were thrilled. We wanted a girl.

The Importance of Physical Characteristics

Respondents took note of a number of their children's distinguishing physical characteristics at or close to the time of birth including size, appearance of physical strength and resemblance (or lack of) between children. These appeared to engender subtle, (and not so subtle), comparisons between them:

> My son shrieked in a loud bellow and he sounded really strong. He got perfect Apgar scores, he was large, large size and strong and he somehow, someone knew somewhere that I needed to have a healthy kid as opposed to one that was gonna be kind of sickly.

> I would look at M (subsequent son) and see A (stillborn girl) a lot of times, because I

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> remembered her face. When he was small, I really did, I'd see her because I never forgot her face. I had pictures. You don't see that much, a little face, but we know it's her. I used to see her when I looked at M. Especially as a baby, because I only saw her as a baby.
>
> One of the problems for me was that J (subsequent son) was a physically beautiful child; blonde, blue-eyed, sunshine, a golden child. The girl I had was dark hair, and a girl and I happen to like dark hair...I didn't like blondes.
>
> There were all sorts of comparisons. Both of them had dark hair when they were born, both had very dainty features, dainty noses. E came out 3 1/2 weeks early and was only 6 lbs. 4 oz. and very different than her older sister had been (prior stillbirth). The births were so different, from stem to stern...

The Fantasied Lost Child vs. the Subsequent Child

Two respondents described viewing their subsequent children in relation to a fantasied notion of what the lost child was or would have been like. In both instances, the dead child retained an idealized quality in comparison with the live, more problematic child:

> One of the problems in the beginning was that J (subsequent son) was difficult to handle. Not mean or negative, but vibrant. I was still very depressed in the beginning about the loss and I had thoughts at these times of the child who died. And when I got angry with J that the other child, the good child, would not have been this way. The dead child was the one you could sort of project all kinds of good things onto. The live child got the brunt of being the bad child.

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> He (subsequent son) was a very difficult baby. For the first year, he never stopped howling. I would be up all night, trying to burp him, to walk him, to put him in a stroller, whatever. He never stopped howling. He was a child who was hard to love because when a kid is howling in your ears you don't want to hug and kiss him...He howled at the least provocation, he was extremely difficult. I often wondered...would the other baby have been this way? Because I used to say if he (live child) would have been my first child...he would have been my only child.

Efforts at Maintaining Distinctions

With an awareness of the potential for "blurring babies" five respondents addressed efforts made to view their children as distinct. These were both psychological in nature:

> I never viewed these kids (2 live subsequent births) as replacements for the others. Those were five separate babies...
>
> That baby (lost one) was over there...this one is here and each has its own place. I will never toally negate the other child, because it was still a part of me...
>
> I worried that she did not become a substitute for A (lost child). I just always feared that. That never materialized though, that way, not even in my mind. Because I think what I always believed was she made a place in my heart. She has her own place, she's (live child) not replacing her. She's another person.

as well as concrete in nature:

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> I never saw these children as replacements. All the gifts I received for the first were never used. I'm still saving them for something. The stuffed animals are now keepsakes...it's just something I need to do...
>
> After he was born, there were some feelings of remembrance of the baby we had lost particularly when we had saved, I had saved everything we had for her. I had packed it all away but when I brought out the little baby seat cover, it said #1 BABY, I felt guilty giving it to my son. Because she was the number one baby. That I remember, that it hit kind of hard. I don't think I did give that to him.

Merging the Subsequent Child and Dead Child

Only two respondents, one in anticipation of birth, the other postpartum, reported difficulties separating the subsequent child from the dead child that were severe enough to interfere with their perceived reality of a new child:

> I wasn't doing the new baby justice. Because the whole time I was pregnant, I would have thoughts pop into my head like "A (dead child) is coming soon." And it was not A, it was another baby, but I couldn't get rid of that thought. Even when I knew it was a boy, I just kept thinking she's coming soon, or this baby's really a girl and she's coming soon. It was scaring me so I had to really concentrate on separating that this was a totally distinct, separate baby. But part of me still anticipated it being A somehow. I'd have fleeting thoughts - the baby's coming soon - it's A and then I'd think no it's not, it's not. I had to talk to myself that way...
>
> After he (subsequent son) was born, I went into the lounge at the hospital where I sat when my daughter

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> was dying and I kept looking through the window of the nursery to see where she was. I was reliving her death and how I used to pace the hallway waiting for them to do procedures. And here I had this new baby, but it all seemed so awkward. He was so gigantic - only 7 lbs but to us he seemed enormous because we loved the little tiny one (premature at 25 weeks) and we were all distorted in our perceptions. A hulking baby - white, not red the way preemies are. And I didn't know what I would do with him and I was afraid to take him home because I wanted him to be near machines. I kept saying "What's his saturation level?" And people would keep saying, "What?" He's not on a ventilator, we don't know what his saturation level is. And I was so totally medically programmed I'd say "What is his creatinine levels in his kidneys?" And then at home, you know after you spend time in the NICU you think that's how you take care of a baby. So those first few days at home, it's like I was carrying a porcelain dish around instead of a baby. Believe me, we were perfectly sane people - but you become like this - warped mentality.

Impact of Others' Need To View The Subsequent Child as a Replacement

Three respondents recognized that in spite of their efforts to avoid the "replacement phenomenon," they battled external pressures; others' needs to treat the subsequent child as a substitute. Two noted angrily:

> It's very hard when everyone was like, "You must be so excited, now that everything you've been through is over." Once the baby's born, you don't get any more acknowledgement for the loss. And everyone warns you..."DON'T MAKE A REPLACEMENT BABY!" but then everyone relates to it like a replacement. I don't. I mean I'm very glad I have a baby. But

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> I'm very clear that M is not G & L - (twins who died). It's very clear that this was this pregnancy...and not that pregnancy.
>
> The hard thing is people make a lot of stupid comments. Like a lot people saying things like "So, are you gonna have another baby? " And it's wonderful - right? (sarcasm) Because it's like N didn't count and he now is a replacement. Weird comments - like, "Are you gonna keep trying till you have a girl?" I'm 40 - it's unlikely I'll keep trying till I have a girl.

Impact of the Subsequent Child on Grief:Resolution or Reawakening of Loss?

The role of the subsequent child in the grief process has been noted to be controversial: does it help heal grief or does it inhibit/reawaken it?

The Subsequent Child as the "Answer"

Of the respondents in this sample, only one stated with any conviction that the mere birth of a child ameliorated feelings of loss:

> It's (the loss) so far away from the way I feel now. Time helped, but it was not the major factor. It was my son. He is and was the solution. That (the loss) was the problem and he is the solution. There's no reason to dwell on it anymore. Right when he was born, the whole thing was over. The bad part was over. It was a bit of shock, but the whole sad part was over.

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The Subsequent Child as a "Distraction" from Grief

Four others acknowledged that a child assisted in the grief recovery process by serving almost as a "distraction" from grief, given the need for absorption in the demands that a child made on their lives:

> At that time, I became totally in the moment. I didn't think about all I had gone through with the pregnancy, the birth and before. It was just so consuming...the pregnancy, the birth and the early months of the baby's life, that all that went before...it just really started to recede.

> The hurt was humbling and it stayed it for a long time. Like mourning a death when you lose somebody...they say a year is the statistical time to feel better. Maybe it's not as gut wrenching anymore after a year. I guess the pain began to fade with the birth of a new child and the fact that I knew I had a responsibility and I needed to go on...

> Having a live baby that demands your time and attention and pulls love from you does help. It obviously becomes easier with time, time definitely does heal but you don't forget. You just don't feel like an open wound anymore.

> His being around prevents me from having a lot of time to dwell on it. It was worse with full time help here because I had more time to feel sorry for myself. I'm so tired now by the end of the day, I can't even make it through all these parenting books...

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Limited Effect of the Subsequent Child on Grief

Three respondents acknowledged their surprise that the subsequent child did not resolve their feelings of loss, as they had expected it might:

> In a peculiar way when they told me I was having twins - in my perverted point of view I thought, "Well, this will makes up for the two losses." But nothing makes up for the losses. Nothing.

> I had viewed a child as a possible solution to my grief. I would say he "assisted" in my recovery, but it's more complicated than that. It may not be intense anguish after the child is born, but it's more just like "chronic sorrow."

> For a long time it was like, "Well, that's behind us and now I have a healthy baby and that's the past and it's all overwith; done with, and it doesn't affect me." I realized later - even one, two years later that I had not worked through the grief and even though I had a kid, it was still affecting me. It was hard for me to enjoy his early life - there was still a great deal of tension on my part...tension that was related to losing the baby. Tension and my delayed grief made it all very difficult.

The Subsequent Child as Reviving/Prolonging Grief

One third of respondents stated strongly and unequivocally that the subsequent child did not diminish their grief, but rather revived or heightened it. In some instances, feelings of depression were exacerbated as well with the birth of another child:

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> Having the subsequent child...it could help, but it doesn't help because it brings in a whole other set of issues, and you'll relive it, (the loss) and grieve more and more things will extend themselves in ways. My friend had a loss and couldn't have a baby after that and she's over it more than I am, because she has a career and does things and moved on. I'm still wallowing in babies all the time. Also, grief is something you do. It's finite, you end it. But then with having the baby, it just seems to reawaken the depression. It just means you have a lifelong reminder.

Primarily, respondents attributed their intense reactions to the fact that finally having a child enabled them to realize and feel more profoundly what they had lost:

> My biggest reaction to the pregnancy losses came after my daughter was born. She was just 6 weeks old and I said, "Now I know what I have lost." It was just an imaginative thing before, now it's really real.

> The other thing I found and it makes sense to me, I'm much more depressed about their losses since M was born. It's very hard because everyone wants you to be excited, but it makes it much more, makes it very real to me that I didn't get to mother them. And so I was fairly depressed - having another one made it much harder...

> Then being a mother...I felt what I would've been able to give to that other child. The attachment to him (live child) carried over to the other child and I realized it would've been the same. So I think a part of me felt the failure with my first one lived on and was brought up when my son was born.

> As much as I love my kids so much, as precious as they are I thought, "There were other little

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> precious people too." I was in states of various depressions after the loss. I didn't even realize till my son was born and healthy, that a cloud lifted from and I could look back and see just how depressed I was and I didn't even recognize the symptoms then. I was trying to say it was O.K.

<u>Grief as an Expression of Loyalty to the Dead Child</u>

Four respondents who recognized and accepted that feelings of "absence" were inevitably aroused by the "presence" of a child, also acknowledged the role of prolonged grief in "holding on" to the dead child. They equated the presence of the live child with obliterating the memory of the dead one and viewed this (remorsefully) as a betrayal:

> Of course you don't want to let go either...it's hard to stop grieving, because you feel guilty about the new baby, and giving it attention. As though you're disloyal...

> I didn't put my thoughts and energy into the new baby until November. November 1 we had the unveiling of the stone for A. That's when I decided, O.K. I'm gonna think about her, but I'm not gonna think <u>just</u> about her. I'm gonna put my energies into thinking about this baby too.

> I had to go on, I had another child. But you can see everywhere...there are pictures of her (dead child) everywhere. She's all over the place. Because I'm most worried that people will forget her. You know D (subsequent son) will have a bar mitzvah in eight years and by then...there'll be no thoughts of her. People will use him to fill that vacuum.

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> (respondent pregnant at time of interview) It's weird - I've had dreams about this (upcoming) baby, but not so much about the other one. I dream about my cat who died, and this baby but I feel badly when I don't dream about the other (lost) baby. But it's strange stuff you do, strange stuff to "hold on." When I came home from the hospital, I spent the whole week in the same clothes. Actually what I had worn to the hospital - a sweat shirt and sweat pants. I kept them on for a week - strangest thing...And I know I will go back to my (bereavement) support group after I deliver. Even with the kid, because you just don't ever get over it, and this (the group) will be the only place for this child. When this child is born, I'll have this child...but the other one, I won't have.

Juxtaposed to these respondents who experienced investment in the new child as disloyalty to the dead one, was this respondent who expressed the complementary feeling, regret about betrayal of the new baby by retaining thoughts of the lost one:

> I got to feeling guilty about feeling about it (the loss). I thought, "How long are you gonna carry this around?" You make everyone feel bad when you bring it up. I felt guilty, so I stopped talking about him as much but I knew I never wanted to let myself forget or my husband forget and I felt I would never forget the other baby. But I started to think about him less because I didn't want to deprive him (subsequent child) by me feeling and thinking about the other baby all the time. Before he was born I really felt he could only be second best, but after no way did I feel that...

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## PARENTING A CHILD AFTER LOSING A CHILD

A review of the literature on parenthood after loss revealed a number of primarily problematic phenomena that might surface for parents raising children subsequent to perinatal loss. These included: unrealistic expectations of both parent and child, overprotection and difficulties with separation from children, perceptions of exaggerated vulnerability, unresolved anger from a previous loss, displaced onto the subsequent child, and treatment of the child as a replacement for the lost one. Less has been written about the potential positive implications of raising a child after perinatal loss, which include heightened feelings of excitement and elation about parenting, increased maturity and stability in parenting, and great love and appreciation for the child who is truly wanted and welcomed.

Respondents were asked to comment on their attitudes toward their children born subsequent to loss and whether or not they felt any particular issues arose in their parenting of their children.

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<u>No Impact on Parenting</u>

Without offering any explanation, only 3 of 32 respondents stated their belief that their prior experiences of loss had no bearing on their feelings and attitudes about parenting. These respondents expressed sheer joy and delight in their children and felt they would have been loving, devoted parents, no matter what.

At the other end of the spectrum, one respondent felt her losses had a profound impact on her experiences as a mother:

> There was something about that jolting reality (of losses) that changed me forever. It does not go away. It makes the basis for which I raise my child. If this child ever goes into therapy someday her issues will not just be about my neurotic personality as well as her father's...but the circumstances of how she got into the world. I think about it all the time, how things were so out of control. And even once she was born, how I was so busy holding onto her that I wasn't even enjoying the pleasure of it. I think I am a totally different parent. I think I will be a different parent forever...

In between the two extremes were the large majority of women who expressed a range of "joys and sorrows" that they felt in parenting their subsequent children. Great emphasis was placed on the positive feelings brought by parenting: tremendous love and gratitude for children, increased

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tolerance and patience and respondents' heightened esteem of themselves as "better parents." Occasionally, "too much of a good thing" became problematic as excessive love was feared to evolve into overindulgence and "spoiling," and gratitude for the lives of their children developed into mothers' unrealistically high expectations of themselves with a concomitant inability to tolerate ambivalent feelings about their children. Other problematic areas noted by respondents were overprotection and difficulties with separation, and excessive worry, particularly about health.

Positive Aspects of Parenting After Loss

Gratitude For the Life of the Subsequent Child

Using various terms, all respondents articulated their feelings of love, appreciation and gratitude for the life of the subsequent child. Children were repeatedly viewed as "blessings," "treasures," and "miracles:"

> I'm thankful every day that I have her. She's definitely a miracle to me. And I look at her and the smallest nuances of her being...I still carry around thoughts of her and how it almost couldn't be. The other side of this is that this is a kid who is truly loved.

> We are totally blessed with him. He's a gift from God. I'm very humbled by the whole experience. I feel so lucky. And even though I would have loved a flock of children - I'm very sorry that my life

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wasn't different - but despite all those losses, and maybe because of them, A is a particularly precious child.

He's so delightful. I think I'm just lucky and blessed to have him. I feel bad that whatever happened happened, but I think I got a better model here.

The good side is I don't take him for granted at all, ever. I think my husband I are able to communicate to him how happy we are to have him as a part of our lives and I think that's a really important message for a kid to get. There's a lot of room for mistakes when your child knows how much you love them and how happy you are to have them in your life.

I realize today we are very blessed. We have one really healthy, great child. Our love that we feel is so great for our child that we would kill for her. The experience of losing a baby was very humbling. I appreciate her and her life differently. Totally. 100%.

I feel I love my children more than most people do. I try to value every phase of their childhoods, even their infancy when I was so tired. It gives you a different perspective when you raise children after you lose them. I didn't have a lot of experience with children. I never thought of myself as maternalistic. I didn't realize till the lost baby how important this all was to me.

I may sound like Pollyanna here, but I really am sort of glad it (losses) happened. It makes me sort of appreciate them in a different way. It's not like I appreciate them more, just appreciate them differently.

I've given a lot more thought to the meaning of life, what are we really here for? People had told me, "When you have a baby you'll see" and I think I

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> do. I'll do anything. I didn't think I would feel that way. If I had to jump in front of a car to save him, I would definitely give my life for his life. I think other people take their children for granted...
>
> I think it's hard to say whether I am a different kind of parent as a result of the losses. I don't know. I think I'm the same basic parent that I would've been, except I have a higher appreciation of what I have because I worked so hard to get it.
>
> You really see that a child is a blessing. It's pure good luck, there's nothing else to it. I've never felt anything but that and I tell him that everyday. I'm sure the miscarriages added to that.

This last respondent attributed her enhanced appreciation of her son not only to the loss suffered prior, but the realization of the potential threat to her own life, when she hemorraghed during the delivery of the dead child:

> Nowadays I can say I am so grateful to have two more or less healthy children, two normal children. I was grateful at the time, but I was even more aware of how lucky I was, how close I came to dying. I think in some ways with N (the subsequent child) it's not even just having lost the baby that affects me, but realizing how I came so close to dying.

The Potential for Overvaluation

Four respondents voiced concern that their immense love and appreciation of their children might border on overemphasis or "spoiling" of them:

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> The other piece of it is...that I'm incredibly indulgent with her. I've created a kid who lives to talk to me all the time. And I think about how my husband and I have never gone away without her, because every morning we can't wait to see her and every night we can't wait to look at her and...talk about the egocentricity of childhood, this child is the center of our lives and in some ways it's inappropriate for her.

Increased Patience for the Mundane

One third of respondents listed as an asset the heightened patience and tolerance they experienced for the daily tasks and woes of parenting that seemed to pale in the shadow of the experience of loss:

> Nothing this child does bothers us. Crying, whatever...Our other friends, whatever they complain about: the noise, the earaches, we're like, "Hey, just bring it on." We're just so glad she's here - healthy, alive and we have so much energy.

> I've never lost my temper with him, he's never tried my patience, never gotten on my nerves...and I would've expected all those things, I think I should be feeling that.

> I cherish my children a lot more after what I had been through. I never felt as a mother that all you do is change diapers, oh, how boring. No, I loved it.

> I can remember, thinking back. I couldn't wait to change her diapers, just to be close to her. I never cared. I never understood how mothers said they just wanted to sleep and get baby nurses. When I went back to work she was 2 or 3 months old. I would run and see three patients, run home, I

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> could barely concentrate. I was totally involved in her life.
>
> With my first child (pre-loss) I was obsessive and she was a lot cleaner! A spot on her pajamas, we changed them - she never sat in a dirty diaper for half a second. (after subsequent twins) Nowadays it's always - "Oh, so somebody's crying...somebody is dirty, somebody is always throwing up..."I'm lucky, the pregnancy losses put it all in perspective.

<u>Increased Tolerance for the Unexpected</u>

Two respondents described the value of their experiences with loss in helping them to accept the unpredictabilities of parenthood and in essence, to lower their unrealistic expectations of themselves and their children:

> In terms of the parenting piece...if I had just had the baby like everybody else seems to - you know, get pregnant, have the baby, I think I would feel more resentful when things don't go smoothly with the kid. I'd be like - well, babies, they should sit up at the table, nicely and do this and do that and if they didn't I would be a lot more disappointed. But now I just say, "Things don't always go smoothly and sometimes they have these bad stages but it's a stage and it'll probably get get better." I think a lot more philosophically about things and I have fewer expectations that things are gonna go the way I imagined because nothing has ever gone the way I imagined in having these kids.
>
> It's helped me to let go. Little things don't bother me. If the dishes don't get done, they don't get done. I used to be a total control freak...

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Inflated Expectations of Self:Intolerance of Negative Feelings

At the same time, half of these women acknowledged that their gratitude and extreme tolerance often evolved into intolerance of their own ambivalent feelings toward their children. Respondents expressed shame for having dichotomous sets of feelings: extreme appreciation for their children coupled with disdain at times for some of the less enjoyable tasks of motherhood. In the extreme, this resulted in respondents' inordinately high expectations of themselves:

> During their infancy...even when I was most tired, exhausted, I wouldn't have the heart, ever, to complain...

> I think another aspect of parenting that can be affected after loss is the demand you put on youself in terms of being the perfect parent. That's something else I had to work on because I don't think any parent can be perfect and the first time through you are as much a novice at it as your kid is at growing up and I think you have to leave yourself room to be imperfect and to experience some of the normal...Yes, you are at your wits end, exhausted. My son cried during the night well into the time he was nine months old and I was up every night until then and I was a walking zombie and exhausted. For the first three months when he cried every night I would dance into his room and get him and feed him and then I

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> started getting tired and by seven months I was exhausted and it was very hard for me to acknowledge I was exhausted till a cousin helped me to see that this is difficult, he still is crying - instead of my just blaming myself for not doing things right. It helped for someone to acknowledge that he's still crying and it's tiring and difficult.

> We have our frustrations...parenting can be too much of the same. Home every night, dinner every night, bath every night, it's so much humdrum and after 6 years...it's hard to admit, but the novelty of caring for her...it's over.

In particular, feelings of guilt ensued for anger felt toward children and occasionally hostile wishes were repressed so that the "worst fear" would not magically become actualized (again):

> Sometimes if I really let myself go I can get angry with her the way other mothers do. But then I feel I don't have a right cause she's sort of a miracle. How can you get mad at a miracle child?

> I don't ever take his life for granted but then there's another thing I battle with...the guilt if I do. So if I find myself nagging my son and screaming at him, I stop and think I should be more grateful for him because he could be dead and I already had one that I lost and I should enjoy him more...I try to live in the knowledge that I can't be perfect of course and I don't appreciate his toys all over and he does push me very hard and tests constantly - but it's not so easy.

> I could never let myself feel angry enough at my kid to say I want to be without her. I can't have that same anger other parents have, because I know what it's like not to have her...

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> I put demands on myself to be the perfect parent and never have any of the normal gripes parents have. I know I feel something inside when other parents say, "Gee, I wish I never would have had my kid." I could never say that. Although I feel there are times I wish he would just leave...and leave me alone. But I never let myself feel I wish I never had him, because I know what that's like.

A Better Parent

A handful of respondents felt that having children after loss made them "better" parents in that their children were truly wanted and mothering became their priority. Two, however introduced competing explanations for this:

> It's hard to tell why I'm a better parent. Because I think I'm a better parent too because I'm older. I can provide them with more. I have more to give them, not materially but in terms of experiences with life, dealing with people. I just have more to offer. I was married 16 years before my daughter was born...

> It's true I lost the child, but I also felt this would be my last child. I was edging up to 40, knowing this was it. I felt I had to do my absolute utmost for my son...I was putting a lot of pressure on myself. (When fearing he had developmental delays) I thought if there are delays now I want to do whatever I can - and even more. Give him the intervention, the support, therapy, the help to reach whatever his abilities are. That's a lot of pressure on a mother!

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## Troublesome Feelings About Parenting

### The Prevalence of Worry

This sample of women almost unanimously exhibited great propensity for anxiety and "worry" about the well-being of their children. One respondent called herself "pathological" in this regard, while another noted that the anticipatory worries of pregnancy simply continued right into parenthood. Another noted the link between the past and present by stating, "You now imagine the worst...because the worst already did happen to you." Respondents appeared to divide their worries about their children into three major areas: preoccupation with survival, excessive health concerns and fears about separation. It became clear however, as respondents discussed their worries that they often could delineate factors other than prior loss that weighed heavily on their feelings. These will be discussed at the conclusion of this section.

### "Obsession" with Survival

Two respondents mentioned feeling "obsessed" with the continued survival of their children and preoccupied with an accompanying commitment to assure it. This appeared to be an extension both of the tentativeness felt throughout

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pregnancy as well as the earlier sense of "transience" felt about the subsequent child's life postpartum:

> There's something about the responsibility of this child growing in my body that took over my life - that's the stuff that's taken over my life now...how responsible I feel for her. I felt responsible for getting her in this world and I feel responsible for keeping her in the world. AND THAT COMES FROM PREGNANCY LOSSES because parents always feel responsible for children, but there's something about the MAGNITUDE OF IT THAT HAS TO COME FROM THAT. I often think about how those other bodies (lost pregnancies) existed too and one day, just like a light, they went out. And so I don't want her light to go out and that's what I always image...keeping that light going. That light just not going away.

> I am overinvolved with my son. When I say overinvolved, I really think I am because there are some days when I look up and I think to myself that I haven't done anything else today except obsess about my kid and that's not good. I'm too deeply worried about them (two subsequent to loss) and their survival. I'm always thinking, everytime he goes somewhere...like he went to the beach today. I'm always practicing, the thought goes through my mind - he could drown, so should I pick up his toys or maybe just leave them where they are and if he drowns I'll be able to see how his toys were when he left them. That is a routine thought for me and I know it sounds crazy...but I'm just used to it now. I WAS NOT LIKE THIS BEFORE. BEFORE I WAS THE KIND OF PERSON WHO WOULD'VE SAID, "Oh my God, I left my baby on the bus." Cause I'm a forgetful person, caught up in my own activities and I DON'T THINK I'D BE REHEARSING ALL THE TIME...There are days I must confess, when I've called all the hospitals looking for my husband and son. First I call all the friends, and I think allright - let's just be businesslike about this. Let's start with

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> (hospital name) and go down the alphabet and call all the hospitals and see if they're in the E.R.

For some, the initial sense of the child's impermanence at birth lingered over time: "I think that's how I raise her, she never feels permanent to me..." and was manifest in various "superstitious" actions taken by respondents over time to protect against the pain of possible loss:

> I didn't baptize her till her first birthday.

> I checked their breathing a hundred times a day. Even now if one of them sleeps a little bit too late I don't want to wake them, but I always wonder if they're O.K. I checked everyday and I refused to have a party until they turned one. It had to be after they were one. I had to know they had made it that far.

> We had started the adoption process after we lost the twins and once I got pregnant we told the worker, but told her we were fairly dubious it would work. She kept the application and told us to call if it works out and she'd cancel the process. I haven't called her yet (three months after subsequent birth) - I can't cancel it. I'm too afraid she's gonna die. I feel like until she's 6 months old or a year...I can't. It's totally magical, but I feel like I'm hedging my bets. If God forbid she does dies, I want to move right along with this (adoption) since the process takes forever.

> I baptized them both myself because - right away, because in case they die, I wanted them both to get baptized. And when I baptized my son (1st subsequent child) my prayer was, "May you bury me" because I want to die before he dies. And with her

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> (2nd child subsequent to loss) I was saying "May you bury me," but not as strongly.

Two respondents' worries extended beyond just their subsequent children's survival:

> I became afraid of letting my husband go to work. I was sure somthing would happen to him and I would lose everything in my life.

> I think the losses made me more of a nervous individual. I think I don't deal well with mortality issues, but I'm constantly thinking that way. I expect the worst all the time. I'm more pessimistic than I used to be. Less riskier. I used to be very risky, independent, get up and go, I think about it all twice now. I think it became an area of concern for me because I used to drive before I gave birth and although I didn't lose children while driving, I no longer drive. I'm afraid of things happening to me when I drive.

Exaggerated Concerns about Health and Physical Safety

Within the realm of maternal worries, half of the respondents noted excessive concern with either their child's health or physical safety, most of which began soon after birth. Mothers worried about germs, illness including cancer, accidents and most ubiquitously, about SIDS (Sudden Infant Death Syndrome).

"Germ Phobia"

Two mothers noted an overconcern with exposure to germs:

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> I got obsessive, crazy. I used to do his bottles over, 3 or 4 times, I really never told people I was doing this. I would do them over, sterilizing them, a "bottle boiling frenzy," convinced I would give him a germ and kill him. (she continued) One time I was on the phone and I was shifting him and the phone hit him and I was convinced I had given him a brain bleed. I still had my AIDS phobia thing, convinced I had given him AIDS and he was gonna die. Everything I did, I was convinced he was gonna die.

> I never allowed her in a shopping cart, I didn't allow her in a store till a year old and I was so afraid people would breathe on her. Cause after I brought her home people told me, "Don't bring her in crowds, make sure people wash their hands, because you don't want her to pick up anything." Believe it or not, she didn't get a cold till nine months because I kept her so isolated. I was always holding her, plus I THINK I DIDN'T BELIEVE I REALLY HAD ONE. When people say, "Didn't you like to go out and show your baby for the first time?" I'm like, "I didn't do that till the summer." I was afraid in winter to bring her out. I would wheel her around the house. I remember when I frist put her in a shopping cart, I was wiping down the handles because she may touch them and then put her hand in her mouth. I was a crazy woman.

Fear of Illness and Accidents

Respondents noted exacerbated concerns about health and safety:

> As far as the aftermath kind of thing...I have a much more heightened awareness for myself and children, afraid of illness. I try not to dwell on things, but if my kid says, " I have a bump on my head," or my daughter says "My legs are tingling," I'll think, "Oh, she has MS." I'm forever running

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> to the Dr. Mom book. If she's just constipated, it's some other major disease...
>
> It's (losses) made me a cancerphobe with her. It's made me - I'm always looking her over if she ever gets sick. I'm so anxious. I'm always listening to her breathing and I'm still doing it and she's five years old. I even went through a period of thinking someone would steal her...
>
> I'm always a step ahead in terms of what could happen. As opposed to letting them explore. I got to the point where I had to go to the playground with my husband and when my son started to do things that irked my stomach, I would go away and let my husband stand with him. Anything he did...more than walking, I thought something was gonna happen to him. It was like he was my treasure and I couldn't be careless...

This respondent commented realistically on the limits of worry:

> I'm so worried and cautious and yet things happen. When my son was with me, he fell down and had stitches in his head. Once he ran out of my arms and into a fireplace...things happen...

<u>SIDS Anxiety</u>

More than half of all respondents alluded to their anxiety about SIDS (Sudden Infant Death Syndrome) when their children were infants. While many acknowledged that they would have had this fear regardless, they felt its pervasiveness during their childrens' infancy was ascribable to their history of loss:

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> Everyone worries and tells stories about SIDS and going in to make sure the baby's still breathing, and I do that too...But there's really a part of me that feels unconvinced that I get to keep this baby. And I know the highest incidence of SIDS is 2-6 months and she's 7 weeks now so we're going into the time when I get very nervous. I can say to myself it's irrational, but that "it's so rare" is no longer reassuring for me. Because everyone knows intellectually that "it's so rare" can happen to you, but I know it now in my gut. So all this, "there are no risk factors...there's no reason to think it would happen, SIDS is quite rare," doesn't make me feel any better.

> I was more protective in the beginning when crib death was an anxiety, which it is for all mothers. I didn't check on him five times a night or anything, but the awareness of all the danger felt like it had an impact on me that was greater than it would've prior to this experience. If he coughed, or was choking, I needed to attend to him immediately, in some way.

> I was a SIDS phobic. I would sleep with my hand in the bassinet. And she was a robust baby and she has a sleep problem now. And I credit myself because she had a mother who was constantly in her room, constantly looking at her. I put a mirror in her crib when she was really tiny and would bring the bassinet into the living room. I would not let her sleep in her own room. I would put her bassinet next to me when I was doing everything...

Overprotection/Difficulty with Separation

Only two respondents felt they were not excessively protective of their children subsequent to loss. If anything, they felt the loss taught them they could not control every circumstance. One noted how the loss

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facilitated, rather than impeded her son's developing autonomy:

> It (losses) added to the sense of humility. The fact that my life is not in my hands. Neither is A's (son's) in my hands. It gave me more of an impetus to allow him his separateness, even as an infant.

Increased worries and fears tended to result in respondents' overprotective feelings and reticence to "let their children go." In many instances, however, they were acutely aware of the desire to overprotect their children and made concerted efforts to work against it:

> I thought the likelihood of becoming very overprotective was great and I didn't want to do that. Having a son helps, because he was a strong boy who wouldn't let me hover over him too much and my husband helped with that as well - he tried to encourage his independence when I was shaking and my knees were knocking and it's worked out well. He's an independent kid with good judgment in not-such-a-safe world. But you have to let your kids go at some point.

> I'm very nervous. But I can't say I'm all that overprotective. I worry about my kids all the time. We have a very nice playground around the corner and my kids are very physically active and I'm always nervous, but I always let them go - that kind of thing.

In other instances, even heightened consciousness and psychological enlightment did not suffice to mitigate

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against separation problems for mother, and eventually child:

> The trauma doesn't end. It's never ended. It's never ended. And there's something very primitive about my experience with her. It always does flash to me - the fact that she existed in my body - but the other bodies did too. And one day, just like a light, they went out. And so, I don't want her light to go out. I don't want her to go away. And now (at 5) she has the most severe case of separation anxiety you've ever seen. She's a classic, by the book kid with separation anxiety. And I did it to her...

Mistrust of Caretakers

One further manifestation of respondents' ambivalence about leaving their children was their expressed reluctance to hire caretakers. However, here again, while seven women discussed their hesitancy, only one (mother of a 2 1/2 year old) had never left her child in the care of a non-relative. One respondent described her "unreasonable" response to a babysitter:

> I let this woman go because she kept touching the baby. It was so irrational. And she would tease and say, "You can't have her, she's my baby." In a playful way. I don't think she understood it. I don't think _I_ understood it, what was bugging me about it. I mean who wouldn't want a person who loved your baby and wanted to hug and kiss them? But it was like she touched her, and that was it...I stayed home from work. It was so irrational.

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Parental Worry and Overprotection of the Subsequent Child: Is it Only a Condition of Perinatal Loss?

As is evident in some of the above quotations, when respondents discussed their problems with excessive worry and separation, a few hypothesized that their difficulties could primarily be attributed to their prior losses, (or at least were exacerbated by them), as this woman further explicated:

> I don't think I would've been this worried or overprotective. I'm clear about that. I don't think I would. I would've been a real noodnicki kind of mother cause that's who I am, and I was willing to look at myself as as just neurotic, but I don't think that's what's evolved. I think probably we're all a little genetically predisposed to anxiety and separation problems - so there's a piece of that, but it definitely has to do with the experiences I had. I think the separation difficulties have to do with me, and I date it all back to the miscarriages.

The following respondents felt they were able to differentiate their experiences of parenting based upon knowledge of raising a child prior to loss:

> It definitely affected my mothering of M more than J (pre-loss child). I had so many years of being a mother to her so I don't feel like it affected the quality of my attachment to her. I'm not worried she's gonna die -

> I'm very fearful for them (subsequent twins). I do, I treat them differently (from pre-loss child).

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> I've seen them step over one another and climb around the counters and my heart is in my mouth. The twins climb up and down the stairs, across contraptions in a gym class, and I almost die. If it was C (pre-loss child) it would've been, "HA, she's fearless." But it's not, it's these kids, who came after the ones we lost, who we almost lost, and who almost killed me! With C, I went on trips with my husband. With them we tried to go away for a weekend. The separation was awful. I just sat there and cried. How can I go on vacation? Get on an airplane and almost die again?

Alternate Explanations for Feelings and Behaviors

Alternately, in discussing their fears, anxieties, and possible overinvestment in their children, some respondents clearly and astutely articulated competing explanations for such, other than a history of loss. Variables mentioned include: characterological predisposition, delayed or late childbearing, "only" or "last" child syndrome, "real" medical problems or developmental delays, and "normative" concerns of first-time parents.

Characterological Tendency

Three respondents felt that they would've been extremely anxious parents even if they had not experienced loss:

> I'm not really more neurotic with her...it's my nature anyhow.

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> I'm neurotic about checking my phone messages, to make sure it's not my son. If I'm out and having a great day, I have to check my messages. That must be characterological. I can't imagine that's all determined by one event. Like I know I have separation issues anyway. If I lose sight of him, it's excruciating panic. Now...is that because of my separation issues or is it really a momentary reexperiencing of losing him? I don't know.
>
> I worry about my kids, but that would've been anyway. I'm very safety conscious. I use a car seat, a seat belt, I buckle her into the stroller, but I would've done that anyway. That's my nature. I'm a really cautious planner.

Delayed or Late Childbearing

One woman felt that delayed childbearing might profoundly influence consequent maternal worries:

> I think a lot of women who delay having children and who haven't had loss err in the direction of overinvolvement and overprotection. They wait longer to have a kid and I don't think that's ultimately in the kid's best interest in terms of their parents' overprotection and difficulty with separation.

Only or Last Child Syndrome

Related to late childbearing, was the fact that for many respondents the subsequent child would be their last, or only child. This was seen to have an impact on overinvolvement as well:

> I felt this would be my last child. That practically, emotionally and financially, and here

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> I was 40, all these reasons meant this factory was closed, no more children, this is it. Also I knew at that point how lucky I was because of the problems with the loss and we knew there would be no more children. So I had do the utmost to help my son.
>
> I was a little nuts. I was close to 37 and I think she was so precious to me because I didn't think I was gonna have anymore. I had her, believing that was it. I never thought there would be anymore. And I raised her like that was it.
>
> I try, consciously, to leave him alone and do certain things. But I'm afraid, because I know I'm not having another baby. If I was younger, I might've had another baby, but I'm too afraid because I don't think I could handle it again and I don't want to tempt fate.
>
> I'd feel like this having just one child, normal pregnancy or not.
>
> I wouldn't say we're more attached to her because of it (losses). We're more attached because she's the only child, not because of the situation. I would say that's why we did different things with her than somebody who had two or three children.

<u>"Real" Medical or Developmental Problems</u>

Just as complications of delivery or the early postpartum period created anxiety and worry, continued medical or developmental problems contributed to exacerbated anxieties and a protracted perception of the child as fragile, vulnerable and in need of greater protection:

> I don't think I would've been that way (overprotective) if she hadn't been so sick. I

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> probably would've been protective, but I had once vowed when I was pregnant that I'd never be overprotective and I don't think I would've been had we not gone through the scare we had when she was born and then the recurrent rotovirus. She has a million food allergies, her system is still very delicate.

> I do feel he's very vulnerable. But he does have asthma which is a life threatening illness and I do feel overprotective of him. I've always been very protective of his needs especially because he has to have medicine three times a day. And he has food allergies. We're scared to death everytime we go out to eat. Is there milk in it? Cheese? So yes..I have to be protective, on top of everything, it's for real reasons. The asthma and milk allergy are real serious.

> Within a month after he was born, I realized he was not tracking and got on the phone and made calls and he was first evaluated at 5 weeks. I was panic stricken. With all I went through - Is this is a retarded child? His learning process was so slow. All my energy became focused on him, whatever input he could get. It was only when he came close to two years that I could begin to relax a little because he started to speak and get vocabulary.

Appropriate Worries of New/All Parents

Finally, four respondents attributed some of their tendencies to be typical of new, or maybe all parents:

> I'm very protective, but a lot of first time parents are overprotective.

> We were hyper-neurotic for a long time. I think I would've been, no matter what. I'm an only child, I'd never been with an infant before, I didn't know much about babies. I was petrified, did not understand babies, had never been around them. I

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> was petrified of this scrawny little, 6 pound itty bitty thing... So now I try not to be overprotective, just cautious. I still have a lot of insecurity, my husband too.
>
> I feel vulnerable, but most parents feel very vulnerable in regard to their children anyway.
>
> I think most mothers are like this - very cautious, overprotective. They can't listen to stories about children on radio, they can't watch anything to do with hurting children. Me, I won't even have children in the car unless my husband is there...I'm nervous about them falling, choking, I worry to the point where it's pathological.

Conclusion

This chapter highlighted experiences of parenting subsequent to loss from the time of delivery. It examined in depth the experience of the postpartum period, including mother-infant bonding; impressions of the subsequent child as a distinct or "replacement" child and the impact of the subsequent child on perinatal grief. Finally, positive and negative aspects of parenting a child after the loss of a child were discussed in detail. The concluding "Findings" section will explore issues "Beyond the Subsequent Child" and detail some of the larger implications of how perinatal loss continues to resonate in the lives of respondents and has ultimately affected and altered the anticipated course of their lives.

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# CHAPTER SEVEN

# BEYOND THE SUBSEQUENT CHILD

The fourth and concluding section of this study focuses on the more global implications of perinatal loss, beyond the birth and parenting of the subsequent child. Respondents reflected on how the experience of loss has affected the anticipated course of their lives, particularly in regard to the resultant configurations of their families and career decisions. They discussed the ways in which prior perinatal loss continues to reverberate throughout their current lives and finally, described any lingering issues that remain for the future.

## REFLECTIONS ON AN ALTERED LIFE TRAJECTORY

### Family Composition

Respondents poignantly discussed the ways in which perinatal loss has ultimately influenced (and altered) their anticipated and desired family constellations. A history of loss often resulted in: a smaller family than hoped for, the possibility for only a single child and the implied lack of a sibling for the subsequent child; the spacing of siblings, and the uncertainty of a yet "unfinished" family.

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Single vs. Multiple Children

At the time that interviews were conducted, seven of 32 respondents had gone on to have (at least one) other child after the subsequent child, while three were pregnant with "subsequent subsequent" children at the time of the interview. (Six respondents had a child prior to the time of loss).

In discussing how perinatal loss had affected the totality of their lives, the greatest remorse was expressed by the remaining 50% of respondents, (16) who, at the time of the interview had less children than originally desired (14 had one; 2 had two) and were either certain it would remain that way or were undecided but in great conflict about the decision to pursue further pregnancy.

HAVING A "SECOND SUBSEQUENT" CHILD

The Desire to Produce a Sibling

As noted above, nearly 1/3 (10) of respondents had had another child, or were pregnant with one at the time of the interview. They had experienced a repeat of anticipatory anxiety and concerns, however the wish for a second child was strong enough to assist them in overcoming their hesitation. One strong motivator to have another subsequent

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child was the wish to provide a sibling for the existing child as this respondent explained:

> Well...it took a long time to get that second baby. Everyone said "it's just nerves" and it's true, I was terrified the entire pregnancy. Especially because at 7 weeks I began to vomit, a few days later I began to bleed, exactly the same thing as before, but this time, it held. I primarily wanted the second one because I felt as an older parent, all my nieces and nephews are older, so I felt they have no one in terms of family and that if something happened to us...she'll be all alone. That was a big push for me, that I didn't feel she should be alone. At least I feel they have each other, and that was important to me. The decision to have the second one was purely emotional. I'm a great list maker, weigh the pros and cons. I was nervous, but in the end...I wanted a second child.

Advanced Maternal Age

Another compelling reason to pursue another pregnancy and to do so quickly was the advancing age of respondents. This resulted in closer spacing of siblings than perhaps had been desired. This respondent revealed her ambivalence about the timing of another child:

> (respondent pregnant during interview) We've been enjoying C (subsequent child) immensely. But I felt like we didn't have a moment to spare before getting pregnant again and as I told you, I'm pregnant now. I have fears, but more than that, there's a part of me that really resents having to do this again, because C will only be 17 months old when I have this baby and I feel very ambivalent about introducing a fourth person into our very perfect triangle. I can't imagine anything that

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> would take me away from her. And yet I've voluntarily done this knowing it's gonna be good for her, that I love my sibs and can't imagine being an only child and I'm 38 and I didn't know whether I could count on getting a conception within the course of a year. So I was really afraid of looking back and saying, "you wasted time" so we started trying and I got pregnant immediately...

The Experience of Another Pregnancy

For the most part, once another subsequent pregnancy was achieved, respondents described a somewhat easier time emotionally with this pregnancy. This appeared related to prior success, the fact that a child already existed and most predominantly, to the lack of time for worry imposed by an existing child:

> Having my daughter was actually more complicated than my son, I wasn't feeling well at all, but I was more relaxed because I had had a successful pregnancy (and I had my son to keep me extremely busy). I had had a successful pregnancy, I knew the doctor was on top of everything and if he handled me once he could handle me again, I think it had a lot to do with that. I was also busy with my son, so I didn't have that time to constantly think about it.

> What happened emotionally was...we figured we had broken the streak and had a healthy baby, so we could try again. So when he was 5 months old, I got pregnant again. I think I was less frightened this time because he existed.

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> (pregnant at the time of the interview) With this pregnancy it's easier, I don't have the same fear, in part because I have C and she is so fulfilling that I almost don't have time...I think this is also partly the "second child syndrome..." I remember with the first pregnancy, I don't think 20 minutes went by that I didn't think about that baby and now...I'm lucky if in the course of the day I think about this baby for 20 minutes. Once you have a toddler...your life is not your own anymore.

> I got pregnant again when he was 19 months old. I was really, really sick, but it was better and I was a lot less crazed. I went into premature labor with her too and I went into the hospital again, but I missed N (subsequent child) so much that I had to come home. I was on medication for the labor, but I played faster and looser with it...

While generally, the subsequent child served as a distraction and an asset to lowering anxiety during the next pregnancy, this respondent noted the added stress created by an existing child when the next pregnancy presented the threat of recurrent complications and consequent reduced maternal availability:

> I found myself nervous at one point. I didn't want to take away from M (subsequent child). Because there were all these questions about would I be able to lift him? All those things you're not supposed to do when you've threatened premature labor before, and I kept feeling like I didn't want to take away from him. Some people would say, "Well, this baby (subsequent subsequent) will be more important than the other one while it's life is still precarious." And yeah, but if it's not born yet, and I've already got one that's running around and wants to go on the swing and I can't

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> lift it...And at some point I just decided I really wanted this second baby so I wasn't gonna be foolhardy and do things I shouldn't, but I tried to be as active as I could with him, rather than just stay home.

Three respondents also commented that postpartum adjustment proceeded more smoothly as well: two suffered less depression than after the first child, and one, a diminished sense of anxiety and heightened vulnerability.

Indecision About Attempting Another Subsequent Pregnancy: Optimistic or Pessimistic Outlook?

At the time of the interview, seven respondents expressed the wish to have more children, but were unsure they would risk pregnancy again. For some respondents, past success did not necessarily breed optimism and they feared a "repeat performance" either of loss or complicated pregnancy. In fact, unlike the above-quoted respondent who felt that the birth of a live child had "broken the streak" (of bad luck), others felt that another pregnancy attempt might just be "pushing their luck." The optimistic respondent felt encouraged by the achievement of motherhood while the pessimistic one, the "magical thinker," felt that pursuing another child might be "asking for too much:"

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> With a second one, I would worry even more cause I figure now I'm really pushing my luck, cause I can't get lucky with this one too. But then I think, maybe it just has to do with the luck of the draw...

Additionally, just as advancing maternal age had rapidly spurred some on to another pregnancy, it also emerged as a factor, which coupled with fear of loss and complications contributed to respondents' hesitancy:

> It's (loss) affected our dealing with a future pregnancy. I had already spoken to the doctor about tying my tubes, but he's made me think over the process in case waiting an extra year or two will help me give it another chance. But I'd have to be prepared to take off a year from everything I'm doing. And I was so restricted and the doctor really monitored my every activity. And when there were problems, there was just no consoling me, so I don't know...

> If I got pregnant again, I still wouldn't buy anything. I wouldn't do anything different than I had done the last time. I wouldn't buy anything and I wouldn't wear maternity clothes. I still have my doubts. I always said I'd never have a baby past 39 and here I am, just 41, if I get pregnant I'll be 42. I'm not a celebrity like Roseanne you know...I don't know where you cut yourself off and say this isn't gonna go on any more. I do worry about having one child if God forbid something happens to her, she's the only one, but to have another child just to saferguard the other...I'm very mixed about it after all we've been through.

> This is it...I think. If I was younger, I might've had another baby, but I'm too afraid. Because I don't think I could handle it again and I almost

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> don't want to "tempt fate" that I could have another normal child. I'm too afraid that if something went wrong, I couldn't handle it, though I guess I could cause I handled the other thing, but I don't know if I could because it was so traumatic for me this way. And I know my diabetes would definitely be more accelerated...I wish it was easier, that I didn't have to go through all this emotion. I also worry I'm 40 and the chances of having a baby with Down's Syndrome, and I might have to terminate, or the baby has spina bifida. I wish I was 30, but now at 40, I feel a lot of turmoil all the time.

> Would I do it again? That's a good question. I don't think so. Because it may be going back to being a pin cushion, maybe being high risk...do I really want to set myself up for that? I think what we've sort of resolved is that whatever plan we had in mind, someone had a different one and we're grateful to have one (child). I think we're gonna let it go at that. The best I can retrieve from my own thinking is that God gives you that that he thinks you can deal with. And I don't know, he's given me a lot. So I don't think we'll have another one.

These two respondents, both with complicated prior pregnancies, worried about the impact of another difficult pregnancy on their families:

> When I contemplate another pregnancy...I think, could I go through that again? Maybe I should just adopt orphaned children. Could I put my family through that again? My son is very demanding now and I'm scared of another miscarriage.

> (after miscarriage of subsequent subsequent child) When I had the miscarriage, I didn't feel terrible because I was kind of anxious about the whole thing. The baby was due in October and I remember

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> thinking I'd have to stay in bed all summer and I wasn't prepared for that...I felt sort of relieved not to have to stay in bed with my daughter and all.

The Impact of the End of Childbearing: Reflections on the "What Ifs?"

Great sadness was expressed by those respondents who, contrary to their original wishes, were certain at the time of the interview, that they had completed their childbearing. In particular, those with single children who had desired more than one, expressed regret that their family size would be smaller than they had intended, and that their children would be "only" children, missing out on the opportunity for sibling relationships:

> (respondent with history of secondary infertility) I kind of set a deadline for myself at 40 because I knew that the success rates for IVF were very low after 40 back then when I was trying. But it took many years to accept that this was gonna be it. One child was not my choice. We've learned to live with it and even found some positives, some advantages in it, but I'm any only child also and that wasn't a positive life experience for me...

> I was disappointed, but I knew, I was already 42, I wasn't gonna do this again. Granted, I was 42, I could have done it, if rather quickly, but I think all the determination, all the gumption, just went away.

> It's hard for me to learn when other mothers with children A's (her son's) age are pregnant again.

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> This is hard for me. We sort of made the decision given our ages, financial situation, that we wouldn't have another child, but it clinched it this year to have the problems we had (respondent diagnosed with breast cancer). And again, talk about loss...even today, I feel so lucky, and I feel bizarre talking this way. I would have loved a flock of children and I'm very sorry that my life wasn't different.

> I think of how different my life would've been if I had the first two...Now I'm an older mother, we just recently moved to the suburbs and everybody's got a lot of kids. And my child was the only child in her nursery class who is an only child. And I'm the oldest mother. And that's because of my problems. And there isn't a person who doesn't walk up to me and say, "You only have one child?" I think in retrospect, I think back on what happened in my thirties...I had infertility and miscarriages, that's what the thirties was about. If this hadn't happened to me, I always assumed I would have had more than one. And that's a decision that has to be made which affects your child's life in a way, because there are all these kids that have sibs, and your child becomes an only child and it's because of this...

> Now at 40, I feel like I'm gypping him (subsequent child) too. I don't want him to miss out and I think he would benefit from having a brother or sister, but I don't think I can handle it. We lost a lot of years...trying to get pregnant, then another year losing a baby, thank God I got pregnant with him right away, but I feel like I lost four years or something. I think, if it hadn't happened, would we have a few children now?

Two respondents who managed to have second (live) children still expressed grief about their "smaller than hoped for" families:

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> Had I had the first two (losses) I might've had a third. I would've liked more, because I really like kids. But I couldn't. I think it bothers me that as an older parent I hope that I get enough time with them. I lost time that I could have had with them...

> I think a lot about the "what ifs." I wanted a large family. *Do I miss those babies?* Not really, but I'm overwhelmed when I think that I had five babies. It's a little overwhelming to think about that...

Impact of Perinatal Loss on the Motherhood/Career Dilemma

Opting for Full-Time Motherhood

Almost one third (10) of respondents commented that their histories of loss affected the course of their lives in that they chose to leave professional careers and stay at home as full-time mothers:

> It (loss) changed my life as a parent in the fact that I'm home. Eleven years down the road...it wouldn't have been like that if this hadn't happened...

> I don't know if I'll ever go back to work. I was planning on it, but this is my priority now. I can't imagine leaving him with someone else, it's hard to get good daycare and so I feel I should stay home. I thought if I ever did have a baby, of course I'm still gonna work, that wasn't even a question, an option. I waited so long...I'm gonna leave now?

> I quit work. We need the money, but I don't want to go back. And that might be the result of the losses. I enjoy every minute with him. I know a lot of mothers who travel, take business trips. I

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> can't. I'm hysterical away from him. I miss him so bad. That's got to be a result of all that.
>
> It changed my parenting because staying home now is a feeling of...they grow up so quickly. If I had two, I would stay home so I think well, if I'd do that with two, why not with one? I worked 15 years as an attorney, and there are other mothers in my office, but I can go back to work later.

Choosing Part-Time Work

Another 10 respondents made the decision to work only part time so that they could have more time to enjoy their children:

> I chose not to work full time because I kept thinking, "Gee, I had one who died, I better enjoy the ones who are alive, while they're little." That's another thing...maybe you have to punish yourself a bit with that too, because someone else would say, "Look you could enjoy them and work outside the home too, you don't have to do this, there's nobody making you do this." It's just that you feel like they're very fleeting at this age.

Regrets about Full-Time Work

Two respondents who felt they had no choice but to work, expressed remorse that they could not be at home more:

> I feel a lack of control not being there, a guilt complex when I go to work, like I just lost my best friend. I only feed them breakfast and dinner now and with my "on-call" schedule (physician) that can go on for 10 days. But it's a fact of life that I have to work.
>
> I still would like to be home with both of them. I feel life is short and you can really lose a

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> lot...you can really lose a lot by doing other things that you never know are gonna be as rewarding as being with the kids because they grow up so quickly and you don't have them after you worked so hard. Doing both, work and being responsible for a home it gets to be a lot, and sometimes I'm totally beat and I wish that were different...

Influence on Career

Four respondents commented on the powerful impact that their losses had on their careers. One changed careers entirely as a result, one changed the focus of an existing career and one felt tremendously aided in her professional development:

> It affected me in terms of my career, I made a major career change (from neuroscience to social work). I started doing pregnancy loss counseling, volunteer, then running some groups and it was really rewarding. I have the knowledge and the sensitivity that I didn't have before. It sort of created a lot of that within me, de novo. After that, when I did that counseling, I knew that science was just gray to me and it didn't matter, I just didn't care about it anymore. But I cared a lot about people suffering in that way because I knew that I could make a difference. I would never have gone for another degree like that if this hadn't happened.

> Since going through the experience myself, I started working with women who have been through loss. My (psychotherapy) orientation is cognitive behavioral, so in addition to acknowledgement of the loss and impact on the next pregnancy, I work with women to provide some stress management.

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> The experience made me a much better social worker. Because I didn't understand how when you put on a hospital gown and lie down that your IQ drops 90 points and everybody talks to you like a moron. I didn't get that piece till I was in the hospital myself. I feel a lot more, and I remember the day I got discharged from the hospital. I had been there for preterm labor for two months and I felt like my skin had been cut off. I just felt so overstimulated and I could see how if you are achizophrenic...forget about it. It was very helpful for me. Also, once I had the miscarriages and was doing a lot if intakes at work, I was always really careful when I was doing a genogram to ask people about their pregnancies. And I was shocked at how almost every woman had a miscarriage. And I was always very interested in how it affected them. And what was interesting to me was that a lot of times it was a turning point in their lives, in one way or the other...

One respondent offered a slightly different variation on how her career path had been affected by her losses:

> I think of all the things I didn't get a chance to do careerwise that would've been different if I wasn't so depressed and I wasn't so busy during the pregnancy holding onto the baby so that I could concentrate instead. I think about all the women who are pregnant and finish their dissertations, or go to med school, they travel, they don't put their lives on hold. And they also may not have the problems going back to work. I could't because I had to be there with her...

## REVERBERATIONS OF LOSS

As noted in the prior chapter on "Parenting the Subsequent Child" respondents commented on the degree to which the past resonated within the present, in their

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experiences of their subsequent children. Beyond what these children evoked from the past, as living reminders of what was lost, mothers mentioned other ways in which memories and feelings of loss were elicited in the present; the past was clearly still alive for most of them.

At one end of the spectrum, one respondent noted, "I think about the losses all the time, several times a week they crop up, because I don't think I ever got over it," while at the other extreme another noted, that eleven years later, "The day of the death goes by, and I don't even remember that day. And it's the day after my (subsequent) daughter's birthday, and I won't even realize it..." Somewhere in between the two extremes fell the response of this woman: "It's not a daily meditation, but not weekly or monthly either, but whenever the subject arises..."

Catalysts of Memory

A number of miscellaneous catalysts were noted to spark memories of loss and these included: the monthly menstrual cycle, one woman's doctoral research on miscarriage, volunteer or professional counseling with women who experienced loss, and unwanted pregnancy resulting in abortion after the births of subsequent children:

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With each period...I relived the loss. And I don't think the experiences ever leave you because anytime my period is off, especially early, or stays longer, right away, it's the fear: something is going wrong even though I'm not trying to become pregnant. Even though immaculate conception would be the only way I could be pregnant...still that worry goes through my mind.

Because of my research (on psychological effects of miscarriage)...my feelings are constantly being brought up about it. I went back to a support group a few weeks ago to deal with my feelings, because they were being brought up with all the research.

I'm reminded of it when I work with people who've had stillbirths. Some women going through it decide they don't know if they can handle anymore. They're very frightened that they would not be resilient enough to be able to bounce back from another loss. They become pregnant and never get a good explanation for why they experienced loss so to keep trying when you think you're gonna come upon another loss...

What was interesting to me was that I got pregnant when L (subsequent subsequent child) was 2. I had an abortion about a year ago and that's when I started thinking about the miscarriages. I hadn't thought about them until then. And then it made me start thinking about what all the other kids could've been like and how it would've been and then I felt really really sad. But that's when I thought a lot about what all the other babies, how they would've turned out...

Anniversary Reactions

The anniversary of the date of the loss or even of the child's due date was a popular reminder of loss,

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particularly when it fell at a more memorable time of year or coincided with the birthday of the subsequent child:

> There is never a January that rolls by every single year since, (7 years) that I don't suddenly come into an awareness of the date...right after the New Year's weekend. At the time my husband and I had gone out to our (vacation) home and it was just an ecstatic weekend of talking about the baby coming, and celebration and New Years and excitement...and then this crashing news.

> The day I delivered her (stillborn) is a day I will always acknowledge. It happened, it is over, there is a beginning and an end to everything...and most definitely life. Maybe on that day and maybe three other days in a whole year I realize...

> One Christmas I had a post-traumatic incident. I started shaking, and having horrible dreams about the hospital every night and I was checking on the babies during the night. All night I checked to see if they were breathing.

> I was afraid I might mix up their names or something but she's just a totally different baby. So I don't think of her like being her sister reincarnated or anything like that. It's just funny that they were born so close (one day apart) so it means every year I'm gonna have to go through this. At some point I'll have to explain to her and she may feel bad that her birthday is a little overcast, it's unfortunate, but there wasn't much I could do about it...except maybe not tell her.

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Attempts to Memorialize

In addition to the incidental markers that "snuck up on them", six respondents described concerted efforts made to remember the lost child at least annually. Three of these made regular cemetery visits, while three commemorated the child in other ways:

> The baby is buried up the road from us (summer home), two minutes walking distance and every weekend that we're in (town) we go. It has a tombstone and that's been very nice.
>
> We didn't have a whole separate burial plot because my husband had this belief that if you have a casket that's too big, that it will, it will cry out to be filled with another person. So he wanted her cremated, but I don't believe in that, so we have this special plot in the cemetery where only babies are born...I'm sorry, not born, I mean buried. The guardian angel plot it's called and I try to go there once a year.
>
> We go to the cemetery a few times a year. At the beginning, we went every month, once a month I wanted to go. And then it kind of stopped especially in the winter and we actually went a couple months ago. My husband goes first to make sure everything looks O.K. We put silk flowers on the grave...I never wanted to put fresh flowers because I didn't want to come there and see dead flowers. Silk flowers seem to last. But he goes and makes sure that from the wind and rain everything looks O.K. because he knows I would get upset if something looked a mess, because he knows that's how I am, very sensitive. So the last time I went I put ivy on the grave. We wanted the ivy on top so we could always be hugging her. So

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> everytime I go I take hold of the ivy, put it on her and cover her...
>
> Every year I buy flowers for my first daughter that died, and that table is where we keep her pictures and everything that we had to do with her and inside that door and it's all roped off...
>
> I have a memento - a shaker kind of wooden box, with some wonderful stuff from when we found out she was a girl...I go in the closet for the box around the holidays, or around the day of her birthday, and periodically I go look at it. I go through the things, look them over and cry and put them back in the closet. Periodically...I do go back to it.
>
> I have a little area of the house, a file cabinet where I keep everything related to the first pregnancy, a sonogram picture, notes I wrote, and I look at it once in a while.

Loss as a Reference Point

One respondent described how her loss surfaced recurrently as a "yardstick" against which to measure subsequent tragedy:

> It just means you have a lifelong reminder. I find when something happens, I lose a job, my husband was in a terrible accident, when those things happen, there's a place in your heart that resonates at that same tone - where you can say, "This is as bad as A dying, or not as bad..." or perhaps the same feeling for a day. You have something to compare it to, like you have a bone that hurts. And it's always gonna be there...

For two respondents, thoughts of their losses emerged in association with other losses, real and anticipated:

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> I think of my lost children, and then I think of my dad, and that was sudden. I lost my father after the babies. And I knew it was gonna happen...I always had a sixth sense when something bad was gonna happen.

> I think of how I lived through that, and I compare it to how...but that's not to say that I don't look at things that I know will happen in my life as almost not bearable. Like if I were to lose my mother...I don't know how I'd go on. You know what I mean?

Other "Living Reminders" of the Would-Be Child

Powerful reminders of the lost child that were mentioned quite commonly were seeing a child of the same age that the lost child would have been, a child with an older sibling, or even a newborn of the same gender as the lost child. These set off thoughts of who that child would have been, and were stirring reminders:

> When I see a woman at (workplace) who was pregnant at the same time I was...if I see her on the street with her daughter, I'll then remember, I would've had a daughter that age. If I see someone where there is that connection, I think about it.

> It still hurts terribly. When I see, there was a woman in the building who was pregnant the same time I was and happily she moved. When I used to see her baby it used to be horrible. When I see babies - she would've been 4 now, obviously I still think about it. It forever changed the way I felt about having babies.

> It doesn't take away anything that you have the subsequent children. I mean, they're your own

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> children, but you always look at children the same age and you calculate in your mind, well, she'd be having a birthday now, or she'd be in school or what would it be like if she were the older one and M (subsequent child) had someone to keep him in line - you think about those things. That's another set of thoughts that run through your brain.
>
> When I see a child my daughter's age with an older sibling, I get really sad. For one thing, I think, "Well, I'd be through with this (having children) by now" and instead I'm still contemplating doing this.
>
> The other thing I remembered was that my step-daughter-in-law had a baby, a boy and that was fine, and she just had a little girl, and I had a lot of difficulty with that, going to the hospital to see her so I don't think it gets resolved. It (the loss) comes up and you get reminded of what you don't have. No matter how many babies you have...

What Size Family?

A handful of respondents mentioned feeling jolted into memory when asked how many children or members were in their families, or whether the subsequent child was the first child. These "thorny" questions raised thoughts of the dead child and his or her ambiguous status as a family member:

> People would stop me on the street and say, oh, you're pregnant, is it your first? All those questions when you've had a perinatal loss are really loaded and it's really hard to know how to answer them because you don't need to be spilling this really disgusting story to the cab driver, and

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> yet it's not my first, and it's not my second, so it's very hard to know what to say.
>
> I never know, do I say there are 3 people in my family or 4? Or are, or were 4 people? And then what does it mean to be a parent? Is it one of your children? Is it only one of your children if it lives, develops and you are able to parent it? Or are you a parent because you have feelings about that child no matter what?
>
> Once in a while, I'm reminded. I was filling out some form about the number of children and I thought three (live) or four?

## THOUGHTS OF THE FUTURE

In regard to the experience of how loss might live beyond them, respondents projected their thoughts into the future in two areas: disclosure of prior loss to subsequent children and their subsequent children's reproductive difficulties or concerns about childbearing.

### Disclosing the Loss to the Subsequent Child

At the time of interview, only three respondents had disclosed to their subsequent children that they had had a sibling who died before their birth. The remaining respondents expressed reticence to do so primarily owing to their childrens' young ages, but had considered how they would approach this in the future:

> (11 year old son) We had no difficulty telling him when it was relevant. We'd go to the grave and

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plant. He talked more about it when he was 5, than now when he's 8. By the time he was 5, we told him he actually had a sister. At 8, he wanted a sib, an older sib. He wanted what he could've had and asked us to adopt an older sib, but we told him we weren't gonna do that.

(12 year old son) It took me a while to share that information (of the loss). My husband probably wouldn't have shared that information, thinking it was not necessarily relevant for my kid to know. But I am not comfortable with secrets - both as a professional (psychotherapist) and personally. They gnaw away at me. I don't like secrets in the family and I thought if at some point somebody mentioned it to him it would be somewhat shocking to him. Not horrible, or anything...but shocking that there was a baby before him, a full-term baby that he didn't know about. He also knew I had a miscarriage when he was 3 or 4, so I had to find a way to explain it to him without frightening him because at 3 or 4 that's a scary concept of a baby dying. Orange and grapefruit seeds...some of them can grow and some don't...so I used that metaphor and he still alludes to it *occasionally* and remembers the difference. It's only in the past 2 or 3 years that I've told him about the stillbirth and I think he was a little shocked by it...

(7 year old son) When I told him, it really brought up a lot for him in the context of him maybe having had a sister, and the family maybe having been together. That was really sad for me. And I allowed myself to feel that longing. In a way I had sealed it off and was able to open up with him. I found I really wanted to talk about it at length...what could've been.

(subsequent son 3 months old) I'm already thinking about how I will tell him, or will I? I think I will, but how or when? I don't know.

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> My older one (6 years old), she doesn't know any of what happened. I feel she's too young to understand, although I don't hide it from her. Like if I happen to be talking to somebody about it and it does come up, but she's never asked me about it. By now I'm sure she's heard me tell people that I had four miscarriages before she was born.

> I don't go to the grave. I think maybe because my daughter doesn't know about it and I don't want to tell her yet, she's too young (6 years old).

> I haven't told her, because I thought at 6, like a sponge, she's only capable of taking in what probably would be to her benefit. Aand I don't feel that telling her at 6 about a stillborn is something she would understand and it would probably only confuse her and send her into some other head problems, so why do it?

Two respondents appeared influenced by their own parents having told them of losses prior to their births:

> Would we ever tell him? We would. My mother told us she lost a baby.

> You see some of these mothers who make a big deal of it and they tell even little kids like my son's age (2 1/2) and I haven't told him because I don't think he's capable of understanding it and if I did tell him it would be because I wanted to do something not because he's capable of hearing it. But I remember when my parents told us about the babies they lost and we were more like 7 years old and every year there was their birthdays and their names and they have cemetery plot and everything...

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Fears for the Subsequent Generation

Four respondents, three with female children and one with a male, expressed anxiety about how their own reproductive failures would affect their children both physically and emotionally. These concerns were more salient with females:

> (referring to baptismal prayer). With her, I was saying "May you bury me," but not as strongly - I was saying, "May you never have reproduction problems. Like your mother." I hope that she never has to go through this, that she won't have anything wrong with her and have to suffer...

> And I worry about her (pre-loss child). In the sense that I don't know what she's gonna think. I wonder far ahead enough to think, "Is she gonna be traumatized enough to grow up and not want to have children?" "Or, is she gonna have 12?" A whole tribe of children and will that become her life's consumption? I just really wonder how it's gonna affect her later on as she develops into a woman. Is she gonna think things like, "If it happens...if God forbid if this happens to her, will she be better able to deal with it having known it second hand from me?" Or will it be worse for her?

> (referring to pre-loss child) And because she's a girl...I also had this feeling..part of what I really felt awful about was that I worried, I still do worry about how she will feel being pregnant as an adult. I mean, her experiences of it with me have been that it's so tentative and I'm worried that she will be more anxious as a pregnant woman than she otherwise would be. There's a whole set of worries that I have that are particular to having a daughter, not a son...

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This respondent, however, expressed fear about the effect on her subsequent son:

> (history of stillbirth and secondary infertility). I project down the road, I tend to be a worrier, so I worry in advance. My son is entering adolescence now and so he's got budding sexuality which will continue to develop. And that restimulates for me the loss associated with infertility. I am concerned that when he finds someone to marry and at some point thinks of having a family, I worry about losses, about inability to conceive, and if they postpone having a family for career development, or whatever they choose, I don't want to push them, but I think inside I'll keep thinking "you better get going, better start trying." Also I would like for him to be able to have more than one child...one child was not my choice. I know when he gets to the reproductive childbearing years I'm gonna be concerned and I'm gonna have to work on myself not to transfer my anxiety. We're not there yet, but I mean - this is an experience you do carry with you all your life...

THIS CHILD AS "MEANT TO BE"

While it was clear throughout respondents' interviews that their past histories of loss had deeply colored their lives, particularly their experiences of subsequent pregnancy and parenthood, ultimately, the joy of the present with their children cast a reciprocal shadow over the past as well. Loewald (1975, p. 360) wrote that the way of reliving the past is apt to be influenced by present experience; memories may change under the impact of the present, for it is not only true that the present is

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influenced by the past, but also that the past - (as a living force within us) is influenced by the present.

Indeed, one respondent revealed her current perspective on her five losses, "It was very devastating to me, and yet, it's hard to really say in retrospect, now that I have children..." Respondents grappled with creating meaning somehow out of tragedy, and perhaps most profoundly, and paradoxically, commented on the present as a direct and positive outcome of the past, in that THIS child, the subsequent child would not have existed had those prior losses proceeded as successful pregnancies:

> I think he's meant to be here and the other one wasn't and I want to give him a very good life and just move on...
>
> If either baby had lived, I wouldn't have J (subsequent child). Which is true for everybody. It's remarkable. At the time the girl died, there was no way to know this; it was as though my world had ended. But that's so temporal. Even if I had had three children...if certainly wouldn't have been that egg.
>
> I feel bad - whatever happened, happened. But I got a better model here. I feel very good about it all.
>
> More recently he (subsequent son, age 12) asked, "Do you think you would've had me if you hadn't had the stillbirth?" And we wouldn't have, because we wouldn't have conceived at that point.

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> I know I lost 4, then 5, probably healthy babies that would have been kids, just like I now have. But then sometimes I say I wouldn't have these two, they wouldn't have come out to be who they are.

Conclusion

This final chapter of research findings focused on the implications of perinatal loss in respondents' lives, beyond parenting the subsequent child. It looked at various ways in which experiences of loss affected the course of women's lives including their family compositions and career decisions. Finally, the ongoing manifestations and reverberations of perinatal loss were detailed. The next and final chapter will provide a summary of the research findings including implications for clinical practice and recommendations for further research.

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# CHAPTER EIGHT

## SUMMARY

This research project explored the experiences of a group of women who achieved pregnancy and parenthood subsequent to perinatal loss. The 32 mothers who participated in the study described shared their experiences of perinatal loss over time, including how it affected subsequent pregnancy and parenthood. It is likely that these women originally approached pregnancy and motherhood with excitement; as "normative developmental processes," not anticipating the difficulties and disappointments that awaited them. A "normal," expectable progression through pregnancy, childbirth and parenthood was altered, as they encountered experiences of emotionally painful, sometimes traumatic loss; frightening, and often turbulent subsequent pregnancy and finally achieved motherhood often with feelings of uncertainty, tentativeness and other vestiges of their past experiences of loss. To define the commonality of experience it may be stated summatively, that these women did not traverse the normal and predictable trajectories of pregnancy and childbearing that most women do, and it was

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the goal of this study to better understand any uniquenesses of their experiences.

A grounded theory approach to research induces theory through empirical observation, letting theoretical propositions emerge from the data provided by respondents. Such abstract principles and concepts may then guide practice in real and human situations (Field & Marck, 1994).

This final chapter seeks to summarize fully the researcher's understanding of the respondents' experiences of perinatal loss, subsequent pregnancy and parenthood with the ultimate aim of arriving at clinical implications and directions for future research in these areas.

Brief Review of Findings

Qualitative research methods (in-depth interview and content analysis) yielded findings in four basic areas of women's experiences: perinatal loss, subsequent pregnancy, subsequent parenthood and life issues beyond the subsequent child.

With regard to perinatal loss, the respondents shared with great affect the feelings recalled from the time of loss. Common and prevailing emotions were sadness and depression, surprise and shock, a sense of powerlessness and

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loss of control, anger and envy. The circumstances and events of the loss were similarly remembered in great detail. These included significant dates, the actual experience of losing a baby, and the treatment they encountered by physicians, hospital staff, including social workers, and other mental health professionals. Finally, respondents shared of their many efforts to cope with pregnancy loss. A variety of strategies were utilized including various forms of ritualized acknowledgement, seeking the support of others (spouses, friends, professional treatment and self-help groups); searching for explanations for the loss, deriving positives or personalized meaning from the experience and pursuing a subsequent pregnancy.

The next section on subsequent pregnancy focused on several areas. The decision-making process involved for pursuing subsequent pregnancy was explored, yielding insight into both practical and psychological motivations for motherhood. Emotions experienced during the subsequent pregnancy were described as were coping devices employed throughout, which included both active strategies as well as psychological mechanisms. With regard to the latter,

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special attention was paid to the way in which women attempted to protect themselves through "guarding," a denial of investment in the pregnancy, and its ultimate impact on prenatal attachment. The special situation of complicated or high-risk pregnancy was explored as was the effects of the use of advanced medical technologies.

Findings regarding the subsequent child began with examination of the childbirth experience, the early postpartum period, including the experience of mother-infant bonding, and respondents' early impressions of their subsequent children, vis a vis the lost child. The impact of the subsequent child on perinatal grief was illuminated and in-depth descriptions of the positive and negative aspects of parenting were provided. This section concluded with a discussion of competing explanations for various facets of parenting experiences that cannot be attributed to a history of perinatal loss alone.

The final chapter looked at issues related to loss that emerged for respondents "beyond the subsequent child." Essentially, this referred to ways in which their experiences of perinatal loss altered their anticipated and hoped-for life trajectories. Perinatal loss ultimately

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affected their family compositions and career decisions; their priorities in terms of work and motherhood. In addition, the 32 women described the many ways in which perinatal loss continued to reverberate in their ongoing lives and resonated within their current experiences. Finally, turning to the future, they shared their concerns about disclosing their histories of loss to their subsequent children and their fears about the reproductive capacities of their children.

## DISCUSSION OF THEMES

### The Surprise Finding: The "Aliveness of Loss"

McMahon (1995) noted that producing a statement of a research problem can sometimes be complicated when the research process itself transforms the original conceptualization of the problem.

In this study, the original research question did not fundamentally change over the course of the research, however, the findings yielded an emphasis in an unanticipated area.

Acknowledging a gap in the literature on perinatal loss, which focuses on short-term effects, and emerging from personal interest, the researcher originally set out to

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study the long term effects of perinatal loss; "shadow grief," with a particular emphasis on its effects on subsequent pregnancy and parenting. The first interview question in which respondents were asked to "simply" describe their experiences of failed pregnancy was intended to be a backdrop for the "meat" of the study which would center on subsequent pregnancy and parenting. Not too long after the inception of the study, the researcher noticed the inordinate amount of time that respondents spent describing in great detail, and with intense affect the stories of their pregnancy losses. If these did not overshadow, they at least equalled in magnitude and meaning, their experiences of subsequent pregnancy and parenthood. Whether loss occurred as much as eleven years ago, or as recently as one month prior to the interview, was early or late gestational age, an isolated instance, or a recurring phenomenon, the wish and apparent need to share the experience in minute detail was a constant.

Initially feeling disappointed and "derailed," the researcher felt as though the data, so openly disclosed was not the data originally sought. With time, the researcher was able to reframe this thought quite to the contrary; in

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fact, the continued power of the experience of perinatal loss in these women's lives was inherent testimony to the aliveness of it, in spite (or perhaps partially a result) of subsequent pregnancy and parenthood; herein lay a beginning answer to the question of whether subsequent pregnancy and parenthood had sufficiently mitigated against feelings of loss. The finding was revelatory. Clearly, for these respondents the feeling of loss was far from entirely over.

Their apparent yearning to share their experiences so fully and deeply caused the researcher to wonder why the emotional need for this was so great. For those whose losses went unacknowledged, perhaps it spoke to their continued search for recognition and validation of their experiences. Those who had shared their experiences, either formally in psychotherapy or a support group, or informally with a spouse, relative or friend, still evidenced an ongoing need to talk about loss. The respondents at times appeared extremely sad, sometimes tearful, at other points intensely angry, and they shared of the continued cathartic effects of telling their stories to someone who was perceived as understanding "from the inside."

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Further, as respondents progressed through the interview, the theme of loss was woven throughout their narratives; it surfaced during the stories of subsequent pregnancy, resurfaced during discussions of subsequent parenthood and resounded powerfully still as they told of their current lives, attesting to the presence of lingering, residual feelings.

The Task of Contending with Dual Emotions

The emotional responses to experiences of perinatal loss, subsequent pregnancy and subsequent parenthood appear complicated by the extreme dichotomy of feelings induced by all three of these experiences. Perhaps there is no greater paradox than experiencing the ambiguity of "giving birth to death." For even where babies were delivered stillborn, respondents referred repeatedly to their experiences of "birth," and only one respondent appeared to know the technical distinction: "I think it's a delivery record they hand you, not a birth certificate." Respondents described in detail the anticipatory joy that ended in the shock and devastating sadness of perinatal loss; the excitement of the subsequent pregnancy that was coupled with anxiety and terror; the simultaneous hope and dread of seeing a viable

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fetus on ultrasound or feeling fetal movement; the formidable goal of turning prenatal detachment into unbounded postnatal investment; the exhiliration of a subsequent birth mixed with the pervading sense of transience, apprehension and fear. Not only were respondents faced with the task of reconciling or at least tolerating greatly dissonant feelings, "constant variations of hope and fear," (Field & Marck, 1994, p. 276), but many of those feelings are not generally associated with pregnancy and childbearing and thus represented further losses: those of certain "normative" developmental processes.

Disillusionment with Science and Technology

Perinatal loss was almost universally reported to result in feelings of complete surprise and shock. Respondents referred to their own "naivete" about the possibility of pregnancy progressing in any other way but "normally;" they anticipated birth with joy and excitement. While this partially may have been due to an innocence about the processes of pregnancy and childbirth, and lack of knowledge about potential dangers (particularly for first-time mothers), the notion that things will go smoothly is likely

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to have its roots in a social context as well, and may be a more recently harbored expectation.

Reproductive losses occurred quite frequently until the 20th century and were seen as inevitable (Herz, 1993). Even much more recently, many of the respondents referred to perinatal losses their mothers or other family members had as commonplace and "no big deal." As one woman remarked, "In those days, everyone lost a baby" (although these losses were often not revealed to respondents until the time of their own losses).

In present times, the expectation is somewhat different; babies are not expected to die, particularly once the risks of the 1st trimester have successfully been negotiated. Modern medicine and advanced reproductive technologies contribute to the (illusory) expectation of a perfect, healthy child as well as to great surprise and disappointment about a different outcome (Herz, 1993, p.144).

This particular group of respondents, well-informed and knowledgeable about pregnancy, relied heavily on self-care, medicine and technology to assure a good outcome. When they faced loss, they experienced not only profound

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disappointment, but an accompanying disillusionment with science, medicine, and statistical facts. Especially in situations where no medical explanation for loss was available, a kind of crisis of faith in what had previously been relied on (intellectual or scientific knowledge and medical compliance) occurred. The realization that there are no guarantees even with modern medicine, engendered feelings of powerlessness, mistrust and diminished faith. The facts offered by professionals were now challenged by personal experiences (Field & Marck, 1994). During the subsequent pregnancy, achievement of pregnancy "milestones" therefore lost meaning and even a live birth did not feel quite conclusive. Nothing could be taken for granted anymore. This was part of a larger sense of vulnerability and lack of control induced by the experience of pregnancy loss.

An Existential Sense of Vulnerability

The shock of perinatal loss; the unpredicatability of a subsequent pregnancy and childbirth left many of the respondents feeling a heightened sense of vulnerability and defenselessness against certain random life events. Moreover, this was a group of respondents who, for the most

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part, expressed that prior to their losses had considered themselves "perfectionistic, and in control of everything." The startling recognition that "anything can happen" at anytime; that life could become death in a moment, challenged their premorbid conceptions and understanding of life (Field & Marck, 1994). Suddenly a sense of safety was gone and this permeated throughout their experiences subsequent to loss, as one woman in reference to parental concerns acknowledged, "You imagine the worst, because the worst already happened to you." What was unthinkable before is no longer, and reason and probabality no longer build faith and quell anxiety. Even at the point of attaining motherhood, life felt transient and uncertain and respondents remained deeply disturbed and shaken by the realization of all that was beyond their control.

The Prevalence of Magical Thinking

Magical thinking and superstition have been noted to be an inherent part of reproduction (Herz, 1993). Given the extent to which respondents had no scientific or rational explanations for events that occurred and the degree to which they ultimately felt out of control of anything related to pregnancy and childbearing, the uses of "magical

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thinking" and superstition were evident throughout their descriptions of their experiences. These were visible in the explanations they derived for pregnancy loss when there were none; in their belief that anticipating misfortune in the subsequent pregnancy would ward it off; in their keeping pregnancy a secret from others; in their trust that remaining detached during the subsequent pregnancy would shield them from the pain of loss were it to occur again; in their belief that their omnipresence, overprotection and anticipation of danger or harm to their subsequent children would help protect them.

Perinatal Loss as a Woman's Experience

As noted earlier, in relation to differences in male and female perinatal grieving styles, mothers' grief reactions have been noted to exceed fathers' (Covington & Theut, 1993), partially because the mother uniquely invests in the fetus as a part of herself (Theut, et al, 1989). Couples have been found to see perinatal loss as a woman's experience (Rosenblatt & Burns, 1986). Indeed, in this research project, respondents' spouses were minimally present in their narratives. While the researcher did not specifically intend to explore marital relationships,

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neither did the respondents spontaneously share much about their spouses, particularly during the experiences of subsequent pregnancy and parenthood. Some references were made to husbands' supportiveness or lack thereof subsequent to the loss, but the overriding impression derived from interviews was that of the woman basically experiencing the loss alone, physically and emotionally.

In addition, as spouses appeared somewhat as background figures, so too did other individuals in the lives of respondents; family, friends, and even the children, those lost and those born subsequently, seemed to exist in the shadow of the mother's experiences. Respondents were clearly center-stage in the retelling of their experiences and while the interviews were intended primarily to capture such, this imposed a limitation in the findings regarding their fuller perceptions of the roles of others in their experiences. Again, this somewhat narcissistic involvement with the loss seems partially to result from persistent feelings of anger about the lack of social acknowledgement received and the ensuing sense of isolation. At the same time however, there appeared to be an element of inconsolability in relation to loss; a feeling that shared

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grief was untenable since "no one can understand" which may have further reinforced a sense of isolation and aloneness with the experience.

The Deleterious Effects of Lack of Acknowledgement

In addition to the above, contributing heavily to a sense of aloneness was the repeatedly expressed lack of acknowledgement by professional personnel felt by most respondents. This occurred almost ubiquitously in encounters with the medical profession: doctors, nurses, and other hospital staff including social workers. The physician's inability to deal with perinatal death was explored in a prior discussion. It was clear from respondents' descriptions that, for the most part, doctors remained clinical and emotionally detached at the time of loss and were most concerned about the respondent's progression to another pregnancy, focusing on physical, not psychological readiness. They tended to be most fixed on the achievement of a successful end-product, a live birth, rather than respecting the very complex emotional processes to get there.

Further, hospital practices as well were at times a source of stress. While these are much improved in regard

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to perinatal loss, a number of respondents still noted insensitive treatment by hospital personnel including exposure to grief protocols that were not always suited to their emotional needs. Fortunately respondents found greater satisfaction with their physicians during the subsequent pregnancy and continued to emphasize the importance of compassion on the part of medical and hospital staff, in addition to consideration of their experiences of perinatal loss during subsequent pregnancy and childbirth experiences. In the experiences of these women, not just doctors, but friends, relatives, spouses and colleagues often exhibited a similar intolerance for the pain of mourning, the anxieties of subsequent pregnancy, and the fears of subsequent parenthood. Particularly once parenthood was achieved, the focus was the live, successful birth with little recognition given to the impact of the past. Respondents faced a "conspiracy of silence" around their losses and the pressures and needs of others for them to "move on." Little acknowledgement exists for the life not yet born, and the notion that the loss is "replaceable" prevails. The strong terminology used by respondents to describe their post-loss "re-entry" into the world, i.e.,

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feeling like a leper, a pariah, a member of a secret club, spoke to their sense of aloneness and of being outcast by mainstream society. Others' discomfort with perinatal loss and need to protect themselves from respondents' (and ultimately their own) grief; the resultant inappropriateness of remarks often made to the grieving mother and her own shame and reticence to share the loss prevented the receiving of interpersonal support just when it was needed the most. Interestingly, it often was not until the time of loss that respondents learned of others' perinatal losses that heretofore had not been disclosed to them. The experience of "others coming out of the woodwork" to share their losses helped diminish the severity of their isolation. Similarly, those women who participated in perinatal bereavement support groups were most likely to feel understood and acknowledged in their experiences, more so even than those in individual psychotherapy.

It is possible that the lack of acknowledgement and understanding reported by most respondents was at least partially responsible for the intensely affect-laden and detailed manner in which they imparted their stories. It appeared that continued understanding and recognition of all

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they had been through was sought. It is also quite possible that their unresolved feelings of sadness and anger served to bind them to their experiences of loss and thereby, to their dead children.

The Potent Drive for Biological Motherhood

Another theme that was salient throughout respondents' stories was their absolute and fervent drive toward biological motherhood. This manifested itself in their persistence at achieving subsequent pregnancy and parenthood after suffering the trauma of loss, in spite of the many anxieties and uncertainties they harbored. While cognizant that "theoretical" professional advice suggests an "optimum grieving time," (at least 6 months) before a subsequent pregnancy attempt, psychologically, they felt they could not wait and opted to attend to grief resolution and subsequent pregnancy simultaneously, choosing almost immediate efforts at subsequent pregnancy. They clearly indicated that childlessness and adoption were not considered favorably; the latter was particularly unacceptable to spouses. While the urgency for genetic childbearing may speak to a biological, or anthropological urge, the social pressures toward biological childbearing cannot be easily dismissed.

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While respondents did not refer directly to these, it is quite possible that the social importance and acceptance of mothering and continuing advances in reproductive technologies (in particular for those who have delayed childbearing) exerted pressures on them, however subtle or unconscious, to attempt pregnancy at all costs.

For one thing, from a sociopsychological viewpoint, it is generally assumed that since all women are themselves mothered, that the ultimate in positive female (maternal) identification is the desire to become a mother. Furthermore, historically, the pendulum has swung in regard to the importance of motherhood to female role definition, emphasizing it during various decades. While alternatives to motherhood were espoused in the 60s, it appears that the present decade has seen the renewed popularity of motherhood (and biological motherhood) as inherent to women's self-definition. The recent "revival" and popularity of motherhood has resulted in its achievement becoming the expectable goal, and if not attained, a sense of shame and failure ensue. Voluntary childlessness has long been stigmatized and is only recently being discussed and studied as an actual choice, since prior it had been assumed to be

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the inevitable result of infertility (witness the recent publication of two books on the subject, Ireland's Reconceiving Women and Safer's Beyond Motherhood: Choosing a Life Without Children). Psychological, social and historical contexts and attitudes, then, might exert a subliminal influence on the desperate pursuit of biological motherhood (and fatherhood as well, i.e., the spouses of respondents who were so adamantly opposed to adoption perhaps feel some of the same social pressures toward biological paternity).

A number of respondents in this study relinquished full-time careers for (stay-at-home) motherhood. This raises the question as to whether they would have opted to do so had their pregnancies progressed smoothly, "normatively" without a prior history of loss. Does the extent of the effort made to have a child place a greater premium on the outcome? Does the struggle somehow increase the value of motherhood or its seeming importance to feminine role identity?

At the same time that motherhood is experiencing renewed popularity, advances are continuously being made in reproductive technologies. These further encourage women to be driven to motherhood, as they hold out the hope of

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limitless possibilities for biological childbearing. In addition, medical professionals generally have not been helpful in setting limits on childbearing efforts because of their eagerness to promote and succeed at, the use of technology. These are issues for consideration in the comprehensive understanding of what propels women so strongly toward biological motherhood. Ultimately, if in fact the decision to pursue biological motherhood does not belong solely to the woman, but rather is heavily directed by external, social forces it seems likely that this will significantly impact upon attitudes and feelings about subsequent pregnancy and parenthood.

The Role of Advancing Maternal Age

A notable characteristic of this study sample was the generally advanced (35+) maternal age of respondents, which introduced its own implications for how loss was experienced. While Toedter, et. al., (1988) found that older women tended to have lower perinatal grief scores, it did not seem that age mitigated against grief in this population. In fact, age exerted a kind of desperate pressure on respondents to attempt subsequent pregnancy quickly before the "biological clock" ran out and they found

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themselves unable to reproduce at all. Age represented diminishing time available for subsequent attempts and was therefore a practical propelling factor in rapid subsequent pregnancy, often in spite of whether perinatal grief was thought to be adequately resolved. The "ideal" of "adequate" grieving time had to be compromised due to the pragmatic reality of advancing age. Maternal age also affected respondents' ultimate family size (the ability to have more than one child), the spacing of their children, which was generally closer than originally desired, and also created the life situation of becoming an "older, first-time mother," which had not been anticipated by many.

The Importance of Personal Context To Understanding the Significance of Perinatal Loss

While the researcher focused on studying commonalities of experience and not on uniquenesses of respondents' stories, it must be remembered that each individual interviewed had a life story; a personal history that they brought to the experience of loss, and thus its meaning must be viewed within that total context, not in a vacuum. Many factors that might impact upon the individual meaning and interpretation of pregnancy loss, such as a history of other

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losses, the respondents' mothers' history of pregnancy loss, and the respondents' premorbid personalities were alluded to but not deeply explored, however, these should not be overlooked in attempting a comprehensive understanding of the emotional effects of loss in the life of an individual. The influence of other significant background factors such as respondents' religion, culture, and socioeconomic class were not sufficiently addressed either by this study and need to be pursued in subsequent research efforts.

Likewise, in relation to the context in which loss occurs, discussions and debates then, about which is more traumatic; early or late loss, one or multiple losses; are all somewhat theoretical when not viewed within a personal context. As was described, for those who experienced both, miscarriages were viewed as negligible relative to full-term loss, but when experienced solely, they were viewed completely and fully as losses in their own right. Similarly, while the obvious assumption may be made that the presence of an existing child mitigates against a sense of subsequent loss, for those who were avidly seeking a sibling for their child, or who desired more than one child, or struggled to explain the loss to their children, this did

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not prove at all to be the case. The experience of perinatal loss cannot be treated solely on the manifest level, and as though it produces universal, common effects. The specifics of a given situation of loss must be considered for their unique implications, i.e., an occurrence of spontaneous loss might engender different feelings than a voluntary therapeutic termination which contains an element of choice and thus more control, but perhaps consequently, more guilt as well. Such variations and complexities in feelings will affect the way loss is experienced and ultimately coped with.

Loss Upon Loss

As they reflected upon their experiences, this group of women recognized that beyond the manifest occurrence of pregnancy loss, they in essence suffered multiple losses: they mourned the loss of a normative pregnancy experience with its attendant joy and excitement. Pregnancy was experienced more like an illness, than a normal developmental process, and this was exacerbated for some by the extensive use of technology, medical monitoring and intervention. Respondents became extremely hypervigilant of their bodies, acutely aware of the passing of time and

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significant pregnancy "milestones" and focused on unusual tasks, such as calculating the survival odds of fetuses at various gestational points. Once pregnancy ended, delivery and the early postpartum period were often times of post traumatic stress, particularly if the respondent had a complicated pregnancy.

Finally, respondents discussed loss in the context of their total lives and shared their grief about the losses of desired family size, spacing of their children, an earlier end to childbearing than perhaps anticipated; in essence, the loss of the anticipated "life plan" they had once mapped out for themselves. Again, importantly, their personal expectations, hopes and dreams contributed ultimately to the personal meaning of the loss in their lives.

Consideration of Competing Explanations for Responses to Subsequent Pregnancy and Parenthood

As premorbid character and history brought meaning to perinatal loss, indeed respondents' emotional responses to the experiences of subsequent pregnancy and parenthood were affected by many phenomena, not just the loss itself. Therefore, as respondents noted some of their parenting tendencies: overprotection, reacting with excessive fear

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and vulnerability, separation difficulty, etc., they astutely pointed out that many of these tendencies were characterological and pre-dated their experiences of loss. Causal connections between loss and subsequent pregnancy and parenthood cannot be made without considering alternate explanations for feelings and behaviors and ruling them out as competing explanations. This is important both in terms of an assessment of how truly unique in their reactions, or like other mothers, these respondents were and then in evaluating whether in fact their service needs are different from those of other mothers.

Emergent Potential Positives of the Experience of Loss

While the clinical literature on perinatal loss tends to focus on "the negatives:" pathological grief, problematic pregnancy and difficulties of parenthood, (from a social work perspective especially), it seems important to highlight the strengths and coping capacities that respondents exhibited throughout their experiences. Various coping skills were exhibited during the loss and post loss period; resilience and courage were evidenced in attempts at subsequent pregnancy. Respondents managed to cope throughout their highly stressful subsequent pregnancies and

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were negotiating parenthood, with great appreciation and love of their children and acute awareness of any potential pitfalls created by their prior histories. Experiencing and surviving the "unthinkable" seemed to foster a kind of internal strength that was not known to respondents before (Field & Marck, 1994). Many relinquished their past perfectionistic ideals, felt humbled by life's fragility, increased their capacity for empathy for others' pain and reexamined their priorities regarding family, career and what they valued in life generally.

The Present Influences the Past and The Past Lives in the Present

Finally, while respondents' experiences of having children was joyous, and provided a positive meaning to loss conveyed in the universal sentiment that had the loss not occurred, the present child would not exist, the present clearly did not obliterate the past. The women described the many ways in which the past resounded in their subsequent experiences and in the present. They demonstrated the potency with which history casts its shadow, gets interpreted through the prism of the present, ultimately remains alive and cannot be minimized nor

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diminished by others. Perhaps then, the term "grief resolution" needs to be reconsidered, since resolution implies some finite or measurable end to the experience, and a desirable goal to be reached by the griever, perhaps with the aid of therapeutic intervention. It is quite possible that perinatal loss cannot be permanently "fixed" and that efforts should not necessarily proceed towards resolution of such but rather towards greater understanding, acceptance and tolerance of its various short and long-term manifestations.

## IMPLICATIONS FOR PRACTICE

The value in studying the experiences of a group of women who have achieved biological motherhood subsequent to loss is in generating theory and understanding that can then inform those who function as caregivers to them. Those who might come into contact with such women would be represented in a variety of medical and mental health professions, and include those who come into contact with them either at the time of loss, or subsequently. Perinatal loss may be presented as the overt problem, or it may emerge spontaneously from the past in association to some other current phenomenon. Given the present context of medical

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policy, with its emphasis on rapid hospital discharge, it is more likely that the issues of perinatal loss and bereavement will not be sufficiently addressed during the very limited approved maternity hospital stay. Therefore it will be even more critical that those professionals who subsequently encounter women who have had perinatal loss (and/or their children); i.e., pediatricians, mental health professionals treating both women and children, etc., be attuned to its possible presence in their history-taking. In either case, whether it emerges immediately after the loss, or further down the road, perinatal loss will be a phenomenon to be aware of and paid attention to for both its short and longer-term implications.

On a positive note, perinatal loss has received increased recognition and attention by caregivers over the last decade. Perinatal grief is acknowledged in hospitals more than ever before and bereavement teams with protocols of care have proven to be quite useful (Herz, 1993). The practices of holding, viewing and picture-taking of the baby, and including parents in disposition arrangements are widely encouraged, changing the prior status of perinatal loss as a "nonevent." While the change in attitude toward

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pregnancy loss is to be commended, Leon (1992) warns of the importance of exercising caution when adapting grief protocols so that they meet individual needs, rather than become "ritualized" or "choreographed." Individual coping skills, and defense mechanisms employed to cope with perinatal loss must be respected. Each pregnancy loss must be viewed in its total life context; the meaning for an individual must be understood and is not to be minimized; particulars of loss must be noted as well.

As the literature documents (Herz, 1993; Peppers & Knapp, 1980) and as women repeatedly alluded to, recovery from perinatal grief is highly dependent upon the compassion and concern of caregivers. In spite of the above-mentioned increasingly sensitized practices on the part of hospital staff in regard to perinatal loss, throughout interviews, the salience of the lack of acknowledgement of pain emerged as an integral obstacle to respondents' emotional healing. Physicians and hospital staff were frequently criticized for their avoidant or unsympathetic behavior, and often abetted rather than helped ameliorate grief. Memories of insensitive treatment by medical personnel were indelibly imprinted in the minds of respondents, even one who suffered

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a loss eleven years ago and may have contributed to their emphasis on relating the story of loss during the interview. While it may be true that physicians are inadequately trained to act as counselors (Herz, 1993) (and are not expected to do so), and may struggle with their own discomforts with death, it appeared from these respondents' reporting, that all they wanted was basic empathy and acknowledgement of their experiences; beyond that they knew to seek further supports and mental health services as needed. The amount of lingering sadness and anger these women felt and demonstrated might have diminished with time, had someone simply listened to their experiences with compassion. While they wanted as much medical and technical information as possible, they reported that this was often provided to the exclusion of any consideration of their emotional states. It seemed particularly critical that where no medical explanation was available and respondents were left "haunted" by an inexplicable loss, that empathy was demonstrated both for the experience and the frustration, bewilderment and anger, at not having any explanation and consequently, nothing to rely on for the future. It appears that those women who actually have

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experienced perinatal loss are the only true experts as to what is needed the most during these experiences, and as such, should be included and consulted in devising perinatal bereavement protocols.

Caregivers need to develop and exhibit compassion and understanding for the complicated emotions of perinatal loss, subsequent pregnancy and parenthood. These are not "normative" experiences and do not simply entail the emotions expected to accompany the events of pregnancy and childbearing. Events that might appear as manifest successes, (achievement of subsequent pregnancy and motherhood) are often fraught with other fears as the present experience becomes overlaid with anxieties of past events and projected fantasies of the future (Field & Marck, 1994). Professionals must be able to balance two ambivalent sets of feelings to help the women who have experienced loss do so; empathy must be conveyed for the degree to which the experience of perinatal loss shakes up a sense of safety and certainty and challenges prior perceptions and assumptions about life.

Perhaps the treatment of perinatal loss and grief requires some shift in perspective on the part of health and

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mental health professionals. While the wish and goal for the "cure" or "resolution" of grief may be reflected in the popularity of hospitals' promoting protocols for perinatal loss, perhaps the idea that mourning will be accomplished through elaborate rituals and practices needs to be re-examined. Respondents seemed to imply that what they sought first and foremost was to be listened to, acknowledged and understood and that these simple acts might have been therapeutic in and of themselves.

It should be noted as well that the wish to heal or "fix" grief may be driven by the professional's feelings of helplessness and powerlessness in the face of death. As one respondent aptly noted, perinatal loss (and perhaps all loss ultimately), evokes to some degree, feelings of inconsolability. Therefore, while women's complaints of emotional abandonment by caregivers and others must be heard seriously and addressed, helping professionals need also to acknowledge (and be supported around) their heightened vulnerabilities to respondents' extreme sadness and anger, in order to realistically assess what they can and cannot provide.

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In regard to the subsequent pregnancy, respect must be provided for the strategy of "protective governance" exercised during subsequent pregnancy to manage the uncertainty of outcome (Field & Marck, 1994, p. 275). Field & Marck, (1994, p. 278) note that an assumption cannot be made that a woman's experience is "safe" just because it is subjectively defined as safe, i.e., she has passed certain pregnancy milestones, or has delivered a live child. Again, here is where facts; reason and personal experience diverge and these have to respected, for caregivers' assumptions do not always accurately reflect women's reality (Ibid.). While factually-based reality must be presented, personal emotional realities and ambivalent feelings must be acknowledged as well.

Caregivers (particularly those in social work or other mental health professions) can also play a role in decision-making processes following pregnancy loss, particularly decisions around the pursuit of subsequent pregnancy or regarding setting limits on continued attempts at subsequent pregnancy. Intervention is particularly warranted in the latter area, since the worlds of medicine and advanced reproductive technology tend not to set boundaries around

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reproductive attempts. The meanings of childlessness and adoption also need to be fully explored and understood to help ascertain and distinguish between the wish for motherhood and the desire for biological motherhood. It should be noted that while caregivers can attempt to appeal to cognition and a rational decision making process, often emotional need dictates and decisions will ultimately be made on the basis of such. While decisions need to be fully explored, professionals must appreciate the "disparate natures of the professional and the personal" (Field & Marck, 1994, p. 280). Support must be provided during the experience of subsequent pregnancy, with full consideration given to the emotional effects of diagnostic technologies, and the impact of past loss on feelings about the current pregnancy. In this regard, behavioral techniques of stress management might be quite helpful to mitigate pervasive feelings of anxiety.

Similarly once parenthood is achieved, complex and sometimes contradictory feelings must be appreciated. The focus should not be solely on the product, as medical professionals have the tendency to do (Holt, 1988). Glazer (1990, p. xii) noted that infertility does not necessarily

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resolve with successful pregnancy or adoption (only childlessness does); the experience is imprinted as part of identity. Likewise, respondents in this study attested to the fact that feeling successful at attaining the goal of motherhood was only one set of feelings they had. The prior experience of loss was not erased. One respondent spoke to this matter: "The experience made me appreciate more that you can still be upset even though you've just gotten exactly what you've wanted." (a subsequent child).

When encountering women who have had loss, attention needs to be paid to the early postpartum period, to assess both strengths and/or any problematic effects, such as signs of post-traumatic stress, heightened postpartum depression, or difficulties with postnatal bonding. If possible, these should be followed over time, to assess for any unfolding difficulties, or problematic sequelae that have resulted from the special circumstances of pregnancy and childbearing after loss. As a preventive measure, women awaiting parenthood subsequent to loss may be apprised of the potential tendencies documented by mothers in this study: delayed bonding, overprotection, heightened vulnerability and fear of illness, separation anxiety, etc. and helped to

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anticipate their own possible feelings, reactions and ultimately parenting behaviors. Mothers can be assisted with acceptance of ambivalent feelings around parenthood and amelioration of guilt for seeming "ungrateful" for what they have finally gotten. Additionally, they can be encouraged to consider how they will handle certain future issues that might arise, i.e., disclosing the "secret" of prior perinatal loss to their subsequent children, as respondents shared concerns about how and when they might go about doing this.

The increased availability and popularity of reproductive technologies will continue to provide more options for biological childbearing subsequent to complications and problems, such as loss. As medicine becomes more complex and sophisticated, attention will still need to be paid to the many emotional effects of perinatal technology and intervention. A more humanistic approach to pregnancy loss and its aftermath will require professionals to focus not just predominantly on biological aspects, but on the many psychological and social implications as well. As "normal" developmental processes are altered, special consideration must be given to the experiences of women who attain

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biological motherhood subsequent to loss, resulting in perhaps some unique and specialized interventions to meet their social-emotional needs.

## AREAS FOR FUTURE RESEARCH

Since the long-term effects of pregnancy loss, subsequent pregnancy and parenthood after loss are areas that have been minimally empirically explored, this research study simply represents a preliminary attempt to understand these experiences in depth, generating new concepts or constructs to inform professional practice. Clearly, further qualitative research needs to be done to continue the effort to comprehensively understand the psychological and social implications of these phenomena. Such research seems timely, given the trend toward delayed childbearing with its attendant potential complications and the advent of high-tech reproductive technologies which continue to increase the probabilities of successful biological childbearing.

While it may be useful to repeat a study such as this one to gather more information, this research sample was clearly limitied by its gender, racial, ethnic, and socioeconomic homogeneity. Future research should also attempt to address the experiences of those "voices" not heard in this study:

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1. Minority women who have achieved motherhood after loss. Since nonwhite populations have much higher perinatal mortality rates (Herz, 1993) than white populations do, their experiences would be quite noteworthy in understanding how perinatal loss is experienced, coped with and affects subsequent pregnancy and parenthood.

2. Low income and poor women who have attained motherhood subsequent to loss. It is likely that these women will not have had the access to medical care and reproductive technology that the middle-class women in this study had, and their experiences without availability of such care would be interesting and illuminating to study.

3. Culturally diverse women. The impacts of culture (and religion) on the experiences of grief, mourning (including beliefs and rituals) and coping behaviors were not elicited by this study. These would be important to understand in terms of potential effects on the "healing" process and decisions around subsequent pregnancy and parenthood.

4. The men who experience perinatal loss. Spouses were not interviewed for this project, nor were their experiences actively elicited by the researcher. Yet it seems as though

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it would be important to understand their perspectives on pregnancy loss and the ways in which the male experience differs from the female's. The impact of perinatal loss on the marital relationship was only minimally alluded to and needs to be further qualitatively explored.

5. The caregivers. Given the amount of disappointment expressed in medical and mental health professionals, it might be important to assess what would be useful to caregivers (physicians, hospital staff, mental health professionals), to enhance their capacities to provide acknowledgement and support to women during and after the time of perinatal loss. Since death induces powerful feelings of helplessness and incompetence, perhaps caregivers need to be helped to maximize their abilities to provide empathic, effective, but realistic care.

6. The "subsequent children." Perhaps down the road it would be most useful to understand any second generation effects of parental trauma through the voices of the subsequent children themselves. Information gained about the effects of an experience on a group that has not directly undergone it, might then have applications to other circumstances in which parental loss or trauma is believed

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to have residual effects on the next generation. While respondents in this study were extremely self-aware, and attuned to their potential proclivities in parenting given their past experiences, it is unknown whether this will be enough to mitigate any long term psychological or social effects on their children. Since this study began to suggest the existence of ongoing reverberations of perinatal loss, it seems worthwhile to continue to study its remnant effects, optimally longitudinally over time, to further assess the long-term implications of the experience.

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# APPENDIX A - LETTER OF INTRODUCTION

## INTRODUCTION

Thank you for taking the time to be interviewed. Before we begin, I would like to explain the purpose of this project and answer any questions you might have.

In my experience as a parent with a history of prior unsuccessful pregnancies, and in speaking with other parents, I have become aware of certain feelings and experiences that may be unique to those of us who attain parenthood for the first time after unsuccessful pregnancies. It is also my impression that some of these feelings and experiences may not be adequately addressed by the people we encounter personally and professionally during the course of subsequent pregnancy and then parenthood. It is therefore my hope that this project will increase understanding of our experiences through investigating and detailing some of the special feelings, concerns and needs we may have as a group. By telling of your experiences, it is an opportunity for you to give voice to little understood phenomena and to inform professionals who are directly involved in such situations.

Therefore, I would like to ask you questions about your previous (unsuccessful) pregnancies, subsequent pregnancy (ies) and what your experiences with your child (ren) have been like. (We can focus on one child at a time, and then perhaps you can tell me about similarities and differences between children).

Because I would like to capture the details of your experiences, I would like your permission to taperecord the interview. If the taperecorder makes you feel uncomfortable at any point, we can turn it off at your request. Neither your name, the tape nor my notes will be shared with anyone nor will I share any names you might mention. This interview will not be used in any way for diagnostic purposes, or psychological/behavioral assessment.

While I hope that you will answer each question honestly and thoughtfully, if you want to skip a question,

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stop at any time and take a break, or continue the interview on another day, we can. If you prefer, you can stop altogether and withdraw from the study. I think you will find the questions interesting and perhaps you might even find it emotionally helpful to talk about your feelings and experiences. If you like, I can provide you with a summary of the study when it is completed.

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# APPENDIX B - INTERVIEW GUIDE

## UNSUCCESSFUL PREGNANCIES

1. Describe your previous pregnancies. What were these experiences like?

2. Did your feelings about those pregnancies change over time? If so, how so?

3. How has having a child affected your feelings about your prior pregnancies? (and feelings affected your decision to have a child?)

4. Would you say you continue to experience feelings about your past pregnancies now? If so, how do they affect you, your daily life?

## SUBSEQUENT PREGNANCY: DECISION MAKING

1. How long after your last unsuccessful pregnancy did you decide to try pregnancy again?

2. Had you at any time considered not trying again, opting for adoption or childlessness instead? If so, what ultimately changed your mind?

3. Did your unsuccessful pregnancies affect your desire/motivation to have a baby? How so?

## SUBSEQUENT PREGNANCY: COURSE OF PREGNANCY

1. How did you feel when you learned you were pregnant with this child?

2. What was the pregnancy like for you? Did you experience any complications? If so, what effect did these have?

4. How did you cope with the various emotions experienced?

5 As time went on did you find yourself thinking about your prior pregnancies? If so, what were your thoughts?

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8. As your pregnancy progressed, how would you describe your relationship to your baby?

9. Did the use of reprocutive technology (sonograms, fetal monitoring or amniocentesis), affect your feelings during this pregnancy? If so, how so?

TRANSITION TO PARENTHOOD

1. Describe your labor and delivery.

2. Did you have any immediate concerns about your child? What were they?

3. Did you find yourself having any thoughts or feelings about your previous pregnancies? What were they?

4. When would you say you began to feel bonded or attached to your baby? How did you know this?

THE SUBSEQUENT CHILD

1. How do you feel about being a parent?

2. What has been most enjoyable? Most difficult?

3. Does your experience with/feelings about your prior, pregnancies continue to play a role in your family life? How has this changed over time?

4. Do you think you view parenthood/your child differently than other people you know with no history of loss? How so?

5. Comment on the overall impact of pregnancy loss on your current life.

Is there anything you would like to ask me about this interview/project?

Is there anything else you would like to tell me that I have left out that may be important to your experiences of pregnancy and parenting?

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Do you know anyone else who might be interested in being interviewed about their experiences?

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## APPENDIX C - INTERVIEW GUIDE - DEMOGRAPHIC DATA

Name of respondent

Age

# of pregnancy losses

Gestational age of each loss

Time between last loss and subsequent attempt at pregnancy

Time since last loss

# of live children

Gender

Ages of children

Work outside home?

Parttime? Fulltime?

Profession

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