AN EXPLORATION OF

THE EXPERIENCE OF SPONTANEOUS ABORTION

by

© Marion Lynne McKay

A thesis
submitted to the University of Manitoba
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ABSTRACT

Spontaneous abortion was identified as a little understood, but potentially complex life experience. The purpose of the study was: 1) to examine parental responses to the experience of spontaneous abortion and 2) to elicit from parents a description of how significant others and health care professionals responded to the spontaneous abortion. The qualitative analysis method of Grounded Theory was used in the analysis of data. Two sources of data were obtained: 1) audio taped interviews of subjects, and 2) participant observer data.

Data analysis resulted in a process theory entitled The Experience of Spontaneous Abortion. Four categories within the theory were identified: 1) Committing to the Pregnancy, 2) Experiencing the Spontaneous Abortion, 3) Putting It In Its Place and 4) Moving On. Within each category, properties, contingent variables and a time frame were identified.

The study found that parental responses to the spontaneous abortion are based on their perception of the value of the pregnancy and their perception of the magnitude of the death of the fetus. Parental responses are influenced by personal attributes, and by the responses of significant others and members of the health care system.

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TO ALLAN:

FOR EVERYTHING

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CHAPTER 1

STATEMENT OF THE PROBLEM

Introduction

A small number of children born at carefully planned intervals is the pattern of family life for many contemporary Canadian couples. Their plans are based on the prevailing belief that it is possible to exert personal control over all aspects of childbearing. This expectation is inconsistent with the realities of the reproductive process. As with any other biological process, there are no guarantees of success in childbearing. In 1985, in Manitoba, there were 17,636 births. One hundred and twenty-three of these were stillbirths. There were also 100 newborn deaths (Government of Manitoba, 1987). Added to this is the unknown number of spontaneous abortions. A further unknown number of pregnancies are electively terminated because of the results of prenatal diagnostic procedures. When one also considers the inevitable occurrence of high risk pregnancies, difficult labours, Caesarian sections, and births of children with long term health problems and disabilities, it is evident that childbearing is a more unpredictable process than is frequently portrayed.

Spontaneous abortion is the most frequent complication

of pregnancy. It results in the loss of the fetus, and the termination of the pregnancy. Even those sources that estimate that anywhere from ten percent (Pritchard, MacDonald, & Gant, 1985) to twenty percent (Borg & Lasker, 1981; Ewy & Ewy, 1984; Panuthos & Romeo, 1984) of all pregnancies end in spontaneous abortion state that the actual pregnancy loss from this complication is likely much higher. Many spontaneous abortions occur before the pregnancy is diagnosed, and many known pregnancy losses are not reported.

Extensive professional and personal experience, supported by an ongoing review of related lay and professional literature, has revealed that the bereavement of spontaneous abortion is a particularly complex life event. Those experiencing spontaneous abortion do so in the context of a culture possessing expectations and behaviours with respect to childbearing and death. Further, the psychological work associated with early pregnancy affects parental responses to spontaneous abortion. Each of these factors; cultural attitudes towards childbearing, cultural attitudes towards death, and the psychological work of early pregnancy, will be considered separately.

Childbearing

The cultural attitudes surrounding childbearing discussed in this section are those generally held by the white, middle class of the Western world. Considerable value is placed on the right to choose both the number of children to be brought into the family unit, and the timing of the birth of these children. Even the bearing of children has become a choice rather than an involuntary consequence of sexual activity. Two developments have had a significant impact on societal expectations with respect to childbearing.

1. Planned Parenthood and the Availability of Effective Contraceptive Methods

The Planned Parenthood movement has had considerable influence on society's expectations about the control of fertility. Knowledge that both mothers and babies are healthier when fertility is limited, that fewer children in the family unit enhances the family's economic status, and that the growth and development of children is enhanced by individualized parental attention have all been powerful influences on the idealization of the small nuclear family. The ideal number of children per family unit has stabilized at two (Daniels & Weingarten, 1982).

Another trend, whose impact has been felt most strongly in this decade, is that pregnancy is delayed, often until the prospective mother is in her late twenties

or even late thirties (Cohen, 1985). Pregnancies are carefully planned around other goals and aspirations of the family unit (Bombardieri, 1981; Cohen, 1985; Daniels & Weingarten, 1982). There is a strong adherence to the belief that children should be born at the time when their birth is desired; that is, when a deliberate decision has been made to conceive (Hatcher et al., 1982). Effective contraceptive methods have made it possible for couples to control both the timing and the number of children who will be born to them. Although not yet perfect, many contraceptive methods are sufficiently reliable that those using these technologies to control fertility do not anticipate unplanned pregnancies.

2. The Consumer Education and Reform Movements in Health Care and Childbirth

Consumer reform movements have arisen in reaction to the previously unquestioned authority of those in charge of the health care system to act unilaterally, both in the general health system, and with individual clients (Ruzek, 1978). Objections to the present system are based on the fact that current medical knowledge is incomplete in many areas, and that physicians often know little more than their clients about how to deal with many health problems. Reformers state that clients should not implicitly trust the health care system to act in their best interests, but actively seek out information themselves (Carver, 1984). In certain instances, they may advocate rejection of medical

intervention in favour of another approach which they believe to be more helpful. For example, abandonment of the medical model in favour of midwives as collaborators in the childbearing process is advocated by some (Barrington, 1985).

The childbirth education movement arose out of dissatisfaction with the management of pregnancy and childbirth in the late 1950s and early 1960s. At that time, expectant parents had little input into the medical care of the mother during the childbearing process. Because they lacked knowledge about the normal process of childbearing, they were forced to trust physicians to make appropriate decisions for them. Fear and helplessness were common emotions as labour approached. Many expressed feelings of grief and loss after the labour and delivery (Elkins, 1980; Feldman, 1980).

The childbirth education movement teaches expectant parents that childbearing is a human experience rather than a medical procedure (Brewer, 1983; Noble, 1983). They advocate that expectant parents have the right to participate in the birth of their children (Elkins, 1980). They encourage parents to be assertive in their relationships with health care workers, and to demand respect for their needs. They advocate reliance on the knowledge, skills, and resources of the expectant couple, and actively promote the dissemination of knowledge about

the childbearing process in order that all those who wish to take advantage of this knowledge will be able to do so.

Death

He that conceals his grief can find no remedy for it.
Turkish Proverb

Fear of death characterizes our culture. Phillipe Aries (1974, 1982) describes the transition of beliefs about death from the Middle Ages to the present in the context of the Christian faith. In the Middle Ages, death was conceptualized as an altered state of being. The dead were merely waiting for resurrection on the Day of Judgement. Since it was believed that all would be raised on the Last Day, death was viewed as a temporary separation which would eventually end. It was only as beliefs about the Resurrection changed that attitudes towards death changed as well. Christians lost their confidence that all would be raised on the Last Day. Death might result in permanent separation after all.

Fear of death thus developed despite the Christian belief that death was not the end of the individual's existence, but rather the mechanism by which one entered a new life. These dichotomous views of death; death as annihilation - death as transformation, are encountered in other religions which believe in an afterlife (Gandhi, 1971). Those who adhere to a formal faith system which

places death within the context of life and afterlife frequently have difficulty believing in this. In an increasingly secular society, many individuals must deal with death in the absence of beliefs which ascribe meaning to the event.

Choron (1964) states that the central issue of death is that it forces the individual to directly confront the meaning of life.

> Then, with apparently incontrovertible logic, the conclusion imposes itself that if after a brief sojourn on the earth man is destined to leave it forever-sometimes suddenly, and often prematurely -and simply return to dust, life does not make sense. (p. 162)

The lack of a meaningful explanation for death, and therefore for life, has resulted in avoidance of the topic altogether. Avoidance has led to a conspicuous lack of societal support for those who are bereaved, emphasis on an ideal (i.e.: brief) period of mourning, lack of permission to express grief openly, and impatience with those who cannot grieve quickly and privately, and get on with their lives (Kastenbaum, 1981).

The Psychological Work of Early Pregnancy

Early pregnancy is a psychologically complex time for both the expectant mother and father. Although the timing and intensity may vary, both parents must work through the many psychological tasks associated with this portion of

the life cycle. Two tasks are particularly affected by the termination of the pregnancy by spontaneous abortion.

The first task is acceptance of the pregnancy and baby. Ambivalence is a common response to pregnancy. The desire to be pregnant may not be concomitant with the desire for a baby. For the expectant mother, these ambivalent feelings are heightened by the physical sensations, some unpleasant, associated with early pregnancy (Hager & Owens, 1987). Ambivalence is also a response of the expectant father. Shapiro (1987) states that the expectant father's ambivalence is frequently expressed as doubts about the paternity of the expected child. These doubts are not so much related to distrust of the wife's fidelity as they are related to doubts that the father holds about his own ability to be part of the process of creating life.

Bonding to the pregnancy and the child may be possible very early in the pregnancy. For parents who have deliberately planned a conception, the bonding process may begin with discontinuation of contraception (Hager & Owens, 1987). The use of prenatal diagnostic procedures such as amniocentesis and ultrasound have also been shown to increase early bonding to the pregnancy (Kay, 1987).

Initially, expectant mothers perceive their babies as part of themselves. In the second and third trimesters, they differentiate between themselves and the child;

forming an emotional bond with the child. Less has been written about the process by which expectant fathers become attached to their expected child. It is believed that acceptance of the reality of the child is difficult as long as the pregnancy is not physically evident to the father. He may not begin to form a relationship with the child until he can feel its movements and see the physical changes in the mother (Hager & Owens, 1987).

A second psychological task of early pregnancy is the assumption of the role of mother or father. In the instance of a planned pregnancy, this process, too, may actually begin before conception as the prospective parents fantasize about their lives after the birth of the child. Parenthood brings with it a sense of continuity in life; the sense of having a future, as symbolized by the expected child as well as a past, as symbolized by one's own parents (Kay, 1987). Becoming pregnant and achieving the role of parent may be a source of self-esteem. In relationships where the role of parent is highly valued, success in achieving that role may bring increased approval from significant others.

In assuming the role of parent, both males and females must make adjustments in previously existing roles. The role of husband/wife is most changed (Hager & Owens, 1987; Kay, 1987; Shapiro, 1987). Other roles and commitments held by each parent must be adjusted to account for the

increased time demands placed upon them by the role of parent (Taubenheim & Silbernagel, 1988; Shapiro, 1987).

Summary

Spontaneous abortion is frequently an undesired outcome of pregnancy, resulting in the loss of the pregnancy and the loss of a potential child. The interplay of cultural norms surrounding childbearing and death with the psychological work of early pregnancy is complex and difficult to describe or predict. However, some general conclusions are possible.

The present trend of delaying pregnancy until the later period of female fertility creates some sense of urgency once the decision to conceive is made. More is at stake, since the time left available for childbearing is shorter. Further, the present cultural emphasis on control of fertility and the childbearing process has resulted in the labelling, whether by themselves or by others, of those who do not achieve these ideals as failures. Consumer advocacy movements in childbirth and health care have been successful in demystifying the process of childbearing and encouraging participation in this event. They have fostered the belief that one just has to mean well and do well in order to succeed. They have been less diligent in pointing out that, even with the most complete knowledge

and the most appropriate actions, pregnancies do not always turn out as planned. Control of the process does not lead to control of the outcome.

Our culture is reluctant to discuss death or interact in a supportive way with those who are bereaved. The death of a child is a particularly undesired life event (Borg & Lasker, 1981; Ewy & Ewy, 1984; Gunther, 1965; Kushner, 1981; Saylor, 1977; Schiff, 1977). Stack (1984) states that those coping with spontaneous abortion have unique problems not encountered even by those whose children have died. These problems are related to a lack of societal acknowledgement that the loss was significant (Bowers, 1985; Kay, 1987; Stack, 1984; Wall-Haas, 1985), the lack of cultural ceremonies to mark the event (Corney & Horton, 1974; Kay, 1987; Wall-Haas, 1985), and the lack of a concrete person to mourn (Kay, 1987; Stack; 1984).

Spontaneous abortion abruptly ends the psychological work of early pregnancy. Loss of the pregnancy before ambivalence has been resolved can lead to difficulties in coping with the loss (Corney & Horton, 1974; Stack, 1984). For the expectant mother who has not yet achieved a separate identity for her child, its death during early pregnancy may be perceived as much the death of part of herself as the death of another person. For the expectant father, whose attachment to the child may be slower to develop, the feelings evoked by an early pregnancy loss may

be intermingled with fears about the life and safety of his spouse.

Kay (1987) states that pregnancy loss involves, as well as the real loss of a child, status loss as the roles and associated rewards of parenthood are withdrawn. Plans must be unmade and anticipated role modifications abandoned. For the expectant mother, loss of the pregnancy can be interpreted as a failure of the self and may cause her to question her competence and ability to fulfill feminine roles (Seibel & Graves, 1980). Symbolic loss is also experienced as the connection with the generations is severed. The future dies with the death of the child (Shapiro, 1987).

There is considerable evidence to support the belief that spontaneous abortion is a difficult life event. However, there is little evidence beyond the anecdotal and case study which examines what the common elements of this experience might be. Our lack of knowledge about this common, but little acknowledged outcome of pregnancy hinders our ability to help those so bereaved.

DEFINITION

For the purpose of this study, a spontaneous abortion has been defined as the unintentional termination of a pregnancy before the 20th week of gestation.

OBJECTIVES

The objective of this study was to examine parental responses to the experience of spontaneous abortion. The study included subjects who had had a recent experience with spontaneous abortion, and subjects whose experience with spontaneous abortion happened in the more distant past. A further objective of the study was to elicit from the parents a description of how significant others and health care workers dealt with the spontaneous abortion.

The questions which guided the study were general in nature and broad in scope. By using this approach, a rich qualitative data base was generated, allowing the researcher to fully examine the experience of spontaneous abortion. Questions guiding the study were as follows:

1. How do couples who experience bereavement as a consequence of a spontaneous abortion perceive this life event?
2. Does the meaning of this experience change over time?
3. What are the emotional responses to spontaneous abortion?
4. What are the physical responses to spontaneous abortion?
5. How long did these responses affect the day to day life of the individual or couple
6. How often did they continue to recur?
7. What are the responses of significant others after the individual or couple experienced a spontaneous abortion?

8. What are the responses of health professionals after the individual or couple experienced a spontaneous abortion?

CONCEPTUAL FRAMEWORK

The conceptual framework upon which this study was based is Symbolic Interactionism (SI). SI is both a theory about human behaviour, and a method of studying human behaviour (Chenitz & Swanson, 1986). As a theory, Blumer (1969) proposed three basic principles of SI. First, people's actions are based on the meanings events, objects, etc. have for them. Second, these meanings are acquired through social interaction with others. Third, meaning, through further experience, interaction or interpretation, may be modified.

The concept of "self" is central to SI. Self is defined as "the capacity to observe, respond to, and direct one's own behavior." (Lauer & Handel, 1977, p. 66). Despite the centrality of the concept, it is not easily understood, nor is its definition and usage consistent amongst those taking an SI perspective in the analysis of human behaviour (Hewitt, 1984). However, four general characteristics of the self can be identified.

First, self is a process (Hewitt, 1984; Lauer & Handel, 1977). There exists an internal dialogue which precedes and mediates action. This dialogue takes place

between the "I" and the "me", which together comprise the self. "I" is analogous to the Freudian id (Hewitt, 1984). It consists of the impulses, beliefs and values which the individual really wants to express. "The 'I' projects organic drives into activity, it serves as the unorganised and spontaneous phase of the self..." (Rock, 1979, p. 119). Therefore, "I" is unpredictable; never accessible to direct scrutiny or expression. "Me" is the individual's understanding of what others desire him to do (Hewitt, 1984). These expectations are formulated within each relationship that the individual has with others and with organized society. An individual possesses many "me's"; one corresponding to each role enacted by the individual (Rose, 1980). Any action undertaken by the individual is a result of the internal negotiations between "I" and "me".

Recognizing self as a process enables Symbolic Interactionists to account for the fact that individuals change over time. Changes in the individual can result from changes in the "I", as the basic impulses and desires of the individual change. These changes can also result from the changes that the individual perceives in the expectations of others.

A second characteristic of the self is that it is reflexive. One can be an object to oneself (Hewitt, 1984). This enables the individual to be deliberately conscious of his own behaviour and to modify it according to the role he

is presently enacting.

A third characteristic of the self is that it is comprised of attitudes (Lauer & Handel, 1977). These attitudes enable individuals to transcend mere habitual behaviour. Many of the attitudes held by individuals are shared by others in the social milieu. It is on the basis of these shared and privately held attitudes that individuals act when confronted with novel situations.

The fourth characteristic of the self is that it is the means by which social control becomes self control (Lauer & Handel, 1977). Internalized social values become the "me" which dominates the "I'. Thus, the individual generally behaves in ways which conform to community expectations. Community expectations do not, however, remain static. They change over time. Much of this change is accounted for by the interactions between individual and collective expectations.

The assumptions of various SI theorists are as varied as their definitions of the self. However, certain themes can be identified which are consistent from one theorist to another. These are most clearly specified by Rose (1980). He sets forth five basic assumptions.

> Assumption 1: Man lives in a symbolic environment as well as a physical environment and can be "stimulated" to act by symbols as well as by physical stimuli. (Rose, 1980, p. 39)

A symbol is "...a stimulus that has a learned meaning and value..." (Rose, 1980, p. 39). Language is the

symbolic environment of humans. In this respect, they are unique from all other species (Heiss, 1981; Lauer & Handel, 1977). The ability to use language is fundamental to the development of the self. The internal negotiations between the "I" and the "me" are possible only through the use of language and the symbols which the words comprising the language convey. Further, the complex interactions between the self and others are also only possible through the use of language.

> Assumption 2: Through symbols, man has the capacity to stimulate others in ways other than those in which he is himself stimulated. (Rose, 1980, p. 40).

This is the essence of what Hewitt (1984) conceptualizes as role-taking and role-making. For example, one adult, through the use of symbols such as objects (lecture notes), positioning (taking position in the front of a classroom) and languages, assumes the role of professor. By so doing, this person confers on all other adults in the room the role of student. Heiss (1981) states that humans act in a conscious manner. Assumption of roles in response to the symbolic communication of others is not done in a ritualistic manner. The individual gives conscious consideration to the demands placed upon him. In response, he may accept, reject or modify these demands. One individual may attempt, through symbolic communication, to direct the behaviour of others, but he does not possess ultimate control over how his

communications will be evaluated and acted on by the other.

> Assumption 3: Through communication of symbols, man can learn huge numbers of meanings and values - and hence ways of acting - from other men. (Rose, 1980, p. 42).

There is universal agreement amongst Symbolic Interactionists that human development depends upon social interaction. "To be a symbolic creature and live in a symbolic environment means to function through shared meanings." (Lauer & Handel, 1977, p. 68). The process of achieving selfhood and social roles begins at birth. It is achieved by a teaching process; not merely through maturation (Heiss, 1981). The human infant is conceptualized as being capable of being socialized into any human culture (Lauer & Handel, 1977).

Symbols and meanings shared by a culture possess cross-sectional stability. Most individuals within the culture will subscribe to them. Without such stability, social life would not be possible. However, cultural meanings and values can change over time. These changes are the result of continual transactions between cultures and individuals within the culture who express meanings and values differing from the prevailing cultural norms. Stability and evolution characterize the social interaction between individuals and their cultural environment.

> Assumption 4: The symbols - and the meanings and values to which they refer - do not occur only in isolated bits, but often in clusters, sometimes large and complex. (Rose, 1980, p. 43).

One type of symbol cluster is a role. Rose (1980) refers to a role as "...a cluster of related meanings and values that guide and direct an individual's behaviour in a given social setting..." (p. 43). An individual, when, for example, taking the role of parent, is able to understand that there are many distinct behaviours required of this role. By attending to key symbols within the situation, symbol clustering enables humans to predict, order and master complex roles.

> Assumption 5: Thinking is the process by which possible symbolic solutions and other future courses of action are examined, assessed for their relative advantages and disadvantages in terms of the values of the individual, and one of them chosen for action. (Rose, 1980, p. 45).

Thinking enables humans to try out new experiences without actual trials and without actually experiencing their consequences (Lauer & Handel, 1977). As was discussed under Assumption 1, active dialogue, either within the individual, or with another individual is not possible without language. Because humans possess rich symbolic language, they are capable of considering many courses of action before deciding upon one specific course. Novel solutions to familiar and unfamiliar situations are possible.

Thinking enables humans to be purposive and rational. They act with specific goals in mind, and with the expectation that those goals will be achieved. Although humans do not always seek immediate gratification, they do,

by and large, act to seek rewards and to avoid costs (Heiss, 1981).

Summary

SI conceptualizes the behaviours of the individual as being the product of internal negotiations between the "I" and "me". These responses are influenced by the communication of symbolic meanings held by the society within which the individual lives. Both individuals and societies change over time as a consequence of continual transactions between the values and expectations held by the individual and those held by society.

Chenitz and Swanson (1986) state that SI is a particularly useful approach when the phenomenon under study is complex, and when the health care system is but one component used by the individual(s) to deal with the phenomenon. Both of these conditions hold with respect to the study of spontaneous abortion. The most fundamental and complex symbols of human existence, birth and death, are inextricably meshed in the event of spontaneous abortion. The health care system plays only a small role in enabling individuals to cope with the aftermath of this experience. Other factors are likely of equal or greater importance to parents bereaved by spontaneous abortion. The use of SI as the conceptual framework of this study

enabled the researcher to examine the roles of all significant factors in the psychosocial environment of the individual which influenced his/her ability to deal with the experience of spontaneous abortion.

CHAPTER 2

REVIEW OF THE LITERATURE

Introduction

Scope of the Literature Search

An extensive review of both professional and lay literature was conducted in the areas of childbirth education, spontaneous abortion, stillbirth, perinatal death and, to a lesser extent, neonatal death. Several factors necessitated a literature search of this scope. An initial search of the professional literature for articles specifically discussing parental responses to the experience of spontaneous abortion revealed that, beyond research into the etiology and treatment of this pregnancy outcome, very limited consideration has been given to the topic. The researcher enlarged the search to include discussions of other types of fetal and early infant death. Initially, only stillbirth was included in the enlarged literature search, but overlaps of this topic with perinatal death and neonatal death necessitated an even wider search. In addition, much of the research conducted in the past two decades on parental responses to spontaneous abortion, stillbirth and perinatal death had been based on the 1970 study by Kennell, Slyter and Klaus examining parental responses to neonatal death. An

understanding of the theoretical underpinnings of this classic study was crucial to the understanding of subsequent research into other types of fetal and early infant death.

A concurrent review of lay literature on the topic of bereavement as a consequence of fetal and early infant death revealed that both the health care system and the wider social system did not acknowledge the impact of these types of bereavement on parents. One last body of literature, that relating to childbirth preparation and education, was briefly reviewed as a further confirmation that bereavement as a consequence of fetal or early infant death is a topic given limited consideration by both lay and professional persons.

Terminology

A source of ongoing difficulty throughout the literature search and analysis was the lack of attention given by most writers to defining the terms chosen by them to specify the type of fetal or early infant death which was the focus of their article or study. In the great majority of articles reviewed by this researcher, definitions of terms such as spontaneous abortion, stillbirth, perinatal death and neonatal death were not given. In several instances, the term chosen by the author(s) was not correct with respect to the type of fetal

or early infant death included in the research or discussion. For example, Phipps (1985-86) stated that the purpose of his research was to examine the responses of parents to a pregnancy subsequent to the experience of stillbirth. Yet, the study sample included parents who had experienced a neonatal death.

Writers in both lay and professional literature experienced difficulty in finding a satisfactory term which would include more than one type of fetal or early infant death or lend itself to a more general discussion of these topics. The terms "pregnancy loss" and "childbearing loss" were most frequently used in these situations. However, these terms were never defined and were therefore open to considerable misinterpretation. In some instances, the terms used to include more than one form of fetal or early infant death were not only not defined, but inconsistent with commonly accepted definitions of the term. For example Toedter, Lasker and Alhadeff (1988) used the term "perinatal grief" to describe parental responses to fetal and early infant deaths as a result of spontaneous abortion, fetal death, neonatal death and ectopic pregnancy. The commonly accepted definition of perinatal death would not include spontaneous abortion and ectopic pregnancy.

In order to impose some order on the terminology found in the following literature review, the researcher adopted

specific strategies. First, definitions of spontaneous abortion, birth, livebirth, stillbirth, perinatal death and neonatal death were adopted by the researcher. These were generally based on those given by authoritative sources in the literature. However, it must be noted that a lack of agreement exists amongst sources which provide definitions of these terms. Definitions adopted by the researcher were as follows:

1. Spontaneous abortion

A spontaneous abortion is the unintentional expulsion from the mother of a fetus before the 20th week of gestation.

2. Birth

A birth is the complete expulsion from the mother of a fetus of 20 weeks or more gestation (Pritchard et al., 1985).

3. Livebirth

A livebirth is the complete expulsion from the mother of a fetus of 20 weeks or more gestation which shows any signs of life at or after birth, such as heartbeat, respiratory effort or spontaneous movement (Government of Manitoba, 1987; Pritchard et al., 1985).

4. Stillbirth

A stillbirth is the complete expulsion from the mother of a fetus of 20 weeks or more gestation in which no signs of life are present at or after birth (Government of

Manitoba, 1987; Pritchard et al., 1985).

5. Neonatal death

A neonatal death is the death of a liveborn infant within the first 7 days of life (Pritchard et al., 1985).

6. Perinatal death

The term perinatal death is used to include all stillbirths and all neonatal deaths (Pritchard et al., 1985).

The researcher adhered strictly to these definitions whenever possible.

A second strategy was developed to deal with confusing and conflicting terminology found in the literature reviewed. Where writers used specific terms, such as stillbirth, in describing a particular type of fetal or early infant death, this term was preserved in the analysis of the literature. Exceptions were made where it was evident that the term chosen did not correctly describe the type of fetal or early infant death discussed, but where the more accepted categorizations could be determined. In these cases, the researcher specifically stated the types of fetal and early infant deaths included in the article rather than the term chosen by the writer to describe them.

A third strategy was developed to deal with terminology developed to facilitate global discussions of bereavement as a consequence of fetal or early infant death. Where writers used the term "pregnancy loss" or

"childbearing loss" in a general sense, these terms were preserved by the researcher. However, the researcher adopted the term fetal and early infant death to describe the variety of pregnancy outcomes which result in such deaths. The researcher is conscious of the fact that this terminology is awkward. Further, it begs the issue of the stage of the embryo, which lasts for the first eight weeks of the pregnancy. Despite these shortcomings, this term was chosen as the one best able to facilitate general discussions on the topics of spontaneous abortion, stillbirth, perinatal death and neonatal death.

The literature review in this Chapter is divided into two major sections: 1) content analysis of selected lay and professional literature on the topic of fetal and early infant death and 2) critique of selected studies examining spontaneous abortion, stillbirth, perinatal death and neonatal death.

Content Analysis of Lay and Professional Literature

Childbirth Education Literature

In reviewing childbirth education literature targeted to expectant couples, the most striking finding was the lack of information given about fetal and early infant death as an undesired outcome of pregnancy. Most conspicuously absent was any discussion of the experience

of spontaneous abortion. The researcher conducted a content analysis of eleven books on the topic of pregnancy and childbirth to determine whether undesired outcomes of pregnancy, such as spontaneous abortion and stillbirth, were discussed. Most books contained only brief references to the terms chosen as representative of an undesired outcome of pregnancy (Appendix A). Discussions of these outcomes were predominately factual rather than dealing with emotional reactions.

Kushner (1979) discussed the responsibility of the childbirth educator in educating expectant parents about bereavement as consequence of fetal and early infant death. As well as suggesting additional preparation of childbirth educators in the area of bereavement, and inclusion of the topic in class content, she outlined specific roles which the childbirth educator and the members of the childbirth preparation classes might assume to support couples who experience a fetal or early infant death during the course of childbirth preparation classes. Despite the time elapsed since this article was written, in the experience of the researcher, the topic of fetal and early infant death is still generally avoided by childbirth educators.

Literature Related to Spontaneous Abortion, Stillbirth, Perinatal Death and Neonatal Death

Seven major themes were identified in the content of lay and professional literature discussing spontaneous abortion, stillbirth, perinatal death and neonatal death. Specifically, these themes were:

1) the emotional/psychological and physical/behavioural responses of a) mothers, b) fathers and c) couples

2) the duration and characteristics of the grief response

3) the characteristics of grief resolution

4) variables influencing the bereaved parent's response to and acceptance of the bereavement

5) implications for the long term physical and mental health of the mother/father

6) implications for future pregnancies, and present and future children

7) implications for long term marital relationships

1. The Emotional/Psychological and Physical/Behavioural Responses to Spontaneous Abortion, Stillbirth, Perinatal Death and Neonatal death

During content analysis of the literature, the researcher placed the responses of mothers, fathers, couples, significant others and health professionals into two categories: 1) emotional/psychological and 2) physical/behavioural. Those responses which could be visually observed or perceived as bodily sensations were placed in the physical/behavioural category. Other responses, which were more descriptive of responses of the

human psyche were placed in the emotional/psychological category.

Appendix B summarizes the parental responses to spontaneous abortion, stillbirth, perinatal death and neonatal death identified in professional literature. Maternal emotional and behavioural responses to these types of bereavement have been described in some detail. Less information is available about the responses of couples, and especially about the responses of fathers.

Bereavement as a result of spontaneous abortion, stillbirth, perinatal death or neonatal death is generally depicted as an undesirable life event. Negative emotions of varying intensity and duration are experienced. These emotions typically exist in response to the perceived loss of an expected child. However, in some instances, the emotions experienced are in response only to the physical threat to the mother posed by the process of the spontaneous abortion. Seibel and Graves (1980) state that even if a spontaneous abortion is a relief because it terminates an unwanted pregnancy, the process of the spontaneous abortion may still be upsetting and frightening.

Mothers.

Comparison of maternal emotional and psychological responses to spontaneous abortion, stillbirth, perinatal death and neonatal death demonstrates a marked similarity

of response regardless of gestational age (Appendix B). Mothers are consistently described as feeling depressed, sad, lost, angry, anxious, shocked, frustrated, hostile and disappointed. Guilt and feelings of failure, inadequacy and shame are reported across all four types of fetal and early infant death reviewed. Also consistently reported are denial, preoccupation with thoughts of the dead baby and a sense of isolation and unreality.

The behavioural and physical responses of mothers are also similar. In all cases, common behaviours include crying, blaming self, blaming others, and physical withdrawal from others. Loss of appetite, alteration in sleep patterns, restlessness, frenzied behaviour, somatic complaints, lethargy and the loss of normal activities of daily living are reported in all four types of fetal and early infant death.

One behaviour consistently reported for stillbirth, perinatal death and neonatal death is the desire of the mother to see her dead baby. This behaviour is not identified in mothers who have experienced a spontaneous abortion. Given the lack of consideration of this topic in professional literature, it is questionable whether the absence of descriptions of the desire to see the fetus after spontaneous abortion is due to the absence of the desire, or due to the systematic failure of health professionals to recognize this desire.

Fathers.

Little detailed description of emotional/psychological and physical/behavioural responses of fathers to the experience of spontaneous abortion was found in professional literature. Hutti (1984) states that there is a general lack of studies relating to the responses of fathers. Stack (1984) implies that responses similar to those of the mother may be observed in the father. Hager and Owens (1987) described responses in the father that are comparable to those of the mother. Conversely, Outerbridge et al. (1983) state that fathers are less likely to be affected by grief.

Where a description is provided in professional literature, the emotional and behavioural responses of fathers to stillbirth, perinatal death and neonatal death are similar to those of the mother (Appendix B). However, sources in the literature state that fathers grieve differently than mothers (Hutti, 1984; Wilson, Witzke, Fenton & Soule, 1985). The major distinction identified between mothers and fathers is the duration of the emotional and behavioural responses. Fathers are reported as experiencing a shorter grief response (Hager & Owens, 1987; Sahu, 1981; Saylor, 1977). The reasons for this difference have not been systematically studied. It has been suggested that the perceived need to provide psychological support to the wife (Connolly, 1982; Forrest,

Standish & Baum, 1982; Kennell et al., 1970), the perceived need to shelter the wife from difficult decisions (Outerbridge et al., 1983), the slower process of bonding to the expected child (Hager & Owens, 1987; Kay, 1987) and fears regarding the safety of their wife (Cooper, 1979; Hager & Owens, 1987) may be factors influencing the more brief emotional and behavioural responses of fathers to these forms of bereavement.

Couples.

Comparison of the emotional/psychological and physical/behavioural responses of couples to spontaneous abortion, stillbirth, perinatal death and neonatal death reveals similar responses (Appendix B). These responses are similar to those found in descriptions of the responses of mothers alone and fathers alone (Appendix B). The impact on the marital relationship receives more emphasis where the couple is used as the unit of analysis. Particular emotional and behavioural responses discussed within the context of the marital relationship include inability to discuss the topic (Jolly, 1976), increased irritability with one another (Cooper, 1979), mutual guilt and blaming (Beard et al., 1978; Bowers, 1985) physical separation during the crisis (Brady et al., 1984) and psychological separation as the result of incongruent grief responses (Kay, 1987; Outerbridge et al., 1983; Sahu, 1981; Wilson et al., 1985).

2. Duration and Characteristics of the Grief Response

There is lack of agreement about the duration of parental grief after fetal or early infant death. Many writers in the professional literature suggest, generally implicitly, that, if the grief after spontaneous abortion is normal, the time to achieve resolution should be relatively brief; ranging from "... a few days to a week ..." (Corney & Horton, 1974, p. 825) to six months (Stack, 1984) to one year (Kowalski, 1980). Scupholme (1978) states that grief resolution after stillbirth or neonatal death should be completed in 9 months. Kowalski (1980) suggests a grief response of 6 to 12 months after perinatal death.

Other writers in the professional literature speculate that the grief resulting from spontaneous abortion, stillbirth, perinatal death or neonatal death may last longer than one year (Outerbridge et al., 1983). Saylor (1977) states that even after a year, mothers who had experienced a neonatal death are significantly more depressed than mothers who had given birth to healthy infants. Such events as the anniversary of the bereavement, the anniversary of the due date of the child, subsequent pregnancies and other bereavements have been identified as causing feelings of grief many years after a stillbirth or perinatal death occurred (Kay, 1987; Kowalski, 1980; Lockwood & Lewis, 1980). Lay writers state

that the grief associated with spontaneous abortion, stillbirth, perinatal death and neonatal death is long lasting and colors much of the individual's and/or couple's remaining life (Borg & Lasker, 1981; Ewy & Ewy, 1984; Panuthos & Romeo, 1984).

Many articles reviewed stated that individuals experiencing spontaneous abortion, stillbirth, perinatal death and neonatal death could be expected to go through a series of stages over time before coming to terms with their bereavement. This was described as the grief process. The most frequently cited models were those of Lindemann (Bowers, 1985; Corney & Horton, 1974; Kennell et al., 1970; Kowalski, 1980; Stack, 1984), Parkes (Forrest et al., 1982; Kennell et al., 1970; Sahu, 1981) and Kubler-Ross (Bowers, 1985; Outerbridge et al., 1983; Wall-Haas, 1985). Consistent application of one model of grieving to one type of fetal or early infant death was not observed.

Estok and Lehman (1983) propose that the model of diminishing burden (Hallet, 1974) is a more appropriate conceptualization of the grief process after perinatal death. In this model, the responses to bereavement are conceptualized as occurring in a cyclical fashion. Waves of grief, sadness and disorganization periodically affect the bereaved person, but as time goes on, the waves occur less frequently and with less intensity. Support for this conceptualization of the grief process following fetal and

early infant death is found in other sources in the professional literature (Connolly, 1982; Kay, 1987) and lay literature (Borg & Lasker, 1981; Ewy & Ewy, 1984; Panuthos & Romeo, 1984).

There is a general lack of agreement about the grief process in all literature related to death and loss. In their analysis of relevant literature, Silver & Wortman (1980) determined that three assumptions were implicit in all models of coping with undesirable life events. They were: 1) that people respond to life crises in specific, predictable ways, 2) that people go through a series of stages over time in an attempt to come to terms with the crisis, and 3) that the crisis is accepted or resolved. After their review, Silver & Wortman (1980) concluded that there is little evidence to substantiate these assumptions. Bowers (1985), Outerbridge et al. (1983) and Kay (1987) state that rigid adherence to the stage model may not be beneficial in helping parents cope with spontaneous abortion, stillbirth, perinatal death and neonatal death because there are tremendous variations both in the range of emotions felt and the sequence in which they are experienced.

3. <u>The Characteristics of Grief Resolution</u>

Entangled in the debate with respect to the length of time required to achieve resolution of the grief process is a lack of consensus as to what actually constitutes

successful resolution. Some writers in the professional literature state that any negative feelings at a significant time distance from the event should be interpreted as incomplete grief resolution (Corney & Horton, 1974; Stack, 1984). In this conceptualization of resolution, the key variable appears to be the ability to forget that the event ever happened. Lay writers do not equate successful resolution of the grief associated with childbearing losses with the ability to forget that the event even happened. They state that occasional flooding of memories and emotions is normal and that bereaved parents do not ever forget the circumstances surrounding the bereavement (Borg & Lasker, 1981; Ewy & Ewy, 1984).

Other writers in the professional literature equate resolution with the successful integration of this tragic event into the life of the individual and family (Lockwood & Lewis, 1980). Acceptance of the reality of the bereavement is central to this conceptualization of resolution. However, final acceptance of the loss cannot be equated with beliefs that the loss was reasonable, fair or just (Wall-Haas, 1985).

Others equate resolution with the capacity to resume one's normal life patterns at an energy level that is not reduced by emotional and interpersonal stress or grief (Kowalski, 1980). Elliott and Hein (1978) identified six variables which characterize successful grief resolution

after neonatal death. These are a) the need to assign blame is diminished, b) active participation in present life and in planning for the future, c) stability of family relationships d) increase in open and sensitive communication e) the family unit is conceptualized as complete and no longer missing a member and f) the relationships the family has outside of its own members continue to grow.

4. Variables Influencing the Bereaved Parent's Response to and Acceptance of the Loss

Variables associated with the self or couple.

The death of a child, whether during later childhood or as a result of spontaneous abortion, stillbirth, perinatal death or neonatal death, is an unnatural and undesired life event. Unique stressors are imposed on survivors (Borg & Lasker, 1981; Ewy & Ewy, 1984; Gunther, 1965; Schiff, 1977). The quality of the marital relationship significantly influences parental response to the bereavement and its subsequent acceptance. Since both parents must cope with a loss of equal magnitude, there is often limited ability to support the other despite the expectation that this support should be available (Schiff, 1977). In addition, incongruent timing of episodes of grief, differing lengths of time needed to deal with the grief and different styles of coping may lead to significant stress on the relationship between the parents (Kay, 1987; Outerbridge et al., 1983). Difficulties arise

where there is an absence of open communication between the spouses (Kennell et al., 1970; LaRoche et al., 1982; Saylor, 1977). Wilson et al. (1985) specifically note that depression after perinatal death is higher in women whose husbands have been depressed and less able to be supportive.

The desire for an infant has been identified as a variable influencing the acceptance of spontaneous abortion (Bowers, 1985), perinatal death (LaRoche et al., 1982) and neonatal death (Kennell et al., 1970). Seibel and Graves (1980) found that even in a population where 72% of the subjects stated that the pregnancy was not planned, most subjects responded negatively to the subsequent spontaneous abortion. It would appear that of greater importance than whether or not the pregnancy was actually planned is the acceptance or non-acceptance of the pregnancy and its accommodation into the life plans of the parents.

The guilt associated with fetal and early infant death is variable which has a negative influence on parental grief response and grief resolution. Termination of the pregnancy before ambivalence about the existence of the child has been resolved can result in strong guilt feelings in the bereaved parents (Corney & Horton, 1974; Stack, 1984). In spontaneous abortion, guilt about not wanting the pregnancy in the first place has been identified as a variable which makes coping with this experience more

difficult. Guilt feelings also complicate the loss of desired pregnancies (Seibel & Graves, 1980). Lack of information about the reasons for the fetal or early infant death may also cause parental guilt. The guilt experienced in response to the lack of information about the cause of the spontaneous abortion has been identified as a significant negative influence on the ability of parents to accept the loss (Seibel & Graves, 1980; Swanson-Kauffman, 1986). Similar guilt responses are reported in parents who have experienced stillbirth, perinatal death and neonatal death (Hager & Owens, 1987; LaRoche et al., 1982; Sahu, 1981).

Kirkley-Best and Kellner (1982) identify the length of the pregnancy as a variable influencing the response to stillbirth. This is refuted by others (Kennell et al. 1970; Peppers & Knapp, 1980) who found no relationship between the length of the pregnancy and the responses of the bereaved parents. Stack (1984) states that there has been no systematic study of the correlation between length of the pregnancy and the subsequent grief response.

Lack of readiness for fetal and early infant death is identified as a variable influencing parental grief responses. The bereavement associated with spontaneous abortion and perinatal death is frequently sudden and unexpected, with no time for anticipatory grief work (Corney & Horton, 1974; LaRoche et al., 1982; Stack, 1984;

Wall-Haas, 1985). Fetal or early infant death may be the expectant parents' first encounter with the death of a significant person (Outerbridge et al., 1983). Therefore, they have limited experience in coping with grief.

Previous bereavement (Morris, 1976), previous pregnancy losses (Brady et al., 1984; Peppers & Knapp, 1980), and subsequent fertility problems (Peppers & Knapp, 1980) have been identified as other variables influencing parental acceptance. Kennell et al. (1970) found a significantly more intense mourning response in mothers who had experienced previous spontaneous abortions or infant deaths than in mothers who had not had these experiences.

A history of psychiatric illness has been identified as a negative factor influencing the ability of mothers to accept stillbirth (Brady et al., 1984) and perinatal death (LaRoche et al., 1982). Saylor (1977) states that the normal depression accompanying the post partum period influences the maternal depression experienced after stillbirth. In contrast, the professional literature on spontaneous abortion identifies psychiatric problems in the mother, especially those involving her femininity and her relationship with her father, as a variable which may cause spontaneous abortion (Corney & Horton, 1974; Stack, 1984).

Maternal age has been identified as a variable influencing grief response after pregnancy loss (Saylor, 1977). Clarke (1979), in a followup study of women who had

experienced perinatal death, found that younger women were more depressed than older women. Toedter et al. (1988), noting that older women had less time available to achieve another pregnancy, hypothesized that, following spontaneous abortion, ectopic pregnancy, fetal death or neonatal death, older women would be more depressed than younger women. No significant correlation between maternal age and grief response was discovered. The lack of correlation between maternal age and grief has also been noted by others (LaRoche et al., 1982; LaRoche et al., 1984).

The presence and subsequent birth of other children has been identified as another variable which influences parental responses to fetal and early infant death. Becoming pregnant again within six months of the fetal or early infant death has been identified as a factor which inhibits the mourning response to stillbirth (Kirkley-Best & Kellner, 1982) and perinatal death (LaRoche et al., 1982; Rowe et al., 1978). The presence of a surviving twin has been cited as a factor complicating maternal grief responses to stillbirth or neonatal death (Laroche et al., 1982; Rowe et al., 1978). The presence of living children has also been suggested as a variable influencing parental responses to fetal and early infant death, but little consensus exists on whether the effect is generally positive, or generally negative (Kennell et al., 1970; Rowe et al., 1978; LaRoche et al., 1982).

Finally, religious beliefs of the mother have been identified as a variable influencing her response to stillbirth (Saylor, 1977). Toedter et al. (1988) hypothesized that possessing religious beliefs would result in a less intense grief response after spontaneous abortion, fetal death, neonatal death and ectopic pregnancy. No significant correlation was found between these two variables. Further, no explanation as to how religious beliefs would influence grief responses was suggested by these or any other sources reviewed.

Variables associated with significant others and health care professionals.

Support from significant others has been identified as an important variable influencing parental responses to spontaneous abortion, stillbirth, perinatal death and neonatal death. The behaviours of significant others, as identified by writers in the professional literature is summarized in Appendix C. Most reported behaviours are non-supportive, directed to minimizing the loss and urging parents to forget the experience. Where significant others have had a similar life experience, supportive behaviours are more likely (Hager & Owens, 1987). Membership in a support group has been identified as a positive influence on parental acceptance of perinatal death (Sahu, 1981).

Bereavement as the result of spontaneous abortion, stillbirth, perinatal death and neonatal death is

frequently unacknowledged by significant others (Cohen, Zilkha, Middleton & O'Donnohue, 1978; Knapp & Peppers, 1979; Outerbridge et al., 1983). Significant others rarely understand the attachment which had already developed between the expected child and its parents (McIntosh & Eldridge, 1984; Stack, 1984). Beliefs that attachment is directly proportional to the length of the pregnancy influences the ability of others to understand the magnitude, for the parents, of fetal deaths such as spontaneous abortion and stillbirth (Lovell, 1983). Because significant others frequently do not understand the experience of fetal or early infant death, the bereaved parents are denied permission to openly mourn their loss (Beard et al., 1978; Brady et al., 1984; Cohen et al., 1978; Kirkley-Best & Kellner, 1982; Knapp & Peppers, 1979; Lovell, 1983; Morris, 1978).

Behaviours of health professionals dealing with parents who have experienced a spontaneous abortion, stillbirth, perinatal death or neonatal death is summarized in Appendix D. The aloof professional manner sometimes adopted by health care workers dealing with bereaved parents is identified as a variable having a negative impact on parental grief responses (Carr & Knupp, 1985; Forrest et al., 1982; Knapp & Peppers, 1979; Speck, 1978). The withdrawal of even routine postpartum care by staff is frequent, leading to isolation of the bereaved parents

(Beckey, Price, Okerson & Riley, 1985; Estok & Lehman, 1983; Kellner, Donnelly & Gould, 1984; Lovell, 1983). Health professionals also negatively influence parental responses to the bereavement by denying the significance of the event (Estok & Lehman, 1983; Wall-Haas, 1985), by responding to parental anger and grief with hostility (Estok & Lehman, 1983) and by forgetting that the bereavement occurred (Benfield, Leib & Vollman, 1978; Kirkley-Best & Kellner, 1982; Lewis, 1976).

Variables associated with the social system and health care system.

The culture of which the parents are a part has a powerful influence on their response to fetal and early infant death (Saylor, 1977). Few cultural conventions exist which provide guidance for appropriate social responses after these types of bereavement. Kennell et al. (1970) state that the ceremonies and customs surrounding death are designed to meet cultural as well as individual needs. Where the needs of the culture are incongruent with individual needs, cultural needs prevail. In contemporary Western culture, most social responses to fetal or early infant death are directed to the need to remove all evidence of the existence of the child rather than to affirm the life and loss of the child.

Bereavement by stillbirth is identified as a particularly stressful life event. The juxtaposition of

birth and death makes stillbirth difficult to comprehend and accept (Kirkley-Best & Kellner, 1982; Speck, 1978). Ceremonies to mark the event and marked graves are infrequent (Jolly, 1976; Lewis & Page, 1978).

Bereavement as a result of spontaneous abortion is even more ambiguous. The short duration of the pregnancy makes it even less likely that society will acknowledge the bereavement (Corney & Horton, 1974; Stack, 1984). Burials and funeral rites for infants spontaneously aborted in early pregnancy are rare (Corney & Horton, 1974; Lovell, 1983; Stack, 1984; Wall-Haas, 1985).

Legal and medical controversies surrounding definitions of birth and death are an additional source of difficulty for those bereaved by spontaneous abortion (Kay, 1987; Lovell, 1983). Expulsion of the fetus before the twentieth week of gestation is not considered to be a birth. No registration of this pregnancy outcome is undertaken. In the absence of birth, was there a death? Kay (1987) describes the experience of spontaneous abortion as a non-real non-event involving the non-death of a non-person.

Some practices adopted by the health care system at the time of fetal or early infant death are identified as having a negative impact on the subsequent ability of parents to deal with and accept the bereavement. The use of anaesthesia or sedation during or after the delivery has

been identified as a variable which contributes to the sense of unreality and to subsequent difficulties with acceptance (Connolly, 1982; Hildebrand & Schreiner, 1980; Kowalski, 1980). Isolation of the bereaved parents through the use of regulations controlling the number and type of visitors in the hospital is identified as a factor contributing to difficulties in dealing with the bereavement (Seibel & Graves, 1980). Placement of the mother on inappropriate wards after delivery is identified as another variable influencing parental response to spontaneous abortion, stillbirth, perinatal death and neonatal death (Kellner, Donnelly & Gould, 1984; Outerbridge et al., 1983). Another practice having a negative influence on parental responses to the pregnancy loss is the prompt removal of the body of the baby (Editor, British Medical Journal, 1977; Kowalski, 1980). Finally, mothers who have experienced spontaneous abortion, stillbirth, perinatal death or neonatal death are frequently discharged early from hospital without consideration of whether this practice is of benefit to them (Kellner et al., 1984; Lewis, 1976).

Hospital based programmes planned to acknowledge the existence of the baby and to provide tangible memories for the parents are an important factor in subsequent parental acceptance of the fetal or early infant death (Connolly, 1982; Lovell, 1983). In the instance of stillbirth,

perinatal death and neonatal death, seeing and, if possible, holding the baby, is widely identified as an important factor aiding parental acceptance (Elliott & Hein, 1978; Hildebrand & Schreiner, 1980, Kennell et al., 1970; Kirkley-Best & Kellner, 1982; LaRoche et al., 1982). Keepsake programmes where parents are given tangible mementos of the deceased child such as pictures, locks of hair, blankets and clothing in which the child had been dressed, and the baby's name bands, have been adopted by some hospitals (Beckey et al., 1985; Carr & Knupp, 1985; Connolly, 1982). Naming the infant, helping to prepare the infant for burial, having a burial service and a marked grave are also widely suggested as measures which may assist the parents to accept the fetal or early infant death (Brady et al., 1984; Hildebrand & Schreiner, 1980; Lewis, 1976; Sahu, 1981). After stillbirth, perinatal death or neonatal death, the provision of autopsy reports is widely identified as a measure which reduces parental guilt and enhances grief resolution (Bluglass, 1982; Cohen et al., 1978; Kellner et al., 1984; Kirkley-Best & Kellner, 1982). Few sources in the professional literature suggest programmes to create tangible memories for parents who experience spontaneous abortion. Kay (1987) states that the limited potential for creating concrete memories of is the crucial distinction between early and late pregnancy loss. Hildebrand and Schreiner (1980) assert that parents

cannot be shown macerated infants or spontaneously aborted fetuses. In contrast, Hager and Owens (1987) state that, in the instance of spontaneous abortion, parents should be able to see the aborted fetus. Provision of autopsy reports to parents who have experienced spontaneous abortion is not discussed in professional literature.

The institution of an ongoing counselling programme lasting several months is also identified as an important intervention assisting parents in the aftermath of spontaneous abortion, stillbirth, perinatal death and neonatal death (Bowers, 1985; Connolly, 1982; Hager & Owens, 1987; Kirkley-Best & Kellner, 1982; Rowe et al., 1978; Seibel & Graves, 1980). Provision of information about the grief response (Elliott & Hein, 1978) and variations in this response between individuals is important. Open and honest communication between health care workers and the parents forms the basis for this intervention (Elliott & Hein, 1978).

5. Implications for the Longterm Physical and Mental Health of the Parents

The normal grief response after spontaneous abortion, stillbirth, perinatal death and neonatal death has been previously discussed. Despite the controversy about the length of time required to resolve the grief or the actual attributes of successful resolution, there is general agreement that the normal grief response is a time limited phenomenon. There is evidence, however, that the

experience of fetal or early infant death may have long term implications for the future physical and mental health of the parents.

The experience of spontaneous abortion, stillbirth, perinatal death or neonatal death is frequently associated with damages in self esteem and self confidence (Borg & Lasker, 1981; Phipps, 1985-86). These changes may be long lasting and affect the individual's ability to take on similar tasks in the future. Shadow grief, which persists for many years after the event, is also described as a longterm consequence of these types of bereavement (Kay, 1987; Kennell et al., 1970). Although the individual, at most times, is able to engage actively and fully in life, certain events such as anniversaries and chance reminders of the bereavement create transient flooding of grief. While sources in the professional literature discuss only these negative long term consequences, the lay literature places considerable emphasis on the transformation of the individual who has actively engaged in resolving the grief associated with fetal and early infant death. They depict the work of grief resolution as an opportunity for personal growth and enriched interpersonal relationships (Borg & Lasker, 1981; Ewy & Ewy, 1984; Panuthos & Romeo, 1984).

For those parents unable or unwilling to endure the difficult task of grief resolution, serious negative consequences exist (Kowalski, 1980). These have been

identified in professional literature as pathological grief and are generally divided into three categories of responses: a) abnormal grief, b) absent grief, and c) Post Traumatic Stress Disorder (Kay, 1987). The first two categories are based on the original typology of pathological grief identified by Lindemann.

Abnormal grief response is marked by severe, prolonged depression (Kay, 1987; Kowalski, 1980; Lewis & Page, 1978; Stack, 1984). Symptoms of depression include: significant changes in appetite and weight (Kay, 1987), sleep disturbances (Corney & Horton, 1974; Kay, 1987), psychomotor agitation or retardation (Corney & Horton, 1974; Kay, 1987; Kowalski, 1980), decreased interest in activities of daily life leading to isolation from others (Corney & Horton, 1974; Elliott & Hein, 1978; Kay, 1987; Kowalski, 1980), fatigue (Kay, 1987), diminished self esteem (Kay, 1987), inability to concentrate (Kay, 1987) and recurrent thoughts of death and suicide and/or actions detrimental to the safety of self and others (Kay, 1987; Kowalski, 1980). Other behaviours indicative of abnormal grief are excessive guilt (Kay, 1987), excessive anger and hostility directed against others (Corney & Horton, 1974; Elliott & Hein, 1978; Kay, 1987; Kowalski, 1980), continual preoccupation with the deceased person (Kay, 1987; Stack, 1984), excessive irritability (Corney & Horton, 1974), anxiety attacks (Stack, 1984), the development of phobias

(McCraw, 1988; Stack, 1984) and psychosis (Lewis & Page, 1978; Stack, 1984).

Absent or delayed grief is a more unusual, but serious pathological grief response. Rather than being locked into the depression and other behaviours associated with abnormal grief, those experiencing absent grief suppress all emotions resulting from the bereavement (Kay; 1987; Kowalski, 1980; Scupholme, 1978). Subtle indications of absent grief may be apparent to the astute observer. These include excessive cheerfulness (Elliott & Hein, 1978; Kay, 1987), excessive pride in the ability to carry on apparently unimpeded by the tragedy (Estok & Lehman, 1983; Kay, 1987), excessive irritability (Kay, 1987) and the development of somatic complaints and psychosomatic illnesses (Kay, 1987; Kowalski, 1980). Stack (1984) states that rushing into another pregnancy may be indicative of absent or delayed grief response. Two case studies, one involving spontaneous abortion (Corney & Horton, 1974) and one involving stillbirth (Lewis & Page, 1978), described the difficulties encountered in subsequent pregnancies when the parents failed to appropriately grieve after a fetal death.

Kay (1987) identified Post Traumatic Stress Disorder (PTSD) as another form of pathological grief following spontaneous abortion, stillbirth, perinatal death or neonatal death. The nine manifestations of this response

are: a) repetitive, unwanted dreams and memories of the event, b) sudden sense of re-enactment of the event, c) diminished response to outside world, d) detachment from others, e) hypervigilance, f) sleep disturbances, g) survivor's guilt, h) difficulties in concentration and forgetfulness and i) increase in symptoms when confronted with a similar situation.

Considerable overlap exists between descriptions of pathological grief found in the literature. It is evident that pathological grief responses vary greatly from one individual to another. In addition, individual pathological grief responses are rarely entirely congruent with any one typology developed to date.

6. Implications for Future Pregnancies and Present and Future Children

Pregnancies subsequent to spontaneous abortion, stillbirth, perinatal death or neonatal death are depicted as a time of heightened stress and anxiety for the expectant parents. Phipps (1985-86) conducted a qualitative study of fifteen expectant couples who had experienced a previous stillbirth or neonatal death. The study identified the tendency of these parents to approach the pregnancy in a task oriented manner, and a state of hypervigilance on the part of the expectant parents. Phipps (1985-86) concluded that the developmental tasks associated with normal pregnancy do not apply well to pregnancies subsequent to stillbirth and neonatal death.

> The previous experience that these couples have in common sets them apart in their response to the developmental challenges of pregnancy, and necessitates a reconceptualization of the processes and demands of adaptation to pregnancy under these circumstances (Phipps, 1985-86, p. 256).

Considerable anecdotal support for these findings is found in the lay and professional literature (Beard et al., 1978; Borg & Lasker, 1981; Ewy & Ewy, 1984; Kirkley-Best & Kellner, 1982; Kowalski, 1980; Panuthos & Romeo, 1984; Ross, 1976).

The professional literature on spontaneous abortion identifies another implication for future pregnancies. Stack (1984) reports anecdotal evidence that the incidence of spontaneous abortion is higher in women who have already had a spontaneous abortion in the previous six months. He implies that the etiology of this subsequent spontaneous abortion may be psychogenic and related to the fact the woman has not yet resolved the grief associated with the loss of the previous pregnancy. Corney and Horton (1974) and Seibel and Graves (1980) also support the suggestion that psychological factors such as unresolved grief may be involved in the etiology of spontaneous abortion. No systematic studies are available which confirm these clinical observations.

Altered parenting practices after spontaneous abortion, stillbirth, perinatal death and neonatal death have also been identified in professional literature. Of

major concern is the phenomena of the vulnerable or replacement child (Beard et al., 1978; Estok & Lehman, 1983; Hildebrand & Schreiner, 1980; Jolly, 1976; Kirkley-Best & Kellner, 1982; Kowalski, 1980; Lewis & Page, 1978; Ross, 1976). Bereaved parents may rush into another pregnancy in the hope of resolving their grief by substituting another pregnancy or child for the one they have lost. Idealization of a fantasy child sets up standards of behaviour and achievement that the replacement child can never hope to attain. Previously born children may also experience considerable difficulty as they suffer in parental comparison to the lost fantasy child.

Overprotective parenting of previously born and subsequent children is identified as another type of altered parenting behaviour (Beard et al., 1978; Forrest et al., 1982; Ross, 1976). A third pattern of altered parenting discussed in the literature is the psychological and physical neglect of existing and subsequent children (Beard et al., 1978; Corney & Horton, 1974; Lewis & Page, 1978).

Although altered parenting practices after pregnancy loss are widely discussed in the professional literature, little evidence beyond the anecdotal was found. No quantitative studies have been conducted which specify the incidence, duration or characteristics of the replacement child syndrome. One qualitative study (Phipps, 1985-86)

described the early responses of fifteen couples to the healthy infant born subsequent to a stillbirth or neonatal death. Delay of attachment for a few days after the birth, overprotective behaviours and renewed feelings of grief for the deceased child were reported by the parents. However, in fourteen of the fifteen couples, these responses were transient, and did not interfere with the long term relationship with the infant. Further, many parents in this study reported that their previous experience of stillbirth or neonatal death enhanced their ability to parent. They reported themselves as being less likely to resent the many repetitive and tiring tasks associated with infant care and more likely to appreciate the joys associated with child raising. Phipps (1985-86) concluded that although parents who have experienced a previous stillbirth or neonatal death may be more vulnerable to altered parenting practices, understanding on the part of practitioners of their unique developmental tasks in pregnancy and early parenthood, and simple interventions such as psychological support may be all that is necessary to enable them to parent effectively.

7. Implications for Long Term Marital Relationships

There is no doubt that the bereavement associated with spontaneous abortion, stillbirth, perinatal death and neonatal death has a direct impact on the relationship between the bereaved mother and father. However, an

examination of professional literature reveals conflicting opinions as whether the impact is generally positive or negative. Seibel and Graves (1980) and Wall-Haas (1985) state that while spontaneous abortion creates the potential for sexual and marital discord, this life experience can also draw a couple closer together. This observation is also made by lay writers (Borg & Lasker, 1981; Ewy & Ewy, 1984; Panuthos & Romeo, 1980) when discussing all forms of fetal and early infant death.

Kennell et al. (1970) and Kay (1987) state that the bereavement associated with spontaneous abortion, stillbirth, perinatal death and neonatal death imposes significant stress on the marital relationship and disrupts the normal patterns of behaviour between the spouses. Forrest et al. (1982) conducted a study of a support and counselling programme for parents who had experienced a neonatal death. When interviewed six months after the death of the infant, half of the women in the study reported that the death had resulted in a closer marital relationship. The other half reported that the bereavement had had a negative impact on the marital relationship. Kowalski (1980) cites studies which concluded that the incidence of separation and divorce after perinatal death is significantly higher than the national (American) average. Hildebrand and Schreiner (1980) state that divorce is a frequent consequence of couples who experience

pathological grief after a perinatal death.

Sahu (1981) states that if the bereaved couples can maintain open communication after perinatal death, the marital relationship may become closer. In a study conducted by Wilson et al. (1985), 82 percent of mothers and 67 percent of fathers reported that the experience of perinatal death had affected their marriage. Of this group, over 90 percent reported that the marital relationship had been strengthened.

Summary

Content analysis of lay and professional literature has revealed many interesting and often conflicting descriptions of the experience of fetal or early infant death. Perhaps this is not surprising when one considers the complexity of the topic under consideration. The range of human responses to this kind of crisis, both at an individual and at a societal level, is so varied that it may well not be possible for one researcher or observer to succinctly and thoroughly describe the experience.

Descriptions of the emotional/psychological and physical/behavioural responses of the mother are frequently the focus of articles surveyed. Less fully described are these same responses in couples, and particularly in fathers. Comparison of the emotional/psychological and physical/behavioural responses of mothers, fathers and

couples reveals that the responses are remarkably similar, and consistent across all types of fetal and early infant death surveyed. Of all forms of bereavement associated with fetal and early infant death, the experience of spontaneous abortion is the least studied and the least understood.

Little effort has been directed to eliciting from those experiencing spontaneous abortion their explanations as to why they responded as they did, or their assessment of the impact of the experience, both in intensity, and in length of time to resolution. No longitudinal studies were found which fully described the resolution of emotional and physical responses. No researchers systematically elicited the parent's perceptions of the responses of significant others and health professionals to the spontaneous abortion.

There is little agreement in the lay and professional literature about the characteristics and duration of the grief response. Comparison of descriptions of "normal" and "pathological" grief responses obtained from professional literature reveal a considerable overlap in the variables associated with these two types of grief. Since the length of time required to resolve normal grief is not certain, and since pathological grief is frequently defined as responses such as depression and guilt which persist past the expected time for grief resolution, it is readily

apparent that little meaningful understanding of the grief associated with fetal and early infant death has been achieved to date.

Considerable effort has been made to identify variables which might positively and negatively influence the parental response to and acceptance of their bereavement. Once more, considerable conflict exists about the impact of many identified variables. This is testimony both to the wide range of possible human responses and the, as yet, limited ability of researchers in this area to attain a comprehensive understanding of these types of bereavement. Research efforts directed to description of these experiences will be given further consideration in the second section of Chapter 2.

The impact of these types of bereavement on the long term physical and mental health of the mother and father, on future pregnancies, on present and future children, and on the marital relationship has also received considerable attention. However, no research, either qualitative or quantitative, on these topics was found during the literature search. Observations from clinical practice and case studies are presently available and provide some insights into these three areas of concern. However, a more complete understanding can only be attained through systematic analysis of these topics.

Critique of Relevant Studies

Studies Examining Several Types of Fetal and Early Infant Deaths

Kennell et al. (1970) conducted one of the earliest studies of maternal responses to early infant death. Both the questionnaire developed by these researchers and the findings of this study have been used in subsequent research on all forms of bereavement associated with fetal and early infant death. The objectives of this study were a) to determine whether early physical contact between an infant and mother leads to "... unduly upsetting reactions after the baby's death ..." (Kennell et al., 1970, p. 344), b) to investigate factors which facilitate bonds between the mother and infant and c) to systematically observe parental responses to the death of a newborn infant. A convenience sample consisting of 20 of 21 mothers whose infants had died in a neonatal intensive care unit (NICU) was obtained. During the course of the one year study, access to the babies in the NICU was arranged in alternating three month blocks. Mothers were either able to have tactile contact with their infants from the time of birth, or were restricted to seeing the babies from behind glass windows for the first twenty days of the infant's lives. Assignment to the contact or no contact group was therefore based strictly on the time period when the infant was born.

Tape recorded interviews with the mothers were conducted three to twenty-two weeks after the death of the infant. Two raters then listened to these tapes and rated the mothers on a scale from 0 to 4 on six key signs of mourning: a) sadness, b) loss of appetite, c) inability to sleep, d) increased irritability, e) preoccupation with the lost infant and f) inability to resume normal activities. The lowest possible Mourning Score, indicating that there was never a problem was 0 and the highest possible score, indicating that each item was a major problem, was 24. Eighteen of the 20 mothers interviewed were scored using this system. The two scores obtained for each subject were averaged. The resulting Mourning Scores ranged from three to twenty-three.

The 9 subjects with the lowest scores were assigned to the Low Mourning group and the other 9 subjects were assigned to the High Mourning group. Associations were then sought between these two groups and variables which might influence the mourning response. Significant findings were as follows (p. 346-347):

a) high mourning is associated with previous pregnancy loss ($p<0.05$)

b) high mourning is associated with positive feelings about the pregnancy ($p<0.05$)

c) high mourning is weakly associated with tactile contact with the infant before its death ($p<0.1$)

d) high mourning is weakly associated with communication failure between the mother and her husband ($p<0.1$)
e) no association was identified between mourning score and length of the baby's life, the expectations that the baby would live, or the number of living children in the family.

Kennell et al. (1970) concluded that all mothers mourned the loss of their newborn infant, and that the mourning response observed was similar to that observed after the death of a close family member. Factors such as marital communication, desire for the baby and tactile contact with the baby before its death might result in a more intense mourning response.

One problem with this study is the use of a rating tool based on the work of Lindemann and Parkes. Lindemann's study of acute grief was conducted using those who had lost adult significant others as the study subjects. Parkes described abnormal grief reactions observed in individuals after the death of an adult significant other. By using these models of grief, this study assumed that parental responses to the death of a newborn infant would be the same as the same as their responses to the death of an adult (Hutti, 1984). Preliminary qualitative studies to verify this assumption would have aided the development of the Mourning Scale used in the study.

The small convenience sample upon which the findings

of the study are based makes the findings of this study difficult to generalize. Particularly, the range of scores designating High Mourning and Low Mourning cannot be extrapolated beyond the subjects included in this study.

Two of the conclusions of this study would appear to be in conflict. First, noting that High Mourning is not equivalent to pathological mourning as identified by Parkes, the authors concluded that tactile contact with the infant before death should not be discouraged even though mothers in this study who had had such contact responded with higher Mourning Scores. The authors stated that "The experience of viewing and touching her newborn infant is not a specific cause of a mother's mourning, because she will have a grief reaction without this ..." (p. 348). In contrast, the finding that High Mourning is associated with poor marital communication led the authors to recommend that mothers be helped to discuss the feelings associated with their bereavement with their spouses. It is difficult to accept that, on the one hand, tactile contact can be tolerated and even encouraged and on the other, poor marital communication should be discouraged when both variables have been positively associated with High Mourning Scores. It would appear that the authors' desire to produce data supporting tactile contact with very ill newborn infants was a factor influencing the interpretation of the results of this study.

Peppers and Knapp (1980) conducted a study to determine whether there are differences in maternal responses to three different types of childbearing loss: a) spontaneous abortion, b) stillbirth and c) neonatal death. Noting that Kennell et al. (1970) had found no association between the length of an infant's life and the subsequent grief response of the mother, and that little research had been done on childbearing losses other than neonatal death, they hypothesized that "... there will be no significant differences in the psychophysiologic responses of mothers regardless of the point in the perinatal period at which the fetus or infant died." (Peppers & Knapp, 1980, p. 156). The independent variable in this study was Involuntary Fetal/Infant Death (IFID), which was defined as a miscarriage, stillbirth or neonatal death. The dependent variable was maternal grief response. This was defined as ". . .a mother's highly variable emotional, physical and social response to the involuntary loss of her fetus or infant." (Peppers & Knapp, 1980, p. 156).

The scale developed to measure the maternal grief response was an expansion of the scale developed by Kennell et al. (1970) and included the following items: a) sadness, b) decreased appetite, c) inability to sleep, d) increased irritability, e) preoccupation with the deceased infant, f) inability to resume normal activities of daily living, g) inability to concentrate, h) anger, i) guilt, j) failure to

accept reality, k) time confusion, l) exhaustion, m) decreased strength, n) depression and o) repetitive dreams of the lost child. For each item, a range of scores from 1 (no problem) to 9 (extreme difficulty) was given. The authors state that the minimum and maximum scores on this scale were 16 and 144 respectively. Since these scores would be based on a set of 16 variables, and only 15 were listed in the article, it would appear that one scale item was omitted from the published study.

A convenience sample of 65 women who had experienced IFID participated in the study. The mean age of the subjects at the time of the study was 34 years. The mean age at the time of the IFID was 25 years. Time lapse from the time of the IFID ranged from 6 months to 36 years, with a mean time lapse of 8.1 years and a median time lapse of 5.9 years. All subjects were white females. All socioeconomic classes were represented.

Each subject completed a self administered questionnaire which was divided into three parts: a) demographic information, b) an obstetrical history and a history of the loss reported for this study and c) the grief scale. Subjects were asked to rate their responses on the grief scale at the time of the loss and at the time that the questionnaire was completed. Subjects were assigned to three groups based on the type of IFID they had experienced. No information was given as to how many

subjects were assigned to each category of loss. Mean grief scores were obtained for each type of loss. Analysis of variance on the three groups supported the hypothesis that there would be no difference in the grief response between the three types of loss.

Two way analysis of variance was conducted to test for interactions between the mean grief scores and other variables obtained from the first two parts of the self administered questionnaire. These variables were not specifified by the authors. No statistically significant interactions were found. Two interactions approached statistical significance. Where subsequent children had been born, subjects reported a less intense grief reaction. A history of difficult pregnancies was noted to result in a more intense grief response.

Confidence in the results of this study is limited by two threats to validity. The first is construct validity. The researchers chose to base their work on that done by Kennell et al. (1970) and included all of their scale items in their grief scale. To these 6 items, they added 10 of their own. All items sought information about negative responses to the IFID. No scale items reflecting positive feelings or ambivalence as a response to IFID were included. Thus, this study assumes, as does that of Kennell et al., that all emotional and behavioural responses to IFID are negative in nature. A qualitative

study eliciting a range of responses to the experience of IFID would have aided the development of items for the grief scale.

One threat to external validity also exists. There is a considerable variation in the time elapsed between the experience of IFID and the completion of the questionnaire. The ability of subject to remember events which occurred, on average, 8.1 years ago would affect the grief scores obtained by the researchers. Life experiences subsequent to the IFID might also affect reported grief scores.

Peppers and Knapp (1980) concluded that this study empirically demonstrated that maternal grief responses are similar in all forms of Involuntary Fetal/Infant Death. However, they also pointed out that many questions about grief responses after IFID remained unanswered. In particular, they noted that, although the mean grief score for each of the 3 types of IFID is the same, ". . it is quite possible that each woman arrived at her grief score by a different route ..." (Peppers & Knapp, 1980, p. 158). For example, mothers experiencing spontaneous abortion might have high guilt scores, whereas mothers experiencing the death of a neonate might have high scores on the scale item about repetitive dreams. They also posed many other significant questions about grief responses which would require further research: a) why the differences in length of grief response, b) what is the impact of previous

fertility/infertility, c) what is the impact of the hospital environment, d) what is the impact of the social environment, e) what is the impact of the responses of the husband and significant others and f) what variables are important in considering future pregnancies. In identifying these research questions, Peppers and Knapp made a significant contribution to future research in the area of fetal and early infant death.

Harris (1984) conducted a qualitative analysis of 9 cases of dysfunctional grieving following spontaneous abortion, stillbirth, infant death or the birth of a severely premature and handicapped child. All cases were obtained from her own private nursing practice. The cases included 4 couples and 5 individual mothers. The diagnosis of dysfunctional grieving was made a priori by the researcher. The criteria used to make this diagnosis was not specified in the article reviewed.

Three questions guided the data analysis. The first question asked what characteristics defined the diagnosis of dysfunctional grieving related to childbearing loss. Five characteristics were identified. The first was normalacy facade. Those experiencing dysfunctional grieving reported an internal tug of war between the conflicting need to behave in a normal manner and need to vent grief by behaving irrationally. A second characteristic of dysfunctional grief was role distress,

particularly in the areas of procreation and parenting. A third characteristic was repression of joy or humour. A fourth characteristic of dysfunctional grieving was attributional guilt. Attributional guilt was directed at self or at others. Harris (1984) states that attributional guilt is a strategy directed to imposing order and reason on a situation which has temporarily suspended the individual's sense of reason and control. Thus, attributional guilt is a coping mechanism. "Yet, little do we, the professionals, know about the role such guilt plays in resolving loss experiences." (Harris, 1984, p. 412). The final characteristic of dysfunctional grieving is phantom baby experiences. Harris (1984) notes that this phenomenon is not discussed in the literature on childbearing losses.

A second question guiding data analysis was directed to the identification of assessment and intervention strategies used in a specialty nursing practice to promote resolution of dysfunctional grief. Three assessment strategies were identified. These were: a) grief behaviour paradox, b) mental imagery and c) diminutive therapeutic effect. The method of implementation of all three strategies was described. Nine intervention strategies were identified and described. These were: a) dream baby identification, b) communication mapping, c) role playing, d) therapeutic use of humour, e) cultural and behavioural

sensitivity, f) emotional time out, g) building self-esteem, h) nurse authenticity and i) group self-help.

The final question guiding data analysis sought to identify similarities and differences between the findings of this study and findings obtained by a review of the literature. Four areas of contrast between what was found in this study and what is found in the literature were identified. In contrast with the emphasis which most literature places on the nurse's role during the hospitalization of women experiencing pregnancy loss, this study indicated that most people are in need of counselling some time after discharge from hospital. While most articles discuss the importance of absolving guilt, this study found that guilt absolution was not necessary for the resolution of grief. Another area of contrast with the literature was the lack of information about normal responses of parents to the birth of a very premature or handicapped infant. Lack of information about the range of responses in this situation led to anxiety on the part of the parents about fully divulging their emotional responses to health professionals lest they be judged as poor parents or potential child abusers. The final area of contrast with the literature is in the length of time for the normal grief process. Harris (1984) states that lack of recognition of "grief lag" (p. 421), where parents postpone grieving, may account for some of the variations observed

in the length of the grieving process.

The fact that the categories of dysfunctional grief were developed using data from cases already diagnosed as experiencing dysfunctional grief results in a circular definition of dysfunctional grief and limits the reliability and validity of this study. Linkages and relationships amongst the categories identified by the researcher are not evident. Little insight is gained into the normal grieving process after pregnancy loss. The characteristics identified in this study were shown to be congruent with or blended with the National Classification Group categories of dysfunctional grieving in all but one dimension. Grieving observed in the subjects of this study was continued past the time expected for dysfunctional grieving.

The assessment and intervention strategies identified in the study are based solely on the clinical practice of the researcher. Contrasting and comparative data from similar clinical practices was not obtained to ensure the density of these categories.

This study makes only a limited contribution to the present body of knowledge about normal parental responses to fetal and early infant death. Further, little light is shed upon the distinction between normal and dysfunctional grief. Descriptions consistent with normalacy facade, role distress, repression of joy or humour and attributional

guilt have all been identified during content analysis of literature describing typical parental responses to fetal and early infant death. Harris (1984), in her article, identifies both length of grief response and intensity of grief response as variables indicative of dysfunctional grief. But the crucial questions of how long? and how intense? remain unanswered.

Toedter et al. (1988) undertook a longitudinal study of the factors affecting the length and severity of grieving following pregnancy loss. The types of loss included in this study were spontaneous abortion, ectopic pregnancy, fetal death and neonatal death. The study was designed to measure perinatal grief at 6 weeks, 1 year and 2 years post bereavement. The present study reports findings from measures taken at 6 weeks post bereavement. Having identified that the lack of a comprehensive tool which would measure grief responses was a major problem with research in this area, the authors, as part of the study, undertook development and validation of the Perinatal Grief Scale.

The dependent variable of the study was parental grief, as measured by the Perinatal Grief Scale. Eleven hypothesis involving eleven independent variables identified from analysis of available literature were formulated. Those variables which were hypothesized to increase parental grief after perinatal death included a)

increased gestational age at the time of the loss, b) decreased quality of the marital relationship, c) increased maternal age, d) poor mental health, e) fertility problems and f) decreased physical health. Variables hypothesized as decreasing parental grief were a) previous births, b) religiosity and c) maternal beliefs that the next pregnancy would be successful. Previous losses and socioeconomic status (SES) were hypothesized as having no effect on parental grief scores.

Forward step-wise multiple regression was used to identify statistically significant ($p \leq .05$) predictors of grief intensity. The strongest predictor of grief was overall physical health. Gestational age was the second strongest predictor of grief, the quality of the marital relationship was the third and pre-loss mental health symptoms was the fourth. No other variables met the criterion cutoff. Statistically significant correlations were also observed between some independent variables. Most striking were the correlations between overall physical health and all but two other independent variables; gestational age and fertility problems.

As part of the validation of the Perinatal Grief Scale, three subscales or factors were identified using varimax rotation. The three factors were named Active Grief, Difficulty Coping and Despair. Multiple regression analysis of Grief Factor Score predictors was then

undertaken. Predictors of Active Grief, in order of strength, were 1) gestational age, 2) marital relationship, 3) overall physical health and 4) pre-loss mental health symptoms. Predictors of Difficulty Coping were 1) pre-loss mental health symptoms, 2) overall physical health, 3) marital relationship, 4) gestational age and 5) presence of living children. Finally, predictors of Despair were 1) overall physical health, 2) marital relationship, 3) gestational age and 4) age of mother. Comparison of this analysis with the results based on the total Perinatal Grief Score show that overall physical health, gestational age and marital relationship are stable predictors for the Total Grief Score and Scale Factor Scores, although their order in each multiple regression analysis varies. Pre-loss mental health symptoms, presence of living children and age of the mother predict the outcomes of only some Scale Factor Scores.

Toedter et al. concluded that the findings of this study support the construct validity of the Perinatal Grief Scale. Further, they conclude that, since all the relationships between independent and dependent variables included in this study were in the direction hypothesized, and consistent with similar studies conducted in the past, additional support for the Perinatal Grief Scale was evident.

The researchers identify numerous areas for further

investigation, including further exploration of the role of overall physical health in the grief response to perinatal death. Other future plans specified were expansion of samples to include non-whites and males, an increased consideration of the role of SES in grief response, validation of a short form of the Perinatal Grief Scale and further analysis of the factor structure of the Perinatal Grief Scale.

This study represents the most ambitious undertaking in identification of variables affecting parental grief responses after fetal and early infant death found in the literature to date. Some problems with the study are evident. First, a variable frequently identified in the literature as influencing parental grief, but not examined in this study was the desire for the pregnancy. Inclusion of this variable would have clarified its impact on subsequent parental grief.

Second, measurement of the variable infertility might have been approached differently. In this study, trained raters scored each subject on the basis of whether or not there was any past or present basis for concerns about future fertility. In actual fact, the perception of the mothers as to their future fertility might be a more reliable predictor of perinatal grief than objective scoring of the reality of that perception.

Third, the correlation of overall physical health with

every outcome variable and all but two independent variables is a significant problem. Scores for this variable were obtained by having each subject rate herself, on a scale of 1 to 5 as having very poor to very good physical health. The concept of health is exceedingly complex, and cannot be measured unidimensionally. Many of the other independent variables are either intimately linked to individual perceptions of physical health, or have a direct impact on physical health. It would seem that this test item was, in reality, remeasuring the majority of other independent variables rather than measuring a separate construct.

Continued work on the development of the Perinatal Grief Scale, especially in the areas specified in this analysis and those identified by the researchers is necessary. However, this line of research holds considerable promise, both for future researchers and for practitioners.

Studies Examining the Experience of Spontaneous Abortion

Seibel and Graves (1980) conducted a survey of 93 women to evaluate the immediate psychological impact of spontaneous abortion. A self-administered questionnaire was completed by every patient admitted to an obstetrical emergency unit during a three month period in 1977. Both open ended questions and forced choice questions based on

the Multiple Affect Adjective Check List (MAACL) were used to elicit the subject's immediate emotional responses to a spontaneous abortion. MAACL items used in this survey were those that measured a) positive feelings, b) depression, c) anxiety and d) hostility. Eighty-nine percent of the subjects checked one or more negative responses to the spontaneous abortion.

Chi-squared analysis was conducted to determine if different responses existed according to whether the pregnancy was planned or unplanned. Those aborting planned pregnancies were more likely to describe themselves as unhappy or very unhappy ($p<0.05$). Selection of 1 or more positive adjectives was correlated with loss of an unplanned pregnancy ($p<0.01$). Finally, selection of 1 or more hostility adjectives was correlated with loss of a planned pregnancy ($p<0.01$). No significant correlations were found between loss of a planned or unplanned pregnancy and selection of 1 or more depression adjectives, 1 or more anxiety adjectives or 3 or more negative-affect adjectives. Seibel and Graves (1980) concluded that "... spontaneous abortions are frequently accompanied by significant psychological symptoms." (p. 165).

One positive aspect of this study was the inclusion of questionnaire items which would elicit responses indicating a positive emotional reaction to the spontaneous abortion. The inclusion of these items reflect an awareness on the

part of the researchers of the broad range of possible emotional responses to early pregnancy loss. It also enabled the researchers to test for a significant relationship between planned and unplanned pregnancies and responses indicating a positive emotional response.

Serious flaws in sample selection and methodology detract from the validity of the findings. It is doubtful that the convenience sample included in this study is representative of the population of all pregnant women who experience a spontaneous abortion. Almost half of the sample (44%) was less than 21 years of age, and 67.8% of the sample was 25 years of age or less. Seventy-two percent of the subjects stated that the pregnancy was not planned. Further, only 30.1% of the sample were married. The relative youth of this sample, the high incidence of unplanned pregnancies and the overrepresentation of single persons may be factors confounding the responses to the spontaneous abortion.

Another confounding variable is the timing of the administration of the questionnaire. Women were asked to complete the MAACL items while they were waiting in the pre-operative area for D&C to treat an inevitable abortion. It is difficult to disentangle responses to the questionnaire which might have been based on concerns about the pain, bleeding or proposed operative procedure from those arising from the spontaneous abortion.

Wall-Haas (1985) conducted a survey of 9 women who had experienced a first trimester spontaneous abortion to identify and describe maternal responses to first trimester spontaneous abortion. Questions about these women's responses to this pregnancy loss were divided into two sections: a) somatic and psychological responses and b) behavioural responses. The items for somatic and psychological responses included questions about feelings of sadness, sleep disturbances, appetite disturbances, preoccupation about the baby, irritability, guilt and anger. For each item, respondents were asked to rate their experience as never a problem, a mild problem, a moderate problem or a big problem.

Behavioural responses were also elicited. Respondents were asked to answer yes or no to each of the following behaviours: crying, praying for baby, depression, disbelief and wanting to be left alone. Another question asked the subjects to rate their relationship with their husband on a scale of 1 (closer) to 7 (more distant) compared to before the spontaneous abortion.

Wall-Haas (1985) found that feelings of sadness, preoccupation with the baby, irritability, guilt and anger were reported as problems for the majority of subjects. Changes in patterns of eating and sleeping were reported as never a problem by the majority of subjects. The majority of women also reported episodes of crying, praying,

depression and disbelief. Four women wanted to be left alone; five did not wish to be left alone. Seven of the nine women reported that they were closer to their husbands as a result of experiencing the spontaneous abortion.

Wall-Haas (1985) makes no specific conclusions based on the findings of her study. Instead, she concluded that "Women's responses to a first trimester spontaneous abortion must be recognized as particularly complex." (p. 53). However, she bases this observation on anecdotal data obtained from the subjects rather than on the survey which she conducted.

Methodologically, this study is similar to those done by Kennell et al. (1970) and Peppers and Knapp (1980). Many of the items on the questionnaire are similar to those used in the earlier studies. Five of the somatic and emotional responses used in this study are identical to those used by Kennell et al. (1970). One item of the 1970 study not used in this survey was the inability to return to normal activities. Items in this questionnaire eliciting responses of guilt, anger, depression and disbelief did not appear in the Kennell et al. (1970) study, but were included in the study conducted by Peppers and Knapp (1980). The same assumption that pregnancy loss is a negative life event resulting in negative types of emotional and behavioural responses underlies this study. No items on the questionnaire elicited positive somatic and

emotional responses to the spontaneous abortion. Further, the questionnaire used in this study was adapted from another researcher, but no information was given about the development or pre-testing of this tool.

This survey used an extremely small sample and the findings cannot be generalized to the population of all women who have experienced a spontaneous abortion. No information was given about the time interval between the spontaneous abortion and the administration of the questionnaire. As well, the sample included women who had had a variety of obstetrical outcomes both before and after the spontaneous abortion studied in this survey. Obtaining a larger, more representative sample, and controlling variables such as obstetrical history, planning of the pregnancy and time elapsed since the spontaneous abortion would have enabled the researcher to set up comparison groups and conduct tests of association on the data.

Swanson-Kauffman (1986) conducted a qualitative analysis of the experience of unexpected early pregnancy loss using Grounded Theory methodology. Twenty female subjects who had experienced a spontaneous abortion prior to the sixteenth week of gestation were interviewed. Transcripts of these interviews were used as the sole data source. Time elapsed since the experience of the spontaneous abortion was not stated, nor were any other characteristics of the subjects.

The literature review conducted during this study was used for two purposes. First, it served as a justification for the present study by identifying the existing lack of systematic study of spontaneous abortion as a specific form of human loss. Second, the literature was used to provide a theoretical framework for the two central concepts of the study; loss and caring.

Two questions guided the initial analysis of data. The first question sought to identify the impact of a miscarriage on a mother's life. Six Swanson-Kauffman Human Experience of Miscarriage categories were identified. These were a) Coming to Know, b) Losing and Gaining, c) Sharing the Loss, d) Going Public, e) Getting Through it and f) Trying Again. Limited information about these categories was available in the article obtained, since the emphasis had been placed on the findings related to the second question of the study.

The second question sought to identify how the woman experiencing spontaneous abortion wished to be cared for in her loss. Many other secondary questions were identified as data analysis proceeded. The categories which emerged as Caring in the Instance of Miscarriage were the following:

a) Knowing. Those who cared understood the unique meaning that the pregnancy loss had for the bereaved mother.

b) Being With. Those who cared experienced the emotions of

the mother with her.

c) Doing For. Those who cared performed tasks for the mother as well as she would have done them for herself, had she been able.

d) Enabling. Those who cared facilitated the mother's ability to grieve and get through the loss.

e) Maintaining Belief. Those who cared continued to believe in the competence of the woman and in her ability to get through the loss and make appropriate decisions about her life.

These categories were well developed. Where variations within the category were evident, the conditions under which these variations occurred were specified. For example, with respect to the category Maintaining Belief, most women needed to know that others still believed in their competence as childbearing women. However, this could only be successfully expressed by those significant others who had also demonstrated behaviours consistent with the categories of Knowing and Being With. In the absence of these conditions, comments regarding future pregnancies were perceived by the women as uncaring and hurtful.

Swanson-Kauffman offers no specific conclusions for her study. She states that the categories identified in her study must be used as insights into the experience of spontaneous abortion and "... not as formulas." (p. 45). She also does not identify any areas where further research

might be useful. However, one area of research which arises as a natural extension of this study would be a qualitative analysis of care givers using the same questions about caring as were used in this study. Both interview and observational data could be obtained on care givers and the subsequent findings compared and contrasted with the characteristics of caring identified by the subjects of this study.

Summary

Research on the topics of spontaneous abortion, stillbirth, perinatal death and neonatal death is generally divided into two spheres of activity. The first of these is the attempt to correlate variables associated with the individual, significant others and the health care and social system which intensify or diminish the grief response of parents. By identifying significant relationships between these variables and the grief response, researchers hope to enable care givers to manipulate the variables in a manner which will facilitate grief resolution. Better understanding of correlations between dependent variables and outcome might also enhance the ability of those in the helping professions to accurately predict the grief response of specific individuals and to tailor interventions accordingly.

Variable manipulation is an appealing, but limited

strategy. Certainly, the attitudes of significant others and health care professionals, practices adopted by the health care system and cultural beliefs have considerable impact on grieving parents. These variables can be modified, but only very slowly and only as the result of considerable effort on the part of change agents. Recommendations for improvements in professional and institutional practices abound in the professional literature. Adoption of these recommendations is another matter entirely.

Most variables identified as having a negative impact on parental grief responses are not readily subject to manipulation. Since no individual can modify his past, nor entirely control his future, most attributes of parents experiencing childbearing losses cannot be modified.

The development and validation of comprehensive predictive tools for the identification of parents at risk for profound or prolonged grief responses is a very recent event (Toedter et al., 1988). Establishing the reliability of these tools through replication studies in clinical settings is yet to be undertaken. Although an exciting prospect, predictive tools will not, in isolation, meet the needs of either bereaved parents nor those professionals involved in their care. A deeper understanding of the experience of childbearing loss is required as well.

The second sphere of research activity contributes to

professional knowledge and practice by studying the experience of childbearing loss from the perspective of those have had such experiences (Hutti, 1986). Qualitative studies of fetal and early infant deaths move beyond simple descriptions of responses of bereaved parents to identify and gain an understanding of the context and meaning of the loss. Content analysis of rich qualitative data enables researchers to develop compelling and concise descriptions of the experience of fetal and early infant death drawn from a wide variety of experiences. In the long run, qualitative analysis of childbearing losses may make a greater contribution to the ability of health professionals to render meaningful, individualized care to bereaved parents because of the emphasis which is placed on context. Many of the apparent conflicts identified and discussed during content analysis of the literature can be explained when the context of the bereavement for each individual is taken into account.

Many questions about the experience of spontaneous abortion, stillbirth, perinatal death and neonatal death remain unanswered. As this review of the literature has demonstrated, spontaneous abortion is the least studied and least understood type of fetal and early infant death. Qualitative analysis of parental perceptions of the impact of this particular life event on their personal and interpersonal lives, and their perceptions of the responses

of significant others, health care professionals and society in general would make a significant contribution to the present body of knowledge.

CHAPTER 3

METHODOLOGY

Method

A qualitative method was chosen for this study. The selection of a research method is determined by the stated purpose of the researcher. Qualitative methods are appropriately selected when the purpose of the researcher includes one of the following:

1. identification of variables for the purpose of instrument development (Knafl & Howard, 1984),
2. illustration of the quantitative findings of a larger study (Knafl & Howard, 1984),
3. description and analysis of new areas of interest, or re-analysis of previously researched areas (Knafl & Howard, 1984; Stern, 1980),
4. conceptualization of an area of interest for the purpose of theory building (Glaser & Strauss, 1967; Knafl & Howard, 1984; Strauss, 1987; Woods & Catanzaro, 1988).

In planning the present study, the purposes of the researcher were to describe the experience of spontaneous abortion and to conceptualize this experience for the purpose of theory building.

Several qualitative methods, including grounded theory, enable the researcher to identify and describe variables and concepts within narrative data (Chenitz & Swanson, 1986; Strauss, 1987; Woods & Catanzaro, 1988). However, grounded theory offers the additional advantage of enabling the researcher to "... generate theoretical constructs which explain the action in the social context under study." (Stern, 1980, p. 21). The product of the grounded theory method is the transformation of raw qualitative data into abstract conceptualizations upon which explanatory and predictive theories are built (Knafl & Howard, 1984).

Three objectives guided the researcher during the planning phase of this study. The first two objectives were specific to the present study and were as follows:

1. to examine parental responses to the experience of spontaneous abortion, and
2. to elicit from the subjects a description of how significant others and health care workers dealt with the spontaneous abortion.

The third objective, a long term goal not specifically directed to the present study, was to develop a theory which would explain and predict individual parental responses during the experience of spontaneous abortion. The grounded theory method was selected because it would enable the researcher to achieve all three objectives.

Grounded Theory

The grounded theory method is distinguished from other qualitative research methods by five features. In reality, these features overlap and are intimately linked to one another. However, for the purpose of clarity, each feature will be discussed separately.

1. The Order and Purpose of Research Activities

In traditional empirical research, the research activities of review of the literature, hypothesis formulation, data collection and data analysis are carried out sequentially. The literature is first reviewed to familiarize the researcher with the phenomenon of interest and to specify relevant dependent and independent variables. Hypotheses are then stated. Data collection is carried out and data analysis begins with the completion of data collection. In grounded theory, data collection, data analysis and review of the literature are conducted simultaneously (Chenitz, 1986a; Stern, 1980; Glaser & Strauss, 1967). Simultaneous work in these three activities enables the researcher to identify and validate variables emerging from the collected data. No hypotheses are stated in advance of data collection and analysis. Instead, hypotheses emerge during data analysis and review of the literature.

2. Theoretical Sampling

Theoretical sampling is linked to the simultaneous processes of review of the literature, data collection and data analysis. In theoretical sampling, "... data collection is controlled by the emerging theory ..." (Glaser & Strauss, 1967, p. 45). The researcher makes conscious decisions about where next to collect data based on the analysis of data already collected in order to verify, compare, contrast and saturate categories emerging from the data (Chenitz & Swanson, 1986; Knafl & Howard, 1984; Stern, 1980; Strauss, 1987).

3. The Use of a Coding Paradigm

During data analysis, the researcher generates codes which describe themes or variables emerging from the data. Initially, these codes are descriptive. However, as data analysis and coding proceed, thematic and descriptive codes are collapsed into abstracted categories which capture or encompass the meanings of the descriptive codes. Finally, linkages between the categories are identified and the categories arranged in a relationship which describes the phenomenon of interest (Glaser & Strauss, 1967; Strauss, 1987). The coding process is facilitated by writing analytic memos (Corbin, 1986b; Glaser & Strauss, 1967; Strauss, 1987) and by producing diagrams of the emerging categories and theory (Corbin, 1986b; Strauss, 1987).

4. Constant Comparative Analysis

In the grounded theory method, every piece of data

collected is systematically compared to every other piece of data in a process called constant comparative analysis (Chenitz & Swanson, 1986; Corbin, 1986a; Glaser & Strauss, 1967; Stern, 1980; Strauss, 1987). Constant comparative analysis is an integral part of the process of developing coding paradigms. Glaser and Strauss (1967) list five purposes for constant comparative analysis: a) to ensure accuracy of data, b) to establish the generality of the data, c) to specify a concept, d) to verify theory and e) to generate theory.

5. Production of a Theory Describing a Social Process Which is Based On or Grounded in the Raw Data

The process of theoretical sampling, constant comparative analysis and development of an increasingly abstracted coding paradigm which specifies linkages and relationships between categorical data results in a theory with the power to explain and/or predict the phenomenon of interest (Chenitz & Swanson, 1986; Corbin, 1986a; Knafl & Howard, 1984; Glaser & Strauss, 1967; Stern, 1980; Woods & Catanzaro, 1988). Two types of theory result from the use of the grounded theory method. The first is the descriptive or categorical theory (see, for example, Hutti, 1986; May, 1980). These theories place data into categories. Each category is distinct from all other identified categories. Linkages and relationships between these categories are not specified. Swanson (1986b) states that these theories produce the necessary blocks upon which

process theories are built.

The second type of theory obtained from the use of the grounded theory method is process theory. Process theories integrate the who, what, where, when and why of the phenomenon of interest to account for change over time (Fagerhaugh, 1986a). Process theories possess linkages, time dimensions, stages and turning points (Fagerhaugh, 1986a). This type of theory enables researcher and practitioners to predict as well as explain the phenomenon of interest (see, for example, Fagerhaugh, 1986b; Stern, 1982).

Validity and Reliability

The issues of validity and reliability have been problematic for researchers using qualitative methods. Methods used to ensure the validity and reliability of quantitative research are not readily transferred to research using narrative data. However, an increased focus on this area by qualitative researchers has produced a small body of literature on validity and reliability in qualitative research. Those aspects of validity and reliability which are related to the grounded theory method are discussed below. Specific measures to control threats to the validity and reliability of the present study will be identified in the discussion of the study design.

Validity

Qualitative researchers equate validity with credibility (Chenitz & Swanson, 1986; Catanzaro, 1988) and trustworthiness (Catanzaro, 1988). Many procedures available to the qualitative researcher ensure that the data collected accurately describes the phenomena of interest. These procedures include careful preparation of participant-observer notes (Catanzaro, 1988; Strauss, 1987), multiple sources of data (Catanzaro, 1988; Strauss, 1987), multiple methods of data collection (Catanzaro, 1988, Chenitz & Swanson, 1986; Strauss, 1987), multiple investigators (Catanzaro, 1988), negative case analysis (Woods & Catanzaro, 1988), informant checking (Woods and Catanzaro, 1988) and constant comparative analysis (Glaser & Strauss, 1967; Strauss, 1987).

Chenitz and Swanson (1986) identify two types of validity for qualitative studies: a) validity during data collection and b) validity during data analysis.

Validity during data collection.

This type of validity is analogous to internal validity and external validity. Several threats to validity during data collection exist. Those that apply to the grounded theory method will be briefly discussed.

1. History

Events extraneous to the phenomena of interest may influence the data collected (Chenitz & Swanson, 1986; Woods & Catanzaro, 1988).

2. Subject maturation

Subjects may change over the course of the research (Chenitz & Swanson, 1986; Woods & Catanzaro, 1988).

3. Subject mortality

Subjects many drop out during the course of the study (Chenitz & Swanson, 1986; Woods & Catanzaro, 1988).

4. Reactive effects of the researcher.

This is a particular problem of field research. Placing the researcher in a setting alters the behaviour of those found in the setting and thus alters the data collected (Chenitz & Swanson, 1986). Reactive effects include subjects changing their behaviour in response to perceived expectations of the researcher, subjects becoming dependent on the researcher (Woods & Catanzaro, 1988), subjects attempting to put themselves in the best light (Woods & Catanzaro, 1988), and subjects responding either positively or negatively to personal attributes of the researcher.

5. Changes in the researcher

Researchers change as a result of interaction with subjects and settings. Alterations in the expectations and biases of the researcher may result in systematic gaps in the data collected as the researcher attends to only certain aspects of the setting and subjects and fails to observe others.

6. Settings

Collecting data from only one setting may result in data which is valid only for that setting and not representative of the phenomena of interest (Chenitz, 1986b).

Validity of data analysis.

This type of validity is analogous to statistical conclusion validity. Validity of data analysis is achieved through critical evaluation of the process of data analysis and theory formulation. The fit of the theory to the data upon which it is grounded, the relevance of the data to the real world and the ability of the data to explain, interpret and predict the phenomena of interest are all tests of the validity of data analysis (Chenitz & Swanson, 1986). Validity of data analysis is enhanced by constant comparative analysis.

Reliability

Woods & Catanzaro (1988) identify four threats to the reliability of qualitative studies: a) the researcher's status within the research setting, b) participant selection, c) the social conditions of the setting and d) methods of data analysis. The first three threats must be consciously and continuously evaluated during the course of the research. Utilization of two specific procedures during data analysis reduces threats to reliability from

the fourth source. The stability of coding paradigms can be assessed by code/recode procedures whereby the same researcher compares the same data coded on two separate occasions (Catanzaro, 1988). The reproducability of coding paradigms can be assessed by having two different coders analyze the same data using the same coding instructions (Catanzaro, 1988).

Exact replication of qualitative studies as another strategy to establish reliability is not possible. However, approximations to replication do exist and these are useful in establishing the reliability of the theory obtained by the grounded theory method. Successful application of the theory in a similar situation is a test of the reliability of the theory (Chenitz & Swanson, 1986). Conversely, reliability of the theory can also be tested by evaluating its ability to explain and predict the phenomena of interest in situations entirely unique from those previously examined.

Design

Subjects

The theoretical population of this study was all parents who had experienced a spontaneous abortion. This would include women who had actually experienced this complication of pregnancy and their male partners at the

time of the spontaneous abortion. The accessible population consisted of those members of the theoretical population who resided within the urban city limits of Winnipeg, Manitoba.

A non-probability sample was obtained for this study. It was drawn from several different sources within the city of Winnipeg. A theoretical sample of 8 subjects was referred to the researcher by themselves, by friends, or by the coordinators of a support group located in Winnipeg. Subjects chosen during theoretical sampling were selected to build on or contrast with the sample obtained to date. Five in-depth interviews were conducted with the eight subjects obtained by theoretical sampling. Two of the interviews were conducted with individuals. One interview was conducted with a woman whose husband subsequently submitted written responses to the interview guide prepared by the researcher. The other two interviews were conducted with couples. A convenience sample of fifteen individuals was obtained during participant-observer data collection.

The natural units of the sample obtained for this study included individuals, couples and groups. A natural unit can be conceptualized as the entity from which data is gathered (Swanson, 1986a). In the majority of research conducted in the health and social sciences, the natural unit studied is the individual (Swanson, 1986a). However, depending upon the nature and scope of the study, natural

units can also be couples, families, groups or even communities.

No constraints were placed on whether the subjects were male or female. Both married and unmarried persons were included.

Limitations placed on the eligibility of subjects to be included in the sample were:

1. The minimum age of subjects was 18 years. This would prevent any complications with respect to consent to participate in the study.

2. Subjects were able to comprehend and speak English. Success of the study depended upon the ability of subjects to describe the experience of spontaneous abortion in a clear and articulate fashion.

3 For convenience during data collection, subjects were chosen who lived within the boundaries of Winnipeg, Man.

4. To facilitate contact between the researcher and study subjects, subjects who had a telephone in their homes were selected.

5. In order to focus on the experience of spontaneous abortion, subjects must have experienced an involuntary pregnancy loss at 20 weeks or less gestation.

Research Questions

Initial research questions were formulated to guide the collection of data describing the experience of spontaneous abortion. Through the analysis of qualitative data, the many variables associated with the experience of spontaneous abortion could be identified and specified.

Initial questions guiding the study were as follows:

1. How do couples who experience bereavement as a consequence of a spontaneous abortion perceive this life event?
2. Does the meaning of this experience change over time?
3. What are the emotional responses to spontaneous abortion?
4. What are the physical responses to spontaneous abortion?
5. How long did these responses affect the day to day life of the individual or couple
6. How often did they continue to recur?
7. What are the responses of significant others after the individual or couple experienced a spontaneous abortion?
8. What are the responses of health professionals after the individual or couple experienced a spontaneous abortion?

Time

The study was retrospective. No limits were placed on the length of time elapsed since the spontaneous abortion experienced by the subjects participating in the study. Studying subjects from a variety of times elapsed since the spontaneous abortion enabled the researcher to examine the process of the experience of spontaneous abortion from the perspective of those who were at various points within that process.

Setting

Two settings in the community were used during data

collection. In-depth interviews were conducted in the homes of interview participants. Participant-observer data was obtained during meetings of a support group which holds monthly meetings in a room made available to them by a general hospital in the city of Winnipeg.

Instruments

Instruments were developed by the researcher to facilitate data collection during in-depth interviews. These will be described below.

Interview Guide

A set of general questions about the experience of spontaneous abortion was developed by the researcher (Appendix E). Final formulation of the questions was guided by 1) the nature of the problem, 2) the review of the literature, 3) the objectives of the study and 4) the conceptual framework and methodology chosen. Prior to its use in the study, the interview guide was submitted to nursing colleagues and individuals who had personal or professional experience in this area for evaluation. Prior to the initiation of data collection, a pilot test of the interview guide was also conducted with one couple who had experienced a spontaneous abortion. Data obtained from the pilot interview was not used in this study.

Demographic tool

A brief set of demographic questions (Appendix E) was

administered to each person who participated in an interview with the researcher. The data obtained from this tool was used to describe the sample obtained for interviews.

Method of Data Collection

Two methods of data collection were utilized during this study. Five in-depth interviews were conducted by the researcher with persons who had experienced a spontaneous abortion. As well, the researcher attended, over the course of seven months, six support group meetings in the role of participant-observer. Details of each method of data collection are specified below.

Interview Data

Five in-depth interviews were conducted during the course of the study. Theoretical sampling was used to obtain more data as data analysis proceeded. Conscious decisions were made with respect to where next to obtain data and what type of data would be required. Whenever possible, the researcher endeavored to obtain interview subjects with demographic characteristics and experiences which differed from the subjects interviewed previously. This approach enabled the researcher to further develop or contrast categories which had already emerged in the data.

Subjects recruited by intermediaries for in-depth interviews were contacted by the researcher by telephone

(Appendix F). A verbal description of the study was given. In situations where the subject was married, the researcher asked whether the spouse would participate in the interview. If some reluctance about joint interviews was expressed, the opportunity for separate interviews was given. An interview was arranged for a mutually convenient time at the home of the subject.

Audio tape recorded interviews were conducted with the subjects obtained by the researcher. Strict adherence to the questions contained in the interview guide was not practiced. Instead, the researcher first elicited some general information about the subjects, and then encouraged conversation to flow to whatever topics were of greatest relevance to the subjects. This enabled subjects to describe their experience with spontaneous abortion as fully as possible in their own words without the imposition of pre-existing ideas about the subject. Clarification and amplification of information given by the subjects was consistently elicited by the researcher. Since data collection and data analysis proceeded concurrently, the researcher modified questions in preparation for interviews to elaborate or contrast categories already identified in existing data.

Participant-observer Data

Prior to the commencement of data collection, the researcher met with one of the group facilitators to inform

her of the purpose of the study and to obtain permission to attend the group meetings for the purpose of data collection. Once formal permission for attendance in the group as a participant observer was granted (Appendix G), the researcher attended six meetings of this support group over the course of seven months. The researcher listened to and participated in the discussions held by the group. The researcher did not direct the course of the discussion, and did not, unless it was appropriate within the context of the discussion, elicit detailed information from group members.

At the specific request of the facilitators, no audio or written recordings were made during the course of the support group meetings. Instead, the proceedings of the meetings were written down by the researcher as soon as possible after the meeting.

Ethical Considerations

Ethical Review

Prior to initiation of data collection, a research proposal was submitted to the Ethical Review Committee of the School of Nursing, University of Manitoba for the purpose of ethical approval. Permission from this committee to proceed with data collection was received on May 17, 1988 (Appendix H).

Consent

Interview subjects.

All subjects participating in in-depth interviews were provided with a written explanation of the purpose of the study (Appendix I). Their role as study subjects was explained. Signed consent was obtained from all persons prior to their participation in the interview (Appendix J). All subjects were offered the opportunity to receive a summary of the study once it was completed.

Participant-observer subjects.

At the beginning of each meeting, the researcher was introduced by the facilitators and the purpose of the researcher's presence was explained. Although no objection was ever raised by participants about the presence of the researcher, the researcher was prepared to withdraw from the group should any such concerns have arisen.

Physical and psychological comfort of subjects

Interview subjects.

Interviews were conducted at a time and place of the subject's convenience. Subjects were informed as to the approximate length of the interview at the time that they were telephoned by the researcher. Subjects were informed in writing and reminded verbally prior to the interview that if they became fatigued or upset during the course of the interview, they were free to discontinue the interview.

If they wished, a second interview could be arranged. They were also specifically informed, both verbally and in writing, that they could decline to answer specific questions within the interview if they desired and that they could withdraw entirely from the study at any time.

Participant-observer subjects.

Participants at the support group meetings had been recently bereaved and were frequently very emotional when describing their feelings and experiences. The researcher, at all times, subordinated data collection to the primary purpose of the group meeting; the provision of a healing and therapeutic environment for group members. Clarification and elaboration of statements made by the participants was sought only when, in the judgement of the researcher, the participants would not be upset by such questions. The researcher continually monitored the emotional atmosphere of the group to ensure that her presence was not interfering with the work of the group.

Confidentiality

All data collected was held in the strictest confidence. Transcripts of the audio tapes were prepared by the researcher. Audio tape recordings and transcripts were identified by a code number only. A list of interview subjects was kept entirely separate from audio tapes and transcripts. Only the researcher had access to the list of subjects and the audio tapes. Only the researcher and her

advisor had access to the transcripts. Audio tapes and transcripts were kept in a locked cabinet. At the completion of the study, all audio tapes were erased.

Transcripts prepared from notes written after the group meetings were handled in the same manner as transcripts prepared from audio taped interviews.

Validity and Reliability of the Design

Validity

Measures taken to ensure the overall validity of the study included the following: 1) careful transcription of audio taped interviews and participant observer data by the researcher, 2) collection of data in two different settings, 3) collection of two different kinds of data; observational data and interview data and 4) the use of constant comparative analysis.

Two threats to validity during data collection were identified by the researcher. The specific threats and measures taken to control them are as follows:

1. History

During data collection, any events mentioned by the subjects, which in the opinion of the researcher, might influence their perception of the experience of spontaneous abortion were explored in as much detail as possible. It was only possible to gain an understanding of how history might affect such data. Elimination of this threat was not

possible.

2. Reactive effects of the Researcher

The researcher specifically acknowledged that data collected from subjects might be influenced by their knowledge of the role and purpose of the researcher. Subjects participating in audio taped interviews were told, prior to the beginning of taping, that the researcher was interested only in their description of the experience of spontaneous abortion and did not have any preconceived expectations about what kind of information was necessary for the successful completion of the study. In addition, open ended questions and an open response to topics introduced by the subjects was used by the researcher to minimize possible hypothesis guessing on the part of the subjects.

The responses to the researcher of subjects who were members of the support group used to collect participant observation data was monitored carefully. Prior to data collection in this setting, the researcher identified two possible responses to her presence in the group. First, participants might be distracted by the presence of the researcher and feel compelled to feed data to the researcher rather than concentrate on the therapeutic discussions led by the group leaders. To control this threat to the validity of the data collected, the researcher stated at the beginning of each meeting that no

preconceived notions about the type of data necessary for the successful completion of the study existed, and that the normal discussions of the group contained the information sought by the researcher. Second, the researcher believed that group participants might be inhibited in their discussions of care rendered by health professionals and the health care system when they knew that the researcher was a nurse. To control this threat to the validity of the data collected, the researcher stated that she did not, at present, possess formal affiliations with any health care institution or organization. The researcher consistently maintained an open response to criticisms of the health care system or health care professionals which were voiced by group participants.

Reliability

During data analysis, a code/recode procedure was carried out on one transcript of an audio taped interview. This procedure confirmed the stability of the coding paradigms. The researcher submitted examples of coding paradigms to her advisors to confirm their appropriateness and internal consistency. A colleague with a Masters Degree in Nursing checked the reliability of the coding paradigms during data analysis.

Analysis of Data

The data analyzed for this study was obtained from

transcripts of audio taped interviews and from transcripts of notes written after observations of the support group. An open ended, flexible approach to sources of data was adopted. No initial hypotheses were proposed. Variables which might influence the responses of parents, significant others and health professionals were identified during the literature review, which was conducted concurrently with data collection and data analysis. This information was used to facilitate data collection and data analysis.

Data analysis proceeded concurrently with data collection. After the typing of a transcript, qualitative analysis of the transcript for emerging themes was conducted. This process was facilitated by the use of a computer software package The Ethnograph version 3.0 (Seidel, 1988).

Themes identified in the data were coded and placed together. Newly coded data were constantly compared with previously coded data. When new themes were identified, previously coded material was re-examined to identify and code these changes.

As coding progressed, abstract categories which incorporated several themes in the data emerged. Thematically coded data were collapsed into the appropriate emerging categories as properties of the category. All coded data was again re-examined to capture modifications in the coding scheme.

Categories were defined and their relationship with one another specified. The properties within each category were also defined and elaborated. Time frames for each category were identified. Contingent variables which influenced parental experiences within individual properties or within an entire category were specified. Finally, subprocesses within the theory were identified. Subprocesses occurred when parental experiences within the category or properties of one category had a direct impact on the experiences within another category or property of that category.

Assumptions

The five assumptions of the theory of Symbolic Interactionism, as outlined in Chapter 1, were accepted for this study. Other assumptions of the study included the following:

1. The researcher was able to objectively analyze the data obtained from the subjects.
2. The researcher was able to understand the perspective of the study subjects.
3. The subjects were able to accurately recall their experience with spontaneous abortion, and were able to verbally express these memories in an articulate fashion.
4. The subjects were able to freely describe their experience with spontaneous abortion with minimal constraints imposed by the presence of the researcher.

Limitations

Limitations of the study were as follows:

1. The retrospective design of this study did not enable the researcher to validate the verbal reports of the subjects with observations of their behaviour at the time of the spontaneous abortion.

2. Due to constraints imposed on the researcher by the nature of the support group observed during the study, data collected by participant observation could only be elaborated or validated by the researcher on a limited basis.

3. The study cannot be replicated.

4. The sample obtained for the study was not representative of the population of all persons who have experienced a spontaneous abortion either directly or through a spousal relationship. Therefore, the results of the study cannot be generalized to this population.

5. Limited consideration was given to the topics of stillbirth, perinatal death, and neonatal death.

6. This study was not predictive and cannot be used to develop any kind of a predictive tool or model of human responses to spontaneous abortion without further research in the area.

CHAPTER 4

FINDINGS

Introduction

This Chapter presents the findings of a qualitative study examining the experience of spontaneous abortion. The Chapter is divided into two sections. The first section describes the sample included in the study. In the second section, the findings of the study are presented.

Description of the Sample

Interview Subjects

Five women and three men participated in the interviews. In two interviews, the husband and wife participated together. In one interview, the wife was alone because her husband was unable to attend. He subsequently submitted to the researcher a set of written answers to the same set of questions which had been used as a guide when his wife was interviewed. In another interview, the woman participant did not wish to have her husband present. One interview was conducted with a woman who did not have a male partner.

The women in the sample ranged in age from 27 to 40 years. Four were married. One was legally separated. All

had experienced a spontaneous abortion. None of the subjects knew the etiology of their spontaneous abortion(s). The gestational age of the pregnancy at the time of the spontaneous abortion ranged from 8 to 19 weeks. Four of the pregnancies involved a single fetus. One pregnancy involved twins. Four of the five women had experienced one spontaneous abortion. One participant had experienced two previous spontaneous abortions and one therapeutic abortion. One participant was a primigravida. Two women had one living child who had been born before the spontaneous abortion. Two women had one living child born before and one living child born after the spontaneous abortion. Time elapsed between the time of the spontaneous abortion and the time of the interview ranged from 3 months to 40 months.

The three men participating in the study ranged in age from 31 to 38 years. All were married. One man, in addition to the one child in his present family unit, had two older children from a previous marriage.

Educational background of the 8 participants included 4 who had completed University programmes, 3 who had completed diploma or equivalent programmes after high school, and one who had completed Grade 9. All participants were urban dwelling Caucasians. Five stated that they were at least partially of British extraction. Two reported themselves as being of Ukrainian descent and

one person was of Finnish descent.

Support Group Subjects

Nature of the Group

A support group for persons who have experienced bereavement as a consequence of fetal of early neonatal death holds monthly meetings in space made available by an urban general hospital. The support group was founded and continues to be led by two lay women who, after personally experiencing spontaneous abortions, found that there was little support offered to them either by significant others or health professionals. Membership in the group is informal. Participants may attend as frequently as they desire. No fees or membership dues are collected. Formal presentations are rare. For the most part, the facilitators and members hold informal discussions of the their experiences and suggest to one another ways of dealing constructively with their emotional response to their bereavement.

Participants

Aside from the researcher, the two facilitators and occasional professional observers, a total of 15 persons participated in the meetings observed by the researcher. Thirteen of the participants were women attending alone. Twelve of these women were married. Two participants attended as a couple, although they were not legally

married.

Of the fourteen women who attended the group meetings, 13 had experienced a fetal death in the first 20 weeks of pregnancy. One, who had attended with her male partner, had experienced the death of a day old infant. This woman, and two others who had experienced early spontaneous abortions, were primigravidas. Two multigravidas had experienced one full term pregnancy and one spontaneous abortion. The other nine women had experienced more than one fetal death. One of these had experienced 3 spontaneous abortions and had no full term pregnancies or living children. The other 8 had one or two living children, but had also experienced two or three fetal deaths. Etiologies of fetal and early infant death experienced by this group included spontaneous abortion of unknown cause, hydatidiform mole, extreme prematurity related to maternal incompetent cervix and neonatal death of unknown cause. Time elapsed from the bereavement experience to attendance at the support group meetings ranged from 1 week to 1 year, although all but 2 members first attended the support group within 3 months of bereavement. Five participants attended more than one meeting. No demographic data on the participants was obtained.

Findings

The result of the qualitative data analysis was the development of a theory entitled The Experience of Spontaneous Abortion. This is a process theory which possesses linkages, time dimensions, stages and turning points. It describes the experience of spontaneous abortion from the perspective of those who have experienced it.

The Experience of Spontaneous Abortion has four conceptual categories. These are: 1) Committing to the Pregnancy, 2) Experiencing the Spontaneous Abortion, 3) Putting It In Its Place and 4) Moving On. Each category has several properties which incorporate related themes and observations. Each category also possesses a time frame and contingent variables. Each of the four categories of The Experience of Spontaneous Abortion will be discussed separately. Then, an overview of the theory as a whole will be presented.

Category I: Committing to the Pregnancy

Committing to the Pregnancy is the process of developing an emotional attachment to the pregnancy and incorporating the anticipated child into personal and family life. Four properties of Committing to the

Pregnancy were identified. Each property contains related behaviours which indicate that the prospective parent is in the process of developing a relationship with the expected child. Not all parents would exhibit all behaviours within a specific property. Nor would each parent necessarily demonstrate behaviours involving all four properties. However, it may be inferred that the greater the number of attachment behaviours within and across the properties, the greater the level of commitment to the pregnancy.

Property 1: Desiring

Desiring is actively wishing or yearning for a child. Those who were committed to the pregnancy stated that they wanted the child. For some, the desire for children was a long term life plan formulated long before deliberate plans for conception were made. One subject stated that she had always taken it for granted that she would one day have children.

> ... it's not unusual that I would want children in my life. Because it's just sort of been part of my life all along. [Case05]

Further, those who wanted children believed that their lives would be incomplete without a child.

> And, as I got into my thirties, I thought, increasingly, that I really did want to have a baby ... I really would feel very badly if we didn't have one. [Case01]

Actively planning conception is one behaviour indicative of Desiring. Another is the acceptance of an

unplanned pregnancy.

> So, it was earlier than we were expecting, and by that, it was a surprise. But none the less, it was a welcome surprise. [Case04]

Some subjects were willing to take unusual risks in order to have a child. For example, one woman, whose husband did not want another child, discontinued contraception without his knowledge in order to have the child she desired. Another subject, who was single, risked disapproval from her family and her peers when she decided to proceed with her plans to become pregnant and have the child she had always wanted.

Certain factors increased the desire for a child. Increasing chronological age was frequently cited as a reason for moving from the abstract consideration of the possibility of getting pregnant to the conscious wish to have a child.

> I'm not getting any younger. [Husband]'s not getting any younger. If we're going to have one, we'd better get on with it. [Case01]

One subject, whose childless marriage ended when she was nearing the end of her reproductive years stated that she believed that she could either begin another marriage or have a child. She did not have enough time to do both. So, she chose to have a child.

A history of infertility or previous fetal and early infant deaths increased the desire of some subjects for a child. They demonstrated a willingness to undergo

considerable physical risks and psychological stress in order to achieve this objective. One couple experienced two spontaneous abortions within a year. The next 2 1/2 years were spent trying to get pregnant again, and undergoing many of the tests and procedures associated with the treatment of infertility. After finally conceiving again, this pregnancy also ended in a spontaneous abortion. Other subjects demonstrated similar determination after previous unsuccessful pregnancies.

> A. stated that if a doctor even told her that she had a 50/50 chance of having a successful pregnancy the next time, she was willing to take the risk. [PO3]

For some subjects, however, the experience of previous unsuccessful pregnancies negatively affected the desire for a child.

> B. stated that she feels at this point that she will not get pregnant again; that her childbearing days are over and it would be better if she moved on to other things in her life. [PO2]

Desiring the pregnancy was the first step in the process of Committing to the Pregnancy. The actual time at which Desiring occurred for subjects in this study varied from many years before conception to a short time after an unexpected conception. However, all interview subjects and all participants in the support group demonstrated a desire for the pregnancy and for the expected child.

Property 2: Conferring Personhood

Conferring Personhood involves engaging in behaviours that confer upon the fetus the attributes or characteristics of a unique human being. Parents who confer personhood believe that the fetus is a real baby. One subject in the study had experienced three spontaneous abortions. Two of them had occurred very close together and very early in the pregnancy. She stated that these spontaneous abortions had not been difficult to deal with, because she had not really even become used to the idea that she was pregnant. The third spontaneous abortion, however, was very different. She stated that she knew she was pregnant as soon as she conceived and quickly developed a strong attachment to the fetus.

> ... right from the beginning, I felt it was a baby. [Case02]

The researcher frequently observed that participants in the support group believed that the fetus lost as a consequence of spontaneous abortion was a real baby. For one participant in the support group, the reality of the baby was so strong that a physician's statement that it was only a fetus caused her considerable psychological distress.

> One woman was extremely upset when her physician corrected her when she referred to the child as a "baby", The physician told her that it was not a baby, but a fetus. She was so distressed by this that she felt unable to go on with the office visit and terminated the visit quickly thereafter. [P01]

Parents Conferring Personhood may choose names for the fetus.

> We had also chosen names and things like that. So that makes it a little bit more realistic, too, when you've done that [Case02]

They are interested in the gender of the fetus, either because they have a specific preference or because knowing the gender would enable them to confer appropriate names and characteristics.

> And [husband] really wanted a girl. [Case04]

> And I've always wondered if that was the daughter I would have liked and didn't get. [Case01]

Another activity consistent with Conferring Personhood is actively communicating with the fetus. This behaviour was described by one support group participant.

> Q. stated that she and her husband had made a great deal of the pregnancy. They had talked to the baby through her abdomen and made plans with the baby. [PO3]

Parents who view the fetus as a unique human being confer human experiences and human emotions on the fetus.

> What I did is I put the baby into a mind-thinking situation. Which, maybe I shouldn't have done. But ... I made this baby a child. And ... gave this baby feelings.... And I felt that a human being, or a baby had died. A baby with feelings. And I almost let the baby experience things. And so that made it even more overwhelming, because my perception of this baby was as a living human being who had experienced the life that I already had. [Case04]

Not all subjects in this study reported behaviours consistent with the property of Conferring Personhood. Those subjects who did engage in behaviours which bestowed

human qualities upon the fetus consistently reported that the human attributes they imagined the fetus to possess were positive and desirable. For these subjects, the belief that the fetus was a unique and important person in their life was well developed, and exerted a powerful influence on their perception of the pregnancy and of the subsequent spontaneous abortion.

Property 3: Safeguarding

Parents who were committed to a pregnancy took measures to ensure the safety of the pregnancy. When the first symptoms of spontaneous abortion appeared, the usual measures of safeguarding a normal pregnancy were replaced with measures directed to attempting to save a threatened pregnancy.

> I had some symptoms for about a week.... And then I talked to my doctor about it and he advised just trying to take it easy as much as possible and contacting him if anything more happened. And, I think it was the Monday night of that week I had quite heavy bleeding and called him again and he asked me to go in to the hospital the following morning. [Case01]

> ... it was really just leaking amniotic fluid until I got closer to the end and I was sort of on and off bedrest. Like, I'd be okay, and then I'd sort of have to be back in bed again.... And then I must have started bleeding again. Because then I had to call the hospital and they admitted me. And then I was in for 10 days until I lost them. [Case03]

For some who had lost previous pregnancies, more extreme measures were taken.

> Because of her previous history of miscarriages and the concern that these pregnancy losses might be related to an incompetent cervix, C. quit her job when she became pregnant so that she could rest as much as possible in an attempt to carry this pregnancy to term. [PO3]

> D. has had 2 late miscarriages related to an incompetent cervix. Subsequent to these losses, she gave birth to 2 living infants. These successful pregnancies were accomplished through medical interventions such as a cervical stitch and complete bedrest. She then became pregnant a fifth time, but experienced a spontaneous abortion at 8 weeks gestation ... This pregnancy loss was very difficult for her, because she and her husband had spent a great deal of time trying to decide whether to try for a third child. They had also gone to considerable lengths, once they had made the decision to go ahead, to conceive at a time when it would be convenient for D. to spend several months on complete bed rest. [PO4]

In contrast, previous experience with spontaneous abortions helped one mother decide that extraordinary measures to save a threatened pregnancy were not appropriate.

> ... and she [physician] just told me basically to go home and not to do too much. To try to put my feet up. Well, I'm not the type of person that will do that and I thought ... if I'm going to lose it, I'm going to lose it. And not sitting at home isn't going to make any difference. And I would have hated to have sat at home, say for 2 or 3 months and then had it happen anyway and wasted that time. [Case02]

Safeguarding behaviours reported by the subjects in this study were all enacted after conception. All subjects in the study were very conscious of the fact that the mother, during pregnancy, must be constantly aware of threats to the well-being of herself and her fetus. Further, they attempted to organize their lives and

manipulate their environments to ensure that such threats were avoided or minimized.

Property 4: Making Room

Making Room is the process of enlarging one's psychological and physical space to accommodate the expected child. Many parents in this study talked about making psychological preparations for the expected child. Psychological preparation also included telling others about the pregnancy. Telling others helped to confirm the reality of the expected child and involved significant others in the process of psychological preparation.

> This was an acknowledged child. We, as a family, had acknowledged the forthcoming of another child. And by acknowledging that, that child exists. [Case04]

The decision as to who would be told depended on the parents' perception of whether the response to the news would be supportive or non-supportive. Supportive behaviours enhanced psychological preparation for the child.

In contrast, non-supportive responses were perceived as threatening to the parents' ability to psychologically prepare for the pregnancy, and were avoided as long as possible. One subject, who was single, experienced considerable anxiety about telling her family about her pregnancy.

> And I really wanted to tell my family, but I really couldn't ... I knew that my Mom wouldn't deal with it well. [Case05]

Making plans about the child's future life is another indication of Making Room. Subjects frequently stated that their plans for the expected baby extended far beyond its early infancy.

> ... well, because I spent so much time thinking about wanting to have this baby. It was like you had practically raised him in all your dreams and in your mind. So he was ... he'd grown up, practically. Eighteen or nineteen years old. [Case05]

Parents who are Making Room for the expected child may modify their present living arrangements in order to provide physical space and necessities for the child.

> ... our trailer at the lake is very small.... And it's fine for the 3 of us. But, when you talk about putting a baby in there and that's pretty cramped.... So we had talked about buying a new trailer.... I had all the plans of changing our office upstairs into a baby's room.... I had bought some wallpaper and some blankets and things for bringing the baby home.... [Case02]

Behaviours consistent with Making Room were observed in all subjects included in the study. All subjects in the study had made psychological preparations for the new baby. All had given consideration to modification of present roles and responsibilities to accommodate the arrival of the expected baby. However, not all subjects had gone on to plan or create physical space for the infant.

Contingent Variables

The length of the pregnancy was identified by many subjects as a factor which increased the strength of the commitment to the pregnancy. This topic was frequently discussed in the support group.

> E. stated that she, too, feels that the longer the pregnancy exists, the more committed one gets to it. [PO2]

Some subjects participating in interviews also stated that they believed that one became more attached to the pregnancy as time went on.

> Plus, also, the longer you have the pregnancy, the more time you have to attach yourself and the more dreams and plans you make. [Case 02]

However, the gestational age of the spontaneously aborted fetus may be only the crudest and most minimal estimator of the strength of commitment to the pregnancy. While it is obvious that more time allows the initiation of more behaviours consistent with Committing to the Pregnancy, some of the behaviours identified in this study, particularly within the properties of Desiring and Making Room, are possible before the pregnancy begins. Further, some subjects in this study reported that they began to enact these behaviours prior to conception.

The strength of commitment to the pregnancy may also be influenced by the fact that this is, in some way, a special pregnancy. This was true for the couple expecting twins.

> I guess the really hurtful part comes in is that this is twins and that if I have another pregnancy, it's not likely to be twins again. [Case03]

Another subject, who had remarried, reported that her third spontaneous abortion was a very difficult experience because it was the first pregnancy of her new marriage and her present husband's first child.

Other contingencies influencing Committing to the Pregnancy were identified during data analysis. However, these have been specified as a subprocess of the Experience of Spontaneous Abortion, and will be described within the section discussing the theory as a whole.

Time Frame

The time frame within which Committing to the Pregnancy takes place begins, in some cases, before conception and does not necessarily end with the spontaneous abortion. For one subject, committing to the pregnancy began long before conception.

> F. stated that she had actively considered getting pregnant for about 2 years before she finally conceived ... so that, when she finally did get pregnant, she felt like she had already been pregnant for 2 years. For her, the length of time that she was actually pregnant was irrelevant. It was the time that she had committed to the decision that counted. [P02]

In the instance of an unplanned pregnancy, commitment may not begin until the parents have reconciled themselves to the unexpected conception. One mother, who had become

pregnant sooner than she and her husband had planned, described the growth of her attachment to the pregnancy.

> We were planning on a second one, but it wasn't a planned pregnancy.... And there was a lot of denial at first. Not that it was any big deal. It's just that it kind of caught us off guard. [Case 04]

Commitment to the pregnancy continued despite symptoms indicating that the pregnancy was in peril. One mother, who realized the significance of the cramps and bleeding she was experiencing, stated:

> Well, when the spotting started I knew that was not a good sign. It was more than just a trace. And I kept hoping it wouldn't happen, because I wanted to have a baby. [Case01]

One couple experienced 6 weeks of uncertainty. Complications in the pregnancy began when the wife noticed that she was leaking amniotic fluid. After bedrest at home failed to control this problem, she was admitted to hospital where she remained until the pregnancy ended. During this time, the couple also found out that they were expecting twins. Throughout this stressful experience, they maintained their commitment to the pregnancy.

> Researcher: ... you had ... six weeks to think about whether this was really going to work or not. Did you stop investing in a future and kind of start taking it one day at a time, then? Or did you continue to look to the end of the pregnancy with some sense that it would be positive?
>
> Father: I think we hoped for the best.
>
> Mother: Yeah, we did mostly.... I would say that I was quite optimistic. [Case03]

For some subjects, the psychological attachment to the child was never ended, or replaced with something else. Even after the spontaneous abortion, they continued to think about the child and even to consciously communicate with the child.

> I think, you know, there will always be somewhere in the back of my mind the fact that there was another child that didn't get to be born. [Case01]

> ... he'll always be there in my mind and always be there in my life. And I don't want to forget him. [Case05]

> During the discussion of memorial services and graves, G. stated that if she wanted to pray about or to the baby, she would go to the baby's grave to do so. [P01]

The commitment to the pregnancy was never really terminated for these subjects. Therefore, no end point to the process of Committing to the Pregnancy was identified in this study.

Category II: Experiencing the Spontaneous Abortion

The category of Experiencing the Spontaneous Abortion describes the psychological responses of subjects during the time that the spontaneous abortion was actually taking place. Although information about physical responses was also sought from subjects, little data relating to this aspect of the spontaneous abortion was obtained. It was evident that subjects were much more concerned about the

psychological impact of the spontaneous abortion than the physical impact.

Three properties of Experiencing the Spontaneous Abortion were identified during the analysis of data. These properties were 1) Dealing With the Unexpected, 2) Assessing the Possibility and 3) Acknowledging the Reality. Each property will be discussed separately.

Property 1: Dealing With the Unexpected

Dealing With the Unexpected is the process of recognizing and responding to physical signs and symptoms indicating that a spontaneous abortion might occur. All subjects stated that the spontaneous abortion was not anticipated. Those who had previously experienced a full term pregnancy stated that they never expected to encounter difficulties with a subsequent pregnancy. Even those who had experienced previous spontaneous abortions and fetal deaths stated that they were not prepared for another unsuccessful pregnancy.

> I just couldn't ... as much as the other 2 miscarriages before, I just couldn't believe this would happen again ... [Case02]

One subject stated that she was so unprepared for the possibility of a spontaneous abortion that she actually missed early symptoms indicating that there might be problems. Only after the pregnancy ended did she look back and recognize them.

> And it dawned on me that I hadn't even paid attention to the fact that I could have a miscarriage.... all that stuff was in all those books that I read, but it was like they weren't there.... I completely blanked them out.... I remember thinking.... how come I didn't cue into the signs and symptoms.... some of them were all there.... [Case05]

Recognition of signs and symptoms indicating that the pregnancy was in jeopardy were accompanied by feelings of fear, disbelief, shock and grief.

> I felt ... like my heart was being ripped out. [Case02]

> I felt really ... miserable and scared ... [Case01]

> Because all the sudden [there was] this gush of blood ... at that point I would say that I was the most terrified of any point ... throughout the pregnancy and labour and delivery ... [Case03]

> ... and then all of a sudden, my bag of waters broke.... I knew it, but I didn't want to believe it. ... I thought, "Oh my God, what happened?". [Case05]

The fear experienced by the subjects was in response to several aspects of the threatened spontaneous abortion. Although no subjects stated that they feared death of the mother as a result of the spontaneous abortion, subjects were fearful because the bleeding and cramps were perceived as a threat to the well-being of themselves or their spouse.

Fear of admission to hospital and fear of the medical procedures commonly used to treat spontaneous abortion was also identified by the subjects.

> That prospect did not appeal to me very much, because there was a general anaesthetic and ... that frightened me. [Case01]

For one couple, the fear associated with medical procedures was based on their perception that the staff caring for the wife did not know what they were doing. The wife's pregnancy was so advanced that it could not be terminated by Dilatation and Curettage (D&C). Instead, it was decided to induce labour in order to expel the pregnancy.

> So, they decided that they would start inducing me ... on the antenatal care ward. But the problem was that the staff there weren't qualified or adept ... at administering the drug. And they couldn't understand the levels that were supposed to be on the IV bag.... And I was very upset that they were giving me the wrong levels and they couldn't get the needle in me and everything.... I was afraid I was going to be given an overdose or something. [Case03]

Fear for the safety of the baby was also identified. Subjects knew that if the spontaneous abortion did occur, the fetus would die.

Some variables increased the intensity of the emotional response to the threat of spontaneous abortion. One subject stated that the fact that the pregnancy had proceeded past the point where most spontaneous abortions occur made her even more unprepared for the symptoms which preceded the termination of her pregnancy.

> I think probably because I'd gone the three months or whatever that they usually say you have problems ... [Case03]

Other subjects stated that the irony of having a joyful event in their lives unexpectedly change to one of sadness

and grief made their emotional responses more intense.

> And you don't expect to go to your first prenatal check, which is supposed to be a happy prenatal check and find out that your fetus is dead. [Case04]

Losing the sense of mastery over one's own life and aspirations intensified the emotional responses to the threat of spontaneous abortion. Several subjects stated that the onset of the symptoms of spontaneous abortion forced them to realize, often for the first time, that they did not have any power to control the outcome of this pregnancy. They also began to realize that control of any aspect of conception and pregnancy was not really possible.

> And any time I had a problem, I was able to overcome it. And this was something I had absolutely no control over. I couldn't stop it when I wanted to. I couldn't even go out and say, well, okay, that's happened and a month later I'm going to be pregnant again. Because I don't have any control over that, either. [Case02]

Emotional responses to the spontaneous abortion were also influenced by unexpected aspects of the process of the spontaneous abortion. Several subjects stated that they had not expected the actual spontaneous abortion to occur as it did. One subject, whose fetus died in utero and who experienced symptoms for several weeks before this was diagnosed, stated that she had not expected a spontaneous abortion to happen in that manner.

> I guess I kind of expected that, if I'm going to miscarry, I'll spot for a few days and then whoosh, it will be over. But it wasn't. [Case04]

Another subject's emotional responses to the termination of her pregnancy were intensified by the diagnosis of a hydatidiform mole. Suddenly, she had to deal with the fact that there had never really been a fetus inside her.

> H.'s third pregnancy was a hydatidiform mole which was diagnosed at 4 months and removed by D&C. She found this experience very difficult to cope with. To her, the pregnancy had been a baby, and the knowledge that there was not even a fetus present was horrifying to her. [PO2]

All subjects in the study reported behaviours consistent with the property of Dealing with The Unexpected. Previous life experiences, and knowledge of the reproductive process did not seem to prepare the subjects for the possibility that a spontaneous abortion might occur. Without exception, subjects described themselves as being shocked and unable to believe that the pregnancy might be threatened. It is within this context that subjects then had to evaluate the degree of real threat posed to the pregnancy by the unexpected signs and symptoms of spontaneous abortion.

Property 2: Assessing the Possibility

Assessing the Possibility is the process of evaluating subjective and objective information in order to assess the degree of threat to the pregnancy. From the time that the first symptoms were noticed until the time that the pregnancy was finally over, subjects attempted to verify whether or not their perceptions that the pregnancy was in

peril were accurate. Initially, hope and apprehension alternated. But as the symptoms continued, and diagnostic tests were performed, the inevitability of the spontaneous abortion became more apparent.

> ... I was having a lot of bleeding in the hospital. And a lot of loss of amniotic fluid . . . . And, at that time, I couldn't see how all this could be happening to me and I could still end up with healthy babies. [Case03]

Part of the verification process was the monitoring of physical signs and symptoms. Many subjects described observing or saving physical evidence such as blood clots which might enable physicians to determine whether the pregnancy had been expelled. Most subjects described this aspect of evaluating the possibility of a spontaneous abortion as very unpleasant.

Verification was also sought through contact with the health care system. Physicians were consulted and diagnostic tests conducted to provide more concrete information on the status of the fetus and the pregnancy. Subjects stated that, during a time of considerable stress, they frequently had to wait for the health care system to respond to the threatened spontaneous abortion. Not being able to control the speed or quality of the response to their crisis made dealing with a difficult situation even more difficult.

Subjects described waiting for physicians to call back, waiting to be booked for diagnostic tests, waiting

for test results, waiting for a stretcher in the emergency department, waiting for a bed on the ward and waiting for a time on the operating room slate. One subject stated that the 24 hour wait between the time her fetus was diagnosed as dead and the time she was admitted to the hospital for a D&C was the most difficult part of her experience with a spontaneous abortion.

> The next day, I waited for the call to go in.... And I went and got my lab work done. And then I got called at 3 [PM] to come.... And then it was a case of waiting for an operating room.... you almost wished that you could abort it, because knowing the fetus was still there, but it wasn't going to be anything ... [Case04]

The husband of this subject also found the experience of waiting for a surgical procedure to remove a dead fetus from his wife's body very distressing.

> My feelings were ... how can you wait that extra day with a non-living thing in your body ... [Case04]

Waiting for the results of diagnostic tests such as ultrasound was also consistently identified by subjects as a variable which increased their anxiety and frustration, and at the same time, diminished their ability to assess the possibility of a spontaneous abortion. Subjects stated that they had wanted to be informed immediately of the results of these tests. Further, they stated that they frequently knew what the results were, and being told by a technician or hospital based physician that they would have to wait until their personal physician could inform them of

the test results made them angry.

> I knew there was something wrong, because I was in ultrasound for over an hour. If there's nothing wrong, you're not in there for that long. And I told the ... girl [technician] "my doctor has told me if there's anything wrong, you're to tell me." So she came back and told me "Dr. [hospital based physician] has gone home." Which I knew he hadn't.... So, I got the news in the waiting room over the phone from Dr. [her personal physician] [Case04]

> I could tell by her face. I could tell by looking on the screen. You have to be pretty stupid not to, you know.... And also the fact that they told us that they would call [my husband] in and they didn't. So the only reason they wouldn't call him in was because there was nothing to show him. [Case02]

Another variable which diminished the ability of parents to evaluate whether the symptoms being experienced posed a threat to the pregnancy was the optimistic feedback initially given by significant others and health care workers. One subject stated that assurances from friends that symptoms such as spotting did not always mean that the pregnancy would be spontaneously aborted interfered with her ability to assess the reality of the threat to her own pregnancy.

> It's really unfortunate that people said that to me, because that really gave me a lot of false hope. [Case04]

Another subject, who went to the emergency department because of severe bleeding, also stated that the neutral and optimistic responses of the physicians who examined her only increased her emotional distress.

> And, of course, they can't ever tell you anything negative. The only person who can tell you anything negative is ... your own doctor, not even the resident. So, you know, each time you're asking any questions, they're trying to be as positive as they can. Well, that's not helping you. I would rather they had said " I'm sorry, ... but there really isn't much of a chance in Hell that this is going to turn out okay.". [Case02]

Subjects stated that the falsely optimistic and slow responses of health care professionals to what they perceived as a medical emergency caused them to wonder if perhaps they had overestimated the severity of the threat to the pregnancy.

> ... [I] almost wondered what I was doing there. Do these people know why I'm here? And is this really happening to me? And maybe it's not really that important. Maybe I'm making a big deal out of nothing. [Case02]

Confusion about test results and conflicting information also diminished the ability of subjects to assess the threat of spontaneous abortion. One subject spent ten days in hospital before her pregnancy ended. During that time, she was continually presented with conflicting information and prognoses by the many health care professionals involved in her care.

Assessing the Possibility occurred after subjects acknowledged that the threat of spontaneous abortion, although unanticipated, was real. Both concrete observations such as diagnostic tests and subjective observations such as the experiences of other people were used to assess the degree of threat to the pregnancy. This

process continued until the time that the spontaneous abortion finally occurred or until final diagnosis of fetal death was confirmed. Subjects then moved from Assessing the Possibility of spontaneous abortion to actually dealing with the reality that this event had occurred.

Property 3: Acknowledging the Reality

Acknowledging the Reality is the process of finally coming to know that the spontaneous abortion has occurred and that the fetus is dead. Throughout the time that subjects waited for final confirmation that the spontaneous abortion was a reality, they were forced to control their emotional responses and try to carry on with their personal lives in as normal a manner as they could manage. One subject described at length how she had to hold herself together as she waited for the ultrasound results and, later, for admission to hospital for a D&C. Final confirmation of the inevitability of the spontaneous abortion caused a flood of grief after the previous numbness.

> And then, poof, all the tears are there. Boy, were they there. [Case04]

Another subject described her response when she was finally told that the fetuses were dead and that the pregnancy was over.

> I bawled my eyes out. [Case03]

Subjects had no difficulty in attaining an

intellectual understanding that the spontaneous abortion had occurred. Most subjects underwent medical or surgical procedures to terminate the pregnancy. Therefore, even if they had not acknowledged the finality of the spontaneous abortion up to that point, finding themselves in a recovery room after the completion of the procedure forced them to accept the reality of the situation. One subject, who experienced a spontaneous abortion without medical assistance, and in a foreign country, was forced to acknowledge the reality of this event because she, alone, had to care for herself and for the expelled fetus.

Some subjects stated that, emotionally, they knew the pregnancy was over even before medical and surgical procedures were performed to terminate the pregnancy.

> ... the Monday evening, I had a lot of ... cramps and bleeding. I think, for me, that was when it really happened.... by the time I got to the hospital, I had stopped bleeding. [Case01]

For other subjects, emotional acknowledgement of the reality of the spontaneous abortion did not take place for some time after the event. This observation was recorded by the researcher after an in-depth interview with one subject.

> She said that her body kept telling her she was pregnant, even though she was not. This feeling persisted for about 2 months. She found the dichotomy between what her head knew and what her body felt very distressing. She would wake up in the morning thinking that the whole thing had been a dream, and that if she would only wake up, she would realize that she was still pregnant and that it really didn't happen. [Case02]

After the reality of the spontaneous abortion was acknowledged, subjects described themselves as feeling very isolated from other people. They stated that they felt alone even when they were with other people. Isolation from significant others such as spouses, and close friends was frequently identified. The isolation experienced by subjects made it very difficult for them to talk to anyone about what had happened.

Psychological isolation was also described in instances where health care professionals did not, in the subject's opinion, consistently attend to their psychological needs during and after the spontaneous abortion. Two subjects described the psychological isolation they experienced while in the hospital.

> But, the nursing staff up there, I felt weren't supportive. It was a procedure to them. And they're busy. I know that from being in the hospital. But, it's not an excuse. [Case04]

> I guess if I had had something more severely wrong, I would have had more attention.... I can't 100% blame the staff, because ... I tend to be the perfect patient. And I guess I could have said something, too. But ... I feel the onus is on them to say something first. [Case02]

The psychological isolation experienced by subjects was frequently increased by the fact that, during the medical or surgical treatment of the spontaneous abortion, they were also physically isolated. Entering hospital and leaving familiar surroundings and loved ones at home increased the subject's perception of being alone.

Subjects reported that they were physically isolated by health care professionals. Even physical care was not consistently offered to subjects who were admitted to hospital. Instead, they were sometimes forced to either ask for or go without the care they felt that they should have been offered to them.

> There was nobody around. I was in ... a dark hallway ... off in a corner.... People kept coming by ... "It won't be long! [she was cupping her hands around her mouth and raising her voice as if shouting a long distance] It won't be long now!" Down the hallway, you know. [Case02]

> So, I put my light on again and I heard them [the nurses] yelling down the hall "What does she want now? I've already bathed her and washed her and taken her to the bathroom."... And I was very humiliated and would have gladly gotten up and gone [to the bathroom] myself if I could have. [Case03]

Subjects stated that they felt empty and lonely for the baby. They became preoccupied with thoughts of their bereavement and circumstances surrounding it. One subject stated that she had difficulty sleeping for about 2 weeks after the D&C which terminated her pregnancy. She stated that, instead of falling asleep, she would start thinking about what had happened to her. Other subjects stated that, for a time after the spontaneous abortion, their ability to work and interact with others was affected by their preoccupation with the bereavement and with the events surrounding the spontaneous abortion.

Behaviours consistent with Acknowledging the Reality of the spontaneous abortion were reported by all subjects

in the study. None denied that the spontaneous abortion had occurred. However, acknowledgement of the spontaneous abortion was not equated with acceptance of the event by the subjects in this study.

Contingent Variables

Many of the contingent variables which influenced parental responses to Experiencing the Spontaneous Abortion have been discussed within the individual properties of this category. However, one previously identified contingent variable was observed to have a significant impact on the entire category of Experiencing the Spontaneous Abortion. This variable is the time spent waiting for the spontaneous abortion to occur.

Waiting created considerable emotional distress for those who had reason to believe that a spontaneous abortion might terminate their pregnancy. Waiting was experienced for two reasons. First, spontaneous abortions do not always occur abruptly and come to completion within a matter of a few hours. Frequently, women experience vague initial signs such as spotting or cramping. These symptoms may subside and recur over the course of several days or weeks. Absence of the symptoms brings hope that perhaps the pregnancy is not in jeopardy. Return of the symptoms or an increase in their severity causes the anxiety and fear to return. Expectant parents ride an emotional roller

coaster while the physiological process of the spontaneous abortion unfolds.

The second aspect of waiting is that which is imposed by the health care system. The subjects in this study did not, in their estimation, always receive rapid responses to their problem. Instead, they were required to wait until the health care system could accommodate them. Subjects described waiting for days, or even weeks to be accommodated for diagnostic tests or to get their test results back. Even when the spontaneous abortion was medically diagnosed as inevitable, they sometimes had to wait several days for the medical or surgical procedures necessary to terminate the pregnancy. Waiting for the health care system to respond was a significant additional stressor. Parents expressed considerable anger about the way that the health care system responded to their spontaneous abortion. After the experience was over, they had to work through their anger about how they were cared for in addition to all the other emotions caused by the spontaneous abortion.

Time Frame

The process of Experiencing the Spontaneous Abortion began with the recognition of the first symptoms indicating that a spontaneous abortion was possible. Experiencing the Spontaneous Abortion ended in the physical sense with the

expulsion of the fetus. Psychologically, it ended with the final acknowledgment that the pregnancy no longer existed.

Category III: Putting It In Its Place

Putting It In Its Place is the process of gaining an understanding of the impact and meaning of the spontaneous abortion. This is a psychological process whereby each person affected by the spontaneous abortion comes to his or her own understanding of the experience. Three properties of Putting It In Its Place were identified: 1) Understanding the Magnitude, 2) Finding Reasons and 3) Expressing the Loss.

Property 1: Understanding the Magnitude

Understanding the Magnitude is the process of evaluating the impact of the spontaneous abortion on one's life. Coming to an understanding of the magnitude of the loss required the parents to place a value on that which was lost and come to an understanding of the effect of the loss on his or her life.

Those who experience a spontaneous abortion generally came to some decision as to the value of that which was lost with the pregnancy. For some, this event involved the death of a significant person. One mother, who was on vacation in another country at the time that the

spontaneous abortion occurred, went to extraordinary lengths to preserve the body of the fetus for the rest of the vacation so that she could bring it home with her for burial. For her, the spontaneous abortion resulted in the death of a significant person in her life. Another couple expressed similar feelings.

> Mother: Like, we had the feelings of the loss.... it was like somebody had died in our family.
>
> Father: The loss of a family member. That was my feeling.
>
> Mother: Yes, it was like that.
>
> Researcher: Just like somebody had died.
>
> Father: A part of me. Yes. [Case04]

This couple placed such a high value on the spontaneously aborted fetus that they found it painful to contemplate any suggestion that it might have been imperfect.

> Father: And I don't like to think of it as having been imperfect in any way. Because, it was a part of me....
>
> Researcher: But, I think what you're saying is that, for someone to tell you that it didn't happen because there was something wrong with the baby was not only saying something about the baby, but it was saying something about you, too.
>
> Father: Yeah, I think so. Yeah. [Case04]

The second aspect of Understanding the Magnitude is coming to a realization of the effect of the spontaneous abortion on one's life. Many subjects stated that this experience had wide reaching implications. For one couple, the psychological impact of the spontaneous abortion was

far greater than they had ever imagined possible.

> I took it a lot ... we both took it a lot harder than we thought we would. [Case04]

For many subjects, the experience represented loss of more than just the fetus. The future, with all of the dreams and plans invested in it, was lost as well. This aspect of the experience of spontaneous abortion was frequently discussed at support group meetings.

> I. felt that her whole life plan had been thrown out of kilter by the spontaneous abortion. [PO5]

Interview subjects also stated that the future was lost as the result of a spontaneous abortion.

> She stated that the most difficult aspect of losing a pregnancy is that the future is lost, whereas when older people die, it is the past that is lost [Case01]

> Because, not only have we had to deal with the loss of the baby, but we've had to deal with the grief of infertility. And that was really tough. So that's what the miscarriage symbolized to me, I guess. It was like the end of a dream or the end of the future, in once sense. [Case02]

Accompanying these feelings of loss was a feeling of emptiness and futility.

> I think the hardest part about the miscarriage is being pregnant one minute and not pregnant the next. And not having anything to show for it. [Case04]

Subjects who had experienced more than one spontaneous abortion evaluated each one separately. Each evaluation was unique. Several subjects identified one particular spontaneous abortion as being more sad or more difficult. One support group member had experienced three spontaneous

abortions within a twelve month period. She stated that the first spontaneous abortion had the greatest impact on her life. She barely noticed her subsequent two spontaneous abortions because she was still preoccupied in trying to deal with the circumstances surrounding the first. Another subject, who had also experienced three spontaneous abortions, stated that the most recent one had been the most difficult because it had occurred later in the pregnancy than the first two. She also stated that this spontaneous abortion was the most difficult to deal with because she believed that it was her last chance to have a child. She believed that she would never be able to get pregnant again.

In order to come to a more rational understanding of the magnitude of the loss, some subjects compared their experience to others with similar or comparable bereavements. For one subject this comparative strategy helped her to conclude that her bereavement was no different than that of others close to her.

> Two of my older sisters had miscarriages. So among the lot of us ... we're about the norm. [Case01]

One subject concluded that, compared to others, she was more fortunate.

> ... my room mate was the same length of pregnancy as mine, but she had carried hers [referring to the dead fetus] for 10 days.... you're not so bad. You were only a day. And lucky you were only 3 months, the girl down the hall delivered two 5 month twins. [Case04]

One couple was even able to find something positive about the impact of the spontaneous abortion on their life. For them, the termination of an unexpected pregnancy, although undesired and difficult to accept, was also an opportunity to return to previously formulated plans about the spacing of the children in their family unit.

> See, the ideal situation . . . not the ideal, certainly, but it was almost as if you were given an opportunity to get yourself back on schedule. [Case04]

Behaviours consistent with the process of Understanding the Magnitude were reported by every subject participating in this study. It would appear that it was necessary for each individual who had experienced a spontaneous abortion to come to some conclusion about the significance of this experience.

Property 2: Finding Reasons

Finding Reasons is the process of finding an answer to the question "why did it happen to me?". Two patterns of behaviour were identified by the researcher very early on in data collection. One was that, invariably, subjects tried to find reasons for their spontaneous abortion. The second finding was that having a reason, no matter how irrational that reason might appear to an outside observer, gave the subjects a framework within which to discuss and come to an understanding of their experience. During the participant-observer phase of data collection, the

researcher observed two situations where no explanation of the bereavement had been formulated. One subject had experienced several late spontaneous abortions. The last of these occurred one year before she attended the support group. She could give no explanation for the spontaneous abortions. She stated that no medical person had ever explained the reasons to her. She also had no explanation of her own for these events. This individual was overwhelmed by feelings of anger and hostility and was unable to talk about anything else during the meeting.

A young couple whose full term baby had died one day after birth participated in one meeting. They, too, had no factual or personal explanation as to why the baby had died. This couple sat in silence for most of the meeting, speaking only when someone asked them a direct question. They could express only feelings of emptiness and anger.

The desire to formulate an explanation for the spontaneous abortion resulted in considerable effort on the part of some subjects to obtain information about this pregnancy complication, even though most of them knew that no concrete explanation was likely possible. Most subjects stated that they asked their primary physicians to identify possible reasons for the spontaneous abortion. Several also requested a consultation with a specialist if their primary physician was a general practitioner. One subject took her list of questions to four different specialists in

order to compare their answers. Many subjects went to libraries to look up information on spontaneous abortion. Considerable frustration was expressed about the current limited knowledge about the etiology of spontaneous abortions and about the limitations place on pathology examinations of the expelled fetus and placenta. In the absence of a concrete medical explanation for the problem, most subjects turned to other ways of explaining why the spontaneous abortion had happened to them.

A frequent explanation for the spontaneous abortion was that it was part of the natural course of life. Those who formulated this explanation believed that a mechanism to reject non-viable conceptions was an integral part of the biological process of reproduction.

> The main thing I believed and still do believe, which is factually true, is that quite a few conceptions simply don't make it. There's something wrong with the egg or the sperm or the conception and it simply isn't meant to come to term. [Case01]

> It was just Mother Nature's way of taking care of it [Case04]

In contrast to the passive process described by those who accepted a biological explanation for the spontaneous abortion, some subjects explained that their spontaneous abortion was the result of direct intervention by some Spiritual Being who acted out of concern for them.

> I get this feeling that because it was a twin pregnancy or whatever ... it was sort of God's way of saying you can't handle it. [Son] would have been only been 17 months old and to have two

> little ones after that ... [Case03]

Further, some subjects believed that this Being intervened because it had other plans for them.

> J. stated that she has begun to believe that she keeps having miscarriages because God wants her to look after other children and not her own. [P03]

> Perhaps His major plan is that we should have one of our own and adopt a child. [Case02]

Some subjects believed that the Being acted to punish them for some misdeed.

> ... I had a fear of God. I thought I was being punished. [Case05]

> K. also stated that perhaps she had been so unfortunate because when she was pregnant with the 3rd child, she had been playing a witch in a theatrical production. She stated that perhaps some misfortune had fallen on the pregnancy because of this. She alluded to the power of forces not known or understood by us. She also felt that she might have been punished by God, although she did not state why she might deserve that punishment. [P02]

Events which occurred prior to or during the pregnancy were frequently identified as reasons for the subsequent spontaneous abortion. One mother wondered if a therapeutic abortion she had undergone many years ago was the reason for her subsequent history of infertility and spontaneous abortion. Another mother believed that the spontaneous abortion occurred because she fell down some stairs.

> The other thing was I fell down the stairs. The doctor says no, but I'm convinced ... to me, it [the fetus] pulled away from the placenta. [Case04]

Delaying pregnancy until the parents were financially

secure was identified as a source of guilt feelings.

> I felt guilt, in the sense that perhaps I ... somewhere along the line I had made a tradeoff. All my material things for a baby. I know it's stupid, but I felt that way. [Case02]

Another mother believed that the spontaneous abortion occurred because she had gone to a foreign country for a holiday and that she had overexerted herself.

External pressures such as illness in the family were given as another reason for the spontaneous abortion.

> There was a lot of pressure the entire time that I was pregnant. And sometimes, I often wonder if that wasn't part of the problem. [Case03]

Where explanations involved some element of wrong doing or inadequacy on the part of the parent, guilt and self-blame were frequently expressed by the parents. High levels of guilt resulting in difficulty coping with the experience were not observed in the subjects of this study. Some subjects used the insights gained from guilt responses to formulate plans for how they would behave during a subsequent pregnancy.

> L. stated that she wanted to know why this kept happening to her. She stated that she was willing to take the blame if it was her fault. She just wanted to know why, so that next time she could do something to prevent it from happening again. [PO3]

Subjects identified as having considerable difficulty in dealing with the spontaneous abortion were those who either had no explanation for the event, or whose explanations involved blaming someone or something else for

what had happened. Blaming behaviours were accompanied by considerable hostility against those identified as being at fault.

> When the conversation in the group was centered around finding an acceptable explanation for the pregnancy loss, M. said that she blames her husband. She stated that one of the theories for the development of a molar pregnancy is that the sperm somehow generates a pseudopregnancy without the presence of an ovum. She believes that her husband's much younger sperm must have been very active in her body and done this to her. She stated that his lack of concern about contraception made the subsequent miscarriages his fault. She stated that she bears all the scars of these pregnancy losses: the emotional strain, the physical and mental exhaustion and the excess weight. She stated that he has had to bear none of the consequences of their losses. [PO2]

> N. blames God. She stated that one evening, she left the house without telling anyone where she had gone. When her husband finally found her, she was throwing stones at the walls of the Chapel ... [PO3]

When asked why the spontaneous abortion had occurred, most subjects had more than one explanation. Each explanation appeared to offer them an opportunity to contemplate or discuss different aspects of their experience. For example, one subject stated that she believed that her spontaneous abortion was God's way of taking care of things. However, she also believed that it happened because she fell down a flight of stairs. These two explanations served different purposes for her. Knowing that this event was part of a larger plan gave her comfort because she could believe that she was not being

singled out for specific punishment. Yet, believing that the fetus tore away from the placenta when she fell down the stairs meant that she did not have to believe that the fetus was defective.

Some subjects stated that their explanations for the spontaneous abortion changed over time. Generally, this process involved rejecting explanations involving guilt or punishment in favour of more neutral or positive explanations. One mother, who had initially felt that God was punishing her stated that she no longer believed this.

> Researcher: What about now?
>
> Mother: No, I don't feel like I was punished. I feel Mother Nature was there and Mother Nature intervened. And I sort of just look at the animal kingdom and that. And look at how all the species are interdependent of each other and how they interact with their world. That's just the way things are to be. And I'm just another creature living here in this world. [Case05]

Other subjects stated that their initial explanation for the spontaneous abortion had not changed, and had even been strengthened through further analysis and experience.

> Researcher: Is that explanation that you had then the same one that you have now, or has it changed?
>
> Mother: I guess ... it's been strengthened now that we have 2 kids and realize how much more work it is to have 2 children as opposed to one child.[Case03]

The formulation of acceptable explanations for the spontaneous abortion did not dissipate parental anger at the injustice of this event. Most subjects expressed anger

about the fact that this had happened to them. Some subjects expressed anger that the world was so unfair.

> Yes, I would be angry at the number of people that I knew that had kids that didn't deserve to have kids. People who didn't take care of themselves when they were pregnant or just didn't know where their kids were.... just angry that I couldn't have the child that I thought I could provide so well for and all these children were out there in homes who didn't really care a lot of the times [Case02]

> I was so angry. Because, why me? Like, I was the one who could do everything right. You know, I knew all the right stuff. And everybody else was having these kids ... they didn't have the foggiest idea about what they should be doing or how important nutrition was, or brain cell development or all this stuff I had under my belt. [Case05]

Others felt that the spontaneous abortion was unfair because they had suffered a great deal during the pregnancy and still had not been successful in carrying it to term.

> I was really sickly with morning sickness up until about 16 weeks. And that was ... that's the part I really resented when I was losing them. It was sort of like, you have to go through this all over again. I just felt so rotten for that length of time and just sort of ... like that part really made me angry. [Case03]

Since the etiology of most spontaneous abortions is never specifically identified, most individuals who experience a spontaneous abortion can never be entirely certain of the cause. Yet, for every subject in this study, identifying a reason for the spontaneous abortion was an important aspect of Putting It In Its Place. Having a reason enabled the bereaved parent to impose rational order on an otherwise irrational life experience.

Property 3: Expressing the Loss

Expressing the Loss is the process of finding ways to create a framework of meaning for the spontaneous abortion so that the experience can become an integral part of the subsequent life of the parent. Three strategies adopted by parents involved in this process were identified. The first strategy was to talk to others about the experience. Most subjects tried, with various degrees of success, to find people who would listen to them while they recounted the experience and described their feelings. This was a difficult process for two reasons. First, the subjects themselves had to gain enough composure so that they could speak about the experience without crying to the point of incoherence. Second, they had to find someone who would listen to them without imposing their own values or judgments. One subject described trying to tell her mother about the spontaneous abortion.

> And I just told her "I don't know how to deal with telling you this because I think you're just going to be judgmental and I don't want to be judged. And I'm going to cry. And I don't want you to tell me that I am a cry baby." [Case05]

Another subject, who could not talk to her husband because they both became too emotional, wrote him letters telling him how she felt instead.

Sharing feelings meant making other people feel ill at ease. Some subjects were aware of the effect that their sharing had on others.

> My way of dealing with it was probably more uncomfortable for other people, because I wanted to talk about it. [Case03]

Attempts to share feelings about the experience of spontaneous abortion were frequently unsuccessful. Sometimes, spouses and family members could not even share their feelings.

> O.'s marital relationship is in considerably more jeopardy. Because her husband is in the military, they are physically separated for 6 months at a time. She also stated that he is a typical product of 18 years of military training - he does not show or acknowledge emotions. She has found it impossible to talk to him. [PO3]

Sharing the experience was possible only when others were able to respond in a positive way. When this happened, subjects stated that the experience enabled them to come to a better understanding of what had happened to them.

> P. has been able to discuss her feelings and show her emotions with members of her family. She feels that being able to be open with these people about her feelings has helped. [PO4]

Most subjects found that they were best able to share their feelings with those who had had a similar life experience.

> There was considerable discussion about the ability to talk about this experience with others. All three women are still encountering difficulty in gaining permission to talk about how they feel with significant others. Q. stated that the upper limit of permission in the real world is one week, maximum. There was generally a sense of agreement from the others in the group that this was so. R. stated that the only people she can talk to are those who have had an experience similar to hers. [PO2]

A second strategy adopted by parents to express the loss was to withdraw physically and psychologically in order to think about what had happened. One father stated:

> I felt that I needed to deal with it on my own. [Case04]

Subjects who withdrew for the purpose of meditation on the loss went for walks, went to church to pray, read poetry, and wrote diaries.

A third way in which parents expressed the loss was to create memorials and symbols for the dead fetus. Participation in organized religious ceremonies was one way subjects created memorials.

> S. and T. stated that they had had a small family funeral for the baby. [P05]

> U. has had her baby buried at the gravesite provided by [Hospital]. This is important to her. She went to the internment service last week. [P01]

One subject chose to bury her child privately in a grave on her own property.

Some subjects stated that they had made donations to various organizations in memory of the deceased fetus. One organization offers an In Memorium page in its newsletter to which several members of the support group planned to make contributions. Another subject stated that she and her husband had made a memorial gift to their church.

> We also had a Book of Alternative Services dedicated in her name. And we thought that was appropriate. [Case 02]

Choosing a name was another way parents established a

permanent remembrance of the dead fetus. Some used the name they had already chosen when they were pregnant. Others, who had not chosen names ahead of time, did so after the spontaneous abortion. One subject decided to name her fetus several years after the spontaneous abortion occurred.

Symbolic remembrances of the fetus were also used to create memories. One subject had a framed verse of Scripture which she stated was her symbolic remembrance of the fetus. Another had a picture of a small child being held in God's hand. Commemorative jewelry was also discussed during support group meetings.

Finally, experiences in life became symbols by which the memory of the fetus was sustained.

> V. described how a canary had come to her window three days in a row. She believes that the bird is her son. When she had been on vacation, she had decided to give her son the middle name of Jay after the jays that were so common where she was vacationing. So, to her, the canary at the window, also a bird, became the embodiment of her son, come to comfort her. [PO2]

Behaviours consistent with the property of Expressing the Loss were observed in all subjects participating in the study. Although not all subjects reported that they created symbolic memorials or retreated for private contemplation, all expressed the loss by talking about the spontaneous abortion with those they could find who would hear them out.

Contingent Variables

The ability of parents to gain an understanding of the impact and meaning of the spontaneous abortion depended on many variables. Generally, these contingent variables fell into three categories: 1) attributes of the individual, 2) responses of significant others and health professionals and 3) the presence of ongoing medical complications.

Attributes of the individual parent was one contingency on the process of Putting It In Its Place. Some parents were much more successful in their ability to understand the magnitude, find reasons and express the loss than others.

The ability to maintain enough composure to think and talk about the event preceded any undertaking of activities in Understanding the Magnitude and Expressing the Loss. Understanding the necessity for this type of personal reflection was another important variable. Finding Reasons did not seem to be a successful process for the subjects in this study unless they were able to move beyond hostile blaming of others for the spontaneous abortion. Previous life experiences were also identified as variables which had an impact on the process of Putting It In Its Place. An example of a negative life experience was exposure to religious teachings that God directly intervenes to punish sinners. Contrastingly, work experience in Psychiatry enabled one subject to understand the necessity of working

through the process of Putting It In Its Place.

> Maybe working in Psychiatry helped in a way. Knowing that you have to pick up and just go. It's not going to happen on its own. That you have to do it. [Case04]

Persistence was another attribute which enabled some subjects to move through the process of Putting It In Its Place. Most subjects described having to try many times before finding someone who would listen to them talk about their experience.

Possessing a set of values and beliefs about life was identified by subjects as another variable influencing their ability to gain an understanding of the impact and meaning of the spontaneous abortion. Most subjects identified themselves as belonging to a particular Christian denomination, but most were not regular attenders of church services. None the less, the subjects who were able to formulate reasons having to do with biological or spiritual checks and balances were those who stated that they possessed or actively contemplated values and beliefs about the meaning of life. One subject responded to the researcher's question about religious beliefs by stating

> I guess slightly religious in the sense of some sort of spiritual ... but I certainly wouldn't pin it down to any particular creed.
>
> Researcher: But you have an organized system of thinking about life and what it means?
>
> Mother: I'm still working on that. [Case01]

A second category of contingencies affecting the

ability of parents to proceed with the work of Putting It In Its Place was the responses of significant others and health professionals. When the responses of these persons to the spontaneous abortion were congruent with the responses of the parents, the parents found that interactions with them were helpful. One subject described her physician as being very supportive.

> You know, when I needed to sit in his office and cry for a while, he'd let me sit and cry for a while. He didn't try to tell me I was being stupid or get over it and have another one. Yeah, I think he understood the fact that I did feel miserable about it and he didn't spend a lot of time trying to jolly me along. [Case01]

Many subjects described the health professionals who cared for them during and after the spontaneous abortion as being uncaring and even judgmental. These interactions caused considerable difficulty for the subjects, since they had to work through their feelings about these interactions in addition to their feelings about the spontaneous abortion. Sometimes they were left to doubt the validity of their emotional response to the spontaneous abortion.

> It is evident that the responses of others to the end of the pregnancy play a large role in the feelings that these women have about their experience. S. recounted her experiences with her 4th and 5th pregnancies. Both times, the fetus was found to be dead after diagnostic ultrasound. In both cases, the doctor had baldly told her "the fetus is dead" in a manner she found was uncaring and even rude. With the 5th pregnancy, when she had burst into tears at the news, the doctor who was present for the ultrasound told her that there was no need to carry on like that; that she could always get pregnant again. [P02]

Similar examples of supportive and non-supportive responses from significant others were given by all subjects who participated in the study. As with their encounters with health professionals, subjects were helped by significant others whose responses indicated that they understood and shared in the bereavement. Responses that conveyed judgement and an inability to understand or accept the magnitude of the loss for the parent negatively affected the subject's ability to work through the process of Putting It In Its Place.

A third category of contingencies of Putting It In Its Place identified in this study was the presence of ongoing medical complications. Only one example of this contingency was found in the sample, but it is logical to assume that with more sampling, more examples would be uncovered. One subject in this study was diagnosed as having a hydatidiform mole. Women who have this type of pregnancy are at risk of developing a rare, but serious form of cancer for about one year after the termination of the pregnancy (Olds, London, & Ladewig, 1988). This subject described the constant medical follow up and the constant fear of developing this cancer as overwhelming. She was unable to think about anything else during that time. There was no physical or psychological energy available to work through the process of Putting It In Its Place.

Time Frame

The process of Putting It In Its Place began with the first premonitions that all was not well with the pregnancy. One subject stated:

> I think I knew that something was wrong. You know, when you get right down to it, I think I knew that things weren't okay. But you try and turn it into your happy time.... But yet, I stopped for coffee on my way to the doctor's office and I was talking with a person and I said "this one's not going as well.". So, obviously, I knew that it wasn't. [Case04]

The onset or continuation of specific symptoms such as cramps, bleeding or loss of amniotic fluid forced subjects to begin to further consider the implications of these events. One subject, who experienced a sudden loss of amniotic fluid and then an absence of any further symptoms for about two days described her behaviour during that time.

> At the same time, I was reading this book.... its the story of this boy who loses his two dogs and how he has to deal with death. And it just seemed that all this time I was precipitating in my head that I would have to deal with this death. [Case05]

One subject, who had to wait 24 hours between the time that his wife's pregnancy was diagnosed as nonviable and the time that she could be booked into an Operating Room for a D&C stated that he became impatient with waiting for the process of the spontaneous abortion to be over, because he wanted to be able to begin to deal with the loss.

> I've accepted that its this way ... let's get it over with and deal with our thoughts. [Case04]

No discernable end point to the process of Putting It In Its Place was identified. Some subjects continued to enact behaviours consistent with this process for many years after the spontaneous abortion had occurred. However, most subjects were also able to move from their initial preoccupation with the process of Putting It Its Place and direct increasing amounts of their time and energy to an active re-engagement in their ongoing lives.

Category IV: Moving On

Moving On is the process of actively re-engaging in personal, family and social life. As opposed to Putting It In Its Place, which is primarily an internal psychological process, Moving On takes place as the bereaved parent resumes activities of daily living and social relationships. Four properties of Moving On were identified: 1) Re-entering the World, 2) Acknowledging the Changes, 3) Working Through the Pain and 4) Trying Again.

Property 1: Re-entering the World

Re-entering the world is the process of resuming family, social and vocational roles. The resumption of on-going roles is coloured by the reality that the anticipated role of parenthood has been modified or lost. The process of re-entry begins as parents begin to inform significant

others such as family members or friends of the spontaneous abortion. This is frequently an emotionally draining experience. One subject described his attempt to tell his mother about the spontaneous abortion:

> But, when I went to tell her, I couldn't speak. I lost my voice, and then I started sobbing. [Case04]

Telling their children about the spontaneous abortion was identified by the subjects as a particularly difficult task.

> W. also talked about the fact that she could not figure out how to tell her son what had happened to the expected baby She knows that he knows that the baby is gone. His nursery school teacher told her that, at the time she was still pregnant, he had chattered constantly at school about his new brother or sister. But, as soon as she had been hospitalized for a D&C, he abruptly stopped talking about it. She is not sure how much he understands about death and she doesn't know how to explain it to him. Further, she isn't sure that she can tell him, even if she knew what to say, because she would probably break down and cry. [P05]

Co-workers, especially those working with the mother, are frequently involved in the pregnancy and must be informed of its unanticipated termination. Since they may not have been aware as family members of any threats to the pregnancy, the news may be greeted with considerable shock.

> And actually, the first person I [told] was [_____] from work.... And she phoned and she says "Oh, how are you and the baby?".... And I said "baby's dead". And it just put the brakes on the conversation. [Case04]

Fathers, too, informed their co-workers of the termination of the pregnancy. However, it did not appear that co-

workers of the male parent were as involved in the pregnancy. Certainly, much less discussion of this event occurred.

> Researcher: Were they aware of what was going on?
>
> Father: Oh, you know ... vaguely. They knew I was, maybe, not in the office as much ... I was in and out sort of stuff. So, there really wasn't a whole lot of discussion in my circle.[Case03]

As friends and acquaintances were encountered on for the first time after the spontaneous abortion, they, too were informed of the spontaneous abortion.

> I had all the hard stuff to do, though. Because ... [wife] was stuck in [the house] for a time. Most of the people were saying " Oh, how is [wife] and the baby?". And ... I would have to deal with that ... all the people at the club and, just, well, any of our friends ... [Case04]

The difficulties of informing friends about the spontaneous abortion was frequently discussed during support group meetings.

> Y. talked about dealing with friends after her last miscarriage. She lives in a small community. She talked about going to the grocery store, and walking up and down the aisles crying, because she dreaded meeting anyone who didn't know what had happened to her. She did not feel that she could respond to the general conversational opening line of "well, what's up?" without telling them exactly what was up. On the other hand, she did not want to embarrass herself or her friends by bursting into tears. [PO4]

On-going roles and obligations provided parents with structure during a time when some aspects of their life seemed to be out of control. Therefore, although resuming these roles was painful, and subjects frequently described

themselves as only capable of going through the motions when enacting these roles, they were generally grateful for the built-in expectations which propelled them back into interactions with the external world.

The role of parent was identified as an important variable in Re-entering the World. Subjects with children at home stated that the necessity of continuing to care for these children forced them to interact with others and with the larger world rather than to physically and psychologically isolate themselves.

> Z. takes comfort in the fact that she has 2 other children. This give her some incentive to keep going. [PO2]

Returning to work roles was also identified as an important step in the process of re-entering the world.

> Researcher: And you went back to work, which was helpful.
>
> Mother: Yeah, it was. Like, it gets your life back on track.
>
> Researcher: And you kept going to work?
>
> Father: Yeah ... it probably made it so much easier for me, because, ... when I'm at work, I think of nothing else but that. [Case04]

Although returning to work was helpful in the long run, subjects described their first few days back at work as a very emotionally difficult time. Interactions with co-workers were awkward. Subjects were preoccupied with their memories of the spontaneous abortion. Much of their available energy was expended in trying to remain composed.

One support group member described her first day back at work after experiencing a spontaneous abortion.

> A. stated that, after her first pregnancy loss, she felt extremely awkward on her first day back at work. When she walked into her workplace, there was complete silence, and no one spoke to her. In order to deal with this, she walked directly to her work area and stood, working, with her back to everyone. She started to cry, because she began to relive all of the memories of her bereavement. [PO4]

Another subject described the difficulty of suppressing her grief all day so that she could do her work effectively.

> I was so busy that I was suppressing how I felt. So I felt like at the end of the day ... I was going to just explode with sadness. [Case05]

An additional stressor for some subjects was the fact that their work involved daily interaction with children.

> The fact that B. works with premature and extremely ill children made her return to work very difficult. [PO4]

> C. and D. both stated that work is an effort because they are teachers and encounter small children daily in their jobs. [PO1]

Social roles and previous interests were also resumed by subjects after the spontaneous abortion. Resumption of these activities were also described as important steps in the process of Moving On.

> Well, it was summer coming and I could water ski ... I think it helped being summer.... because before if you were pregnant, you couldn't do certain things ... and ... it gave you something else to do to sort of occupy your time ... [Case03]

> I was working on the birth study off and on. So I had that ... you know, I had enough things to keep me busy ... [Case01]

Many of the activities of Re-entering the World were forced upon subjects. Friends and family members had to be informed of the spontaneous abortion. Failure to do so would have resulted in misunderstandings and deterioration of the relationships. Resumption of previous roles and responsibilities was also not generally a matter of choice. The external world, with all of its expectations and requirements was not changed because of the spontaneous abortion. What was changed was those who experienced it.

Property 2: Acknowledging the Changes

Acknowledging the Changes is the process of coming to an understanding of the long lasting or permanent effects of the spontaneous abortion on one's life. For most subjects, the experience of spontaneous abortion forced them to reconsider, or to consider for the first time, fundamental aspects of their lives. Relationships with others, life plans and aspirations, and beliefs and values were examined in the light of this experience. After this analysis, some subjects concluded that, for the most part, they could proceed on much the same basis as before. For others, the experience of spontaneous abortion was a turning point in their lives.

Subjects described themselves as being different as a result of their experience.

> I think that, if I have to be honest with myself, I have changed, never to return to the way I was

> before. And my husband has changed, too. [Case02]

Perceiving oneself as different as a result of the spontaneous abortion took time and was difficult to accept. Most subjects would have preferred to return to their former state rather than deal with the changed aspects of themselves.

> I guess I'm mad because I've lost all that naivety. I'm no longer naive. I will never be that naive again. And that's, I think, sad. You lose a part of yourself when you lose that. [Case02]

Most changes in the self identified by subjects were perceived as positive changes. This was true even if the changes resulted in a more cautious approach to life plans. Subjects stated that their experience made them more aware of the realities of life and less likely to count on plans turning out as anticipated.

> ... it woke me up, I can tell you. [Case04]

> I think I'm being a little more flexible.... I think I really am the kind of person that ... had wanted to always get what she wanted ... always got what she wanted.... because I always believed if you worked hard enough you'd finally get it ... this is the only thing in my whole life that I didn't have a lot of control over [Case05]

This was particularly true with respect to counting on subsequent pregnancies being successful.

> One thing we both said is ... you never take anything for granted. Because something like that you do take for granted until you have experienced something like that. Everybody expects to give birth to a very healthy baby. It's not the case. [Case04]

One subject stated that she had previously believed she could be happy only if she could become pregnant and have a child. After experiencing a spontaneous abortion, she realized that having a child was not the only way in which she could attain future happiness.

> And, you know, it isn't just this one path that would make me happy ... just to have this baby.... I've ... got these three pathways. Like I could get pregnant, and I'll be happy. I might not get pregnant, and I could still be happy. Or I could adopt a child and that would make me happy, too. So ... I've got lots of choices in my life. [Case05]

Subjects stated that they had learned to place more value on the present and to appreciate the relationships they already possessed.

> Things that you cherish you don't take for granted, because you don't know how long you're going to have them. [Case04]

> I sometimes mentioned in one way or another that it may have been for the best. I am happy with what I've got, or am lucky to have what I have. [Case02B]

One subject stated that she had learned to place less value on material possessions. She described her response to her lawyer when she went to consult him about private adoption.

> ... When the lawyer said it would probably cost six hundred to seven hundred dollars, I thought, "Huh! So? Like?". You know, it didn't matter anymore. Money didn't matter. The important thing was to have another child. [Case02]

Another subject stated that the experience of spontaneous abortion and the death of what he had considered to be a member of his family had forced him to

reconsider the whole issue of therapeutic abortion.

> Researcher: So you changed your mind about that, then?
>
> Father: I think it made me jump off the fence a little bit more.... I'm not going to make judgement on a person because they'd do it. I'm just saying that to me ... whereas I might have had a more liberal feeling before towards it in my own personal circumstances, I think I wouldn't now. [Case04]

Many subjects stated that the experience of spontaneous abortion had forced them to reconsider their responses to others who had had this experience. Most felt that they had previously been very unaware of the impact of the spontaneous abortion and they regretted their indifference.

> I know that people at work said silly things to him ... they said "oh, you're young. You can have another one ... and you have one, you should be happy you have one.". Same kind of things as which people said to me. Which I maybe said to other people before this happened to me. I don't know. I hope not, but ... probably I did. [Case02]

They stated that, in the future, they would respond in a more caring and compassionate manner to those who experience spontaneous abortion.

Increased sensitivity to the grief of others was not limited to those who had experienced spontaneous abortions. One subject described the contrast between how she had dealt with two friends. One friend had had a spontaneous abortion prior to the subject's own experience. The other friend had experienced the death of a newborn grandchild a

few weeks after the subject's spontaneous abortion.

> When she [first friend] had her baby, and I said really cruel things like, "oh well, I'm sure that it was nature's way ... and I'm sure you could just try again." When I know that if somebody dared say that to me, I would have been so angry.... And I thought, those words came out of MY mouth.... But at least I know the difference between that scenario and how I dealt with [second friend]. [Case05]

Some subjects believed so strongly that societal responses to spontaneous abortions and other types of fetal and early infant death were inappropriate that they deliberately took action to change these responses. The two facilitators of the support group observed during the course of this study are lay people. They founded the group because they wanted to provide to others the emotional support that they themselves could not find when they had experienced spontaneous abortions. One subject stated that she planned to lobby to change present practices with respect to the performance of pathology examinations after spontaneous abortion. Another subject, a teacher in an elementary school, deliberately began to talk to her children about birth and death. She would do this when the children, during their "sharing time" would tell the class about births and deaths in their own lives.

> So I felt really good in the classroom ... that those events came up. Because then I could start talking with my kids about it ... I felt I was really being a real teacher. We were talking about real things for a change. I always thought I was a good teacher and did talk about real issues, but I realized that those were two issues that I hadn't talked about and those are the two

> big issues in the world that aren't talked about. And boy, I was mad about it. [Case05]

One subject stated that, as a result of her experience, she had learned that she could not live as a totally independent person. She now realized that she needed the help and support of others in her life.

> Researcher: So, far from isolating you in the long run, it has pushed you towards other people in the sense that you understand that you need them, and they need you.
>
> Mother: Yeah, right. Not that it's easy for me to ask, but at least I know that I should. [Case05]

Subjects stated that the experience of dealing with the spontaneous abortion had enabled them to develop strengths that they could carry over into other aspects of their lives.

> D. stated that her grief experience from having had 2 miscarriages really helped her when her father recently died. Unlike her other siblings, she understood how she felt and why she was feeling that way. [PO2]

Subjects learned more about their own strengths and abilities to deal with adversity.

> Now I know that I'm an even bigger survivor. I can survive quite a few things now. So, I learned that about myself. [Case05]

Changes in the individual resulted in changes in relationships with other family members. In contrast with changes within the individual, changes in family relationships identified by the subjects were more likely to be described as either negative or positive. One

subject stated that her experience of several late spontaneous abortions had had a negative impact on her relationship with her daughter.

> E. states that the pregnancy losses have had a negative impact on her relationship with her daughter.... She states that she has always been very overprotective of her daughter, and her subsequent failures at having more children have made her even more protective.

In contrast, one father stated that his relationship with his son was better after he had gone through the experience of a spontaneous abortion.

> Tonight, [Son] was in a shitty mood. And he put me into a shitty mood. But I make a special point now, whereas before I wouldn't have. I probably would have let him go to bed not having acknowledged that he was my son, or something like that. But, tonight I went down there, and, you know, the old family hug routine ... which is an every night routine with us now. Whereas [I] probably wouldn't have been before. [Case04]

Marital relationships also changed as a result of the experience of spontaneous abortion. One subject stated that impact on the marital relationship was so negative that the marriage would likely not survive.

> F.'s marital relationship is in considerably more jeopardy.... She and her husband have started seeing a minister for marital counselling, but she states that as far as she is concerned, there is no hope for the marriage. [P03]

Several subjects stated that the marital relationship was presently undergoing stress as partners dealt with the spontaneous abortion in dissimilar ways and at a dissimilar pace. However, they expressed a belief that, in the long run, the relationship would likely survive.

> G. stated that she had felt that her marriage was in real peril, but that she now feels that it will last. [PO3]

One subject stated that, although some changes in their lives were negative, their marriage had been strengthened by their experiences.

> I'm not sure all the changes have been good, but ... well, they say that something like this will either break your marriage or make your marriage. It has made our marriage. [Case02]

Subjects stated that relationships with members of the extended family and friends had also changed as a consequence of the spontaneous abortion. Subjects expressed surprise about the unexpected responses of some significant others. One subject stated that a cousin to whom she had not been very close, and who had never had any personal experience with spontaneous abortion became one of her greatest supports. However, a close friend, whom she had expected would support her, did not do so.

Supportive responses of family members and friends resulted in the strengthening of the previous relationship. Where little or no support was received, relationships deteriorated. In instances where continued interaction with such individuals was important or unavoidable, some subjects attempted to work through the pain of these strained relationships and maintain them. However, this was not always the case. One subject stated that relationships with several of her husband's siblings were virtually non-existent because they had never acknowledged

that this couple had experienced several spontaneous abortions.

For the most part, relationships with family members, even if strained, were maintained. Severed relationships were more likely to be those involving friends.

> Researcher: So, it's changed your relationships and you don't see them reverting back?
>
> Subject: No, I felt that if people aren't willing to accept the changes in me ... I will never be that way again. But, I guess they're not that understanding. I guess they never were friends in the first place ... [Case02]

Acknowledging the Changes was a more individualized process than Re-entering the World. In instances where personal and interpersonal responses to the spontaneous abortion were congruent, little change in the individual was necessary. It was only when the individual found that, as a result of this experience, perceptions, values and relationships were altered that Acknowledging the Changes became necessary.

The property of Acknowledging the Changes is very complex. It is possible that this property is, in fact, an emerging category. Further data collection and analysis would be necessary to elaborate and saturate Acknowledging the Changes as a category with properties, contingent variables and a time frame.

Property 3: Working Through the Pain

Working Through The Pain is the process of taking on the on-going grief work associated with the bereavement of spontaneous abortion. For those who had maintained a commitment to the pregnancy and expected child even after the spontaneous abortion, this was a life-long task. For these individuals, the grief of spontaneous abortion was cyclical. Resolution of grief, in the sense that the experience was forgotten and never thought of again, was not observed. Instead, as the individual re-engaged in personal, family and social life, constant reminders of the spontaneous abortion occurred. The work of dealing with these reminders and with the accompanying emotional response was an integral part of the subsequent life experiences of each individual.

The subjects in this study realized that reminders of the spontaneous abortion were built into the rest of their lives and that they must learn to deal with them. They described the reminders of the spontaneous abortion as being painful or hurtful. Often, these reminders were unanticipated, leaving no opportunity to prepare in advance for the sudden feelings of grief. One subject described her experience while driving to meet her husband before going to a Memorial service for their baby.

> I think what really did me in was seeing them bury the ashes, because I wasn't expecting that. I was driving down Archibald, going to the hotel to meet him [husband] for coffee and I drove by

> and they had all the little urns, or whatever. And there was ... the priest, the sister and another reverend there. And I didn't expect that to be part of it. I guess I had detached the fetus from the service. You know, the body from the spirit. [Case04]

Another subject unexpectedly broke into tears the first time she and her husband tried to have intercourse after the spontaneous abortion. She was suddenly reminded of the dead fetus because of the re-enactment of the sexual act that had caused its conception.

Coming home to nurseries made ready for the expected baby was another early reminder of the bereavement.

> H. stated that she has gone into the baby's room, which was all ready, and has started to put things away. I asked her how she felt when she was doing this. She just shrugged, and then said "it was okay." Then she stared down at the floor again. [P06]

Some of these reminders came as a consequence of simply being a part of a larger world.

> I. and J. feel that the world is full of pregnant women and children, and that they are constantly in flight from such encounters. They are also, to their surprise, constantly confronted with conversations about pregnancy, children, labour and deliveries and D&Cs. They don't know whether this is fate, hurting them when they are vulnerable, or whether these conversations have always been held in their presence, and they just didn't notice before. [P01]

One subject drove past the cemetery where the couple's fetus had been buried every day on the way to work.

> I drive by that spot every day on the way to work. And I do look from time to time and think about it. [Case04]

Friendships and working relationships with others who

had children or were pregnant were another reminder of their bereavement. Baby showers in honour of infants born to friends and colleagues were identified as a particularly painful reminder of their own spontaneous abortion. Encountering pregnant friends and colleagues was another reminder of their own bereavement. Even if the bereaved parent could deal with pregnant women, some level of psychological discomfort was created.

> Part of the problem ... not part of the problem, but I knew a lot of girls pregnant the same time that I was due. And I know it's really difficult for them, and yet that kind of makes it easier for me. Going to work and seeing the girls pregnant.

Another source of reminders of the bereavement was anniversaries. These could be anniversaries of the date that the spontaneous abortion occurred, anniversaries of the due date of the deceased fetus, or other special dates close to those significant to the spontaneous abortion.

> There's going to be reminders for years. Because ... the D&C was the day before my brother's birthday. And the baby's due date was my brother-in-law's birthday, which is 2 days after my birthday [CASE04]

The anniversary of the due date of the deceased infant was a particularly strong reminder.

> K. stated that spring was going to be terrible. She and her son had planted tulips in the fall for the baby, which was due in the spring. Now spring would come, the tulips would be in bloom, and there would be no baby. [PO6]

One subject made a special effort to commemorate the anniversary of the due date of her fetus.

> You see, September 20 was his birthday. And I wanted to ... do something about that.... I had a little memorial for him. And I planted a tree. And I had that little tree blessed.... And I had a couple of little poems that I wanted to read for him. [Case05]

Subsequent fetal and early infant deaths were another reminder of the deceased fetus. Even when the subject felt that previous deaths had been dealt with, another similar death caused the old grief to return.

> L. talked at length about how hard grief work was. She stated that, after her third pregnancy loss, she started to relive the first two losses as well. This really upset her, because she had believed that her grief work about the first two babies was over. She stated that she then realized that she would have to start all over again and work to resolve all three of her pregnancy losses. She really dreaded this process, because she knew it was going to be a lot of hard work and she didn't want to do it. But she also realized that, if she was to go on with her life, it had to be done. [P06]

Encountering individuals whose responses to the spontaneous abortion had been interpreted by the subjects as non-supportive or non-sympathetic is another component of Working Through the Pain. Any interaction with these individuals was painful for the subjects because, regardless of the context of the present interaction, painful memories of the past were invoked.

Sometimes, subjects could not find a way to deal with these individuals. This made subsequent encounters very strained. Where it was possible, these individuals were avoided. However, accidental and unavoidable contacts were always possible, and therefore the subject was constantly

vulnerable to further painful reminders and further grief work. One subject, a member of the support group, had never dealt with her anger about how health care professionals had cared for her during several spontaneous abortions. The situation had escalated to the point where every health professional was an unpleasant reminder of her negative experiences. She was no longer able to trust or effectively communicate with any physician or nurse involved in her care.

Over time, most subjects came to an understanding of why significant others and health professionals behaved in non-supportive ways and were able to forgive them. Although the words or actions which caused the pain were not forgotten, the memories were no longer accompanied by grief and anger. Forgiveness enabled the subjects to re-establish and maintain a relationship with these individuals. One subject stated that her grandmother had not been very supportive when she was told about the spontaneous abortion. The grandmother's greatest concern was that another relative, who was also pregnant, not be told because it might upset her. Although very hurt by her grandmother's response, this subject was able to understand the reason for the response and maintain a relationship with her grandmother.

> I really didn't care about my cousin that day. And I thought, it's pretty ignorant of her to remind me of somebody else's pregnancy.... she wasn't feeling my pain at all.... And I had to

> say to myself "This is just her. She doesn't know what to say.". [Case04]

Another subject stated that she was able to understand the reasons for the awkward and painful responses of many significant others and this enabled her to forgive the inadvertant pain these responses created for her.

> And it's very difficult for other people. Like, I quite understand that. They have no idea what to say. And so some of them would say nothing. [Case03]

Working Through the Pain may represent a lifelong task for those who believe that spontaneous abortion results in the death of a desired baby. Avoidance of reminders of this event is not possible. Instead, parents must learn to anticipate and allow for times of increased grief in order to deal with their emotional responses. And they must learn to deal with the unexpected and painful reminders of their past.

Property 4: Trying Again

Trying Again is the process of making the decision of whether or not to attempt another pregnancy. In reaching this decision, bereaved parents consciously considered whether they are willing to take the risk of another pregnancy. The subjects in this study made a variety of decisions about Trying Again. For each individual, this decision was based upon their perception of the risks and benefits of another pregnancy.

Two subjects in the study had experienced successful pregnancies subsequent to a spontaneous abortion. They stated that the birth of a healthy child had helped them to resolve some of their feelings about the spontaneous abortion. Another subject was pregnant at the time of her interview. She, too, stated that the decision to become pregnant again had helped her to recover from her grief after the spontaneous abortion.

> And ... deciding to have another baby right away. That probably helped my feelings of the loss or the emptiness or whatever. [Case04]

One subject stated that, although she had not entirely given up on the idea of becoming pregnant again, she was not longer willing to take extraordinary measures to conceive.

> ... if it happens, it happens. I'm not going to use the charts of the thermometer or anything else again. To me, that was putting myself through a month to month mental stress I didn't need to be under. I finally realized that I have a wonderful child; I have a husband, a home and I should be happy and content with that. [Case02]

Other subjects, after careful consideration of the possibility of Trying Again, decided that another pregnancy was not worth the risk. Some of these subjects decided to simply leave their family constellation as it was at present and not to consider adding any more children to the family unit. Other subjects reconsidered the ways in which children might be added to their family unit. They began to give serious consideration to the possibility of

adopting children or taking in foster children as other ways to enact the role of parent.

One contingency on the decision to Try Again was the ability to overcome the fears associated with being pregnant again.

> ... one thing I know. I don't want to get pregnant right now. I'm not ready for that. I'm still too scared. [Case05]

Other contingent variables affecting the decision to Try Again are discussed as a subprocess of the Experience of Spontaneous Abortion.

Contingent Variables

Most contingent variables associated with the category of Moving On were discussed within the specific Property that the variable affected. However, some variables affected parental behaviours within the category as a whole.

One important contingent variable affecting the process of Moving On was the subject's desire to not let the spontaneous abortion have a negative impact on the rest of his or her life. One couple stated that they very deliberately went through what they considered to be all the necessary steps to deal with the spontaneous abortion because they did not want to risk the possibility that this bereavement would cause them difficulties for the rest of their lives.

> ... we said we want to remember, but we don't want it to be a roadblock in our life. [Case04]

Attributes of the individual identified as contingent variables in the category of Putting It In Its Place were also important in the process of Moving On. The ability to draw on past life experiences and the ability to verbally and symbolically express feelings enabled parents to work through the many painful aspects of Moving On. The internalization of a set of values and beliefs about life also assisted subjects to actively re-engage in their world.

The support of significant others was also identified as a variable which affected the process of Moving On. Subjects reported that, where family and friends gave them support at the time of the spontaneous abortion and during times of remembering, the process of Moving On was made easier. Conversely, lack of support at these times made the experience of Moving On more difficult.

The subjects in this study did not identify the responses of health professionals as being a significant variable influencing them in the overall process of Moving On. Health professionals did play a role within the one property of Trying Again. The impact of health professionals on the decision about another pregnancy is discussed within a subprocess of the Experience of Spontaneous Abortion.

Time Frame

The process of Moving On began very soon after the actual spontaneous abortion. One subject stated that she believed the work of dealing with reminders of the spontaneous abortion could begin while the mother was still in hospital, although she did not personally have the experience she described.

> I think it would be really cruel to put a woman having a miscarriage or having a [therapeutic] abortion in the maternity area. And I'm glad they didn't do that. I think it would have been really cruel to have someone being wheeled down to surgery past the nursery windows. [Case01]

No specific end to the process of Moving On was identified. It is a lifelong process that is enacted as long and as frequently as the spontaneous abortion is remembered.

The Experience of Spontaneous Abortion

Four subprocesses within the Experience of Spontaneous Abortion have been identified. To some extent, these subprocess have been suggested during discussions of contingent variables influencing each category or property within the theory. It is important, however, to more closely examine these subprocesses within the context of the entire theory.

Subprocess 1: The Impact of Committing to the Pregnancy on Experiencing the Spontaneous Abortion, Putting It In Its Place and Moving On

Without exception, the subjects in this study stated that they had experienced the spontaneous abortion of a desired pregnancy. Desiring is one property of the category Committing To The Pregnancy. In many instances, the subjects had also enacted behaviours consistent with the properties of Conferring Personhood, Safeguarding and Making Room. It may be inferred that the longer these behaviours exist and the more of them that are enacted, the greater the parental commitment to the pregnancy. Strong commitment to the pregnancy may result in considerable parental grief during Experiencing the Spontaneous Abortion. Further, the work of Putting It In Its Place and Moving On may be more difficult and more lengthy for those parents who had developed a strong commitment to the pregnancy.

Subprocess 2: The Impact of Finding Reasons on Trying Again

Finding Reasons is a property within the category Putting It In Its Place. Trying Again is a property within the category of Moving On. However, it was evident that, for the subjects in this study, the decision for or against another pregnancy was contingent upon the success with which subjects were able to find reasons for the spontaneous abortion.

Experiencing one spontaneous abortion, even if a reason could not be determined for this event, did not seem to discourage parents from attempting another pregnancy. Frustrating as the lack of a specific reason for the pregnancy might be, the very absence of a specific reason appeared to make the subjects more likely to believe that another pregnancy could be successful.

> [Her physician] reassured me that everything was all right; that there was no reason why I couldn't go ahead and have another baby ... give myself enough time to be sure everything was back to normal and then go ahead. [Case01]

Experiencing more than one spontaneous abortion appeared to result in a need for more concrete information about the etiology of this complication of pregnancy. Finding medical reasons was helpful, because this enabled subjects, in their opinion, to weigh the risks and benefits of another pregnancy.

> H. and I. stated that they could not say for certain whether they would risk another pregnancy. Both stated that if they could know the reason for the last spontaneous abortion(s), that might help them decide what to do. [P03]

Where medical problems could be easily controlled or eliminated, subjects might decide that another pregnancy was worth risking. Greater caution was evident if the management of the next pregnancy would be complicated and require major adjustments on the part of the pregnant woman. For example, the requirement to be on bedrest for most of the next pregnancy caused subjects to give the

possibility of conceiving again very careful consideration. No subjects in this study were informed by physicians that another pregnancy was not likely to be successful.

Multiple pregnancy losses and a history of infertility were more likely to cause subjects to give even more serious consideration to the possibility of Trying Again. Some subjects, after weighing their previous experiences against the possibility of another unsuccessful pregnancy, decided that it was simply not worth the risk.

Subprocess 3: The Impact of Expressing the Loss on Moving On

The ability of parents to find significant others who would listen to them talk about their experience influenced parental behaviours within all properties of Moving On. Re-entering the World included the tasks of telling others what had happened. This task was very difficult in instances where those being told either did not want to listen to subjects talk about their experience, or where, although they listened, they responded in a way that the subject believed was inappropriate.

Expressing the Loss also influenced behaviours within the property of Acknowledging the Changes. Subjects stated that the relationships with those who diminished the impact of the spontaneous abortion, or whose responses were non-sympathetic had either been entirely severed, or were much more distant than in the time before the spontaneous

abortion. In order to Move On with the parent, significant others had to share in the work of Expressing the Loss.

Significant others and health care workers who did not respond appropriately to subjects who wanted to talk about their experience became painful reminders of the experience itself. In Working Through The Pain, subjects had to find ways to put the pain of unsuccessful attempts to Express the Loss behind them if the relationship with these persons was to continue.

Subprocess 4: The Impact of Trying Again on Committing to the Next Pregnancy

Two subjects interviewed during the study had experienced a successful pregnancy subsequent to a spontaneous abortion. One subject was pregnant again at the time that the interview was conducted. Other subjects participating in interviews and in the support group had experienced several spontaneous abortions. Some observations about the impact of the Experience of Spontaneous Abortion on committing to a subsequent pregnancy were possible.

Previous fetal and early infant deaths or a history of infertility may increase the desire for a child and motivate parents to take very real risks in order to have a child. At the same time, there may be ambivalence about the pregnancy.

D stated that even though she had planned this

> pregnancy, she was apprehensive - she wanted it and she didn't want it [PO4]

Safeguarding behaviours may also be intensified as a consequence of a previous spontaneous abortion. However, Conferring Personhood and Making Room may be delayed. One subject stated that her subsequent pregnancy was not as carefree an experience because of the memories of the spontaneous abortion.

> What it has done is ... being pregnant this time ... is not make it, so you're as enthusiastic. Because you're not over the danger point. And even though we are excited about it, you don't go into work and blurt that you're pregnant. Because you never know what the outcome's going to be. [Case04]

The Experience of Spontaneous Abortion may permanently alter parental perceptions of pregnancy and childbearing. It may also resulted in a change in the ways that parents formed a commitment to subsequent pregnancies.

An Overview of the Theory

The Experience of Spontaneous Abortion is a process theory based on data grounded in the parental experience of this event. It describes the events preceding, during and after a spontaneous abortion from the perspective of parents who have had this life experience. The theory outlined in this study can be likened to a trajectory with four major points along the path. These major points are the four categories of the theory: 1) Committing to the Pregnancy, 2) Experiencing the Spontaneous Abortion 3)

Putting It In Its Place and 4) Moving On. The forward movement of the trajectory captures the passage of time as the work of each of the categories is encountered and dealt with by each individual.

The theory is not linear. Individuals do not move along this trajectory in a step-wise sequence by finishing the work of each property within a specific category before moving on to the next. Instead, the properties and categories overlap. Individuals, at any given time, may be working through several properties within one category. Further, more than one category may be dealt with simultaneously. The individual experience of spontaneous abortion depends on 1) the necessity, for each individual, to go through the work of each property and/or category, 2) the willingness of each individual to undertake this work and 3) the ability of each individual to do it. Considerable evidence of the importance of each of these factors is presented within discussions of the four categories and their component properties.

The single element common to all subjects in the study was the spontaneous abortion. The spontaneous abortion, therefore, is also the central link in the theory. Regardless of how unique the rest of the trajectory may be for any individual moving along it, the spontaneous abortion is the common thread that binds their experience to that of all others who have also had this experience.

CHAPTER 5

CONCLUSIONS

Introduction

Qualitative analysis of data using the grounded theory method resulted in the identification of a process theory describing the experience of spontaneous abortion. This Chapter presents an analysis of the theory outlined in Chapter 4. The findings of the theory of the Experience of Spontaneous Abortion will be discussed. The results of the study will be compared and contrasted with other research conducted in the area of fetal and early infant death. The relevance of the conceptual framework to the findings of the study will be examined. Recommendations for future research, nursing education, nursing practice and institutional policies will be presented. Finally, a summary of the study will be presented.

Discussion of the Findings

Committing to the Pregnancy

The category of Committing to the Pregnancy described the process of emotional attachment to the pregnancy and the incorporation of the expected child into personal and family life. General support for the properties of

Committing to the Pregnancy identified in this study are found in the lay literature and in the anecdotal articles and case studies presented by health care practitioners.

Researchers in the area of fetal and early infant death have given little consideration to the impact of parental behaviours such as Desiring, Conferring Personhood, Safeguarding and Making Room on subsequent parental responses to undesired pregnancy outcomes. Instead, contingent variables such as gestational age of the fetus and maternal age have been used as the independent variables measuring parental commitment to the pregnancy and predicting the intensity of the grief response following a spontaneous abortion. Conflicting findings using these measures of parental commitment are reported in the professional literature.

Toedter et al. (1988) and Kirkley-Best & Kellner (1982) found that parental grief increased with increased gestational age of the fetus at the time of its death. In contrast, Kennell et al. (1970) and Peppers and Knapp (1980) found no relationship between the gestational age of the deceased fetus and subsequent parental grief. As has been demonstrated in this study, the length of the pregnancy may not be the most accurate estimator of parental commitment. Many behaviours consistent with parental commitment to the pregnancy were enacted by parents even before conception. An instrument

incorporating parental behaviours reported in this study would result in a more accurate estimation of the duration and intensity of parental commitment to the pregnancy and a more accurate prediction of parental grief responses after fetal and early infant death.

Conflicting findings are also reported in the literature when maternal age is used as a predictor of the intensity of the grief response after fetal and early infant death. As with gestational age, this study clearly demonstrates that maternal and paternal age are not, in themselves, a measure of parental commitment. Instead, it is impact of parental age on desiring an infant that influences subsequent parental grief after spontaneous abortion.

No studies reviewed by the researcher discussed the duration of commitment to the pregnancy. In the professional literature, there appears to be an implicit assumption that commitment to the pregnancy ends with the unexpected termination of the pregnancy or the death of the newborn infant. This study found that parental commitment to the expected baby did not end with the spontaneous abortion. Parents continued to maintain the psychological space created for the expected child for many years after the spontaneous abortion. Support for this finding is found in lay literature on the experience of fetal and early infant death. Writers such as Borg and Lasker

(1981), Ewy and Ewy (1984) and Panuthos and Romeo (1984) state that bereaved parents do not forget or replace children who die during pregnancy or in early infancy.

Some questions about parental commitment to the pregnancy are not answered by this study or by others conducted on this topic. All subjects in this study enacted behaviours consistent with Committing to the Pregnancy. Therefore, at present, the Experience of Spontaneous Abortion does not fully describe the experience of parents who did not form a commitment to the pregnancy prior to the spontaneous abortion. Anecdotal literature and case studies give very limited consideration to the impact of not committing to a pregnancy on the subsequent response to spontaneous abortion. No qualitative or quantitative research has been conducted in this area.

In the present study, Making Room and Desiring were identified as properties of Committing to the Pregnancy which could be enacted prior to conception. Conferring Personhood and Safeguarding were reported by subjects in this study only after the conception of the fetus. Yet, it is not certain that these behaviours are confined to the time of the pregnancy alone. It is well known that many women who plan their pregnancies also take steps to improve their physical health and nutritional status prior to conception. Considerable anecdotal evidence therefore exists for the proposition that Safeguarding may be enacted

prior to as well as after conception.

Making Room may be one property of Committing to the Pregnancy that is subject to considerable variation between individuals, ethnic groups and cultures. The provision of physical space and material necessities in preparation for a new baby is not always an observed behaviour of expectant parents. Concerns about parental responses to these preparations should the baby not survive the pregnancy may cause the delay of these preparations until such time as the danger of such an occurrence is over.

Experiencing the Spontaneous Abortion

The category of Experiencing the Spontaneous Abortion described the psychological responses of parents during the time that the spontaneous abortion was actually taking place. The responses reported by subjects in this study are similar to those identified during the content analysis of professional literature. Since the purpose of this study was to describe parental psychological responses during the spontaneous abortion, no distinction was made between the responses of male and female subjects in this study. During data collection and analysis, the researcher came to the conclusion that gender did not cause the observed psychological responses to the spontaneous abortion. Instead, gender was a contingent variable that might influence the intensity and duration of these

responses. While men might be observed to have a less intense and shorter psychological response to the spontaneous abortion, the range of responses observed in the men in this study was no different than that observed in the females.

Experiencing the Spontaneous Abortion was identified as a category very early in data analysis. However, the properties of this category did not emerge until very late in the process of data analysis. Because of the wide range of possible parental experiences during the actual process of the spontaneous abortion, this category and its properties are less well developed and less saturated than the other categories and properties of the theory. Contingent variables are likely not completely identified. None the less, some important elements of Experiencing the Spontaneous Abortion have been identified.

The impact of the responses of health care professionals on Dealing With the Unexpected, Assessing the Possibility and Acknowledging the Reality are clearly described within the context of the parental experience. Health care professionals do not create, nor can they prevent, parental responses such as shock, disbelief, anger and despair. However, the responses of health care professionals do influence the intensity and duration of parental responses to spontaneous abortion. Knowledge about the impact of their responses on parental experiences

might enable health care professionals to accept parental responses to the spontaneous abortion and make them less likely to tell parents how they should respond.

The impact of waiting for the physiological process of the spontaneous abortion and waiting for the response of the health care system has not been identified in the professional literature as a factor influencing parental responses and behaviours during the time that the spontaneous abortion is actually taking place. In this study, subjects clearly identified this contingent variable as one which increased the intensity of parental anxiety and anger.

Findings within the property of Dealing With the Unexpected demonstrated that the subjects in this study were not prepared for the possibility of spontaneous abortion. This finding is consistent with descriptions, in both lay and professional literature, of the shock and disbelief which accompany a spontaneous abortion. In the statement of the problem, this researcher questioned whether social attitudes about childbearing and the lack of discussion about the possibility of spontaneous abortion were implicated in these responses. In other words, would more education about this complication of pregnancy reduce or prevent parental shock and disbelief when the spontaneous abortion actually occurred? The findings of this study demonstrate that those who knew about the

possibility of spontaneous abortion and even those who had previously experienced spontaneous abortion still responded with shock and disbelief to the first symptoms indicating that the pregnancy was in peril. Perhaps, if prospective parents really believed that a spontaneous abortion could happen to them, they would be unwilling to risk becoming pregnant in the first place. Planned conceptions may be contingent on an optimistic belief that the pregnancy will be successful. Health care professionals should be aware that shock and disbelief are normal responses to spontaneous abortion. Although it is important to provide information about spontaneous abortion as a complication of pregnancy at every possible opportunity, the provision of this information may not prevent parental responses of shock and disbelief.

The final important finding within the category of Experiencing the Spontaneous Abortion is the clear distinction drawn between acknowledging that the spontaneous abortion actually occurred and acceptance of that fact. Acknowledging the Reality simply meant agreeing that the spontaneous abortion had occurred. All subjects in this study were able to do this. Acceptance, on the other hand, required some admission on the part of the subject that the spontaneous abortion was something that should have happened. The two responses are not conceptually equivalent; nor do they occur at the same

time. However, the terms acknowledgment and acceptance are frequently linked or used interchangeably in professional literature describing parental responses to spontaneous abortion and other forms of fetal and early infant death. In order to more fully understand the parental experience of spontaneous abortion, it is important that the distinction between these two concepts be preserved.

Putting It In Its Place

The category of Putting It In Its Place described the process of gaining an understanding of the impact and meaning of the spontaneous abortion. Subjects in this study described the loss of the fetus as a consequence of spontaneous abortion as being equivalent to the death of a family member. This finding supports the work of Kennell et al. (1970), who found that parents who had experienced a neonatal death experienced a grief response which was similar to that following the death of an adult member of the family. The finding that spontaneous abortion represented the loss of future dreams and plans, leaving a sense of emptiness and futility, is also supported by findings in lay and professional literature.

Researchers conducting studies for the purpose of identifying variables which intensify parental grief responses after fetal and early infant death have reported that multiple experiences with this form of bereavement

result in a more intense grief response (Peppers & Knapp, 1980). In other words, subsequent bereavement experiences would result in a more intense grief response than the first. Support for this finding was not found in the present study. Some subjects in the study experienced more than one spontaneous abortion. It was evident that each spontaneous abortion was a unique life experience, and that the parental perception of the magnitude of each one was different. The order of the spontaneous abortions and the total number experienced by subjects did not appear to be factors which determined which spontaneous abortion would be identified as the most difficult or the least difficult to cope with. Instead, the value placed on each pregnancy lost as a consequence of spontaneous abortion depended on a variety of variables associated with the individual and with external circumstances operating at the time of the pregnancy and spontaneous abortion.

Parental behaviours identified in the property Finding Reasons have been frequently discussed in lay and professional literature. The findings of the present study support observations made by Harris (1984) that attributional guilt may be a mechanism by which parents who experience fetal and early infant death attempt to impose order and reason upon an otherwise irrational event. The subjects of this study frequently identified behaviours committed or omitted by themselves as reasons for the

spontaneous abortion. However, the guilt directed at the self did not appear to result in difficulty in dealing with the tasks associated with Putting It In Its Place and Moving On. Instead, these explanations were frequently used as a framework within which the subject could talk about the experience and come to some understanding of its meaning.

The finding that parents may formulate more than one reason for the spontaneous abortion has not been previously discussed in professional literature. With the exception of Harris'(1984) observations on attributional guilt, writers in professional literature have not discussed the role of finding reasons for the spontaneous abortion in the subsequent ability of parents to deal with this experience.

This study showed that parents who experience a spontaneous abortion do create memorials to the dead fetus. Measures such as naming the baby, having a funeral or memorial service, making memorial donations and creating symbolic remembrances of the deceased infant were identified by some subjects as measures which helped them deal with their grief and gave them comfort in their time of sorrow. These findings support writers such as Kay (1987), Connolly (1982), Cooper, (1979), Jolly (1976), Lewis (1976), Morris (1976, 1978, 1988) and others who have long argued that any measure taken which can reinforce the reality of the fetal or early infant death will assist

parents in dealing with their grief.

Behaviours of health care professionals were identified in this category as contingent variables which facilitated or impeded the ability of bereaved parents to put the spontaneous abortion in its place. This finding is important because, as was already observed in the discussion of the previous category, health care workers are not the central players within the theory of the Experience of Spontaneous Abortion. Their role is to support the bereaved parents who must deal with this experience. A clear understanding of the experience is necessary before supportive roles and behaviours can be identified. The review of the literature conducted during this study revealed that health care professionals frequently identify appropriate behaviours for themselves prior to achieving the necessary understanding of the experience of spontaneous abortion.

The present study found that parental responses directed to putting the spontaneous abortion in its place could begin with the first premonitions that the pregnancy was not going well. Further, the study found that Putting It In Its Place could continue for many years after the spontaneous abortion. Similar findings were not discussed in professional literature on the topic of spontaneous abortion.

Moving On

Moving On was defined as the process of actively re-engaging in personal, family and social life. Discussion of parental behaviours included in the category of Moving On are given limited consideration in professional literature. Discussions involving pathological responses where parents were not able to Move On were a more common finding.

Considerable support is found in the lay literature for the finding that the experience of spontaneous abortion caused changes in the parent and in his or her relationships with others. Borg and Lasker (1981), Ewy and Ewy (1984) and Panuthos and Romeo (1984) place considerable emphasis on the potential for individual change and growth as an outcome of experiencing a fetal or early infant death. Subjects in this study frequently identified changes in themselves which they perceived as positive and permanent. Professional literature, on the other hand, placed much more emphasis on pathological changes in the parent as a consequence of fetal and early infant death.

Researchers studying the impact of fetal and early infant death on significant relationships such as marriages and friendships have obtained conflicting results. Researchers have reported that marital relationships are more likely (Hildebrand & Schreiner, 1980) and less likely (Forrest et al., 1982) to break down after neonatal and

early infant death. This study clearly demonstrates that the impact of the spontaneous abortion on relationships between the bereaved parent and spouses, family members and friends is based on the congruency between the parental perception of the magnitude of the event and the significant other's perception of the event. It is not the spontaneous abortion itself that causes strengthened or severed relationships. It is the perception held by each actor in the relationship that causes the relationship to be changed.

Subjects in the support group frequently discussed the importance of being able to forgive those individuals whose responses to the spontaneous abortion were uncaring and hurtful. It would appear that the ability to forgive these individuals allowed parents to maintain or re-build relationships that might otherwise have been permanently severed. The role of forgiveness as a mechanism by which the pain associated with some of the memories of the spontaneous abortion can be left behind is not discussed in professional literature.

An important finding of the present study is that the parental experience of Moving On includes the life long task of dealing with recurrent grief and cyclical reminders of the spontaneous abortion. This finding supports the work of Kay (1987), Estok and Lehman (1983), Connolly (1982) and others who have postulated that the bereavement

associated with spontaneous abortion and other types of fetal and early infant death is never forgotten and becomes an integral part of the subsequent life of the bereaved parent. Support is also found in this study for the proposal by Elliott and Hein (1978) and Kowalski (1980) that grief resolution after fetal and early infant death is best equated with the capacity to resume normal life patterns and relationships.

Overview of the Theory

The Experience of Spontaneous Abortion describes parental perceptions and responses to spontaneous abortion. Subjects in this study experienced the spontaneous abortion as a bereavement involving the death of a desired child. Events which preceded the spontaneous abortion were shown to have an impact on parental grief responses. The spontaneous abortion had an impact on the parent and on parental relationships with family members, friends and health professionals. Parents who experienced a spontaneous abortion frequently changed their beliefs and values as a result of dealing with this experience. Changes within the self created changes in relationships with others.

This study also demonstrates that the spontaneous abortion is never forgotten. Subsequent to the spontaneous abortion, the parent must deal with recurrent grief, and

with memories and reminders of the spontaneous abortion for the rest of his or her life. The findings of this study support those who state that emphasis on models of grieving which emphasize a forward progression of stages of grief leading to resolution may not be an appropriate conceptualization of the grief subsequent to spontaneous abortion.

No subjects in the sample of this study were uncommitted to the pregnancy. Therefore, the theory as a whole describes the responses of parents who experienced the spontaneous abortion of a desired pregnancy. However, the identification of a subprocess describing the impact of Committing to the Pregnancy on the subsequent three categories of Experiencing the Spontaneous Abortion, Putting It In Its Place and Moving On allows for future research on the experience of those parents who were not committed to the pregnancy at the time of the spontaneous abortion.

The identification of contingent variables, time frames and subprocesses within the theory as a whole enhances the ability of the theory to explain a wide range of individual parental responses to spontaneous abortion. Each parent and the circumstances of each spontaneous abortion are unique. The theory of the Experience of Spontaneous Abortion, because of its emphasis on context and contingent variables, is able to account for observed

differences in parental responses.

Because the theory of the Experience of Spontaneous Abortion describes parental experiences even prior to conception of the pregnancy, the theory has elements in common with many other outcomes of pregnancy. The structure of the theory allows for linkages with theories describing the parental experience of a normal pregnancy and parental experiences with other forms of fetal and early infant death. For example, using the category of Committing to the Pregnancy as the link, another process theory could be developed describing parental experiences during a normal pregnancy, or during the experience of stillbirth. Linkages with theories describing a variety of experiences during pregnancy, labour and delivery will result in the development of a comprehensive theory describing the parental experience of the childbearing process.

The theory of the Experience of Spontaneous Abortion is conceptually linked to theories of loss and bereavement. The processes of Committing, Experiencing, Putting It In Its Place and Moving on would appear to be integral parts of any bereavement or loss experience.

The theory of the Experience of Spontaneous Abortion is also conceptually linked to theories of coping, hardiness and vulnerability. Although the terminologies and operational definitions used by researchers in this

field vary, all theories describe a dynamic relationship between an undesired life event and the individual affected by it. The fundamental premise of all theories of coping, hardiness and vulnerability is that, between an event and the consequences to the individual lie a host of intervening variables which have an impact both on the process and on the outcome (Clarke & Driever, 1983; Kobassa, 1979; Kobassa, Maddi & Courington, 1981; Rose & Killien, 1983). This premise also underlies the theory of the Experience of Spontaneous Abortion.

The findings of this study contrast with the work of some writers in the professional literature who speculated that the grief associated with spontaneous abortion is less intense than that associated with other fetal and early infant deaths, and that this grief is of a brief duration. Support for the findings of this study are found in lay literature describing parental responses to all forms of fetal and early infant death.

The findings of this study support the qualitative study conducted by Swanson-Kauffman (1986). Considerable similarity exists between the Swanson-Kauffman Human Experience of Miscarriage categories and the categories and properties of the theory of The Experience of Spontaneous Abortion described in this study. The categories of Caring in the Instance of Miscarriage identified by Swanson-Kauffman (1986) described the caring behaviours of

significant others desired by women who experience a spontaneous abortion. These behaviours are identified as contingent variables in the present study. The theory of the Experience of Spontaneous Abortion extends Swanson-Kaufmann's theory to include events preceding the spontaneous abortion and to describe the impact of the experience of spontaneous abortion on a subsequent pregnancy.

The findings of this study also support the work of Phipps (1985-86). Phipps found that the experience of stillbirth or neonatal death resulted in a changed pattern of parental commitment to a subsequent pregnancy. The present study identified that parental commitment to a pregnancy subsequent to spontaneous abortion was different. Although a child may be even more desired as a consequence of previous spontaneous abortion, more ambivalence about the actual pregnancy may also exist. In addition, parental behaviours strengthening commitment to the pregnancy may be delayed.

The theory of the Experience of Spontaneous Abortion provides a framework within which parental responses to spontaneous abortion can be described and explained. It clarifies current knowledge about parental responses to spontaneous abortion by explicitly separating the essential elements of the Experience of Spontaneous Abortion from the contingent variables which may influence the intensity and

duration of the experience. Further, it forms the basis for future research to develop a theory capable of prediction of parental responses. Finally, the theory can also be used as the basis for the development of instruments to measure and predict parental responses to spontaneous abortion.

The Relationship of the Findings to the Conceptual Framework

The conceptual framework of this study was Symbolic Interactionism (SI). Three basic principles of SI were identified by Blumer (1969). These principles, and their relevance to the findings of this study will be briefly discussed.

The first principle of SI is that people's actions are based on the meanings that events or objects have for them. The biological events of pregnancy and spontaneous abortion hold no meaning outside of that which individuals confer upon them. Those who perceive a pregnancy as desirable and place value upon the expected child engage in behaviours which both demonstrate and strengthen their commitment to the achievement of that desirable goal. If the desired pregnancy is lost as a consequence of spontaneous abortion, parental behaviours are consistent with those expected as a response to a significant disappointment or loss.

The second principle of SI is that meanings are

acquired through social interaction with others. Our society perceives pregnancy and the birth of healthy children as highly desirable events. On the other hand, the spontaneous abortion of a pregnancy is not perceived as a significant life event. The theory of the Experience of Spontaneous Abortion clearly describes the difficulties encountered by parents who must reconcile the conflicting values placed on these two intimately linked biological events. The use of SI as a framework for the analysis of the experience of spontaneous abortion enabled the researcher to develop a rich description of the interactions between individuals who have experienced a spontaneous abortion and other members of the social system. Difficulties arose for parents in situations where their perception of the spontaneous abortion was not congruent with that held by those with whom they interacted. For the majority of subjects in this study, their belief that the spontaneous abortion represented the death of a desired child was incongruent with societal beliefs that a spontaneous abortion is a minor complication terminating an early pregnancy to which little parental commitment had been made. It is within the context of these conflicting perceptions of the same event that parents must struggle to find their own meaning for the spontaneous abortion.

The third principle of SI is that, through further

experience, interaction or interpretation, meanings may be modified. In the case of spontaneous abortion, the individual undergoes more rapid and intense change than does society as a whole. Through contemplation of their own experience of spontaneous abortion, parents are able to achieve a balance between their own perception that the spontaneous abortion was a significant life event and their knowledge that society does not generally share their point of view. For some subjects, balancing conflicting perceptions meant modifying a previously held belief that spontaneous abortion was not a significant life event. Balancing of conflicting values and meanings was also achieved by deliberately interacting with those who shared their perception of the meaning of spontaneous abortion.

The use of SI as a framework for the analysis of the experience of spontaneous abortion enabled the researcher to develop a rich description of the interactions between the individuals experiencing the spontaneous abortion and those significant others in their lives whose own values and beliefs about this event had a direct impact on the parental response. The struggle to find meaning for the spontaneous abortion forced the individual parent to modify previously held values and beliefs. Modification of fundamental values about the biological events of birth and death caused changes within the individual. Changes within the self created changes in relationships with others.

SI also states that socially held values, although stable, are not static. They can change over time as the result of transactions between the individual and the society within which that individual lives. It is possible to change present societal beliefs that spontaneous abortion is minor complication of early pregnancy. This can be accomplished by public education and by meaningful interaction between those who experience spontaneous abortion and those who, through personal or professional relationships, care for them.

Recommendations for Future Research

The present study was based on a small sample of urban, Caucasian and middle class adults. Although a variety of experiences with respect to the spontaneous abortion was obtained by the researcher, in most other respects, the sample was very similar. Subjects were urban dwelling, Caucasian and, for the most part, members of the middle class. Further development of the Experience of Spontaneous Abortion is necessary. Using the same design, sampling should be expanded to include subjects from rural and remote areas, from different socio-economic groups, and from other cultures. Theoretical sampling should be used to increase the density of all categories and properties identified in this study through the use of new and

contrasting examples. For example, the category of Committing to the Pregnancy could be more fully developed by deliberately seeking out subjects who did not exhibit behaviours identified as consistent with parental commitment to a pregnancy.

The theory of the Experience of Spontaneous Abortion can also be further developed and elaborated through the use of other research designs. A longitudinal study following parents from a time prior to conception until the end of the pregnancy, regardless of the pregnancy outcome, would yield a rich data base to further develop the category of Committing to the Pregnancy. A participant-observer study would more fully identify and develop the properties and contingent variables within the category of Experiencing the Spontaneous Abortion. A longitudinal study following subjects who have experienced a spontaneous abortion over a period of several years would contribute to a better understanding of the intensity and duration of behaviours within the categories of Putting It In Its Place and Moving On. Longitudinal studies would also clarify and validate the time frames presently postulated for each category and for the theory as a whole.

More research is necessary on the concepts of grief and grief resolution. It is evident, when reviewing the current research on the grief associated with bereavement, that little consensus exists about the characteristics of

normal and abnormal grief. A clear understanding of grief resolution is yet to be achieved. The theory of Symbolic Interactionism states that the words used to symbolize complex life events convey powerful messages. Perhaps, in the area of death and bereavement, the wrong word has been used to symbolize the grief experience after the death of a significant other. The word resolution conveys the meaning that there is a point when the grief is finished and need no longer be dealt with. As the results of this and similar studies indicate, no such end point to grief exists. Perhaps those who work or conduct research in the area of bereavement would be wise to choose another term to symbolize the bereavement experience. This researcher suggests that the terms grief work or grief experience, which are already in common use in bereavement studies, be substituted for the term grief resolution.

Further research is needed to clarify the role of attributional guilt as a mechanism used by individuals to impose order and reason on situations that would otherwise be irrational and threatening to the individual. There is clear evidence in this study and in the work of Harris (1984) that attributional guilt may be a mechanism enabling the individual to cope with an incomprehensible life event. Further research on attributional guilt in fetal and early infant death, and comparative research on other life events where attributional guilt is used as a coping mechanism

would lead to a deeper understanding of this phenomenon.

Research connecting the present findings in qualitative and quantitative research on parental grief following fetal and early infant death is necessary. The work of Toedter et al. (1988) in developing a Perinatal Grief Scale is conceptually linked to the present study and to the work of Swanson-Kauffman (1986). A clearer understanding of the essential elements of parental responses to spontaneous abortion and the variables which influence this response would result in the development of more sensitive instruments to actually measure and predict parental grief responses.

Research linking present knowledge of parental responses to fetal and early infant death to theories of coping, hardiness and vulnerability is also necessary. Many conceptual similarities exist between the work of Antonovsky (1979), Kobassa (1979), Rose and Killien (1983) and Clarke and Driever (1983), and the findings of the present study. Further research on fetal and early infant death using models of coping and vulnerability would add to the present body of knowledge on this subject.

Finally, research on the attitudes of health care professionals to the experience of spontaneous abortion is necessary. The findings of this study clearly demonstrate that the responses of health care professionals influenced parental responses to the spontaneous abortion. A clearer

understanding of the attitudes of health care professionals to this type of bereavement would facilitate improvements both in professional education and professional practice.

Recommendations for Nursing Education

Nursing education forms the foundation upon which future practice is based. It is important that nursing students are well prepared for their work with those who are bereaved. Considerable emphasis has been placed in recent years on preparation of nurses to care more appropriately for the dying. The same emphasis needs to be placed on preparation to care for the survivors.

Less emphasis should be placed on models of grief which conceptualize grief work as a step-wise forward moving series of stages. In the opinion of this researcher, these are not accurate representations of the grief work after bereavement. Instead, nursing students should be introduced to the concept of grief as a cyclical life-long process.

Nursing students should be given the opportunity to follow bereaved individuals on a long term basis in order to come to a clearer understanding of the grief process. Preparation for this experience should include discussions of the essential elements of grief after bereavement, and the discussions of variety of circumstances that can result

in a bereavement experience. These learnings can be specifically related to the bereavement of spontaneous abortion and other forms of fetal and early infant death.

Clinical experience with clients actually in the process of having a spontaneous abortion is difficult to plan. However, efforts should be made to plan ways in which nursing students could follow a pregnant woman and her family from the time the spontaneous abortion is first threatened to some time after the client has returned to her community. Experiences such as this would enable the nursing student to develop a deeper understanding of the impact of spontaneous abortion on individuals and families.

Nursing students need to be reminded at every opportunity that the right to place a value on any event which brings an individual to the health care system for care resides with the individual and not with the health care system and health care practitioners. The health care system and those who work within it are frequently guilty of imposing their perceptions and values upon the individuals for whom they care. It is possible that this is an unconscious act committed with clients who are undergoing experiences with which the health care practitioner has limited or no personal experience. Nursing education which places an emphasis on empathy, on sensitivity to the perceptions of others, on individualization of client care, and on the rights and

dignity of those to whom nurses render care will produce nurses better prepared to respond to the needs of parents bereaved as a result of spontaneous abortion.

Recommendations for Nursing Practice

Many of the recommendations made to improve nursing education can also be applied in actions to improve nursing practice. Increasing the sensitivity of nurses who care for parents experiencing spontaneous abortion would do much to improve the care presently described by subjects participating in this study. Nurses need more knowledge about the impact of spontaneous abortion on individuals and families. Spontaneous abortion is rarely a life-threatening event for the mother. The medical and surgical interventions necessary to care for the woman experiencing a spontaneous abortion are also generally uncomplicated. It is all too easy for nurses and others who care for clients experiencing a spontaneous abortion to fall into the trap of believing that, since this is a minor medical problem, it is also a minor life event.

A rarely considered aspect of the nursing care of those who experience spontaneous abortion is long-term follow-up of the individual and family after the spontaneous abortion has occurred. Whenever possible, a referral should be made to Public Health Nurses working in

the communities where these individuals reside. The findings of this study clearly demonstrate that much of the Experience of Spontaneous Abortion occurs outside of the institutional setting. Public Health Nurses possess the knowledge base and the necessary access to plan and carry out community based follow-up for those who experience spontaneous abortion. With the development of more sensitive instruments which will enable practitioners to predict the intensity of parental grief response to spontaneous abortion, referral and follow-up could be priorized so that parents identified as being at high risk for intense grief responses could receive more rapid and appropriate care.

Recommendations to Improve Institutional Responses

Recommendations in this section are directed to two distinct institutions: 1) hospitals and 2) religious organizations. During the literature review and data collection, the researcher became aware that a wide variety of hospital policies dealing with the care of those who experience a spontaneous abortion existed. These ranged from an entire lack of any policy to the preparation of an elaborate protocol outlining specific actions required on the part of nurses, pastoral care workers, social workers, pathologists, attending physicians and others. The Resolve

Through Sharing programme developed by La Crosse Lutheran Hospital and Gunderson Clinic, Ltd. of La Crosse, MN is one example of a comprehensive programme planned to support and care appropriately for parents who experience fetal and early infant death. All hospitals who provide medical and nursing care to women experiencing spontaneous abortion should plan and implement policies and protocols directed to the improvement of the care given to these individuals. Several articles outlining hospital based programmes providing support to parents bereaved by fetal and early infant death are available. Rather than simply adopt a programme planned by another institution, each hospital should plan its own programme based on its unique organizational structure and the needs of the clients that it serves. In planning the programme, hospitals should enlist the support and cooperation of community based public health programmes to carry out the long term follow up of clients once they return to the community. Further, support groups and parents who have been bereaved as a consequence of fetal and early infant death should be consulted during the development of the programme. Follow up programmes should be multidisciplinary. The needs and wishes of the individual client should guide the implementation of any interventions outlined in the programme.

Hospitals should give careful consideration to the

pre-operative and post-operative placement of clients who are admitted with threatened or inevitable abortions. Frequently, these clients are admitted to emergency departments or acute care wards where their particular medical problem may be the least life threatening of all clients for whom nursing staff must render care. It is not surprising that subjects in this study frequently stated that they did not receive much nursing care or even see many nurses during their stay in hospital. One subject stated that she believed that all D&C procedures should be done in free standing clinics. In this type of setting, clients experiencing a spontaneous abortion would not have to compete for care with those clients experiencing more life threatening medical problems. Although the concept of free standing clinics would not likely gain favour within the present health care system, the concept of placing clients experiencing spontaneous abortions in areas where they would not be competing with others who are more seriously ill has merit. The increasing focus on ambulatory care facilities and day surgery provides a possible alternative to present client placement practices. These, and other options should be explored in detail.

The health care system must act to reduce the length of time that clients must wait for diagnostic tests and for the results of those tests. Waiting for the health care system to respond to the threatened spontaneous abortion

was identified as a significant stressor by subjects in this study. Consideration must be given to developing more effective strategies to priorize the booking of tests based on the urgency of the presenting problem. Clients could then be certain that the response to their problem was based on their needs and not the needs of the system. The traditional approach of having the client return to the referring physician for test results must also be reconsidered.

Protocols for pathology examinations after spontaneous abortion should be reviewed, and more importantly, the rationale for the protocols should be carefully explained to clients who have experienced a spontaneous abortion. Subjects in this study were very distressed about the fact that it is customary to wait until a women has experienced three spontaneous abortions before asking for a pathologist's report on the expelled fetus and placenta. Strong rationale for the limitation on the provision of pathological examinations after spontaneous abortion likely exists. However, clients, who are not members of the health care system and the scientific community, are not aware of these rationale. They interpret the unwillingness of physicians to provide them with pathology reports as indifference to their problem.

Hospitals should treat the bodies of aborted fetuses with the same respect given to others who die while in

hospital. The parents of the fetus should be given the opportunity to arrange to have the body of the fetus buried privately at a site of their choosing. Where parents do not wish to do this, or where they are unable, the hospital should provide burial for the body. At least one hospital in urban Winnipeg presently has a marked gravesite where the remains of fetuses and newborn infants entrusted to the hospital are buried. Other hospitals should provide a similar service for their clients.

Even in our increasingly secular society, religious organizations are frequently involved in the care of the dying and the burial of the dead. Ambiguity about whether spontaneous abortion actually involves the death of a distinct human being makes the role of religious organizations in this type of bereavement difficult to define. Certainly, different religious traditions would have different viewpoints on the humanness of the aborted fetus. However, the fact that some subjects in this study demonstrated a desire for some type of ceremony or ritual in memory of the fetus clearly shows that there is a need for organized religions to be prepared to respond to the needs of parents who experience spontaneous abortion.

Summary of the Study

Spontaneous abortion was identified as a little understood, but potentially complex life experience. Current cultural beliefs and practices with respect to childbearing and death make spontaneous abortion a particularly difficult life event. Contemporary Western culture places a high value on the ability to plan and exert control over conception, pregnancy, and labour and delivery. An individual or couple who experience a spontaneous abortion may believe that they have failed in their attempt to master the tasks associated with the childbearing process. Yet, in reality, humans are not able to control the biological process of reproduction.

Contemporary Western cultural beliefs and practices surrounding birth and death also present difficulties for parents who experience a spontaneous abortion. Spontaneous abortion is an ambiguous event. Since the fetus has not developed to the point of viability outside of the uterus, spontaneous abortion is not generally considered to be a birth. Therefore, it is difficult for those who experience a spontaneous abortion to define this event as a death. Further, in a culture that avoids the topic of death and offers limited support to those who are bereaved, few supports are available to those who experience spontaneous abortion.

An extensive review of the literature on the entire topic of fetal and early infant death revealed that health care professionals and the wider social system give limited consideration to the impact of spontaneous abortion on the lives of parents so bereaved. Much of the literature reviewed for this study consisted of anecdotal discussions and case reviews presented by health care practitioners concerned about the experience of parents who were bereaved as a consequence of fetal and early infant death. Emphasis was placed on the identification of variables which might intensify or lessen the grief experienced by these parents.

Quantitative research examining any type fetal and early infant death is very limited. Even less research on the topic of spontaneous abortion has been conducted. The findings of quantitative research conducted to date are difficult to generalize because of small, unrepresentative samples and methodological errors.

Qualitative research in the area of fetal and early infant death is a more recent development. The findings of these researchers has increased the ability of health care professionals to understand the experiences of parents who have been bereaved as a consequence of fetal or early infant death. However, more research of this type is necessary in order to confirm and further develop present findings.

The purpose of this study was: 1) to examine parental

responses to the experience of spontaneous abortion and 2) to elicit from the parents a description of how significant others and health professionals responded to the spontaneous abortion. Two sources of data were obtained: 1) audio taped interviews of subjects who experienced, either directly or indirectly through a spousal relationship, a spontaneous abortion and 2) participant observer data collected from the discussions of a support group for parents who had experienced bereavement as a consequence of fetal and early infant death.

A qualitative method of data analysis called Grounded Theory was chosen. Data analysis resulted in a process theory entitled The Experience of Spontaneous Abortion. Four categories of the theory were identified: 1) Committing to the Pregnancy, 2) Experiencing the Spontaneous Abortion, 3) Putting It In Its Place and 4) Moving On. Subprocesses of the theory were also identified. The theory describes parental experiences preceding, during and subsequent to the spontaneous abortion.

REFERENCES

Antonovsky, A. (1979). Health, stress, and coping. San Francisco: Jossey-Bass Publishers.

Aries, P. (1974). Western attitudes toward death: From the Middle Ages to the present. Baltimore: The John Hopkins University Press.

Aries, P. (1982). The hour of our death. New York: Vintage Books.

Barrington, E. (1985). Midwifery is catching. Toronto: NC Press, Ltd.

Beard, R., Beckley, J., Black, D., Brewer, C., Craig, Y., Hill, A., Jolly, H., Lewis, E., Lewis, H., Limerick, S., Liston, J., Morris, D., Scriven, D., & Wilson, R. (1978). Help for parents after stillbirth. British Medical Journal, (Jan 21), 172-173.

Beckey, R.D., Price, R.A., Okerson, M., & Riley, K.W. (1985). Development of a perinatal grief checklist. JOGNN, 14(3), 194-199.

Benfield, D.G., Leib, S.A., & Vollman, J.H. (1978). Grief response of parents to neonatal death and parent participation in deciding care. Pediatrics, 62(2), 171-177.

Bluglass, K. (1982). Problems with perinatal pathology. British Medical Journal, 285(11).

Blumer, H. (1969). Symbolic Interaction: Perspective and method. Englewood Cliffs NJ: Prentice-Hall Publishing Co.

Bombardieri, M. (1981). The baby decision: How to make the most important choice of your life. New York: Rawson, Wade Publishers, Inc.

Borg, S., & Lasker, J. (1981). When pregnancy fails. Boston: Beacon Press.

Bowers, N. (1985). Early pregnancy loss in the infertile couple. JOGNN (supplement), 14(6), 55s-57s.

Brady, T., Berminghman, D., Kealan, D., Magee, D., Prendergast, P., & Malone, J.P. (1984). Stillbirth: The mother's view, Irish Medical Journal, 77(5), 133-139.

Brewer, G. (1983). Nine months: Nine lessons. New York: Simon & Schuster, Inc.

Carr, D., & Knupp, S. (1985). Grief and perinatal loss: A community hospital approach to support. JOGNN, 14(2), 130-139.

Carver, C. (1984). Patients beware: Dealing with doctors and other medical dilemmas. Scarborough: Prentice-Hall Canada, Inc.

Catanzaro, M. (1988). Using qualitative analytical techniques. In N.F. Woods & M. Catanzaro (Eds.). Nursing research: Theory and practice. St. Louis: The C.V. Mosby Co.

Chenitz, C. (1986a). Getting started: The research proposal for a grounded theory study. In C. Chenitz & J. Swanson (Eds.). From practice to grounded theory: Qualitative research in nursing (pp. 39-47). Toronto: Addison-Wesley Publishing Co.

Chenitz, C. (1986b) The informal interview. In C. Chenitz & J. Swanson (Eds.). From practice to grounded theory: Qualitative research in nursing (pp. 79-90). Toronto: Addison-Wesley Publishing Co.

Chenitz, C. & Swanson, J. (1986). Qualitative research using grounded theory. In C. Chenitz & J. Swanson (Eds.) From practice to grounded theory: Qualitative research in nursing (pp. 3-15). Toronto: Addison-Wesley Publishing Co.

Choron, J. (1964). Death and modern man. New York: Collier Books.

Clarke, H., & Driever, M. (1983). Vulnerability: The development of a construct for nursing. In P.L. Chinn (Ed.). Advances in nursing theory development. Rockville, MD: Aspen Systems Corp.

Clarke, M. (1979). Depression in women after perinatal death. The Lancet, 1(8122), 916-917.

Cohen, J. (1985). Parenthood after 30?: A guide to personal choice. Toronto: Lexington Books.

Cohen, L., Zilkha, S., Middleton, J., & O'Donnohue, N. (1978). Perinatal mortality: Assisting parental affirmation, American Journal of Orthopsychiatry, 48(4), 727-731.

Connolly, K.D. (1982). The management of perinatal death. Irish Medical Journal, 75(12), 456-457.

Cooper, J. (1979). End this conspiracy of silence. Nursing Mirror, 149(23), 31-33.

Corbin, J. (1986a). Qualitative data analysis for grounded theory. In C. Chenitz & J. Swanson (Eds.). From practice to grounded theory: Qualitative research in nursing (pp. 91-101). Toronto: Addison-Wesley Publishing Co.

Corbin, J. (1986b). Coding, writing memos, and diagramming. In C. Chenitz & J. Swanson (Eds.). From practice to grounded theory: Qualitative research in nursing (pp. 102-120). Toronto: Addison-Wesley Publishing Co.

Corney, R., & Horton, F. (1974). Pathological grief following spontaneous abortion. American Journal of Psychiatry, 131(7), 825-827.

Daniels, P., & Weingarten, K. (1982). Sooner or later: The timing of parenthood in adult lives. New York: W.W. Norton & Co.

Dunlop, J. (1979). Bereavement reaction following stillbirth. Practitioner, 222, 115-118.

Editor. (1977). Grief and stillbirth. British Medical Journal, (15 Jan.), 126.

Elkins, V. (1980). The rights of the pregnant parent (rev. ed.). Toronto: Waxwing Productions.

Elliott, B.A., & Hein, H.A. (1978). Neonatal death: Reflections for physicians. Pediatrics, 62(1), 96-99.

Estok, P., & Lehman, A. (1983). Perinatal death: Grief support for families. Birth, 10(1), 17-25.

Ewy, D., & Ewy, R. (1984). Death of a dream. New York: E.P. Dutton, Inc.

Fagerhaugh, S.Y. (1986a). Analyzing data for basic social processes. In C. Chenitz & J. Swanson (Eds.). From practice to grounded theory: Qualitative research in nursing (pp. 133-145). Toronto: Addison-Wesley Publishing Co.

Fagerhaugh, S.Y. (1986b). Getting around with emphysema. In C. Chenitz & J. Swanson (Eds.). From practice to grounded theory: Qualitative research in nursing (pp. 205-214). Toronto: Addison-Wesley Publishing Co.

Feldman, S. (1980). Choices in childbirth. New York: Bantam Books.

Forrest, G.C., Standish, E. &, Baum, J.D. (1982). Support after perinatal death: A study of support and counselling after perinatal bereavement. British Medical Journal, 285, 1475-1479.

Gandhi, M.K. (1971). Why fear or mourn death?. (A.T. Hingorani, Ed. and publisher). "Pocket Gandhi Series" No. 21. Bombay: Bharatiya Vidya Bhavan.

Glaser, B.G., & Strauss, A.L. (1967). The discovery of grounded theory: Strategies for qualitative research. Chicago: Aldine Publishing Co.

Government of Manitoba. (1987). Maternal and child care vital statistics (11th update). Winnipeg, MB: Maternal and Child Health Directorate, Community Health Services Division, Manitoba Health.

Gunther, J. (1965). Death be not proud: A memoir. New York: Harper & Row.

Hager, A., & Owens, O. (1987). Early pregnancy loss: miscarriage and ectopic pregnancy. In J.R. Woods & J.L. Esposito (Eds.). Pregnancy loss: Medical therapeutics and practical considerations (pp. 23-50). Baltimore: Williams & Wilkins.

Hallet, E. (1974). Birth and grief. Birth and the Family Journal, 1(4), p. 21.

Harris, C.C. (1984). Dysfunctional grieving related to childbearing loss: A descriptive study. Health Care for Women International, 5, 401-425.

Hatcher, R., Josephs, N., Stewart, F., Guest, F., Stewart, G., & Kowal, D. (1982). It's your choice: A personal guide to birth control methods for women...and men too!. New York: Irving Publishers, Inc.

Heiss, J. (1981). The social psychology of interaction. Englewood Cliffs, NJ: Prentice-Hall, Inc.

Hewitt, J.P. (1984). Self and society: A Symbolic Interactionist social psychology (3rd ed.). Boston: Allyn and Bacon, Inc.

Hildebrand, W.L., & Schreiner, R.L. (1980). Helping parents cope with perinatal death. American Family Physician, 22(5), 121-125.

Hutti, M. (1984). An examination of perinatal death literature: Implications for nursing practice and research. Health Care for Women International, 5, 387-400.

Hutti, M. (1986). An exploratory study of the miscarriage experience. Health Care for Women International, 7, 371-389.

Jolly, H. (1976). Family reactions to stillbirth. Proceedings of the Royal Society of Medicine, 69, 835-837.

Kastenbaum, R. (1981). Death, society, and human experience (2nd ed.). Toronto: The C.V. Mosby Co.

Kay, J. (1987). Pregnancy loss and the grief process. In J.R. Woods & J.L. Esposito (Eds.). Pregnancy loss: Medical therapeutics and practical considerations (pp. 5-20). Baltimore: Williams & Wilkins.

Kellner, K., Donnelly, W., & Gould, S. (1984). Parental behavior after perinatal death: Lack of predictive demographic and obstetric variables. Obstetrics & Gynecology, 63(6), 809-814.

Kennell, J., Slyter, H., & Klaus, M. (1970). The mourning response of parents to the death of a newborn infant. The New England Journal of Medicine. 283(7), 344-349.

Kirkley-Best, E., & Kellner, K. (1982). The forgotten grief: A review of the psychology of stillbirth. American Journal of Orthopsychiatry, 52(3), 420-429.

Knafl, K.A., & Howard, M.J. (1984). Interpreting and reporting qualitative research. Research in Nursing and Health, 7, 17-24.

Knapp, R.J., & Peppers, L.G. (1979). Doctor-patient relationships in fetal/infant death encounters. Journal of Medical Education, 54(Oct), 775-780.

Kobassa, S. (1979). Stressful life events, personality and health: An inquiry into hardiness. Journal of Personality and Social Psychology, 37(1), 1-11.

Kobassa, S., Maddi, S., & Courington, S. (1981). Personality and constitution as mediators in the stress-illness relationship. Journal of Health and Social Behavior, 22, 368-378.

Kowalski, K. (1980). Managing perinatal loss. Clinical Obstetrics and Gynecology, 23(4), 1113-1123.

Kushner, H. (1981). When bad things happen to good people. New York: Avon Books.

Kushner, L. (1979). Infant death and the childbirth educator. MCN, 4(July/August), 231-233.

LaRoche, C., Lalinec-Michaud, M., Engelsman, F., Fuller, N., Copp, M., & Vasilevsky, K. (1982). Grief reactions to perinatal death: An exploratory study. Psychosomatics, 23(5), 510-518.

LaRoche, C., Lalinec-Michaud, M., Engelsman, F., Fuller, N., Copp, M., McQuade-Soldatos, L., & Aziman, R. (1984). Grief reactions to perinatal death - A follow-up study. Canadian Journal of Psychiatry, 29(2), 14-19.

Lauer, R.H., & Handel, W.H. (1977). Social psychology: The theory and application of Symbolic Interactionism. Boston: Houghton Mifflin Co.

Lewis, E. (1976). The management of stillbirth: Coping with an unreality. The Lancet, 2(2986), 619-620.

Lewis, E., & Page A. (1978). Failure to mourn a stillbirth: An overlooked catastrophe. British Journal of Medical Psychology, 51, 237-241.

Lockwood, S., & Lewis, I.C. (1980). Management of grieving after stillbirth. The Medical Journal of Australia, 2, 308-311.

Lovell, A. (1983). Some questions of identity: Late miscarriage, stillbirth and perinatal loss. Social Science and Medicine, 17(11), 755-761.

May, K. (1980). A typology of detachment/involvement styles adopted during pregnancy by first-time expectant fathers. Western Journal of Nursing Research, 2(2), 445-461.

McCraw, R.K. (1988). Extreme phobias following missed abortion and D&C. Health Care for Women International, 9, 177-183.

McIntosh, N., & Eldridge, C. (1984). Neonatal death - the neglected side of neonatal care? Archives of Disease in Childhood, 59, 585-587.

Morris, D. (1976). Parental reactions to perinatal death. Proceedings of Royal Society of Medicine, 69, 837-838.

Morris, D. (1978). Help for parents after stillbirth. British Medical Journal, (18 Feb), 439-440.

Morris, D. (1988). Management of perinatal bereavement. Archives of Disease in Childhood, 63, 870-872.

Noble, E. (1983). Childbirth with insight. Boston: Houghton Mifflin Co.

Olds, S., London, M., & Ladewig, P. (1988). Maternal-newborn nursing. Don Mills, Ont.: Addison-Wesley Publishing Co.

Outerbridge, E., Chance, G., Beaudry, M., MacMurray, S., Pendray, M., & Shea, D. (1983). Support for parents experiencing perinatal loss. Canadian Medical Association Journal, 129, 335-339.

Panuthos, C., & Romeo, C. (1984). Ended beginnings: Healing childbearing loss. New York: Warner Books.

Peppers, L.G., & Knapp, R.J. (1980) Maternal reactions to involuntary fetal/infant death. Psychiatry, 43(May), 155-159.

Phipps, S. (1985-86). The subsequent pregnancy after stillbirth: Anticipatory parenthood in the face of uncertainty. International Journal of Psychiatry in Medicine, 15(3), 243-264.

Pritchard, J.A., MacDonald, P.C., & Gant, N.F. (Eds.). (1985) Williams Obstetrics (17th ed.). Norwalk, CT: Appleton- Century-Crofts.

Rock, P. (1979). The making of Symbolic Interactionism. London: The MacMillan Press Ltd.

Rose, A. (1980). A systematic summary of symbolic interaction theory. In J. Riehl & C. Roy (Eds.). Conceptual models for nursing practice (pp. 38-50). Norwalk CT: Appleton-Century-Crofts.

Rose, M., & Killien, M. (1983). Risk and vulnerability: A case for differentiation. Advances in Nursing Science, (April), 60-73.

Ross, T. (1976). Stillbirth - A new approach. Nursing Mirror, (Oct 7), 40-41.

Rowe, J., Clymna, R., Green, C., Mikkelsen, C., Haight, J., & Ataide, L. (1978). Follow-up of families who experience a perinatal death. Pediatrics, 62(2), 166-170.

Ruzek, S. (1978). The women's health movement. New York: Praeger Publishers.

Sahu, S. (1981). Coping with perinatal death. The Journal of Reproductive Medicine, 26(3), 129-132.

Saylor, D. (1977). Nursing response to mothers of stillborn infants. JOGN Nursing, 6(4), 39-42.

Schiff, H. (1977). The bereaved parent. New York: Penguin Books.

Scupholme, A. (1978). Who helps? Coping with the unexpected outcomes of pregnancy. JOGN Nursing, 7(4), 36-39.

Seibel, M., & Graves, W. (1980). The psychological implications of spontaneous abortions. The Journal of Reproductive Medicine, 25(4), 161-165.

Seidel, J.V. (1988). The Ethnograph version 3.0 [computer program]. Littleton, CO: Qualis Research Associates.

Shapiro, J.L. (1987). The expectant father. Psychology Today, (Jan.), 36-42.

Silver, R., & Wortman, C. (1980). Coping with undesirable life events. In J.Garber & M.E.P. Seligman (Eds.), Human helplessness. New York: Academic Press.

Speck, P. (1978). Easing the pain and grief of stillbirth. Nursing Mirror, (June 1), 38-41.

Stack, J. (1984). The psychodynamics of spontaneous abortion. American Journal of Orthopsychiatry, 54(1), 162-167.

Stern, P. (1980). Grounded theory methodology: Its uses and processes. Image, 12(1), 20-23.

Stern, P. (1982). Affiliating in stepfather families: Teachable strategies leading to stepfather-child friendship. Western Journal of Nursing Research, 4(1), 75-89.

Strauss, A. (1987). Qualitative analysis for social scientists. Cambridge: The Cambridge University Press.

Swanson, J. (1986a). The formal qualitative interview for grounded theory. In C. Chenitz & J. Swanson (Eds.). From practice to grounded theory: Qualitative research in nursing (pp. 66-78). Toronto: Addison-Wesley Publishing Co.

Swanson, J. (1986b). Analyzing data for categories and description. In C. Chenitz & J. Swanson (Eds.). From practice to grounded theory: Qualitative research in nursing (pp. 121-132). Toronto: Addison-Wesley Publishing Co.

Swanson-Kauffman, K. (1986). Caring in the instance of unexpected early pregnancy loss. Topics in Clinical Nursing, 8(2), 37-46.

Taubenheim, A.M., & Silbernagel, T. (1988). Meeting the needs of expectant fathers. MCN, 13(March/April), 110-113.

Toedter, L.J., Lasker, J.N., & Alhadeff, J.M. (1988). The Perinatal Grief Scale: Development and initial validation. American Journal of Orthopsychiatry, 58(3), 435-449.

Wall-Haas, C. (1985). Women's perceptions of first trimester spontaneous abortion. JOGNN, 14(1), 50-53.

Wilson, A.L., Witzke, D., Fenton, L.J., & Soule, D. (1985). Parental response to perinatal death: Mother - father differences. American Journal of Diseases of Children 139(Dec), 1235-1238.

Woods, N.F., & Catanzaro, M. (1988). Designing studies to describe phenomena. In N.F. Woods & M. Catanzaro (Eds.). Nursing research: Theory and practice. (pp. 133-149). St. Louis: The C.V. Mosby Co.

APPENDIX A

SURVEY OF LAY LITERATURE TO DETERMINE THE FREQUENCY OF DISCUSSIONS OF UNDESIRED OUTCOMES OF PREGNANCY

Table A–1
Frequency of Use of Terms Representing an Undesirable Outcome of Pregnancy

	One sentence	Less than 1 paragraph	One paragraph	Less than half page	Less than 1 page	One page or more	Total
Abortion, spontaneous	4	0	0	0	0	0	4
Birth defects	6	1	3	0	1	2	13
Fetal abnormalities	1	0	0	0	1	0	2
Fetal death	0	0	1	0	0	0	1
Fetal deformities	1	0	0	0	0	0	1
Genetic anomalies	2	1	2	0	0	1	6
Intrauterine death	2	0	0	0	0	0	2
Miscarriage	7	1	1	0	0	1	10
Neonatal death	0	0	0	0	0	0	0
Perinatal death	2	0	1	0	0	0	3
Stillbirth	5	1	1	0	0	0	7
Total	30	4	9	0	2	4	49

N=11

LIST OF BOOKS SURVEYED

Barrington, E. (1985). Midwifery is catching. Toronto: NC Press, Ltd.

Bing, Elizabeth. (1970). The adventure of birth. New York: Ace Books.

Bombardieri, M. (1981). The baby decision: How to make the most important decision of your life. New York: Rawson, Wade Publishers, Inc.

Brewer, B. (1983). Nine months: Nine lessons. New York: Simon & Schuster.

Clulow, C. (1982). To have and to hold: Marriage, the first baby and preparing couples for parenthood. Aberdeen: The University Press.

Cohen, J. (1985). Parenthood after 30?: A guide to personal choice. Toronto: Lexington Books.

Daniels, P., & Weingarten, K. (1982). Sooner or later: The timing of parenthood in adult lives. New York: W.W. Norton & Co.

Elkins, V. (1980). The rights of the pregnancy parent. (rev. ed.). Toronto: Waxwing Productions.

Feldman, S. (1980). Choices in childbirth. New York: Bantam Books.

Kramer, R. (1978). Giving birth: Childbearing in America today. Chicago: Contemporary Books.

Noble, E. (1983). Childbirth with insight. Boston: Houghton Mifflin.

APPENDIX B

EMOTIONAL/PSYCHOLOGICAL AND PHYSICAL/BEHAVIOURAL RESPONSES OF MOTHERS, FATHERS, AND COUPLES TO SPONTANEOUS ABORTION, STILLBIRTH, PERINATAL DEATH AND NEONATAL DEATH

Table B-1

Responses of Mothers to Spontaneous Abortion

Source	Emotional/ Psychological Response	Physical/ Behavioural Response
Corney & Horton	Depression Disappointment Grief, normal Grief, pathological Sense of loss Anger Sadness	
Seibel & Graves	Disgusted Nervous Afraid, lonely Feel terrible Sad Anxious Depressed Hostile	Blame self Blame partner
Stack	Intensity of mourning not related to gestational age. Guilt Sadness Disbelief Anger Frustration Disappointment	Uncertainty Powerless Helplessness Blame
Wall-Hass	Sadness Preoccupation with baby. Irritable Anger Depression Disbelief	Self blame Crying Praying Want to be alone
Bowers	Guilt Inadequacy Sense of failure	

Table B-2

Responses of Mothers to Stillbirth

Source	Emotional/ Psychological Response	Physical/ Behavioural Response
Grubb (a)	Case study describing mother's alternation between belief and disbelief while waiting for the delivery of her stillborn child	
Grubb (b)	Concerns re: loss of body intactness. Concern re: being incarcerated by death within. Concerns re: future of body and self Concerns re: differentiating between self and dead fetus.	
Lewis	Guilt Shame Sadness Feeling of nothingness.	Avoid people Frenzied
Ross	Emptiness	Wanting to see baby
Jolly	Pent up grief, often for years	
Kowalski & Osborn	Fear Depression Grief	

Editor, British Med. Journal	Distress	Helplessness Unsatisfied with care. Change doctors. Quickly become pregnant again. Go back to work. Fling selves into time consuming tasks.
Saylor	Shock Disbelief Sense of loss Loneliness Feel cheated Anger	Kubler-Ross: 1. denial 2. anger 3. bargaining may not occur 4. depression 5. acceptance
Beard et al.	Feel inadequate feel a failure as a woman.	
Lewis & Page	Shame Guilt Sense of failure as a woman.	Avoid people
Dunlop	Shock Denial Depression Guilt Anxiety Re-integration	
Lockwood & Lewis	Delayed grief Sense of evil Fear of insanity Guilt Inadequacy	Revulsion Search for reasons for the stillbirth.

Kirkley-Best & Kellner	Shock Numbness Anger Guilt Despair Depression Hallucinations Illusions of presence of the deceased. Devaluing of self Chronic grief Delayed grief Absent grief	
Brady et al.	Numbness Anger Futility Guilt Sadness Sense of failure	Blaming Crying

Table B-3

Responses of Mothers to Perinatal Death

Source	Emotional/ Psychological Response	Physical/ Behavioural Response
Morris (1976)	"I do not wish to get over his loss. I simply wish that his life and death should be absorbed into my own." Sad A failure Fears for future pregnancies. Lonely	Empty Physically exhausted.
Rowe et al.	Usual grief responses, but study showed an increased abnormal grief response if: 1. presence of surviving twin 2. another pregnancy within six months.	
Clarke	Depression Younger women more depressed than older women.	
Hildebrand & Schreiner	Grief similar to death of any other loved person. 1/3 may have morbid grief reaction.	

Kowalski	Normal responses include: Preoccupation with image of deceased. Guilt Hostility	Somatic distress Loss in pattern of ADL.
	Distortions: Delayed grief Agitated depression.	Overactivity without sense of loss. Acquisition of symptoms of deceased. Initial diagnosis or exacerbation of psychosomatic disease. Furious hostility against specific persons. Formal manner resembling schizophrenia. Lasting loss of pattern of social interaction. Activities detrimental to self.
Sahu	Guilt Depression Empty Lonely Irritable Hostile Angry Increased emotional distance. Loss of femininity. Sense of futility.	Loss of appetite Sleep problems Tightness in chest or throat. Shortness of breath. Sighing Fatigue Aching arms Unable to return to usual patterns of conduct.

Laroche et al. (1982)		Crying Sleeplessness Blame self Blame physician Not able to do ADL Nightmares Somatic complaints Nervousness Unable to leave home
Forrest et al.	Sadness Anxiety Guilt Irritability Anger Shock No expressed emotion. Anger Feel cheated	Tearfulness Lethargy Insomnia Palpitations Search for cause of death. Numbness Empty
Estok & Lehman		Submerge feelings in renewed commitment to work.
Carr & Knupp	Why? What did baby look like? Distanced from spouse.	Feeling full and empty at the same time. Crying Wanting to get labour over with.
Wilson et al.	Mothers have significantly more depressive symptoms than fathers at first; less difference as time goes on. Mothers have greater need for ongoing support.	

Table B-4

Responses of Mothers to Neonatal Death

Source	Emotional/ Psychological Response	Physical/ Behavioural Response
Kennell et al.	Sadness Preoccupation with infant.	Loss of appetite Increased irritability. Inability to resume normal ADL.

Table B-5

Responses of Mothers - Mixed Discussions

Source	Emotional/ Psychological Response	Physical/ Behavioural Response
Speck	Spont. Abortion: Grief proportional to awareness of baby: likely increases as pregnancy advances. Feelings of failure as a woman.	
		Stillbirth: Empty, even if baby still in utero
Outerbridge et al.	General: Mothers more likely to feel guilty. Sense of failure as a woman.	
	Spont. Abortion: May still grieve if attached to baby, but also may not.	
	Stillbirth: Grief process may begin before birth.	Wish to see baby.
	Neonatal death: As for stillbirth	
Lewis	Stillbirth & Neonatal death: Shame Guilt	Feel a void where there was once fullness. Isolate selves Protect others from their distress.

Peppers & Knapp	General: Sadness Preoccupation Anger Guilt Failure to accept reality. Depression	Loss of appetite Inability to sleep Irritability Inability to resume normal activity Difficulty in concentration. Time confusion Exhaustion Lack of strength Repetitive dreams about the dead child.
Lovell	General: Feel deviant Shame Guilt Doubts re: self Isolated Devalued Sense of unreality; sometimes long lasting and not related to seeing baby. Angry Hurt	Feel apologetic because they sense that they are a source of discomfort to others
Kay	General: Numbness Shock Denial Feeling of loss Sadness Anger Inadequacy Jealousy	Emptiness
	Prolonged/ pathological grief: Depression lasting more than one year. Psychosis Anxiety attacks	Onset of physical illness.

Hager & Owens	Spont. Abortion: Response may begin when bleeding starts. Fear for self Fear for baby Denial Anger As spont. abortion happens; shock & disbelief	Helplessness Blaming

Table B-6

Responses of Fathers to Spontaneous Abortion

Source	Emotional/ Psychological Response	Physical/ Behavioural Response
Stack	General statements that the same responses can be found in men	

Table B-7

Responses of Fathers to Stillbirth

Source	Emotional/ Psychological Response	Physical/ Behavioural Response
Ross		Avoids topic
Editor, British Med. Journal	Distress Rose of husband in shaping subsequent plans of wife not known.	Helplessness
Saylor		Same stages as wife (Kubler-Ross). Likely more rapid progress through the stages than wife. May become impatient wife's slower progress.
Lewis & Page	Guilt related to ambivalence about the pregnancy.	
Cooper	Fears for the safety of their wife	
Brady et al.	Perceived by wives as being very upset	

Table B-8

Responses of Fathers to Perinatal Death

Source	Emotional/ Psychological Response	Physical/ Behavioural Response
Hildebrand & Schreiner		Men tend to avoid talking about baby, believing that it is best if baby is forgotten.
Kowalski	Same as mothers	Same as mothers
Sahu	Same as mothers	Same as mothers
Forrest et al.	Feel obligated to stay calm and controlled.	As reported by wives, cope by plunging into work as soon as possible.
Connolly	Afraid to talk to wife for fear it will upset her.	
Estok & Lehman		Become over-involved in work.

Table B-9

Responses of Fathers to Neonatal Death

Source	Emotional/ Psychological Response	Physical/ Behavioural Response
Kennell et al.	More grief if father had accompanied baby to another hospital.	Deny grief. Maintain or increase work commitment. Feel they cannot afford to be upset, because their wives are upset.

Table B-10

Responses of Fathers - Mixed Discussions

Source	Emotional/ Psychological Responses	Physical/ Behavioural Responses
Speck		Spont. Abortion: At a loss as to what to do. Avoids wife Blames self
Outerbridge et al.	Spont. Abortion: Less likely to be affected by grief.	
		Stillbirth: Protective: want to shield wife from decisions. Usually does not want to see baby.
	Neonatal death: Stress related to the many people he must care for.	
Lewis	Stillbirth & Neonatal death: Guilt	
Kay	General: Isolation Anger	

Hager & Owens	Spont. Abortion: Fear for well-being of partner. Powerlessness. Bewildered by intensity of spouse's response. Guilt Disbelief Anger Frustration Pessimism Relief

Table B-11

Responses of Couples to Spontaneous Abortion

Source	Emotional/ Psychological Response	Physical/ Behavioural Response
Bowers	Isolated Shock Disbelief Mutual guilt	Helplessness Mutual blame Somatic responses related to grief.

Table B-12

Responses of Couples to Stillbirth

Source	Emotional/ Psychological Response	Physical/ Behavioural Response
Lewis		Blame others
Jolly		Unable to discuss the subject.
Beard et al.	Sense of failure Sense of loss Grief	Blame others Blame selves
Cooper	Feeling of dehumanization. Shock Sense of unreality. Denial Disbelief Anger Unprepared Sense of social ostracism and isolation. Depression	Unable to recall details of event clearly. Irritable with one another.
Brady et al.	This study makes a particular note of how physically separated couples are when this happens and how the separation can affect their respective mourning and cause additional stress.	Alone - physically separated from their spouse.

Table B-13

Responses of Couples to Perinatal Death

Source	Emotional/ Psychological Response	Physical/ Behavioural Response
Morris (1978)	Grief experienced and need for help is the same as for any other bereavement in the family.	
Cohen et al.	Most pressing issue is "what have you done with my child?". Those who did not know experienced a variety of fears. 1. Child not dead, but being experimented on. 2. Baby on display in a jar. 3. Baby sectioned, cremated or thrown away to destroy evidence of negligence.	
Hildebrand & Schreiner	Devastated Feelings of unreality. Loneliness Depression Guilt Preoccupation with dead baby.	Somatic complaints Angry hostility Irritability Loss of routine patterns. Difficulties with friends and family. Divorce
Kowalski		Increased incidence of separation and divorce.

Sahu	Women feel more guilt than men. Men resolve grief more quickly. Stress on marital relationship.	Breakdown in communication. If communication open, can strengthen the relationship.
Connolly	Shock Anger Denial Depression Sadness Adaptation	Apathy Increased activity Restlessness Tension
Laroche et al. (1984)	Sadness Preoccupation with dead infant. Guilt	Loss of appetite Sleeplessness Irritability Unable to return to normal activities.
Kellner et al.	Causes a grief response as severe as and in some ways more disruptive than that seen in families where adult members have died	
Carr & Knupp	Loss of control Stress Fear Anxiety Shock	
Wilson et al.	If fathers depressed and less able to be supportive, marital relationship declines and wife is more depressed. Father's response to the loss may be more central to the nature of the couple's ultimate adaptation than has been previously recognized.	Changes in marital relationships. Of the 82% of women and 67% of men who stated that the baby's death affected the marriage, over 90% reported that the marriage had been strengthened.

Table B-14

Responses of Couples to Neonatal Death

Source	Emotional/ Psychological Response	Physical/ Behavioural Response
Kennell et al.		Disturbance in pre-existing marital relationship.
Elliott & Hein	Normal: Anger Guilt Depression Shock Fantasies re: baby. Preoccupation with death. Isolation	Emptiness Exhaustion Difficulty sleeping. Difficulty eating Crying Hostility Blaming
	Pathological: Inability to cope with the grief.	Inappropriate cheerfulness. Inappropriate hostility. Agitated depression. Continuing isolation. Development of medical problems.
Benfield et al.	Depression Disbelief Anger Guilt Fears that it will happen again. Why?	Crying Praying for baby Wanting to be left alone.
White et al.	Bewildered	Helpless

McIntosh & Eldridge	Grief response is independent of the size of the baby. High incidence of emotional problems.	Helpless

Table B-15

Responses of Couples - Mixed Discussions

Source	Emotional/ Psychological Response	Physical/ Behavioural Response
Speck	General: Loss Failure Grief	
	Stillbirth: Anxiety Shock Disbelief "What have you done with my baby?". Intense longing for baby. Hurt Depression	Crying Anger against God Anger against others. Anger against self.
	Cong. abnormality: Shock Disbelief Denial - "wrong baby". Failure Shame	Isolate selves and baby. Resent time taken away from marital relationship to attend to baby.

Outerbridge et al.	General: Shock Disbelief Confusion Anguish Anger Guilt Loneliness Relief Sadness Depression Resentment Spont. Abortion: Incongruent grieving may result in marital discord.	Denial Hostility Sleeplessness Nightmares Jealous
Malcolm & Wooten	General: Feel a terrible void. Isolated	
Scupholm	Stillbirth and Neonatal death: Grief Shock Disbelief Anger Guilt	Abnormal manifestations: Silent Indifferent Blase
Knapp & Peppers	Guilt	Anger directed at physicians.
Harris		General: Dysfunctional grief 1. Normalcy facade 2. Role distress 3. Repression of joy or humour 4. Attributional guilt 5. Phantom baby experiences
Kay	General: Incongruent grieving	Marital stress

SOURCES

Beard, R., Beckley, J., Black, D., Brewer, C., Craig, Y., Hill, A., Jolly, H., Lewis, E., Lewis, H., Limerick, S., Liston, J., Morris, D., Scriven, D. & Wilson, R. (1978). Help for parents after stillbirth. British Medical Journal, (Jan. 21), 172-173.

Benfield, D.G., Leib, S.A., & Vollman, J.H. (1978). Grief response of parents to neonatal death and parent participation in deciding care. Pediatrics, 62(2), 171-177.

Bowers, N. (1985). Early pregnancy loss in the infertile couple. JOGNN (supplement), 14(6), 55s-57s.

Brady, R., Bermingham, D., Keelan, D., Magee, D., Prendergast, P., & Malone, J.P. (1984). Stillbirth: The mother's view. Irish Medical Journal, 77(5), 133-139.

Carr, D., & Knupp, S. (1985). Grief after perinatal loss: A community hospital approach to support. JOGNN, 14(2), 130-139.

Clarke, M. (1979). Depression in women after perinatal death. The Lancet, 1(8122), 916-917.

Cohen, L., Zilkha, S., Middleton, J., & O'Donnohue, N. (1978). Perinatal mortality: Assisting parental affirmation. American Journal of Orthopsychiatry, 48(4), 727-731.

Connolly, K.D. (1982). The management of perinatal death. Irish Medical Journal, 75(12), 456-457.

Cooper, J. (1979). End this conspiracy of silence. Nursing Mirror, 149(23), 31-33.

Corney, R.T., & Horton, F.T. (1974). Pathological grief following spontaneous abortion. American Journal of Psychiatry, 131(7), 825-827.

Dunlop, J. (1979). Bereavement reaction following stillbirth. Practitioner, 222, 115-117.

Editor. (1977). Grief and stillbirth. British Medical Journal, (Jan. 15), 126.

Elliott, B.A., & Hein, H.A. (1978). Neonatal death: Reflections for physicians. Pediatrics, 62(1), 96-99.

Estok, P., & Lehman, A. (1983). Perinatal death: Grief support for families. Birth, 10(1), 17-25.

Forrest, G.C., Standish, E., & Baum, J.D. (1982). Support after perinatal death: A study of support and counselling after perinatal bereavement. British Medical Journal, 285, 1475-1479.

Grubb, C. (1976a). Is the baby alive or dead: Psychological work of a woman with an intrauterine fetal death. Maternal Child Nursing Journal, 5(1), 25-37.

Grubb, C. (1976b). Body image concerns of a multipara in the situation of intrauterine fetal death. Maternal Child Nursing Journal, 5(2), 93-116.

Hager, A., & Owens, O.M. (1987). Early pregnancy loss: Miscarriage and ectopic pregnancy. In J.R. Woods & J.L. Esposito (Eds.). Pregnancy loss: Medical therapeutics and practical considerations (pp. 23-50). Baltimore: Williams & Wilkins.

Harris, C.C. (1984). Dysfunctional grieving related to childbearing loss: A descriptive study. Health Care for Women International, 5, 401-425.

Hildebrand, W.L., & Schreiner, R.L. (1980). Helping parents cope with perinatal death. American Family Physician, 22(5), 121-125.

Hutti, M.H. (1984). An examination of perinatal death literature: Implications for nursing practice and research. Health Care for Women International, 5, 387-400.

Jolly, H. (1976). Family reactions to stillbirth. Proceedings of the Royal Society of Medicine, 69, 835-837.

Kay, J. (1987). Pregnancy loss and the grief process: In J.R. Woods & J.L. Esposito (Eds.). Pregnancy loss: Medical therapeutics and practical considerations (pp. 5-20). Baltimore: Williams & Wilkins.

Kellner, K., Donnelly, W., & Gould, S. (1984). Parental behavior after perinatal death: Lack of predictive demographic and obstetric variables. Obstetrics & Gynecology, 63(6), 809-814.

Kennell, J.H., Slyter, H., & Klaus, M.H. (1970). The mourning response of parents to the death of a newborn infant. The New England Journal of Medicine, 283(7), 344-349.

Kirkley-Best, E., & Kellner, K. (1982). The forgotten grief: A review of the psychology of stillbirth. American Journal of Orthopsychiatry, 52(3), 420-429.

Knapp, R.J., & Peppers, L.G. (1979). Doctor-patient relationships in fetal/infant death encounters. Journal of Medical Education, 54(Oct), 775-780.

Kowalski, K. (1980). Managing perinatal loss. Clinical Obstetrics and Gynecology, 23(4), 1113-1123.

Kowalski, K. & Osborn, M. (1976). Helping mothers of stillborn infants to grieve. Maternal Child Nursing, 2(1), 29-32.

LaRoche, C., Lalinec-Michaud, M., Engelsmann, F., Fuller, N., Copp, M., & Vasilevsky, K. (1982). Grief reactions to perinatal death: An exploratory study. Psychosomatics, 23(5), 510-518.

Laroche, C., Lalinec-Michaud, M., Engelsmann, F., Fuller, N., Copp, M., McQuade-Soldatos, L., & Azima, R. (1984). Grief reactions to perinatal death - a follow-up study. Canadian Journal of Psychiatry, 29(2), 14-19.

Lewis, E. (1976). The management of stillbirth: Coping with an unreality. The Lancet, 2(2986). 619-620.

Lewis, E. (1979). Mourning by the family after a stillbirth or neonatal death. Archives of Disease in Childhood, 54, 303-306.

Lewis, E., & Page, A. (1978). Failure to mourn a stillbirth: An overlooked catastrophe. British Journal of Medical Psychology, 51, 237-241.

Lockwood, S., & Lewis, I.C. (1980). Management of grieving after stillbirth. The Medical Journal of Australia, 2, 308-311.

Lovell, A. (1983). Some questions of identity: Late miscarriage, stillbirth and perinatal loss. Social Science and Medicine, 17(11), 755-761.

Malcolm, N., & Wooten, B. (1987). It's hard to say goodbye. The Canadian Nurse, (April), 26-28.

McIntosh, N., & Eldridge, C. (1984). Neonatal death - the neglected side of neonatal care? Archives of Disease in Childhood, 59, 585-587.

Morris, D. (1976). Parental reactions to perinatal death. Proceedings of Royal Society of Medicine, 69, 837-838.

Morris, D. (1978). Help for parents after stillbirth. British Medical Journal, (Feb. 18), 439-440.

Outerbridge, E.W., Chance, G.W., Beaudry, M.A., MacMurray, S.B., Pendray, M.R., & Shea, D.R. (1983). Support for parents experiencing perinatal loss. Canadian Medical Association Journal, 129(Aug 15), 335-339.

Peppers, L.G., & Knapp, R.J. (1980). Maternal reactions to involuntary fetal/infant death. Psychiatry, 43(May), 155-159.

Ross, T. (1976). Stillbirth - a new approach. Nursing Mirror, (Oct. 7), 40-41.

Rowe, J., Clyman, R., Green, C., Mikkelsen, C., Haight, J., & Ataide, L. (1978). Follow-up of families who experience a perinatal death. Pediatrics, 62(2), 166-170.

Sahu, S. (1981). Coping with perinatal death. Journal of Reproductive Medicine, 26(3), 129-132.

Saylor, D. (1977). Nursing response to mothers of stillborn infants. JOGN Nursing, 6(4), 39-42.

Scupholme, A. (1978). Who helps? coping with the unexpected outcomes of pregnancy. JOGN Nursing, 7(4), 36-39.

Seibel, M., & Graves, W. (1980). The psychological implications of spontaneous abortion. The Journal of Reproductive Medicine, 25(4), 161-165.

Speck, P. (1978). Easing the pain and grief of stillbirth. Nursing Mirror, (June 1), 38-41.

Stack, J. (1984). The psychodynamics of spontaneous abortion. American Journal of Orthopsychiatry, 54(1), 162-167.

Swinton, A., (1977). Grief and stillbirth. British Medical Journal, (April 9), 971.

Wall-Haas, C. (1985). Women's perceptions of first trimester spontaneous abortions. JOGNN, 14(1), 50-53.

White, M.P., Reynolds, B., & Evans, T.J. (1984). Handling of death in special care nurseries and parental grief. British Medical Journal, 289(July 21), 176-169.

Wilson, A.L., Witzke, D., Fenton, L.J., & Soule, D. (1985). Parental responses to perinatal death: Mother-father differences. American Journal of Diseases of Children, 139(Dec.) 1235-1238.

APPENDIX C

EMOTIONAL/PSYCHOLOGICAL AND PHYSICAL/BEHAVIOURAL RESPONSES OF SIGNIFICANT OTHERS TO SPONTANEOUS ABORTION, STILLBIRTH, PERINATAL DEATH AND NEONATAL DEATH

Table C-1

Responses of Significant Others to Spontaneous Abortion

Source	Emotional/ Psychological Response	Physical/ Behavioural Response
Stack		Often no response
Wall-Haas		Minimize loss
Bowers		Lack of acknowledgment.

Table C-2

Responses of Significant Others to Stillbirth

Source	Emotional/ Psychological Response	Physical/ Behavioural Response
Lewis		Avoid parents
Ross		Avoid topic
Kowalski & Osborn	Anger Relief that the anxious waiting for the delivery of the stillborn baby is over	Protective
Beard et al.	Often unaware of how long it takes to mourn a stillborn child	
Lewis & Page		Avoid parents

Table C-3

Responses of Significant Others to Perinatal Death

Source	Emotional/ Psychological Response	Physical/ Behavioural Response
Hildebrand & Schreiner		Imply guilt: "You worked too hard". "You didn't take care of yourself". Tell couple to forget about the baby. Stop visiting Won't bring their children to visit. Encourage replacement babies.
Sahu		Do not appreciate the depth of the bonding of the parents to the baby. Do not know how to face the parents.
Kellner et al.		Find it difficult to understand parent's emotional responses. Assume there was no attachment to the baby. Assume the parent's intense grief is pathological.

Carr & Knupp	Upset	Attempt to diminish the size of grief. "Have another" Protective; trying to shield parents from realities and decisions required after baby's death.

Table C-4

Responses of Significant Others to Neonatal Death

Source	Emotional/ Psychological Response	Physical/ Behavioural Response
Benfield et al.		Give unsolicited advice and reasons for baby's death. "Get pregnant again". "Your fault because _____".

Table C-5

Responses of Significant Others - Mixed Discussions

Source	Emotional/ Psychological Response	Physical/ Behavioural Response
Speck		Spont. Abortion: Minimize loss
Outerbridge et al.		Neonatal death: Lack of sympathy or understanding in the workplace
Scupholme		Stillbirth and neonatal death: Remove all evidence of baby; clear nursery, etc.
Lewis		General: Avoid talking to the mother. Silence
Hager & Owens		Spont. Abortion: Supportive if they have had the experience. Unable to understand.

SOURCES

Beard, R., Beckley, J., Black, D., Brewer, C., Craig, Y., Hill, A., Jolly, H., Lewis, E., Lewis, H., Limerick, S., Liston, J., Morris, D., Scriven, D., & Wilson, R. (1978). Help for parents after stillbirth. British Medical Journal, (Jan. 21), 172-173.

Benfield, D.G., Leib, S.A., & Vollman, J.H. (1978). Grief response of parents to neonatal death and parent participation in deciding care. Pediatrics, 62(1), 96-99.

Bowers, N. (1985). Early pregnancy loss in the infertile couple. JOGNN (supplement), 14(6), 55s-57s.

Carr, D., & Knupp, S. (1985). Grief after perinatal loss: A community hospital approach. JOGNN, 14(2), 130-139.

Hager, A., & Owens, O.M. (1987). Early pregnancy loss: Miscarriage and ectopic pregnancy. In J.R. Woods & J.L. Esposito, (Eds.). Pregnancy loss: Medical therapeutics and practical considerations (pp. 23-50). Baltimore: Williams & Wilkins.

Hildebrand, W.L., & Schreiner, R. L. (1980). Helping parents cope with perinatal death. American Family Physician, 22(5), 121-125.

Kellner, K., Donnelly, W., & Gould, S. (1984). Parental behavior after perinatal death: Lack of predictive demographic and obstetric variables. Obstetrics & Gynecology, 63(6), 809-814.

Kowalski, K., & Osborn, M. (1977). Helping mothers of stillborn infants to grieve. Maternal Child Nursing, 2(1), 29-32.

Lewis, E. (1976). The management of stillbirth: Coping with an unreality. The Lancet, 2(2986), 619-620.

Lewis E., & Page, A. (1978). Failure to mourn a stillbirth: An overlooked catastrophe. British Journal of Medical Psychology, 51, 237-241.

Outerbridge, E.W., Chance, G.W., Beaudry, M.A., MacMurrary, S.B., Pendray, M.R., & Shea, D.R. (1983). Support for parents experiencing perinatal loss. Canadian Medical Association Journal, 129(Aug 15), 335-339.

Ross, T. (1976). Stillbirth - a new approach. Nursing Mirror, (Oct. 7), 40-41.

Sahu, S. (1981). Coping with perinatal death. Journal of Reproductive Medicine, 26(3), 129-132.

Scupholme, A. (1978). Who helps? Coping with the unexpected outcomes of pregnancy. JOGN Nursing, 7(4), 36-39.

Speck, R. (1978). Easing the pain and grief of stillbirth. Nursing Mirror, (June 1), 38-41.

Stack, J. (1984). The psychodynamics of spontaneous abortion. American Journal of Orthopsychiatry, 54(1), 162-167.

Wall-Haas, C. (1985). Women's perceptions of first trimester spontaneous abortion. JOGNN, 14(1), 50-53.

APPENDIX D

EMOTIONAL/PSYCHOLOGICAL AND PHYSICAL/BEHAVIOURAL RESPONSES OF HEALTH PROFESSIONALS TO SPONTANEOUS ABORTION, STILLBIRTH, PERINATAL DEATH AND NEONATAL DEATH

Table D-1

Responses of Health Professionals to Spontaneous Abortion

Source	Emotional/ Psychological Response	Physical/ Behavioural Response
Seibel & Graves		Focus on physical care.
Stack		Often no response
Wall-Haas		Minimize loss
Bowers		Lack of acknowledgment.

Table D-2

Responses of Health Professionals to Stillbirth

Source	Emotional/ Psychological Response	Physical/ Behavioural Response
Lewis		Reluctant to know or remember anything about a patient who has had a stillbirth. Supportive MDs experienced physical symptoms.
Ross	Guilt Failure Feel that they have lost to "the enemy".	
Editor, British Med. Journal	Anxious Sad	Offer more drugs Whisk baby away Non-communicative MDs tend to forget about stillbirth.
Swinton		Despite lack of training, most staff do relate to the parents.
Saylor	Uncomfortable	Awkward
Beard et al.	Failure Loss Grief	
Lewis & Page		Isolate the parents Avoid the parents Deny own anxiety Fail to remember the stillbirth at a later time.

Kirkley-Best & Kellner	Fail to remember the stillbirth at a later time

Table D-3

Responses of Health Professionals to Perinatal Death

Source	Emotional/ Psychological Response	Physical/ Behavioural Response
Morris (1976)	Use disassociation as a means of coping with their feelings.	
Morris (1978)		Do not know what is done with bodies of deceased infants.
Hildebrand & Schreiner	Perceive death as their fault and are therefore unable to support parents.	Prescribe sedatives and treat symptoms, but do not discuss the death.
Kowalski		Impose firm control (for example, anaesthesia, withhold baby), allegedly to protect mother, but more likely to protect self.
Forrest et al.		Education which emphasizes technical rather then psychological care makes them tend to withdraw.
Estok & Lehman	Acute pain Shock Guilt	Avoidance Encourage parents in magical thinking (lucky you already have . . . You can always have . . .). Hostile and negative behaviour in response to parent's anger.

Kellner et al.	Guilt Defeat Resentment Anxiety	Find it difficult to understand parent's emotional responses. Assume there was no attachment to the baby. Helplessness Anxiety is often projected as personal feelings of aggressive or accusing behaviour to parents, or denial. Make decisions re: options offered to parents on basis of demographic and obstetrical characteristics of the patient and in accordance with their own beliefs. Avoid patients Discharge patients early.
Carr & Knupp	Frustration	Lose warmth and become coldly professional when baby's death is detected. Forget to support one another.
Beckey et al.	Anxiety Depression	Helplessness Avoidance

Table D-4

Responses of Health Professionals to Neonatal Death

Source	Emotional/ Psychological Response	Physical/ Behavioural Response
Elliott & Hein		Coldness Disapproval Indifference
Benfield et al.		Forget about or are unaware of baby's death. Find it hard to cope with death.
McIntosh & Eldridge	Guilt Depression	Regard death as failure. Burnout

Table D-5

Responses of Health Professionals - Mixed Discussions

Source	Emotional/ Psychological Response	Physical/ Behavioural Response
Speck	Stillbirth: Sense of failure Anxiety	Withdraw from parents.
Outerbridge et al.		General: Tendency to paternalism. Responses based on self-image of one who cures. Stillbirth: Reluctant to discuss the stillbirth with the parents.
Malcolm & Wooten	General: Grief feelings similar to parents.	
Lewis		Stillbirth and neonatal death: Discharge mother early. Forget that the mother had this experience in subsequent visits.

Knapp & Peppers	General: Fear of death is manifested in the way they deal with survivors. Think less about death, but are more afraid of it. Failure Mourning Inadequacy Guilt	Insensitive Aloof Unconcerned Helplessness Pediatricians feel trapped.
Peppers & Knapp		General: Neglect parents Argue over who will tell them.
Lovell		General: Authoritarian Anxious Devalue deformed baby. Withdraw all care, even routine care such as TPR and BP. Discharge early

SOURCES

Beard, R., Beckley, J., Black, D., Brewer, C., Craig, Y., Hill, A., Jolly, H., Lewis, E., Lewis, H., Limerick, S., Liston, J., Morris, D., Scriven, D., & Wilson, R. (1978). Help for parents after stillbirth. British Medical Journal, (Jan. 21), 172-173.

Beckey, R.D., Price, R.A., Okerson, M., & Riley, K.W. (1985). Development of a perinatal grief checklist. JOGNN, 14(3), 194-199.

Benfield, D.G., Leib, S.A., & Vollman, J.H. (1978). Grief response of parents to neonatal death and parent participation in deciding care. Pediatrics, 62(2), 171-177.

Bowers, N. (1985). Early pregnancy loss in the infertile couple. JOGNN (supplement), 14(6), 55s-57s.

Carr, D., & Knupp, S. (1985). Grief after perinatal loss: A community hospital approach to support. JOGNN, 14(2), 130-139.

Editor. (1977). Grief and stillbirth. British Medical Journal, (Jan 15), 126.

Elliott, B.A., & Hein, H.A. (1978). Neonatal death: Reflections for physicians. Pediatrics, 62(1), 96-99.

Estok, P., & Lehman, A. (1983). Perinatal death: Grief support for families. Birth, 10(1), 17-25.

Forrest, G.C., Standish, E., & Baum, J.D. (1982). Support after perinatal death: A study of support and counselling after perinatal bereavement. British Medical Journal, 285, 1475-1479.

Hildebrand, W.L., & Schreiner, R.L. (1980). Helping parents cope with perinatal death. American Family Physician, 22(5), 121-125.

Kellner, K., Donnelly, W., & Gould, S. (1984). Parental behaviour after perinatal death: Lack of predictive demographic and obstetric variables. Obstetrics & Gynecology, 63(6), 809-814.

Kirkley-Best, E., & Kellner, K. (1982). The forgotten grief: A review of the psychology of stillbirth. American Journal of Orthopsychiatry, 52(3), 420-429.

Knapp, R.J., & Peppers, L.G. (1979). Doctor-patient relationships in fetal/infant death encounters. Journal of Medical Education, 54(Oct), 775-780.

Kowalski, K. (1980). Managing perinatal loss. Clinical Obstetrics and Gynecology, 23(4), 1113-1123.

Lewis, E. (1976). The management of stillbirth: Coping with an unreality. The Lancet, 2(2986), 619-620.

Lewis, E. (1979). Mourning by the family after a stillbirth or neonatal death. Archives of Disease in Childhood, 54, 303-306.

Lewis, E., & Page, A. (1978). Failure to mourn a stillbirth: An overlooked catastrophe. British Journal of Medical Psychology, 51, 237-241.

Lovell, A. (1983). Some questions of identity: Late miscarriage, stillbirth and perinatal loss. Social Science and Medicine, 17(11), 755-761.

Malcolm, N., & Wooten, B. (1987). It's hard to say goodbye. The Canadian Nurse, (April), 26-28.

McIntosh, N., & Eldridge, C. (1984). Neonatal death - the neglected side of neonatal care? Archives of Disease in Childhood, 59, 585-587.

Morris, D. (1976). Parental reactions to perinatal death. Proceedings of Royal Society of Medicine, 69, 837-838.

Morris, D. (1978). Help for parents after stillbirth. British Medical Journal, (Feb 18), 439-440.

Outerbridge, E.W., Chance, G.W., Beaudry, M.A., MacMurray, S.B., Pendray, M.R., & Shea, D.R. (1983). Support for parents experiencing perinatal loss. Canadian Medical Association Journal, 129(Aug 15), 335-339.

Peppers, L.G., & Knapp, R.J. (1980). Maternal reactions to involuntary fetal/infant death. Psychiatry, 43(May), 155-159.

Ross, T. (1976). Stillbirth - a new approach. Nursing Mirror, (Oct. 7), 40-41.

Saylor, D. (1977). Nursing response to mothers of stillborn infants. JOGN Nursing, 6(4), 39-42.

Seibel, M., & Graves, W. (1980). The psychological implications of spontaneous abortion. The Journal of Reproductive Medicine, 25(4), 161-165.

Speck, P. (1978). Easing the pain and grief of stillbirth. Nursing Mirror, (June 1), 38-41.

Stack, J. (1984). The psychodynamics of spontaneous abortion. American Journal of Orthopsychiatry, 54(1), 162-167.

Swinton, A. (1977). Grief and stillbirth. British Medical Journal, (April 9), 971.

Wall-Haas, C. (1985). Women's perceptions of first trimester spontaneous abortions. JOGNN, 14(1), 50-53.

APPENDIX E

INSTRUMENTS

INTERVIEW GUIDE

As you know, I am interested in hearing about your experience with a miscarriage. Perhaps we could begin with you telling me some of the background information about your experience. Could you tell me how long ago the miscarriage happened and some of your memories about the experience.

1. What was your emotional response at the time you (your partner) had the miscarriage?

2. What was your physical response?

3. How long did these emotional and physical feelings continue to affect your daily life?

   emotional

   physical

4. How long did these feelings continue to recur?

   emotional

   physical

5. What meaning did the miscarriage have for you at the time that it happened? How did you explain this event to yourself and to others?

6. Has this meaning changed since the time of the miscarriage?

7. How did your family and friends respond at the time of the miscarriage?

   to you

   to your partner

   How long did these responses continue?

8. How did the health professionals who were involved at the time of the miscarriage respond??

   to you

   to your partner

   How long did these responses continue?

DEMOGRAPHIC DATA

Please answer these questions as accurately as you can. YOU MAY OMIT ANSWERING ANY QUESTIONS IF YOU PREFER.

1. Age: _____ (in years)

2. Sex: Male _____ Female _____

3. Education:

   a) Highest Grade in Grade or High School _____

   b) Trade/Vocational/Diploma/Technical School _____

   c) University: diploma _____

      degree _____

4. Marital status (at present): Single (never married) ____

   Married or common law ____

   Separated ____

   Divorced ____

   Widowed ____

5. Marital status at time of miscarriage:

   Single (never married) ____

   Married or common law ____

   Separated ____

   Divorced ____

   Widowed ____

6. Reproductive history of your family unit:

   Number of pregnancies _____

   Number of living children _____

   Number of miscarriages _____

   Number of stillbirths or Infant deaths _____

7. Do you consider yourself: Not religious _____

Slightly religious _____

Moderately religious _____

Strongly religious _____

8. Religious affiliation:
(If none, please state "none"): _____

9. How many people are there in your extended family (parents, siblings, grandparents) _____

How many of these people would you describe yourself as being close to? _____

10. How many close friends do you have? _____

11. What is your ethnic background? _____

APPENDIX F

FOLLOW-UP TELEPHONE CALL TO ARRANGE INTERVIEW

Hello. This is Marion McKay calling. You recently expressed interest in participating in a study which I am conducting on miscarriages. Are you still interested in participating in this study? Do you have any questions about the study at this time?

If you still wish to participate in the study, I would like to arrange a date and time for the interview. Do you have a partner who also wishes to participate? Did he/she receive a copy of my presentation and a consent form? Do you wish to be interviewed separately or alone?

When would be a convenient time to get together for the interview.

Please let me confirm your name and address.

Thank you. I look forward to meeting you.

APPENDIX G

LETTER TO SUPPORT GROUP REQUESTING ACCESS FOR DATA COLLECTION

May 24, 1988

Marion McKay
22 Leeds Ave.
Winnipeg, Man.
R3T 3X2
Telephone: 269-5292

Dear :

Subject: Research Project

I am a Masters Student in the School of Nursing at the University of Manitoba. I have completed the course work required for this program, and am ready to begin work on my thesis. The Chairperson of my thesis committee is Dr. Janet Beaton.

My thesis topic is an exploration of the experience of spontaneous abortion, more commonly referred to as a miscarriage. I am interested in hearing first hand, from people who have had such an experience, their description of the effect of this event on their lives. I am interested in interviewing both men and women. I am also interested in hearing accounts of this experience from both those who have recently experienced a miscarriage, and from those who have experienced this event in the past. These interviews will be tape recorded, and will be used to develop a comprehensive description of the experience of spontaneous abortion. The results of this study will be used to inform health care professionals about the experiences and feelings of those who have experienced a spontaneous abortion.

I am approaching your group because you provide support to such people. With your permission, I would like to attend a general meeting of your group to present my research topic and recruit any volunteers who might be interested in participating in this study.

Those persons who volunteer for the study will be provided with written information about the purpose of the study and the manner in which it will be conducted. The rights of participants in the study will be upheld. Any information given to me by participants will be held in the

strictest confidence.

I would be happy to meet with your Advisory Board at your earliest convenience to provide you with further information about the study. I look forward to receiving your response to my request in the near future.

Yours truly,

Marion McKay

May 26, 1988

Marion McKay
22 Leeds Ave.
Wpg. Man.

Dear Marion:

After discussion with _____, co-founder of _____, we felt it was best for us to refer parents with losses to you for your interviews.

You are welcome to attend our monthly meetings as a participant/observer.

Yours truly,

TYPED COPY OF HANDWRITTEN LETTER RECEIVED FROM SUPPORT GROUP

APPENDIX H

ETHICAL REVIEW COMMITTEE APPROVAL

Winnipeg, Man.

Telephone:

April 20, 1988

Dr. Theresa George
Chair
Ethical Review Committee
School of Nursing
University of Manitoba
Winnipeg, Man.
R3T 2N2

Dear Dr. George:

Re: submission of proposal for Ethical Review Committee approval

In accordance with your committee's requirements, I am submitting ten copies of the research proposal for my thesis project for ethical review.

I will be personally carrying out this research project. I plan to begin data collection as soon as possible after approval from the Ethical Review Committee is received.

The members of my thesis committee are:
Chair: Dr. Janet Beaton
Dr. Helen Glass
Dr. Gordon Harland

If you require any further information, please do not hesitate to contact me.

Yours truly,

Marion McKay

Winnipeg, Man.

Telepnone:

May 12, 1988

Dr. Theresa George
Chair
Ethical Review Committee
School of Nursing
University of Manitoba
Winnipeg, Man.
R3T 2N2

Dear Dr. George:

Re: revisions of proposal requested by the Ethical Review Committee

Enclosed, please find the revisions to my proposal which we discussed May 10. I hope that these will meet with your committee's approval. In addition to the revisions which were requested by your committee, I have made one additional revision. In Appendix F, in my presentation to a group asking for subjects to volunteer for the study, I included a definition of spontaneous abortion as point f) in the listing of requirements for subjects participating in the study. This revision is included in the pages which I am submitting to you.

I look forward to receiving permission to proceed with my thesis project in the near future. If you have any further questions or concerns, please do not hesitate to contact me.

Yours truly,

Marion McKay

The University of Manitoba

SCHOOL OF NURSING

ETHICAL REVIEW COMMITTEE

Proposal Number N# 88/13

Proposal Title: An exploration of the experience of spontaneous abortion.

Name and Title of Researcher(s): Marion McKay
M. N. Student
School of Nursing
University of Manitoba

Date of Review: May 4, 1988

Decision of Committee: Approved: ✓ Not Approved: _____

Approved upon receipt of the following changes: _____
Submitted on May 12, 1988

Date: May 17, 1988

Theresa George, R. N., Ph.D. Chairperson
Associate Professor
Position

NOTE:

Any significant changes in the proposal should be reported to the Chairperson for the Ethical Review Committee's consideration, in advance of implementation of such changes.

APPENDIX I

WRITTEN DESCRIPTION OF STUDY

WRITTEN INFORMATION GIVEN TO INTERVIEW SUBJECTS

Hello. My name is Marion McKay. I am a Masters Student at the University of Manitoba in the School of Nursing. I have had many years of experience as a Public Health Nurse, working in Winnipeg. My area of special interest is promoting the health of young families with children or those contemplating having children.

As part of the Masters program, a thesis project is completed by the student. I am presently preparing to begin this project. My thesis supervisor is Dr. Janet Beaton. My topic is an exploration of the experience of miscarriage. I am interested in talking to both men and women who have had this experience in their lives. I would like to include both those who have had this experience recently and those whose experience occurred several years ago.

What I would like to do at this time is to tell you about how the study will be conducted and what those who volunteer to participate in the study will be asked to do. Please feel free to interrupt me to ask any questions that you might have.

The study will consist of taped interviews using a set of questions which I have developed. I expect that each interview will take about 1 to 1-1/2 hours to complete. If the interview is more lengthy than that, or if you become tired during the interview, I can arrange to finish it at

another time. I would like to interview some couples together. However, if couples prefer, interviews can be conducted separately. Please discuss this with one another before making your decision about how you wish to be interviewed. For those who do not have partners, or whose partners do not wish to participate in the study, I will be happy to interview you alone. I will get the names and telephone numbers of those who are interested in participating and I will telephone you in the near future to arrange an interview at a time and place that is convenient for you. For those who want more time to think about this opportunity, or wish to volunteer on a confidential basis, I have provided my telephone number at the end of this handout. Please telephone me if you decide to participate.

People who participate in this study must be:

a) a minimum age of 18 years

b) able to speak and comprehend English

c) live within the boundaries of Winnipeg, Man.

d) have a telephone so I can contact you to arrange an interview.

e) have experienced a miscarriage before the 20th week of the pregnancy

Your participation in this project is voluntary. You may withdraw at any time if you so desire. Any information that you share with me will be kept absolutely

confidential. Only my thesis supervisor and myself will have access to the tapes and transcripts of your interview. All tapes and transcripts will be identified by a code number only. No one except myself will know the names of those who participate in this study. This list of names will be kept entirely separate from the list of code numbers. Both lists will be kept under lock and key.

I am required to obtain signed consent from those who volunteer to participate in the study. Please read the consent form carefully before you sign it, and if you have any questions, please ask me. You will be provided with a copy of the consent form. If you wish to obtain a summary of this study once it is completed, please complete the sheet attached to the consent form.

Thank you for your time and attention. If you have any questions, I will be pleased to answer them.

Marion McKay

APPENDIX J

CONSENT FORM

CONSENT FORM

This certifies that I, _____, having met the conditions set out for this study, agree to participate in the study. Specifically, I understand and agree to the following:

1. The purpose of the study is to study the experiences of people who have had a miscarriage (spontaneous abortion).

2. The study is being conducted by Marion McKay, a Masters Student at the University of Manitoba. Her supervisor is Dr. Janet Beaton, who is a Professor in the School of Nursing at the University of Manitoba.

3. I have been provided with a written explanation of the study.

4. I understand that my participation involves a taped interview which will be conducted at a time and place convenient to me. The interview will take approximately 1 to 1-1/2 hours to complete. It may be done in two phases if necessary.

5. I understand that I may withdraw from the study at any time without any penalty to myself. I may decline to answer specific questions during the interview if I so wish. I further understand that participation in this study will not result in any direct benefit to me.

6. I understand that any information which I provide during the course of the study will be kept in absolute confidence. Only the researcher and her supervisor will have access to the tape and transcript of my interview. The tape and transcript will be identified by code number only. My name will not appear on any transcript or tape. Only the researcher will know the names of those who participate in the study, and this list of names will be kept separate from the list of code numbers. Both lists will be kept under lock and key. Upon completion of this study, the tapes will be erased.

7. I understand that I will be provided with a copy of this consent form.

8. I understand that I may contact Marion McKay at any time if I have further questions about my participation in the study. Her telephone number is

My signature below indicates my willingness to participate in this study.

Date	Participant	Researcher

I wish to receive a summary of the results of this study:

No _____

Yes_____

If Yes: Name _____

Address _____

_____

_____

APPENDIX K

A TAXONOMY OF THE THEORY OF THE EXPERIENCE OF SPONTANEOUS ABORTION

The Experience of Spontaneous Abortion

Category I: Committing to the Pregnancy

The process of developing an emotional attachment to the pregnancy and incorporating the anticipated child into personal and family life.

Property 1: Desiring

Actively wishing or yearning for a child.

Property 2: Conferring Personhood

Engaging in behaviours that confer upon the fetus the attributes of characteristics of a unique human being.

Property 3: Safeguarding

Taking measure to ensure the safety of the pregnancy.

Property 4: Making Room

Enlarging one's psychological and physical space to accommodate the expected child.

Contingent Variables:

Age
History of infertility
Previous fetal or early infant death
Responses of significant others
Parental time invested in planning the pregnancy
Number of committing behaviours enacted
Designation of a pregnancy as special

Time Frame:

From before conception to an indefinite time after the spontaneous abortion.

Category II: Experiencing the Spontaneous Abortion

The psychological responses of the parents during the time that the spontaneous abortion was actually taking place.

Property 1: Dealing with the Unexpected

The process of recognizing and responding to physical signs and symptoms indicating that a spontaneous abortion might occur.

Property 2: Assessing the Possibility

The process of evaluating subjective and objective information in order to assess the degree of threat to the pregnancy.

Property 3: Acknowledging the Reality

The process of finally coming to know that the spontaneous abortion has occurred.

Contingent Variables:

Length of the pregnancy
Sense of irony
Perception of loss of control
Unexpected aspects of the spontaneous abortion
Waiting
Optimistic feedback from others
Receiving confusing and conflicting information
Psychological isolation imposed by others
Physical isolation imposed by the health care system

Time Frame:

From the recognition of the first symptoms of the spontaneous abortion to the final psychological acknowledgment that the pregnancy no longer exists.

Category III: Putting It In Its Place

The process of gaining an understanding of the impact and meaning of the spontaneous abortion.

Property 1: Understanding the Magnitude

The process of evaluating the impact of the spontaneous abortion on one's life.

Property 2: Finding Reasons

The process of finding an answer to the question "Why did it happen to me?".

Property 3: Expressing the Loss

The process of finding ways to create a framework of meaning for the spontaneous abortion so that the experience can become an integral part of the subsequent life of the parent.

Contingent Variables:

Attributes of the individual
Responses of significant others
Responses of health care professionals
Ongoing medical complications

Time Frame:

From the first premonitions that the pregnancy was in jeopardy. No end point to parental behaviours within this category was identified.

Category IV: Moving On

The process of actively re-engaging in personal, family and social life.

Property 1: Re-entering the World

The process of resuming family, social and vocations roles.

Property 2: Acknowledging the Changes

The process of coming to an understanding of the long lasting or permanent effects of the spontaneous abortion on one's life.

Property 3: Working Through the Pain

The process of taking on the on-going grief work associated with the bereavement of spontaneous abortion.

Property 4: Trying Again

The process of making the decision of whether or not to attempt another pregnancy.

Contingent Variables:

On-going role demands
The ability to forgive
The ability to overcome fears
Attributes of the individual
Responses of significant others
Responses of health care professionals

Time Frame:

Soon after the spontaneous abortion. No end point to parental behaviours within this category was identified.

Subprocesses of the Theory

1. The impact of Committing to the Pregnancy on Experiencing the Spontaneous Abortion, Putting It In Its Place and Moving On.

2. The impact of Finding Reasons on Trying Again.

3. The impact of Expressing the Loss on Moving On.

4. The impact of Trying Again on Committing to the Next Pregnancy.