

RECURRENT PREGNANCY LOSS AND CHRONIC SORROW

by

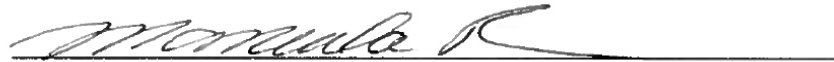
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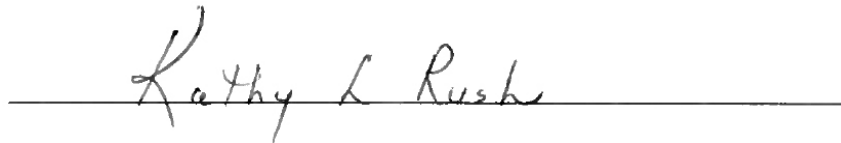
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REQUIREMENTS FOR THE DEGREE OF

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We accept this major project as conforming to the required standard

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Abstract

Recurrent pregnancy loss refers to three or more consecutive miscarriages and affects an estimated 1% of conceiving couples. This rarity is reflected in the lack of research and understanding of these women's experiences. This paper examines recurrent pregnancy loss in relation to the middle-range nursing theory of chronic sorrow through a comprehensive literature review and theory application. As this paper does not involve the conduct of new research, and because research has never been done on chronic sorrow in this population, the author composes and reflects on autobiographical narrative to provide an exemplar. This paper also includes a practice innovation designed for women experiencing singular or recurrent pregnancy loss. The author suggests chronic sorrow is a normal response to recurrent pregnancy loss that gives validity to these women's grief experiences. Nurses, as health care professionals likely to meet women experiencing recurrent pregnancy loss, are well placed to assess and address chronic sorrow in this population.

Acknowledgements

I am appreciative of my major paper committee, Manuela Reekie and Dr. Kathy Rush, for supporting my ideas and way of working. A special thank-you to Dr. Georgene Eakes for encouraging my use of her theory, then for taking time to read and revise my writing. I am thankful for my family, who thinks me amazing, and for my loving husband, who grieves with me for all our lost children. I wish no women would experience what I have, but some will, and I would like to help.

Chapter One: Statement of Issue

Purpose of the Paper

This paper had two main objectives. The first objective was to apply the psychosocial experience of recurrent pregnancy loss to the theory of chronic sorrow and suggest appropriate nursing interventions. This was achieved through a literature review of the theory of chronic sorrow and subsequent theory application. The author used the theory's framework and model (Appendix A) to apply women's experiences of pregnancy loss to the theory of chronic sorrow throughout Chapter Three. Autobiographical narrative provided a complementary exemplar but was not integrated with the literature. As literature available on the non-physiological aspects of recurrent pregnancy loss was limited, personal information was invaluable. The secondary objective was to provide support and encouragement, in the form of a booklet (Appendix D), for women who experience singular or recurrent pregnancy loss, as a way of bridging the gap in health care interactions between professional understanding and women's losses. The author anticipated this paper will extend the understanding of recurrent pregnancy loss by proposing chronic sorrow as a normal response, offering women increased validation and support.

Rationale of the Paper

There is a dearth of literature examining chronic sorrow in women experiencing pregnancy loss, though the author found one dissertation dealing with chronic sorrow and infertile couples (Casale, 2009). There is also limited research on the psychosocial experience of miscarriage as either a single or recurrent event, which is the focus of this application.

Miscarriage has appeared increasingly in literature published during the past century through the medicalization of pregnancy, as birth moved from the domain of women in the home

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to doctors in the hospital, and advances in obstetric and gynecologic technologies. Societally, miscarriage is not often acknowledged or understood, and women rarely expose their stories. As miscarriage usually refers to early pregnancy loss, many women are not visibly pregnant and may not have shared their news publicly. This effectively hides the source of a woman's grief, as there is no outward evidence of the loss. Sociopolitical disagreement about abortion and when life begins compounds the loss for a woman who considers her miscarriage the loss of a whole child and future. Women's experiences of miscarriage and the health care profession are unfortunately negative. Often treated as a low medical priority and unsuited for maternal or child services, these women can receive brief and insensitive medical care.

Significance of the Paper

Serrano and Lima (2006) recounted recurrent miscarriage as a traumatic event affecting an estimated 1% of conceiving couples. A miscarriage experience, while characterized as a common and non-urgent medical occurrence, can involve every aspect of a woman's body, mind and wellbeing. The relative rarity of recurrent miscarriage limits social awareness of associated grief. Women who grieve these losses deserve personal, social and professional sensitivity, which can only come through a better understanding of their experiences.

Women who experience multiple pregnancy losses often grieve deeply and at length outside socially accepted norms. There are no life memories for others to acknowledge and these women are a minority next to those who experience singular pregnancy loss. Women who experience multiple losses often have knowledge of or access to few truly empathic individuals. Negative or insensitive interactions can compound physical, emotional and social losses. Nurses who meet these women often feel at a loss regarding what to say and how to act, possibly

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contributing to their own sense of professional inadequacy and women's sense of isolation. Yet nurses are educated to recognize physical and emotional loss along life's continuum, and have the basic tools of therapeutic communication and advocacy that could benefit women experiencing recurrent pregnancy loss. This paper's significance is in recognizing that recurrent miscarriage is a sorrowful life event worthy of attention, and that the theory of chronic sorrow provides a normalizing and well suited perspective of women's experiences. Better understanding could help nurses recognize the needs of women experiencing recurrent pregnancy loss, and provide much-needed comfort and hope.

Approach to the Paper

To meet the first objective of understanding recurrent pregnancy loss in relation to the nursing theory of chronic sorrow, a literature review of the theory was followed by an application of women's experiences to the theory. This was done in combination with autobiographical narrative of the author's personal experience, a methodology discussed next. To meet the secondary objective of sharing information with women, a practice innovation was developed. The innovation is a booklet written to women suffering pregnancy loss (Appendix D), further described in Chapter Four.

Literature for chronic sorrow and pregnancy loss was found through Boolean searches of the PubMed and CINAHL databases using the following search terms: "spontaneous abortion" AND "grief" AND "nursing"; "involuntary pregnancy loss" AND "nurse*"; "recurrent involuntary pregnancy loss"; "recurrent first trimester miscarriage"; "recurrent miscarriage" AND "grief"; "chronic sorrow". Articles pertaining to the physiological and medical aspects of

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pregnancy loss were disregarded. Some hand searching was conducted for seminal works involving pregnancy loss and grief theories.

Methodology of the Paper

Autobiographical narrative was used in addition to examination of the literature and theory application. For the purposes of this paper it should be noted that theory application was not an application of theory to life, but an exploration of women's experiences against the framework of a theory. In this paper autobiographical narrative was the author's retrospective storytelling, an exemplar of recurrent pregnancy loss and how chronic sorrow can be experienced in reality. The author is both a perinatal registered nurse and a sufferer of recurrent pregnancy loss so her exemplar complements the limited research available on women's experiences. The author intended her story to emerge through the written word, both honoring her experience and seeking meaning. The purpose of such a narrative in the context of this paper is to provide a new perspective, be honest, seek understanding for self and others, and enable connection between the author's voice and the reader (Bullough & Pinnegar, 2001; Settelmaier, 2007). Her story is now open to interpretation and alternative meaning making, with no intentions to rigidly reflect either the literature on chronic sorrow or others' experiences of recurrent pregnancy loss.

Despite the author's use of narrative as personal storytelling only, autobiographical narrative as research, even nursing research, has precedence. There is some argument over the legitimacy of autobiography in academia, whether it is self-indulgent or educational. In their discussion of self-study research, Bullough and Pinnegar (2001) acknowledged "many researchers now accept that they are not disinterested but are deeply invested in their studies, personally and profoundly" (p. 13). This transition from objectivity and academic aloofness to

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personal interest parallels growing acceptance of qualitative research as alternative and complementary to traditional quantitative methods. The field of nursing is a leader in pioneering non-quantitative methods because of the knowledge to be gained from lived human experiences (Parse, 1996). The author's human experience adds value to the literature and helps the reader engage with the information in a personal way.

In her inclusive examination of non-quantitative nursing research Parse (1996) outlined several methods which share elements of autobiographical storytelling as a way of understanding. Heuristic research seeks the meaning of human experiences through a rigorous autobiographical research design, narratives are meant "to honor and understand human expressions" through language (p. 12), hermeneutical research interprets personal and historical events through an established nursing theory or framework, and phenomenology allows content to emerge from the research participants' stories. According to Parse (1996), any autobiographical methodology requires that understanding be related to human experience. Bullough and Pinnegar (2001) wrote, "only when a theory can be seen to have efficacy in a practical arena will that theory have life" (p. 15). The value of autobiographical narrative is that it can benefit both the author and the reader. "Exploring one's identity through critical reflective practice can lead not only to enhanced practical knowledge... but also to transformative learning - research can then become a journey of personal development" (Settelmaier, 2007, p. 176). Autobiography helps map a writer's "sensitivities to her research topic," and promotes the reader's identification with the author (Settelmaier, 2007, p. 176).

To include an autobiographical narrative within this paper, the author chose to place italicized first person excerpts prior to each main section throughout the theory application in

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Chapter Three, through nursing implications in Chapter Four, and at the beginning of the discussion in Chapter Five and the conclusion. The brief narratives were meant to provide the author's perspective only, and show her personal engagement with the themes that are subsequently addressed through the literature. Further reflection on the methodology of autobiographical narrative and main themes of the paper occurs in the discussion, Chapter Five.

Chapter Two: Introducing Chronic Sorrow

Approximately one woman out of a hundred conceiving couples will experience three or more consecutive early pregnancy losses, likely unsolved and potentially followed by more (Serrano and Lima, 2006). This is a woman who wants a child, and is suffering persistently from each and all losses. This woman experiences the loss of a pregnancy as the death of a child, and is invalidated by social debate on the value of a non-viable pregnancy. While recovering her body and person from one loss, managing grief and relationships, she is faced with the fear and anxiety attached to her new pregnancy. Isolation from truly empathic individuals is common as this woman does not fit in mainstream maternity services where she is likely to meet a fellow sufferer. Knowing what the experience of loss is like, she is challenged to find joy in her new pregnancy only to lose that as well. Her internal struggles and the negligent but well-intentioned help from others make coping a constant negotiation, and it takes little to trigger a return of overwhelming grief and desolation. She is at risk of experiencing chronic sorrow.

A Review of the Literature

The concept of chronic sorrow was introduced as a normal response to recurrent grief (Olshansky, 1962). A Nursing Consortium for Research on Chronic Sorrow (NCRCS) was created to expand the research on chronic sorrow (Eakes, Hainsworth, Lindgren, & Burke, 1991). The NCRCS research led to the development of the middle-range nursing theory of chronic sorrow. This represented a combination of inductive research and a critical literature review, using conceptual analysis according to Walker and Avant (1995). Chronic sorrow is periodic, pervasive recurring sadness connected to a single or ongoing significant loss (Eakes, Burke, & Hainsworth, 1998). In chronic sorrow a significant loss resulting in disparity between a desired

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and actual reality creates a recurring grief cycle involving coping methods and triggers associated with the loss. Chronic sorrow differs from other cyclical and staged grief models (Kubler-Ross, 1969; Lindemann, 1963; Parkes, 1972) by not having resolution of grief as an ultimate outcome. Chronic sorrow allows grief to be experienced outside of a time-bound continuum, and normalizes grief previously described as complicated, prolonged, or pathological (Teel, 1991). The theorists posited that calling chronic sorrow a normal response to a significant loss is meant to validate and not minimize the experience (Eakes et al., 1998).

The model and framework of chronic sorrow (Appendix A) begins with a description of the distinct or ongoing loss. Literature is unanimous that the loss be considered a significant event by the person experiencing it, and that the measure of significance is individualized (Casale, 2009; Eakes et al., 1998; Hainsworth, Eakes, & Burke, 1994; Hobdell & Deatrck, 1996). An initial grief experience may include somatic responses, depression, mourning, decreased investment, and suffering where the sense of self is threatened (Casale, 2009; Melvin & Heater, 2005). Common emotions connected to chronic sorrow are shock, sadness, guilt, anger, frustration, fear, jealousy, isolation, and loss of life's enjoyment (Casale, 2009; Eakes et al.; Hainsworth et al.; Hobdell & Deatrck; Melvin & Heater). Due to its cyclical nature, chronic sorrow can have periods of neutrality or happiness (Teel, 1991) interspersed with episodes of "re-grief," although the loss is described as "never-ending" (Eakes et al., p. 179).

In chronic sorrow the loss experience results in disparity "when the individual's current reality differs markedly from the idealized" (Eakes et al., 1998, p. 181). This disruption also happens when anticipated grief responses diverge. Chronic sorrow becomes "a normal response to an abnormal situation" (Eakes et al., p. 180). Chronic sorrow most often affects those who

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experience disparity with developmental and social norms, such as parents of disabled children. Infertility is included in chronic sorrow research because it is a long-term condition of great importance to individuals, with an uncertain outcome (Casale, 2009; Hainsworth et al., 1994).

Loss resulting in disparity can lead to chronic sorrow. There are four tenets of chronic sorrow: It is pervasive, permanent, periodic, and potentially progressive (Eakes et al., 1998). Chronic sorrow could be considered a life-long process. Therefore, the theoretical model and framework (Appendix A) depends on the presence of management methods, or coping strategies, as chronic sorrow involves continuous adaptation (Casale, 2009).

Effective internal management methods are positive individual coping strategies that have the potential to delay onset and reduce intensity of trigger events. Coping with chronic sorrow usually involves establishing a sense of control over one's life (Casale, 2009; Eakes et al., 1998), as attempts at situation modification can result in feelings of failure and hopelessness. Focus is on actions the individual directs such as crying, sharing, distraction, pursuing personal interests, cognitive therapy, and information seeking (Eakes et al.; Hainsworth et al., 1994). Chronic sorrow deals with identity, self-concept and personal integrity, and cannot be hurried. Suzanne Martin (2005), a nurse and mother of a mentally challenged son, wrote of the experience with chronic sorrow this way: "When we are ready, we will accept and not deny, share and not hold back. In the meantime, please be patient, be there and pray with us and for us" (p. 38).

Effective external management refers to methods involving others, such as counseling, support groups, and supportive relationships. Efficacy depends on acceptance of chronic sorrow,

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as non-normalization by others can contribute to an individual's feelings of isolation and pain (Hainsworth et al., 1994). The idea is that others can augment personal coping (Eakes et al., 1998; Teel, 1991). Eakes et al. note nurses are well suited to address chronic sorrow because their profession often requires empathy, caring, and "taking time to listen, offering support and reassurance, recognizing and focusing on feelings" (p. 183).

The result of management methods is either increased comfort or discomfort, setting up the individual to manage future trigger events. Triggers are reminders of grief - an idea, image, person, environment - that reactivate the disparity of the initial loss, bringing the sense of grief back into focus (Eakes et al., 1998; Hainsworth et al., 1994; Roos, 2002). The inability to control the appearance of reminders causes some authors to compare chronic sorrow to chronic illness in its trajectory (Casale, 2009; Eakes et al.; Hainsworth et al.; Melvin & Heater, 2004).

Chronic sorrow research to date has included individuals with multiple sclerosis (Ahlstrom & Isaksson, 2008), parents and families of children with chronic illnesses and disabilities (Bowes, Lowes, Warner & Gregory, 2009; Hobdell, Grant, Valencia, Mare, Kothare, Legido & Khurana, 2007), victims of abuse (Smith, 2009), and infertility (Casale, 2009). The theory and its subsequent research have focused on validating and normalizing experiences of loss, depathologizing grief, and developing evidence-based supports.

Chapter Three: Applying Recurrent Pregnancy Loss to the Theory of Chronic Sorrow

Background of Recurrent Pregnancy Loss

Some of my earliest memories are of being a four-year-old playing Mommy with my dolls. My vision of my future has never existed without motherhood, and I always assumed because the role came to me naturally that I would just as naturally conceive and bear children. As a nurse I gravitated towards the maternity unit, falling into my professional role with ease and joy. At that time it never hurt to help other women give birth. I had confidence that I would see my greatest desire, to become a mother, come to fruition. My first pregnancy fit perfectly with my vision. I became pregnant quickly and suffered all the wonderful symptoms that assure women there are changes in their bodies. When I started bleeding heavily in conjunction with a sudden cessation of my pregnancy symptoms, I was simply too well informed not to recognize the signs of impending miscarriage. So started an almost quarterly cycle of pregnancy and loss, a couple of gestations reaching beyond the supposed safety of twelve weeks. I hated the familiarity of the miscarriages, though they were as different as any births, and I hated that my hope was curtailed by my knowledge. I didn't even bother seeking health care support at first because I had some idea of the insensitivity of the environment, and I knew exactly by how much each loss lowered my chances of carrying a term pregnancy. No physician would help me anyhow after only a couple miscarriages. I hated the word miscarriage, and being a statistic, and I never felt more alone than when I was given an uninformed platitude. Being told by medical professionals to go ahead and try conceiving again was like being given a one-way airplane ticket to a war-ravaged country after being the sole survivor of a recent plane crash. I have yet to meet and share with another woman with similar experience.

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Recurrent miscarriage is defined as three or more consecutive losses (Callender, Brown, Tata, & Regan, 2007; Klock, Chang, Hiley, & Hill, 1997) before 22-24 weeks gestation or the current accepted age of viability. Armstrong and Hutti (1998) included late (second and third trimester) pregnancy loss, stillbirth and neonatal death within the first 28 days of life in their description of perinatal loss. For this paper pregnancy loss refers to a blighted ovum, molar or ectopic pregnancy, or embryonic or fetal demise prior to the age of viability, followed by miscarriage at an indeterminate time. The author would like to suggest women experiencing nonconsecutive pregnancy losses interspersed with one or more live births could also fit into this description, though the focus here is on childless women.

Pregnancy loss is a term this author believes better captures the experience of women, versus medicalized terms that can delegitimize women's perspectives of their loss (Freda, 2011; Morrissey, 2007). Miscarriage may be an adequate word to recount the physical process of tissue exiting a woman's body, but it is a poor way of describing the psychological experience of pregnancy loss. For example, the medical term for a miscarriage is a spontaneous abortion, words fraught with social misunderstanding and judgment and perhaps uncomfortable for women experiencing the losses. A blighted ovum can be considered a non-pregnancy, invalidating some women's beliefs about what constitutes life. Miscarriages are also called unsuccessful pregnancies, which women may perceive as implications of failure in their attempts at motherhood. Even miscarriage can have a negative connotation by suggesting the pregnancy was somehow a mistake, or fumbled. A spiritual counselor experienced at caring for bereaved mothers, Morrissey (2007) acknowledged a woman's grief at being told her pregnancy was

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considered “incompatible with life” by physicians and friends (p. 1415). Words can have power, and it behooves others who know better to speak sensitively.

Pregnancy loss has become medicalized with the transition of birth from the home environment into the hospital, and increased technology and antenatal intervention gives the impression miscarriage should be rare or obsolete (Bansen & Stevens, 1992). Miscarriages are unfortunately common, affecting up to a third of all pregnancies and considered low-risk and low-priority occurrences by medical professionals, with blood loss monitoring and pain management as standard treatments (Morrissey, 2007; Murphy & Merrell, 2009). Recurrent pregnancy loss is relatively rare, affecting only 1% of conceiving couples (Serrano and Lima, 2006). There is considerable literature on perinatal and neonatal death as distinct events compared to recurrent pregnancy loss.

Description of Recurrent Pregnancy Loss

The grief experience of pregnancy loss. *I used to be surprised at the extent to which my pregnancy losses affected my daily living, and still do. I call it a many-tentacled animal, touching everything about me and my life. After my first loss I discovered there is suffering worse than physical pain. Expletives felt apt. After my second loss I wanted to curl up in a ball, alone, and stay that way for a long time, but I had to wait almost four weeks for the miscarriage to occur. I still had to go to work and buy groceries and vacuum my house. Most women, after they give birth, receive frozen lasagna and flowers, and no one thinks anything of it when the new mothers lay on the couch all day and coo over their infants and breastfeed. I had sore breasts and no baby to suckle. I had a choice to tell people of my loss despite my unreadiness to disclose, or to suffer in silence. I had given birth with all the pain and none of the joy. I would rather*

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experience 48 hours of acute vaginal pain to hold my baby than weeks of contractions with only blood in my hands. I was unprepared for the afterbirth of miscarriage. The insomnia and morning headaches persisted for years, longer than any night feedings, and I still have night terrors where I awake wondering who is going to die next. I hear that's called death anxiety. I feel guilty for contributing to my husband's pain, and judgment from others who think I should grieve differently. I feel like I lost more than a baby. I lost all my children, bliss in pregnancy and hope for the future, the comfort of relationships, and enjoyment of life.

Chronic sorrow begins with a description of the single or ongoing experience of loss. The loss is considered by the individual to be a significant life event, and is accompanied by many feelings and grief behaviors. A first pregnancy loss would be experienced as a single event, while subsequent losses are ongoing or compounded events. Therefore, the grief experience of recurrent pregnancy loss may also be ongoing, multi-layered and dynamic.

Pregnancy loss is not only a miscarriage, but also a birth and a death, each a significant life event. Pregnancy loss is the loss of the expected child, the future child, the role of pregnancy and motherhood, maternity clothes and baby showers, birthday parties and piano lessons (Adolfsson, Larsson, Wijma, & Bertero, 2004; Hutti, dePacheco, & Smith, 1998), the loss of innocence for future pregnancies (Brost & Kenney, 1992; Coté-Arsenault & Mahlangu, 1998), and “the loss of an entire lifetime” with a family who plans were made for (Cohen, 2001, p. 11). “At least with normal labor,” a mother recounted, “you have the miraculous birth of a little baby and the agony is worth it” (Steele, 1992). Hutti (2005) stressed that there is biological loss (lack of motivation, fatigue and distinct physical pain), loss of self (psychosocial and physiological vulnerability), and loss of memories and parental hope. Acute and chronic anxiety from previous

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losses may affect endocrine and immune systems (Klock et al., 1997). Because pregnancy loss encompasses taboo topics like sex, death and infertility, social isolation may be part of women's experiences. As well, social tolerance of grief expression is often shorter than experiences of grief (Murphy & Merrell, 2009). Living children and a history of therapeutic abortion do not buffer women from grief related to pregnancy loss (Klock et al.; Woods-Giscombé, Lobel, & Crandell, 2010; Zaccardi, Abbott, & Koziol-McLain, 1993). There is some evidence that increased maternal age can increase distress levels in women experiencing pregnancy loss because of decreasing childbearing years (Serrano & Lima, 2006). Zaccardi et al.'s research on grief showed "there is no subgroup of women who could be expected not to experience loss and grief" (p. 41). No factor has been shown to universally affect grief intensity in women experiencing one or more miscarriages, suggesting factors influencing grief depend on what the pregnancy means to each individual (Hutti et al.).

The significance of pregnancy loss is not identical for all women; some view it as devastating, a threat to their very identities, while others feel it is an unfortunate learning experience (Brost & Kenney, 1992). Attachment theory would suggest pregnancy loss is grieved as much for the psychological loss as the physical loss. Adolfsson et al. (2004) and Armstrong and Hutti (1998) believed psychological preparation, attachment and bonding often begins prior to conception. No literature denies a mother's attachment can begin well before birth, regardless of her desire for the pregnancy. Misconceptions about pregnancy loss are that grief intensity depends on the length of gestation - the longer the pregnancy, the greater the sense of loss - and that the knowledge that one can or does get pregnant again lessens grief (Brost & Kenney; Hutti, 1984; Neugebauer et al., 1997). Women do not forget their losses.

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Pregnancy loss is a traumatic event, with grief lasting for weeks to years (Hutti, 2005). Women who experience a single loss are 2.4 times more likely to experience depressive symptoms in the following year than women with a history of depression are likely to experience postpartum depression after a live birth (Neugebauer et al., 1997). Any experience of grief should be considered normal, reflecting the uniqueness of every pregnancy and woman. There has been a shift in grief literature from letting go of the source of grief to an acceptance of holding on (Callister, 2006), and the Perinatal Grief Intensity Scale was created to determine various grief responses in women (Hutti et al., 1998). A woman's desire to hold on to and cherish what she has lost, or her reluctance to explain her grief may have more to do with previous interactions and the private nature of her pregnancy (Adolfsson et al., 1994). Wheeler (1994) affirmed that women's grief from pregnancy loss is an "appropriate, self-limited, emotional response..." encompassing "many feelings [that] vary in their intensity and duration" (p. 221).

Partner grief also affects women experiencing pregnancy loss. Parents grieve differently (Hutti, 2005; Serrano & Lima, 2006). Some men do not understand the profound attachment a woman can have to her pregnancy and wonder why she grieves with such intensity and prolonged duration. Fathers can also feel loneliness, pain, inadequacy (Callister, 2006), loss of self-worth and libido (Serrano & Lima), and hold back their feelings to avoid causing their partners further pain (Swanson, Connor, Jolley, Pettinato, & Wang, 2007), effectively isolating women from the comfort of shared loss. When fathers are frustrated and angry, women may feel guilty for contributing to their loss by showing sadness.

The grief experience of pregnancy after loss. *I am constantly afraid. I am afraid of never conceiving again and of becoming pregnant again because, for me, pregnancy has always*

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been followed by loss. My husband and I frequently wonder whether we will ever move out from under this shadow of fear, and how we are to meet life's other challenges if we cannot overcome this. What makes it difficult is that I do not want to move on from my dead children. I want to take them, or the memory of their possibilities with me. I would like to enter pregnancy with a measure of joy and hope, and I have discovered that denying my excitement does not lessen my grief. Just as pregnancy loss keeps me up at night and my body depleted, so does pregnancy keep me on-edge with fear. How many times can I do this? Early pregnancy is tiring, as is recovering from a miscarriage, as is grief. I am constantly experiencing all three at once. It's exhausting.

Pregnancy after loss, and not only pregnancy loss is a significant experience. Much of the grief associated with recurrent pregnancy loss involves the anxiety and persistent grief experienced throughout subsequent pregnancies (Adolfsson et al., 1994; Armstrong & Hutti, 1998; Bansen & Stevens, 1992; Coté-Arsenault & Mahlangu, 1998; Woods-Giscombé et al., 2010). Women who experience one loss may also have similar pregnancy related concerns as women experiencing many losses, although the focus here will be on recurrence. For many women simply contemplating another pregnancy causes anxiety, including related events such as sexual activities and menstruation (Armstrong & Hutti). The knowledge that they may still have a normal term pregnancy may not overcome their anxiety. Instead, anxiety can overshadow subsequent pregnancies and may not necessarily resolve as a pregnancy progresses. In fact, while some women do experience decreased pregnancy related anxiety as each subsequent pregnancy reaches certain in utero milestones, other women experience worsening anxiety as later pregnancies progress beyond the gestational age of previous pregnancy losses (Coté-Arsenault & Mahlangu; Woods et al.). Women can experience ambivalence in future pregnancies, which often

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heightens feelings of self-blame and guilt after subsequent pregnancy losses (Serrano & Lima, 2006). They may have suspended hope, not wanting to feel deeply about successive pregnancies in preparation for another loss, or they may deny their grief until that pregnancy is also over (Brost & Kenney, 1992). Still others carry fear either until they are passed the stage when they previously miscarried, until birth, or always in association with events related to the initial loss (Bansen & Stevens). St. John, Cooke and Goopy (2006) described how women experiencing pregnancy loss gain a sense of belonging when in each other's company, but experience a return of isolation when they are pregnant again because they no longer fit in that group. Recurrent pregnancy and pregnancy loss is a constant flux between acceptance and disassociation.

The unique experience of recurrent pregnancy loss. *I anticipated my third loss. How could I not? My experience is a unique form of personal torture, and I become more and more aware that some unfortunate woman has to be the one who never has a term pregnancy. I do not want to conceive of a future in which I have no children, and I cannot help but feel it is unfair when I recall how thoughtfully I pursued skills and characteristics associated with motherhood in lifelong anticipation of fulfilling my most desired role. It is difficult for me to see mothers who prepared minimally for their role, whose dreams were quickly made and easily realized, and who I feel do not fully appreciate how blessed they are. As a mother - which I consider myself to be - I cannot countenance stopping attempts to conceive. As a woman there are limits to what I can bear, or to what I can handle in a given time. There is a ceiling to the disruption of life my husband and I will tolerate. It is also difficult to consider other options for the creation of a family if our energies are focused on our pregnancies. It was not until my fourth consecutive loss that I began to consider pregnancy loss as lifelong grief. While the idea of feeling exactly that*

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way with that intensity for the rest of my life was daunting, accepting the enduring nature of my sorrow freed me to grieve more in tune with my needs. I listen to my body and my heart more, and am sometimes able to express to certain people where my boundaries are for conversation and activities. The more I accept my grief experience, the more relaxed and hopeful I become that a vision may again exist where I get to play Mommy.

There is limited research on the psychosocial nature of grief in women experiencing recurrent pregnancy loss, including studies of pregnancy following perinatal loss and phenomenological findings on the experience of miscarriage as a single event. There is, however, research showing increased grief intensity, relational challenges and pregnancy related anxiety in multigravidae women without children compared to primigravidae or women with children (Coté-Arsenault & Mahlangu, 1998). This suggests childless women experiencing recurrent pregnancy loss, specifically, endure grief, social struggles and anxiety to a greater extent than other women. Though each pregnancy loss may have physical and emotional similarities, it would be unfair to say a woman experiences each subsequent pregnancy loss the same.

Pregnancy loss as a single event may have many associated psychosocial losses, and pregnancy subsequent to loss may be an anxiety-producing challenge. Recurrent pregnancy loss combines the distinct grief of each pregnancy loss with the unease of each pregnancy, as well as the cumulative despair and hopelessness from perpetually expecting negative experiences. Because of this, the theory of pervasive, permanent, periodic and potentially progressive chronic sorrow accurately reflects the unique ongoing grief that can accompany recurrent pregnancy loss.

This author would like to include personal experiential evidence that validates and expands upon the limited research findings. This author has learned that the psychophysiology of

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each pregnancy loss experience is both distinct from and similar to the others. Just as many women remember details about their pregnancies and birth experiences, so too can be the memories of pregnancy loss. This creates a wealth of memories a woman can relive, making the losses a living part of her life. Subsequent pregnancies for this author were characterized well by the literature - the anxiety, relational and social difficulties, and somatic challenges - magnified by the inability to view a situation from any other perspective. In many ways the experience was, and still is, a long dark tunnel with little encouragement for hope. What is not addressed in the literature is the constant need to navigate life and waning ability to cope with any type of loss. Sometimes grief intensifies faster than it can be managed. Loss of enjoyment in food leads to a loss of the ritual of preparing and eating meals with someone. Loss of control over emotional outbursts forces truncated social interactions. The lack of acceptance of grief responses by others causes a loss of self-acceptance. Sleep and energy loss threaten a sense of humanness. There needs to be incorporation of the losses into a new self, else continued losses could be felt as personal attacks or self-disintegration. Chronic sorrow is, therefore, a way to normalize the experience of recurrent pregnancy loss while validating the ongoing nature of the loss.

Disparity in Recurrent Pregnancy Loss

I stumbled across the theory of chronic sorrow on the lookout for explanations of cyclical grief. With so much of myself invested in dreams associated with pregnancy, I feel I have to do justice to the ongoing nature of my loss. I struggle with self-labeling. Am I suffering depression, social isolation, inertia, or a mental breakdown? I do not feel any of these fit the complexity of my emotional experience, and I reject medical labels such as infertility. I'm not infertile but I've

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had no term pregnancies; I'm in the in-between. Chronic sorrow fits. My grief is normal. I realize I may be okay with not being okay.

Disparity occurs when actual reality differs greatly from the desired reality. The description of pregnancy loss involves women's experiences of grief, whereas disparity is the result of their unanticipated grief responses. Significant loss with unresolved disparity can develop into chronic sorrow (Eakes et al., 1998). One might think resolution of disparity would be a solution to the theory, but one must remember that chronic sorrow is a normal response and not an illness or atypical grief pattern to be fixed.

Disparity from recurrent pregnancy loss begins with the occurrence of an unexpected, unwanted, or feared result. Disparity is more commonly experienced by those who feel outside of common socio-developmental patterns, such as a woman of childbearing age without children. A woman may view motherhood as her primary or greatest role (Brost & Kenney, 1992), and the loss as a personal failure (Adolfsson et al., 2004) or a "violation of cultural norms" (Casale, 2009, p. 32). Women in most cultures are socialized to be mothers, and may feel a distinct loss of self-esteem, confidence and identity, distrust in their bodies, and what Casale (2009) called "reproductive vulnerability" (p. 45). Mothers may prepare psychologically for pregnancy their whole lives (Hobdell & Deatruck, 1996), and when their reality turns out differently "it is their identities and rights as mothers that have been lost" (Adolfsson et al., p. 551). Hutti et al.'s (1998) examples of pregnancy loss disparity included when a mother perceives the pregnancy and baby as real and is told that the results of her miscarriage did not constitute a real baby; when a physical miscarriage experience does not proceed as expected or significant others do not acknowledge the loss as expected; when mothers feel unable to influence any aspect of the

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miscarriage experience. Disparity resulting from pregnancy loss may feel too overwhelming to manage. A pregnancy loss is the only experience where the death of a loved one is not only with, but also inside and a part of the grieving individual. These women want “to be seen as the women they felt themselves to be - mothers-to-be” (Adolfsson et al., p. 558).

Effective Internal Management Methods of Recurrent Pregnancy Loss

There is nothing I can do to lessen my grief, though I am discovering ways to manage the disruption of my life caused by grief. In the feature film Sleepless in Seattle (1993) the main character describes his grief over his deceased wife this way: ‘Well, I’m going to get out of bed every morning, breathe in and out all day long. Then after a while I won’t have to remind myself to get out of bed every morning and breathe in and out. And then, after a while, I won’t have to think about how I had it great and perfect for a while.’ I use structured grieving, an oxymoron to my mind before I tried it. I allow time every day, or more or less often, to feel sad, to cry, to ruminate over my loss if I want to. Then, when I feel depleted, purged, or better, I can get up and go about my life. At least, until I need another moment. The idea is not to interrupt grieving or disallow spontaneous expressions of grief, but to gain a sense of control over turbulent emotions.

Effective internal management of chronic sorrow focuses on actions individuals can control. Women experiencing recurrent pregnancy loss can feel pushed about by intense and conflicting emotions such as shock, loss, grief, dysphoria, guilt, anxiety, emptiness, despair, anger, social isolation, somatization, depression, self-judgment, death anxiety, helplessness, fear of loss, rage, betrayal, deprivation, yearning, wanting to be alone, fear of being alone, loss of meaning, cautious hope, and hopelessness (Adolfsson et al., 2004; Morrissey, 2007; Swanson, 1999). Things women can control to effectively manage their sorrow are crying, expressing

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themselves with trusted people, searching for information and meaning, setting physical and social boundaries, and pursuing enjoyable activities. Crying is a physical and emotional release, and some do not understand a woman's need to ruminate (Adolfsson et al.). Other women wish they could stop thinking about their loss to prevent feeling at the mercy of chaotic outbursts. Allowing time and space for expression can help women control the outpouring of emotion, instead of feeling controlled by it.

Sharing with others may seem like a double-edged sword. Friends and family may wish to help but feel at a loss, may expect direction a woman cannot provide, or that understanding her grief will only be possible through full disclosure. Sharing with a partner, when met with acceptance, often results in an increased sense of comfort for women. Being held and spoken to can ease the isolation that women feel.

There is nothing specific women should feel, but they may need to focus - to the point of exclusion - on their own emotional needs, as their bodies are plain worn out. Pregnancy, miscarriage, the postpartum period and grief are each exhausting on their own. Finding ways to punctuate time during grief can be helpful, such as performing an informal memorial service (Brier, 2008). Mourning rituals are absent in pregnancy loss because the pregnancy was not visible, was unknown or unacknowledged by others, and because of a lack of cultural customs surrounding miscarriage (Adolfsson et al., 2004; Casale, 2009; Zaccardi et al., 1993). Mothers fare worse in grief without some ritual such as holding the products of the miscarriage, a ceremony, acknowledgement of anniversaries, or a burial place that can be visited (Hutti, 1984).

Some women try to lessen attachment to future pregnancies in an effort to reduce expected grief, but research shows their grief experience is ultimately unaffected (Brost &

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Kenney, 1992). However, behavior changes (i.e. eating and activity habits) during subsequent pregnancies also resulting in loss may alleviate some feelings of guilt because women feel they have tried everything and cannot be at fault (Callender et al., 2007). Effective internal coping in recurrent miscarriage is not meant to resolve grief but to manage it, hopefully increasing women's sense of comfort.

Ineffective Internal Management Methods of Recurrent Pregnancy Loss

Disclosure is tricky for me. By not sharing my story I remove some opportunities for comfort, and I have received judgment that any loneliness I experience is my own fault. By disclosing I open myself to the possibility of informed hurt, somehow worse than ignorant comments. I wish I could untell some people because conversation is stilted, and they look at me in apology and for approval. I am learning to feel normal in my grief and I want to be treated as normal. I do not have the energy to soothe others' awkwardness, or to ensure they are comfortable with my loss. Pregnancy and pregnancy loss occur in my womb, the very center of my physical body and identity. I get angry when other people feel they have a right to what goes on in there. When my husband wants to share with others I feel torn between honoring his need for social comfort and what feels like a violation of my body.

Ineffective internal management methods are things women experiencing recurrent pregnancy loss do purposefully or unconsciously that result in discomfort. Hutti (2005) suggested grief is worse in women who have low emotional strength, which can characterize those experiencing recurrent pregnancy loss. Efforts that attack women's remaining emotional reserves can amplify their grief, such as cynicism, negative self-talk, or repression of feelings. Yet women can become distressed when they feel pressured by time or others to grieve in a

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certain way, at the same pace they did previously, or as quickly as someone else (Swanson et al., 2007).

Physical reminders of pregnancy - swollen breasts, abdominal tenderness, lochia - are unavoidable as the body readjusts to its non-pregnant state (Bansen & Stevens, 1992; Callister, 2006), and some women experience the loss of their pregnancy weeks before they miscarry, suffering persistent pregnancy symptoms even as they are grieving. Not addressing these physical symptoms as part of the loss, and ignoring the consequences of insomnia, appetite changes, and fatigue will deplete physical and emotional reserves. A woman may not be able to change these disturbances, but acknowledging her limitations and adjusting to her needs may help. Reed (1984) suggested some women have tried conception to manage their grief, but there is no evidence that pregnancy resolves grief or that grief lessens with longer periods between pregnancies. Women may adopt hypervigilance and fixate on behaviors they believe can influence pregnancy outcomes as their way of controlling pregnancy related anxiety, potentially increasing their current state of anxiety (Coté-Arsenault & Mahlangu, 1998).

Women who feel unready or coerced to share, or who do not want to share with certain people should heed their own feelings. Women who reveal pregnancy loss may regret it, wish they could recall the disclosure (Coté-Arsenault & Mahlangu, 1998), and feel they were somehow exposed in an intimate way. No one disputes a woman's private right to her sexual and reproductive body, and the experience of her pregnancy loss should be viewed the same way.

Effective External Management Methods of Recurrent Pregnancy Loss

When I cry and am held by my husband, I feel better. When others respect my boundaries and do not question what seems to be odd behavior, I feel accepted and normal. When I can vent

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my frustration over the swarm of pregnant women at the supermarket and somebody listens to me with sympathy, I feel there is a safe place for me to grieve.

Johnson and Langford (2010) believed early external intervention helps women experiencing pregnancy loss, but there is a lack of consensus about the best protocol. Many people are ignorant of the woman's loss if she has not announced a pregnancy, and she may remove herself from social situations after experiencing oblivious insensitivity. Those who do know may be wary of offending, and contribute to her isolation by continuing silence. Just as the significance of the loss is individualized, so should the approach be. Hutti (1984) suggested asking mothers what they want and proceeding accordingly. It is important to accept their feelings, as women experiencing pregnancy loss typically feel guilt and self-judgment already. Pregnancy loss is experienced much like a more visible neonatal death (Bansen & Stevens, 1992), and "that the women's grief is taken seriously by others is important to them" (Adolfsson et al., 2004, p. 553).

Women experiencing pregnancy loss, more than anyone, recognize the absence of joy, and do not want to minimize others', so they may seclude themselves from pregnant women or women with young children (St. John et al., 2006). A sense of belonging through a support group offers more credible validation from a fellow sufferer (Hutti, 2005). Still, women with recurrent loss may not identify any longer with women experiencing a first loss, or women experiencing loss who have living children. Anxiety-reduction techniques are valuable because of known pregnancy related angst associated with pregnancy after loss.

Health care professionals may not be favorites of women experiencing pregnancy loss, as health care interactions are often linked to women's negative experiences. Yet these

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professionals, along with counselors and spiritual advisors can be poised to acknowledge women's loss and grief (Melvin & Heater, 2004; Slack, 1997). It helps to recognize "many parents do not want to forget their dead babies, feel grief is a lifelong process, and resist the notion that they will someday feel as though the loss never happened" (Hutti, 2005, p. 635). Professionals can provide comfort, and help women to reintegrate the loss into their lives as a non-damaging experience.

Ineffective External Management Methods of Recurrent Pregnancy Loss

One of the most difficult things for me to decide is what to share and with whom. Being able to make eye contact with a sympathizer during an emotional moment and receive a comforting look is like a life ring in the ocean. However, sometimes those who know my story, or parts of my story, can be the most horrible offenders. There is nothing more isolating than having someone advise me about my own experience.

Ineffective external management of recurrent pregnancy loss can be described as insensitive interactions that contribute to women's discomfort, including avoidance and neglect. Intimate partner conflict and distance is understandable within the experience of recurrent pregnancy loss (Serrano & Lima, 2006). The relationship becomes unsupportive to the woman when her partner judges her grief responses and ignores her need to share or be private (Coté-Arsenault & Mahlangu, 1998; Hutti, 2005).

Silence is a common theme in studies on pregnancy loss. Silence comes both from those who avoid the subject due to discomfort or a lack of understanding, and from the women who remove themselves from those who, even inadvertently, trivialize their experiences (Bansen & Stevens, 1992; St. John et al., 2006). "While society relishes birth, there is a silent disregard for

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the grief and despair that pregnancy loss evokes” (St. John et al., p. 8), and a failure to appreciate the impact of the loss (Brier, 2008). Hainsworth et al. (1994) reviewed that coping can be heavily influenced by social support and appraisal, made difficult because pregnancy loss is not socially considered a real death (Bansen & Stevens). There is no public ritual for acknowledging pregnancy loss (Brier, 2008), and “society’s tolerance of visible grief is limited” (St. John et al., p. 6). Women fear rejection because of the lack of social acceptance. Bansen and Stevens reported unhelpful social interactions experienced by all women in their study on early pregnancy loss. “People’s comments about their pregnancy loss often did not satisfy the women’s need for support, despite good intentions,” suggesting people should allow women to direct their own needs (Bansen & Stevens p. 88). Uninformed comments usually serve to minimize the loss and inhibit women from sharing and feeling able to move through grief (Johnson & Langford, 2010). Mothers exposed to these behaviors experience discomfort by feeling required to shed their grief (Zaccardi et al., 1993), feeling forced to withdraw from relationships to protect themselves (Brost & Kenney, 1992), and feeling victimized when unable to confront those who intentionally or unintentionally cause hurt through words or actions (Hutti et al., 1998).

Health care professionals and the health care system perpetuate women’s grief through a lack of psychosocial support. Focusing on the physical aspects of pregnancy loss and treating miscarriage on an outpatient basis leaves women and couples “alone with their sorrow” (Serrano & Lima, 2006). These women are left out of mainstream health care services. St. John et al. (2006) lamented, “because the women were no longer pregnant, they did not require antenatal care. They were mothers, but without a child so they did not require maternal and child health services” (p. 10).

Trigger Events in Recurrent Pregnancy Loss

For over two years now I have tried to avoid certain people, places and activities that I associate with my losses. I know it's perceived as rejection, and is to a certain extent. It is suffocating to be around pregnant women. Sometimes I wish they would miscarry and save me the pain of their presence. More often I wish there was a moratorium on conception. I frequently work myself to exhaustion so that I can fall into bed at night and not lie awake for hours unable to stop thinking. I used the downstairs toilet in the night because being near the shower in the dark where I labored through my miscarriages was unbearable. I cannot eat lasagna. I try not to buy groceries on my own - that place is a minefield. There is almost the same amount of relief in avoiding a reminder of my pregnancy losses as there is in someone like my husband validating my response to those reminders. I am tired of navigating life, and I feel frustrated that I have so many reminders for so many losses, as if there is no escape.

The theory of chronic sorrow is differentiated from other grief models by the presence of trigger events that remind the individual of the initial loss and recreate the disparity of desired and actual reality that causes ongoing grief. Some trigger events are unfamiliar, creating new associations with previously felt emotions, while other triggers are repetitive. In recurrent pregnancy loss the trigger events are a recurrent pregnancy or loss, both distinct and repetitive events, or things women associate with any of their previous losses. Because women can be “sensitive to every word and gesture” during the experience of pregnancy loss, triggers could be plentiful (Adolfsson et al., 2004, p. 544). Hutti (2005) recited a more obvious litany: “Mother’s and Father’s Days, family holidays, anniversaries of the baby’s birth, death, and expected due date, resumption of the sexual relationship, and the first menstrual cycle after the loss,” events

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multiplied in recurrent pregnancy loss (p. 632). For most women, encountering pregnant women or women with young children is difficult, as is conversation about and images of these women. There seems to be no end to the places - parks, sidewalks, stores, libraries, churches - women might avoid to mitigate such encounters. Women may close their eyes or ears as they pass by a trigger to evade emotions when they feel overwhelmed. Women may find smells and music heavily associated with memories of their losses. Many women have articles in their homes in preparation for their babies, and even knowing the items are there can cause distress. Activities associated with motherhood can be challenging, especially if the woman ever fantasized about her baby. Chronic sorrow has been compared to post-traumatic stress disorder, although the former recognizes trigger events and uses active coping throughout the grief cycle (Callender et al., 2007). The constant need to navigate life in anticipation of trigger events and their possible consequences is challenging, and can wear upon women already burdened with grief.

Chapter Four: Implications for Nurses

Nursing Encounters

I visited the emergency room for two of my miscarriages. For one I was dropping off the products of miscarriage for genetic testing and for the other I wanted pain relief. I happened to be assessed in triage by the same nurse both times, though she gave no indication she remembered me. On the first occasion I clearly stated I wanted to hand my tissues over and go home. I didn't like seeing my life's biggest dream in a little plastic bottle. My face was obviously red and swollen from hours of crying, I was in physical pain but it was manageable, and the emergency waiting room was full of sniffling children and bored adults. I waited in what felt like personal purgatory for three hours and went home without anyone talking with me or acknowledging the discomfort of the waiting area. The second time I was experiencing physical pain unmanaged by oral analgesia at home, although I was able to move independently and speak coherently and wait as necessary. I was quickly ushered into a private sitting area. I still only briefly saw a physician and a nurse, but I received the requested treatment and went home with a follow-up phone call (to evaluate the effect of the medication). The only difference between those two incidents was my disclosure of intense physical pain. It doesn't seem fair that physical needs garner more attention than emotional ones, when it is the latter that lasts longer and causes me more damage.

Coté-Arsenault and Mahlangu (1998) noted that women experiencing pregnancy loss did not put nurses and physicians on a list of supportive people. It seems women are generally dissatisfied with their hospital and health care interactions surrounding pregnancy loss, and they hold these memories for a long time (Murphy & Merrell, 2009). Sadly, with obstetric

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development focused on technology and advancing assisted reproductive technologies, the professional reaction to pregnancy loss can be one of neglect. Most women cannot even access diagnostics until three miscarriages have occurred. While this is fiscally responsible health care due to the prevalence of pregnancy loss, sorrow is perpetuated in those with recurrent loss because they are treated as deprioritized citizens, with any care focused on physiological intervention during miscarriage rather than on the emotional impact of the loss (Johnson & Langford, 2010; Wheeler, 1994). Nurses admitted to spending more time preparing to deliver bad news to miscarrying mothers than to planning emotional follow-up (Murphy & Merrell). “As the health care professional who has the most contact with women suffering an involuntary pregnancy loss, the nurse has an opportunity to provide holistic care, which is so much a part of the philosophy of nursing” (Reed, 1984). Nurses should be able to anticipate the potential for grief associated with pregnancy loss and for anxiety during subsequent pregnancies (Armstrong & Hutti, 1998; Zaccardi et al., 1993).

Nursing Practice

When I was a new perinatal nurse I remember stepping into the hallway from the room my client was laboring in to grab a glass of water. From across the unit I heard a horrible yell and commented to a coworker that a woman must be experiencing unimaginable pain. I learned later that she was, as her term baby never took his first breath. The nurses who were in the room for that delivery and attempted neonatal resuscitation were distressed for weeks, and couldn't work for days after. The woman, her partner and family members were closeted with the nurses for hours, but requested to be discharged in the wee hours of the morning to avoid other mother infant dyads. I remember assessing several women in maternal triage who felt anxiety over an

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absence of fetal movements, and experiencing instant relief or panic depending on whether I located an audible fetal heart rate with the Doppler. I have not yet experienced pregnancy loss with a client since my own losses, and I wonder if I will feel paralyzed or activated, and whether I will be able to bear witness to other women's suffering.

Understanding the experience and creating a relationship. Nursing interventions to help mothers manage grief and chronic sorrow related to pregnancy loss begin with understanding the loss experience and developing a trusting nurse-client relationship. Miscarriages are common, recurrent ones significantly less so, and every experience is unique. Hutti (2005) suggested parents may wish to focus solely on physical care needs and comfort, but are likely to respond well to questions about grief because they can control disclosure. Limbo and Kobler (2010) called nurses witnesses, sharing the burden of a mother's grief, and Melvin and Heater (2004) believed client responsiveness indicates an "invitation to be a close traveling companion on an uncertain journey" (p. 65).

Normalizing grief responses. Grief is a normal response to pregnancy loss, and chronic sorrow is a normal response to ongoing loss. Normalizing chronic sorrow provides mothers with much-needed acceptance, and assessing for signs associated with chronic sorrow in mothers with recurrent pregnancy loss will help clinicians implement anticipatory interventions such as support services and follow-up care (Casale, 2009). Nurses can also be aware of potential triggers, and talk about the presence of triggers in women's lives (Eakes et al., 1998). Hutti et al. (1998) acknowledged that not all women will grieve after early pregnancy loss. Swanson (1999) performed research following women up to a year after their pregnancy losses to learn there is a marked difference in the crisis and chronic stages of these women's grief. Findings showed that

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women's experiences of grief were basically the same one year post loss as at six weeks, suggesting that six weeks after a pregnancy loss is a good indication that the crisis stage of grief has ended and women might be open to accepting intervention. These findings were similar in women who went on to have a live term pregnancy (Swanson, 1999). This fits with chronic sorrow in women experiencing recurrent loss because they experience ongoing grief with episodic crises in the form of trigger events and subsequent pregnancies and losses. Nurses can capitalize on this research to follow-up on women six weeks post loss. A phone call, visit or appointment acknowledges that her sorrow is remembered, as is the understanding that she may need help and not know where to find it.

Specific interventions. Nurses can care for mothers experiencing pregnancy loss by providing adequate pain management and correcting misconceptions about miscarriage that may contribute to a sense of guilt (Steele, 1992). Careful tissue handling, learning the sex of or naming the fetus, creating mementos, and keepsakes are respectful ways to offer tangible care and validate the loss (Callister, 2006; Wheeler, 1994). Nurses can recognize that both parents may be in crisis and unable to provide each other with ideal support, and “advise men that women often want to know that their partners are also grieving” (Hutti, 2005, p. 632). Parents are often incapable of retaining information and nurses can provide repetitive explanations, and delay decision-making until families regain a sense of control (Cohen, 2001; Steele, 1992). Nurses can also acknowledge they may be too busy to provide physical and emotional support, and that finding a support person is necessary. Offering a support staff or spiritual counselor may be welcomed (Roehrs et al., 2008; Steele, 1992; Wheeler, 1994).

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Johnson and Langford (2010) argued for evidence-based interventions to meet the emotional needs of women experiencing early pregnancy loss. Thomas (1997) and Wheeler (1994) reported that evaluating the emotional support of women and families is of paramount importance. By understanding the significance of the loss and a woman's history with recurrent pregnancy loss, nurses can use basic skills of therapeutic listening and family centered care to discuss families' expectations of their grief processes and their perceived ability to cope (Hutti, 2005; Wheeler, 1994). Nurses can foster a caring environment where expression of emotion is accepted, fears are acknowledged, and there is freedom to make meaning and explore the impact on daily living (Hutti, 2005). Discharge planning can include information on the normalcy of grief responses and plans for follow-up (Neugebauer et al., 1997; Swanson et al., 2007). Because subsequent pregnancies are a large part of the grief cycle for these women, prenatal care designed for women who have previously suffered pregnancy loss may offer them a sense of belonging and hope (St. John et al., 2006).

Overwhelming needs can challenge nurses, who feel they have to be perfect at everything. Thomas (1997) only admonished referring to miscarriage as common in front of the woman, as it is not so to her, or trying to alleviate pain by encouraging a woman's ability to re-conceive. The literature does not show a decline of grief, but rather intensified anxiety and worry accompanying future pregnancies (Armstrong & Hutti, 1998; Brost & Kenney, 1992; Callender et al., 2007). Nurses are in the awkward position of helping "women to establish a balance between the benefits of regaining some sense of personal control over future pregnancies, whilst recognizing the limitations of holding strong beliefs about personal control in a situation in which that outcome is ultimately uncertain" (Callender et al.). Nurses, by education, experience

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and gender majority, are likely the best-suited health care professionals to interact meaningfully with these women. Nurses are also likely to span the environmental continuum of women's health care interactions, from the hospital, clinic, community, to the home.

Practicing Self Care. Nurses are witness to suffering, medical futility, death, cumulative loss and moral distress in their work (Limbo & Kobler, 2010). Morrissey (2007) acknowledged “professional carers often feel at a loss themselves and they too need love and support” in their work (p. 1415). Nurses experience helplessness, frustration and guilt in the face of emotionally challenging work situations, and may need their own bereavement follow-up after helping a family through pregnancy loss (Cohen, 2001). Nursing administration is responsible for helping nurses develop personal and team coping strategies to work with pregnancy loss. Professional avoidance is a strategy, but not sustainable (Murphy & Merrell, 2009). Roehrs, Masterson, Alles, Witt, and Rutt (2008) suggested several coping strategies for nurses working with pregnancy loss, such as crying alone or with families, focusing attention on family members, concentrating on care tasks, and using coworkers and debriefing as supports. This author, as a registered perinatal nurse and woman experiencing recurrent pregnancy loss, recognizes that nursing practice is fraught with potential trigger events for nurses who have experienced their own losses. Some nurses in this situation may find they are unable to provide a family with empathic care while others may feel empowered that their loss can offer validation and credible comfort.

Reporting on a practice innovation. As a perinatal registered nurse and sufferer of recurrent pregnancy loss the author has a unique perspective. It has been the author's experience that women's interactions with health care and society fall short of acknowledging the personal significance of their losses. Pursuing a connection between literature on pregnancy loss and a

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developed theory like chronic sorrow helped the author understand the reach of her own grief experience. However, there may be many women who know isolation and pervasive sadness without the benefit of normalizing their experiences. These women form a special club where acceptance is desired but membership is not. These are the women who know better, who will not minimize others' experience of pregnancy loss through negligence, and who can provide credible comfort. The author chose to write a booklet (Appendix D) because it implies storytelling, as opposed to a pamphlet, which is information-driven. Although this booklet is not a story per se, perhaps readers will identify with one or several ideas written in it, and know that they are not alone. This booklet will be printed at the author's expense and freely offered to any emergency or maternity department, clinic or program wishing to offer it to their clients.

Nursing Staff Education

As an undergraduate nursing student I thought the maternity rotation was sunshine and butterflies. I missed the part about birth having the potential to reveal a woman's psychosexual insecurities. In my role as a nurse educator I think my personal boundaries include introducing compassionate language and an alternative perspective, but I do not want to be anyone's teachable moment.

Years ago it was standard practice to withhold the fetus from the mother after miscarriage to avoid causing her further distress. We now know this actually contributes to grief and denies parents an opportunity for closure (Morrissey, 2007). Medical and nursing education has advanced since then, but there is still a gap in the literature contributing to nurses' feelings of unease and inadequacy when dealing with pregnancy loss (Cohen, 2001; Roehrs et al., 2008). Despite the frequency of miscarriage, nurses are more prepared to deal with neonatal loss than

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early pregnancy loss (Easterwood, 2004; Hutti, 1984). Cohen (2001) pointed out the lack of bereavement training, not only in perinatal and neonatal nurses, but also in emergency department nurses, who are even more likely to meet a women experiencing early pregnancy loss. Some theories addressed in nursing education can help guide nurses' understanding of the psychosocial nature of pregnancy loss, such as grief models, transition models dealing with an incorporation of the new self, and attachment theories. Easterwood (2004) developed an Early Pregnancy Loss Algorithm specifically to address this education-practice gap. The algorithm starts with nursing staff education, assessment of family support needs and emotional support needs, and ends with a positive outcome being validation of loss. The algorithm was examined in one specific hospital population, but introduces the idea that nurses could follow standardized, time-friendly routine assessments even for an experience as traumatizing and individualized as pregnancy loss.

Nursing Research

I am disappointed that there is so little literature on recurrent pregnancy loss, though I recognize it is commensurate with the relative rarity of the experience. I now imagine different ways of getting this information to women like me who suffer pretty much alone. My favorite idea so far is to start a support group; I would like to share with women experiencing similar losses. Part of the desire is selfish - I want to commiserate and feel my grief is normal and justifiable - but I also want to help. This would be fine for a small gathering, a local group without much quantitative impact, which does not reduce the value of the idea. However, the value of researching these women's experiences to inform practice has the potential for far-reaching benefit, and that excites me. It's difficult to be excited about anything to do with pregnancy loss.

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There is limited research on the psychosocial aspects of pregnancy loss, and less on recurrent pregnancy loss. What there is focuses on qualitative examination of miscarriage as a distinct event, on the development of grief assessment tools for women who have experienced a pregnancy loss, and on couples dealing with infertility. There is obvious difficulty in obtaining randomized controlled trial research on perinatal loss and grief because withholding treatment of any sort from these women is unethical. Brier's (2008) critical literature review examined duration and intensity of grief following pregnancy loss to help clients understand their grief processes and to address nurses' personal coping. Chronic sorrow is a developed nursing theory with positive application to certain populations, and nurse researchers could capitalize on the suitability of the framework for women experiencing recurrent pregnancy loss.

Chapter Five: Discussion

I have no regrets about how I managed, and continue to manage my grief, only that my husband and I have to go through this. I lived the experience of chronic sorrow before I knew how to describe myself. I like the acceptance and normalization it brings; I wish I could have had something to point others to for when I could not explain. Hey! I'm normal. I am not rejecting your company because I don't like you but because you remind me of my pain and I need some time away. Maybe a long time. I'm lonely but I don't want visitors. I am poor at socializing because I feel unable to engage in the events of your life. Dialoguing and others' life challenges seem petty right now. I only read stories where happy endings are inevitable. I am indecisive because there is no pattern to what upsets me. I cry because I'm not pregnant, because I am, and because time is passing. I don't even know why I'm crying and that's okay too.

Reflection on Major Themes

The author found it challenging and rewarding throughout this paper to position herself objectively. She presented the literature independent from the narratives so a reader unable to identify with the personal stories could still value the research. She intended the narratives to be both a linguistic expression of her own engagement with the theory and research, and for the benefit of those unconnected to a grief experience of pregnancy loss. The author also found it imperative to reflect on her own story to avoid inserting bias into gaps created by the literature. However, the combination of literature and autobiographical narrative made it difficult for the author to position herself as a writer, sufferer and nurse, respectively, and further reflection on major themes allowed her to integrate some of her story more fluidly with the literature. The significance of the loss, pregnancy related anxiety, the presence of and lack of control over

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trigger events, and clinicians' lack of direction emerged as four major themes of chronic sorrow in women experiencing recurrent pregnancy loss.

The significance of the loss is described by researchers as the individualized attachment women have to their own pregnancies. Serrano and Lima (2006) found conflicting results about pregnancy loss-related grief and maternal age, length of pregnancy and number of miscarriages, suggesting attachment to pregnancy is the greatest indicator of significance of the loss. What the loss means to a woman will explain how she experiences her grief (Hutti, 1984; Murphy & Merrell, 2009). This author perceived her children, born and unborn, and the role of motherhood as primary aspects of her past and future identity, and pregnancy loss as a personal threat to self and enjoyment in life. The significance of her losses was, and is the main factor affecting her grief experience, a significance directly invalidated by implications that living children have more value than desired children, or that the author should care more about others' living children than her own non-living ones. It has been difficult for the author to feel and express interest in others when their life events hold less importance to her than the loss of a pregnancy. Other people tend not to recognize or acknowledge the value of something invisible. The author agreed with the literature that acceptance and validation of one's grief experiences strengthen management methods and help one feel more supported.

Pregnancy related anxiety is an understandable and normal response in women experiencing recurrent miscarriage. This author's reality has been a justified mistrust of pregnancy, and a series of powerful trigger events. She could not wish away her anxiety, or rely on grief to dissipate with each subsequent pregnancy. The author knew anxiety needed to be managed to allow pregnancy related happiness, but that was never accomplished prior to a

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subsequent loss. Unfortunately, as she continued to experience pregnancy losses she began to wonder if the negative experience and outcome of her pregnancies was worth the attempts.

The presence of and lack of control over trigger events can cause women considerable weariness, as they are constantly watching for things that may remind them of their loss. This continuous navigation of environments was exhausting for the author, and could not guarantee the absence of triggers in her life. Some triggers could be avoided, like specific images, people or environments, but this was never without the consequences of loneliness and guilt. Women may feel protected for a time as they regain their emotional strength, but also isolated from activities and relationships that offer support along with the potential for hurt. The author identified with Swanson's (1999) research about the crisis and post-crisis phases of grief following pregnancy loss, where women develop an ability to express their needs approximately six weeks after their miscarriages. While the length of time can be individualized, the idea that there is a self-determined period where women require and desire cocooning for their own healing was relieving and normalizing for the author. Ultimately, she learned that comfort derived from positive coping and acceptance of grief by self and others helped to manage the experience of ongoing loss caused by trigger events.

Clinicians or, more specifically, nurses are similarly unsure of how to cope with pregnancy loss according to the literature. While mothers are overwhelmed by loss, nurses experience feelings of inadequacy and anxiety regarding professional and personal boundaries. However, short of adding to the information overload of nursing education, the author found it helpful to remember that birth, death, physical and emotional loss, and chronicity are already addressed regularly in nursing education and practice. Nurses are trained in communication

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techniques and patient-family centered care. These basic tools provide nurses with learned assessment skills enabling them, whether in the maternity or emergency unit, home or community, to recognize actual or potential loss and address it, using cues from mothers and families to examine care planning needs. As well, nurses have a female gender majority which, in the case of pregnancy loss, may offer some form of tacit understanding between women and mothers that allows nurses to be credible witnesses in women's grief.

Reflection on Methodology

Theory application in this paper generated an understanding of how women's experiences of recurrent pregnancy loss fit with the theory of chronic sorrow. Parse (1996) suggested knowledge generated from a nursing perspective and linked to a nursing theory is nursing knowledge, while a generic perspective generates knowledge for anyone. This author could not objectively divorce personal knowledge from nursing knowledge for herself, being both a nurse and woman experiencing loss, but suggests that new understanding and knowledge gained by nurses and non-nurses alike is just as valid and useful.

Reflection on the theory of chronic sorrow. The theoretical model of chronic sorrow (Appendix A) is a well-developed framework to understand ongoing grief and loss. The model is cyclical, and allows interpretation. This author decided against recreating or altering the model for the population of women experiencing recurrent pregnancy loss for two reasons. First, it must not be assumed that recurrent pregnancy loss automatically leads to chronic sorrow, or that chronic sorrow is the only long-term outcome of such an experience. Second, the significance of pregnancy loss is individualized, and women's experiences within the chronic sorrow framework ought to have room for personal inference. For example, management methods do not have static

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results, and what is effective for one may not be for another, and what is effective at one time may not be at another. For this author the model was an ideal picture of her experience, and emotions easily fit within the model's tenets. This author was mindful that the value of the model is that it is flexible and normalizing, fitting a variety of pregnancy loss and life experiences.

Reflection on the value of autobiographical narrative. Including autobiographical narrative as an exemplar of literature was a visceral choice. This author invested profoundly in this topic, and received a measure of healing from applying her pregnancy loss experiences to the theory of chronic sorrow. With the limited research and literature surrounding recurrent pregnancy loss, excluding any form of narrative abandoned the existing literature to a theoretical realm. Theory must show practical application to flourish (Bullough & Pinnegar, 2001). The author believed offering personal narrative was necessary for a holistic perspective of recurrent pregnancy loss and chronic sorrow. Autobiographical narrative integrated with theory application could be a foundation for knowledge generation provided the narrative is honest and not self-indulgent (Bullough & Pinnegar; Settelmaier, 2007). That this author was a nurse, subject and academic writer potentially made her a most appropriate vessel for increased understanding on this topic.

What the author discovered through writing autobiographical narrative was sensitivity to language and boundaries. The author was determined throughout to keep personal narrative independent from examination of the literature to avoid alienating those who do not identify with the narrative. However, despite intentions to differentiate research findings from her narrative, the author discovered that the theory so accurately reflected her own experience she could not avoid some overlap. It was also important to pay particular attention to language, which this

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author believed has power to either welcome or ostracize a reader. The written word has personal significance, and this author felt she could best honor her experiences and most effectively communicate through this form. For example, this paper did not refer to women who have experienced but who are experiencing pregnancy loss in the active present tense, signifying that the experience is current and ongoing. This paper also avoided referring to Recurrent Pregnancy Loss as RPL, popular elsewhere, because the abbreviation may trivialize and dehumanize the experience of the term for readers. By modeling language she felt was appropriate to the experience of pregnancy loss this author hoped to influence the use of sensitive language in like writings. The author also recognized that this paper created foundational support for a future platform of research.

The author also became more aware of personal boundaries of disclosure. Part of the author's experience of recurrent pregnancy loss was the inability to escape grief, and having relationships where there was relief from reminders was a blessing. Allowing others to read the narratives increased understanding of this author's experience while narrowing her avenues of anonymity. There were elements of the author's narrative excluded for privacy, and to discourage others from expressing entitlement to her experiences. Excerpts were restricted to what was meant for the benefit of others without causing personal disrespect. If readers made meaning or gained new understanding from what is written here, this author wished to honor their identification regardless of their profession or prior understanding.

Conclusion

Pregnancy loss is lonely, but I am convinced there are others who can identify with me and me with them. I do feel this paper taught me something new about myself, and gave me hope

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that there can be meaning if not purpose to all my losses. I am aware there may be more losses in my future, and I am not naive enough to think my sorrow is over or even fading. While I no longer think I am at fault for the intensity of my grief, I am still grieving. I continue to dislike and avoid many things I associate with my losses, and I find it irritating to tolerate those I perceive as invasions of my personal coping space. They just don't get it. They don't get me. I am learning to accept grief not ending, and to be comfortable with a new way of being. I know I am not the only woman to have suffered such. And if I never bear a living child, as difficult as that is for me to even contemplate, I am still a mother.

Fly (lyrics)

Fly, fly little wing,

Fly beyond imagining.

The softest cloud, the whitest dove

Upon the wind of Heaven's love.

Past the planets and the stars,

Leave this lonely world of ours.

Escape the sorrow and the pain

And fly again.

Recorded by Céline Dion about pregnancy loss, who went on to experience recurrent attempts at in vitro fertilization (Goldman & Galdston, 1996).

Recurrent pregnancy loss refers to three or more consecutive early miscarriages, affecting 1% of couples, and women's psychosocial experiences are poorly researched and understood. The middle-range nursing theory of chronic sorrow explains a normal response to abnormal

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circumstances, and accurately describes the experience of ongoing grief caused by the events of recurrent pregnancy loss. Chronic sorrow can develop from the significant ongoing loss of multiple pregnancies and resulting disparity when a woman's loss experience differs markedly from what she anticipated. Chronic sorrow is described as pervasive, permanent, periodic and potentially progressive based on the efficacy of management methods and trigger events reminding women of their losses. Use of the theory's framework (Appendix A) to address the experience of recurrent pregnancy shows that singular pregnancy loss can result in many of the same feelings as recurrent pregnancy loss, but that recurrence creates the cycle of ongoing loss particular to chronic sorrow versus other grief models. Women experiencing recurrent pregnancy loss perceive their losses as significant and grieve appropriately to those feelings, encountering social isolation, insensitivity and intense pregnancy related anxiety. Positive management methods involve normalization of feelings and acceptance, resulting in increased comfort and ability to cope with trigger events. Nurses can help by assessing emotional and support needs in women experiencing recurrent pregnancy loss, recognizing chronic sorrow as a normal grief response, and acknowledging the potential need for non-judgmental long-term support. Chronic sorrow in relation to women experiencing recurrent pregnancy loss is a valid description of women's stories, and women could benefit from research. However, as research applying the theory of chronic sorrow to this population of women has yet to be done, including and reflecting upon autobiographical narrative served to create a more holistic perspective of pregnancy loss by introducing an exemplar from an academic writer, nurse and sufferer.

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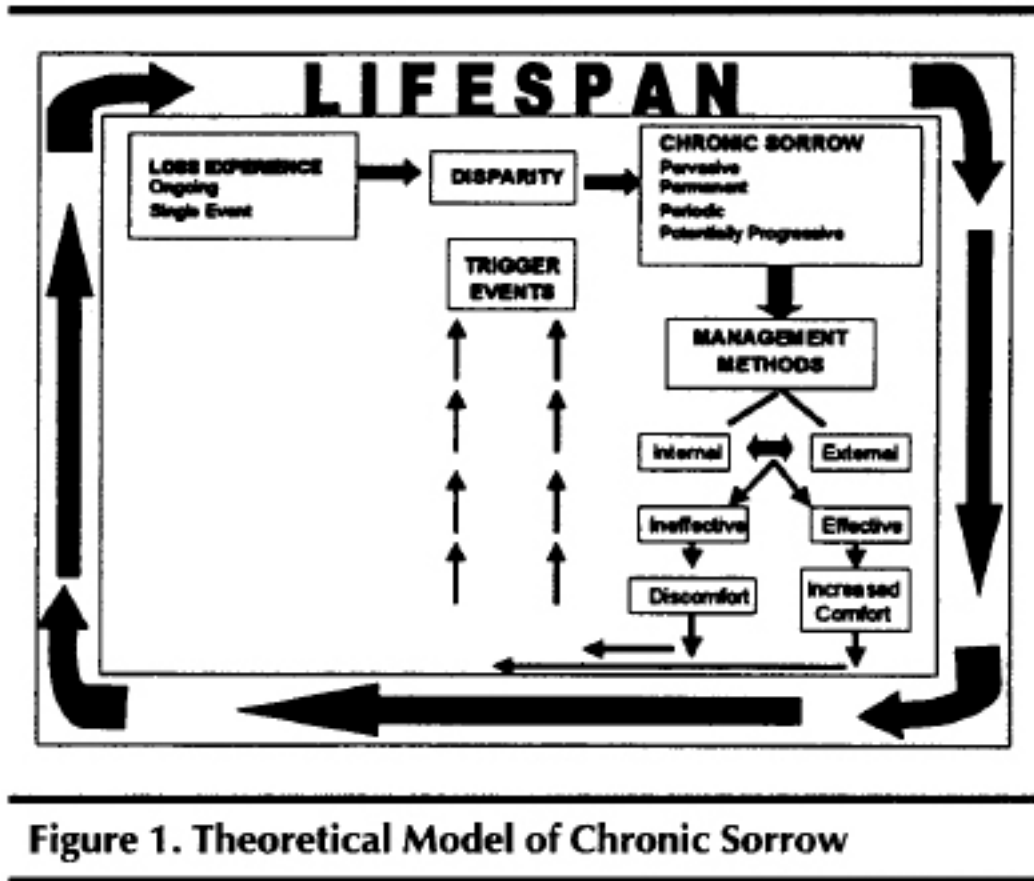
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Appendix A

Theoretical Model of Chronic Sorrow



Eakes et al., 1998, p. 180.

Appendix B

Permission to Reprint Theoretical Model

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Original Wiley figure	Figure 1. Theoretical Model of Chronic Sorrow (p. 180)

Appendix C

from: Gene Eakes Gene.Eakes@...
to: Karen Larochelle <larochellekaren@...>
date: Wed, Sep 19, 2012 at 1:30 PM
subject: Re: Major Paper from MSN Candidate, BC, Canada

Karen,

Thank you for giving me the opportunity to read your major paper. It is eloquently written and incorporating your "lived experience" serves a vital role in bringing the relevance of the Theory of Chronic Sorrow to life. It appears you managed to juxtapose your experiences with the theory in such a way as not to cloud the relationship but rather to illuminate it. I applaud you for daring to integrate the two. I certainly support that recurrent pregnancy loss (or a single such event) would likely result in the experience of Chronic Sorrow. As you are well aware, nothing can fill the void (i.e. disparity) created by such a loss. Indeed, having a subsequent child would still not replace the one who had been lost.

Again, I commend you on your work and encourage you to continue to pursue both your education as well as your research using the theory. I would welcome hearing how your studies progress.

Georgene Eakes, R.N., Ed.D

Appendix D

Booklet

You are a Mother: The Sorrow of Pregnancy Loss

Forward

Pregnancy loss is often a time of silent grief that is profoundly personal. I was 16 weeks pregnant with our son when I experienced my own pregnancy loss. It was an experience of grief and depth of sorrow I will never forget. As a Registered Nurse in the emergency department I care for women in their anguish over pregnancy loss. My own experience gives me a deeper understanding and respect for their personal meaning, and physical and emotional suffering. I often wonder how they manage when they leave the ER department. Do they receive adequate support or follow up care, or do they, too, suffer in silence? Information resources can support women experiencing pregnancy loss, provide a means for understanding their own grief experiences, and offer a voice to express themselves with. It could make all the difference.

Lucy Cross, RN, BSN, Patient Care Coordinator ER, and friend of Author

Word from the Author

I am sorry this happened to you. It is unfair. There was nothing you did or did not do to cause this, and you deserve comfort for as long as you need it. I am a registered nurse working in maternity, and a sufferer of recurrent pregnancy loss. I am a mother with no living children. I wish no women would experience what I have, but some will, and I would like to help.

Support and Information Needs

You may be told that miscarriage occurs in up to a third of all pregnancies, and that most women who experience one, or several, will go on to have normal low-risk pregnancies. Yet this

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is probably unhelpful. A loss, even when followed by a live baby, may still be just as painful a loss, and every woman grieves in her own way.

For information on your physical health and finding out about future conception, your physician is the best person to see. This booklet is for coping with your loss, and to help you understand that women who grieve for their lost pregnancies share a special bond of sorrow. The end of this booklet contains several websites with hope for coping with pregnancy loss.

The Effect on Self

Pregnancy loss is not only a miscarriage, but also a birth and a death, events that can all have significant impact on your body and sense of wellbeing. It is wholly appropriate to recognize physical and emotional symptoms related to your loss lasting for days, years, or life-long as you journey through your own grieving process.

The physical process of miscarriage takes hours to weeks, and the body's return to its non-pregnant state will take longer depending on the length of your pregnancy. Your body has given birth so bleeding, cramping, abdominal tenderness, nausea, back aches and cervical-vaginal pain may range from mild to intense, and the tissues of pregnancy may or may not be recognizable. As the urgent stages of miscarriage pass you may feel exhausted, uncomfortable, empty and bereft. You may have known about your loss long before you miscarried, and suffered persistent pregnancy symptoms as a constant reminder of your grief.

The emotional journey of pregnancy loss does not depend on the length of your pregnancy. Sadness, guilt, anger, irritability, sleeplessness, isolation, anxiety, jealousy, appetite changes, and loss of enjoyment in life are common, and there is no particular way women *should* feel after pregnancy loss. Your loss experience will reflect the desire and attachment you had for

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your pregnancy, the dreams and preparations you made for your child, and the future plans you are mourning. Whatever your experience, emotions that contribute to persistent sadness are a normal response to your loss, and there is nothing wrong with your feelings.

The Effect on Couples

Some couples feel distanced while others feel closer during pregnancy loss. It is normal for men and women to experience miscarriage differently, but this does not mean that the loss is any less painful for either. Many men feel inadequate to comfort their partners, and do not wish to contribute to their partner's pain by showing their emotions. Women may want to share the loss together, and not understand silence. Pregnancy loss can certainly affect sexual activities, socializing and future outlooks on life. Some couples or individual partners may have anxiety about resuming sexual intimacy, attempting to conceive again, or pursuing medical answers to their loss through testing and diagnostics. Finding ways to cope together may be challenging, and support groups or counselors may provide credible comfort. Consider creating a personal memorial, finding ways to remember through mementos or keepsakes, celebrating special dates and anniversaries, or choosing a place for a real or symbolic burial. Pregnancy loss is not often publicly acknowledged, and finding meaningful ways to honor your loss may help.

The Effect on Relationships

Society may not be a comfortable place for you if you have experienced silence or insensitivity. Most people do not know what to say if you tell them about your pregnancy loss. You may have told few or no one you were even pregnant, and not wish to divulge your loss. If things people have said in ignorance or with good but unhelpful intentions have hurt you, you may feel physically and emotionally vulnerable. You may also not feel confident enough to

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confront these people and explain how they are hurting you and how they can help you instead. You have the right to keep your personal and reproductive body private. Alternatively, if there are friends, family members or advisors you do trust to listen and accept your feelings, sharing may help you gain a sense of control over a situation you have had no ability to influence.

Being around pregnant women or women with young children, and seeing like images is difficult for most women experiencing pregnancy loss. Seeing or doing anything that you associate with your loss may remind you of intense grief feelings where your loss is freshly painful. Avoiding these triggers may be your way of coping, while constantly feeling the need to navigate your daily life and interactions can prove exhausting. You may feel unable to engage in others' life events and happiness, and experience guilt or isolation because of that. Learning coping strategies, and having a partner or close friend understand this experience of ongoing grief can give you practical support in those moments when you feel overwhelmed.

The Fear of Recurrence

Becoming pregnant again may be wonderful and joyful, and it may also be accompanied by worry. You may be comforted to know that research shows there is no age, life situation, or time between pregnancies that definitively alters women's emotional experiences of pregnancy loss or pregnancy after loss. Many women hope with bated breath for their subsequent pregnancy to advance beyond the gestational age at which they experienced their previous loss, but it would be normal to have conflicting emotions throughout a pregnancy after suffering a loss. Feeling anxious, wanting to feel less attached to your next pregnancy so as not to be disappointed if you lose it, and being hypervigilant about your appetite and activities does not make you a bad mother. It would be wonderful if you could regain a sense of blissfulness during pregnancy.

Recurrent Pregnancy Loss

Perhaps a partner, counselor, health care professional or spiritual advisor could help you work through this stage of your journey.

Facing an Uncertain Future

A rare 1% of women who conceive experience three or more consecutive pregnancy losses, which can cause considerable upheaval in their dreams of children and family. It can be considered a form of infertility, and comes with the pain of multiple miscarriage experiences. A persistent and pervasive sense of sorrow is a normal response to significant ongoing loss, and this journey may feel never-ending. Many women experience hopelessness and despair, and just as many find their way through. I am sorry if this is happening to you. It is unfair. There is nothing you are or are not doing to cause this, and you deserve comfort for as long as you need.

Resources

<http://www.babyloss-awareness.org/>

<http://www.copingtogether.info/>

<http://www.miscarriageassociation.org.uk/>

<http://www.miscarriagesupport.org.nz/index.html>

<http://pregnancyloss.info/>

<http://www.silentgrief.com/>