WOMEN'S EXPERIENCE OF RECURRENT EARLY PREGNANCY LOSS

by

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Abstract

There is a paucity of research which explores women's experience with recurrent early pregnancy loss. This grounded theory study explored, described, and explained the basic social psychological process of recurrent early pregnancy loss.

This grounded theory study included 12 women who had experienced at least two consecutive early pregnancy losses. The data were collected by 18 unstructured tape-recorded interviews. Interviews were analysed using constant comparative analysis. The core category of the spiraling cycle of hope and loss emphasized the major behavioural and interactional variation within the process of recurrent early pregnancy loss. Six selective categories and their properties were related to the core category: cautious celebrating; losing the pregnancy; mourning the loss; searching and seeking; deciding what next; and hope. The findings indicated that the experience of recurrent early pregnancy loss is substantive in nature, and the women experienced a unique grieving process.

Based on the findings of this study, the implications for nursing practice, education and research were identified in order to enable health care
providers to formulate an effective therapeutic course of recovery and care for these women.
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Chapter one
Introduction

**Background to the Problem**

Pregnancy and motherhood are significant developmental events in a woman's life cycle. No process is more critical for the human species than that of procreation. Schuster (1992) stated that "approximately 95% of newly married couples expect to have their own children someday" (p.661). Spontaneous abortion, the most common complication of pregnancy, shatters this dream and alters the trajectory of childbearing for 10-20% of these couples (Anderson, 1989; Bobak, Jensen & Zalar, 1989; Katchadourian, 1989). Unfortunately, for five percent of all pregnant women, spontaneous abortion will become a recurrent event (Stephenson & Rowe, 1991).

It has been well documented that pregnancy is a time of physical and psychological transformation (Flager & Nicole, 1990; Lederman, 1990; Rubin 1967a, 1967b, 1975; Woods & Esposito, 1987). Certain tasks must be completed to facilitate the transition to motherhood. The first maternal task is to seek safe passage for mother and child through pregnancy, labour and delivery (Rubin, 1975). Spontaneous abortion, the
most common complication of pregnancy, alters the trajectory of childbearing (Bobak, Jensen & Zalar, 1989). This prevents the achievement of the first maternal task of pregnancy for 15 to 31% of pregnant women (Cavanaugh & Comas, 1982; Neeson & May, 1986; Rock & Zacur, 1983; Snyder, 1979; Strobino, Fox, Kline, Susser & Warburton, 1986; Wells, 1991; Wilcox et al., 1988).

The downward trajectory caused by spontaneous abortion destroys the woman's dream of having a child, thereby triggering the natural grieving process (Engel 1964; Kowalski, 1991; Lindemann, 1944; Peppers & Knapp, 1980a; Simos, 1977). Grieving a perinatal loss is an arduous and isolating process because society has no recognized rites or rituals to mark the event (Hutti, 1988b; Leppert, & Pahlka, 1984; Reed, 1990). For those women who experience recurrent early pregnancy loss, the altered trajectory of childbearing and bereavement becomes a serial process.

In the last decade a number of studies have addressed the impact of a single miscarriage on the woman (Black, 1991; Day & Hooks, 1987; Iker, 1991; Leppert & Pahlka, 1984; Peppers & Knapp, 1980a; Reed,
1990; Swanson-Kauffman, 1983). Nevertheless, we know very little of the impact of recurrent loss.

**Problem Statement**

A number of researchers have explored the human experience of miscarriage. Notwithstanding, there is a paucity of research which explores the experience of recurrent early pregnancy loss.

**Purpose**

The purpose of this study was to explore, describe and explain the basic patterns common in the experience of recurrent early pregnancy loss. The purpose formulates the following question: What is the experience of women who have had recurrent early pregnancy loss?

**Definition of Terms**

- **Recurrent early pregnancy loss**: two or more documented consecutive spontaneous abortions at a gestational age of 20 weeks or less (Stephenson & Rowe, 1991).
- **Spontaneous abortion**: is the preterm delivery of a non-viable fetus before the 20th week of pregnancy (Stephenson & Rowe, 1991).
- **Miscarriage**: lay term used synonymously with spontaneous abortion and refers to the spontaneous demise of a pregnancy.
Perinatal loss: refers to the death of a fetus before birth, or death of a baby within the first 28 days after birth (Woods & Esposito, 1987).

Infertility: the inability to conceive and/or carry a pregnancy to term after one year of regular sexual intercourse without contraception (Olshanky, 1992; Sandelowski, 1987).

High-risk pregnancy: a pregnancy in which a significant possibility of fetal demise, fetal anomaly, life-threatening illness in the newborn, or serious health risks for the expectant mother exist (Kemp & Page, 1987, p.180).

Theoretical Perspective of the Study

The qualitative methodology of grounded theory is based on the social philosophy tenet of symbolic interaction (Glaser & Strauss, 1967). Blumer (1969) stated that symbolic interaction "is a down-to-earth approach to the scientific study of human group life and human contact"(p.47). Symbolic interaction focuses on how individuals define their reality, how they interact with others, and how they construct their actions over time (Blumer, 1969).

Grounded theory is an exploratory research approach which is grounded in the data without logical
deduction from a priori assumptions (Glaser & Strauss, 1967). Qualitative research methodology is utilized to explore and describe the phenomena under study because the variables pertaining to the concept have not been established (Stern, 1980). In grounded theory the researcher "discovers what is going on, rather than assuming what should be going on" (Glaser, 1978, p.159). Grounded theory was the research methodology chosen for this study because there is a paucity of information about the human experience of recurrent early pregnancy loss (Chenitz & Swanson, 1986; Glaser, 1992; Glaser & Strauss, 1967; Hutchinson, 1986; Simms, 1981; Stern, 1980; Stern, 1985).

Review of the Literature

The purpose of the literature review in a grounded theory study is to establish the scope and type, if any, of the previous research on the substantive area to be studied. However, the researcher must be extremely cautious to avoid premature closure and contamination of the generation of concepts as a result of the initial literature reviewed (Chenitz & Swanson, 1986; Glaser, 1978; Glaser, 1992).

The review of the literature in this study will proceed from a general overview of perinatal loss and
miscarriage studies. Secondarily, literature which refers to the maternal tasks of pregnancy and the process of altering the trajectory of pregnancy will be reviewed in order to form sensitizing concepts prior to data collection (Omery, 1983).

Grounded theory methodology defines three types of literature: technical literature which is related to the substantive area under research; non-technical literature that includes anecdotal stories, diaries, records, documents that can be used as primary data; and professional literature that is unrelated to the substantive area (Glaser, 1992). The initial literature review process for this grounded theory study utilized technical literature to establish the range, scope, intent and type of related research on the substantive area under study (Chenitz & Swanson, 1986). The technical literature was also used to establish the purpose, background and significance for the exploration of the substantive area under study. The three types of literature reviews were continual throughout the research process of constant comparative analysis. This process facilitated the establishment of parsimony and scope, the two prime attributes of theory (Glaser, 1992).
Perinatal Loss

The accumulation of knowledge pertaining to experience of perinatal loss has increased over the past two decades. Multiple studies have explored the single phenomena of miscarriage; however, no empirical studies have isolated and explored the psycho-social aspects of recurrent early pregnancy loss.

One of the earliest studies of pregnancy loss was initiated by sociologists Peppers and Knapp (1980). This study explored the similarities and differences of the maternal grief process by 65 women who had experienced one of the following: miscarriage, stillbirth, or neonatal death. The authors expanded the grief scale developed by Kennell, Slyter and Klaus (1970). A three-part questionnaire was developed to collect sociodemographic information, and data related to the loss itself, and to explore the subjects' responses to the symptoms on the grief scale. The authors compared the grief responses, and reported that the three groups shared the same reactions: sadness; loss of appetite; inability to sleep; irritability; preoccupation; inability to return to normal activity; difficulty in concentration; anger; guilt; failure to accept reality; time confusion; exhaustion; lack of
strength; depression; and repetitive dreams of the lost child. In-depth interviews revealed that those who had a history of difficulties in pregnancy experienced a more intense grief reaction. Peppers and Knapp (1980) also noted that those who had experienced a miscarriage perceived that they were treated as surgical patients and that no one recognized them as grieving mothers.

A convenience sample was the foundation for this research, a factor which diminishes the generalizability of the findings and, therefore, compromises external validity. The authors did not provide evidence of reliability and validity to support the use of the original grief scale or the subsequent modified grief scale used to achieve the reported findings. No information was provided to establish the framework of the interviews. The authors clearly stated that "data collected from the interview schedule have yet to be fully content analyzed" (Peppers and Knapp, 1980, p. 157). In spite of this declarative statement, interview data were used to verify and elaborate the authors findings although no method of objective, systematic or quantitative analysis was used.

Leppert and Pahlka (1984) described the grief pattern of 22 women who experienced a spontaneous
abortion. The participants in this study were registered for prenatal care with the authors' obstetrical practice. Initial data were collected by in-depth interviews; subsequent data were collected by telephone interviews. The authors reported the stages of grief as: shock; disorganization; volatile emotions; guilt; loss; relief and re-establishment. The first three stages were short lived. The women focused on why the miscarriage had occurred. The women also expressed feelings of bitterness because society did not recognize their loss with any rites or rituals. Guilt was the strongest stage of the grief process; in seeking a cause for the loss, the women reflected on what they should not have done. The authors reported that all women entered the last stages of grief about three to four months after the loss.

The researchers accepted available subjects from their own practice, if they met the sample criteria. This method comprised a convenience sample, a non-probability technique. Since the sample was not selected randomly, generalizability is restricted to the sample of the study. The method of data collection was reported to be through interview; however, the authors did not report the framework or structure of
the interview format. This study would have been enhanced if there had been a greater description of the analysis conducted to achieve the findings.

A study by Swanson-Kauffman (1986) was one of the first nursing research efforts to isolate and systematically explore the phenomena of early pregnancy loss. This qualitative study examined the experience of miscarriage and the caring needs of 20 women and it utilized a combination of qualitative methodologies: phenomenology, ethnography and grounded theory. These methods were melded together to form what the author called a qualitative methodology for research in nursing. Each informant was referred to the study through a mediator: an obstetrical care provider, parish priest, or a common acquaintance. The participants had experienced a miscarriage within 15 weeks of the initial interview. Data were collected utilizing taped recorded interviews guided by semi-structured interview schedules. Using the complex matrix analysis from blending qualitative methods, the author identified six categories of the miscarriage experience.

The first category, "coming to know," represented the period of time when the woman acknowledged the
increasing evidence of the inevitable loss of the pregnancy. The second category, "losing and gaining," represented the assessment by the woman of the meaning of the loss for herself. The third category, "sharing the loss," depicted the amount of recognition and support received by the women throughout the loss. The fourth category, "going public," described the process of communicating to others the knowledge of the loss. It indicated that a failure to reveal the loss to others made an impact upon the experience of the pregnancy loss. The fifth category, "getting through it," compared the grieving patterns and the amount of time to achieve grief resolution for each woman. The final category, "trying again," examined the various decisions made by the women in order to plan for future pregnancies, and identified the fears for future losses.

A second aspect of Swanson-Kauffman's (1986) study was the "caring needs" of women who experienced miscarriage. The caring categories are the thought processes of the participants which seemed to accompany the external caring behaviours provided by others. These categories were: 1) knowing; 2) being with; 3) enabling; 4) doing for; and 5) maintaining belief.
The findings of this study resulted in the first description of a sequence of responses to early pregnancy loss. The limitations of this study are the small sample size and a possible sample bias. A more racially and culturally mixed sample may have revealed a greater variation of responses. The mixing of research methodologies resulted in a complex data analysis. Unfortunately, the researcher did not state explicitly the type of analysis applied to produce the findings.

Day and Hooks (1987) studied the psycho-social aspects of miscarriage by examining the relationship between the recovery of 102 women who had experienced a miscarriage and the resources which facilitated their recovery. The authors explored the characteristics of the participants which increased or decreased their vulnerability to stress following miscarriage. The participants were randomly selected from rural and semi-urban centers in an attempt to achieve a representative sample. The authors utilized a mailed questionnaire to collect data. The questionnaire was created utilizing the Family Adaptation and Cohesion Evaluation Scale (Olsen, Portner, & Bell, 1982).
Day and Hook's (1987) findings revealed that miscarriage was a significant stressor event which was affected by the lack of transitory rituals to mark the loss of the anticipated family member. The authors suggested that, within the family resource structure, cohesion was a crucial variable, and that recovery was a function of adaptability which promoted the recovery and resolution of the loss. However, the researchers did not test for content validity or test-retest reliability of the selected questions used from the original tool.

Reed (1990) studied the relationship between age, parity, and the emotional care given by obstetrical nurses to the women who experienced a miscarriage. The researcher utilized a 14-item questionnaire as well as nine vignettes. The questionnaire measured various aspects of emotional care. Each vignette systematically combined age and parity status to represent different situations. The questionnaires and vignettes were mailed to 396 randomly chosen obstetrical-gynecological nurses in one American state. The results from the 309 respondents revealed that there was no interaction between the age and parity status on the emotional experience of the subject as
perceived by the attending nurse. In isolation, parity status did affect the nurses' rating of the perceived emotional seriousness of the loss. Nurses rated the miscarriage to be less emotional for women who previously had a successful pregnancy, therefore, assigning to these women a lower priority of care. Reed suggested that nurses interpret the emotional needs of women who miscarry to be important; however, the researcher found the nurses were unable to convey their concern through their nursing care. Unfortunately, this study does not delineate the woman's perception of the miscarriage event. The study explored the nurses' perception of the women's attitudes toward their miscarriage event. The results of this study suggest that because the nurses are unable to clearly interpret the women's perception of the event, they may display an attitude of indifference to the women's loss.

The use of vignettes as a self-report technique increases the potential of response biases leading to measurement error. The author concluded that the results of the study were questionable in that nurses may have answered the questionnaire as they believed they "should have" rather than with perfect candour.
Black (1991), a social worker, investigated the experiences of 121 women who underwent prenatal testing and lost their pregnancies as a result of miscarriage or termination due to a serious fetal defect. This study explored the women's perceptions of themselves in relation to their male partners after pregnancy loss. The researcher accepted available subjects from women enrolled in an American chorionic villus sampling and amniocentesis study who met the sample criteria. This represented a convenience sample.

Data were collected by the use of semi-structured telephone interviews and completed mailed questionnaires. The questionnaires utilized the 32-item self-report Dyadic Adjustment scale. The researcher also employed a semi-structured interview framework that integrated a five-item partner support scale into the questions. Black concluded that supportive follow-up protocols and educational materials assisted the couple to cope with their loss. It was suggested that all health care providers should be familiar with the particular features of grief and bereavement associated with pregnancy loss so that they can assist the couple to define what the loss of the pregnancy means to them.
Black (1991) utilized quantitative and qualitative methods to analyze the data. However, the type of qualitative analysis applied to the interview data is not reported. A possibility of response bias exists with the use of mailed questionnaires because the participants may provide socially desirable answers. However, the study does provide guidelines for supportive follow-up protocols and educational material to assist in the care of women who lose their pregnancies due to a serious fetal defect.

The Hansen and Stevens (1992) qualitative study examined 10 women's experience of miscarriage in early pregnancy. The participants were gathered with the use of informal networking and referrals from obstetric healthcare providers, a method which again creates a convenience sample. The subjects had experienced a miscarriage within the first 15 weeks of their first desired pregnancy.

Data were collected by tape recorded interviews conducted two to four months after a participant's miscarriage. The researchers utilized the qualitative methodology of phenomenology and they applied content analysis to the data which ensured a systematic and objective data analysis.
Bansen and Stevens (1992) identified four major categories of the miscarriage experience: the miscarriage event; dealing with the loss; interacting with outsiders; and facing the future. The first category, "the miscarriage event," represents the woman's description of the physical and psychological experience of the process of miscarriage. The second category, "dealing with the loss," describes the process of searching for the cause of the miscarriage and the guilt associated with a perception that something was done to have caused the loss. This category also encompasses the mourning process and establishes that it may take up to two years to complete the process. The third category, "interacting with others," depicts the women's interaction with family friends and the public after the miscarriage. A common experience shared by several women in the study is that family and friends attempted to diminish the woman's loss by implying that the miscarriage was not actually a "real" loss. The final stage, "facing the future," describes the impact the miscarriage had on their perspective on the future.

The authors concluded that miscarriage is a major life event and that each miscarriage experience is
unique. The resolution of the grief process, however, is hampered by the hush that surrounds the miscarriage event. The results of this study cannot be applied as generalizations due to the nature of the research methodology. A limitation of the study is the possibility of sample bias.

Iker's (1991) study examined the experience of miscarriage from the couple's perspective, and it utilized the qualitative method of phenomenology. Informants were procured through physician referrals and by advertisements in local newspapers. This method represents a convenience sample. Data were obtained by two unstructured tape recorded interviews. The couples were initially interviewed within two to four weeks after the miscarriage event and subsequently a month after the initial interview. Data were collected and analyzed concurrently to identify meaning units and subsequently to establish themes of the miscarriage experience. The results of the data analysis depicted the couples' miscarriage experiences as a composite of four interrelated grief motifs with a satellite theme of health care interactions. The four interrelated grief motifs were: Discovery; Disclosure; Definition; and Decision.
The initial motif, Discovery, represented the awareness by the couple that the pregnancy had ended. This was characterized by the couple's grieving behaviors and emotional expressions of their loss. The second motif, Disclosure, encompassed the couple's actions of telling and story sharing which validated and normalized the couples loss. The third motif, Definition, depicted how the couples discussed and reviewed their individual meaning of what was lost. The final motif, Decision, reflects the couple's shift from their loss to future plans. The together but separate content of the couple's miscarriage experience depicts the incongruent grief process which results in three well grounded representations of the experience: the woman's story, the man's story, and the couple's story of loss. The external theme of health care interactions reflects that each couple identified that their interactions with health care providers had a significant impact upon how they dealt with the miscarriage.

Due to the nature of the research method the findings of this study cannot be used as generalizations. A limitation of this study is the small sample size and the possibility of sample bias.
The findings of this study would have been enhanced by a larger sample size and the use of theoretical sampling.

The review of the technical literature proceeded from a general overview of perinatal loss literature. Several studies provided a general description of the women's sequence of responses to the single event of early pregnancy loss (Black, 1991; Bansen & Steven, 1992; Iker, 1991; Leppert & Pahlka, 1984; Swanson-Kauffman, 1986). Other studies found miscarriage to be a significant stressor event (Bansen & Steven, 1992; Day & Hooks, 1987). All studies concluded that women experience a unique process of grief resolution after the single miscarriage event. However, it is not known if this information is applicable to women who experience recurrent early pregnancy loss.

Sensitizing Concepts

Reva Rubin (1967a, 1967b) explored the stages, sequencing and factors affecting the attainment of the maternal role. Rubin (1975) defined pregnancy as a stage of "identity reformation, a period of reordering interpersonal relationships and interpersonal space, and a period of personality maturation" (p.143). Rubin found that the attainment of the maternal role was
dependent on four tasks of pregnancy work. The four maternal tasks in pregnancy are: seeking safe passage for self and her child through pregnancy, labour and delivery; ensuring the acceptance of the child she bears by significant persons in her family; binding-in to her unknown child; and learning to give of herself (Rubin, 1975, p.145). Women who experience a spontaneous abortion fail to achieve the maternal tasks of pregnancy. The identity reformation, reordering of interpersonal relationships and interpersonal space cease to evolve and the natural grieving process marks the loss not only of the future child but of maternal role attainment.

Women who experience recurrent early pregnancy loss are considered high-risk with respect to the potential threat to life of the fetus in future pregnancies. Poland, Miller, Jones & Trimble (1977) reported that once a woman experienced a perinatal loss her risk of a subsequent miscarriage increased by 23% and increased to 49% after two consecutive losses. The authors also concluded that women who have never had a live birth prior to their subsequent loss should be identified as high-risk.
Snyder (1979) explored the relationship between the high-risk mother and a holistic model of childbirth. Snyder utilized Rubin's (1975) research to emphasize that childbirth is a multidimensional experience influenced by physiological, societal, psychological and cultural variables. Snyder utilized these multiple variables to create a framework, the holistic model, as a guide to nursing interventions for high-risk pregnancies.

Snyder's (1979) holistic model not only recognizes the developmental crisis of childbirth and maternal role attainment, it also acknowledges the women's apprehension surrounding the possible altered outcome of the pregnancy. Snyder's model is diagrammatically represented by five concentric circles each depicting a facet of the childbirth experience. The core circle represents the physiological adaptations of the maternal system to the pregnancy. The second circle corresponds to the pregnancy and the achievement of the maternal tasks of pregnancy. The third circle depicts the dynamic interpersonal relationships within the woman's peer and family system that are affected by the childbirth experience. The fourth circle symbolizes the societal system affecting the childbirth
experience which includes the variables of socio-economic status, political influences and health care as it relates to the individual woman. The final circle is the cultural system, within which the previous variables of the model operate. Snyder defines the cultural system as encompassing attitudes, social forms, racial customs and cultural values pertaining to the childbearing experience and children within the culture (Snyder, 1979).

Two central tenets of the holistic model are the use of the physics term, "trajectory," and the element of time. The element of time is essential to the concept of pregnancy because there is a progressive predictable linear chronology to the normal pregnancy. The beginning is conception, the duration is approximately nine months and the process ends with delivery of the child. This sequenced path of pregnancy is also delineated as the trajectory of childbearing. The trajectory of childbearing provides a basis on which expectations are defined and is a major determinant of behavior for all those involved in the childbearing process. The individuality of each woman's experience reflects the invariable
unforeseeable interactions of the model's unique parts, which form a solitary, complex whole.

In the high-risk situation of recurrent early pregnancy loss, the trajectory of pregnancy is altered and is no longer predictable. The possible premature termination of the pregnancy can have a ripple effect upon the other rings within the holistic model. Little is understood about the woman's experience of recurrent early pregnancy loss and the coping behaviors utilized by the woman to regroup and reorganize her behavior in terms of the altered trajectory. This lack of information makes it difficult for health care professionals to formulate an effective therapeutic course for the woman because the only theory to guide practice is based on the experience of single miscarriage.

The review of the literature has shown that there is a growing body of knowledge which addresses the impact of miscarriage for women who experience a single event of miscarriage. However, it is not known if this knowledge is relevant to women who experience recurrent early pregnancy loss.
Description of the participants

For this study, twelve women volunteered to participate. Their ages ranged from 21 to 40 years. All the women were married except one; this woman lived in a common-law relationship.

All twelve of the participants had experienced at least two consecutive early pregnancy losses. Six of the twelve participants had at least one living child. Of the twelve participants: two had experienced two consecutive losses; five had experienced three consecutive losses; three had experienced four consecutive losses; and two had experienced five consecutive losses. At the conclusion of this research project, four of the participants were pregnant and one woman had decided to cease efforts to conceive.

Assumptions

This study was undertaken on the assumption that the events of recurrent early pregnancy loss are unique and significant in the life of women who experience them. As a result, it is assumed that women who experience recurrent early pregnancy loss have distinct needs and concerns, in contrast to women who experience the single event of spontaneous abortion. Finally, it is assumed that the most accurate sources of
information are the women's own descriptions of their experiences of the phenomenon under study.

Limitations

The sample was limited to the following women: those referred to the recurrent pregnancy loss clinic at the Women's Health Center; those meeting the selection criteria outlined in Chapter Two who consented to be interviewed. The study includes twelve women. The data have not been generalized to apply to other subject groups due to the nature of the sample.

Summary

This chapter has established the background for this study. The purpose, definition of terms, assumptions, limitations and the selection criteria also have been identified. Chapter Two delineates the study methodology and reviews the selection procedure, the process of data collection and analysis. The issues of reliability, validity and ethical considerations are also presented.
Chapter Two

Methodology

Introduction

This section describes the research design of this study, sample selection, data collection procedures, data analysis and procedures for protection of human rights.

Research Design

Grounded theory was the qualitative research design chosen for this study because it works better than other designs when there is a paucity of literature which explores the phenomena under examination. This approach reveals process, and increases the social and psychological understanding of the phenomena under study (Glaser & Strauss, 1967). Grounded theory is an analytical approach which seeks to define the social situation because "it is impossible to test theory where no theory exists" (Stern & Pyles, 1985, p.3). Grounded theory advanced the goal of this study, which can be described as the generation of a theoretical description of the human experience of recurrent early pregnancy loss. Grounded theory methodology employs a systematic process of data collection and analysis in order to develop an
inductively derived theory grounded in the data (Glaser & Strauss, 1967; Glaser, 1992). In this study the primary source of data was derived from the formal, unstructured, audio-taped interviews with the participants (Chenitz & Swanson, 1986; Glaser, 1978; Hutchinson, 1986). Secondary forms of data were derived from: the investigator's field notes; observations; literature on miscarriage; literature on recurrent spontaneous abortion; and other literature relevant to the unfolding concepts of the analysis (Glaser, 1992; Morse, 1989; Sandelowski, Davis & Harris, 1989; Strauss & Corbin, 1990).

**Selection Criteria**

Twelve participants were recruited through the Women's Health Center, Vancouver, British Columbia. This center provides the only recurrent pregnancy loss program within the province of British Columbia. An introductory letter (Appendix A) was distributed to women who attended the clinic. The following criteria provided direction for initial selection of potential study participants. Rationale is provided to substantiate the criteria.
Selection Criteria:

Women: 1. Who have experienced two or more abortions under 20 weeks to a maximum of five losses. 
Rationale: This is the target population

2. Who have the ability to read and communicate in English. 
Rationale: To facilitate effective communication between the researcher and the participants.

3. Who have reached, at least, the age of 19 years. 
Rationale: The concerns of teenage motherhood may confound the experience.

4. Without major diagnosed underlying chronic illness. 
Rationale: Complications of chronic illness may cloud the experience.

5. Who had a live birth and subsequently experienced two or more consecutive documented recurrent early spontaneous abortions to a maximum of five losses. 
Rationale: This is a subset of the target population.

6. Women who have had a maximum five losses.
Rationale: The complex nature of multitudinous pregnancy loss could confound the target experience.

7. Married or living with the same partner for more than one year.
Rationale: An uncommitted relationship may confound the experience.

Selection Procedure

Each of the informants for this study was referred to the research through a mediator. Fifteen women were identified by their obstetrical care provider at the Recurrent Loss Clinic as potentially suitable candidates. Those candidates interested in participating in this study were given an introductory letter (Appendix B) and each gave permission for the researcher to contact her by telephone to answer any questions about the study and to arrange an initial meeting. Fourteen of the fifteen informants were initially contacted by the researcher; one woman called the researcher after receiving the introductory letter. Three of the women declined to continue in the study and requested that their names be withdrawn from the list of participants. They stated as their reason for
declining, emotional distress over their recent pregnancy loss.

In Grounded theory, data analysis and data collection are simultaneously carried out and sampling is continual due to the fact that the evolving data analysis directs the need for selective sampling to discover the variations in the phenomena under study (Glaser, 1978). This research study used non-probability convenience sampling procedures. Selective sampling was utilized because the research population of women who had experienced two or more documented consecutive recurrent early pregnancy losses was difficult to identify by ordinary research means (Strauss, 1987). In order to "examine the phenomenon where it was found to exist," (Chenitz & Swanson, p. 9) women at the Recurrent Loss Clinic comprised the initial sample. The sample was comprised of twelve women who met the stated criteria and agreed to be interviewed and tape-recorded. Sampling continued until saturation of all levels of codes was complete and no new conceptual information was available to indicate new codes or the possible expansion of established codes. Once saturation of each concept was obtained, a conceptual framework was developed and
verified by further data collection. Baker, Wuest and Stern, (1992) stated that "the selection of participants and data sources is therefore, a function of emerging hypotheses and the sample size, a function of theoretical completeness" (p. 1358).

**Data Collection and Analysis**

The data collection and analysis proceeded simultaneously. Through the process of constant comparative analysis all data collected were coded, compared and contrasted with all other data within each interview and between subsequent interviews (Figure 1). Each interview was a source of data for questions for all subsequent interviews, and it was a case to be compared with all other cases. Utilizing the process of theoretical coding and memoing, the emerging theory was modified and core variables emerged. Theoretical relationships and related concepts were compared with data for validation. Theoretical completeness was achieved as the category expanded, dimensionalized, saturated, delimited and integrated into a constructed substantive theory of the human experience of recurrent early pregnancy loss (Stern & Pyles, 1985; Strauss, 1987).
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*Figure 1.* Coding paradigm for constant comparative analysis. Strauss, A. (1987) p.19.
Data collection, analysis and verification occurred concurrently until saturation was reached (Strauss & Corbin, 1990). Strauss (1974) stated that, "Everything is data" (cited in Stern, Allen, & Morley, 1984). Secondary forms of data utilized for this study were the investigator's field notes, observations, literature on miscarriage, and literature on recurrent spontaneous abortion. All of these data increased the researcher's theoretical sensitivity.

An interview guide (Appendix A) established the aim of the unstructured interview and instituted a framework within which the interview was conducted (Burgess, 1982). This guide introduced the theme of the interview and helped to focus the informants' thoughts so that they were able to tell their stories about recurrent pregnancy loss (Chenitz & Swanson, 1986; Field & Morse, 1985; Harr & Thistlethwaite, 1990; Sandelowski, 1991) The question which began the initial interviews was: "I'd like you to tell me what it's been like for you to have experienced several pregnancy losses."

Each informant was interviewed once and the initial interviews generally lasted about one hour. The initial interview took place in either the
informant's home or at the Women's Health Center in a private room. Six informants were interviewed a second time in their homes and these interviews lasted approximately 45 minutes. The length of time from the loss varied for the participants, the longest was seven months, and the shortest was one month. The first interview for this project took place on April 8, 1993. All second interviews were completed by September 29, 1993.

All the interviews were tape-recorded and transcribed. The researcher listened to the audiotape and noted corrections of transcription errors. Field notes were written following the interviews to record nonverbal behavior, setting description, and the researcher's perceptions of the interview. These field notes were added to the transcripts, the transcripts formatted and lines numbered.

Coding

The process of analyzing data in grounded theory methodology is defined as coding. Coding is pivotal in the generation of theory; the fracturing of data into codes reduces the data into condensed abstract units. There are two distinct elements of coding which are
central to grounded theory: substantive and theoretical.

Data Analysis

Open Coding

The verbatim transcripts were analyzed line by line to generate conceptual labels called substantive codes. Substantive coding begins with the process of open coding; each word, as well as the larger units of sentences and paragraphs of the transcript is examined, and key words were identified as used by the informant. The substantive codes were derived by utilizing the words of the participants which described the action in the sentence, and which provided a tentative conceptual framework (Glaser & Strauss, 1967; Strauss, 1987). The portion of the first transcript, reproduced below, illustrates the open coding which occurred during the beginning of data analysis.

The first one, we only knew for a 1st loss week about a week that I was knew 1 week pregnant.
So then it went up and down really quick.

The open codes were then examined to identify family related codes or cluster codes. From the open coding, 64 cluster codes were created. Some examples of cluster codes common to all participants were: no
trouble getting pregnant; the losing experience; telling everyone about the pregnancy; wanting another baby; and trying again. The cluster codes were compared and the researcher developed and assigned the codes to categories (Stern & Pyles, 1985). The original 64 cluster codes were collapsed to establish 15 substantive codes. For example, the cluster codes of: not painful, bleeding, mild cramps, dilation and curettage, saving the contents of conception, surprise of the loss, and did not think it would happen again, were collapsed to establish the substantive code of the surprising event of losing. Questions were asked about each data set: What is the data or study descriptive of?; what category does this incident indicate?; what is actually happening in the data? (Glaser, 1978). These questions posed by the researcher enhanced theoretically sensitive analysis, which fostered the exploration of the conceptual relationship between the substantive codes and the theoretical codes (Glaser, 1992).

Axial Coding

The next phase of analysis was axial coding. The categories were then further analyzed to establish links and interrelationships, to determine the
dimensions of the categories and the theoretical links between each category. The researcher utilized the six postulates of the coding families: causes, contents, contingencies, consequences, covariances and conditions, to establish the dimensions of each category. The data were then reduced to reveal the core category which depicts the major processes that explain the phenomenon of recurrent early pregnancy loss (Glaser & Strauss, 1967).

Selective Coding

Strauss and Corbin (1990) defined selective coding as "the process of selecting the core category, systematically relating it to other categories, validating those relationships, and filling in categories that need further refinement and development" (p. 116). The categories provided a tentative conceptual framework by which to expand and densify the emerging theory. The researcher employed the process of continual selective sampling to expand, support or disprove the tentative hypothesis generated from the data (Glaser, 1978). A review of the literature in the substantive field was undertaken in order to identify concepts that were related to the integration of categories and properties of the
emerging core variable. Saturation of the data was achieved when no new information was revealed or added to the existing categories. Figure 2 illustrates the process of relating the core category to the substantive categories.

**Emergence of the core category**

The spiralling cycle of hope and loss emerged from the data analysis as the core variable which explains the major behavioural and interactional variations of recurrent early loss (Hutchinson, 1986; Strauss, 1987). The substantive categories and their properties were related to the core category and this condition established the density and saturation of the relationships which creates theoretical completeness (Strauss, 1987). The core concept integrated all the categories: it accounts for variation in the behaviors of the participants; it allows for overlap between the categories; and it demonstrates the logical links in the process.

The final step in grounded theory is the theoretical sorting of data achieved by the reduction and recoding of memos and by the integration of theoretical codes. Stern & Pyles (1985) stated that "the written report gives a clear, precise rendition of
Figure 2.
Selective Coding and Core Category Relationship

Figure 2. Selective coding and core category.
the theory substantiated by the data and the existing literature" (p.18). Grounded theory is a matrix method of research whereby data collection, coding and analysis occur simultaneously; however, this produces a mere description. Vital to the process of grounded theory generation is the event of theoretical sensitivity. Theoretical sensitivity to the researcher's knowledge, understanding, experience and skill. Strauss & Corbin (1990) define theoretical sensitivity as the researcher's ability to recognize important data and to give it meaning to foster the construction of theory that represents the reality or "fit" of the phenomena under study (p.46).

Reliability and Validity

In qualitative research the measures used to ensure reliability and validity are unique and differ from the terms defined in quantitative methodology. Lincoln and Guba (1985) defined four factors utilized in the naturalistic-qualitative paradigm of inquiry which establish trustworthiness of data: credibility, transferability, dependability and confirmability. Credibility is the confidence which individuals, as well as the researcher, have in the truth of the findings. This was established by peer debriefing and
informant checks. Peer debriefing was accomplished by sharing data and on-going analysis with thesis committee members experienced in qualitative data analysis. Informant checks involved having the informants review the data analysis, interpretations and conclusions. The informants validated the substantive theory as an accurate representation of their experiences with recurrent early pregnancy loss.

Transferability was achieved by providing a process trail through the data analysis. The dependability of the findings and the confirmability of the data were reviewed by two members of the thesis committee.

**Ethical Considerations**

Permission to conduct this study was received from the research committees of the University Hospital and the University of British Columbia, Behavioural Sciences Screening Committee for Research Involving Human Subjects.

At the initial meeting with each informant, the researcher reviewed the consent form (Appendix C) and a written consent was obtained before the taped interview began. The participants were informed that they could withdraw from the study at any time without
consequence. Participants were informed that all information was confidential and used only for the purpose of this study. The researcher explained the procedure for storage, transcription and disposal of data.

The research question addressed the woman's experience of recurrent early pregnancy loss. During the interviews, each woman included her experience of the first miscarriage in telling her story. Analysis of these stories resulted in a process which was consistent with previous descriptions (see Appendix D). The findings presented in chapter three describe the women's experience of recurrent loss.

Summary

This chapter reviewed Grounded theory methodology and its use in this research study. The selection criteria, selection procedures, data collection and analysis, reliability and validity, and ethical consideration were also discussed.
Chapter Three

Data Analysis: the discovery

(L) As women we grow up, from the time we're little girls and grow up just assuming we're going to get married and have our babies and that's all there is to it, but it's not the case.

In this chapter the outcome of data analysis is described. This chapter begins with a description of the core category followed by the theoretical portrait of the recurrent early loss experience that evolved through grounded theory methodology. Integrated throughout this chapter are quotes from the participants that illustrate and substantiate the researcher's interpretations.

The Recurrent Early Pregnancy Loss Experience

Central to the women's descriptions of their experience were the stages through which they moved during each pregnancy loss experience. The recurrent early pregnancy loss categories depict the conceptual ordering which underlies the core category; the spiralling cycle of hope and loss. The recurrent early pregnancy loss categories are: cautious celebrating; losing the pregnancy; mourning the loss; searching and seeking; deciding what next; and hope. These
categories are sequenced; however, they are not mutually exclusive.

Recurrent Early Pregnancy Loss: A Descriptive Analysis

Paramount to the women's descriptions of their recurrent early pregnancy loss experience were the concepts of hope and loss. Analysis led to the depiction of the core category as two interconnected spirals. A spiral is defined as "a curve which continuously changes its plane, and sometimes its curvature in relation to a fixed axis; continuous increase and decrease in two or more quantities alternately because each depends on the other" (Oxford Advanced Learner's Dictionary, 1989, p.1233). The conceptualization of the core category is illustrated by Figure 3.

The women in this study experienced the greatest amount of hope after their first experience with early pregnancy loss. This is reflected by the widest curvature of the spiral of hope (Figure 3). The participants expressed their hope as a desire to achieve their goal of a successful pregnancy outcome for their second pregnancy. Consequently, when the second pregnancy resulted in a loss, the curvature of the spiral of hope decreased in size. With each
Figure 3. The Spiraling Cycle of Hope and Loss
succeeding pregnancy loss, the curvature decreased on the spiral of hope until only a miniature curvature remained after the fifth loss. The participants who had experienced a fifth pregnancy loss had not lost all expression of hope. They were able to express some hope that they might still be able to have a baby.

The first miscarriage experience introduced the concepts of loss and hope to the participants. Until the women experienced their first miscarriage, they did not acknowledge the possibility of loss or associate it with their pregnancy. The women had expressed the expectation that they would get pregnant and have a baby without any difficulty at all. When the unexpected miscarriage occurred, loss and hope were initially experienced. Hope was introduced because the women's expectation of achieving a pregnancy without any difficulty had been shattered. The element of doubt concerning their ability to give birth to their own children presented the concept of loss to the participants.

The spiral of loss was intertwined with the spiral of hope. The loss spiral began as a petite spiral which originated after the first pregnancy loss. When the spiral of hope was at its widest curvature, the
spiral of loss was at its narrowest curvature. The spiral of loss increased in curvature after each subsequent pregnancy loss. The loss spiral was at its widest curvature after the fifth recurrent loss. This factor reflected the collective experience of the participants after each pregnancy loss, their sense of loss increased and their sense of hope diminished.

In the core category each spiral is dependent on the other; the curvature of hope does not change without a corresponding inverse change in the loss spiral. Each participant's spiral of hope began when the woman decided to conceive or try again. Each participant's spiral of loss began when the woman was aware that fetal demise had occurred or when she suspected that pregnancy loss would occur. The women's goal of giving birth to their own children was the fixed axis around which the interconnected spirals of hope and loss continuously change.

The women described a process which occurred while they were experiencing the spirals of hope and loss. The process is depicted by the selective categories of the recurrent early pregnancy loss experience generated from the constant comparative analysis of the data were as follows: cautious celebrating; losing the pregnancy;
mourning the loss; searching and seeking; deciding what
next; and hope. Figure 4 depicts the partial audit
trail which illustrates the comparing and collapsing of
substantive codes in order to develop selective
categories and the core category.

Cautious Celebrating

Cautious celebrating is the first category in the
basic social psychological process of recurrent early
pregnancy loss. This first category also encompasses
the selective categories of: "confirming the
pregnancy"; "comparing the pregnancy"; "watching for
signs of losing"; and "sharing the GOOD news." For the
women, cautious celebrating meant being excited and
hopeful when first feeling symptoms of pregnancy, being
afraid to confirm their symptoms for fear they might
lose it, always checking to see if they might be
bleeding, still being hopeful yet afraid to tell
others, and finally feeling enough confidence to share
the news with others. After their first loss, each
woman had experienced negative rationalizing comments
and lack of social support from those with whom they
shared the news of their loss. The women acknowledged
the possibility that they might experience another
Substantive Category

- Confirming the Pregnancy
- Comparing the Pregnancy
- Watching for Signs of Losing
- Sharing the "GOOD" News
- Premonition of Losing
- Surprising Event of Losing
- Comparing the Loss Event
- Confirming the Loss
- Mourning Period
- Feeling Depressed
- Sharing the "BAD" News
- Searching for Answers to WHY
- Appraising Options
- Setting Limits
- Trying Again

Selective Category

- Cautious Celebrating
- Losing the Pregnancy
- Mourning the Loss
- Searching and Seeking
- Deciding What Next

Core Category

The Spiraling Cycle of Hope and Loss

Figure 4.

Recurrent Pregnancy Loss
miscarriage and as a result they were cautious in their celebration of the news of their pregnancy.

**Confirming the pregnancy**

The curvature continues on the spiral of hope with the confirmation of the pregnancy. The spiral of hope narrows with each subsequent pregnancy in the spiraling cycle of hope and loss. The confirmation of the pregnancy began with the women's recognition of physical symptoms of pregnancy.

(E) I knew when I was pregnant, and the signs in the breasts...

(H) I didn't get to my period due date but I knew I was pregnant, well, because of the symptoms.

As the physical evidence of pregnancy increased each woman individually evaluated the context and consequences of the condition and how it would affect her future well-being. This mounting physical evidence of pregnancy resulted in the process of transformation and reorganization of her systems to include the roles of mother and parent. The women also started to bond emotionally with the unborn child and acknowledge the new life inside them with the confirmation of the pregnancy.
(D) I missed a period since conception; it was about two and a half months; I waited to have my blood test because you get attached right from the start, you're more attached, your hopes are built up more.

Each participant confirmed her pregnancy at different points in time. Some participants utilized home pregnancy test kits to confirm their pregnancy status.

(A) I had taken that pregnancy test at home from the drug store and I knew I was pregnant because I felt nauseous.

(B) I always did the pregnancy test and then went in, and all of them I had ultrasounds, and most of them I had two ultrasounds.

Two other women stated that confirmation of the pregnancies did not occur until they had ultrasounds.

(D) I had a positive pregnancy test for the last one but I wanted to wait until the ultrasound and see the picture and see the little heart beat. Then you know it's real and you can bond. For me, I had to wait to see the picture.

(G) I was three months and I had seen the doctor and asked what about the ultrasound; I thought he forgot it but he booked me, it took 45 minutes. All I wanted was to be sure everything was alright, it was my third baby you know, just to be alright and to see it you know then everything is ok.

With each subsequent loss the formal confirmation of the pregnancy was delayed. The length of time it takes to reach official confirmation varied among the
participants and increased with each subsequent pregnancy. Nevertheless, confirmation by the health care provider was sought, in the form of blood tests, urine tests, and ultrasound. This confirmation reinforced the act of cautious celebrating.

Delay in officially confirming the pregnancy was an avoidance behaviour exhibited by all the participants. By avoiding "confirming the pregnancy," the women delayed thinking about their past experiences with pregnancy loss. The lack of confirmation suspended the women's acknowledgement that another early pregnancy loss was conceivable.

(F) The doctor told me I was pregnant, I was really confused. I was very confused I couldn't feel happy, I couldn't feel good about this one, I knew it was going to be scary.

(B) After the last time, I was saying maybe I am pregnant but I was scared to go and really check it out...I made the appointment and cancelled. I made another one and postponed it until later on.

The participants expressed a type of magical thinking, a process whereby they felt that the ultimate cause which unleashed the cascading sequela of early pregnancy loss was the act of "confirming the pregnancy."
(E) The third pregnancy I didn't even want to go to a doctor; if this is meant to be it is, and I'm not going in to have them do all those blood tests and ultrasounds. I've never come out of an ultrasound without losing the baby so I'm not having one and that was that!

One woman stated that she thought she was pregnant but refused to see the doctor to confirm her pregnancy because of her past experience.

I didn't want to go to the doctor because I have to have an internal examination and I just don't want it. The last one I wasn't bleeding until he checked me out, then I started bleeding and I lost it.

She finally visited the doctor to confirm the pregnancy after 17 weeks. In an attempt to control and avoid another pregnancy loss the women delayed confirmation of the pregnancy.

(L) You feel robbed when you first find out you're pregnant because you can't get really super excited because you're afraid to get excited. I actually did a home pregnancy test first and then went in; it was confirmed and then I had an ultrasound. I didn't go for a pregnancy test until I was nine weeks pregnant.

(G) I knew the good news that I was pregnant from my urine test; it was positive. After the last time I was saying maybe I am pregnant but I was scared to go and really check it out. I made the appointment; I postponed it.

(J) I knew I was pregnant almost right away 'cause I felt, sick in my stomach; again I
did a home pregnancy test. I knew I was pregnant but I waited to see the doctor. I was nine weeks pregnant but I don't know why I waited so long but I did. When I did see him he did an ultrasound to confirm it and that's how I knew for sure, but I don't know why I waited so long; I knew I was pregnant.

The participants who had experienced three, four and five recurrent losses avoided confirmation of the pregnancy until they had passed the time at which the previous loss had occurred. Once the pregnancy was officially confirmed the women began the perpetual vigil of watching for signs of losing.

**Comparing the pregnancy**

"Comparing the pregnancy" was a behaviour utilized by the women to review the events of their present pregnancy in relation to their previous pregnancies in search of common elements and variations. It was an attempt to control and prevent another loss in that they accentuated the differences in their various experiences, an effort which gave them hope and created a positive emotional environment in which to frame their present pregnancy.

(G) With my previous experience the doctor told me if you're bleeding, spotting, you need bed rest so I just relaxed with bed rest because that's what I did before. After a few days I had a spot as usual and with this spot I knew more or less; but the other pregnancy was not like this.
what made me think that this one was working out from the pregnancy was it was very different than all of the first three put together. All day you feel like you want to be sick but you're not actually sick. I didn't have that before so I thought that there's something different about this one; it's not the same.

I thought, well, this is different and my sickness is different and I was putting these things together saying maybe this one's working and then, so, I started having hope.

Watching for signs of losing

Watching for signs of losing was a behavior exhibited by each of the women. This condition was the result of fear and anxiety associated with their past experience of pregnancy loss and the threat of another. The uncertainty of the pregnancy outcome and the fear of repeating their past miscarriages overwhelmed the women, which stifled the normal emotions of excitement and joy associated with pregnancy confirmation. As one woman poignantly described her mixed emotions:

I sort of held off, I was getting excited and attached but not too enthusiastically in the beginning. I was afraid after I hit the twelveth week; I thought, great, we're past the danger period, no problems and I let myself get really excited.

Watching for signs of losing was a natural response experienced by the women as a direct result of their knowledge of what they had gone through with previous miscarriages. The participants watched for
recognizable cues to impending pregnancy loss such as bleeding and reduced breast tenderness. Even the six women who had already had a baby prior to their recurrent pregnancy loss experience participated in the activity of watching for the presence or absence of indicators of pregnancy loss.

(E) ever since the first one, I think every time I have to go to the washroom, three and four, five times a day I’m checking for spotting...you know, the first sign, checking my breasts constantly to see how sensitive my nipples are.

(A) You go to the bathroom a hundred times a day to check for bleeding. I was having a vaginal discharge that I'd never seen before in the other ones. When I first saw it I thought it's something negative. It was brown and I thought it was blood and I started crying; I said that's it because my other ones started like that.

The underlying motivator for watching for signs of losing was the fear of losing the pregnancy. Watching for signs of losing also had a positive effect because the women were relieved when they didn't find the signs of losing.

(L) My doctor told me what to do if, you know, I should start spotting or anything, and I thought, well, that's okay 'cause this one's a keeper.

(H) ...cause I'd look for these symptoms, you know, and worry that I was going to have another miscarriage.
Sharing the GOOD news

"Sharing the GOOD news" with others fulfilled the purpose of facilitating sociocultural support for the women and the pregnancies. However, with each subsequent loss, the women shared the GOOD news with fewer and fewer people.

(E) After going through like two and three losses I stopped; not only did I stop telling people initially that I was pregnant but my willingness to share it with people changed.

(F) The second time I didn't tell very many people, I just told my roommates, I told my parents, I didn't even tell all of my family which is rare.

(L) I mean it's real to you even though you may not tell all your friends or your family. I told even fewer people this last time.

The women eventually hesitated in sharing their GOOD news with their partners. This hesitation was attributed to the magical thinking associated with initiating the cascading sequela of the recurrent loss event.

(H) Telling friends and family and I was saying to everybody, you know we're pregnant again but don't get excited and they'd say, well, what do you mean? Well, another couple of weeks and then we can get excited.

The participants expressed their unwillingness to share their GOOD news with their partners so that they could gain more chances at trying to have a baby.
After their second and third losses the women had mutually agreed with their partners on the number of times they would try to have a baby. However, after they had experienced repeated losses the women were willing to try more than the number previously agreed on with their partner. As a result the women stopped telling their partners they were pregnant, for if the partner did not know, and a miscarriage occurred, it was not included in the official number agreed upon in the setting limits category.

(B) With the second one I didn't tell anybody not even my husband; I wanted to wait until after three months.

(K) I thought, well, I'd better wait before I tell anybody; I wasn't able to even tell my husband; I just felt it was better to wait.

For these women who stopped sharing their news with their partners and family, their social support system had diminished to one person, their physician.

(L) I was a bit more guarded after each loss. I hadn't told anyone, except my doctor knew. She's really great to talk to but its not the same as family. The next time I'm going to tell my family I'm pregnant right away because they find out after the fact, so why not share the joy and be joyous. You're devastated when it doesn't work out. So not to have that joy you're sort of suppressing that joy but you get all the pain anyway.
Unfortunately the majority of women in this study experienced a whiplash effect when telling people they had previously had miscarried. Instead of validation of their situation, most heard comments which they thought devalued their experience:

(J) "Oh well, don't worry you can always have more... We had a chat and she said the miscarriages are because there's something wrong with the baby and it's the best thing that could ever happen to you. I thought I don't need to hear this."

(I) They don't really understand they think that by saying, oh it must have been, something must have been wrong or it just wasn't meant to be, that it will just make it go away but it doesn't go away.

(E) I got a lot of platitudes from people, oh well at least you can try again and you're young and oh it wasn't meant to be.

"Sharing the GOOD news" with fewer people was a coping behavior employed by the women to protect themselves from the unwanted comments of others which they experienced after their first and the subsequent loss experiences.

The women wanted the unborn child to be accepted by their family, friends and society, and yet they began to carefully select with whom they would share their news. Anyone who had trivialized their Bad news
from previous losses were excluded from the GOOD news in subsequent pregnancy confirmations.

(B) After going through two and three losses I stopped telling people I didn't want to hear all the empty platitudes, nobody said, "I'm really sorry to hear you lost the baby it must be such a loss for you or that sort of thing. I have a friend who's been very supportive and I still share it with her but my willingness to share with others has certainly changed.

Another aspect of being reluctant to share the news of another pregnancy related to fear of rejection by family and friends because of her inability to become a mother. The women deferred "sharing the GOOD news" with others as a protective measure to shield themselves from: the pain of telling people they had miscarried; having to think about whether they should try again; and from having to think about possibly never being able to have a baby.

(K) I would tell my husband and then a few close friends; I thought, well, I better wait until it was three months first before I do let anyone know.

(B) The next time we waited we were waiting twelve weeks, maybe fourteen weeks.

(J) With the second we told a few close friends and some of our family but not everybody. We really were just kind of waiting to see what was going to happen.
Losing the pregnancy

The next step in the recurrent pregnancy loss process was losing the pregnancy. The women talked about more than just the physical aspect of miscarriage. They also identified other losses such as: the loss of self-esteem, the loss of parenthood and the loss of their body not performing the way they perceived it should. With each loss the women realized that they could not control their own bodies and achieve a successful pregnancy.

"Losing the pregnancy" category delineates the collective process experienced by the participants which encompasses the substantive codes of: premonition of losing; surprising event of losing; comparing the loss event; and confirming the loss. Losing the pregnancy category depicts the acknowledgement, by the participants, that they had miscarried once more and they acknowledged the multiple feelings of loss that accompany the miscarriage.

Premonition of Losing

After their first experience with miscarriage the women expressed they had a feeling that another miscarriage might happen to them. The substantive code, Premonition of Losing, illustrates the women's
anticipation and foreboding of another pregnancy loss even though they did not have any signs or symptoms. This premonition reflected the women's anxiety, fear, uncertainty, and lack of control which came as a result of previous losses. Several women expressed their premonitions of losing the pregnancy in the following terms:

(E) you know one afternoon I just, something felt wrong, you know, I knew, there's something definitely wrong and a sense of panic goes through my body; I mean I knew it without having to do the physical tests.

(J) Right from the moment when they said, oh congratulations you're pregnant, I felt very strange; it's hard to describe but I didn't feel like this was a keeper both physically and emotionally something wasn't right but in terms of the pregnancy the doctor said everything was okay, but I just had this feeling, it's just hard to explain, just a feeling.

(A) ...when I got pregnant I had an idea that this might happen again.

Surprising event of Losing

Though the women had premonitions and expected another miscarriage to happen, when it did, it still was a surprise. As one woman so vividly described her emotions:

(L) I was very disappointed and you sort of feel like your body has tricked you again.
How could it do this to you, how could it deceive you...

Several other women expressed their reaction to the surprising event of losing in these terms:

(F) I couldn't believe that I would miscarry again.

(I)...I don't think I really thought that I would lose it again.

(L) ...It was a great surprise, all your hopes are shattered once again.

The fear and anxiety which accompanied each pregnancy was reinforced when the anticipated loss happened. Some of the participants experienced a decrease in their fear of loss as they passed the time of the previous loss, only to be surprised when the miscarriage occurred.

As one woman stated:

(D) We're past the danger period, no problems, and I let myself get attached, and then when I lost it I had a really hard time, I didn't want to believe it, it was such a surprise, just when we passed the danger period

These feelings of surprise reinforced the woman's sense of lack of control over the miscarriage event. It was a reminder that her control over her body and its ability to carry a pregnancy was not and would never be complete.
(I) I remember thinking while I was lying in the O.R. you know just how unfair everything was 'cause it had taken so long to have this, to make this baby and then it was all going to be over in a matter of minutes, it only takes ten minutes or something and I'm thinking, well, six months we tried to have this baby and in a matter of ten minutes it will be all gone... even though I knew that it had died two weeks before, it just seemed so cruel to think that they could just take it away so fast.

Several women experienced feeling of self-blame and questioned why they kept losing their pregnancies. They expressed feelings of being abnormal.

(I) I guess after the third one I really started to think what's wrong with me. I was very surprised that this kept happening. I really started to think that there was really something wrong with me.

(K) You can't help but feel a little bit like you're a little older but defective somehow in terms of not being able to have a baby. In my own mind it's a bit of a stigma not being like other women.

Comparing the loss event

As the women progressed in their process of recurrent pregnancy loss, they began to compare one miscarriage to another. In comparing the loss event each woman examined all aspects of the miscarriage to establish and recognize the unique pattern of losing (Sorenson, 1990).
(C) You start bleeding and that's it, like all the other pregnancies that I've had as soon as I start bleeding I know that's it.

(C) I had another miscarriage and it seems like I'm starting all over again into the same pattern: get pregnant, get excited only to be broken when the miscarriage happens.

(J) I'd started having spotting and it wasn't as bad as the first time, I knew it was going to be kind of the same situation that we were dealing with the first time.

(A) The second one wasn't so hard emotionally because, well, the first one I lost around eleven weeks so it was bigger, it was very painful and plus the shock of it being the first time!

Comparing the loss event also helped them identify a possible cause for the miscarriages. Trying to find a cause was important to reduce self-blame and guilt. As this participant illustrates:

(E) Blaming the loss of both pregnancies on various things either physical or previous actions or whatever just looking for what caused it. Did I go up stairs too many times or I should have missed my dance class looking for what I'd done wrong.

Confirming the loss

After the women experienced two or more miscarriages, they sought a specialist's care to assist them in achieving a successful pregnancy. One aspect of the treatment they received at the Recurrent Loss Clinic was weekly ultrasounds when they did become pregnant. These ultrasounds were utilized to assess
the progress of the pregnancy. Unfortunately, the confirmation of the pregnancy loss was often established during the weekly ultrasound procedure. The following women express their experience of confirmation:

(C) I had four scans, the baby was fine up until seven weeks and then I had a scan I think a week later and it had died between that time.

(D) When they did the scan I just sort of felt, you know, it can't be: you're looking at somebody else's instead of mine.

(I) I thought everything was ok and when I went for my twelve week ultrasound there was no fetal heart beat.

(H) He said it didn't feel like eleven weeks growth so he sent me for an ultrasound and they said the baby had died.

Mourning the Loss

Confirming the loss triggered the women's grieving response to the death of their future child, dreams for their future life, and thoughts of what might have been. The mourning which the women described was painful mourning because they had to relinquish their wishes, hopes and fantasies about what might have been and face the fact that their dreams might never be realized. Each woman reviewed what the pregnancy loss
meant to her self and how the loss would impact upon her present and future life.

The substantive codes of this category were: "the mourning period"; "feeling depressed"; and "sharing the BAD news". Mourning the loss, reflects the prospective and retrospective nature of grieving multiple early reproductive losses. Mourning was a complex process because the past pregnancies were once again mourned along with the current loss. Not only were the women mourning their multiple losses they also started to mourn the loss of their reproductive abilities. The threat of infertility increased with each loss.

Mourning period

Funeral rites are a source of valuable social support; however, for couples who have experienced recurrent early pregnancy loss this critical social support is absent. There are no socially accepted mourning customs which support those who have lost a future baby through miscarriage. Consequently, the participants strove, during their mourning period, to create their own unique rites and rituals which enabled them to mark their significant loss. As one woman explained:
(B)...When we find out we're pregnant we go out and celebrate and have a big dinner so when we miscarry, it's the same thing. Once we think we're okay, then we go out and have an expensive dinner.

Another participant expressed her wish to honor her losses:

(E)...We would burn four candles around the fertility goddess and the candles represented the four unborn children.

Such rites and rituals enabled the women to validate and reinforce the significance of the unborn child's worth. The rites and rituals created to mark the death of the unborn child also indicated the transition from attachment to separation and loss for the women.

The six participants, who had a living child prior to the subsequent loss, marked their mourning period by having quiet, close times with their children. As two women explained:

(I)...I'm glad, I don't know how I would be able to cope not having had [children], they help you get over things like this, it makes you appreciate what having a child is all about, you recall just how precious it really is...

(J)...I'm able to accept it somewhat because I already have a child...that makes it a lot easier and that consoles me quite a bit. I felt very sad and I spent a lot of time playing and hugging, that sort of thing, that made me feel a lot better.
The participants who had no living children expressed their mourning period in these terms:

(L) I thought this happened again and let's get on with it, shove it in the drawer, deal with it later and I think that this time the drawer was full and it started coming back on me.

(K) It's nice to have other people around but you have to resolve it yourself, you can't count on other people, you just have to work it through yourself and no one else can do it. I'm allowed to be upset. I'm allowed to be sad.

(I) You think a lot, did you do something wrong, maybe there was something wrong with the baby, maybe there wasn't. You just try and accept it, but you never do. The weeks go by and you still think, if I were pregnant I'd be sixteen weeks, so you never forget.

The intensity of mourning the loss decreased over time for the women; however, their wish for a child never disappeared. Unanticipated mourning was triggered for some of the participants by anniversary dates and seeing newborn infants the same age as their unborn child would have been. This triggered mourning was transient. Several women described their transient mourning in these terms:

(L) I find when you get close to what your due date was that's very difficult for me; as the due date came closer, I became more depressed. It was due at Christmas, I found that difficult at Christmas.

(E)...Friends having a baby and you can't; I find it more difficult. I guess that
resentment sort of turned me into irrational thinking, oh God who wants one of these barfing drooling crying little things anyway, so I started not even wanting to go and visit her anymore. I just don't want to deal with it.

(D) My friend has a child that's a year old. It's very tough for me especially going and visiting her after the first, second and third miscarriages. I didn't even want to go there anymore, holding a bouncing baby on my lap having just miscarried, it was really tough. I felt resentful, I was very upset, it wasn't supposed to be that way. It creates a sadness and reminders of what I'm missing and this is something I can't have. I just stopped going to visit.

Even though the severity of mourning diminished with time, each loss had made a significant impact upon the women's lives. During the mourning period each participant moved through her grief work at her own pace. Deciding what to do next in her life signalled the end of the mourning period and re-incorporation into her normal life patterns once again.

Feeling Depressed

"Feeling Depressed" is how the women described their mood and the wish to withdraw and the state of low activity which accompanied their mourning period. During their mourning period the women reflected on their losses, and the implications of their losses, in terms of future plans.

(B) We watch TV, actually you sit and just be depressed and feel sad together on the couch.
We just sort of talk about what if and do you really want to have a baby, stuff like that.

(C) It took a long time to feel better, I would sit there and I would mope, then I would realize, I'm depressed and I would just try to focus on other things that I knew I couldn't do if I had a child.

The women described their depression as a time of reflection which helped them to integrate their loss into their present situation. As one woman stated:

(K) I don't think it's bad depression. I think it's really good depression because you... you know its the only chance you get to deal with the loss.

The depression experienced by some of the participants was complicated by personal situations which interfered with their grief work. One woman described her complicated loss experience in the following story:

(I) The hard part I guess this time was I was home with my mom because she was dying, they didn't think she'd live longer than a few days so I went home and of course I was sort of scared cause I knew I was pregnant; and I thought you know with all the sadness around. I knew it was going to be stressful. My mom knew I was pregnant of course she really wanted me to have this baby too and I thought it would keep her going. I went for an ultrasound and I didn't tell her I was going and that's when I found out the baby had died. Now I have two losses to deal with, my mom and the baby. I get the kids off to school and I have lots to do around the house but I just sit and cry, I can't get motivated to do anything.
All of the participants had experienced their losses within a short span of time causing a pile up of emotions. As the number of miscarriages increased the women decreased "sharing the GOOD news" consequently they mourned, veiled in a shroud of silence. This silence complicated the women's grief work because their social networks were unavailable: no one knew of their pregnancies and therefore there was diminished or absent social support for them during their losses.

Sharing the BAD news

The last substantive code of "mourning the loss" category, is, "sharing the BAD news". This category described how the women announced their loss to others. "Sharing the BAD news" helped the women to grieve by involving others who would listen, and honour, the women's perceptions and emotions of their loss. By "sharing the BAD news" the women attempted to maintain their social support network which they created in the "Sharing the GOOD news" category. The women in this study shared the BAD news so that their grief could be acknowledged and validated as normal reactions. However, most of the women received unhelpful comments and no positive support when they shared their BAD news.
(L) One woman I knew she asked, how are you doing, and I said I'm okay. I don't say I'm fine anymore I just say, oh I'm okay 'cause that's how I was feeling. She said, well, it's not like you've had five or six, and I just died inside; I thought how can you be so heartless, it really hurt. Later on I told her, what you said was very hurtful. I know you didn't mean to hurt me but I want you to be aware of it so you don't say it to someone else. I didn't need to hear that because for me this is as bad as hopefully it will get.

(K) I have friends that are so eager to talk about it and that scares you away and there's others that really just don't know what to say or what to do. I didn't share with those people because I didn't want people feeling sorry for me.

(I) Lots of people tell you it's the way it should be because there must have been something wrong with the baby. Well, that hurts a lot. It doesn't make it go away, it doesn't take away the hurt. You stop telling people like that. They only add to the hurt. It's hard for people to understand when you're not showing yet.

(G) One of my co-workers commented, maybe being pregnant is not for you; another one said, I was a frustrated mother. Maybe they were trying to cheer me up telling me, oh, forget it, if you can't have a baby forget it, what's the big deal anyway. I mean it hurts so much when they say that to me, not supportive, it really hurts, it's not a joke.

The women utilized their past experience with loss, and early pregnancy loss, to formulate coping behaviours in their later loss experiences. As the losses increased and the social support networks diminished, women sought acknowledgement and validation for their grief from the only person who knew of their
pregnancies: their physician. Physicians provided support and feedback to reinforce the women's formulated coping behaviours.

With each subsequent loss the participants shared the GOOD news with fewer people; consequently they shared the BAD news with fewer people. As a result, the participants experienced increasing feelings of isolation and despair arising from the lack of acknowledgement of their suffering. They did, however, use their diminished social networks to reduce the negative effects of recurrent early pregnancy loss and to buffer their stress, during their mourning process.

As two participants expressed:

(D) Most people are usually shocked to find out I've only had one child after so many pregnancies and they seem to shut up right away, they'd start saying this and that, and it's so hard, at least they care and I've had five miscarriages.

(E) I stopped telling people after the fact, when it happened because I didn't want to hear that again, you know, oh, you're still young, oh, you can still try again, people around you seem to be, to be very unemotional about it. My mother in law has been fairly supportive, sometimes by not saying anything at all. She was there physically, emotionally, verbally. She was aware of what was going on and it was a help just to know she was aware of my pain.
Searching and Seeking

The category of "searching and seeking" was derived from the substantive code of "searching for answers to why" recurrent miscarriages are occurring. This searching and seeking category was initiated by the confirmation that the pregnancy had failed. The participants sought out specific information to answer the questions as to why they were experiencing recurrent reproductive losses. The participants displayed their problem-solving skills in this category by their abilities: to search for information; to analyze their situation in order to determine alternate courses of action; to weigh alternatives with respect to desired or anticipated outcomes; and to select and implement an appropriate plan of action.

"Searching and seeking" depicted the participants' adaptive behaviours which they utilized to gain control over their future reproductive choices. At the inception of this study, all the participants were attempting to acquire accurate information about the specific cause for repeated reproductive loss. The uncertainty of causation inhibited their grieving process. The lack of information about their individual reproductive losses greatly increased the
participants' anxiety. "Searching and Seeking" for information provided a focus and reduced anxiety because the women were actively doing something which made them feel more in control.

The women in this study expressed their unique need to search and seek the answer as to why they kept having repeated losses in the following ways:

(K) I just want to find out why, I feel like I just want that question answered.

(C)...I needed answers to why this was happening to me and my doctor finally sent me here. I mean I needed answers and I wanted help and I wanted to have a baby Now! not tomorrow...

(B) We went to genetic counselling because it was just part of the process of finding out why.

(D) I've been searching and following other avenues for a cause, everything from Chinese herbs to doing "God IS" workshops, the right thing and the wrong thing and rebirthing. I figure that I do have the power to choose my own mind and I'm in control so there must be a reason I'm creating these miscarriages. What is it that I'm doing or have done to deserve to be punished for my sins so I was looking for answers and blaming it on non-medical answers or non-physical reasons.

"Searching and seeking" helped the women to find the cause of their recurrent losses, which provided the participants with a sense of completeness and fostered a true acceptance of their past losses.
(E) I've just found out, that's a great relief and prior to that, I've been looking for every non-medical reason. I also tried all those sorts of holistic and non-medical approaches to finding the answer. Now I know what caused the other losses and nothing I could have done would have stopped it.

Deciding What Next

"Deciding what next" is the category which encompasses the substantive codes of "appraising options" and "setting limits." This category comprises aspects of the aforementioned "searching and seeking" because the subsequent categories are dependent upon the information gathered.

Appraising Options

"Appraising options" was a behaviour described by the participants, which they utilized in an effort to regain control over their present life circumstances and plan for their future. In "appraising options" the participants explored alternate forms of achieving their dream of having a child. The most prominent option discussed by the participants with their partners was adoption.

(F) If I can't have children, it would mean adoption.

(L) I would love to adopt, my husband's not so open about adoption. I can't live my life hoping he'll change his mind but we've never really had to discuss it in too much detail.
(J) Both my husband and I feel that adoption wouldn't be something that we would be interested in, I don't think that's an option.

Although several participants had stated that adoption was an alternative to having their own child, none of the participants had initiated the adoption process. They still were waiting for answers to the cause of their reproductive losses.

Setting limits

The second substantive code in "Deciding what Next" was "setting limits". "Setting limits" on the number of times the participants would keep trying to have a baby was a prominent behavior described by the women who experienced recurrent early pregnancy loss. "Setting limits" was a form of creating controls and establishing boundaries, whereby the participants continually shifted back and forth between how many attempts they were willing to experience.

(B) Initially we were only going to go for five; probably now that I've had five we will stop, I think, at seven.

Each participant evaluated her own level of coping which initiated the process of setting limits on the number of times she would try to achieve a pregnancy. The number of tries was arbitrary. Nevertheless, it
was dependent upon the individual woman's assessment of the likelihood that she could continue to cope if the situation of pregnancy loss was repeated.

One woman expressed "setting limits" in the following terms:

(E) I can't say no, I can't choose not to have a child because I'd be afraid I would regret it for the rest of my life.

Others decided that they would not try again for their hoped-for child. The decision was a very complex one which weighed on their minds; they had closed the door on becoming a parent and stopped the process of recurrent early pregnancy loss.

(K) I was only going to keep trying until I was forty. I know in my heart that I have to stop. At some point you have to draw the line.

(G) ...Just one more and that's it!

**Hope**

The last selective category of the recurrent early pregnancy loss experience was "Hope." This category comprises the substantive code of "trying again." Though the participants had experienced several early pregnancy losses they were able to continue to hope for their future child.

As one woman explained:
(A) I think after a while, well, crying can't change it so I would just get excited about trying again, put my hopes forward; I'm excited, I want to try again to have a baby.

Another woman explained:

(C) I never lost hope, never give up hope. Just keep trying, it will happen, I'm going to just keep pushing, you gotta never give up.

With each loss the women expressed less confidence in being able to achieve their goal of having their own child. This doubt triggered the women to examine and assess the reality of achieving their goal in using the information they received in the categories of "Searching and Seeking" and "Deciding what next."

As two of the participants stated:

(E) Rationally weighing out whether or not we wanted to try again was this some great sign from God or Mother Nature that it just wasn't meant to be.

(L) I don't know if I can go through this again. I really want to have another child, at least one more, so I'm sure I will try again but it's scary.

Hope diminished when women felt uncertain that they could have successful pregnancies. This uncertainty tipped the balance between hope and loss to the negative side, the loss.

(F) If you're in a state of hope, then you don't have the answer and you're not secure.
For the women who had experienced four and five losses the spiral of hope was now diminished to a petite curvature and the spiral of loss had widened in its largest size. The women had not given up hope, the focus of their hopes had shifted to finding out the cause of the recurrent losses. In seeking help from their physicians the women demonstrated their belief that this help would enable them to achieve what they could not alone.

(I) ...If we didn't want another one we wouldn't be trying, we wouldn't be going through all this, tests and stuff if we didn't want it. Hope means that maybe one day we'll have a third child and that I can be happy again.

The women demonstrated their ability to continue their hope by searching extensively for information and help in finding a cause for their recurrent losses. The women's hoping was also depicted by the expectation that their physician would be able to solve the problem which would enable them to achieve a successful pregnancy.

As one woman explained:

(F) Hope is really a bummer because when you're hoping there's got to be doubt. It means that you're vulnerable and that you are teetering on the edge of not knowing and admit the control is in somebody else's
hands. If you're in a state of hope then you don't have the answer.

The women were also able to focus beyond their present situations and look to their futures. This behaviour shielded them from despair when their hope for a child was not realized in attempts at reproduction. In looking to the future the women once again reviewed their past experiences. Reviewing their past experiences enabled the women to recall their successful life achievements which fostered hope that once again they would be able to try and possibly achieve their goal.

As some of the participants stated:

(H) ...We'll try again, we'll keep practicing till we get it right and that's about it really. My husband and I are both very big on positive thinking in every aspect of our lives. I do believe that we'll get a baby somehow.

(C) ...Through this all I've never given up hope. I just want to keep going, I've never given up.

The women recognized the risk of trying again; however, they still hoped for the positive event of a successful pregnancy and birth of their future child.

(B) Every time you still have more hope and this time there was less hope.
...In my heart I guess it's the hope, I haven't given it up.

Central to the ability of the women to hope was the support they received in their particular life situations. Support from their partners, family, and friends influenced and fostered the circumstances that enabled hope to flourish. The exchange of telling the GOOD news and sharing the BAD news with others established an environment in which the women could express their desires and to have their hopes supported and encouraged by others. All the participants hoped that the present situation of loss would be eliminated in subsequent attempts to have a child.

(C) I would talk to my mom everyday. She was always there for me.

(L) I have support in my family, a couple of my sisters are very supportive.

(L) I think it's really important that you talk it over with your partner that you share, it's easy to focus on your own pain but we share in the planning of our future and hopefully the next time I'll get pregnant and stay pregnant.

The category of hope reflects the women's belief that retaining hope nourishes the desired outcome even in difficult and trying situations. Confronted with the possibility that they were unable ever to have babies, the women remained hopeful. Hope was the light
that illuminated the end of the dark spiral of loss for
the women in this study.

Summary

This chapter has described the analysis of the
data that illustrates the women's experience of
recurrent early pregnancy loss as two interconnected
spirals: Hope and Loss. One complete curvature on the
hope spiral represents a cycle in the complex process
of hope. In addition, one complete curvature on the
loss spiral, which is intertwined with the hope spiral,
represents a cycle in the complex process of loss. The
dominant process affecting the spirals was the loss
event. With each loss the spiral of hope decreased and
an opposite reaction was experienced in the spiral of
loss. The consequence of this phenomenon had a
significant impact on the lives of women who
experienced recurrent pregnancy loss.
Chapter Four

Discussion of Findings

Introduction

Chapter three presented the outcome produced by grounded theory data analysis of women's experience with recurrent early pregnancy loss. In this chapter the findings of the data analysis of women's experience with early pregnancy loss will be discussed in relation to the literature.

In the past two decades researchers have increasingly explored the phenomenon of miscarriage. Researchers have investigated the psychosocial impact and the etiological aspects of the single miscarriage event (Anokute, 1986; Bansen & Stevens, 1992; Beard & Sharp, 1988; Black, 1991; Bryant, 1985; Cohen-Overbeck, Hop, Den Ouden, Pijpers, Johoda & Wladimiroff, 1990; Day & Hooks, 1987; Flagler & Nicoll, 1990; Halmesmaki, Valimaki, Roine, Ylikahri & Ylikorkala, 1989; Herz, 1984; Hutti, 1986; Hutti, 1988b; Iker, 1991; Leppert & Pahlka, 1984; Peppers & Knapp, 1980b; Reed, 1990; Reinharz, 1988; Sammons, 1990; Seibel & Graves, 1980; Stack, 1984; Stucker, Caillard, Collin, Gout & Poyen, 1990; Swanson-Kauffman, 1986). The literature is replete with experiential, self-help and anecdotal

Most theoretical papers which address recurrent pregnancy loss have focused on etiological investigations resulting in advancement of medical understanding and treatment (Ballem, 1991; Bowie, 1991; Colwell & Wilson, 1991; Dahlberg, 1984; Daya, 1988; Denegri, 1991; Fluker, 1991; Laferla, 1986; McBride, 1991; McComb, 1991; Misri, 1991; Poland, Miller, Jones & Trimble, 1977; Rock & Zacur, 1983; Steer, Campbell, Davies, Mason & Collins, 1989; Stephenson & Rowe, 1991; Wells, 1991; Woods & Esposito, 1987). Although miscarriage has been recognized as a crisis event for women, no research has been published in the literature which explores the devastating serial situation of
recurrent early pregnancy loss. As a result, the following discussion will rely on research that has examined the women's experience with the single miscarriage event, loss, grief, hope and related subject areas.

**Paradigms of Hope and Grieving**

The core category that emerged from the data analysis was the spiralling cycle of hope and loss. This core category depicted the basic social process by which the women in the study described how they coped with their unique problem of recurrent early pregnancy loss. The core category captured the meanings of the women's actions, interactions with other people, and accounted for the variations within their behaviour patterns. Each spiral of hope began with the confirmation of the pregnancy. The interwined spiral of loss began when the woman becomes aware that fetal demise had occurred.

**Hope**

In this study, hope was one of the major constructs of the basic social psychological process of recurrent early pregnancy loss. The women expressed their hope as being able to achieve their goal of a successful pregnancy. Even after the fifth pregnancy
loss they were able to express some hope that having their own children was still possible. Hope, the first aspect of the core category, has been explored extensively in the psychological literature (Averil, 1991; Haase, Britt, Coward, Leidy & Penn, 1992; Harvey, Orbuch, Weber, Merbach & Alt, 1992; Herth, 1993; Lange, 1978).

The findings of this present study parallel Averil's (1991) perspective of hope. Averil (1991) stated that "a person cannot hope for something unless they also fear that the hoped for event might not happen therefore hope and fear are two sides of the same coin" (p.15). This perspective of hope was expressed by the women throughout their recurrent loss experience. Although they had experienced repeated losses and feared the possibility of future miscarriages, the participants still hoped to have a successful pregnancy. This perspective of hope expressed by the participants also corresponds to the definition of hope by Haase, Britt, Coward, Leidy and Penn (1992). They defined hope "as an energized mental state involving feelings of uneasiness or uncertainty and characterized by a cognitive, action-orientated expectation that a positive future goal or outcome is
possible" (Haase, Britt, Coward, Leidy & Penn, 1992, p.143).

There are similarities between the description of hope expressed by the participants and the description of hope given by Harvey, Orbuch, Weber, Merbach, and Alt (1992). Harvey, Orbuch, Weber, Merbach, and Alt (1992) found that "hope is a valuable quality of the human mind in times of crisis and stress, because it allows the individual to continue to try to work toward solutions even in situations that stimulate pessimism and hopelessness" (p.121). The findings of the present study demonstrate this perspective of hope through the categories of losing the pregnancy to trying again. The women lost their pregnancies, and yet hope facilitated their search for answers to why they had repeated losses. The answers they received served to increase their hope that they would be successful in their next pregnancy attempts.

Dufault and Martocchio (1985) defined hope as a multidimensional dynamic life force which is composed of two spheres, generalized and particularized that have six common dimensions: affective; cognitive; behavioural; affiliative; temporal and contextual. The authors define generalized hope as that which protects
against despair and casts a positive glow on life. In contrast, particularized hope is concerned with a hoped-for event or object which can improve upon the present life situation (Dufault & Martocchio, 1985). The women in the present study demonstrated particularized hope: even though the women had experienced repeated miscarriages. Their hope focused upon improving their chances, so that in subsequent attempts, they would have babies.

The women repeated the grieving process with each pregnancy loss, yet they retained hope that they would have a child. Dufault & Martocchio (1985) state that the affective dimension of hope focuses upon the sensations and emotions which are part of the coping process. The affective dimension includes: the attraction to the desirable outcome; a sense of personal significance of the outcome for the individual's well-being; feelings of confidence about the outcome; feelings related to the uncertainty of the outcome, and the extensive spectrum of feelings which may accompany hope (Dufault & Martocchio, 1985, p.382). Dufault and Martocchio (1985) found that "when obtaining a hoped for outcome becomes less realistic or impossible, the individual expresses emotions
associated with grieving. Therefore, grieving is part of the hoping process" (p.383). This particular property of the affective dimension of hope was a significant finding of the present study.

The cognitive dimension of hope depicts the process by which the individual perceives and processes reality in relation to hope. As the women in this study waited for their test results they focused their hopes on the results. The women hoped that the results would provide the answer to why they were experiencing repeated losses and that the physician could fix the situation, and thus enable them to have babies. Lange (1978) found that the cognitive dimension of hope reflected the rationalizing chain which shields the affective components of hope from threatening facts of reality. Yates (1993) found that when individuals hope they "hope for a specific desired future outcome, object or event" (p.702). Dufault and Martocchio (1985) concluded that as individuals "wait for new evidence to support their hope they focus on other hopes" (p.384).

The behavioural dimension of hope centers on the action orientation of the hoper and her relationship to hope. This dimension includes actions in the
psychologic, physical, social and religious realms. Psychologic actions of hope are mental activities such as planning, making decisions, and thinking about how to create an environment which would facilitate the achievement of the desired goal. Actively waiting for favorable circumstances is an action in the psychologic realm (Dufault & Martocchio, 1985).

The women in this study demonstrated this dimension of hope in their interactions with others. Sharing the good and bad news was a poignant example of the behavioural dimension of hope whereby the women sought help and support from others to sustain and foster their hope. Harvey, Orbuch, Weber, Merbach, and Alt (1992) found that social interaction of hope begins with confiding an experience or account-making with others to solicit support, empathy, understanding and gain new perspectives on how to deal with present and future situations. Iker (1991) also found that couples who experienced a miscarriage, utilized telling and story sharing to validate, normalize, and gain an understanding of their loss. Searching for answers as to why they experienced repeated losses was another behaviour demonstrated by the women.
Deciding "what next" was a means by which the women in this study sought assistance and support from their partners to achieve their hoped-for baby: this condition can be defined by the phrase "just one more try." The affiliative dimension of hope is composed of social interactions, mutuality attachment and intimacy, which foster hope in the individual (Dufault & Martocchio, 1985). The women in this study demonstrated the affiliative dimension of hope in multiple ways. They sought support from their partners by: sharing the news of the pregnancy and subsequent loss; mutually appraising their options; setting limits on the number of times they would keep trying to have a baby; deciding to try again or stop trying to have a baby. Dufault and Martocchio (1985) postulated that the element of sustaining relationships is critical in fostering and supporting individual hope. The authors also found the relationships included in the affiliative dimension are personal, both with the living and dead, but also the relationship with a spiritual being such as God, Buddha, and the Creator or Mother Nature (Dufault & Martocchio, 1985).

The temporal dimension centers on the hoping individual's experience of time: past, present and
future, in relation to hopes and hoping. The present is defined as "the now that gives the future an opportunity to emerge" (Dufault & Martocchio, 1985, p.388). Another property of the temporal dimension of hope is the protective aspect of keeping hopes non-time specific.

The women in this study demonstrated some evidence of temporal hope in setting limits on the number of times they were willing to try and have a baby. Some of the women had not set a fixed number on how many times they were willing to try, giving themselves a non-specific time frame. This non-specific time frame fostered their hopes of achieving their goal of having a baby. Several participants had established a fixed number of attempts with their partner. However, as the women reached the limit of their specific time frame, they began to adjust the number of times they would try without seeking input from their partners. Dufault and Martocchio (1985) postulate that this type of time frame adjusting behaviour is an attempt to "expand the possible and extend opportunities for positively affecting the hope" (p. 387).

Past experiences help the individuals deal with the present and future events. Past memories of
fulfilled hopes foster hope in individuals. The six women who had their own children utilized this property of temporal hope to sustain and rejuvenate their hope for another child. Dufault and Martocchio (1985) found that in the absence of any past fulfilled hope, individuals sometimes review past events by focusing on successful coping. For the women who did not have their own children they focused on how they had coped with their previous pregnancy losses to demonstrate the temporal dimension of hope. Yates (1993) described this aspect of hope, as, the individual's ability to imagine something which has not yet been realized.

In this study, sharing the GOOD news of their pregnancies with others fulfilled the purpose of facilitating sociocultural support for the women and their pregnancies. Dufault and Martocchio (1985) concluded that the last dimension of hope is contextual, in that the focus is on life situations that surround, influence and are internalized as the individual's hope. It is within the family life cycle that the individual's contextual dimension of hope originates. Phillips (1992) stated that a family is a collection of people who are interrelated, interacting, and interdependent (p. 28). Therefore, the
individual's life cycle is a part of, and is apart from the family system. Carter and McGoldrick (1989) concluded that the individual's life cycle occurs within the family life cycle, which is the primary context of human development" (p. 4).

Other external factors which may influence the patterns of relating and functioning within the individual's life situation are: extended family, friends, neighbours, work, religion, ethnicity and socioeconomic status (Carter & McGoldrick, 1989). The most prominent example of contextual hope demonstrated by the women in this study was the act of sharing the news of their pregnancy and subsequent losses.

In the basic social psychological process of recurrent early pregnancy loss the women were able to retain their hope even after multiple miscarriages. The women's ability to retain hope reflects the belief that when hope is maintained it nourishes the desired outcome even in difficult and trying situations (Yates, 1993). Lange (1978) postulated that "hope makes life under stress tolerable; it is the light at the end of the tunnel" (p. 171). Theut, Pedersen, Zaslow, & Rabinovich (1988) concluded that a subsequent pregnancy after perinatal loss represents another chance to
experience pregnancy; achieve a successful outcome; and re-establish the women's reproductive role within the family. The authors also found that after perinatal loss, women often expressed that they felt their bodies had failed them (Theut, Pedersen, Zaslow & Rabinovich, 1988).

Some of the women in this study stated that they felt different and abnormal because they couldn't have a child. Olshansky (1992) established that previously infertile women perceived themselves as being different and abnormal compared to "normal" pregnant women. In this study, several of the women who previously had a child stated that they did it once and they found it difficult to understand why they were not able to to repeat their past experience. Bernstein, Brill, Levin and Seibel (1992) reported that women who have had a successful reproductive outcome may be motivated primarily by a desire to repeat their positive life experience. Several women expressed that trying to have a baby became the focus of their lives. Reinharz (1988) reported that the subjective state of allowing oneself to get pregnant turns into a state of trying to achieve a successful reproductive outcome and the individual develops a fear of possible infertility.
Sandelowski (1988) found that women could not quit trying to have a child and move on with their lives. This persistence of hope maintained by themselves and others kept them trying to have children. This pursuit of fertility was preventing the women from other life pursuits, but they could not stop trying to have a child as long as hope existed. Olshansky (1990) also found that many infertile couples had focused several years on attaining the goal of a child. Kowalski (1991) concluded that for the couple there is no resolution to perinatal loss, with the passage of time, the loss becomes less all-consuming.

Grieving

There has been an evolution of bereavement theories since the first intrapsychic theory of grief proposed by Freud (1917). The psychological literature abounds with research which has been built on the work of previous theorists such as Freud. Subsequent theories reflect each individual's approach (Adler, 1943; Bowlby, 1980; Carlson, 1978; Carter, 1989; Cody, 1991; Engel, 1962; Kubler-Ross, 1969; Lindemann, 1944; Parkes, 1965; Rando, 1988).

In this study, loss was the second major construct of the basic social psychological process of recurrent
early pregnancy loss. Mourning their losses was a complex process in that the women mourned their past pregnancy losses with each subsequent loss. The women described their losses as painful because they had to relinquish their wishes, hopes and fantasies concerning what might have been and what might never be. The women reviewed the meaning for themselves of the loss and how the loss made an impact upon the present and future.

The lack of socially acceptable mourning customs for miscarriage forced the women to create their own unique rites and rituals to mark their significant losses. These rites and rituals enabled the women to validate and to reinforce the significance of the unborn children. They also helped to initiate the transition from attachment to separation and loss. The women also described transient unanticipated events of mourning, which were triggered by anniversary dates and seeing newborn infants.

McAll and Wilson (1987) concluded that the use of the Christian Eucharist is an acceptable ritual to mark the death of an unborn child. This rite of passage promotes: immediate relief of grief; completion of
grief work; and the psychologic release of the departed into the care of God.

The severity of the women's mourning diminished with time; yet the impact of the loss remained significant in their lives. Each woman progressed through her grief work at her own pace during the mourning period.

Lindemann (1944) utilized the medical model to provide a framework for his classical psychiatric research study which defined the normal course of grief. Engel (1962) utilized general systems theory to explore grief responses. His further research in loss resolution described four phases of loss and grief (Engel, 1964). Kubler-Ross (1969), utilized a five stage model to depict the coping mechanisms by which dying patients resolve their grief. Carter's (1989) study identified nine themes of grief associated with the death of a loved one. Carter also compared and contrasted the study's findings with those of Freud and Kubler-Ross in order to develop her themes associated with bereavement. All of these authors developed conceptualizations of the bereavement process, but their studies held little significance for the present
study except for the fact that they provided a general framework with which to view the grief process.

The findings of the present study have similarities with Rando's (1988) phasic process of grief. She conceptualized grief as a developmental process involving multiple fluctuations over time. She defined grief as the process of experiencing psychological, social, and physical reactions resulting from the individual's perception of a loss (Rando, 1988, p.11). Rando (1988) described grief as a phasic process with three broad categories: avoidance, confrontation and re-establishment. The phase of avoidance is characterized by the emotions of shock, denial and disbelief. The second phase, confrontation is distinguished by a highly emotionally charged state whereby the individual confronts what they have lost. The emotional reactions of grief are most intense during this phase. The last phase is re-establishment which is represented by a gradual decline of the acute grief emotions experienced in the second phase. The individual also experienced emotional and social reentry into their everyday world. Rando (1988) stated that grief is not static following an unalterable course progressing in only one direction, but rather a
"roller-coaster ride of emotion, with foreign feelings, and a confused sense of self" (p.26).

The description given by the women in this study during the categories of cautious celebrating and losing the pregnancy has similar elements which agree with Rando's (1988) avoidance phase. Delaying the confirmation of the loss is similar to the denial described in Rando's avoidance phase. In this study the surprising event of the losing category depicts the women's emotions of shock and disbelief of losing another pregnancy. The second phase of Rando's (1988) process was confrontation. This phase parallels the categories of losing the pregnancy and mourning the loss in this study. The women experienced their most intense emotions of grief during these aspects of the recurrent loss process. The last phase of Rando's (1988) process of grief was reestablishment, which is comparable to this study's categories of searching and seeking, deciding what next, hope and cautious celebrating. Rando (1988) found that there was a decline of acute grief emotions and social re-entry. The women in this study experienced a decline of acute grief emotions and reentry into their social world
which was initiated in the category of searching and seeking.

Swanson-Kauffman (1986) described the process of grief resolution of women who experienced the single event of miscarriage. Consequently there are similarities between all of the categories in her description of early pregnancy loss and the description of the grief process described in this study. Her first category of "coming to know" depicts the acknowledgement by the woman that demise of the pregnancy is unpreventable.

In this study, the women acknowledged the demise of the pregnancy in the second category: losing the pregnancy. Her second category, "losing and gaining," is analogous to losing the pregnancy and mourning the loss categories in this study. The third and fourth categories, "sharing the loss" and "going public" are similar to sharing the bad news in this study's mourning the loss category. Swanson-Kauffman's fifth category, "getting through it" compares to mourning the loss in this study whereby the women signalled the end of their grief by initiating the last three categories. Her final category, "trying again" is equivalent to the
last three categories of this study: "searching and seeking," "deciding what next," and "hope."

Swanson-Kauffman's study does not address the unique aspect of cautious celebrating which was present in this research study. The categories of her study have similar aspects which compare to this study; however, her categories do not illustrate the complex nature of recurrent loss depicted by this research.

The bereavement theories presented earlier in the chapter provide a general description of the process of grief. The resolution of grief follows a distinct process which is not linear in its progression but moves over time to an end point of resolution of the loss. The women in this study demonstrated a similar process; however because the grief process reoccurred it became evident that women who experienced recurrent early pregnancy loss, go through a unique process of grief. The authors whose work seems most relevant to the findings of this study were presented in this discussion (Rando, 1988; Swanson-Kauffman, 1986).

**Maternal Tasks of Pregnancy**

The maternal tasks of pregnancy (Rubin, 1975), and the high-risk mother and the holistic model of childbearing (Snyder, 1979) were utilized in the
present study to form sensitizing concepts prior to data collection and analysis. After data analysis, similarities with Rubin's (1975) research, which supported the findings, were identified. Confirming the pregnancy, in this study, signalled the process of transforming and reorganizing the women's self systems to include the roles of mother and parent. The women also started to bond with their unborn child. Rubin (1967) found that "the childbearing period was assumed to be a preparatory period in maternal role acquisition" (p. 345). The first maternal task of pregnancy, seeking safe passage for self and child through pregnancy, labour and delivery, begins with the confirmation of the pregnancy (Rubin, 1975).

Cautious celebrating of the pregnancy was a protective behaviour demonstrated whereby the women acknowledged the possibility that another miscarriage might occur. Stainton, McNeil and Harvey (1992) suggested that the attainment of the expected and hoped-for maternal role is threatened by the increased level of uncertainty in the high-risk perinatal situation. The authors noted that in a high risk situation the women attempt to achieve the development tasks of pregnancy, however the emphasis is
overshadowed by the uncertainty of the pregnancy outcome.

Some women in this study expressed the desire to confirm their pregnancy by actually visualizing the image of their baby by ultrasound. All the women sought official confirmation, from their physician, of their pregnancy at various times.

Seeking safe passage for self and infant is the first maternal task of pregnancy (Rubin, 1975). Stainton, McNeil and Harvey (1992) found that in the high risk pregnancy there is a distorted reliance on technological and medical information as a means of maintaining control of the pregnancy and ensuring safe passage for the unborn child. Flager and Nicoll (1990) postulated that during pregnancy multiple sources of information are sought to gain information about the probable course of pregnancy. Stainton, McNeil, and Harvey (1992) reported that in the high-risk situation, seeking information becomes a desperate search for meaning. The acceptance of the reality of the pregnancy enables the woman to "bind-in to the idea of the child, her child, during pregnancy" (Rubin, 1975, p.149).
In the present study sharing the GOOD and BAD news was a means used by the women to gain sociocultural support for themselves and their unborn child. Unfortunately, the women shared their news with fewer people after each loss in an effort to protect themselves from unwanted, unhelpful comments by others. The women did not want sympathy from others. The women wanted the people with whom they shared their stories to understand what it was like to have suffered multiple losses and support them in their efforts to have a child. Rubin (1975) found that the second maternal task of pregnancy was "securing and assuring acceptance of the child by persons with whom she is most intimately involved" (p. 147).

Creating a supportive nurturing environment is critical to the successful transition of the women's self-image, beliefs, values, priorities, behaviors patterns, and relationships with others during the pregnancy (Rubin, 1975; Synder, 1979). Flager and Nicoll (1990) described that gaining acceptance of the unborn child by others is an interpersonal and intrapersonal task which occurs in the woman's own personal social situation. Stainton, McNeil and Harvey (1992) also identified that owing to the uncertain
outcome the women's need for acceptance of her unborn child by others is heightened and extends beyond the family network.

The women in this study demonstrated the opposite reaction described by these authors. The women decreased their social support until, in some cases, only their physician knew of their pregnancy. However, Stainton, McNeil and Harvey (1992) cited that "there is a greater involvement of and with more numerous health care professionals in a high risk situation". In this study the women did have increased interactions with their physician at the Recurrent Loss Clinic as part of their treatment protocol. They saw her weekly and used her as a primary support person.

After experiencing repeated pregnancy losses the women delayed confirming their pregnancies in an effort to protect themselves from the realization that another miscarriage could be possible. Binding-in to her unknown child is the third maternal task described by Rubin (1975). Rubin (1975) stated that the maternal task of binding-in was to incorporate the pregnancy and child into the woman's entire self-system. Muller (1990) noted that during the first trimester the pregnant woman binds-in to being pregnant. Flager and
Nicoll (1990) found no precise starting point or timeline for the maternal tasks. However, before acceptance of the pregnancy can occur an awareness of the pregnancy is pivotal. Further to this, the authors concluded that a positive pregnancy test provides tangible evidence of a potential child; however, visualization by ultrasound provides the critical evidence that the pregnancy is real. Stainton, McNeil and Harvey (1992) suggested that women who have experienced perinatal loss attempt to protect themselves in subsequent pregnancies from binding-in to avoid the pain of loss. The authors also reported that, as the pregnancy progresses, protecting themselves against binding-in to the infant is increasingly difficult to maintain. Flager and Nicoll (1991) also suggest that fear of loss may interfere with the woman's binding-in process until the threat of loss has past.

During the process of recurrent pregnancy loss the women in the study focused their lives on having children. While attempting to have a child some women denied themselves vacations. Others focused their time around preparing their homes for the baby's arrival, such as building an extra room or furnishing and
decorating the baby's room. All of the women participated in multiple medical procedures to help isolate a possible cause for their recurrent losses. Rubin (1975) stated that learning to give of herself is the final maternal task of pregnancy. Stainton, McNeil, and Harvey (1992) noted that in a high risk situation giving of oneself is intensified due to the rearranging of family functioning and personal relationships required of the situation.

The Process of Recurrent Early Pregnancy Loss

The next section of this chapter will present the literature used to assist with the discovery of the recurrent early pregnancy loss process. The discussion will be organized under the selective category headings beginning with cautious celebrating.

Cautious Celebrating

The process of cautious celebrating was well articulated by the women in this study. They were quietly hopeful. With each loss the women delayed confirming their pregnancies. The length of time to official confirmation varied among the women and increased with each pregnancy. The women compared their present pregnancy with their previous experiences. This was an attempt by the women to
control and, hopefully, prevent another loss by accentuating the differences, between this pregnancy and previous ones, which created a positive emotional environment for their present pregnancy.

Sorenson (1990) found that women search for consistent indicators to verify and indicate how the pregnancy is proceeding. Comparing the present pregnancy with their past experiences was found by Herz (1984) to be a form of seeking a cause and effect relationship in an effort to reduce self-blame for losses of unknown origin. McCall (1988) postulated that causal attributions are utilized by women to assist the resolution of maternal grief following a miscarriage. However, Sorenson (1990) noted that, when there is lack of consistent symptoms between pregnancies, there is increased anxiety for the expectant mother. Because each pregnancy is different, women do not know how to interpret their symptoms as a result they seek professional confirmation to normalize their symptom patterns. Sorenson (1990) asserts that the physician's opinion is most highly valued when there is a lack of symptom pattern. Olshansky (1990) suggested that when infertile women confirm their pregnancy, they experience a feeling of disbelief; not
trusting the results of the pregnancy tests and not believing that they have achieved their long awaited goal.

Confirming the pregnancy also initiated the women's behaviour of watching for signs of losing. Watching for signs of losing was due to the fear and anxiety associated with having another miscarriage. These emotions overwhelmed the women's normal emotions of joy and excitement associated with confirming a wanted pregnancy.

Bernstein (1990) concluded that when pregnancy does occur for infertile women there is often no sense of celebration. Anxiety overwhelms the excitement for women who have experienced perinatal loss because they are afraid of experiencing another loss (Bernstein, 1990). Theut, Pedersen, Zaslow & Rabinovich's (1988) research showed that there was increased maternal anxiety subsequent to a miscarriage. Harris, Sandelowski & Holditch-Davis, (1991) asserted, when pregnancy does occur for infertile women, there is a sense of reproductive achievement which is overshadowed by waiting to lose, simultaneously mixed with vehement hope for a baby. The authors depicted the waiting to lose phase of their research as one where the infertile
women were constantly alert for signs of impending miscarriage because they had little confidence that their child would be born. Harris, Sandelowski & Holditch-Davis (1991) established that infertile women protected themselves by holding back from celebrating and from believing that the pregnancy would actually result in a baby. This study supports the aforementioned research findings.

During their medical treatments the women received weekly ultrasound. The women found the ultrasound images helped to establish that the pregnancy was real for them. Van Riper, Pridham, Ryff (1992) established that during the perinatal period the expectant mother constructs a mental image of her future child. Witzel & Chartier (1989) concluded that attachment is based upon the fantasies, expectations and hopes for the child. Sandelowski (1988) found that ultrasound converts maternal fantasies of the fetus into reality by providing a real image of the baby. Herz (1984) asserted that bonding is often enhanced by ultrasound visualization because women who have experienced reproductive difficulties have a reluctance to bond which is a self-protective measure. The findings of
this research are similar to what Herz (1984) and Sandelowski (1988) found.

Sharing the GOOD news helped facilitate the incorporation of the unborn child into the family for the women in this study. Carter and McGoldrick (1989) asserted that "families incorporate new members only by birth, adoption, or marriage and members can leave only by death" (p. 5). Brown (1989) reported that during pregnancy all family members develop certain expectations, wishes and fantasies; consequently, the family forms an emotional connection to the unborn child. Van Riper, Pridham, and Ryff (1992) found that during the perinatal period interactions with friends, relatives, and co-workers help to develop the mental image of the infant. Phillips (1992) postulated that the family system has a boundary that is selectively permeable facilitating the movement in and out of information according to the perceived needs of the system.

Social support acts as a buffering or mediating factor in reducing stress and anxiety during pregnancy and provides information and validation for changes the pregnant woman experiences (Curry, 1990; Sorrenson, 1990). Sharing the GOOD news promoted the reduction of
anxiety and provided coping support for the women in their cautious celebrating. Further to this Gersie (1991) stated that social support is an important factor in the coping process.

Relationships provide information and problem-solving skills which an individual can draw on to solve basic tasks and devise strategies for meeting the life cycle transitions of pregnancy. Zachariah (1994) concluded that especially when individuals are under stress and experiencing anxiety, they derive comfort and security from others.

After repeated losses the women shared their GOOD news with fewer and fewer people in an effort to protect themselves from the devaluing comments of others. Olshansky (1992) noted that infertile couples may pull back dramatically from contact with families and fertile friends. Harris, Sandelowski and Holditch-Davis (1991) cited that a protective mechanism for infertile women was to refuse to share the news of the pregnancy too early or to restrict the news to a select group of family or friends.

Some of the women in the study expressed a type of magical thinking. The women felt that the ultimate cause of their multiple losses was the act of
confirming the pregnancy. As a result these women delayed the confirmation of their pregnancy for as long as possible. Rando (1985) noted that magical thinking of childhood was not restricted to the young as it was also described by perinatal bereaved parents. Such parents feared that if they thought or said something it would come to pass in reality. This form of magical thinking resulted in the parents avoiding others, which significantly reduced the social and emotional supports needed for coping with the grief process. Magical thinking is defined by Lesser & Paisner (1985) as an inappropriate assignment of causation which is exacerbated by anxiety, and an intense desire, or hope, for a certain outcome. Berstein, Brille, Levin and Seibel (1992) noted that "as an isolated short-term defense mechanism, magical thinking is a normal human response to stress" (p. 337). Several researchers concluded that magical thinking is utilized as a coping behaviour to buffer the fear and anxiety associated with a cognitively constructed cause of past losses and the uncertain outcome of the present situation (Izard, 1991; Stainton, McNeil & Harvey, 1992; Theut, Pederson, Zaslow & Rabinovich, 1988). Searching for causes provides a sense of inner completeness, and promotes a
true acceptance of the loss (Lazarus & Folkman, 1984; Cassel, 1976; Wispe, 1991).

The women of this study delayed the confirmation of their pregnancy in an effort to eliminate what they felt was the ultimate cause of their losses: the act of confirming the pregnancy. Delaying the confirmation also shielded the women from painful reminders of their past losses. Harris, Sandelowski and Holditch-Davis (1991) established that infertile women experience a superstitious fear of creating the very loss they dread. The women demonstrated this fear by refusing to make too strong a commitment to the pregnancy and not by getting too involved in expectations that would tempt fate and trigger the loss of the pregnancy (Harris, Sandelowski, & Holditch-Davis, 1991).

Kowalski (1991) identified the fact that women who have experienced a perinatal loss often establish milestones relating to the time at which the previous infant died. Passing the milestone reduced anxiety; however, it did not resolve the anxiety owing to the fact that the women were aware that many things could still go wrong during the pregnancy.
Losing the Pregnancy

Losing the pregnancy involved multiple losses for the women in this study. These included the: loss of a significant person; loss of self-esteem; loss of stages of growth and development; loss of a dream; loss of creation (Anderson, 1989; Brown, 1989; Brown, 1992; Friedman & Gradstien, 1982; Gardner & Merenstein, 1986; Hardin & Urbanus, 1986; Herz, 1984; Iker, 1991; Kowalski, 1991; Leppert & Paulka, 1984; Lovell, 1983; Reinharz, 1988). They experienced a loss of self-esteem when their bodies did not function as they wanted. For some of the women their chance of achieving the next development stage of family vanished with the loss of the pregnancy. The women also lost their dreamed-for child.

Kowalski (1991) stated that a loss of self-esteem results for the woman when the body does not perform its designated function of sustaining the pregnancy. When the pregnancy fails, women suffer a loss of self-esteem by virtue of the loss of the parenting role (Brown, 1991; Hardin & Urbanus, 1986). Carter and McGoldrick (1989) concluded that the miscarriage fractures the transformation of the woman's self-system, which is initiated by confirming the pregnancy,
causing the loss of the developmental stage of becoming a parent. Losing the pregnancy eradicates the future child, dreams and thoughts of what might have been (Brown, 1989; Harr & Thistlethwaite, 1990; Rando, 1985).

As the women became pregnant, part of the treatment protocol at the Recurrent Loss Clinic was weekly ultrasound to assess the progress of the pregnancy. Consequently, the confirmation of the pregnancy loss for some of the women was established during their weekly ultrasound. Several authors found that confirming the loss fills a perceptual need by which the woman is able to identify what has been lost (Davidson, 1984; Ryan, Cote-Arsenault & Sugarman, 1990; Stack, 1984). Davidson (1984) concluded that there is a need to confirm that the wished for child was a reality. Further to this, he stated that confirmation of the baby's existence, for the woman, is the most important element in subsequent attempts to resolve feelings of loss. The women had cautiously celebrated their pregnancies in a heightened environment of fearful expectation of a loss. Confirming that the pregnancy had been real and that they had seen an
ultrasound image of their child helped the women to grieve their loss.

Mourning the Loss

After repeated losses the women shared their BAD news with fewer and fewer people. They withdrew from social activities and grieved for their lost child alone. For the women who had a living child prior to their loss, they marked their mourning period by having quiet, close times with their children. Jacob (1993) reported that "the type of death; the relationship of the loss; significance of the relationship; age of the bereaved; past coping strategies; social support systems; physical and mental health status of the person experiencing the loss" are variables which affect the mourning process (p. 1791).

Several authors have identified parental grief as one of the most intense grief reactions which may take a lifetime to resolve (Jacob, 1993; Rando, 1984; Miles, 1985; Demi & Miles, 1986; Parkes & Weiss, 1983; Theut, Pedersen, Zaslow, Cain, Rabinovich & Morihisa, 1989; Toedler, Lasker & Alhadeff, 1988). In the mourning which follows an early pregnancy loss, women relinquish "wishes, hopes, and fantasies about one who could have been but never was" (Leon, 1990, p.35).
Simos (1977) defined mourning as the expression of grief which "involves the specific psychological task of breaking the emotional tie with that which has been lost and eventually reinvesting one's attachment to living people and things" (p. 338). Mourning is a ritual of remembrance, whereby each of the bereaved appraises what the pregnancy loss meant to them individually, subjectively and situationally (Cody, 1991; Hammer, Nichols & Armstrong, 1992; Lazarus & Folkman, 1984).

Mourning rituals associated with other losses, such as last rites, memorial services and funerals, help to provide the bereaved with assistance and information about what society expects from them. In contrast, early pregnancy loss is difficult to mark socially by mourning because there is a difficulty recognizing a life and mourning a death for which there is no visible body (Leon, 1990; Toedler, Lasker & Alhadeff, 1988). There are no rites, rituals, or customs which mark early pregnancy loss, within North American society, to provide guidelines for the bereaved and help with the resolution of the loss (Carlson, 1978; Herz, 1984; Kowalski, 1991; Reinharz, 1988; Rosenfeld, 1991). Some of the women in this
study created their own rites and rituals to help them
mourn the loss of their children.

Mourning the loss was a complex process for the
women in this study owing to the multiple losses
experienced with recurrent early pregnancy loss.
Anderson (1989) stated that grieving in infertility is
a response to the loss of a child and also the loss of
a chance to experience pregnancy (p. 10). Toedter,
Lasker, and Alhadeff (1988) concluded that in perinatal
loss the absence of a visible and publicly acknowledged
"object" to mourn makes the grieving more difficult and
complex. Kowalski (1991) identified the fact that in
perinatal death there is no ability for the woman to
complete the relationship and to say good-bye. For
some of the women in the study, mourning was
complicated by personal life situations which
overshadowed their pregnancy loss. Lederman (1990)
asserts that negative loss events and life stresses
such as the loss of a significant family member can
compound perinatal grief.

Sharing the BAD news for the women promoted
resolution and helped to resolve their loss. However,
most of the women stopped sharing their news after
receiving devaluing comments and no positive support
for their loss. Consequently, the women experienced increasing feelings of isolation and despair by the lack of acknowledgement by others of their suffering. Kowalski (1991) found one of the most powerful factors providing support for parents working through the perinatal bereavement process is the presence of a social network. Sorenson (1990) concluded that women used their social support system to reduce uncertainty, to gather information and to validate their feelings. However, a lack of feedback that acknowledges their view of the situation may lead to further uncertainty and anxiety.

Witzel and Chartier (1989) asserted that there is a general failure by others to respond in a supportive way when miscarriage occurs. Others are often unaware of the depth of attachment between the mother and the unborn infant. Witzel and Chartier (1989) found that friends do not expect, nor are they able, to understand the woman's grief and consequently they afford her little support. Individuals are uncomfortable with grief owing to the difficulty of dealing with their own feelings. As a result they may avoid the issue by ignoring the woman's needs. Witzel and Chartier (1989) concluded that normally supportive relationships may
fail to provide the degree of support that the woman who has experienced a miscarriage has come to expect. Kowalski (1991) found that a lack of awareness or understanding of the importance of the pregnancy leads people to exhibit inappropriate demonstrations of comfort. Hutti (1991) postulated that grieving women often found communication channels closed to them because others avoided and discouraged discussion of the loss. Kowalski (1991) asserted that inappropriate demonstration of comfort by others are attempts to fix the situation for the grieving women, resulting from a genuine interest in alleviating her pain and suffering.

With each subsequent loss the women shared the GOOD news with fewer people which resulted in them sharing the BAD news with fewer people. The women's diminished social networks were utilized to reduce the negative effects of recurrent early pregnancy loss and to buffer their stress during their mourning process. In this study the women recounted their stories of loss in emotional and moving ways, often crying at the remembrance of their lost children. The opportunity to tell their own story of their experience with recurrent loss was important for the women in this study because it provided validation for the significance of their
losses. Iker (1991) asserted that telling and story sharing, promoted normalization of the couple's grief and provided validation for their loss. Kowalski (1991) identified the fact that sharing the news of the loss with others promoted the resolution of grief work by involving family and friends who listen to them and honour the woman's perceptions and feelings of the loss. Witzel and Chartier (1989) reported that the extent of attachment and bonding by the mother can be clearly seen in the women's story of their loss. They speak of the "baby," and the miscarriage tends to be viewed as the loss of a significant person and not as a non event. Wispe (1991) established that telling others of their loss was used by the bereaved as a means of increasing others' awareness of their suffering and the need for the suffering to be alleviated. Gersie (1991) postulated that telling the story of their grief to others is purposeful in that it allows for: expression of feelings and emotions; the experience of "being heard"; having their grief acknowledged and shared; the reception of support; and it allows for the ordinary to return (p. 233). Telling the loss story also allows us to "remember the past with a degree of pleasure, while it is inclusive of our
grief so that we can discover a new imagined future, one which encompasses hope and the belief that change is possible" (Gersie, 1991, p.232).

The women in this study recounted each of their losses in minute detail indicating the profound significance of the losses. Kowalski (1991) stated that the love for this particular infant never leaves but grief behaviours and the investment in the infant subsides sufficiently so that attachment can occur for a new infant (p. 372). Further to this, Kowalski found that the loss remains significant throughout the woman's lifetime. She can recall specifics of the loss event as though it had occurred yesterday (Kowalski, 1991). Anderson (1989) established that functional sorrow is a normal response for infertile women to a life event which significantly jeopardizes the women's feelings of self-worth and restricts their ability to feel in control of their lives. Witzel and Chartier (1989) found that grief could be "exacerbated by reminders of what the woman does not have: the child that did not live to experience the events she sees other mothers and children experiencing" (p. 9). Kowalski (1991) concluded that grief may never end. Anniversary dates, photographs and unexpected visits
from old friends activate acute sadness resulting in a small-scale bereavement process.

Each of the women stated that certain events or situations triggered another transient grieving process for them. Some of the reminders which triggered grief were due dates, other pregnant women and small children. Teel (1991) established that chronic sorrow is a sadness that recurs throughout the lifetime of an individual. The sadness is variable in intensity and is not constant and unrelenting but rather interwoven with periods of neutrality, satisfaction and happiness. The sorrow can be triggered by life stage transitions, anniversary dates and family cycle transitions (Teel, 1991). Further to this Teel concluded that chronic sorrow is part a normal grief response that follows an event of lifelong implications, when the individual is more acutely aware of the relationship that has been lost. Witzel (1989) asserts that a vivid crystal-clear memory of the events surrounding the loss such as specific scenes of the loss, or an anniversary effect either on the date of the miscarriage, or the due date, are indicators of the attachment and the importance of this loss to the mother.
Harris and Thistlewaite (1990) assert that it is imperative that care givers acknowledge and recognize the value of hearing the mother's loss story so as to decrease isolation and vulnerability in her bereavement. Gersie (1991) concluded that we need to mourn the life lived and the life that was not lived. Story telling enables grieving individuals to deal with the present, our very survival depends upon the establishment of this contact (Gersie, 1991). A similar interpretation could be made for the women in this study. They needed to tell their story but lacked a nonjudgemental environment in which to express the significance of their losses.

Six of the women in this study had a child previous to their subsequent losses. These women described the need to be close and to touch their children during their time of mourning. Neugebauer, Kline, O'Connor, Shrout, Johnson, Skodol, Wicks and Susser (1992) stated that for women who miscarry, the presence of living children may afford indirect psychological support because the children represent evidence of past reproductive success.
Searching and Seeking

The women sought specific information to answer the questions as to why they were experiencing recurrent reproductive losses. Some of the women gained the answers for their losses from their various medical tests. Others were still awaiting the results of tests at the conclusion of this study. The information gathered in the searching and seeking category helped to establish what the women would do next. Depending on the answers, some women chose to try and have another child while one woman stopped trying.

In research related to coping and stress, Lazarus and Folkman (1984) found that individuals who seek specific information recover better from illness and stressful situations than those who typically avoid information. Seeking information is a coping strategy utilized by the individual to address the immediate crisis which results from a lack of knowledge, skill or experience (Lazarus & Folkman, 1984). Bowlby (1980) found that information-processing, was a positive attribute of mourning, which enabled the individual to accurately, completely and swiftly process the information brought about by the loss. Cassel (1976)
postulates that informational support is gained in the form of sharing experiences of miscarriage, advice giving and receiving feedback from others. This form of feedback aids an individual in the maintenance of a social identity and a sense of integration during a developmental crisis (Cassel, 1976). Sandelowski (1988) asserted that the most significant expression of ambiguity for infertile women was the absence of knowledge as to why they could not carry a live infant to term. In an effort to reduce ambiguity, infertile women searched for the ultimate cause of their losses by comparing science with religion, rational with the irrational; and the temporal with the spiritual (Sandelowski, 1988, p. 72). Toedler, Lasker and Alhadeff (1988) found that in perinatal death the cause is often unknown. As a result, various myths and the guilt associated with the myths, surface as the cause of the loss.

Deciding what next

In deciding what next the women appraised their options and set limits on the number of times they would try to have a child. Appraising options was a behaviour demonstrated by the women in an effort to gain control over their present life situation.
Setting limits is a form of establishing boundaries and attempting to gain control whereby the women continually shifted back and forth between how many attempts they were willing to make. Setting limits is a positive coping strategy because the individual recognizes that "something must be done to manage the situation" (Lazarus & Folkman, 1984, p.35). Seligman (1975) defined control as one's ability to choose, make decisions and actively create meaning in one's own life. Olshansky (1992) established that setting limits and making such decisions, rather than remaining in "limbo", enables infertile women to view themselves as successful in resolving their infertility.

In appraising options, the women in the study reviewed all the options open to them in achieving a child. Most of the women chose adoption as the primary alternative to having their own child. Sandelowski, Harris and Holditch-Davis (1989) identified the infertile couple's process of negotiating paths to achieving parenthood. Two of the patterns in this process included "taking a break" and "drawing the line". Taking a break depicted the couple withdrawing from the pursuit of parenthood for an undetermined amount of time. In contrast, the authors postulated
that "drawing the line" determined when the couple permanently ceased efforts to achieve parenthood. A notable finding in this pattern was that "couples drew the line on doing (sic) infertility yet still harboured a faint hope that pregnancy might occur". (Sandelowski, Harris & Holditch-Davis, 1989, p.225). Harvey, Orbuch, Weber, Merbach and Alt (1992) noted that hope "involves setting goals, taking action, assuming some control and placing the process of hope within some time frames" (p. 135). The preceding research supports the finding of the present study.

Summary

In this chapter, the research findings of this study were compared with the available literature. There is a paucity of previous research which addresses the woman's experience of recurrent early pregnancy loss. As a result, the core category and its dimensions were discussed in light of related subject areas. Certain aspects of this study's conceptualization were verified while others have not.

The literature is congruent with this study's findings that the complex process of recurrent early pregnancy loss is created and maintained by the interlocking spirals of hope and loss. The spiral of
hope is created when the decision to try again is established. Throughout the process of recurrent pregnancy loss, the cycle of hope diminishes with each subsequent loss. However, the participants maintained enough hope to repeatedly initiate the spiralling cycle of hope and loss. The spiral of loss is created after the first miscarriage experience and increases with each consecutive early pregnancy loss. The informants reported that they shared the news of their pregnancy and loss with fewer and fewer people each time. Several women only shared the news with their physician. This aspect of the recurrent loss experience was not identified within the literature. However, the impact of hope and loss in the perinatal situation have been previously identified in the literature and support the findings of this study.

In the following chapter, the study's summary, conclusions and implications for research will be presented.
Chapter 5

Summary, Conclusions, and Nursing Implications

Multiple studies have explored the phenomena of single miscarriage; however, no empirical studies were identified which isolated and explored the psychosocial aspects of recurrent pregnancy loss. This study was conducted to explore, describe, and delineate the basic patterns common in the experience of recurrent early pregnancy loss from the women's perspectives. Grounded theory was the research methodology chosen for this study because there is a paucity of information which explores and describes the human experience of recurrent early pregnancy loss.

Participants were selected from the Recurrent Loss Clinic at the Women's Health Center, Vancouver, British Columbia. Twelve women participated in this study contributing a total of 18 interviews. All 12 of the participants had experienced at least two consecutive early pregnancy losses. Six of the 12 participants had at least one living child. At the conclusion of this research project, four of the participants were pregnant and one woman had decided to cease efforts to conceive her own child.
The initial interviews were tape-recorded and transcribed. Observations and field notes were written following the interviews to record nonverbal behaviour, to establish description, and to record the researcher's perceptions of the interview. These field notes were added to the transcripts.

Data collection, analysis and verification occurred concurrently. Substantive codes were then further analyzed to establish links and interrelationships and to determine the dimensions of the categories and the theoretical links between each category. The spiralling cycle of hope and loss emerged from the data analysis as the core variable which explained the major behavioural and interactional variation of the recurrent early pregnancy loss process.

Six selective categories and their properties were related to the core variable: cautious celebrating; losing the pregnancy; mourning the loss; searching and seeking; deciding what next; and hope.

In "cautious celebrating", the participants described their conflicting emotions of excitement, anxiety and fear associated with confirming the pregnancy. As the physical evidence of pregnancy
increased the women started to compare their previous pregnancies with the present one. This comparing process was intertwined with excitement because they were pregnant yet the emotions of fear and anxiety overshadowed this excitement as the women were fearful of having another miscarriage. This anxiety and fear was demonstrated by the women constantly watching for physical signs of losing the pregnancy. The anxiety that the participants experienced also was demonstrated in their decreased willingness to share the GOOD news of their pregnancy with others. They shared the news with fewer people until, in some cases, only their physicians knew they were pregnant.

Losing the pregnancy was the second selective category. Several of the participants experienced a premonition of losing the pregnancy which was subsequently followed by the actual event of losing the pregnancy. The women actively participated in comparing losses in an effort to identify a familiar pattern to all their losses. The participants sought confirmation of their loss to establish that the demise of the pregnancy had really occurred.

Confirming the loss triggered the mourning process. Mourning the loss was a complex process
because the past pregnancies were once again mourned along with the current loss. The mourning period was marked by withdrawal and state of low activity in which the women reflected on their losses and the implications of their losses for future plans. Sharing the news of the loss with others was also demonstrated by the women in an effort to share their grief and solicit social support for their loss.

Searching and seeking for answers to why they were experiencing repeated miscarriages demonstrated the women's problem solving skills. Utilizing the information they gained, the women were able to decide what they would do next. They appraised their options and set limits on the number of times they would attempt to have a child. The final category of hope demonstrates that, although the women had experienced several early pregnancy losses, they were still able to continue to hope for having a baby.

The spiralling cycle of hope and loss integrates all the categories in the following ways: it accounts for variation in the behaviours of the women; it allows for overlap between the categories; and it demonstrates the logical links in the process of recurrent early pregnancy loss.
The women in this study experienced the greatest amount of hope after their first pregnancy loss. With each succeeding pregnancy loss, the curvature on the spiral of hope decreased until only a miniature curvature remained after the fifth loss. The intertwined spiral of loss began with a petite spiral which originates after the first pregnancy loss. With each succeeding pregnancy loss, the curvature on the spiral of loss increased. The curvature on the spiral of loss is at its widest point after the fifth loss. The interconnected spirals reflected the collective experience of the women in this study. Their sense of hope diminished as their sense of loss increased; yet enough hope remained to support the women in another attempt to have a baby. These findings indicated that the women's experience of recurrent early loss was substantive in nature.

The results of this study delineated the basic patterns common for the participants in the experience of recurrent early pregnancy loss. The results are not generalizable as they depict the unique experience of the study participants. However, based on the study findings, the following conclusions can be made.
1) The experience of recurrent early pregnancy loss for women is substantive in nature. The process of recurrent early pregnant loss is represented by the intertwined spirals of hope and loss.

2) Women who experience two or more consecutive miscarriages experience a unique grieving process similar yet distinctly different from women who experience a single miscarriage.

3) The basic social psychological process of recurrent early pregnancy loss is described by the spiralling cycle of hope and loss which is created by the selective codes of: confirming the pregnancy; comparing the pregnancy; watching for signs of losing; sharing the GOOD news; premonitions of losing; the surprising event of losing; comparing the loss event; confirming the loss; mourning period; feeling depressed; sharing the BAD news; searching for answers as to WHY; appraising options; and setting limits and trying again.

4) Women who experience recurrent pregnancy loss share the news of their pregnancy with fewer people after each loss. As a result their social support networks diminished to only their physician after multiple losses.
5) Women who experience recurrent early pregnancy loss experience transient episodes of grief triggered by reminders of their losses.

6) There is no absolute number of times women who experience recurrent pregnancy loss will try to have a baby.

7) The women's grief diminishes with time but the loss is never resolved.

8) Finding answers as to why the women experienced recurrent loss helps them to appraise their options and make future plans with respect to reproduction.

9) These women are sensitive to the devaluing comments and rationalizations of others.

10) The women want a non-judgmental environment in which to tell their loss stories.

**Implications for Nursing Research**

This study's findings suggest that the basic social psychological process of recurrent early pregnancy loss is a multifaceted process. Further research would increase understanding of the recurrent early pregnancy loss process.

1) Replication of this study with a more racially and culturally mixed sample may reveal a greater variation
of responses resulting in an altered composite of the recurrent early pregnancy loss process.

2) Replication of this study with a larger sample size would enhance and possibly reveal a greater variation in the composite of recurrent early pregnancy loss process.

3) Replication of this study exploring the process of recurrent early pregnancy loss from the father's perspective would enhance the health care providers understanding of the husband's experience with recurrent loss.

4) Replication of this study exploring the couple's experience of recurrent early pregnancy loss would enhance our understanding and improve care for these couples.

5) Replication of this study exploring the extended family's experience with the couple who experience recurrent pregnancy loss may provide valuable information on social support for these couples.

6) Replication of this study exploring the experience of women who experience recurrent early pregnancy loss of unwanted pregnancies will enhance the health providers understanding of these women's grief experience.
7) An exploratory study of bonding with their new babies for couples who have a history of previous recurrent early pregnancy loss would provide a pattern of behaviours which could be compared with present research on bonding of fertile couples.
8) An exploratory study which describes and explores the transient process of grieving after recurrent pregnancy loss which was delineated by the women in this study would enable health care providers to deliver sensitive care.

Implications for Nursing Practice

The findings of this study suggest the following implications for nursing practice.

1) Nurses must recognize and acknowledge the complexity of losses which accompanies the process of recurrent early pregnancy loss so that they can provide sensitive, appropriate care.

2) Nurses must use effective therapeutic communication skills so that the woman's losses can be acknowledged and validated.

3) Nurses must use effective active listening skills to observe and acknowledge the woman's perception of the meaning of her pregnancy loss. This
information will be utilized to formulate effective nursing care for the individual.

4) Nurses must use effective therapeutic communication skills so that they can provide the needed information or help the woman access the information she needs from some other source. This process also provides an environment for the nurse in which to correct misinformation on the part of the woman.

5) Increased understanding, by nurses, of the needs and concerns of these women would facilitate establishment of a telephone support system whereby the attending nurse could contact discharged women in order to offer verbal support and information during the first week following loss.

6) Increased understanding, on the part of public health nurses, of the needs and concerns of these women would facilitate establishment of a follow-up home visit program for the first week after loss in order to increase support for women who experience recurrent pregnancy losses.

7) Increased understanding, on the part of nurses, of the needs and concerns of women who experience
recurrent pregnancy loss would facilitate a family framework assessment in order to evaluate social support and the needs of care for the client.

8) Nurses should create more opportunities for informal forums between women who have experienced recurrent early pregnancy loss and skilled educators in order to provide an environment for the women to share their stories and receive empathy, validation of their losses, support and assistance in coping with their life situations.

**Implications for Nursing Education**

The findings of this study suggest the following implications for nursing education.

1) Nursing educators should include recurrent early pregnancy loss content when teaching about loss and grief in order to increase competent application of current knowledge. This increased knowledge would facilitate effective data assessment, nursing diagnoses, interventions, and outcomes of care for women experiencing recurrent early pregnancy losses.

2) Nursing educators should include recurrent early pregnancy loss content within communication skills education. These efforts would increase the
nurses' participation in: listening, understanding, clarifying, and defining the woman's perception of her loss. In addition, these skills would facilitate increased effective communication between the nurse, client and the client's support systems, e.g. partner, family and friends.

3) Nursing educators should create more opportunities to formally disseminate the current research in order to increase awareness of the significant impact of recurrent early pregnancy loss on women's lives. Workshops and seminars should be provided to facilitate dissemination. Possible target groups would be: Ambulatory Care Nurses Group, Operating Room Nurses Group, Community Health Nurses Group, Emergency Nurses Group, Holistic Nurses Group, Home Care Nurses Professional Practice Group, Nurse Educators Interest Group, Perinatal Nurses, Psychiatric-Mental Health Nursing Practice Group, and Palliative Care and Bereavement Support Group.

4) Hospital based nurse educators should provide in-service education programs in order to disseminate information on the unique process of recurrent
early pregnancy loss. These programs would increase understanding of the needs and concerns of these women in order to facilitate sensitive, appropriate care by health care providers. Target groups for the in-services would include: emergency staff; operating room staff; recovery room nurses; perinatal staff; day-surgery staff; public health liaison personnel; pastoral care workers; social workers and mental health nurses.

Conclusion

In conclusion, this study has explored and described the basic social psychological process of recurrent early pregnancy loss. The results indicate that the process of recurrent pregnancy loss is unique, intertwined with aspects of hope and loss. Hope diminished with each loss until only a minute amount remained after the fifth loss. With each succeeding pregnancy loss, the women experienced a mourning process. The grief was significant; however, it diminished over time, a factor which enabled the women to experience renewed hope and to try again to have other children. It is hoped that the findings of this study will facilitate a greater understanding by health care providers of effective therapeutic courses of
recovery and care for these women through their process of recurrent early pregnancy loss.
References


Appendix A

Sample Interview Questions
Sample Interview Questions

1. Tell me about what it has been like for you to have been through two miscarriages?

2. What kind of effect did your losses have on your personal relationships?

3. What kind of effect did the care you received have on your overall experience with miscarriage?
Appendix B

Introductory Letter
Dear:

My name is Catherine Hogan. I am a registered nurse and I am currently a student in the Master of Science in Nursing Program at the University of British Columbia. I am doing a research study with women who have experienced two or more recurrent miscarriages. I believe that it is important to explore human experiences by asking the people who live them to teach me about them. It is hoped that the results of this study will enable nurses to provide improved quality of care to women who experience recurrent early pregnancy loss.

If you agree to participate, you will be interviewed by myself about your experience with recurrent early pregnancy loss. Interviews will last approximately one hour and two to three are planned. I will arrange to interview you at a time that is mutually convenient and in a setting of your choice. The interview will be audiotaped and then transcribed. If you wish, you may refuse to answer any of the questions during the interview. Following the completion of the study, the tapes will be erased. Your privacy will be protected at all times. Any information that you share will be held in the strictest confidence and you will never be identified in any published or unpublished materials. You may withdraw from the study at any time without jeopardy or prejudice to your health care.

If you wish to participate in this study, please sign the accompanying consent form and retain a copy for your records. I will call you and arrange an interview time that is convenient for you. If you have any questions prior to signing the consent form, please telephone me at 222-1673, or my thesis supervisor, Professor Elaine Carty at 822-7444.

Sincerely,

Catherine Hogan R.N., B.S.N.
MSN Student, UBC School of Nursing
Appendix C

Participant Consent Form
Participant Consent Form

I agree to participate in the nursing research study "A Grounded theory study of women who experience recurrent early pregnancy loss" to be conducted by Catherine Hogan R.N., B.S.N., who is a graduate student in the Master's of Science in Nursing program at the University of British Columbia.

I understand that my participation includes two to three audiotaped interviews, with Catherine, at a location of my choice. I understand that the interviews will be transcribed for analysis and will be modified as necessary to conceal my identity. I understand that my name or other identifying information will not be associated with any published or unpublished material arising from this study. I further understand that audiotapes will be erased upon completion of this study.

I understand that my participation is voluntary and that I may withdraw at anytime without jeopardizing any health care being received by me. I understand that I have the right to refuse to answer any interview questions.

I understand that I may clarify any further questions by contacting Catherine Hogan at 222-1673, or Professor Elaine Barry at 822-7444.

My signature on this form verifies my intention to participate in this study. I have received a copy of this consent form for my records.

__________________________  __________________________  __________
Participant's signature    Telephone number  Date

__________________________  __________
Witness  Date

__________________________  __________
Investigator's signature    Date
Appendix D

First Miscarriage Experience
Appendix D

The First Miscarriage

- Confirming the Pregnancy
- Sharing the “GOOD” News
- Shock and Fear of the Losing Event
- Confirming the Loss
- Mourning Period
- Sharing the “BAD” News
- Seeking Information on Miscarriage
- Searching for Answers to WHY
- Trying Again

Celebrating
Losing
Mourning
Searching and Seeking
HOPE