WOMEN'S EXPERIENCE OF LIVEBIRTH
AFTER STILLBIRTH

by

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ABSTRACT

Women who experience pregnancy subsequent to stillbirth have a powerful history that changes their life and future childbearing. Over the last decade, women who have experienced livebirth after stillbirth have begun to describe an emotionally laden, high anxiety period in their lives.

The purpose of this study is to further understand the physical and psychological experience of livebirth following a stillbirth by listening to women's narratives of their experience through the continuum of the pregnancy, labour, birth, and postpartum periods. The goal of the research is to provide insights that could assist in improving health care to this vulnerable subset of women.

Using an interpretive description design, 14 women were interviewed who had a history of stillbirth and who had subsequently delivered a healthy baby or were currently pregnant with a healthy fetus. Findings that were generated from a constant comparative analysis of the data supported the findings of other authors in regards to a pregnancy experience that is fraught with anxiety, fear, and depression. In addition, women's experience of labour and birth may include such psychological or emotional phenomena as flashbacks, numbness, or dissociation during labour and birth.

The women's need for reassurance, control, and choice during the continuum of the subsequent pregnancy was a strong emerging theme throughout the findings of this study. Additional themes included a powerful urgency to get pregnant again, a need for the history of stillbirth to be known by health care providers, recognition that psychological and emotional work in the postpartum period overrides physical discomfort, and the importance of the sex of the baby. An interpretation of these
women's accounts allows us to challenge some current beliefs and practices, such as the preferred mode of delivery for both the stillbirth and the subsequent livebirth. In addition, the women's diverse experiences of interactions with the health care system and the health care professionals within it reflected patterns and themes within both positive and negative interactions. This study provides a context within which health care providers can examine and improve their practice regarding care for women experiencing livebirth after stillbirth.
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DEDICATION

To my mother, Dorothy Annette Redfearn Keith (1922-2004),
who always knew I'd be a doctor some day.
CHAPTER ONE
INTRODUCTION

Childbirth has traditionally been “women’s work,” a “part of nature,” in which some newborns survived and some died. Historically, how women coped with a baby’s death was largely a private matter. Although the experience of losing a child is often cited as the most painful type of loss (Jacob & Sandrett-Hibdon, 1994; Kubler-Ross, 1969), it is also a human life experience that is uncomfortable for society. It is important to research such “uncomfortable” life experiences in order to increase our understanding and potentially remove the social boundaries that prohibit open communication about these fundamental experiences. Serious studies of women’s experience of perinatal loss did not begin until the 1970s.

Difficult life events that are not commonly shared, such as the loss of a baby, cause many of us to “turn a blind eye” to those experiencing them. Turning a blind eye may be the result of an inability to handle another’s pain or of the desire to maintain distance from the possibility that that pain could one day be our own. For caregivers, the ways in which we interpret or identify with the experience of poor pregnancy outcome have a potential impact on how we provide care for the women concerned. Furthermore, how care provided for women experiencing a pregnancy loss has the additional potential to impact their experience of a subsequent birth.

Background of the Study

Many women perceive a pregnancy loss, regardless of the gestation, as the loss of a child. The literature addressing perinatal loss has grown in the last 30 years, and is now
considerable. As a result of the growing body of research, particularly regarding management of stillbirth (e.g., providing keepsakes, photographs, encouraging holding the baby, etc.), the special needs of women and families experiencing a perinatal loss are now better acknowledged and practice changes have been incorporated into hospital policies over the last 15 years.

The impact of the experience of perinatal loss on a subsequent pregnancy and birth has become the topic of a growing body of literature, particularly in the last 10 years. The work done to date has begun the process of developing a clearer understanding of women’s experience of subsequent pregnancy after loss, particularly in terms of the experience of pregnancy itself (Armstrong & Hutti, 1998; Côté-Arsenault, 2003a; Côté-Arsenault & Marshall, 2000; Turton, Hughes, Evans, & Fainman, 2001). However, despite the growing knowledge base in this field, two areas require further attention.

First, more research is needed to address women’s experience through the continuum of the subsequent pregnancy experience, including pre-conception, pregnancy, labour, birth, and postpartum, in order to more accurately apprehend the overall nature of the experience. The literature that does address the continuum of the experience either focuses on specific elements such as depression and anxiety (Hughes, Turton, & Evans, 1999), addresses the experience with couples without separating out women’s and partners’ experiences (Phipps, 1985-6), or acknowledges an exploratory study from a clinician’s perspective (Lever-Hense, 1994). Of note, the earlier studies by both Lever-Hense and Phipps focus on the population of women or couples who specifically experienced stillbirth. The majority of the more recent literature addresses pregnancy subsequent to “perinatal” loss that includes spontaneous and therapeutic abortions, late
trimester abortions, stillbirths, and neonatal deaths. Although all perinatal loss is potentially tragic and, arguably, the grief component is therefore likely to be similar, I believe the experience of stillbirth can be differentiated from the other types of perinatal loss.

The findings of some studies of perinatal loss indicate that the interpretation of the loss and the resolution of grief of early and late pregnancy losses are different (Theut, Zaslow, Rabinovich, Bartko, & Morihisa, 1990). Other studies suggest that perinatal loss, regardless of the gestation, provokes similar grief responses (Côté-Arsenault & Mahlangu, 1998). However, stillbirth can be seen as distinct from the other types of perinatal loss, particularly in terms of the labour and delivery experience. Stillbirth requires that labour and birth occur despite the knowledge that a live baby will not be the outcome, while women who experience newborn death have the experience of having given birth to a living child. Although women who have miscarriages can often undergo a different type of labour and birth to deliver the embryo or fetus, it would seem that women carrying a pregnancy to term inevitably have more time to attach. Women's experience of labour and birth in a pregnancy following stillbirth is not well understood and needs to be examined in the context of the whole pregnancy experience.

**Background of the Researcher**

My clinical background as a midwife and perinatal nurse includes 25 years of caring for women throughout pregnancy, labour and birth, and postpartum. As a perinatal nurse, I spent 15 years caring for women in the labour and delivery ward of a busy

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1 Women experiencing miscarriage have up to 6-8 hours of contractions before passing the embryo or fetus, particularly women who are having their miscarriage at home. They may also have to collect the products and bring them to the lab -- in some instances the embryo is very clearly outlined.
community hospital and consequently provided care for many women who experienced the labour and birth of a stillborn fetus. I believed that the care provided to women during the experience of stillbirth would impact not only their future memory of the event, but also potentially their ongoing health. I often noticed discomfort in colleagues faced with providing care to these women. I also recognized that I seemed to provide care for women with a fetal loss more frequently than my colleagues as I often volunteered (or was volunteered) for the assignment. My interest in this research was generated as a result of these caregiving experiences.

In addition to my experience as a care provider, I also provided care for women who experienced a stillbirth from a management perspective. I was Head Nurse of Labour and Delivery for 7 years and also of Antepartum and Postpartum for 2 years. As Head Nurse of Labour and Delivery, I retained keepsakes (pictures, hair locks, etc.) for those women who were unable to take them, for various reasons, at the time of the birth. Most returned for these keepsakes at a later time and discussed with me the impact of the experience on their lives and the ways in which the care that was provided had assisted or hampered their grieving.

In addition to their experience of stillbirth, women talked about their readiness, or lack of readiness, to undertake another pregnancy. I have been fortunate enough sometimes to care for those same women through the pregnancy, labour, and birth of a subsequent livebirth. My observations as a caregiver and perinatal educator, along with my discussions with other caregivers, have resulted in a belief that the experience of giving birth to a healthy infant following the experience of a stillbirth is different from the experience of women without such a background. In particular, the experience of
labour and birth seemed to require that significant additional reassurance be offered by
the care provider; furthermore, women’s process through labour appeared to be affected
by the previous labour that had resulted in a stillbirth.

Purpose of the Study

The primary goal of this research project is to further understand the physical and
psychological experience of livebirth following a stillbirth through listening to women’s
narratives of the experience. By listening to women describe their experience we raise the
profile of this small subset of women and begin to remove the implicit social boundaries
surrounding discussion of stillbirth. Whereas much of the perinatal loss literature
addresses all loss regardless of the gestation, the focus of this study is limited to women
experiencing a stillbirth. In this study I separate out the experience of stillbirth (gestation
greater than 20 weeks) so as to allow the findings to be specific to the selected
population. This permits examination of the potential for the specific experience of
stillbirth to affect the subsequent pregnancy experience.

In addition, the research attempts to identify similarities and differences in the
women’s experiences, in order to consider potential patterns that might inform caregiving
practice. The act of describing not only what is happening, but why it may be happening,
has the potential to facilitate the identification of nursing/midwifery care interventions
that can enhance or mitigate the experience. Women’s descriptions of care interventions
that they perceive to be beneficial or detrimental have the potential to influence care
delivery in the future.
The findings from the study could assist in the development of practice standards for health care providers in nursing and in other disciplines such as psychology and midwifery. The ultimate goal is to improve the quality of perinatal care to women.

Significance of the Study

We know from the existing literature that subsequent pregnancy after stillbirth is fraught with anxiety and potential for complicated grieving, although the actual incidence of such grieving is low (Côté-Arsenault, Bidlack, & Humm, 2001; Crowther, 1995; Franche & Mikhail, 1999; Hughes et al., 1999; Hunfeld, Agterberg, Wladimiroff, & Passchier, 1996; Turton et al., 2001). We also know that changes in practice and interventions designed to facilitate healthy grieving are helpful, perhaps even essential. Although the picture of subsequent pregnancy after loss is becoming clearer, a gap remains regarding the continuum of preconception to postpartum, particularly the labour and delivery experience. Although the existing research on subsequent pregnancy highlights reducing anxiety as a primary concern for intervention, it largely overlooks the anxiety-provoking experience of labour and birth. Research that seeks to describe the continuum of the subsequent pregnancy experience, which offers explanatory suggestions, and identifies appropriate care recommendations, would move the current state of knowledge forward. Indeed, some authors have recommended longitudinal and prospective studies that address the full course of the subsequent pregnancy (Franche & Mikhail, 1999; Lamb, 2002). Others have also recommended further examination of caregiver interventions (Côté-Arsenault & Mahlangu, 1999). Contributing to improved health care delivery for women is a significant potential contribution of this research.
Research Objectives

The specific research objectives are:

1. To generate knowledge, awareness, and understanding of women’s experience of livebirth following an unexpected stillbirth.

2. To apply new knowledge to contribute to the improvement of health care to women experiencing a livebirth with a history of stillbirth.

Research Questions

Based on the objectives, the specific research questions are:

1. What is the impact of stillbirth on a subsequent pregnancy, labour, and birth of a healthy newborn?

2. What are the physical and psychological components of the perinatal experience in a pregnancy that follows a stillbirth?

3. What caregiver interventions assist/impede the experience of livebirth following stillbirth?

Defining Key Terms

Perinatal

The perinatal period includes pregnancy, labour, birth, and postpartum, generally to a period of 6 weeks. Perinatal often includes the period of pre-conception, although this remains the subject of some controversy. The impact of stillbirth on subsequent livebirth will be defined by the participants and included within the continuum of pre-conception to postpartum.

Stillbirth

Stillbirth in this study is defined according to the Department of Vital Statistics in British Columbia as greater than 20 weeks’ gestation with no signs of life at birth. Also,
for the purpose of this study, stillbirth refers to an unexpected event, one in which pregnancy was anticipated to be healthy until the intrauterine death occurred.

**Livebirth**

Livebirth in this study is defined as birth at term (greater than 36 weeks and 7 days gestation) in which a healthy newborn was delivered.

**Healthy newborn**

The term “healthy newborn” includes all livebirths who require minimal resuscitative support at birth. The defining criterion will be that the baby is well enough to be cradled in his/her mother’s arms by 10 minutes of age. I have deliberately chosen not to use Apgar\(^2\) scores due to the subjective nature of the score, the poor inter-rater reliability between scorers, and the poor relationship between the assigned score and care decisions (e.g. some babies with 5-minute Apgar scores of 6 are cared for routinely, others go to Special Care Nurseries).

**Organization of the Thesis**

In the current chapter, I introduce the research topic and specific objectives. Chapter two begins with a summary of the literature related to stillbirth as a context within which to understand the growing body of literature about pregnancy following perinatal loss. The majority of chapter two examines the literature that addresses the effect of perinatal loss (and stillbirth in particular) on a subsequent pregnancy.

Chapter three outlines the research methodology, beginning with the philosophical and theoretical orientation that influences my approach to the research, and

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\(^2\) Apgar scoring is a tool used to assess newborn health at birth. A score out of ten is assigned to all newborns at one and five minutes (and sometimes 10 minutes) respectively.
then proceeds with a description of the research design and the procedures used to obtain a sample, collect and analyse the data, and maintain rigor.

Chapters four and five comprise the findings of this study. Chapter four describes women's stories of stillbirth as a context within which to understand the experience of livebirth after stillbirth, which is described in Chapter five. Women’s voices are threaded throughout the findings as exemplars of their experience.

Chapters six and seven conclude the dissertation with a discussion of the positioning of this study within the existing knowledge and implications for clinical practice, education, and future research.

Summary

The loss of a baby is recognized as a difficult life experience, both by people who have experienced it, and people who have not. The social boundaries surrounding discussion of stillbirth make integration of the experience for those who experience it particularly difficult. In addition, the potential for the experience to impact future childbearing is likely to be significant. The primary goal of this research project is to further our understanding of the physical and psychological experience of livebirth following a stillbirth, by listening to women’s narratives of the experience. It is my hope that this study contributes to increased awareness of the specific experience, improve the provision of health care to the selected population, and begin to remove the social boundaries surrounding discussion of stillbirth.
CHAPTER TWO

REVIEW OF THE LITERATURE

Introduction

The existing literature suggests a growing interest in the experience of women in a pregnancy subsequent to stillbirth, although the data are still limited. The literature regarding the experience of pregnancy subsequent to stillbirth provides several areas of commonality, but many questions remain unanswered, or the subject of continuing debate.

In order to understand the research on pregnancy subsequent to stillbirth, it is important to understand the context of the experience of stillbirth from which it derives. The literature regarding stillbirth is extensive. A summary overview of what is known follows, in order to establish the context of the literature of pregnancy subsequent to stillbirth and to understand the progression of knowledge.

Overview of the State of Knowledge Regarding Stillbirth

Discomfort of caregivers and the lack of understanding for parental and caregiver response to perinatal loss have resulted in a long history of poorly managed care. Caregivers ignored the loss, recommending that parents move on as quickly as possible. Interventions that are now recognized as harmful, such as removing the child as quickly as possible after birth without parents having the opportunity to see or hold their child, not allowing discussion of the experience, and placing mothers of stillborns in common rooms with mothers of live children, were commonplace (Lewis, 1979; Borg & Lasker, 1981).
In the 1970s research began to describe the experience of perinatal loss and recommend strategies to facilitate grieving (Cohen, Zilkha, Middleton, & O’Donohue, 1978; Kennell, Slyter, & Klaus, 1970), and this continued through the 1980s. Stillbirth was still not recognized as a “social death” (Doka, 1987, 1989), meaning that parents did not have the socially recognized right to grieve for a stillborn. However, the “rugby pass” management of stillbirth as described by Lewis (1976, 1979) was gradually acknowledged as inappropriate and harmful, and the meaning of stillborn loss for parents began to be recognized as a real loss requiring grieving (Bourne & Lewis, 1984; Bowlby, 1980; Toedter, Lasker, & Alhadeff, 1988). More recently it has been noted that parents of stillborns grieve the loss of a baby, loss of future hopes and dreams, and loss of the ideal child (Brown, 1993).

During the 1980s and 1990s, programs of information, counselling, and support were recommended and implemented and hospital practices began to include policies and checklists to provide guidance for caregivers in meeting parents’ needs (Lasker & Toedter, 1994). Accepted interventions that were thought to assist in resolution of grief included recognising the meaning of the loss for the parents using appropriate terminology as identified by the parents (baby versus miscarriage), facilitating contact with the baby, providing mementoes such as pictures, lock of hair, footprints, etc., facilitating grieving rituals as desired (baptism, memorial service, or funeral), providing honest information (an explanation of the death as a priority if possible), encouraging open communication, assisting in the making of choices, and providing support (Brown, 1992; Lasker & Toedter, 1994; Lovell, 1983; Malacrida, 1998; Robertson & Kavanaugh, 1998; Taner-Leff, 1987).
More extensive research was published in the 1990s. These later studies are diverse and focus on a variety of themes: circumstances surrounding the loss, sense of failure, the problem of few or no memories, disenfranchised grief, isolation, somatic complaints, gender differences (Radestad, Nordin, Steineck, & Sjogren, 1998; Wallerstedt & Higgins, 1994); themes related to change, expectations, inexpressibility (Solari-Twadell, Bunkers, Wang, & Snyder, 1995); significance of the loss (Brown, 1993); and effectiveness of coping and intervention strategies (Gardner, 1999; Harrigan, Naber, Jensen, Tse, & Perez, 1993; Hopper, 1991; Murray, Terry, Vance, Battistuta, & Connelly, 2000). Accessing helpful emotional and practical support appears to be the most crucial intervention strategy in alleviating distress following traumatic childbirth (Allen, 1998).

As a result of the research of the last 30 years, most of which focused on the acute incident and a brief aftermath, programs of intervention and routine practices for dealing with parents suffering a perinatal loss have changed considerably. Lasker and Toedter (1994) evaluated the changes in practice by inquiring into patient satisfaction with hospital care and interventions following pregnancy loss, and suggested that the changes in practice over time were considered both valuable and “essential” by the 194 participants.

The most recent literature in this field has begun to explore the needs of nurses, midwives, and other health care professionals as they recognize the impact of their own feelings when caring for bereaved parents (Foster, 1996; Gardner, 1999; Thomas, 1990).
Effect of Stillbirth on a Subsequent Pregnancy

Allen (1998), among others (e.g., Lyons, 1998), has reported that all women who experienced labours that they perceived as traumatic (not exclusively as a result of perinatal loss) identified intense feelings of not being in control. Symptoms include intrusive imagery concerning the labour, self-blame, inability to cope, mistrust of others, anger, tearfulness, guilt, panic, and feeling stressed (Allen, 1999; DSM IV, 1994). The experience of previous distressing labours led to fear and avoidance of future childbirth (Allen, 1998; Lyons, 1998; Niven, 1992; Ryding, 1993). This appeared to occur even if the distress was short-lived (Allen). It may logically follow that these feelings may be intensified when a new pregnancy is considered after a live child has not been obtained as a result of the birth.

The lay literature has had a significant impact on the progression of knowledge regarding perinatal loss. The literature is full of personal narratives and clinical practice reflections, particularly around the experience of the loss. Bereaved parents Borg and Lasker offer a comprehensive account of the experience of pregnancy loss in When pregnancy fails (1981), which includes the experience of stillbirth and feelings about having another baby. In this account, parents, care providers, clergy, lawyers, funeral directors, and childbirth educators all contributed input in order to approximate the lived experience. Moreover, the sensitive and emotional nature of the experience has stirred creative writing such as short stories and poetry (Fertig, 1989; Mock, 1997), and published personal accounts in magazines such as the Mothering magazine, Parents magazine, and Canadian Living. In addition, Internet websites (e.g., SPALS – Subsequent Pregnancy After Loss Support, Parenting After Loss) have been created
which include poignant stories of lost pregnancies and babies along with information and contacts for support.

The professional literature has followed a similar path in that there is a growing body of material related to perinatal loss and the impact of the loss on a subsequent pregnancy. As previously noted, it is important to clarify that the literature on perinatal loss does not necessarily incorporate the experience of stillbirth. Perinatal loss in the generic sense includes miscarriage, stillbirth, and neonatal death to 28 days. Much of the recent literature relates to perinatal loss in which the specific experience of stillbirth is included in the broader context. The findings of such studies are often applicable to the experience of stillbirth particularly insofar as the pregnancy part of the continuum is concerned. The existing perinatal loss literature thus focuses predominantly on the specific experience of pregnancy as a component of the continuum of pregnancy - postpartum (Côté-Arsenault, 2003; Côté-Arsenault et al., 2001; Côté-Arsenault & Dombeck, 2001; Côté-Arsenault & Morrison-Beedy, 2001; Crowther, 1995; Franche & Mikhail, 1999; Hunfeld et al., 1996; Melender, 2002; Turton et al., 2001).

A synthesis of the perinatal loss literature reveals certain commonalities in the experience of subsequent pregnancy after loss (including stillbirth), including heightened anxiety, potential for depression, attachment or replacement issues, and some conflicting information around timing of the pregnancy and healing of grief. A survey of the state of knowledge regarding these findings follows.
Common Findings in Women’s Experience of Subsequent Pregnancy after Loss

Anxiety

The anxiety experienced by mothers following a pregnancy loss is well documented (Armstrong & Hutti, 1998; Côté-Arsenault & Mahlangu, 1999; Hunfeld, Taselaar-Kloos, Agterberg, Wladimiroff, & Passchier, 1997; Lewis, 1978; Phipps, 1985-86; Theut, Pedersen, Zaslow, & Rabinovich, 1988). Ryding (1993) found that the fear of losing a baby was the most powerful trigger for post traumatic stress (PTS) reactions among mothers who demanded a Caesarean section in a pregnancy subsequent to one which was perceived as traumatic. Ryding also reported that PTS may recur during subsequent pregnancies or be triggered during delivery.

In the last 5 years, Côté-Arsenault with others has produced a body of work addressing women’s experience of subsequent pregnancy following perinatal loss (Côté-Arsenault, 2003a, 2003b; Côté-Arsenault & Freije, 2004; Côté-Arsenault et al., 2001; Côté-Arsenault & Dombeck, 2001; Côté-Arsenault & Mahlangu, 1999; Côté-Arsenault & Marshall, 2000; Côté-Arsenault & Morrison-Beedy, 2001). In three of the publications (1999, 2001, 2003a) the women studied were between 17 and 28 weeks pregnant with a history of miscarriage, stillbirth, or neonatal death. The remaining studies sampled women at varying stages of pregnancy, however the majority of the women in the samples suffered early pregnancy losses. Côté-Arsenault’s studies addressed the impact of loss on the mother’s emotions and concerns arising in the subsequent pregnancy, her changed expectations for pregnancy, the relationship of anxiety to the assignment of fetal personhood, and the weaving of the lost babies into the fabric of the family. Data were collected through the use of questionnaires, focus groups, individual interviews and
participant observation. The most common finding across Côté-Arsenault’s studies was the lack of impact of gestational age of the loss on the women’s increased anxiety. Other themes among the findings included wondering if the baby was healthy, expecting to lose the baby, changed expectations, a perception of “changed self,” and an increased need for vigilance. Côté-Arsenault concludes by recommending that caregivers need to acknowledge mothers’ increased anxiety and provide additional support.

Although most stillbirths are unexplained, Hunfeld et al. (1996) considered the quality of life and anxiety in pregnancies after late pregnancy loss in which the loss was due to congenital anomalies. Hunfeld et al divided pregnant women with (n=24) and without (n=26) a previous pregnancy loss into those who had subsequently delivered a healthy baby and those who had not. They found that women who experienced a loss and had not yet delivered a healthy infant showed a lower quality of life and increased pregnancy-related anxiety.

In summary, heightened anxiety during a subsequent pregnancy is the most frequently documented variation from normal pregnancy experience in the reviewed studies.

Depression

Women experiencing a pregnancy subsequent to stillbirth are also vulnerable to depression. Most of the literature reports that anxiety and depression occur together in a subsequent pregnancy. According to Boyle, Vance, Najman, and Thearle (1996), despite some variance (11% to 35%) at different periods from 2 months to 2 years, the reported rates of anxiety and depression are comparable across various studies.
Boyle et al. (1996) found anxiety and depression rates to be significantly higher between subjects and controls for greater than 2 years following the loss. The scores (using the Delusions Symptoms States Inventory) were highest at 2 months following the loss and showed the most significant drop prior to 8 months. In their cohort study of 60 women with a history of loss > 18 weeks, Hughes et al. (1999) also found significantly higher rates of depression and anxiety in this population than among controls. However, unlike Boyle et al., they found that depression and anxiety in the third trimester was also significantly higher than controls. In addition, Hughes et al. found that pregnancies conceived at least 12 months after the loss were similar to controls at all measurements. They concluded that vulnerability to depression and anxiety is related to time since stillbirth.

Franche and Mikhail (1999) executed a comparison study using couples to assess emotional adjustment with and without a history of loss. The 31 pregnant women and 28 men in the loss group reported significantly more depressive symptomatology and pregnancy-specific anxiety than couples in the comparison group. In addition, women reported more depressive symptoms than men. Franche and Mikhail’s findings differentiated depression from anxiety in that depression in women was associated with their belief that their behaviour affected fetal health, while anxiety was associated with the belief that health care professionals’ behaviour affected fetal health.

In summary, the majority of the studies of subsequent pregnancy after stillbirth report that anxiety and depression are usually found together, particularly if the pregnancy occurs close to the loss. They also reported that women experiencing a pregnancy subsequent to a stillbirth were significantly more vulnerable to depression than
the general pregnant population, and described such depression as occurring up to 2 years after the loss.

**Attachment and Replacement Issues**

A lack of investment in the pregnancy is typical of subsequent pregnancy after loss and is often evidenced by delayed engagement in social customs such as announcing the pregnancy or not desiring a baby shower. According to Phipps (1985-86), this behaviour should be interpreted as self-protective rather than maladaptive, and extra time to allow for questions and reassurance should be provided during the antenatal period.

In their comparative study of 31 expectant mothers, 15 of whom were in their first pregnancy and 16 of whom had experienced a late pregnancy loss, Armstrong & Hutti (1998) examined the relationship between anxiety and prenatal attachment. Using the Pregnancy Outcome questionnaire to measure anxiety and the Prenatal Attachment Inventory to measure prenatal attachment, they found that the loss group showed significantly greater levels of anxiety and significantly lower levels of perinatal attachment when compared with primiparous women of a similar gestational age. In a follow-up three-group comparative study, Armstrong (2002) looked at couples’ emotional distress and prenatal attachment following perinatal loss but found no relationship between pregnancy-specific anxiety and depressive symptoms and prenatal attachment. She found that couples with and without a history of loss did not differ in their level of prenatal attachment. Armstrong (2002) does not offer a potential explanation for the discordant findings of both studies, although she acknowledges that the research is conflicting on the relationship of anxiety and depression on prenatal
attachment and recommends replication of studies such as these in order to identify what
the association may be.

Lack of investment in a pregnancy can result in what Phipps describes as an
"analogue" (1985-1986, p.244) of the "vulnerable child syndrome" (Green & Solnit, 1964). This concept and the similar "replacement child syndrome" (Poznanski, 1972), were introduced into the literature approximately 30 years ago. Although these syndromes pertain to the difficulty of parenting following the loss of a child (as opposed to fetuses or newborns), Green and Solnit (1964) posited that unusual concerns during pregnancy and unresolved grief reactions were also listed as possible predisposing factors. Cohen (1966) also concluded that stresses need not involve the child itself but any situation in which adaptation to the pregnancy could be affected. As noted by Robertson and Kavanaugh (1998), the applicability of these theories' terminology to perinatal loss is somewhat suspect, given that the understanding of perinatal loss has changed considerably since the 1960s and 70s. Nevertheless, the more recent literature still refers to decisions made by mothers to get pregnant again quickly in order to "replace" the child (Lever-Hense, 1994).

Post-natal attachment has also been addressed in the context of infants born subsequent to stillbirth. Hughes, Turton, Hopper, and McGauley (2001) studied the relationship between previous stillbirth and the pattern of attachment to the next child. In their case-controlled study, Hughes et al. considered factors in the mother that might be associated with the pattern of infant attachment. Data collected at 12 months of age showed a significant increase in disorganization of attachment to the mother compared
with controls. This was strongly predicted by unresolved loss in the mother as measured by the Adult Attachment Interview.

In summary, the literature identifies both prenatal and postnatal attachment as potential difficulties for women experiencing a pregnancy following perinatal loss. The potential for a "replacement child" is an older concept that continues to be debated in the literature in terms of its applicability to perinatal loss.

Literature that Addresses the Continuum of Pregnancy to Postpartum

Women’s experience of subsequent pregnancy after loss has been captured most holistically in descriptive and grounded theory nursing and psychological studies (Brost & Kenney, 1992; Lever-Hense, 1994; Phipps, 1985-86). Lever-Hense provided a comprehensive description of 10 women’s experiences of livebirth after stillbirth, creating a cognitive map explaining the maternal processes of livebirth following a stillbirth. Her findings indicated a shared experience that included such themes as fearing reoccurrence, resisting attachment, protecting the child, attempting to replace the child, accepting the live child, and acknowledging the lost child. Although Lever-Hense did not discuss the experience of labour and delivery, she addressed the experience of mothering.

In an exploratory descriptive study using grounded theory methods of analysis as described by Glaser and Strauss (1967), Phipps’s (1985-86) interviewed 15 couples with a history of a previous stillbirth or neonatal death who had had a healthy newborn subsequent to the loss. Phipps found that these couples often conceptualized the pregnancy as a task to be completed. The goal was to produce a healthy baby and this created a state of increased anxiety and hypervigilance in the mothers. Some mothers
were reassured by increased medical procedures, while others found that such procedures exacerbated their anxiety. Implications for caregivers included suggesting a minimum wait period of 6 months prior to the next pregnancy, including fathers in the pregnancy management, considering anniversaries of the child’s birth or death as crisis points, and alerting hospital staff to the women’s history.

Robertson and Kavanaugh (1998) and Warland (2000) have both provided a clinical practice summary of the needs of parents and suggested care interventions in a pregnancy subsequent to stillbirth from a nursing and midwifery perspective respectively. Both studies recommend care plans that traverse the continuum of the antenatal period through the postnatal period and suggest that care can be instrumental in helping parents achieve a positive birth experience. Specific interventions are suggested in each of the pregnancy, labour and birth, and postpartum periods such as reinforcing the health of the baby, extra home visits, providing education, allowing time to discuss parental fears and answer questions, providing continuity of care in labour, and supporting parents to attach to their new baby.

In summary, the research literature addressing the continuum of the experience of pregnancy after loss is scant. Professional clinical literature accounts for the majority of the small amount of information available. Phipps’s grounded theory study (1985-86) and the clinical practice literature show similar results and recommendations. Nursing and midwifery care interventions are suggested that have the potential to assist women in navigating the anxiety-laden subsequent pregnancy experience.
Unanswered Questions and Contentious Issues

Timing of the Next Pregnancy

The literature shows a lack of consensus regarding either the optimal time to attempt conception and/or the potential detrimental effects of an “early” pregnancy after loss. Suggested wait periods range from no time restriction to at least one year, or until grief is resolved. The continuing debate hinges on the potential for increased depression in an early pregnancy, versus a belief that pregnancy can be a healing mechanism for grief (Borg & Lasker, 1981; Hughes et al., 1999; Phipps, 1985-6; Smith & Borgers, 1988-89).

Turton et al. (2001) looked at a cohort of pregnant women in the third trimester and one year postpartum whose previous pregnancy ended in stillbirth to assess depression, anxiety, and PTSD symptoms. They found that PTSD symptoms were prevalent in the pregnancy following stillbirth, particularly when conception occurred close to the loss. They suggested that there may be an advantage in delaying pregnancy for at least a year to reduce the likelihood of distressing symptoms arising in the next pregnancy.

Davis, Stewart, and Harmon (1989) and Crowther (1995) interviewed 24 and 48 women, respectively, to ascertain their perception of postponing a subsequent pregnancy. Both found that women were dissatisfied with the medical advice provided, and that most women conceived again quickly despite medical advice to the contrary. In addition, In their descriptive study, Montigny et al. (1999) found that parents were often given conflicting information regarding when to become pregnant again. They concluded that
parents should be given purely factual information and allowed to make their own decisions.

Finally, given the potential for women to conceive quickly after a loss and the added potential for depressive symptoms in the subsequent pregnancy, Wallerstedt, Lilley, and Baldwin (2003) promote interconceptional counselling as a beneficial alternative to improve outcomes, acknowledge fears and anxieties, evaluate genetic risks, facilitate grieving, and explore attachment and parenting issues.

In summary, the majority of the literature continues to recommend a waiting period prior to conceiving a pregnancy after a loss in order to allow resolution of grieving and prevent depression in the next pregnancy. However, there is evidence that women’s reactions to this advice are not positive, and that their subsequent actions regarding conception rarely comply with the advice.

Resolution or Reintegration of Grief

Grief over the death of a child, and consequent mourning of the loss, are generally expected. However, some authors have argued that perinatal grief is significantly different than other forms of grieving (Wallerstedt & Higgins, 1994; Solari-Twadell et al., 1995). Research has shown that up to 25% of mothers meet criteria for a psychiatric case of “prolonged mourning” one year after this type of loss, compared to only 10% in the general population (Hughes, 1998). Hunfeld, Wladimiroff, Verhage, and Passchier (1995) found that feelings of inadequacy, previous life events, and previous mental health treatment contributed to more intense grief reactions. However, Kitzinger (1992) cautions that giving women a psychiatric label following an overwhelmingly stressful labour risks locating the issue (problematically) away from her care to a problem with her mind.
It is difficult to identify the boundary beyond which normal grieving becomes abnormal. Lewis and Page (1978) described a case of unresolved mourning that resulted in a profound disturbance in mothering. They opined that women who are pregnant are at particular risk and that quick pregnancies result in a replacement baby that is difficult for the mother to separate from the stillbirth. More recently, Theut et al. (1990) surveyed 25 couples to inquire into whether grief reactions persisted 16 months after the loss. They found that women who experienced a late pregnancy loss (as different from men, or women who had an early pregnancy loss) were more likely to display higher grief scores (using the Perinatal Bereavement Scale) during the subsequent pregnancy. They concluded that there is a degree of emotional attachment in both early and late pregnancy losses but that the physical relationship is more intense for parents who experience a late loss.

Rachman (1990) suggests that emotional processing needs to occur in order for healing to take place. His work on emotional processing indicates that successful processing can be gauged by the person’s ability to talk about, see, listen to, or be reminded of emotional events without experiencing distress or disruptions. However, Rachman did not focus specifically on a perinatal population, so his findings must be interpreted with caution in terms of their applicability to perinatal grief.

It has been suggested that in a pregnancy subsequent to perinatal loss the pregnancy itself can be part of the healing process (Robertson & Kavanaugh, 1992). In addition, Griffiths (1999) stated that parents are more likely to be depressed soon after the stillbirth than after a lengthy period of bereavement. He posited that depression in
pregnancies that occur shortly after the stillbirth is potentially part of the natural course of bereavement, rather than a sign of complicated mourning.

In summary, resolution of grief may be assisted or hampered by a subsequent pregnancy. Some of the literature indicates that women who are pregnant are at particular risk for complicated grieving and the earlier the pregnancy occurs following the loss, the more likely it is that grief will be unresolved. The question of whether this is a normal grieving process or complicated in the face of pregnancy is undetermined. In addition, there is some evidence that women who experienced late pregnancy losses as opposed to early losses are more likely to display higher grief scores.

**The Experience of Labour and Birth**

There is very little in the literature regarding women's experience of labour and birth in a pregnancy subsequent to stillbirth. Although the research highlights reduction in anxiety as a primary concern for intervention in subsequent pregnancy, the experience of labour and delivery, perhaps the most anxiety-producing stage of the perinatal experience, is largely overlooked in favour of pre- and post-labour interventions and support. Even in those studies that include the labour and birth component (Caelli, Downie, & Knox, 1999; Lever-Hense, 1994; Phipps, 1985-6; Robertson & Kavanaugh, 1998), the experience remains poorly understood. While these studies suggest that the experience of labour and birth is difficult and potentially significantly different from the experience of women who have not experienced a loss, they find insufficient data on which to make any particular inferences. Recommendations include offering fetal monitoring throughout labour (Caelli et al.; Phipps), assisting with fear (Lever-Hense), ensuring that hospital staff is aware of past history, providing a private room, and
providing immediate evidence of the baby’s health (Phipps; Robertson & Kavanaugh), using a sensitive approach, and providing parents with information on the status of labour (Robertson & Kavanaugh).

It is widely accepted that support in labour for normal childbirth is associated with decreased medical interventions and increased client satisfaction (Hodnett, 1996). It stands to reason that appropriate support in labour for those women at higher need for support may contribute to improving care for women experiencing labour following a birth that resulted in a dead baby. The literature currently lacks research identifying what “appropriate” care might be for these women, and this area needs to be further addressed in the context of the overall pregnancy experience.

In summary, the experience of labour and birth is a critical part of the continuum of pregnancy and should not be divorced from the context of women’s experience of a subsequent pregnancy after a stillbirth. The few studies that include a labour and birth component make some recommendations for changes in practice. However, the labour and birth component requires further and fuller examination.

Caregiver Interventions

Despite a growing body of literature on subsequent pregnancy after stillbirth, caregivers are still unsure regarding the specifics of appropriate or supportive care for these women. There is a growing recognition that offering support at crucial milestones or anniversary points, explaining procedures such as antenatal tests and fetal monitoring, providing factual information, and giving reassurances about normalcy once the baby is born is helpful (Robertson & Kavanaugh, 1992). It is clear that caregivers may be unsure about the appropriate level of surveillance.
Communication between caregivers and their pregnant women patients is always seen as important but all too often the experience is reported as unsatisfactory. Crowther (1995) interviewed 48 pregnant women, 28 of whom had had a previous stillbirth and 20 a neonatal death. She found dissatisfaction with the quality of information provided by hospital staff, rapid conception despite medical advice to the contrary, and poor or confused knowledge of the events surrounding the death.

According to Brost and Kenney (1992), the goal of the health professional during subsequent pregnancy is to help integrate the previous loss into parents’ lives. Brost and Kenney’s clinical article summarizes the literature on pregnancy following perinatal loss and makes recommendations for nursing practice such as increasing sensitivity, building trust, being prepared for explosive emotions, and becoming aware of the various dimensions of grief responses.

Caelli, Downie, and Letendre (2002) report on a midwife-led program in Australia and Canada providing psychological and social support for parents during a pregnancy subsequent to the loss of a stillbirth. This 52-week program offers education for mothers and fathers, 24-hour telephone support, and the presence of a midwife as a support person in labour if desired. Caelli et al. conclude that the program has very positive effects on the adjustment to parenthood, improves expectations of the pregnancy, and provides additional benefits by connecting couples with a similar history.

In summary, psychological and social support are commonly referred to in the literature as a critical component of care for women experiencing a pregnancy subsequent to stillbirth. Unfortunately, communication between caregivers and the women is not
always positive and recommendations in the literature are often too broad and/or vague to be helpful. However, one detailed outline of a program of support was described.

**Subsequent Pregnancy Outcomes**

Medical studies have addressed the significance of previous stillbirth in light of maternal and neonatal outcomes of subsequent pregnancies and/or appropriate interventions for pregnancies following a stillbirth. Robson, Chan, Keane, and Luke (2001) compared the outcomes of subsequent births to women with a previous unexplained stillbirth with matched controls to determine if women with a previous stillbirth were at higher risk of adverse perinatal outcomes. They found that women in the previous loss group had increased incidences of gestational diabetes, induction of labour and Caesarean section, fetal distress and postpartum hemorrhage, and forceps and emergency Caesarean delivery.

Freeman, Dorchester, Anderson, and Garite (1985) studied 7052 patients between 1976 and 1982 to ascertain information on antepartum fetal heart rate monitoring. Of these women, 337 gave a history of stillbirth as a reason for testing. Previous stillbirth significantly increased the risk for a positive contraction stress test and respiratory distress syndrome in the neonates. Therefore, previous stillbirth was found to be a significant risk factor, primarily when associated with a diagnosis of hypertension or intrauterine growth restriction. Weeks, Asrat, Morgan, Nageotte, Thomas, and Freeman (1995) added to Freeman et al.'s work and examined when fetal testing should begin in 300 otherwise healthy patients with a history of stillbirth. They found no pregnancy interventions for abnormal tests before 32 weeks’ gestation and therefore recommended postponing fetal monitoring until at least 32 weeks’ gestation.
In their comparative study of 92 women with pregnancies subsequent to stillbirth, Heinonen and Kirkinen (2000) found that pregnancies following stillbirth are at somewhat higher risk for pre-term birth and low birth weight infants than controls. However, their findings also indicate that the probability of a favourable outcome is good. Similarly, in their case-control study of several thousand newborns in South America, Paz, Otaño, Gadow, and Castilla's (1992) also identified that previous fetal loss is associated with low birth weight and certain malformations. In their study assessing the compliance of women in Zaire with referral for hospital delivery (previous stillbirth was included as a rationale to refer), Dujardin, Clarysse, Criel, De Brouwere, and Wangata's (1995) found that the mothers' perception of risk was a crucial factor in both the decision-making and the compliance rate for women with a history of stillbirth. The overall referral success was only 33% and depended on the women's cultural interpretation of the event.

In summary, medical studies regarding outcome of pregnancy subsequent to stillbirth identify several potential adverse outcomes that caregivers need to be aware of. The history of stillbirth therefore appears to be a risk factor in the management of a subsequent pregnancy.

**Summary of the State of Knowledge of Subsequent Pregnancy**

Despite a growing body of lay and professional literature investigating the experience of livebirth following stillbirth, there is still relatively little information available. Within the continuum of care from pregnancy to postpartum, the experience of pregnancy itself has received the most attention. There is good evidence that heightened anxiety and depression are common during subsequent pregnancy, especially when the
pregnancy occurs close to the time of the loss. In addition, the literature notes potential difficulties regarding feelings of replacement of the dead child, and potential for decreased prenatal attachment to the fetus.

The literature reflects conflicting information regarding the timing of the next pregnancy and the mechanism of resolution of grief. Some studies continue to recommend a waiting period between the loss and a subsequent pregnancy, whereas others recognize that women’s actions related to doctor advice is often incongruent with that advice, and recommend that information and education be provided to women so that they may make their own decisions. Whether or not a subsequent pregnancy is related to the process of resolution of grief remains unclear. Grief scores are significantly higher for women who have experienced a loss than for controls. Psychological and social support is recommended for women who become pregnant following a loss, particularly when the pregnancy occurs close to the loss.

Literature on the experience of labour and birth for women experiencing a pregnancy subsequent to stillbirth is scant, although some studies have identified that the experience is likely to be significantly different. As a critical part of the continuum of the whole experience of pregnancy, labour and birth should not be divorced from the context of women’s experience of a subsequent pregnancy after a stillbirth. The lack of current information is a crucial gap in the literature.

Much of the literature addressing clinical practice issues related to subsequent pregnancy is comprised of professional descriptions of helpful interventions to assist women through the experience. With the exception of those medical studies related to pregnancy outcome, which identify several potential adverse outcomes and provide
guidance, studies regarding caregiver interventions as a whole are poorly researched. Recommendations discussed in the literature are helpful but are often too broad and vague.
CHAPTER THREE

METHODOLOGY

Theoretical/Philosophical Orientation

The choice of research topic and approach reflects certain basic assumptions about what constitutes knowledge and how knowledge is attained. According to Guba and Lincoln (1994), these underlying assumptions can be located within four paradigms or worldviews: positivism, postpositivism, critical theory, and constructivism; all of these imply competing ontological, epistemological, and methodological criteria. However, Crotty (1998) suggests that Guba and Lincoln’s paradigms have overly distinct boundaries, and reprioritizes the underlying tenets into objectivist/subjectivist (positivist/non-positivist) distinctions. This creates room for a theoretical perspective (constructionism) that accepts a blending of objectivity and subjectivity in order to create meaning.

Constructionism (as distinct from relativist Constructivism) creates knowledge through “intentionality,” which relies on an interdependence of subject and object (Crotty, 1998). Although I accept the critical realist ontological stance in postpositivism that desires to apprehend reality as closely as possible, I acknowledge the tension that exists between a priori reality (reality is out there somewhere), and Crotty’s social construction of reality versus construction of social reality. I draw upon constructionist ideology as socially constructed meaning (shared individual human experiences moving towards a construction of social reality) to examine women’s experience of livebirth following stillbirth. In accepting this notion, I acknowledge an indistinct border between
what Guba and Lincoln would classify as postpositivist or constructivist ideology. Although I remain unconvinced that maintaining objectivity at the expense of subjectivity is truly conducive to knowledge development, I do not wish to entirely forgo the pursuit of commonality (through objective interpretation) which may allow some form of shared reality to be discovered (as opposed to constructed). I believe that constructionist ideology allows the blend between subjective/objective to occur without sacrificing epistemological integrity.

Although examining the experience of livebirth after stillbirth by creating meaning (knowledge) through interplay of subject and object is a critical first step in this research, the process cannot stop there. The ultimate goal of nursing research is to develop knowledge that ultimately has the potential to inform practice. Therefore, an interpretation of the findings that moves towards some degree of explanation is critical for the generation of nursing knowledge. Nursing research that is geared towards a practical end is consistent with my philosophical belief that nursing is a practice, as opposed to a science or an art. Therefore, the question of how care providers impact women's experience forms a critical component of this research. Thus I hope to use participants' insights to improve future care delivery.

**Research Design: Interpretive Description**

Interpretive description, as outlined by Thorne, Reimer Kirkham, and Macdonald-Emes (1997), and Thorne, Reimer Kirkham, and O'Flynn-Magee (2004), was selected as a methodological approach with the potential to develop tentative explanation on the basis of description, thereby providing an opportunity to begin to answer the research questions and generate knowledge that might improve perinatal care for the selected
population. Interpretive description falls somewhere between phenomenology and grounded theory in terms of its guidance for approaching data and generating findings. Although I acknowledge that phenomenology has the potential to generate useful descriptive findings, for the purposes of this dissertation I considered phenomenology to be insufficient for my purposes in that it precludes explanatory theorizing (Van Manen, 1990). Hence, thick description consistent with a phenomenological philosophical perspective would not go far enough from my perspective to produce knowledge that might meaningfully inform practice. In contrast, grounded theory derives from assumptions that there is a basic social process underlying the phenomenon of interest and creates a means by which to discover and articulate it (Glaser & Strauss, 1967; Strauss & Corbin, 1990). In the context of this study, which represented a phenomenon about which so little is known, it seemed inappropriate to presume the presence of such a process that might be common across individual contexts and therefore a descriptive, exploratory method seemed more in keeping with the current state of knowledge. Further, given the rarity of the phenomenon of livebirth after stillbirth, the requirement of theoretical saturation had I employed grounded theory methodology might have made it difficult to obtain a sufficiently large and diverse sample to generate meaningful findings.

Sandelowski’s (2000) argument for “qualitative description” simplifies the philosophical issues (phenomenology, grounded theory, ethnography) in the methodological debate by reducing the “choice” to basic or fundamental. Nevertheless, the aim remains the production of a descriptive summary. Sandelowski acknowledges that researchers using qualitative description will be able to ascertain the “who, what, and where” of events (p. 339), but interpretive description allows me to consider the “why.”
In summary, interpretive description values clinical interpretation as foundational knowledge, supports purposeful sampling, does not rely on direct observation, encourages a comparison of commonalities and differences, and generates nursing practice knowledge as its goal. In addition, interpretive description is consistent with my philosophical belief in both the constructed nature of the experience that is the focus of this research, and the potential for shared reality (Thorne et al., 1997).

**Participant Inclusion and Exclusion Criteria**

The criteria for inclusion in the research study are as follows:

1. Women who have experienced the live birth of a healthy newborn within the last 15 years and/or women who are currently pregnant with a healthy fetus.
2. Women who have a history of giving birth to a stillborn fetus prior to the current pregnancy or prior to giving birth to a healthy newborn.
3. Women who are/were married or in a stable relationship for both the stillbirth and the subsequent livebirth or current pregnancy.
4. Women who have the ability to speak and understand English.
5. Women who have the cognitive ability and desire to share their experience of livebirth following stillbirth.

Criteria for exclusion in the research study are:

1. Women who do not meet the above criteria.
2. Women who experienced a livebirth and a stillbirth as a result of a twin (or other multiple) pregnancy.
3. Women who are currently pregnant with twins or other multiple.
Recruitment and Sample

Interpretive description methodology requires purposeful, as opposed to probability, sampling. Rather than examining the experience compared to a controlled situation or examining the effect of an independent variable on a dependent variable, the goal of this research is to understand the physical and psychological experience of livebirth following stillbirth. Therefore, this research includes a purposeful sample of women who have a history of giving birth to a stillborn baby and who have each subsequently given birth to a healthy newborn. The timeframe between the stillbirth and the livebirth was not limited. Women’s memories of events surrounding birth are known to be accurate, regardless of the time elapsed (Simkin, 1991). However, the time of the stillbirth was limited to the period following 1990, because practices surrounding stillbirth management particularly around labour and birth were significantly different prior to this time.

Recruitment of participants began with a letter (Appendix A) that introduced the researcher and explained the study and its potential benefits. The letter was sent to local (i.e., within the Lower Mainland of Vancouver) Obstetricians/Gynaecologists, General Practitioners, Registered Midwives, and key personnel in local hospital administration (VP Medicine, Nurse Managers of local labour and delivery units, B.C. Women’s Family Practice Administrator, B.C. Reproductive Care Program Medical Consultants). A total of 110 individualized letters were mailed. In addition, several copies were made available to key contacts in hospital administration, who were encouraged to make as many copies as they required. In addition to the original 110 letters of introduction, I learned through conversations with primary care providers and nurses (e.g., assessment room nurses) that
several other letters of invitation were copied and offered to women whom they considered appropriate for the study. Most of these women were pregnant at the time.

Identifying those physicians who are currently practising obstetrics proved to be something of a challenge. The B.C. College of Family Physicians does not maintain a list of practitioners providing maternity care. For the sake of practicality and cost, I relied on my own knowledge of the community (as a perinatal care provider), and selected only those practitioners I knew to be practising maternity care to receive letters. My hope was that recipients would recognize my name and that this would assist in case finding, so the priority was to send letters to key personnel within the Lower Mainland who would both recognize my name and be in a position to facilitate access to participants. The remainder of practitioners practicing obstetrics would be caught through the letters sent to hospital administration.

The primary care providers were requested to identify potential participants from their patient base and provide an information letter (Appendix B) to them explaining the study. The researcher’s contact number was included in both letters with an invitation to discuss questions and/or concerns. Women who were interested in participating in the study were asked to contact the researcher directly at the contact numbers provided. The letter of invitation stated explicitly that choosing to participate (or not) would in no way affect potential participants’ health care delivery. Informed consent was discussed with and obtained from women who indicated a desire to participate, and who met the other inclusion criteria (Appendix C).

Although the recruitment process appears somewhat circuitous, this was in fact a deliberate measure in response to the sensitive nature of the subject matter. Although it is
possible to place information letters or brochures explaining the research in public forums in which potential participants are likely to gather (e.g., prenatal classes), I chose to restrict my recruiting activities to access through professionals due to the potential for pregnant women who have not experienced a stillbirth to be upset by material referring to it.

The extensive recruitment strategy resulted in 14 interested women who experienced a livebirth subsequent to a stillbirth. This sample size was large enough to generate "a new and richly textured understanding of the experience" (Sandelowski, 1995, p.183) and small enough to ensure that descriptions and analysis of individual participants' experience were sufficiently in depth (Sandelowski).

My original intent was that all participants would have stillbirth as their first birth. However, five women who had a history of livebirth prior to the stillbirth but were anxious to participate also contacted me. These self-identified women also had the experience of livebirth after stillbirth and I determined that although they did not fit the original criteria exactly, their stories were important and might contribute meaningfully to the research. These women's experience of livebirth prior to stillbirth was not examined except where it related to the experience of livebirth after stillbirth. The variation in the women's history of livebirths prior to and following a stillbirth shed additional light on the research phenomenon through comparison. This additional variation may assist in developing a beginning sense of patterns and themes that could help explain a rare phenomenon infrequently seen in the clinical context.

The sample was limited in that very few participants were currently pregnant at the time of the study. Several pregnant women approached by their caregiver indicated
interest in the study but subsequently failed to contact me. The possibility that their initial interest was expressed to please the care provider cannot be ruled out; furthermore, the nature of the study was such that many potential participants - women experiencing a pregnancy following a stillbirth and feeling additionally vulnerable during pregnancy - may simply have considered the subject too difficult.

The final sample consisted of 14 women with a history of livebirth or healthy pregnancy following stillbirth. A detailed description of the sample is located in Appendix G. All agreed to participate and provided informed consent.¹ All the women were Caucasian, between the ages of 31 and 43 at the time of the research, and with greater than high school education. The women's ages varied between 28 and 37 at the time of the stillbirth. Although not planned, the sample was homogeneous in the sense that all the women experienced late pregnancy losses greater than 28 weeks gestation, the majority close to term. Nine of the women experienced stillbirth as their first pregnancy greater than 20 weeks; 5 had a history of livebirth prior to the stillbirth as well as a livebirth after the stillbirth. Three were currently pregnant during the data collection phase.

Data Collection

Interviews

Consistent with the research design, semi-structured in-depth interviews were conducted with all the women. For those women who were pregnant at the time of

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¹ This study does not sample the perspectives of the partner/family or caregivers; the impact of family or caregiver experience is restricted to that identified through the eyes of the woman. This is not to say that these perspectives are not important, but rather that the intent of this study is to highlight the women's perceptions of family/caregiver influence as it contributes to the experience.
recruitment, two interviews were completed, one during pregnancy and one following the
birth.

All interviews were conducted by the researcher and tape-recorded with
permission. They were held at a time and location acceptable to the participant and
chosen to optimise each participant’s comfort. The interview tapes were transcribed
verbatim by a transcriptionist.

Interviews with the women were largely unstructured, in order to allow the
participants to reveal what was important to them. However, a semi-structured interview
guide was used as a prompt when needed. Questions such as “What is the experience of
having a healthy baby like after having experienced a stillbirth?” and “How did your
experience of stillbirth impact the time interval between pregnancies?” assisted the
women in relaying their story. In addition, the use of the interview guide functioned as a
trigger for the researcher to ensure that similar data were collected from all participants.
Each interview was $1 \frac{1}{2}$ to $2 \frac{1}{2}$ hours in length.

Rapport was easily established and at the end of the interview, each participant
was invited to contact me directly should they wish to add to or correct their data, or
share additional comments. Several women also contacted me following the interview for
other reasons, such as sending birth announcements, providing updates on previously
shared health concerns, or asking about the progress of the thesis. The ease of
communication implied by these interactions lends additional credence to the interview
data, given that the better the rapport established, the better the data are likely to be (Hall
& Stevens, 1991; May, 1991). In addition, each participant agreed to be contacted again
to provide clarification of interviews as needed, and/or to assist with responses to a preliminary analysis of commonalities within the entire sample.

**Intended Participant Observation**

In addition to interviews, participant observation of prenatal classes, caregiver appointments, or labour and birth was intended for a sub-group of willing women who were currently pregnant and indicated a desire for my attendance. Participant observation has inherent difficulties, which can be summarized as follows: First, for those women who were currently pregnant, livebirth could only be known retrospectively, so that a degree of “blind faith” that the ultimate outcome would meet this study’s inclusion criteria was required. Second, the ethical considerations of performing research during labour make it difficult to persuade hospital ethics boards to permit the research; however, it was thought that consent from the woman should mitigate the number of refusals. Third, my own clinical experience made maintaining objectivity and resisting the urge to participate during the observation particularly difficult. Last, the observations performed for this study had the potential to be biased by my clinical expertise and my previous experiences of livebirth following stillbirth.

Despite such difficulties, Silverman (1998) cautions that substitution of interviews for direct observation of behaviour is a mistake. He highlights the gap between how people reflect on their behaviour, and what they actually do. I was persuaded by his assertion that “We need to question the argument that observational or other naturally occurring data are “unavailable” even in the supposedly “private” sphere of human interaction” (p.114).
The planned observations described above were intended to supplement the interview data. A separate written consent was to be obtained prior to each observation, and detailed field notes recorded for each observation. As an additional data source, participant observation has the potential to enhance the richness of the data and, with careful attention to participant consent and to reflexivity in data analysis, can enhance research.

As only three women in the sample were currently pregnant at the time of recruitment, the potential for participant observation was limited and observation ultimately proved impossible for various reasons. Firstly, hospital processes were prohibitive: for example, I accompanied one woman to a non-stress test, but was asked by the attending health care provider to remain outside in the waiting area, despite the woman's willingness to have me attend.4 Secondly, the women in the sample did not attend pre-natal classes. Lastly, I perceived that asking to attend the labour and birth for the remaining two participants would be intrusive. Although I still believe that the observation of labour and birth would add valuable data to the story of women's experience of livebirth after stillbirth, its inclusion in this study proved overly ambitious and beyond my grasp. Participant observation was therefore not used in this study.

Anecdotal Materials

Supporting documentation was obtained from the participants in the form of art, photographs, jewellery, and stories and articles written by the women. Most of the women shared some form of individual memento or written material that they had created or had commissioned to assist them in the grieving process. These anecdotal materials
were important to the women and sharing them proved to be a significant component of the interviews.

Hospital records were considered as supplementary sources of data but were rejected in favour of women's reflections. Due to the unpredictable nature of childbirth, and the individuality of "normal" birth experience, hospital records listing such variables as overall length of labour, length of second stage, use of analgesia, caregiver, would be unlikely to be beneficial in and of themselves. Instead, the women's perception of these events was deemed relevant to this study.

In addition, the lay literature around women's experience of stillbirth and/or livebirth following stillbirth was considered a data source, which assisted in the development of a beginning framework.

Field notes

Field notes were made immediately following each interview, recording my perceptions, noteworthy elements of the environment, continuing conversations outside of that captured on the tape, and any other details that I considered important to retain for future comparison or clarification during data analysis. A key example of a continuing conversation that became important to a participant's experience was the one around a woman's sadness at not knowing where her baby had been taken following the stillbirth. My experience with the hospital policies at the time made it possible for me to offer to assist her in finding out this information. This woman felt that participating in this research would be "worth it" if she knew where her baby was. With her permission, I was

4 Furthermore, I was not able to interview this woman until after the baby was born, as she cancelled several appointments. This left only two women in the sample who were pregnant at the time of data collection.
able to discover the information and thereby provide comfort after several years of painful “not knowing.”

**Data Analysis**

Consistent with qualitative research in general, and interpretive description in particular, an inductive analysis of the data was undertaken. More specifically, immersion in the data occurred prior to beginning a formal coding process (Lincoln & Guba, 1985; Thorne et al., 1997). This allowed critical analysis and interpretation of individual cases and potentiated reframing of the data to facilitate recognition of common concepts as they evolved. Techniques of content analysis, constant comparison, and thematic analysis (Sandelowski, 1995) were used and the data reduced using an organizing framework based on the interview questions (Miles & Huberman, 1984). The data analysis was a dynamic process interspersed with periods of data collection (cognitive versus practical) in a back and forth process (Sandelowski; Thorne et al.). The data collection/analysis process continued until redundancy occurred.

Coding of the data was done mechanically rather than through the use of a computer software program in order to ensure that nuances and inflections of key words and phrases by participants were captured and ascribed appropriate meaning. My personal reactions and reflections were acknowledged and scrutinized in a process of reflexivity, which countered the effects of potential bias (due to clinical expertise in the substantive area) and contributed to sound data analysis (as distinct from personal opinion). Although the potential for researcher bias has been acknowledged, it should also be stated that the researcher’s clinical expertise facilitated intuition and creativity in data analysis (May, 1994).
The Pursuit of Rigor

The nature of qualitative research modifies the classical interpretation of reliability and validity familiar to researchers using quantitative research techniques. Reliability (the replicability of research findings) and validity (the accuracy of research findings) have been redefined to better fit the complexity and uniqueness of qualitative research (Wilson, 1989). Guba and Lincoln (1981) and Sandelowski (1986) have identified the following criteria for attaining rigor in qualitative inquiry: truth value or credibility, applicability of fittingness, consistency or auditability, and neutrality or confirmability.

Credibility

Credibility refers to the extent to which the interpretation of the research is representative of the participant's perspective, rather than researcher-defined. It relates to the truth value or presentation of faithful descriptions that resonate with participants. In this study, participant statements were regularly reflected back to them during interviews in order to ensure the accuracy of my interpretation. I then listened to the tapes to pick up inflections and emotions not immediately identifiable on the transcripts. In addition, I related interpretations of early interviews to later participants in order to ascertain whether previously recorded women's perceptions of their experience reflected those of others. This also assisted in clarifying the progress of my ongoing data analysis and facilitated the depth of interpretation.

Fittingness

Fittingness is achieved when the findings are applicable to settings outside the one in which the research was performed and the findings are viewed as significant and
appropriate. Specifically, the findings “fit” the data and are applicable to the real world (Sandelowski, 1986). As with the criterion of credibility, fittingness is achieved through participant verification and additionally through feedback from dissemination of the findings. Other than the participant verification of later interviews with those of previous interviews previously described, a formal process of member checking was not undertaken. The intent of interpretive description is for the researcher to interpret the findings as described by the participants, not for the participants to affirm that the findings are correct. This is consistent with the more recent concerns Sandelowski (1993) has expressed about the process of member checking in qualitative research.

During both my coursework and my work with the B.C. Reproductive Care Program, I shared my perceptions as a care provider with colleagues, particularly my observations of women in labour. My colleagues confirmed that my observations resonated with their own experience. Lastly, assistance from my dissertation committee, whose substantive and methodological expertise is considerable, helped to ensure that the criterion of fittingness was met.

Auditability

Auditability is achieved if an external researcher can clearly follow the decision trail used by the study investigator and arrive at similar conclusions (Sandelowski, 1986). All interviews were initially transcribed by a transcriptionist and confirmed by the researcher through comparison with the tapes. The transcripts were first read without making any coding notation in order to obtain a feel for the data. The second stage involved underlining of key data elements that stood out in the data with a single reference word or phrase noted in the margin. A third reading of the transcripts identified
possible key overriding processes or recurring themes. The data collection and analysis were performed concurrently, such that some transcripts were coded before all interviews were completed. The first-stage analysis assisted with ongoing data collection and furthered understanding in following interviews. Towards the end of data collection themes were compared across transcripts to identify commonalities.

Confirmability

According to Sandelowski (1986), “Confirmability is achieved when auditability, truth value, and applicability are established” (p.33). Given that the latter three criteria were met, confirmability should be assured.

Ethical Considerations

This study, like all research involving human beings, had to balance the benefits of the research with the interests of the participants (May, 1991). Ethical approval was obtained and maintained throughout from the Behavioural Sciences Screening Committee of the University of British Columbia. Due to its sensitive subject, the research had the potential to open up unresolved issues from the past and create considerable discomfort in the participants. Whenever this occurred, I provided emotional support, reiterated to the participant their right to terminate their participation at any time, and provided options for ongoing support (e.g., professional counselling services, support groups). I also recognized the potential for this research endeavour to function as “therapy” and was cognisant of balancing participants’ need to talk with the specific needs of the research.

All data collected in the process of this research study was kept confidential and retained in a locked filing cabinet accessible only to the researcher. Participants were kept anonymous through the use of coded identification on all transcripts and tapes. The codes
are known only to the researcher. A signed agreement to maintain ethical standards was
obtained from the two transcriptionists who transcribed the interview tapes. At the
conclusion of the study, all identifying information was removed from the transcripts and
field notes, and tapes were erased. The unidentifiable data will be retained for a period of
5 years in order to facilitate dissemination of the findings and publication of results.

Limitations of the Study

The study is limited by the small sample size and the homogeneous sample of
white, middle class women, all with at least high school education and many with
university degrees. Although some of the women were married to men of differing race
and culture, the study focused on the experience of the women. The potential ethnic
influence of the women’s partners was apprehended only insofar as they were
incorporated into the stories of the women.

The research is also limited by the choice to sample women (as distinct from
couples or mothers and fathers). There are potential obvious strengths to considering the
experience of couples, however, the particular interest and goal of the research was to
explore the nature of the physical experience of pregnancy, labour, and birth, in addition
to the psychological or emotional experience. It was decided that the continuity of the
findings had the potential to be better served by restricting the sample for this study,
however, women’s voices proved insufficient to fully capture the experience of labour
and birth. Future attempts to ascertain the experience of labour and birth will require the
perspectives of partners and health care providers who care for women in labour.

The study is also limited by the inability to incorporate participant observation as
a data collection strategy which, if it had been included, had the potential to enhance the
description of the experience and assist in mitigating the methodological concerns of
exclusively retrospective data based on memory. However, the potential for researcher
bias and potential difficulty in maintaining objectivity may have diluted the benefits.

The role of the researcher is informed by expertise in the substantive area as a
nurse and a midwife although I have never experienced livebirth or stillbirth. This has the
potential to be a limitation in regards to the potential loss of connectedness that may
result from an inability to share the experience.

Summary

This dissertation involved a qualitative study and used an interpretive description
design. The majority of the data were collected through in depth face-to-face interviews
with 14 participants who gave birth to a healthy newborn following the experience of
stillbirth. Additional supporting documentation was obtained through anecdotal materials
shared by the women, lay literature, and documented field notes.

I originally envisaged a sample size of 15-20 and intended to include only those
women whose stillbirth was their first birth. These intentions then shifted to include
women who had given birth to a live child prior to the stillbirth and who self identified as
having a story to tell that was appropriate to the research. In addition, despite an
extensive recruitment strategy, the sample size was a little smaller than the intended
sample. Last, participant observation proved to be impossible and therefore the methods
used were those that accommodated the reality of the sample recruited.
CHAPTER FOUR

WOMEN’S STORY OF STILLBIRTH: A TRAGIC HISTORY

Introduction

The purpose of this research is to begin to understand women’s experience of pregnancy and birth following a history of stillbirth. In order to more fully appreciate the impact of stillbirth on the subsequent pregnancy, it was both important for the women to tell their story of stillbirth and also to understand the context within which the women were approaching the delivery of a subsequent baby. The women’s stories naturally commenced with their experience of stillbirth and its impact on their lives. The sharing of the natural sequence of their experience clarified and enhanced the story of their subsequent pregnancy and birth.

All women were able to remember and describe in significant detail the emotional and physical experiences of the pregnancy, labour, birth, and postpartum of the birth that resulted in stillbirth. The women struggled emotionally in the re-telling of their stories as these memories brought on tears and renewed pain. On each occasion, I reinforced their right to terminate the interview at any time, but each woman chose to continue her story. My perception was that it was important for them to share their stories, some women indicating that telling their story was particularly helpful to them because they rarely had the opportunity to share this significant time in their lives. The insights obtained from the women’s stillbirth stories are described in this chapter as a basis for understanding the nature of the findings around the subsequent pregnancy described in the following chapter.
Hearing the News

The joyful anticipation of a new baby with all its attendant hopes and dreams is shattered in the event of an unexpected stillbirth. Intrauterine death of a viable infant is uncommon (approximately 7 in 1000, according to B.C. Vital Statistics) and therefore most caregivers have little experience of managing the physical and emotional responses of women in this situation.

When a caregiver is unable to hear a fetal heart, he/she immediately conveys the possibility of caregiver error to the woman and refers/defers the situation for technological assistance. Non-stress tests and ultrasound are diagnostic tools used to confirm what is already suspected by both the woman and the caregiver. In my experience, it is common practice for caregivers not to convey suspected “bad news” until they are absolutely sure, and thus evade the discussion in an attempt to avoid “upsetting” the woman unnecessarily and maintain an element of hope. In addition, many caregivers such as nurses and technicians do not feel they have the professional right (by virtue of training or position) to share their suspicions. Regardless of the appropriateness of these choices from a professional perspective, the caregivers’ inability to share their concerns upfront effectively prevents women from voicing their fears. The women in this study endorsed this perception. They felt that voicing their fears would make these fears real, and they were afraid of the reality they already suspected. One woman described the experience as follows:

You know something’s quite wrong, right. But you don’t have any experience to know what it is and, at the same time you are also thinking, oh this must be just how it goes, right. You’re trying to sort of help yourself out -and I just remember
saying to them... because at [the hospital] we have to move a million miles to where the labour and delivery is - and I kept asking them to hurry - I was, you know, hysterical -whether it’s intuition or whatever it is but- you are waiting for the ultrasound equipment to be moved in. And you know they couldn’t find a pulse on this child anywhere. So at this point the child had died I’m sure.

This agony of “suspended grieving” or “suspended fear” can last for a considerable period of time, because of health care processes and caregiver referral. Women are usually expected to transport themselves to hospitals, labour and delivery units, and/or ultrasound departments, wait in silence while a series of unknown nurses, technicians, and radiologists perform their individual assessments, and ultimately wait to be told officially what they have already sensed they will inevitably hear. My participants’ stories of their experience reinforced this knowledge of common practice. The following excerpt examplifies one woman’s experience of suspended fear:

I knew from the first second she put that thing [fetal doppler] on my belly when there’s no heartbeat I knew right away then. But of course no-one’s saying anything, right. No one said anything. She’s still trying- it must have been - it felt like forever but it must have been only 5 minutes but it felt like eternity and there’s this silence and she’s just trying to find it and find it and find it and I’m ready to scream out “Get someone in here who knows what they’re doing.”

Anyway, the other nurse [more experienced nurse] took over and whatever and he still really didn’t say anything. Like they didn’t find the heartbeat and they kind of

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5 This process of referral and lengthy delays is common in my experience as a labour and delivery nurse and midwife.
went away and I just - I couldn't even look at my Mom because she was just - I just would know...

The above scenario is typical of women's experience where loss is discovered in the antenatal period, as is most common. One of the participants in this study lost her baby during advanced labour and the experience of hearing the news in this situation is different. The deterioration of the health status of the fetus constitutes an emergency in the labour and delivery unit. This woman's experience of the emergency was one of fear and panic but unlike the participant above, she believed that whatever needed to be done was being done. She "went to sleep" expecting to wake up to her baby, with no expectation that the baby might die. In this instance, she was informed by the anaesthetist in the recovery room that her baby had died. She remembers the doctor holding her and gently telling her the news. Her expectation of waking up to a live child, only to be told that the baby had died, resulted in a complete denial of the information. Her response in the midst of the crisis displays her struggle to make sense of the shock:

My first thought was (a) he's wrong, he's not dead. My baby's not dead and I yelled at the doctor to go back in and I remember the words I used. I said go try some more of your tricks because he was holding me or something. That was in my head. I was yelling at him. I was angry and he very gently - I don't remember any of this visually - I remember the words and I remember what was going on

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6 The emergency requires a series of interventions to try and recover the fetal heart. These interventions include changing position, starting an intravenous infusion, providing facial oxygen, performing a vaginal exam, and applying a scalp electrode. These interventions are performed quickly and with considerable urgency. Ultimately, if these interventions fail, an emergency Caesarean section is performed.

7 In the event of an emergency Caesarean section, a general anaesthetic is usually given which means that women are not conscious for the birth.
and I remember asking but I don’t remember visually. I think either my eyes were closed because I was drowsy or my husband and parents tell me that my eyes were rolling into the back of my head a lot. And then he said “No we’ve tried everything.” And then I thought “OK, then it was the wrong baby.” He said “It’s the right baby, I’m so sorry.” And then I thought, “OK, then if it’s the right baby, I am in a nightmare.” And I just started to hit my head trying to wake up.

The difference between hearing the news in the antenatal period versus the intrapartum period seems to reflect a difference in expectation. The “suspended fear” previously described by women experiencing difficulties in the antenatal period apparently prepares the women for the eventual news that the baby has died. It is not that antepartum women expect the news initially, but rather that by the time they are told, they have already deduced it. Women in the antenatal period often expect what they are about to hear as they have already suspected the outcome. Women who lose a baby in labour have no such suspicion, or preparation.

In addition to the timing of the news, participants reported varied experiences of how the news was conveyed and by whom. In terms of how the news was conveyed, some caregivers showed greater sensitivity than others. Most of the women claimed that the information was relayed to them in a factual, succinct manner such as, “I’m sorry, your baby’s gone” or “You know, the baby isn’t alive anymore.” Participants perceived the manner in which the words were spoken, rather than the words that were used per se, as helpful or not helpful.

Participants noted tone of voice and the use of touch. One woman described a positive interaction: “You know the nurse sat with me and held my hand...finally the
nurse said to the technician, ‘You know you can tell her.’” The women describe that sensitivity goes a long way in assisting them during this difficult time. The tone of voice and emotional inflections used by participants as they described hearing the news clearly conveyed their appreciation of, or displeasure with, the approach of the caregiver. I observed how participants relayed anger with narrowed eyes, fisted hands and averted eyes, and relayed appreciation with soft eyes, a gentle tone, and tears.

Some of the women attributed inappropriate communications on the part of the health care professionals who conveyed the news of the baby’s death to issues arising from the professional’s personal limitations or from the institutional context associated with the encounter. An example of this type of experience came from a small hospital on a holiday weekend in which the radiologist had to be called in. The nurses had been unable to hear the heartbeat and had informed the woman that she would have to wait until the next day for a radiologist to do the ultrasound. She refused to wait until the next day. The radiologist came in and while doing the ultrasound said, “Well, the baby’s heart is not beating. I hope that makes you happy now.” The radiologist’s response seems to suggest a lack of caring and inappropriate anger. The woman’s refusal to accept the limitations of the small facility’s lack of readily available personnel seems to have resulted in the radiologist’s punishing retaliation. It is clear that our societal expectation of appropriate responses in conversing with someone who has sustained an unexpected loss requires sensitivity and empathy. Caregivers, as a part of society, are therefore expected to conform to this expectation.

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8 This response seems to reflect the caregiver’s needs and issues rather than the mother’s. More thoughts about this will be pursued in the discussion.
In addressing the issue of who should "do the telling," participants reported various scenarios. As with the manner in which the news is conveyed, the question of who breaks the news reflects the tension between following appropriate professional policy (e.g., radiologists or doctors give diagnoses, rather than technicians or nurses) and "doing what feels right" in a particular circumstance. In many instances, participants experienced silence from a stream of caregivers due to the caregiver's lack of comfort or belief that they did not have the authority to convey the news. However, there were instances in which "doing what felt right" won out over protocol. The previous example of the woman whose nurse told the technician it was OK to tell her (the woman) illustrates this tension.

In summary, the women in this study vividly recall hearing the news of their baby's death, and the precise circumstances surrounding it. How the news is shared, when, and by whom all contributed to or mitigated the women's experience of the tragedy. Caregivers in general often respond with a predictable "chain of events" approach, coupled with a silence that only adds to the women's fear. Caregivers who display sensitivity coupled with a more "human" response that reflects societal expectations rather than a restrictive (sometimes inappropriate) medical environmental approach assist in the grieving process.

**Wanting the Baby Out (not wanting to labour)**

Several participants recalled that the shock of discovering that the baby had died quickly gave way to a second shock as they realized that they would need to labour and
deliver the baby as if it were an anticipated livebirth. Upon learning that the baby was no longer alive, the women wanted to get the baby out by immediate Caesarean section (C/S). Common expressions included: “Get it out of me! I just want a Section”; “Okay, well... make it go away - I’m waiting now for them to take the baby out”; “I initially thought C-Section just to... cause it would be easier to go to sleep and wake up and have it gone”; and “I’m not that strong... I couldn’t do that... it’s crazy.” The theme of wanting the baby out applied explicitly and exclusively to those who learned of their baby’s death in advance. Those women already in labour did not describe the same experience.

The women’s attempts to obtain a C/S were all unsuccessful. Reactions to hearing the physician explain the medical rationale for choosing vaginal birth ranged from disbelief to acceptance. When reporting these transactions to me, the women focused on the medical rationale that a vaginal birth was safer and better for future children rather than the emotional and psychological evidence that labouring and giving birth facilitates the grieving process. The question of choice and the women’s struggle with the decision made for them to labour and deliver their stillborn continue to be an issue as they reflect on it in retrospect. Some women reported that the decision to have a vaginal birth was a good one in retrospect but others were still angry about not being offered the choice. One woman explained:

This experience represents those women who found out their baby had died in the antenatal period. Those women who were in labour at the time experienced the same “wanting the baby out,” but were spared the shock of finding out they would have to labour and deliver.

The women’s recounting of the conversation left it unclear whether the health care provider in fact presented both the physical and psychological arguments for recommending a vaginal birth. It will be interesting to consider the ramifications of the recent debate on Caesarean section on demand, and its outcome, for the management of intrauterine death and women’s desire to get the baby out by Caesarean section. Should Caesarean section become a medical choice for all women, the focus on the psychological aspect of giving birth to a stillborn baby will become the key to the decision for women giving birth to a stillborn.
Having the C-Section should have been my option because I hated that delivery. The fact that I ended up with a C-Section for all of my babies (subsequent pregnancies) left me with an interesting little issue. I have a full labour experience that no one wants to talk about. And you can’t really discuss it with other Mums because they all know that my babies are all C-sections. So I got left with this sort of nebulous experience that is barred.

Distinct from the experience of women in whom labour had not begun, those women who had already begun labour did not report the same negotiation for an immediate C/S. Their focus appeared to be on getting through the labour. As one woman states, “I went into labour so I didn’t have to decide.” Another, uncommon reaction was a “matter of fact” assessment of the information and resulting decision. One woman related that “They [the medical people] opted for me not wanting to do the C/S because she was small enough to pass and the recovery time is much better so that was a no-brainer for me to choose vaginal.”

There is a small subset of women for whom medical illness precedes and causes the loss of the baby. In these instances, negotiation around mode of delivery is not possible and the sequence of events most commonly seen and described by healthy women in the antenatal period does not occur. For example, one woman in my study was delivered of twins by C/S in order to save her life. This woman was so ill and disoriented that she was unaware of the decision-making process. The twins were both born stillborn. She was told (much later) that the babies had likely passed away several minutes prior to

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11 I noted in my field notes that my perception of this woman was that she seemed to skim the surface as if she were pushing away the real emotions. This woman was pregnant at the time of the interview.
the delivery. For the remaining women, once the decision for vaginal birth had been made (or agreed to), some were given the choice of waiting for the onset of labour or having labour induced. The choice was sometimes taken away from them as labour ensued spontaneously, but most women, given the choice, preferred to induce labour.

In summary, participants found learning that they needed to labour and deliver the baby both repugnant and shocking. In addition, they felt a sense of urgency around “getting the baby out.” Although their verbalization of desire for C/S did not influence the medical management approach of vaginal birth, which was considered “healthier,” most women were given the option of induction where there was a choice to be made. The inability to choose C/S is a decision that still upsets some participants in retrospect.

The Experience of Labour and Birth

Participants noted that the shock of hearing the news and knowing they had to deliver the baby was made worse by the lack of prenatal preparation for the eventuality of actually losing a baby. Although most of the women had prenatal preparation in the form of prenatal classes, the possibility of stillbirth was never discussed. Therefore, the details of giving birth to a stillborn, the legal requirements regarding decisions to be made and forms to be signed were unknown to them. Of course, such decisions are all the more difficult when one is in a state of shock and grieving. The women found it difficult to reconcile birth with death:

She [the nurse] asked me questions like, “would you like to hold the baby when it’s born?” Again, I hadn’t even considered that. You know, what kind of funeral

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12 This woman’s medical experience of stillbirth is very rare. Following the birth she remained unconscious for a week and although she was told about her babies, she hallucinated and lost touch with the reality of the situation due to her medical condition.
arrangements. You know, I’m thinking of birth. I am not thinking of death. Um, you know, “have you thought of a name?” ... So all of a sudden in that capacity of trying to give birth but having to think of all these other things. It was hard. Some participants reported that a protective numbness came over them. One woman described the feeling of numbness as “sleepwalking.”

For many participants, getting into labour was a waiting game. As previously discussed, when given the choice, the women chose induction over waiting for spontaneous labour. It is often clinically difficult to stimulate a woman into labour when she is not physically ready for labour, and for some women the process of induction took several days. For those women in whom induction was difficult, the many medical procedures that were required seemed bizarre, given the situation. One woman described being taken to the labour and delivery area and having all the equipment and personnel brought into the room. She felt as if a machine had started and described the “mechanical business of birthing the baby.” In addition, some of the women reported feeling like “an alien that had landed in their area.” They reported that caregivers’ inability to make eye contact with them, or their avoidance of entering the room, contributed to feelings of acute alienation.

Labour, once established, often progressed quickly. Most of the women were offered and accepted medication to decrease anxiety and epidurals or narcotics to manage

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13 Uneffaced and undilated cervices require pre-treatment with a prostaglandin agent in order to prime the cervix. The most common drug at the time (1990s) required 3 insertions at 6 hourly intervals or enough to ripen the cervix sufficiently to commence an intravenous containing oxytocin, a uterine stimulant. Even if the cervix does not require prostaglandin, it often takes several hours on oxytocin to stimulate labour.

14 Comparing induction to a “business” is an interesting concept. It has a negative connotation that is far removed from the joyful emotional experience of our notion of birth. This may be a way for women to detach themselves from the emotional roller coaster they find themselves on, and to cope with the physical details of the stillbirth process.
pain. The general consensus was that pain was not a necessary component of giving birth, particularly in these specific circumstances, in which a live baby could not be anticipated. The physical memory of the labour was not predominant where pain was well controlled. Some of the women described feeling in a “blur” for the labour and delivery, and most did not remember being in extreme physical pain. Some, however, experienced breakthrough pain despite the epidural or were told by caregivers that they “didn’t need it [the epidural].” These women’s memories of the physical part of the labour were acute, especially during the transition period.\(^{15}\)

For women who have had babies before, transition often leads quickly to the birth of the baby. The joy of making it through transition and having a live newborn at the end does not occur for women delivering a stillbirth and the combined physical and psychological experience is traumatic. One participant describes the period of transition and birth:

I was freaking out. It was like a panic attack. I couldn’t breathe properly. And then they gave me that face gas and said it would help me but when that went over my face I felt claustrophobic and wanted to rip it off. Nothing was right and it was just- I was very anxious. I could feel her coming down the birth canal. I thought it would be like (first child) but none of that sensation at all. …So she was born and they wrapped her up and I can’t remember if they took her away and brought her back or if they wrapped her up and gave her to me right away. That part is kind of a blur but what I do remember is when she came out it was dead quiet.

\(^{15}\) Transition is the period of labour at the end of the first stage just prior to the second stage. It usually occurs around 8-9 cms dilated. It is often reported as a difficult period in all labours. The second stage
Even if physical pain was well controlled, participants found the labour experience psychologically difficult. Many of the women reported maintaining some hope that “they” [the medical people] were wrong about the baby being dead, and this hope kept them going throughout the labour. These women experienced a fear of the labour coming to an end:

I kinda lost control. I knew the end was coming and I wasn’t ready to face- I just wanted it to be over with but again I didn’t want it to happen because until she was born you know I felt that they were wrong.

In addition to being fearful of the labour coming to an end because this would confirm the diagnosis of death, some women described not wanting the labour to end because this would mean the baby was no longer with them. As long as the baby was inside, they were still together. They noted the irony in the situation of trying to push the baby out when there seemed to be nothing to gain from succeeding.

Most of the women in my study found the actual birth experience difficult. They described feelings of emptiness or hollowness at the birth. Some of them, however, described a sense of peacefulness and calm once it was over. The fact that the baby was stillborn could no longer be denied and reactions to the baby were conflicted, ranging from revulsion on one hand, and appreciation for the beauty of the baby on the other. In many cases, both reactions were present at the same time and followed quickly on from each other in their description. As one woman explained, “I mean it was the most horrendous sort of lifeless thing. And yet she was perfect.” The experience of the birth begins at 10 cms.
was also largely influenced by the behaviour of the caregivers. Sensitivity or lack of sensitivity greatly impacted the memories of the women.16

The experience of labour and birth varied depending on whether the stillborn was the first child or not. Those women who had a live child at home found some comfort in this fact, which mitigated their despair throughout the finding out, labour, and birth stages. All these women indicated that they did not know how they would have coped if they had not already had a living child. They acknowledged that, awful as this event was for them, it would have been worse if the stillborn had been their first. After finding out that her second child was stillborn, one woman went home to wait for induction and explained:

I don’t know if I could have gotten through it without her [live child]. Because just going home [prior to going back for induction of labour] and seeing her and she’s healthy and she’s happy to see me and just hugging her felt -was -it helped so much knowing that I could do it.

Another woman used pictures of her first child as focus points in labour and as a way of reassuring herself that she had the capacity to deliver a live baby. Her son visited her in the labour room after the stillbirth. She says of his visit:

We had given him the choice if he wanted to come and see the baby or not. And he did so he came and he held her, just for probably about a minute and then gave her back and told us that she was kind of ugly [laughs]. And anyway, I mean it helped me too, having him there was something we could hang on to.

16 This will be discussed in more detail under caregiver interactions and interventions sections which follow.
In addition to the psychological benefit of having a live child at home, the physical benefits of previous delivery were also apparent. Multiparous\textsuperscript{17} women generally laboured more quickly and the time interval between attempted induction and established labour was usually shorter than among the primiparous\textsuperscript{18} women.

All the women expressed feelings about whether being with other women and babies was detrimental or appropriate for them during the stillbirth experience. They indicated that in most instances they were kept at a distance from the hustle and bustle of the labour ward, but they also reported being able to hear and be upset by the sounds of others giving birth: “They put me in a room far removed from the other ones but I could still hear women screaming in labour and the baby screaming when they are born and that was really hard.”

These women found the experience of remaining in the labour and delivery area upsetting. However, one participant found that being taken to a surgical ward as an alternative was not beneficial either. In this instance, caregivers never made reference to the fact that she had delivered a baby. This woman related that this experience made coming to terms with her loss more difficult. She stated that she wanted the fact that she had given birth to be acknowledged.

There was an additional common thread throughout the women’s experience, which is not directly related to labour and birth, but which tended to come up during their recounting of the labour and birth. The women experienced a great deal of guilt and a belief that something they had done must have caused the death. They identified falls, failure to call the doctor sooner, failure to do movement counts, and delay in setting up

\textsuperscript{17} Women who have delivered at least 1 term infant.
\textsuperscript{18} Women delivering their first child.
the baby’s room as possible causes for the stillbirth. Regardless of the reassurances provided by caregivers, the women tried to make sense of their loss based on their own personal interpretations. Autopsy findings rarely identify a cause for most cases of stillbirth, and this perpetuated the women’s ideations of cause. Participants reported that autopsy findings that did identify a cause were reassuring, but did not necessarily remove their sense of guilt.

In summary, participants’ experiences during labour and birth suggested many commonalities. All the women felt unprepared for the procedures and decisions they were suddenly forced to make. Most also reported hoping that the medical people were mistaken and the baby would somehow be alive at the time of birth, and this hope helped them get through the labour. Despite this hope, most also reported the fear of the labour coming to an end and having to face the finality of the loss of the baby. The women experienced a sense of emptiness at the time of birth and had conflicting reactions to their baby which included revulsion and adoration. Most of the women (although not all) were offered and given pain management and anti-anxiety medication, which affected their memories of the physical process of labour and birth. Most of the women described feeling guilty that they had somehow caused the stillbirth.

The differences noted in the women’s experiences were largely related to whether or not a woman was having her first. For those women in whom the stillbirth was their first birth, the process of getting into labour was often long and tiresome. Women who had given birth before tended to have quicker labours and derived comfort from both the existence of their previous child and the knowledge that they could deliver a live child.
Saying Good-bye

When the women in this study talked about "saying good-bye," they meant this both literally and figuratively. Participants experienced the process of saying good-bye to the baby differently and individually. Some of the women could hardly wait to hold their baby immediately after it was born, while others were not immediately able to do so.¹⁹ One woman described feeling pushed to hold the baby despite her protestations and remembered this as the worst part of the whole experience:

They wanted us to hold the baby, which we didn’t want to do. And then they wanted us to hold the baby - which we didn’t want to do. And then it was quite insisted upon that we hold the baby and it was brought to us. I felt that [was] incredibly hard. And I would never have to and in 20/20 hindsight that was probably bar none the worst part of the experience.

The individual nature of the women’s responses and desires around the stillborn baby is reflected in variations in the need for ongoing contact with the baby. Some women felt the need to keep the baby with them for up to 3 days, trying not to sleep while the baby was with them. Others wished for only a short quiet time after the birth. The appearance of the baby, along with the onset of postmortem changes, seemed to play a role in when women decided to give the baby up. They wanted to remember the way the baby was when they first saw him or her, before postmortem changes altered their appearance.

Each woman chose different rituals in working towards saying good-bye. Many felt comforted by a short service in the room provided by a hospital chaplain. Others struggled with naming the baby, particularly deciding whether to "waste" a favourite

¹⁹ It has become generally accepted that women should be encouraged to hold their baby after it is born.
name on a baby that would never hear it used. One woman with a large family present took comfort in observing each family member cuddling and saying their own individual good-byes to the baby. Prior to releasing the baby, certain tasks seemed important to some women and not to others. For one woman, changing the baby’s diaper was important. For another, ensuring the skin was clean of blood was paramount. It was particularly upsetting to these women when the tasks that were important to them were not (or could not) be performed. One woman explained that she still cries over not having bathed her baby:

When he was born the skin was peeling back so they figured he had probably been dead a day or two before even going into labour and that probably triggered the labour. They wouldn’t wash him off and I felt really guilty that I couldn’t do it. Cause they said I couldn’t do it- I could- I could. They just didn’t want to.

The explanation provided by caregivers following this interaction (that the baby would have been too macerated to bathe) was not perceived as helpful or sensitive, or even accurate.

In addition to identifying specific tasks that they felt needed to be performed, most women were uncomfortable with any action that treated the baby differently to how a liveborn would be treated. For example, one woman described how a nurse put the baby on a chair while she left the room for something. The woman indicated that she had already held the baby, had given him back to the nurse, and was upset by the fact that the baby could be left unattended on a chair. Several of the women stated that they wanted their baby to be attended and cared for in their absence. One woman told me that she took great comfort from the fact that her midwives had sung lullabies to the baby on the way
down to the morgue. Another woman asked the nurse to watch over her baby when she left the hospital.

Once the desired rituals were completed, the women adopted a gradual approach to letting the baby go for the last time. One woman reported that she needed to bring the baby back several times before she could finally let it go for the last time. She felt more comfortable giving her baby to his father as an interim step than simply giving him to a care provider. She stated:

I knew that it felt like the natural time to let him go. And I was very happy to have my midwives- well first of all I gave him to [husband] and that was a lot easier for me to be able to give him to his father than to someone else.

Once the women had completed saying their good-byes to the baby it was important for them to leave the hospital, as they wished to remove themselves from the environment of healthy mothers and babies, put the experience behind them, and return home. They now found themselves in an extraordinary situation: although they were new mothers, they were carrying a silent history as they left the hospital, leaving the baby behind. Women who deliver a live baby leave the hospital with a baby in their arms, and the people they encounter both inside and outside the hospital congratulate them and coo at the baby as they make their way out. Women in this study described the feeling of “empty arms that ache.” This is particularly distressing when other mothers are leaving the hospital at the same time and they observe new babies put into car seats with balloons and flowers. Some of the women reported “breaking down” at that point and requiring support to leave:
Once I was sort of strong enough to stand up I went home. And you know, I don’t know what else you would do, but that was terrible as well because you are leaving without the child, right. And we went down, I guess my husband went down to bring the car so I’m standing there, the same place everybody leaves with their baby- so I had a total breakdown there and [the nurse] actually came down.

Women in this situation have only the memories or mementos of the stillborn, such as pictures taken at the birth, to take with them. Some of the women were initially very uncomfortable with the notion of taking pictures but all appreciated having them in retrospect; indeed, many wished they had more. In particular, some women commented on their inability at the time to take pictures with their own camera. Most could not tolerate the thought of even bringing a camera with them to the hospital. Because many hospitals use an instamatic camera, which gives poor picture quality and limited film life, many participants described regret and sorrow over having only the hospital photographs, and wishing they had “good” ones instead. Nevertheless, hospital pictures were described as important even if other pictures were taken by the family. One woman recounted that, of the three rolls of film taken by her family, none of the pictures turned out, so she was very relieved that the hospital had taken the few instamatic pictures.

In addition to the mementos received at the hospital, many of the women created personal memorabilia such as scrapbooks, a foundation in the baby’s name, artist renditions of a prized picture, poems, and even articles for publication. They reported

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20 Since the late 1980s, it has become hospital policy to provide keepsakes to women who have had a stillbirth. These keepsakes generally include photographs of the baby, handprints and/or footprints, baby bracelets, blanket and hat, and lock of hair. Each hospital is different in terms of which keepsakes are taken, but it is standard to provide some mementos for the parents to keep. Often women are not open to accepting these mementos immediately but in my experience, virtually all return for them at some point. As a Head Nurse of Labour and Delivery, I have received calls from women sometimes up to 20 years following their loss wondering if we had kept mementos of their stillborn that they could have.
struggling with the notion of how or whether to display these creations. They were sensitive to the potential reaction of outsiders who might perceive the mementos as morbid should they be displayed in a public location in the home, such as a living room. For this reason, many of the women opted to keep their treasures in a private location such as the bedroom. Still others chose not to display at all and reported keeping all their keepsakes in a drawer or storage area, bringing them out to peruse on anniversaries or special occasions. Many of the women reported that having an interview scheduled with me triggered them to pull out their mementos and look at them. Most reported the experience as bittersweet but soothing, rather than upsetting.

In summary, participants found “saying good-bye” difficult. Most considered holding the baby as important, albeit sometimes only in retrospect. However, this was not a unanimous finding. Occasionally the memory of holding the baby is one that continues to cause great pain and revulsion. Most participants performed certain personal rituals that they found helpful in their farewells to the baby. They reported being anxious to leave the hospital as soon as they emotionally ready to leave the baby, and physically able to leave the hospital. The finality of leaving the baby and the hospital was an intense emotional and draining experience, but mementos provided by the hospital and/or created by the women themselves were treasured and continue to provide solace and comfort.

**Dealing with a Postpartum Body: The Forgotten Mother**

Although labour and birth were completed and the women had returned home, the physical changes, aches, and pains of postpartum remained. Many of the women skimmed over their physical postpartum experience, and sometimes this evolved into denial of the postpartum status: “I was tired and I was actually bleeding quite heavily at
one point. I think it was Mum who said, ‘You gotta take it easy. You’ve just had a baby you know.’ I said ‘No, I haven’t.’”

Participants’ focus was largely on coping with grief. Some of the women found that their emotional pain was so great that they were not aware of their physical selves, although others described feeling sore and miserable. For those women who were aware of their physical pain, the most troubling concern arose when the milk came in. This physical change reminded them that there was no baby to feed, which increased their emotional pain. In addition, their engorged breasts were painful. Many of the women were given drugs to suppress the milk and some were given instructions to bind their breasts. Participants found both interventions emotionally distressing. One woman described feeling that her body had “betrayed her.” Another was disgusted by her physical postpartum body:

I felt self-loathing because I have this postpartum body and these big breasts that are all bound up and so you kind of smell a little bit of old milk and just- that was emotionally and physically very hard and I was not prepared for that by anyone.

My findings suggest a lack of consistency in the practice of postpartum follow-up for women having stillbirths. The women in my study reported various experiences of postpartum follow-up care, ranging from never being contacted once they left hospital, to being contacted once, to being followed-up every day. It is usual practice after any birth for Community Health Nurses to make regular postpartum visits in the home once women have left hospital. The focus of these visits is to assess the mother and baby and provide teaching. A large amount of time is usually spent on breastfeeding issues.
woman reflected that she supposed that if you didn’t have a live baby you got lost in the shuffle. The women who had continuous postpartum follow-up found it extremely helpful. One woman who was being cared for by a midwife compared her care to that following a livebirth. She sounded particularly impressed when she said, “She still came as if the baby was still okay.”

Although the physical postpartum experiences of the women and their care were largely unreported and diverse when reported, they consistently focused on the psychological aspect of postpartum and the emotional struggle with loss. Some of the women took tranquilizers and/or antidepressants, some attended private counseling. These women found it difficult to differentiate between whether they were suffering postpartum depression (PPD) or grieving normally. One woman steadily deteriorated after the birth and required a stay on a psychiatric ward in hospital.

Most of the women obtained psychological support through Internet chat groups, books, and support groups. The Internet was particularly beneficial to those women who did not feel comfortable in a group setting but required some interaction. Many of the women felt that, even if family and friends were supportive, they could not talk with them to the degree they needed to. They needed to talk with someone who had been through what they had been through. Even if family and friends were able to converse with the women initially, many women in my study felt the push from their family and friends to “move on.” These women required an alternate source to facilitate their grieving for as long as necessary. One woman explained that her experience was utterly

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23 Midwives generally visit Days 1, 2, 3, 5, 7, 14, 28 and 6 weeks.
24 It is difficult for caregivers to make the distinction between grieving and PPD as well. Time usually defines the distinction as PPD does not usually improve without treatment.
removed from that of her friends, because she was “missing someone that no-one knew.” Some women reported a fine line between needing support to talk about their grief, and needing support to move through the grief. One woman stated that the support groups, although helpful initially, never moved her through the stages of recovery. She did not want to “wallow” in her grief for a long time.

In addition to coping with their loss through talking, removing the concrete reminders of the baby also helped postpartum recovery. Most of the women reported that family and friends performed activities such as tearing down wallpaper, removing cribs, etc., and returning the home to as close to pre-baby status as possible. In addition, some women reported leaving the home and going on vacation. They found that uninterrupted time away from phones and flowers facilitated their grieving. Interestingly, some of the women found flowers especially distressing because they found having to throw out dead flowers reminded them of their loss: “Sending flowers I found really disturbing because they died a week later and you’re left with- I mean they were beautiful and I actually photographed every arrangement. So I photographed them and then threw them away before they died.”

In summary, participants’ postpartum experiences largely focused on the psychological aspects of coping with the loss. The physical experience was often “forgotten” by both the women themselves and the caregivers. Women who reported physical concerns were most commonly troubled by engorged breasts. Coping with the loss was facilitated by support groups, Internet chat rooms, reading literature, and getting away. Family and friends assisted by removing concrete reminders of the baby such as nursery items.
Dealing with Family and Friends

Participants explained that one of the most difficult tasks was notifying family and friends of the loss. Most of the women in my study shared that they felt unable to face people, so that it fell to their husbands to share the sad news. Some of the women chose birth announcements as a way to notify relatives without needing to speak with them and also record for posterity the birth of their stillborn infant. One woman shared that planned birth announcements prepared prior to the birth became a vehicle for her to share her feelings about losing the baby:

I’d already addressed and posted envelopes which I was just going to put a birth announcement in and I kept saying, “what am I going to do with those envelopes?” and when we came home we did a letter where we explained about the baby and announced her and just talked about our feelings because there wasn’t a ceremony or whatever that was held … and also so you don’t run into someone at Safeway and they say something.

Although the women indicated that family and friends were often a great support, they also noted that they could be a source of pain. Friends who were perceived as providing the best support were those who provided the concrete necessities of daily living such as food, housekeeping, and hairdressing. Close friends and family who were able to listen and remain present with the women’s grieving were considered extremely helpful, but were found to be all too rare. The women noted the multiple ways of grieving they observed and reflected that the loss of the baby was hard on close family and friends as well as themselves. They noted that their loss often brought up unresolved issues for
their friends and relatives. As a result, they often found themselves in a position of needing to comfort others rather than receiving support from them:

My mother, bless her soul, was not really someone I could talk to. She would just be weeping and crying. You know she broke down about the baby. I ended up comforting her more than she would ever comfort me. I presume she had unresolved issues but she never really discussed them.

In further discussing the impact on family, the women’s stories contained multiple reactions and interpretations of their husband’s handling of his own grief in particular. The women reported extreme differences in how their partners reacted to the loss, the birth, and the postpartum period. Some women received absolutely no support from their partner and shared that the marriage eventually dissolved as a result. These women described partners who were absent at critical times, missing the birth, refusing to pick them up from hospital or return them for postpartum visits, and refusing to talk about the loss or be there for them. At the other extreme, some husbands proved to be the women’s greatest support, catering to the women’s every need, sometimes to the detriment of their own health.25

The women’s most common reflection concerned the lack of sensitivity in people’s reactions and responses. They indicated that most people simply did not know what to say and made inappropriate or insensitive remarks, such as “There must be a reason,” “You can always have another,” or “You must have something you’re supposed to learn from this.” In addition, some of the women reported highly inappropriate

25 Although the partner’s experience of loss is not a focus of this study, their stories (through the women’s eyes) piqued my interest as having a huge impact on the experience/resolution of the grief. This would be a very interesting area in which to pursue further research.
comments challenging their ability to protect their baby. One woman was told, “If you hadn’t gone to a midwife, he would be here today.” Participants found these types of comments extremely distressing, not least because they were perceived as minimizing their loss:

Some people don’t mean to be rude or inappropriate but humans can be pretty stupid. They can be inconsiderate and not even realize it. I mean I had a woman who has had four children, my mother’s age and she said, “Well, maybe next time you’ll be more careful.” And I thought, “How dare you?” I mean I really wanted to reach out and slap her. And I said to her “More careful, what are you talking about?” And I was more, I was focused when I approached her and said “What exactly are you referring to?” [she said] “Maybe next time, just rest more.” And then they try and backpaddle...another time [someone] said to me “Well maybe next time don’t eat sushi when you are pregnant.”

Most of the women expressed gratitude and appreciation for those people who simply acknowledged the loss by saying “I’m sorry” or “I’ve been thinking of you.” They found that people’s attempts to fill an uncomfortable silence with unfortunate clichés contributed to their pain, although they recognized that most attempts to convey sympathy were well intended. In addition to poorly chosen words, well-meant gestures sometimes caused unintentional hurt:

The worst thing that happened after [the birth] was the office sent me a balloon bouquet. Yeah. The manager of the office thought that it would cheer me up so she wanted to send me something festive and cheerful. And I took it totally the wrong way. And I looked at it and the guy at the door thought it’s your birthday
or something. And I looked at him and I shut the door in his face. I was just
appalled. It hurt my feelings so much. You know, they just did not understand and
of course later I thought, well, how could they understand?

The women in my study reported that although most of their friends and family
were there for them at the beginning, the attention quickly died away. They were
expected to move on with their life, and if they were unable to move on, they were
gradually abandoned, even to the point of losing friendships. They reported that while
many of their friends enjoyed sharing birth stories, they felt that their loss of a child
constituted such a different reality that it could not be shared. As one woman put it,
"Usually after labour women love to talk about their births and their babies and I thought
well, who wants to listen to my story."

These women felt that they belonged to a “private club” to which only women
who had experienced a stillbirth could belong. They noticed that “women came out of the
woodwork” with their own stories once they realized you shared the experience. Most of
the women reported being surprised at the number of stories they now heard, considering
that they had never heard such stories before becoming part of “the club.” Interestingly, a
few participants had mothers who had also experienced a stillbirth, and they reported the
difficulty their mothers had in sharing this experience. The mothers were apparently
amazed by the differences in management of their daughters’ experience, as compared to
their own, and this often awakened upsetting memories of their own stillbirth.26

As time passed and the grieving process evolved, the women described their

26 Most of these mothers told their daughters that they never held their baby and often never saw it. This
was common for their generation. According to my participants’ accounts, their mothers experienced
distress and ongoing grieving for their own child through their daughters’ experience.
attempts to return to normal life. Many had great difficulty becoming involved in family functions such as weddings, funerals, and holiday dinners. Sometimes such events went well and the women were glad they took part. At other times they felt ostracized or removed from the festivities, often due to off-hand but upsetting remarks by other guests. Those women who had a child also found it difficult to care for that child and become fully engaged in their activities. Most of the women reported a “one day at a time” or “one foot in front of the other” approach to coping.

In summary, some of the women in my study obtained great support from their family and friends, and shared those gestures or interactions that they found the most beneficial. However, they most commonly reported unintentional insensitivity on the part of family and friends, and noted that common clichés were distressing and minimizing to their experience. They described feeling as if they were part of a private club that few others could belong to, and feeling like outsiders in many social activities while they were grieving. In addition, they noted that the impact of their husband’s response to the loss was profound and varied significantly. The women recognised that the responses of family and friends, whether helpful or hurtful, evolved from the pre-existing interpersonal relationships between them. The women’s interpretations largely recognized that the loss was difficult for family and friends as well, and, for this reason, they often rationalized unhelpful remarks and forgave them in retrospect. The same could not be said of the interactions with caregivers.
Helpful Interactions and Interventions by Caregivers

Despite participants’ recognition that caring for someone having a stillbirth must be difficult for the care provider as well as for the woman (one woman suspected that “they must draw short straws”), they nevertheless expressed higher expectations of professionals in terms of knowing what to say and how to say it. When good, sensitive care was provided, the women considered it critical to their ability to get through their traumatic experience. One woman described the nurse who cared for her during labour and birth as a “mental lifesaver.”

There was significant commonality among the things that the women found comforting or helpful in their care provider. They most frequently identified compassion as the most helpful quality, and also used the word “respect” to describe this quality. Participants reported sensing immediately whether or not compassion was present in the way they were handled upon presentation to labour and delivery. They considered it “compassionate” when staff clearly knew they were coming, were aware of their story, greeted them, and took them to a quiet place with a minimum of fuss: “They [the staff] had been pre-called and made sure that I was sort of ushered off into a little room. There wasn’t a lot of fuss over, oh you gonna have a baby or anything like that.” Care providers who communicated in a way that conveyed to the women that they recognized how difficult this must be for them and guided them through the process, were reported as the most supportive and appreciated.

The women also perceived continuity of care as very helpful. The best care was described as care consistently provided by the same compassionate caregiver. However, one woman noted that if continuity of caregiver was not possible, at least providing
continuity of care was an improvement over multiple caregivers with no interaction between them. For participants, continuity of care meant several things: caregivers were aware of the woman's history, the woman did not have to repeat her story or answer questions that had already been asked, and the caregiver knew what information had been provided and what was still needed. Sometimes the women reported that caregivers who "broke the rules" such as visiting hours to accommodate women's wishes relayed a compassionate message to them. The message the women received was that the caregiver appreciated what they were experiencing, that it was hard and different from the norm, and that the caregiver was trying to help them as much as possible.

Often the caregiver's intuition and "knowing" were reported as the most helpful. Caregivers who had the ability to intuitively discern what the women needed communicated an expertise that was greatly appreciated. The caregiver's ability to discern when quietly sitting with the woman was preferable to providing information or talking was an example of this intuitive expertise. One woman reported that her care provider "just seemed to know" when to enter the room and when to leave. She "knew exactly what I needed." Another woman noticed that her nurse gave the impression that she had all the time in the world for her even though she felt sure that the nurse had many other duties.

As well as the mode of interaction, participants reported certain concrete interventions as particularly helpful. The most commonly reported was the provision of

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27 Continuity of care is defined as a single approach to treatments, required interventions, and teaching. Continuity of care can be provided by different caregivers with a similar approach to care.

28 Interestingly, the most helpful interactions such as intuitiveness reflect the qualities of an "expert" nurse as described by Benner. This type of expertise may be what is required to best manage the labour and birth of a stillborn.
mementos. Although the women sometimes indicated that they did not initially want these reminders, they all expressed relief in retrospect that caregivers took them and gave them to them anyway. Mementos were seen as critical in facilitating the women’s grief and in providing concrete evidence that the baby’s life had been a reality for a short time. The women indicated that these reminders are comforting to them even now. In addition to mementos, the assistance of the hospital chaplain and attending support groups postpartum were also commonly reported as beneficial. However, the women reflected that, as with the example of the chaplain, certain rituals are important for some and not for others. Other examples of such necessarily individual rituals included whether or not to hold the baby, length of time needed to say good-bye, choice of method of delivery, and whether they wished to be near other women with babies or not. The women in my study did not think that “one size fits all” in terms of policies on managing stillbirth.

In addition to providing choices about individual needs related to helpful interventions, the women were particularly verbal about their emotional needs. They indicated that they needed their caregiver to accept the emotion, be present with them, and be able to listen. They did not need to be consoled. Some of the women noted that, similar to their experience with family and friends, some caregivers were distant and unable to provide support. In some instances the women found themselves actually providing support to the caregiver, as in the following recollection of a dialogue between a participants and her nurse:

She was very tense, she was very distant...like unsure of what to do and she was I

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29 Whether the chaplain was considered beneficial or not was largely a matter of individual preference and whether the spiritual needs of the women were being met. Women who were not religious often found the chaplain’s visit unhelpful.
would say in her late 40s. Clearly [she] had been doing this for quite a few years. So I asked her if she had any children and then she told me she had had a miscarriage, so then I asked her questions and so she ended up telling me her story and once she- she talked about how they weren’t allowed to hold their baby and they weren’t- it was handled very differently then than it is now and so really it was all about her reliving her experience and maybe even resentful of it being different for her loss. So once she talked about her story and her demeanour changed and it was like somehow free to be released to the present so that was good, but again I had to take care of her first.

The women summarized their need for emotional support by indicating that caregivers needed to be comfortable with and prepared for the emotional nature, and exceptional dimensions of the stillbirth experience.

Unsupportive Interactions and Interventions by Caregivers

Although participants shared many stories of helpful interactions, some also related very difficult and hurtful interactions and interventions with caregivers which were clearly unsupportive, some bordering on unprofessional. These borderline unprofessional interactions largely originated from caregivers who did not have a direct relationship with the woman, such as on call physicians, referral obstetricians, and radiologists. One woman’s account of her delivery by the obstetrician exemplifies such distress:

As soon as she was born he put her up on my stomach and he’s like, “OK, let’s get the placenta out. Let’s have another push here.” Like I was just like, you know, this baby’s been put on me, this dead baby. I didn’t know what to do with
her and he was just you know....he was doing his job but he didn’t have any compassion.

Inappropriate responses left a lasting impact on the memories of the women who experienced them. However, most of the difficult stories related by the women reflected insensitivity rather than inappropriateness. This fine line was recognized by the women themselves, who believed that insensitive responses were likely generated by ignorance rather than professional inappropriateness. One of the most common examples of this type of response was false reassurance. The women knew enough in these instances to sense that something was wrong and they found reassurances that everything was fine belittled their fear. One woman who rushed to hospital after experiencing an antepartum bleed and whose baby was later discovered to have passed away relates this example:

I kept asking them to hurry. And they kept saying, oh you know, calm down, this is normal. And I guess it was sort of a treatment that I was, you know, hysterical woman in labour sort of thing and I was- something was stuck in my mind, no, no something is really wrong... Anyway, we arrive there and, again, we are constantly told we are fine.

Most women indicated that they realized that the caregivers who were insensitive probably were not used to dealing with death (particularly death of babies) and did not know how to communicate appropriately.

Similarly, the women related other instances in which well-intentioned professionals attempted to provide support and information but came across as “preaching.” The women found the intrusive nature of these interactions difficult to
handle. They described trying to suppress their anger and shared their frustration at feeling the need to restrain themselves:

She’s just one of those people who just talks for the sake of talking so she turned and started explaining to the “crowd” ... like my parents and [husband], that they need to take this time to be with one another and that everyone here needs to support each other and support me and do this...and it’s a time for hugging and it’s a time for- and very, you know- like we’re so polite that we’re all going “thank you, thank you, thank you” when all I wanted to do is say “get the **** out of my room- I don’t want to be talking to you. I don’t know you. I’m dealing with the worst day of my life and I’m having to pretend to listen to you because I’m being polite and you’re saying stuff that’s so obvious it doesn’t need to be said and you’re saying it to people you don’t know.” It was just ridiculous.

Common practice and hospital policies sometimes stood in the way of caregivers’ ability to be helpful. Often the lack of clarity regarding accepted protocol or professional responsibility created a difficult interaction. This was most commonly related by the women regarding notification that the baby had died. The women recalled that it seemed to be no-one’s responsibility to announce (or confirm) that the baby had died, and this silence or awkwardness made the experience more difficult for them. Another common concern was the lack of prenatal preparation for the eventuality of a stillbirth. The women felt they had no information upon which to base any decisions and had no idea of the labour and birth process. Interactions regarding these decisions (e.g., vaginal or Caesarean birth), combined with caregivers who were sometimes unable to engage in supportive interactions, made the experience worse. Another protocol that created
anguish in one woman was the baptism of the baby by a well meaning nurse. This woman’s nurse gave the baby a name that was not the one chosen by the parents. When the woman discovered that a baptism with a different name had been performed, she was tormented with how to complete the stillbirth forms which required the name of the child.

Last, some women described feeling abandoned, unsupported, and alone. Sometimes this was experienced as a physical abandonment, for example being discharged after finding out the baby had died and told to contact their doctor, or put in a room away from other mothers and babies. Sometimes the experience was one of psychological abandonment: “I was treated like I had a tumour that was waiting to be born.” The women who felt abandoned were most commonly the same women who experienced insensitive or inappropriate remarks by their caregivers.

In summary, the women in my study reported varying interactions with caregivers, some helpful, some not. They reported needing compassion, continuity of care, to be treated as an individual, for caregivers to know their history, and to receive emotional support through caregivers’ ability to listen rather than console. In addition, in more concrete terms, they appreciated mementos of the birth, information, and referral to support groups.

Most commonly the women described the nursing and primary physician care as compassionate, but ancillary medical care as lacking in sensitivity. Some of the women suggested the potential need for two care providers – one for the medical care and one for the personal care. The women most commonly reflected that insensitivity was likely due to the infrequency of managing stillbirths and the personal discomfort of those

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30 Baptism of the baby is often performed in the event of a stillbirth, depending on the religion of the caregiver and hospital policy.
individuals who were perceived as unhelpful. The most common occurrences of unhelpful interactions or interventions were false reassurance, lack of prenatal preparation, sense of abandonment, and lack of choice.

**Summary**

The goal of this chapter was to describe the experience of delivering a stillbirth for the women in my study, in order to establish the context for understanding their experience of livebirth after stillbirth. The women reported a highly distressing sequence of events occurring over a short period of time, which left a major impact on their lives in the long-term.

The sequence of events involved physical procedures and emotional experiences that none of the women felt prepared for. Prenatal classes and preparation failed to prepare them for the sad event that they all experienced. This chapter described the details of the women’s experience related to hearing the news, wanting the baby out, their stories of labour and birth, managing postpartum, and dealing with family and friends. In addition, interactions with healthcare providers in terms of interventions that were perceived as helpful or unhelpful were described.

The women greatly appreciated sensitivity and compassion, continuity of care, and individual respect whenever these were offered, and noted that all of these had beneficial effects on their ability to cope with the experience. Although nursing and primary physician care were largely described as compassionate, other medical personnel and consultants were often perceived as unable to meet the women’s needs.

Certain key factors emerged as critical in the women’s experience. These include the time delay in finding out the baby had died and the resulting “suspended fear” and
false reassurance they experienced prior to the diagnosis, the lack of choice about
Caesarean section or vaginal birth, the inability to determine the cause of the loss (in
most instances), the individual needs for performing personal rituals in saying good-bye
that were not always respected, and the unintentional insensitivity of family, friends, and
caregivers.
CHAPTER FIVE
TRYING AGAIN: WOMEN’S STORIES OF LIVEBIRTH AFTER STILLBIRTH

Introduction

Women’s stories of their stillbirth experience describe an extremely difficult time in their lives. The impact of stillbirth on a subsequent pregnancy can be profound, and sets a context for future childbearing that needs to be better understood by caregivers and society at large. An analysis of participants’ experiences of subsequent pregnancy suggests themes relating to specific timeframes throughout the childbearing period, which reflect the chronology of pre-pregnancy, pregnancy, labour and birth, and postpartum. The findings have therefore been organized under these sub-headings.

The Need to be Pregnant Again

The desire to be pregnant again was commonly shared by the women in this study. Some of them indicated that they talked about having the next baby as early as the ultrasound in which they heard the news of the fetal demise or the induction of their stillborn baby. Most of the women acknowledged that their health care provider encouraged them to wait a period of time following the stillbirth before trying for another pregnancy. The most commonly reported recommended interval was 3 months, but recommendations ranged from advice to try again immediately to advice to wait a year.31 Many of the women acknowledged that waiting was probably good advice in retrospect, but explained that they felt unable to consider it rationally at the time. Although these women acknowledged that they were probably not emotionally ready, many described

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31 The recommendation for a year was made in only one instance. The woman given this recommendation had a medical complication that required additional physical recovery time in the opinion of the caregiver.
becoming “obsessed” with the need to get pregnant. Others stated that they simply “had”
to get pregnant: “I was hell bent to get pregnant again,” “I had to prove to myself I could
do it.” One woman described the experience as follows:

I was obsessed with getting pregnant even though we were told we should wait a
year. Depending on what professional it was that we talked to, some said 3
months, some said a year. Looking back I know I wasn’t ready emotionally but
I’m not sure that I ever would have been ready… I just, after a year I decided
that, OK that’s it, I wanna get pregnant, I wanna get pregnant now….it took us
almost a year. I pretty much fell apart emotionally during that year trying month
after month.

Most of the women tried to comply with medical advice regarding a waiting period but
explained that the wait felt interminable. One woman described “counting the days for 3
months” until she could try to get pregnant again. Another woman stated that each
menstrual period felt like another death.

Although the desire to be pregnant again was strong, the women felt concerned
about whether or not their physical bodies had healed. They recognized various
indications such as a normal menstrual cycle or a test to determine that the ovaries were
working as reassurances that their bodies had recovered. Although most were able to wait
in order to meet their physical recovery needs, few were able to consider recovery of their
emotional health. The following example illustrates the tension between emotional
instability and the strength of the desire to be pregnant:

I started trying to get pregnant like pretty much right away. I just kept waiting to
ovulate -- waiting to ovulate and I bought those ovulation tests—just obsessed—
obsessed with it. Within two days [of the stillbirth] I was thinking “I want to have another baby” So it was just immediately. I remember having a bath and sitting crying in the tub because [husband] was talking to me and I said “I want to have another baby.”

All of the women in this study acknowledged their grieving and emotional fragility following the birth of their stillborn baby, but found that the strength of their emotional desire for a new pregnancy outweighed their intellectual awareness that waiting would benefit their healing. Many were unable to wait despite both the medical advice to allow a period of recovery and their own instinctual knowledge that waiting would be beneficial. Some felt that a pregnancy would assist with the grieving:

The only way I felt that I was going to feel better was to have a healthy baby again. So even in the midst of my depression and all that, all that I wanted was another baby. And um, I knew I wasn’t well enough to do that immediately but at the same time, I knew that [a healthy baby] was what was going to make me well.

Although the women clearly wanted another baby quickly, some recognized that they were frightened by the prospect of another pregnancy. The thought of potentially going through the agony of stillbirth again terrified them, as they felt they would be unable to cope should stillbirth reoccur. Some of the women noted that they were afraid to try again until they could understand why their stillbirth had occurred.\(^{32}\) Two of the women were so frightened that they seriously considered adoption rather than risking another stillbirth. However, the women’s desire to conceive proved stronger than such

\(^{32}\) Unfortunately, in most cases of unexplained stillbirth, autopsy results find nothing wrong. This can be very frustrating for parents as they often blame themselves. In contrast, autopsy findings that indicate a cause of death can be reassuring to the women.
fears. In one instance, the fear itself was a motivating factor for pursuing pregnancy. This woman’s decision to get pregnant quickly was based on the fear that if she did not try again as soon as possible, she would be too scared to ever try again:

I remember [the doctor] saying as long as you know you have—I think it was two healthy periods, then you can try and it was just like—I don’t know—I don’t know if it was—we just thought “Yeah, we want to do it again” and I think of it as conquering or sort of thinking, “We’ve got to do it; if we don’t do it now, we’ll be so scared” so it was just timing and making sure my body was okay and then it was like. “Yeah, well, let’s try.”

For the women in this study, the decision to become pregnant seemed more likely to be made according to the women’s wishes. About half of the women noted that their husbands were not ready to pursue another pregnancy. Nevertheless these same husbands went along with the women’s strong desire to get pregnant as soon as possible. In some instances, the women compromised with their partners and negotiated the decision of when to get pregnant again:

We were told to wait for 3 months. I was counting the days. [My husband] was not ready emotionally in 3 months. You know it was very scary. So we waited four. And that was a difficult time for us because I was so anxious. I was thirty-six and nervous all of a sudden about my ability to conceive. We had conceived [name of stillborn baby] you know the first time without protection use. But all of a sudden I thought, well, if this [name of stillborn baby] can fall on my shoulders, what next? Maybe I am never going to be able to conceive again. So I was very
anxious to conceive. [Husband] was a little more reluctant. We finally came to an agreement at 4 months.  

All the women in my study, including those whose relationship had deteriorated after the stillbirth, expressed that their desire to conceive was strong.

In summary, participants reported that they felt the need to become pregnant again quickly, often becoming “obsessed” with conceiving. This need superceded both the fear of reoccurrence of stillbirth and the women’s incomplete emotional healing. The women either disregarded the medical advice received regarding interpregnancy interval, or counted the days until they could try again. The physical recovery of their bodies was an important factor prior to pursuing a subsequent pregnancy.

PREGNANCY: A TRIAL TO BE ENDURED

Finding Out: Mixed Emotions

Participants’ strong, “obsessive” need to become pregnant evolved into conflicting emotions once the pregnancy was confirmed. The majority of the participants described their initial reaction to the news that they were pregnant again as “happy but scared.” One woman described feeling sad that she wasn’t as happy as she thought she should be, attributing her muted happiness to her fear. These women wanted and accepted the pregnancy but acknowledged their fear of the path that lay ahead. The following response exemplifies the feelings expressed by most participants:

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33 For this woman, the issue of age may have had a potential influence on the desire to become pregnant quickly. However, it seems likely that the stillbirth was a greater influence considering the ease with which pregnancy occurred for her in the past.

34 The birth of their stillborn seemed to exacerbate relationship difficulties for two of the women. The relationships eventually failed but both women became pregnant again after the stillbirth.
I didn’t have a period between delivering [name of stillborn baby] and getting pregnant again and what if whatever had caused her to [die] – I think I had the autopsy results by then so I was so excited but I was so scared. [I] just said “Oh, I can’t go through that again.”

Although most of the women were happy to discover their pregnancy, two of them were actually upset when a pregnancy occurred, despite acknowledging that they secretly wanted or were outright trying to achieve a pregnancy. When they realized they were pregnant, both of these women hoped and prayed for a miscarriage. They described crying and feeling “empty” when they found out about their pregnancy. It seems that the confirmation of the pregnancy instigated second thoughts about their desire to be pregnant, with some participants telling themselves that they were wrong to have tried as they really “weren’t ready.”

In addition to the most common initial reaction of being happy but scared, another frequent theme among the women was their clear differentiation between “being pregnant” and “having a baby.” The women described taking the pregnancy day by day and not expecting a live baby at the end of it. As one woman stated, “I guess when I’m pregnant, I kind of don’t acknowledge that I’m pregnant until the baby’s born…. It’s just not a given that when you’re pregnant you’ll have a baby.” A typical response to being pregnant was “Well, maybe we’re going to have a baby.” Another woman described her own lack of faith in a happy outcome as extending to tainted beliefs and behaviour around all pregnant women:

I remember crying [when I found out about the pregnancy] – like it was such a mixed emotion. It was like “Yay!” and then it was like “Oh my God! Can I do this
again?" It was totally – like I always said “Anyone who experiences this [name of stillborn baby] is like tainted.” Because you don’t – even now if someone says to me, “Oh, I’m pregnant” and I’ll say out loud “Oh, that’s great! Congratulations!” but in my heart I’m going, “I’ll be even happier in 10 months’ time and you’ve got a healthy baby.” Like I don’t do shower presents early; I don’t go to showers; I just don’t do it. I don’t want to jinx anybody. So with [her pregnancy of subsequent birth] it was a mix. It was like happy and really nervous – really scared.

Many participants handled becoming pregnant in a matter-of-fact manner in order to address their fear of potentially not having a baby at the end. These women experienced a lack of engagement in the pregnancy that one woman described as “We were happy we were pregnant but we weren’t going there kind of thing.” Participants commonly described a business or checklist approach to becoming pregnant, such as “OK, step 1 done, I’m pregnant,” or “OK, we’re in the [new] house, like we’ve got everything set up now, so got pregnant.” In contrast to most of the women’s lack of engagement, the strength of will and determination to look forward to her new baby allowed one woman to describe absolute joy when learning of her pregnancy. She stated that she “very deliberately did not want to go through the pregnancy fretting...very deliberately wanted to look forward to the baby and enjoy the baby for itself.”

In addition to their inability to fully engage in their pregnancy, the women in this study commonly expressed their terror of losing another baby and their perceived
inability to survive another loss.\textsuperscript{35} One woman who had had two miscarriages between her stillbirth and the subsequent livebirth explained:

"Four years after [name of stillborn baby] I got pregnant again. Um, and of course, this time it was like well, yeah, so what? I was very nervous and I just kept thinking you know, [I'm] going to lose this one too...I didn't want to tell people...I didn't want to tell everyone because it would just make it too hard if something happened."

Although most women did not talk about when they shared the news of being pregnant with others, some described needing to keep their pregnancy a secret, as in the above example. These women were unable to share their pregnancy as they felt the consequences would be too hard to handle if a second loss occurred.

Although fear of loss was a common theme among the women in this study, the extent to which such fears affected their becoming pregnant again varied considerably. One woman who had previously delivered stillborn twins experienced something of an emotional roller coaster with her subsequent pregnancy. Like most of the women, she was obsessed with becoming pregnant, but "wasn't happy at all" and recognized that she was not ready when a new pregnancy occurred. Her hopes rose to some degree when she discovered that she was again pregnant with twins, because she believed that a twin pregnancy is "special." When a subsequent ultrasound confirmed only one heartbeat, she "shut down," not wanting the baby, and even hoping to miscarry. She was so afraid of losing another baby that she did not want to engage at all with the pregnancy, to the

\textsuperscript{35} Most of the women in this study differentiated between stillbirth and miscarriages. Three of the women experienced miscarriages between their stillbirth and subsequent livebirth. The reaction to the miscarriages varied from disappointment, to not particularly affected, to sorrow. Whether the women's described fear of being unable to go through losing another baby included their miscarriage was individual to the women.
extent of not wanting to touch her belly when she showered. She did not tell family members that she was pregnant until she was 7 months along, as she did not want people talking to her about the pregnancy. She acknowledged that she “was a mess emotionally.” Although this example is extreme, many participants expressed their own fear of loss and connected their inability to engage in the pregnancy with that fear.

The common themes of happiness accompanied by fear, lack of engagement in the pregnancy, and terror of another loss were frequently cited. Less frequently, participants described various ways in which they determined to take care of themselves once they found out about the pregnancy. One woman described the pregnancy itself as her way of taking care of herself. She stated, “Just carrying a baby again helped and being pregnant helped me.” Another woman decided to quit her job when she became pregnant so that she could focus on taking care of herself.

In summary, the women in this study most commonly reported happiness tempered by fear upon learning of a subsequent pregnancy. Other common themes included a clear differentiation between being pregnant and having a baby, a lack of engagement in the pregnancy, and a terror of going through another loss. The lack of engagement in the pregnancy often resulted in a business or checklist approach to the pregnancy.

Living with Fear

Terror of loss continuing throughout the pregnancy was a common theme among the women in this study. One woman explained that she thought she would need to be “put in a coma for 9 months.” Participants recognized that, for them, pregnancy was no longer the “glowing, radiant time that it’s made out to be.” They described a loss of the
innocence and naiveté that they had previously experienced with the pregnancy that resulted in a stillbirth. One woman explained:

I mean it was a very stressful pregnancy because I was worried that it would happen again, not so much that [name of stillborn baby] happening again but that whole sort of bubble of nothing’s going to happen. I mean you never think that anything’s going to happen when you’re pregnant for the first time – it’s just not something you think about so that whole bubble of “it’s going to be perfect and nothing is going to happen” was gone.

In addition to their loss of naiveté, the women described changes in their assessment of risk and their decision-making around risk management. For example, many of the women were offered an amniocentesis. Some women indicated that the test was offered because of their age, others that it was offered because of their previous fetal demise. Regardless of the indication, the majority of the women decided against having an amniocentesis out of fear related to the small risk of ensuing miscarriage, a risk they said they would previously have taken. The women noted that they felt much more vulnerable to misfortune, and experienced pregnancy more as wanting time to pass than an enjoyable process. One woman stated, “I remember counting – literally crossing days off on the calendar, getting to the end, worrying about the end, worrying about every step in between.”

Although the women experienced some variation in the manifestations of their

36 An amniocentesis is an invasive procedure in which a small sample of amniotic fluid is removed from the uterus with a needle and syringe. A genetic portrait can be obtained from the sample.
37 Although not a focus of this research, women in my study who had experienced a second pregnancy following the initial subsequent pregnancy following stillbirth commonly reported less anxiety with the second subsequent pregnancy.
fear, there was commonality in the triggers precipitating increased fear. Most of the
women described waiting for ultrasounds, nonstress tests, and other antenatal tests as
very emotional occasions. The women’s previous experience of finding out about their
stillbirth during one of these tests, sometimes in the same room, brought back a feeling of
sadness when they were repeating the same activity or found themselves in the same
environment. Additional individual triggers for fear often included those which related to
the specifics of the previous pregnancy. For example, one woman who had lost her baby
at 28 weeks became less fearful at 32 weeks’ gestation because by this stage she expected
that the baby could probably survive if it was born. Other women’s anxiety increased as
the third trimester approached and they were more fearful of events during labour.
Interestingly, one woman claimed that she did not worry much during her pregnancy at
all: “I don’t know, maybe I’m kinda stupid but I wasn’t carrying a lot of fear. I was just
kinda moving on to the next step, the next baby.” She indicated that she thought she was
in a better comfort zone than many of her caregivers.

Although this woman experienced her pregnancy emotionally in a very different
way than the rest of the women in my study, she did share the rest of the women’s
observations regarding fetal behaviour and fetal movement. All of the women indicated
that they were much more aware of how the baby behaved in utero and were particularly
sensitive to fetal movement. They described incidents of being alternately frightened and
relieved when they were not aware of the baby moving. One woman explained:

There was one time the baby had gone to sleep. [I] didn’t feel the baby, couldn’t
wake the baby. [I] lay down on my back and shook the baby, Baby woke up very
irritated. Little fists and little feet going as fast as it could. I had a bit of a giggle myself. [I] cried and moved on.

Another woman described becoming particularly anxious at night, and being unable to sleep until she had felt the baby move. Participants generally described themselves as being very “tuned in” to their bodies and their babies.

For a small number of women in this study, the experience of fear in pregnancy was exacerbated by their incomplete emotional and psychological healing following the stillbirth. These women suffered from major postpartum depression following their stillbirth and required therapy and even occasionally hospitalization. For these women, the fear was as much for themselves as for their baby. They were afraid they would be unable to cope if anything went wrong.

In summary, the women in this study experienced fear of loss that generally extended throughout the pregnancy. The pregnancy was experienced as marking time, and moving from one hurdle to the next. The women described a loss of naiveté in pregnancy, recognizing that the baby might be lost at any time. They were therefore quick to be frightened and experienced alternating periods of panic and relief. The women described being particularly in tune with their bodies and their babies’ behaviour, focusing most particularly on fetal movement.

**The Need for Reassurance**

The women’s fear during pregnancy created a need for constant reassurance. In addition to their attempts to reassure themselves by activities such as stimulating their babies to make them move or doing research on the incidence and/or the cause of their stillbirth, they looked for greater security through their choice of caregiver and plan for
care. The women’s choice of caregiver, availability of technological support, and an altered plan for care were sources of medical reassurance.

Most of the women in this study changed their care provider, or supplemented their primary care provider with a specialist, or both. Where the cause of the stillbirth was known and was related to an obstetrical complication, primary care was usually assumed by an obstetrician or maternal/fetal medicine specialist. Some of the women requested that their primary care be provided by a specialist even when there was no medical indication and a stillbirth was unlikely to reoccur. These women found specialist care reassuring and believed that the specialist would be able to handle any problems should they arise. One woman described her negotiation with physicians:

I found it hard to find a doctor this time around. I had a family doctor who I wasn’t particularly impressed with before [name of stillborn baby] died. I had tried to get into this particular doctor while I was pregnant with [name of stillborn baby] but she never took any new patients. After he died, at a time when I was really yearning for information and understanding, I didn’t have a doctor I trusted to take me through that. I called that doctor’s office a couple of times. And each time, “no, she didn’t take any new patients” and she was a doctor who I had heard wonderful things about from various friends of mine who delivered babies. And so finally I wrote a letter and I said, you know, in one paragraph, this is what happened. Lost a baby in [month] and we’re hoping to be pregnant again one day and if that happens I would really, what would help me a lot through that pregnancy would be to feel like I’m really in competent hands. In the hands of somebody who understands how difficult this will be for me. And so she called
me that night and took me on as a patient and so I felt so relieved. I felt like a weight was off my shoulders once that happened.

Some women chose to stay with a well-liked primary care provider, recognizing that the stillbirth had occurred through no fault of their caregiver. In those instances where the women chose to stay with their original primary care provider, an obstetrician was often consulted to reassure both the woman and her provider. Many of the women availed themselves of the option for sharing care between a family physician and a specialist. However, one woman who wished to share care between her midwife and a physician found this difficult. She explained that due to B.C. Medical Service Plan restrictions, she was forced to make a choice. She felt the need for enhanced medical security and therefore chose a physician for her primary care. However, she continued to maintain contact with her midwife who provided massage therapy during the pregnancy.

In addition to their caregiver changes, most of the women in this study experienced heightened antenatal surveillance throughout the pregnancy, which increased as the pregnancy came closer to term. The increased surveillance varied significantly among the women and included prenatal visits, ultrasounds, and non-stress tests that were all increased from the norm. Some women had all of these increased; others had only one increased or had various combinations of them.

The women varied somewhat in their desire for more frequent antenatal visits. The majority felt that increasing the number of prenatal visits assisted (or would have assisted) with their need to be reassured. The frequency of antenatal visits was generally the care provider's decision and therefore the women's desire for changing that frequency
was evaluated and told to me in retrospect. One woman who attended a normal number of visits explained:

I would have liked more visits. I would have liked just anything to reassure me, so more visits, more ultrasounds maybe, although I’m not sure, but just having the option, -- more non stress tests. I didn’t. And this doctor’s, I think, approach was to normalize my pregnancy experience. But my pregnancy experience wasn’t normal and there was no way you could make it normal....my stress level’s abnormal, my fears are abnormal and so her approach, as kind and well intended as it was, didn’t work for me.

In contrast, some of the women attended a normal schedule of visits, one choosing to do so despite being offered more frequent assessments:

P: I went to regular appointments. She told me I could come more frequently if I was concerned and I didn’t think so -- which surprised me but again I had those scary mornings where I’d wait for the movement and “okay, if I don’t get it now, I’m going” but I did – I’d get movement and get on with my life kind of thing....But no, I didn’t do any extra – other than my own checks

R: And that was your choice because it was offered to you or..?

P: There was no reason to. I mean I never even had so much as a blip. Like my pregnancy was textbook. If I wanted her to move, she moved. Like, I don’t know, I had no bleeding, I had no pain, I had nothing to really set any alarm bells off...There was no reason to really get – I don’t know. Somehow I just got through it I guess.
Despite some variations in their satisfaction with the antenatal course some of them undertook, the majority of the women in this study who attended an increased number of visits found them reassuring. One woman described her ability to be reassured by the increased surveillance. Her response was typical of those women who received increased visits:

It was nice to be able to come in every two weeks to make sure – just to hear the baby because between the ultrasounds and the every two week [visits], I was hearing the baby’s heartbeat every week basically because they would sort of run off each other. So visits every two weeks and then the ultrasounds every three weeks so it's pretty much every week that I could hear the baby was OK. And it’s reassuring to hear their heartbeat and know it was OK.

As shown in this example, ultrasound scans were one of the most utilized forms of technological reassurance. The majority of the women had more than the one ultrasound at 18 weeks’ gestation that is recommended for normal pregnancy. The frequency and timing of ultrasounds varied. Ultrasounds occurred as early as 7 weeks to confirm pregnancy, and as late as the week of delivery to rule out a cord around the baby’s neck. The frequency of ultrasounds also varied, with some women having serial ultrasounds every 2 weeks or every month. According to the women in this study, many of the ultrasounds were performed to reassure both themselves and their caregiver that all was well. One woman indicated that her fetal growth was a little under the expected level and as a result she was booked for ultrasounds every 2 weeks. She acknowledged that this was most likely done for her own reassurance:
I was a little bit behind in my measurements all the time and I asked my doctor — again having to ask — I said I'm concerned about this and she kept on saying "I'm not at all because the curve is right, etc." But I asked to go see an obstetrician. I did and this doctor was concerned enough that he wanted me to go for serial ultrasounds to just confirm the baby's growth. That ended up being a non-issue but I needed that kind of reassurance.

Although the women noted that waiting for ultrasounds and fetal monitoring increased their fear, they also described the tests as reassuring. Participants described first listening to the baby's heartbeat as alternately pleasurable and sad. These women described being reminded of their stillbirth when they first heard the baby's heartbeat. Although they were reassured that the heartbeat was there, they also relived the experience of hearing their stillborn baby's heartbeat for the first time. As the pregnancy progressed, hearing the heartbeat became reassuring. One woman actually purchased a fetal Doppler in order to reassure herself by listening to the heartbeat at home. However, she never actually used the Doppler because she feared she might not use it properly and therefore not hear the fetal heart.

As the pregnancy came closer to term, non stress tests (NSTs) were also frequently used for reassurance in addition to routine auscultation. Although a minority of women chose not to be monitored, or indicated they would have liked more monitoring, most described having "lots" of NSTs, and perceived the NST as reassuring rather than bothersome. One woman described being "happy to do it as at least I'd know everything was still fine with me." Most participants happily did whatever was necessary to safeguard their baby's health. One described "loving" her weekly NSTs. She stated:
That was one of the most relaxing times in the week for me....I’d just sit and chat with the nurses because I got to know them and they let me go into these special rooms that weren’t even very clinical feeling...and they [the nurses] were just so supportive and kind and ...just so nice that the whole time I’m thinking I don’t have to be worried while I’m sitting here that he’s dying because I know [he’s OK] because I’m listening to a heart right now.

In addition to scheduled NSTs, additional NSTs were sometimes performed to check on the baby following a scare regarding perception of decreased movement or following a fall. Once the fetal heart was heard the women were immediately relieved. One woman explained that once they “turned up the heartbeat [on the fetal monitor] nice and loud we were fine.” Another woman described how much she appreciated the “open-door” policy of the hospital in that she felt able to drop in for a NST whenever she needed reassurance.

In contrast, one depressed woman who described her behaviour during pregnancy as “going through the motions” hated having both ultrasounds and NSTs. She stated that hearing the fetal heart “made her want to throw up.” She also tried to attend a Vaginal Birth after Caesarean Section (VBAC) class but felt as though she did not fit in. The instructor asked all the participants in the class “what they had at home” (a colloquialism commonly used in maternity care to refer to previous children).38 The woman in my study was the only participant who had no children at home, and as a result she found her depression exacerbated and did not return to the class. Although this woman experienced particular issues not common to most of the women, she nevertheless highlights the

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38 It could be assumed that women attending a VBAC class have experienced a previous Caesarean section and would therefore have at least one child. Unfortunately, the history of stillbirth is often overlooked.
complicated notion of fear of loss in pregnancy and the importance of managing the need for reassurance, however the woman presents.

In addition to increased technological assistance, the women described additional non-technological ways in which they tried to enhance relaxation and decrease stress. For example, they described taking yoga classes, reading, or attending personal counseling or support groups. Participants found that all of these were helpful and enhanced the medical and technological support they received. Some of the women were advised to maintain fetal movement counts as a way to monitor their baby's well being and decrease stress. Some of the women used the fetal movement charts whereas others did not, most citing an inability to keep up with it. Support from family and friends was invaluable when it was received, but some of the women described unsupportive family relations and friends who did not understand their situation and were therefore unable to be helpful.

In summary, all the participants described the need for reassurance during the pregnancy following stillbirth as central to their antenatal journey. Their heightened fear of loss led most of the women to make alterations in their pregnancy plan of care and management. These alterations included a change of caregiver, the addition of an obstetrician as primary care provider or consultant, and/or increased antenatal surveillance. Increased antenatal surveillance often included an increased frequency of antenatal visits, and an increased number of ultrasounds and non-stress tests. Although

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39 The practice of fetal movement counting is controversial. It is sometimes suggested as a tool to assess fetal well being in the antenatal period for all at-risk pregnancies, not only following stillbirth. The controversial nature of the test makes analyzing its use with this sample of women not particularly beneficial.
the women described feeling anxious while waiting for these tests, they also mostly felt reassured by them.

**Coping with Anniversaries**

The women in this study were split on the notion of whether or not they experienced particular anxiety around anniversaries related to the stillbirth. About half of them did not focus on anniversary dates and the other half struggled with the special dates as they occurred. The most common anxiety expressed was when the EDD of the current pregnancy was the same as that of the stillbirth. This caused extreme distress to the extent that women bargained with their caregiver for a change of due date and made an agreement early on in the pregnancy that the birth would not take place at the same time as their stillbirth. One woman explained:

His due date was actually the same as hers...I specifically told lots of doctors “don’t say that” and then they’d say it and I’d say “any date but that date please.”

It started off when they’d say [one date] then they’d say [another date a week later] and they’d finally figure out [a third date]. That was her due date...so my doctor said “We’ll go with the earliest and we’ll probably go 2 weeks before that just to – like as soon as he’s viable – like I was so stressed that they thought it’s better just to get the baby out [as soon as possible].

The majority of the women in this study were pregnant at the first year anniversary of their stillborn’s birth date. Despite the new pregnancy, many women grieved and marked the occasion as special, acknowledging it by poring over mementos, memory boxes, talking with close friends, or arranging family gatherings. In contrast, one woman approached chose not to talk about the stillbirth until she had a live baby.
However, she described herself and her family as being “very conscious” of the first anniversary, with her mother “mention[ing] it very sideways.” This woman described the time leading up to the anniversary as a “sort of really hard week and a half,” although much energy seemed to be put into avoiding the pain. Another woman described her feeling of being pregnant at the one-year mark as “quite momentous.” She described all the first year anniversaries as difficult, a typical response among the women in my study. She stated:

The first year I think is definitely the hardest. The first Christmas, the first birthday – all those things you sort of – Father’s Day, Mother’s Day – those types of things. I had just finished with that midway through the pregnancy so I’m sure I was still grieving but the focus was off [name of stillborn baby] at that point. It was more on day-by-day with the pregnancy but not enjoying it so much as worrying about it.

For some women, the one-year anniversary was made more difficult by certain additional factors. For example, one woman had decided to move the burial site of her stillborn and chose to perform the re-burial on the anniversary of the death. This event was made all the more distressing by the fact that the woman was currently pregnant. Another woman described being at exactly the same stage with the subsequent pregnancy at the anniversary of the stillbirth. She described mourning the loss of a baby she did not have while sitting in the same maternity outfits, in effect “living the identical pregnancy a year

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40 This woman’s mother also had a history of stillbirth which her daughter (the woman in this study) indicated she “never talks about.” It is possible that the family dynamic influenced a perceived expected behaviour which may be contributing to this woman’s reaction to the first anniversary.
later,” and finding this very difficult to accommodate “in her head.” Occasionally, the due date of the stillbirth was not perceived as an anniversary. One woman described the date of the loss itself as the only one that was remembered.

For the women who were not yet pregnant, the focus on the anniversary of the stillbirth did not compete with a current pregnancy, but, for most, highlighted the fact that they were not yet pregnant and were still childless. Some couples chose to travel with their partner for the first anniversary. One woman explained that she and her husband needed to do something special together to mark the date and therefore traveled to their home province. The anniversary of the stillbirth was a difficult day for the women, whether they were pregnant or not.

Although the first anniversary of the stillbirth was the most frequently described anniversary, some of the women referred to “hurdles” in their pregnancy as milestones or anniversaries to “get through.” For example, one woman who had experienced two miscarriages between her stillbirth and the livebirth described the gestational ages of the three losses as hurdles to pass. Once she successfully negotiated the first trimester, her anxiety increased exponentially as she approached the 37-week mark when she had had her stillborn.

In summary, the majority of the women in this study acknowledged and grieved the first anniversary of the stillbirth. However, there was some variation in the importance the women gave to anniversaries, with about half of them finding the first year difficult with each special day and holiday, and the other half not focusing on

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41 In order to recognize the pregnancy as identical with regard to synchrony of gestational age and calendar month, the due date would be the same and therefore known to the woman.
anniversaries. Some women described anniversaries of previous losses as “hurdles” to get through during the pregnancy.

**Caregiver Responses**

The caregivers who were perceived as most helpful by the women in this study were those who communicated effectively, supported the women in their need to assume more control, and offered choices.

Most of the women in this study read voraciously and were very knowledgeable about the incidence, causes, and possible prevention of stillbirth following their own experience of stillbirth. They were therefore disbelieving of false reassurances and wary of restrictive advice given by care providers. As one woman explained, “It doesn’t matter what they [caregivers] say, you’re never sure it won’t happen again.” One woman whose stillbirth was due to a genetic abnormality described her frustration with her physician during a conversation regarding her triple screen\textsuperscript{42} results. She indicated that the physician called to tell her that her baby had Down’s syndrome and that she needed to have an amniocentesis immediately. The woman understood the non-diagnostic nature of triple screening and knew that Down’s syndrome could not be diagnosed by triple marker screening. She asked the physician to read the actual results and, having heard them, confirmed for herself that Down’s syndrome had in fact not been diagnosed and indicated to her physician that, in her opinion, her level of risk did not warrant an amniocentesis. The advice to have an amniocentesis immediately was therefore declined. Another woman described her consultation with an obstetrician in the third trimester as stressful.

\textsuperscript{42} Maternal Serum Screening (triple screen) is an antenatal blood test that compares levels of certain factors in the maternal blood that in some combinations and levels may indicate increased risk for certain fetal abnormalities.
He had told her that if she was overdue by a certain number of days, he would have to induce her. She believed he was concerned only with the medical picture and did not consider her emotional needs or her desire to choose her own path. These examples highlight participants’ frequently and strongly expressed desire to be offered choices about their care options and control in the decision-making.

In addition to the need for control and choice, the women described the importance of effective communication during their interactions with their caregivers. Some of the women expressed that they did not want to feel rushed during appointments, explaining that they required time for questions. They needed their caregiver to “cater to their fear” or “allow them to be as paranoid as they needed to be.” Most importantly, the women expressed a need for the caregiver to “open the door to talk” and then be available to listen. One woman explained:

I need to be able to talk about, you know, my fears. I couldn’t just brush those under the obvious and say “No, I’m not afraid this time because everything’s going to be OK.” That wasn’t what it was so – so I think too for, you know, caregivers or obstetrician or whoever, if they can um, you know ask how you’re feeling, are you bothered or anything. That way if you need to talk about it you can.

The women acknowledged that their fear during the pregnancy increased their need for compassion and understanding. They expressed their desire to have their stillbirth acknowledged, but also recognized that women are different in their need to talk about the loss during a subsequent pregnancy. One woman suggested that the loss should be acknowledged and that the woman should then be asked whether she was comfortable
talking about the stillbirth. Effective communication between the woman and her
caregiver was greatly appreciated where it occurred, and many of the women described
very positive relationships with their care provider. There were also some notable
exceptions, however, which suggests there is room for improvement in most interactions.

Flexibility was another common attribute that the women needed from their care
providers. They required flexibility around dating of the pregnancy, planning the time
and mode of delivery, and willingness to make time for occasional unplanned fetal heart
assessments for reassurance. As previously described, many of the women experienced
pregnancies that were close to the anniversary of their stillbirth. The women needed to
have the due date changed or “fudged” in order to maintain their emotional health. Most
of the women reported that their care providers willingly altered the date. In addition, the
women's need for early delivery was also accommodated. The mode of delivery,
however, often required some discussion between the caregiver and the woman. One
woman described her attempt to obtain a C/S and her eventual agreement to be induced:

I was determined I was going to have a C-section. I was going to INSIST on it
[woman’s emphasis] on or before my due date, like I wanted to as early as they
would take the baby. My doctor referred me to an obstetrician and that was my
question “How early can you take this baby out?” And “I want this baby taken
out.”... and she really wanted not to do that and she said “Well, you know -- ” She
didn’t tell me she wouldn’t do a C-section but she never really acted like she
would. She kind of just said, “We’ll induce you but nothing earlier than 38 weeks
do we want to induce.” I said, “OK.”
In contrast, a small number of the women described interactions in which the physician gave a “sales pitch” for an elective Caesarean section. One woman was given the choice and told that it was up to her whether she waited for spontaneous labour, tried induction, or had a C/S. She acknowledged that “after a little bit of back and forth,” she “forced” him to tell her that he really wanted to do a C/S. The women often indicated that the physician’s anxiety played a role in the decision regarding time and mode of delivery.

Many of the women described examples of caregiver flexibility in dating the pregnancy and planning the delivery, but few reported caregivers who allowed for “on the spot” reassurance. One woman expressed appreciation of her caregiver’s flexibility and understanding as her fear increased closer to the due date:

He said, “If you need to go in, you come in here anytime you want. I don’t care how busy I am, I’ll take 5 minutes and check your heartbeat – check the heart rate of the baby.” I said, “OK” but I never took him up on it but I always knew I had that available to me. So just the support of being able to validate your freakish nature [was helpful] – because you are going to be freaking out.

Another woman described the “open door” policy for NSTs in her hospital as a “Godsend.” Both of these women gained great peace of mind from knowing that reassurance was available as and when they needed it.

Participants perceived increased vigilance, although often described as an expression of caregiver anxiety as much as maternal anxiety, as very reassuring. As previously described, they appreciated the additional ultrasounds, extra visits, and NSTs. Some of the women benefited particularly from the nurses performing the NSTs. One woman stated:
It's the people actually dealing with you on the ground. The technicians -- nurses are the people who make the difference for me...it was the people doing the non-stress tests that made me feel the best. They gave me the most reassurance and tended to me like I needed to be tended to.

Continuity of care was brought up in a small number of women's stories regarding their caregivers in pregnancy. Although continuity of care was described as beneficial, it was not reported as a high priority in this timeframe. Continuity of the NST nurse was the most beneficial description in this context.

Many of the women in this study described caregiver interactions that were positive. However, they also provided several instances in which ancillary medical personnel such as ultrasonographers, radiologists, and technicians were described as insensitive. These stories are similar to the women’s stories of stillbirth. Many of these personnel were unaware of the stillbirth history, and this resulted in unfortunate interactions such as "What's this with [examination room number], why can't you go in?" Another woman was asked by an ultrasound technician if she had been there before. She described the interaction:

I said, "Oh, I had ultrasounds every 3 weeks" and the woman said, "Wasn't that kind of excessive?" I said, "Well, I lost my first." And she was like "Oh." Know what I mean? Like they're just not compassionate at all to the fact that I had lost my first.

In addition to ancillary medical personnel, Medical Office Assistants (MOA) need to be aware of and sensitive to the woman's history. One woman described not being
recognized by the MOA on her return for prenatal care, despite this same MOA having seen her for the whole pregnancy that resulted in stillbirth. She explained:

She’s spent the whole first pregnancy weighing me you know, and all those things you do every visit you have. And then when I came back and was pregnant again, she said, “Oh, how lovely for you now, your first child or something.” It’s like she blocked it out or something. Often I’d have to get booked and have to sit in the waiting room with new babies coming in for shots and so on. And that was terrible.

Participants in this study particularly and strongly recommended that all personnel, not just primary care providers, be made aware of their history and be able to maintain some sensitivity in their interactions with women experiencing a pregnancy subsequent to stillbirth.

In summary, the women’s most predominant and important requirements of their caregiver during the pregnancy subsequent to stillbirth were control and choice. Women felt the need to take more control over their pregnancies and wished to have choices offered to them rather than be a passive recipient of care. The women also highlighted their need for a compassionate caregiver who could provide time and opportunity to talk and ask questions, and listen to concerns. In addition, the women benefited from caregiver flexibility, particularly in relation to alteration of their due date, the need for planned early delivery, and permission to show up unannounced for a fetal heart check when concerned. Increased vigilance such as extra visits, NSTs, and ultrasounds were seen as reassuring and therefore desirable. Last, the need for all medical personnel,
primary and ancillary, to know women's stillbirth history was highlighted as particularly important, and was described as an area in which much improvement was needed.

LABOUR AND BIRTH

The Need to Plan

For the women in this study, the experience of pregnancy was one of considerable anxiety, in which the goal of delivering a healthy baby was foremost. Their experience of loss of control in the pregnancy and birth of a stillborn seemed to result in the need to try to take back as much control as possible during their subsequent birth. The need to take control and arrange for labour and birth to be different was negotiated early with the primary care provider. Participants identified that the ability to plan their birth provided a feeling of security.

Planned induction was a common theme among the women in this study. For at least six of them, the estimated date of delivery (EDD) was the same or very similar to that of the loss.\textsuperscript{43} The anxiety around repeating history was exacerbated by the similar dates. One woman explained:

It was very much my own personal drive to do this [get pregnant] but I hadn't planned it that it would be you know a year to the day of practically having this child. And it ended up I got pregnant and at the same time. And... I said to my doctor, "I cannot have this child on the same day"... so we booked a time for me to be induced.

\textsuperscript{43} Women's need to get pregnant, previously discussed, resulted in most women either ignoring medical advice and trying to get pregnant immediately following the loss, or waiting anxiously for the commonly recommended three months to elapse. The timing of a subsequent pregnancy therefore often fell three months following the loss. Nine months of pregnancy plus these three months result in a due date occurring one year following the loss.
The induction rate for the women in this study was very high. Of the 14 women participants, 10 were induced. A common rationale for induction, in addition to ensuring that the birth date would be different from the stillbirth, was to get the baby out as soon as it was grown, before anything bad could happen to it. Most women tried to plan for delivery at as early a gestational age as possible. One woman received an amniocentesis prior to her induction in order to assess the baby's lung maturity so as not to have to wait any longer than necessary before giving birth. Another woman's story of planned induction was typical:

I didn’t want to go past 38 weeks. That was OK with my obstetrician so at 38 weeks she had checked me and sent me for an ultrasound to make sure everything was OK and [I] had gone in for an induction. And I just, thank God, because I, we have to get this baby out of here before anything else goes wrong.

Planned induction was the most common agreement between the women and their caregivers, but anxiety caused two of the remaining four women to book Caesarean sections. One of the women indicated that she thought the decision to have a booked C/S was as much about her doctor’s anxiety as her own. She recognized that a C/S was probably not necessary but that she and her doctor just “wanted to get it over with.”

One woman met with hospital staff and anaesthesiologists in addition to her primary care providers to discuss her delivery plans. She stated:

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44 The induction rate for the general population averages 15-25%. In B.C. for 2002-2003 the induction rate for all mothers (excluding late terminations) was 21.7%.

45 Amniotic fluid can be tested for several factors, including lung maturity.

46 There was a total of four Caesarean sections (booked and emergency) in the women having a subsequent birth after a stillbirth. Although the sample size is small, the C/S rate (28.5%) is comparable to the overall provincial C/S rate.
I wanted hopefully to give birth in the operating room. Of course I can’t do that. But I want the labour room that’s closest to the operating room. You know, these sorts of things would make me feel like I am taking care of as many things as I can in case something goes wrong. To make it, to have the baby make it. And I want the doctors and nurses…like I want somebody there the whole time…That’s the kind of care I need emotionally and maybe physically. I need it emotionally because I don’t know if I need it physically.

This woman’s primary concern was that an immediate C/S could be provided if needed. She was not reassured by the response she received and therefore demanded and received an elective C/S. She explained:

We went to [the hospital] and talked to the doctors there. Essentially I wanted to know if I tried a natural birth and an emergency arises, how quickly can you get me from the birthing room to a C section? And, although I was told that changes are excellent, guaranteed that it would be extremely quick, [they said] we can’t absolutely guarantee that because we don’t know what else is going to be going on etc. There may be other emergencies, we don’t know if there’s going to be a waiting period for an anesthesiologist, whatever, for an operating room. Given that I couldn’t be given an absolute guarantee, I didn’t want to take any chances and so we decided on a Caesarean.

Only two of the women allowed spontaneous labour to occur. These women’s need to plan was actualized in plans for how labour would be managed, rather than controlling the mode of birth.
Plans for labour included personnel and location requests, fetal monitoring expectations, and changes in previously held beliefs or expectations of self for labour and birth. In terms of personnel, in addition to their previously arranged choice of caregiver, some women asked for a specialist to remain nearby or to perform interventions that were particularly frightening. For example, one woman's stillbirth experience occurred with the onset of what she thought was “breaking of the water” but turned out to be an antepartum hemorrhage. She was therefore afraid to be at home when her water broke. Her planned induction included a rupture of the membranes which she requested be performed by a specialist. She explained:

You know, they tell you it was like winning a lottery and you are one in a million....And it doesn’t matter what they say, you are never sure it won’t happen again right because it’s [the hemorrhage] such an influence...I wanted to have more, you know, whatever control I could manage so I talked to my doctor and I said “I’d like to have a specialist nearby.” I liked [my doctor] very much but I just felt like I needed to do more things. Whether it was right or wrong, I needed more security somehow. So I had this specialist all lined up [to rupture the membranes].

Another woman planned for a doula and a massage therapist to attend her in labour, which previously she had not felt she required. Another switched from a male obstetrician to a female one.

Planning the location in which to labour and birth was very important for the women in this study. Some refused to attend the same facility and planned to attend a different facility with higher-level newborn care or perinatal specialists. One woman chose a planned a homebirth because, in addition to her desire for a homebirth, she
“wasn’t going back to that hospital.” If they chose to birth in the same facility, it was particularly important to participants that the rooms they had occupied during the stillbirth experience be avoided at all costs. The women enlisted their physician’s help in arranging to be in different labour rooms or to avoid the assessment area if that was the location of previous distress. One woman explained the importance of location:

There was a whole lot of rigmarole over the course of the pregnancy where I had letters being written by [her doctors] and I’m speaking to people and whatever about getting into [special birthing area] because I said I didn’t want to labour in the same kind of labour rooms. I felt that this was a special circumstance and I hoped that it would be -- I think if you’re doing this [giving birth after a stillbirth] I think you should at least have a pleasant room… I think it’s only fair. I think we earn that right.

In another instance, the woman with a history of stillborn twins made pre-planned arrangements to avoid sharing a room with any mother having twins. When she had a failed induction that went to C/S, this woman’s physician arranged to have the baby remain in the recovery room with her. This was against the rules of the institution, but created a crucially different environment from the previous birth.

The need for reassurance regarding the fetal heart during the pregnancy extended to the labour. Many of the women referred to their need for continuous monitoring of the fetal heart as the sound decreased their anxiety. The women made plans both to remain in the hospital during induction and to maintain connection to an audible beating heart. One woman related that she told her care provider that “You can either keep me in a bed or I’ll camp out on the doorstep.” In those instances where the women were unable to
remain in hospital, their fear kept them close at hand. One woman described sitting on a bench outside the hospital door until it was time to return for a further insertion of the medication used to induce labour.

The need to plan for reassurance in labour changed participants’ previously held beliefs or expectations for labour and birth. One woman decided that she was no longer in favour of a drug-free pregnancy and labour. She wanted to be numb. This change in her expectations of herself resulted in the plan for an epidural; she also joked that the IV should be started a week before. This woman acknowledged using humour to allay her fears. She described herself as “being scared of being scared.” The more she could do to control the labour to make it easier on herself, the better. This sentiment was common among the women and resulted in a variety of needs being planned for and met. Those women who had delivered a live child prior to the stillbirth relayed differences in their expectation of labour and birth for this pregnancy than for their first live child. Previously, the focus had been on the process of labour, as a live child was expected. However, the focus of a subsequent labour following a stillbirth was to deliver a live child. The need to plan to allay fear was the same for all of the women but the women whose only experience of birth was stillbirth could only compare to what they had expected of normal labour and birth, not to what actually occurred in a healthy pregnancy, labour, and birth.

In summary, the women in this study needed to take control and plan how and when the birth subsequent to stillbirth would take place. The majority of the women demanded an induction as soon as the baby was mature. Two of the women planned a booked Caesarean section. All of the women talked about the need to plan the labour and
birth, taking as much control as possible. The plans included changes in care provider or additional care providers, room and/or hospital location changes, increased vigilance and fetal monitoring, and reduced expectations of labour. The goal was to get through labour as easily as possible with a healthy child as the outcome.

**The "Forgotten" Labour**

Although the need to plan for labour and birth was important for the women in this study, the actual experience of labour was not an important focus. Although some of the women were able to remember the sequence of events of their labour, most did not. They talked about going into labour and then having the baby. The time that encompassed the actual labour was not described, or was mentioned in only scant detail. In many cases, the women talked about being “completely dissociated” or “not being there.” They just “wanted to get it over with and know [the baby’s] healthy.” One woman explained:

> It was probably a very normal birth. Um, yeah, I mean he was fine when he arrived...you know, to be honest it doesn’t really register with me, sort of the whole birthing process because I was so hardened in my heart to get it done.

Another woman could “not remember exactly what went on” during labour. Her fear was that she would have a baby who did not cry. She described labour itself as “inconsequential.”

Although the labour per se was not a focus, the women did recall when an event occurred in labour that frightened them and made them think that history was repeating itself. For example, one woman described becoming hysterical when her membranes
ruptured (water broke) during labour. She thought that it was blood (like the last time), and could not be convinced that it was fine. She stated:

My water broke at like 5:00 in the morning and I freaked out. I absolutely lost it because it was the same feeling of the blood and it brought it all smashing back to me. I just remember feeling a gush and I rang for the nurses, like 5:00 in the morning and my family’s flaked out and I just said “something’s happening” and I rang for the nurse...and she said “Yeah, you broke your water” and they flipped on the lights and then it all just started gushing out and I was just hysterical – I was hysterical. And she kept – and I remember her saying “It’s fine -- it’s fine, it’s clear, it’s water, it’s fine.” And I couldn’t stop, I was just hysterical. Someone needed to reach out and slap me, like I was just out of control.

For the majority of the women, flashbacks to the stillbirth occurred more frequently and frighteningly in the second stage of labour. These women interpreted common occurrences as frightening and as heralding another stillbirth. For example, two women described their reaction to a slowing of the fetal heart (not entirely uncommon) in the second stage of labour. One woman said she was scared that “it was happening again.” She remembered closing her eyes while she was pushing and not opening them again until the baby was on the table being cleaned up. Participants interpreted being afraid of pushing in various ways. One woman believed that pushing was causing the fetal heart to slow and that if she pushed, the baby would be stillborn. Another indicated that she was scared to push because she was afraid to tear. She pushed for three hours.

47 The second stage of labour is from when the cervix is completely dilated until the birth of the baby. This is the stage where pushing the baby out occurs.
48 The second stage of labour varies considerably but generally averages about 1-2 hours for first babies and ½ to one hour for subsequent babies.
During my interview with her she mused that she might have been afraid in the back of her mind that when the baby came out something would be wrong. In summary, the urge to push seemed to create or exacerbate fear toward the end of labour for many of the women: “When I felt the urge to push I was thinking I can’t do this. If she doesn’t cry right away I’m going to freak right out.”

The women did not consider the birth itself an exciting event, and glossed over it as simply another milestone to get through in the hopes of having a live child. In fact, not wanting to watch the birth was a reoccurring theme. One woman was offered a mirror to be able to watch the baby being born, which she refused. She explained: “I was really scared. If I can’t see, then it doesn’t hurt [if the baby is stillborn].” Whereas birth is generally an exciting and momentous occasion for women in the general population, for the women in this study the experience of birth was merely a means to an end.

Like the women who delivered vaginally, both women who had a planned C/S and therefore did not experience labour describe a comparable experience of dissociation. One woman described herself as having no emotion, as being “absolutely flat” while waiting for the C/S to take place. The other woman stated that she was nervous about the whole procedure and further explained that “My emotions and stuff just froze through the whole thing.” In addition, one of the women who was induced but was unable to establish in labour and who therefore had a C/S also described herself as emotionally withdrawn and “stone-faced.”

The “forgotten” labour of the subsequent pregnancy was a distinctly different recounting of events from the stillbirth account in which every detail was relayed and recalled. It is also different from the birth stories of women without a history of stillbirth
in which the details of labour are also easily recalled and shared. One woman in this study indicated that she remembers the labours of both her stillbirth and her second live child after the stillbirth, but does not remember much about the first labour after the stillbirth. Her interpretation is that her worry that “It was going to happen again” made her put her guard up and this kept her “pretty much out of it.”

Although the majority of the women in this study described an overwhelming lack of engagement in the labour and birth and a fear of history repeating itself, one woman described having “moved forward” from her stillbirth experience and feeling that she was “in the moment” with the new baby. This woman’s story focused on procedural events and her lack of faith in medical science. She felt that her own assessments were belittled and described what she perceived to be several errors in medical judgment. She did not talk about her labour experience except in terms of describing medical judgment.

Commenting on her induction, she stated:

I attempted for that natural delivery but she [the baby] just wasn’t going anywhere. She was slightly engaged. Her head was down, wasn’t going anywhere. And after the [induction medication] incident, I could feel these two little fists down my pelvic bone. And that was the end of the engagement. She just shoved as hard as she could. I felt the whole baby moving up. The doctor walked in. He said, “How are you doing?” I said, “Well, I think the baby’s gone back up the birth canal.” He said, “Babies don’t do that dear.” So he had a look for her and she had disappeared. She had gone up and she didn’t want anything to do with this birthing process.
This woman was delivered by C/S after a four-day failed induction. She was awake for the C/S and described the birth as follows:

I think it was a really moving experience. I can’t say for sure that it wasn’t tempered by what we went through. I don’t think that when we were in the OR [Operating Room] and having the baby delivered that we were really giving it any more thought about what happened to us. Um, we were really in the moment with the baby that was going on right then and there. And obviously we talk about it, we’ve talked about it but I would say we were pretty much right there with that baby and not thinking about what our previous experience had been.

In summary, with the exception of this one woman, the women in this study felt largely dissociated from the labour experience and instead focused on the outcome of achieving a live birth. Some women described flashbacks to their stillbirth experience, most occurring in the second stage of labour. Their flashbacks were related to the fear that history was repeating itself.

**The First Cry**

The transition from fear to relief was the major theme among the women in this study. For some the actual sound of the baby crying was the catalyst that ended the fear, as their apprehension around the birth disappeared with the cry. One woman explained:

She was screaming her head off and that was all that mattered and it was just – it was just wonderful....She could have come out all deformed and we wouldn’t have cared at that point...as long as she cried we’d be fine.

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49 It is interesting to consider whether the exceptional experience of this woman is in fact unique among this population or whether my sample of women contained more than the usual number of women for whom dissociation in labour was typical. This woman claims to have “moved on” but her sarcastic and angry tone in the interview suggests there may be other dynamics at play.
Although there was joy in the birth of a healthy baby, the predominant emotion was relief. Most women described their joy and relief as co-mingled. Making it through labour and birth was “like finishing a race” for one woman, who indicated that after the baby was born there was “such intense relief and joy that it was unbelievable.” Another woman attempted to further describe the experience as follows:

P: I remember just being relieved when she came out.

R: What was it like to have a healthy baby?

P: Oh God! It was like – awesome! I remember it was just like “Yay,” and I just sort of go “Wow! I can have a healthy baby.” That was huge when I think of it now. ‘Cause I think you’re so worried it’s going to happen again – and that entered my mind a lot – like a lot. I remember thinking, “I don’t know what I’ll do if it happens again. So when she came out …it was a great feeling; it was just like a huge relief. All I wanted was a healthy baby.

For some of the women the relief was gradual, as they could not believe they had a healthy baby; they continued to expect that something would be wrong with the baby. For these women the passing of fear was dependent on certain factors. One woman described feeling “in total shock at birth.” She described being unable to lose her fear until the baby was weighed, checked over, and they were lying in bed together. For other women, the catalyst for letting go of the fear varied from seeing a “thumbs up” sign from a physician, feeling the baby’s heartbeat next to theirs, to holding a baby that was pink, moved, and opened its eyes. Their experience was one of cautious joy that evolved, rather than outright joy.
Although all of the women in this study delivered healthy babies, not all of the babies cried at birth. Four of the babies required a little support following the birth, which exacerbated the women’s fear. These women described being terrified, scared, “freaked out,” and emotionally withdrawn. Their fear continued until they were told or could hear for themselves that the baby was OK. One woman described her extended fear at her C/S, and her final relief:

They pulled her out and they didn’t show her to me – because now I know why – they had to get oxygen to her, she was all blue. And I remember thinking at that point, “Here we go again.” But flat – no emotion whatsoever. It was very odd. And then I heard “It’s a girl and she’s OK.” And at that moment I heard her cry and I just lost it. It was like 2 years of emotional release for me. I didn’t hear her very well because her father was sobbing so loudly. It was a euphoric time – a very, very happy time.

Another woman whose baby required support following a vaginal birth validates the extended fear and relief experience:

Because the cord had been wrapped around and she’d come through so fast, she didn’t cry when she was born. And I was just so scared and I just kept saying “She’s not crying, she’s not crying.” ...and then she started to cry and it was just a HUGE, HUGE [woman’s emphasis] relief.

This woman went on to explain that the experience of hearing the cry with this birth was very different from her first healthy pregnancy. She describes hearing her first baby cry as “the best moment of my life, there was so much joy.” The stillbirth was the complete
opposite and the birth subsequent to the stillbirth was “somewhere in between. I was scared the whole time that something was gonna go wrong.”

Some of the women were surprised by their emotions, or by the lack of them. Two women specifically described expecting themselves to cry at the birth only to find that they were not as emotional as expected. Both explained that they continued to be worried that something would be wrong with the baby. One of the women described being “awed” by her breathing baby but not emotional.

In summary, the women’s experience of the birth was a continuation of fear that extended until they were able to recognize that a healthy baby had been born. For many, this recognition occurred with the baby’s first cry and was experienced as relief co-mingled with joy. For some the relief was gradual and did not occur until the baby had been checked by a physician, or until the women observed certain indicators that reassured them. These indicators varied and included observing the baby’s colour, holding the baby, or seeing the eyes opening. The participants’ predominant experience was one of relief that history had not repeated itself.

The Impact of the Caregiver

The women’s experience of labour and birth was assisted or hampered by their interactions with their caregivers. The women’s overwhelmingly stated and important need was that their caregivers should be aware of and sensitive to their history of stillbirth. They found it particularly distressing to be asked repeatedly about their stillbirth. One woman described her experience of a caregiver standing in the room with the chart that he had not read, and her consequent need to explain her history to him. She
shared that she found she was doing this “hundreds of times and that it wasn’t even always upsetting but just really tiresome”.

In addition to having to repeat their history several times when caregivers were unaware of it, many of the women in this study related instances where lack of knowledge of their history created difficult and upsetting interactions. They perceived their needs as being minimized due to the caregiver’s ignorance of their history. One woman described her experience with an obstetrician who her family physician had arranged to perform an induction of labour by rupturing her membranes, a function usually performed by the family physician:

He [the obstetrician] was gonna break my water for me so um, when he came in, first of all he couldn’t figure out why a perfectly healthy woman needs a specialist to come in to break this water and told me so, and said “Why isn’t your doctor doing this for you?” Again, it was like, did anyone even brief him on why I’m here? I don’t know, I think that your mental state is as important as your physical and he definitely wasn’t helping me with that. And I found that really harsh.

Anyway, he did it and left the room. I never saw him again.

In another situation, the primary caregiver was unavailable for the delivery. Although this was not a common occurrence, the impact on the woman was considerable. The woman felt isolated and fearful. She explained:

I had strangers around me the whole time; people who didn’t know my history...

It would have made me feel good to know – for people to know. For people to deal with us differently as a result – maybe a little bit more – things that people say to reassure people who are afraid or whatever.
Nurses who provide break relief need to be as aware of the woman’s history as the primary nurse. One woman described an episode that could have been avoided if the nurse had known her history. She stated:

There was a nurse covering while the other one [primary nurse] was on break and I don’t know if she knew the whole situation [history] and when – so she was still there when [baby] was born and everyone started crying and she said “I’ve never seen such a reaction from everyone for a baby being born”. Well I thought, first of all there might be a reason for that and second of all even if there wasn’t, why are you saying that?

Although staff’s lack of awareness of a woman’s history created unfortunate incidents for many of the women, some of the women’s care providers went out of their way to notify staff of their history prior to their admission, and participants perceived this as extremely helpful:

My doctor was great about preparing everyone in that area [maternity] that they all knew what had happened to me so um, I didn’t have people walking in that didn’t know what had happened or possibly would say something that was not appropriate.

In addition to staff knowing their history, the women in this study most frequently described continuity of nursing care throughout labour (by a nurse who knew their history) as the most beneficial impact of a caregiver. Most nurses were described as sensitive, caring, reassuring, compassionate, or sweet, and the continuous presence of a caring nurse was highly valued. One woman explained:
I was able to get a little more rest because I wasn’t listening to the heartbeat every two seconds. But I knew someone else was watching. And I think just having someone hovering...someone was in my room all the time and that was huge....I had an instant liking for her and when things got hairy with the heart rate and whatnot, she was my saving grace. If she hadn’t been there, I don’t know what – I think I would have truly lost my mind.

"Continuity," "compassion," and "reassurance" were also words used to describe the benefits of midwifery care in labour. One woman had the same midwife for both her stillbirth and her next pregnancy and was comforted by the knowledge that the midwife was aware of her history and did not need to ask questions in labour.

Continuous nursing or midwifery care was further improved by caregivers who understood how to approach the women’s history in the least obtrusive manner. Most of the women described the best nurses as those who acknowledged their history, "opening the door" to talk but not pushing them for detailed accounts of their stillbirth experience. Even nurses who knew the women’s history sometimes focused too much attention on the stillbirth. Some of the women were distressed by the "endless questions" regarding the stillbirth. These women wanted to focus on delivering the baby they were carrying and not on their history. All of the women felt that it was important to acknowledge the stillbirth but then equally important to follow the lead of each individual woman regarding their need to talk about it or to focus on the current baby.

In addition to praising caregivers who met their psychological needs regarding their history, the women in this study appreciated caregivers who were sensitive to their concrete needs during labour. One woman said that the most helpful thing was her
doctor’s willingness to “accept where she was” and not just “pat me on the head and say don’t worry.” Concrete interventions such as early induction, continuous monitoring of the fetal heart, and being able to stay in hospital were particularly reassuring, making the women feel properly acknowledged and assisting them with managing their fear.

Additional specific concrete needs were individual to each woman. As one woman explained, those who have been through previous stillbirth may feel that they deserve “special treatment,” although the expectations of that special treatment vary. For example, one woman found the chatter and talking in the birthing room upsetting, and was disappointed that her caregivers seemed insensitive to her need for quiet. More positively, another woman commented specifically on how much she appreciated her nurse ensuring that she had a private room after the birth, which was extremely important to her. In complete contrast, one woman indicated that she “didn’t need the fluff,” but simply wanted a doctor who was taking good care of her. This woman approached the birth in a very business-like manner. Although their specific needs varied, most of the women shared stories of caregivers doing what was necessary to help, even if this broke the rules of the facility. Although their descriptions mentioned an occasional nurse who was more focused on keeping to the rules than facilitating an exception that would benefit the woman, such stories were in the minority.

In summary, awareness of the history of stillbirth was the participants’ most important expectation regarding their caregiver. In addition to knowing their history, continuity of nursing care was particularly important and appreciated. Caregivers were perceived as most helpful when they were compassionate and reassuring. Last, sensitivity
to individual needs regarding the desire to talk about the stillbirth or not, and meeting concrete requests such as room choice were interpreted as caring and supportive.

POSTPARTUM

Integrating the Present with the Past: Comparing and Contrasting

The postpartum experience of the women in this study varied considerably. Although there were areas of commonality, variations seemed to depend on the degree to which recovery from the stillbirth had occurred. Some women felt that they had “moved on” and were able to feel unadulterated joy in their new baby. Others still felt trapped in their sorrow to the extent that the sorrow overshadowed the joy and relief of a livebirth.

Despite a variation in intensity, most of the women in this study experienced moments of renewed grief for their stillborn. The joy of experiencing all of the new wonders of a live baby seemed to highlight what they had lost and caused periods of momentary sadness. One woman stated:

It was a euphoric time – a very, very happy time. At the hospital I had a very short-lived but a very intense grieving moment for [name of stillborn baby]. I was sobbing, sobbing, holding her [livebirth]. And it’s been sort of a different phase of grief, not as sharp as it used to be. And absolutely livable but I realize just how much we missed out on with him because we get to raise her.

These moments of sadness were often triggered by activities that the women knew they would never be able to undertake with their stillborn, such as bathing or feeding the baby. The periods of transitory sorrow sometimes continued for the first few weeks. One woman described her sadness at taking the new baby out for a walk in what should have
been the stroller for her stillbirth. Another woman described the sadness as extending to
every first occasion, such as Christmas and the first day of school. These “glimpses of
grief” were common to both those women who experienced joy following the birth and
those who continued to struggle with their grief.

Another frequent experience among the women was their fear that something
could still go wrong with their healthy baby. They were on alert for “something which
was going to surprise them” and were anxious and unsure “if the baby would be OK.”
Although the fear of something going wrong was common, it also varied in intensity.
Some women described “waiting for something terrible to happen” whereas others were
concerned with specific issues. One woman was particularly fearful of Sudden Infant
Death Syndrome (SIDS). She described that her fear of SIDS was consistently in “the
back of her brain” until one year had passed and the fear “was removed”. For most
women the fear lessened over time although for some the need to protect and be
physically close to their baby was intense and continued for some time. One woman
described her experience with her one-year old:

She still sleeps with us. It’s terrible but she sleeps in our bed for part of the night,
every night, because I think I was so anxious that she was going to die like [name
of stillborn baby] and she had to be right beside me and I had to make sure she
was breathing all the time – and that sort of anxiety -- and I probably caused her
to be a not very good sleeper because she’s – when she wakes up I have to be
right there so she would never sleep in her crib so – but then I don’t think I could
have put her in her crib because I was so anxious that something was going to
happen to her and to have the stress of losing another one would be too hard.
The need to protect and stay close seemed to be as much about self-reassurance as it was about the baby. One woman described holding on to the baby the whole night after it was born and reveling in the similarities and differences of the new baby from their stillborn. Later on she recounted that although people offered to hold him and change him, she “wanted to do everything for him.” She explained:

I just wanted to do everything for him. Just like you know, all those things like getting up in the night and feeding him. Being tired- it just didn’t matter to me. Like I was so, I remember thinking like you know I’d rather be up with my baby and know he’s alive than to be, not to have that...it [name of stillborn baby] just totally changed my perspective on those inconveniences.

Some of the women described a nervousness or awkwardness around new baby care similar to the experience of women who have not delivered a stillbirth. Concerns included difficulties with breastfeeding, diaper care, sleeping positions, and other routine functions of caring for a new baby. Although one woman described being “scared I was going to kill her” if she did not do the right thing regarding positioning her baby or burping her baby, the anxiety described by participants did not seem to be out of proportion to normal first-time mother anxiety.

Most of the women described experiences of momentary grieving and fear that something would still go wrong with their baby. However, the overall postpartum experience varied significantly and seemed to be on a continuum from elation to despair. Those women who described themselves as having “moved on” talked about their postpartum experience as “euphoric” or “full and whole.” Although many of these women compared their new baby’s physical characteristics to those of their stillborn, they
talked about the new baby as “being his [or her] own person.” They sometimes credited their stillbirth history with giving them a greater sense of joy and love around the experience of having a live baby. The physical aches and pains of postpartum were inconsequential. One woman explained:

P: It was wonderful and we immediately started saying how much she looked like [name of stillborn baby]. We did do that. “Oh, look at her ears and look at her this and that” and we, you know, just to – I don’t know, just the miracle of her -- of her being alive and her eyes being open where [name of stillborn baby] eyes were never open and so that was just kind of wild. Just – it was amazing to have her look at us. I think that was the most amazing part -- just reveling in her whole aliveness. [laughs]

R: What was your postpartum experience like? After having a healthy baby?

P: Wonderful! It was – it was inconsequential. Even though I was full of stitches and suffering and I suffered terrible engorgement and everything just like I did the first time, I didn’t care...I didn’t even notice because I was so consumed with the baby.

Another woman made a striking comparison between her postpartum physical condition following her stillbirth and her condition following her livebirth, highlighting the overwhelming difference in the experience. She stated:

I felt poisonous after the first, stillbirth. And I felt toxic for months. I felt unhealthy; I felt sick. I wasn’t throwing up or anything like that but I felt REALLY sick and unhealthy. I felt bloated, I felt gray-coloured, I felt terrible –
and after having [livebirth] I felt vibrant, alive, if anything the opposite, flush-faced and healthy.

In contrast, two of the women were completely unable to get past their own needs or emotions and did not feel they could "bond" with their baby. One woman stated: "I remember thinking I made a big mistake. Why did I have a child? I just want my life to be back to normal." Another woman described being disappointed in herself for her inability to be happy. She stated:

People were doing so much for us. They wanted me to be happy. And it was our first live baby and I couldn’t get into it. I wanted to have nothing to do with it. I wanted it just to stop....but I was doing the best I could. So, I just felt like I had failed again. I failed the first time. I failed in taking babies completely to the end and I lost one. And now I was a failure because I couldn’t be positive.

Despite significant effort, these women were unable to put the baby’s needs above their own. One woman said: "I felt so let down and so sad that this little person needed me and I just didn’t feel like being there emotionally." These women also experienced more concern with physical postpartum symptoms, difficulty breastfeeding, and ongoing depression.  

Regardless of whether or not their own postpartum experience was happy or sad, many of the women in this study expressed that the experience of having a livebirth did not negate the stillbirth. These women did not want to forget their stillbirth and were disappointed in family and friends who expected that they should “be over” the stillbirth.

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50 It is difficult to differentiate postpartum depression from unresolved grief, and to determine where they may intersect. I am neither equating these women’s experience of depression with classic postpartum depression, nor assuming they are distinct.
or that the healthy baby “fixed” the stillbirth experience. Family and friends who visited postpartum often made insensitive remarks. One woman explained:

Everyone’s like “oh, it’s great you have a baby and everything’s fine…I guess now you can see, now that you’ve got this beautiful baby, now you can see why God allowed the other one to die.” I’m like “NO!” [woman’s emphasis] You know, I don’t know what he meant by that but I was like, some people say some ridiculous things. You know that’s what I mean when I say just because we had another baby, I didn’t want to forget. We still had another baby [name of stillborn baby]. It wasn’t just over you know.

The woman in this example was able to intellectualize her experience and other people’s lack of sensitivity. In contrast, another woman described her anger with family and friends who were unsupportive during her stillbirth experience, and her struggle both to understand their perspective and to maintain relationships with them when they visited her after the birth of her subsequent baby. The women who experienced this difficulty with their family and friends observed that “people don’t know how to grieve but they know how to celebrate.”

In summary, participants’ postpartum experience varied. Participants shared the experience of momentary episodes of grieving for their lost baby and anxiety that something could still go wrong with their healthy baby, and this resulted in some women over-protecting their baby in order to ensure that he/she was still breathing. Their emotional experience varied from elation to despair that seemed to reflect the degree to which their grief around the stillbirth was resolved. Although a few of the women were unable to bond with their baby, most found significant joy in the subsequent birth.
Postpartum discomfort was often ignored and described as “inconsequential.” Despite the joy, some of the women described being troubled by family and friends who assumed that the livebirth erased the anguish of the stillbirth.

**Sex of the Baby**

The sex of the baby was an important issue for most of the women in this study, for different reasons. The reasons were individual and included the baby being its own person, not having to live up to anybody, symbolism, and being “meant” to have a certain sex.

In addition to their individual reasons, some of the women discussed their concerns about not wanting to have a replacement child. Others were very clear that this baby was its own person and that replacement was not a factor. Of those women who were concerned about replacement, some were afraid that if they had a baby of the same sex they would be “replacing” their stillborn, whereas others felt that if they had the same sex they were “meant” to have whichever sex their stillborn was. The concern about replacement, therefore, was not exclusively related to whether the sex was the same or different. Interestingly, all but one of the women who talked about not wanting a replacement child ultimately delivered a different sex. The one woman who had a boy subsequent to her stillbirth who was also a boy explained that having the same sex made the past return. Although she did not describe the boy as a replacement, she noted feeling that she would have been better able to connect with her baby if it had been a girl. It is difficult to know what if any difference it might have made in the women’s experience if more of those women who were concerned about replacement had delivered a baby of the
same sex. In total, about half of the women in my study delivered a baby with a different sex and the other half had the same sex.

For some women the emotional pull of one sex over the other made them afraid that if the baby was the wrong sex they would have difficulty coping. For example, one woman expressed that she would have felt cheated if she had not had a girl (same sex). Another woman indicated that although she was clear that her current baby was not a replacement for her stillbirth, her ability to cope was increased by having a different sex:

I’m REALLY GLAD [woman’s emphasis] that it wasn’t a girl because I probably did get pregnant too fast, if it would have been a girl I think there would have been some serious confusion — there would have been some issues. Because it was — I mean it was the same pregnancy a year later...And if that had been a girl, it would have been — I think it would really have screwed with my head.

Some women were mentally prepared for, and expected, one sex or the other. One woman was convinced she was having another boy and was shocked when the baby was born a girl. She described falling instantly in love with her girl but reflected that “I don’t know what I would have felt if she had been a boy and holding another little boy with another little penis there — would that have done something different to the experience? I don’t know.”

Over half of the women waited for birth to find out the sex of their baby but many needed to know early and made arrangements for ultrasounds in pregnancy. These women described needing to mentally prepare for the baby by incorporating the baby’s sex into their preparation. One woman stated that since the only relationship she had with her stillbirth was pregnancy, she wanted to ensure that the relationship in this new
pregnancy was optimized. She wanted to know the sex so she could name the baby and have a relationship in utero in case this was the only relationship she would have. She explained:

That’s all I had with her [name of stillborn baby] and I didn’t enjoy it more. I thought part of if that’s all I had with this baby, then at the very least, on some level I could bond even more so if I know the sex I can name the child and have so – if this is the only relationship I get to have with this baby, then I’m going to just make it – I guess I was really trying to safeguard myself in case he died. At least I did the pregnancy the best I could and tried to bond with him as much as I could that way.

Another woman, who had a live boy before her stillbirth and whose stillbirth was also a boy, explained that her subsequent baby (a girl) going to Special Care Nursery and her fear that the baby might not come back out was related to the baby’s sex. Her lack of experience with a girl in Special Care Nursery frightened her.

In summary, the issue of the baby’s sex was important for the women in my study but for individual reasons, including the baby being their own person, not having to live up to anybody, symbolism, and being “meant” to have a certain sex. There was some degree of commonality regarding the issue of replacement of the stillbirth but the women’s descriptions with regard to replacement was not sex-dependent. Over half the women found out the sex at birth whereas the remainder utilized ultrasounds and amniocenteses to find out the sex during pregnancy. The need to know the sex antenatally

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51 Her subsequent livebirth was delivered a little bit early and therefore went to Special Care Nursery for observation.
was explained as an opportunity to enhance the antenatal relationship and permit better mental preparation.

**First or Second Child?**

Two thirds of the women in this study indicated that questions regarding which number baby they were having or how many children they had were often troubling and difficult to answer. They were unsure about whether or not to include the stillbirth in their number of children. Their responses ultimately included telling everyone, telling no-one, or telling selected people.

A small number of the women always acknowledged their stillbirth. One explained that she would not dishonour her son by pretending that he did not exist. In contrast, a few of the women indicated that their history of stillbirth was a private matter, and they did not share it with others. They therefore did not include the stillbirth in their response. However, for most of the women the decision was difficult to make and their answer most often depended on who was asking the question. They described having an internal discussion with themselves about whether they wanted to “get into the whole thing” or not. One woman who was pregnant subsequent to stillbirth explained:

I found I really had to psyche up to go out in public places because you’re always asked if it’s your first...how do I answer that? And I just ended up doing it kinda depending on the person that asked it. I just, by gut instinct – I ended up using that a lot you know – sometimes I’d say “No, I lost one”...Sometimes I’d say “Yeah, it is,” if I just don’t want to go into it and all. You know, but then you have to deal with the “Oh, it’s lovely,” “Oh it just gets worse.” Sometimes it’s easier just to be blunt and unsocial.
Some of the women found that their response changed over time. They described initially including the stillbirth but indicated that were not doing so any longer. This change seemed to occur particularly as the women had more children. Although the stillbirth was not acknowledged publicly, one woman described apologizing to her stillbirth in her head every time she did not include him in her response. In contrast, another woman included her stillbirth in the number of children but did not go on to say that one was no longer living. She explained:

At the beginning I told everybody that I had [name of stillborn baby]. After [livebirth after stillbirth] I would tell everybody I had two but then there’s some people – like if somebody at the grocery store said “Oh, how many kids do you have?” and I don’t want to go into it-like if I don’t want to do the whole like “I’ve got two live [births] and I’ve had a stillbirth” – if I don’t feel like saying that at the time I won’t say anything. But if it’s most people, I just say that “Oh, I’ve got three.” I won’t go into the fact that one is not living any longer.

The decision about whether to answer the question truthfully by including the stillbirth was also affected by the women’s interpretation and experience of the responses they received if they did answer truthfully. The women described being disappointed by people’s responses. One woman noticed a certain look on people’s faces that clearly told her she had “freaked them out.” Another explained: “It was like you were being mean to them by telling them that.” Although painful, this type of response assumed an understanding on the part of the receiver regarding what a stillbirth is. This was not always the case. One woman described trying not to be hurt by the incorrect assumption of many people. She explained:
And people don’t get it. So even if you said, “No, my firstborn was a stillborn.” [they responded] “Oh, you had a miscarriage.” I don’t know how many times I heard that. They don’t get it, right? Well, they’re different, so – and you just have to remember and this is what I always thought- “No-one knows and it’s not intentional, no-one’s trying to be hurtful. They don’t know.”

In summary, most of the women in my study expressed anxiety around how to respond to questions regarding the number of children they had. Some of the women always included their stillbirth; others maintained their stillbirth as a private matter. However, most of the women reflected on the question and responded based on who the questioner was and whether they wanted to “get into the whole thing.” An important factor in their decision-making was the experience of disappointing responses from other people that included disturbing reactions and lack of understanding.

FOREVER CHANGED:

SUMMARY OF THE IMPACT OF STILLBIRTH ON WOMEN’S LIVES AND CHILDBEARING

The Loss of Future

The women in this study reflected on their stillbirth as a loss that is very different from other types of loss. They contrasted the experience of losing a parent or other close person -- a relationship which was developed, known, and then lost -- with the experience of losing a stillborn child -- a relationship that was never fully established. They differentiated their experience as a loss of future rather than past. The women further explained that their sadness was not regret over the loss of an existing relationship, but
rather regret over lost potential, hopes, and dreams. One woman stated, “everything is out of order when a child dies.”

Some of the women differentiated the loss of a pregnancy from the loss of a stillbirth. These women highlighted the loss of a full term baby -- a life -- as distinctly different from the loss of a pregnancy, and were upset when the loss wasn’t acknowledged as such. One woman explained:

People don’t ****ing get it. They don’t get that she was a real baby, and I didn’t even get that until I held her in my arms, that it’s like a weird loss of pregnancy thing but it’s so not. It’s a loss of life.”

The women in my study described learning to live with their loss, but consistently commented that the memory “will never go away.” As one woman put it, “It will always be there. I mean I can certainly live with that and accept it and enjoy other things but you know you’ll never forget it.” These women feel they are part of a “private club” in which talk about stillbirth can only be shared by those who have themselves experienced it. Once women become part of the club, “this whole other world” opens up in which people feel as if they can talk to each other about their experience.

An Altered Perspective on Pregnancy

The women’s loss resulted in an altered perspective of their own subsequent pregnancy(s) and that (those) of others. They reflected on the absolute unpredictability of who gets “tagged” to have a stillbirth. The nature of chance -- its injustice and randomness -- was often hard to digest and affected their perspective on all future pregnancies. The women never again equated pregnancy with live birth for themselves or others. One woman explained:
When I see a woman that is 8 to 9 months pregnant walking down the street, I just say a little prayer for them every time. I think “Oh, I hope they’re going to be OK. I REALLY hope they’re going to be OK.” Before the stillbirth I wouldn’t even give it a second thought.

The women described a loss of buoyancy and joy in pregnancies following the stillbirth. One woman, referring to her own subsequent pregnancy, stated: “I think I want so badly to have a little bit of happiness again. Little bit of that lightness and excitement about pregnancy and changes.” The specific focus on her own pregnancy gave way to a more philosophical approach as time went by. Another woman explained that her situation seemed unique to her at first, but that she changed her perspective over time to include a broader level of the experience. She stated:

I think, in retrospect, I’ve actually broadened my view now in the sense that when I hear of somebody losing a child at 5 months’ gestation or shortly after birth, I feel we’re like part of a pack, right. We’re all in the same boat. But at the time, it felt – my situation [fetal death in labour] felt so unique to me.

This change over time was also experienced by the women who went on to have additional pregnancies following the first pregnancy after the stillbirth. For example, one woman explained that, with a small child in tow, she was no longer asked whether the pregnancy was her first and was unlikely to be asked about the pregnancy at all. One woman described her stillbirth as “receding” bit by bit as time passed and additional pregnancies occurred.

Some of the women in this study expressed a desire to help other women through the experience of recovery from stillbirth. They felt that their retrospective perspective
might assist in giving hope to women experiencing recent loss. Interestingly, their experience also seemed to assist women with an old history of stillbirth. Three of the women in my study had mothers who had experienced a stillbirth. For these mothers, their daughters’ experience either brought up the trauma they had managed to suppress, or helped with their own healing of unresolved grief by allowing them to share the experience. The women whose mothers had delivered a stillbirth reflected that they saw a pain similar to the one they were experiencing reflected in their mothers’ eyes. These women also reflected that their mothers sometimes indicated that they were jealous of their daughters’ interaction with her stillbirth.

In addition to their perspective on stillbirth, two of the women in my study indicated that their thoughts on abortion had also changed as a result of their stillbirth. One woman indicated that her baby would have been so challenged had it lived that she was frightened by the prospect, and would therefore consider a termination for subsequent pregnancies if an abnormality were diagnosed. In contrast, the other woman expressed that her experience of pregnancy and loss made her perceive each pregnancy as more special and as an opportunity not to be wasted.

**Protecting Pregnant Women**

The women’s experience of stillbirth made them protective of other pregnant women. They described being aware that their story might upset pregnant women and attempting various means to protect them, such as canceling dinner plans made prior to the loss by making up another excuse for canceling, not attending perinatal loss support groups when pregnant again in case other women were there who wanted to be pregnant,

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52 All of these women delivered their stillbirth prior to the time where stillbirths were acknowledged and women were encouraged to see, hold, or keep mementos of their baby.
trying not to have their conversation overheard in the labour room where other women were in labour, and lying when asked by a pregnant woman how many children they had. One woman even described trying to protect her obstetrician by not talking about her stillbirth because her obstetrician was also pregnant.

Some of the women in this study described feeling sorry for friends who were pregnant. The women recognized that these pregnant women would be made more aware of what might happen to them simply by knowing them. One woman described her experience with her sister:

You should enjoy the first pregnancy. I always feel bad if people know me because they’re scarred by it. I mean, they already know. Like my sister when she got pregnant. She just had a baby in June. I mean she knew – her husband’s a doctor and – but she has me to scar her experience. She knew that things – and she got paranoid at the end... She said “I won’t let them let me go overdue or whatever because of what happened to you.”

The women in this study talked about wanting to share their experience of surviving stillbirth in order to encourage other women. One woman who delivered a healthy baby after a stillbirth stated:

I would love to sort of bring a sense of hope to a woman who is going through something like that [a stillbirth] – about what the future holds. You know it’s not just about conceiving again but what that feeling of carrying another child was like.
An Altered Perspective on Life

In addition to changing their perspective on pregnancy, the women’s experience of stillbirth also altered their perspective on life in general. The women described “walking in a completely different world.” Their experience of stillbirth was credited with making them more compassionate, less judgmental, and stronger. Their stillbirth experience was both a part of life, and something that affected all aspects of their lives.

The women also described being extremely thankful for what they had, and counting their blessings. They indicated that they were more thoughtful, appreciated the simple things, and realized what was really important. One woman reflected:

P: Everyone goes through something in their lives whether it’s your children or family or job or a house or whatever you know so. Like you just gotta be thankful for what you have.

R: It’s one way you cope is it?

P: Yeah. That’s it you know. You can feel sorry for yourself the rest of your life but you know, you still have a lot to live for that’s for sure.

Living through stillbirth gave another woman what she described as “a gift.” She explained that her father told her he loved her for the first time while she was holding her stillborn, and that this changed the family dynamic in a really good way from then on.

Finally, one woman’s reaction to a robbery in her house while she was pregnant exemplifies the changed perspective on life experienced by most of the women in this study. She stated:

I just remember thinking, “OK, I can’t get too upset here because I’m pregnant.”

Like everything ended up being, it was a good lesson on, you know, things aren’t
all that important. You know, all the stuff that’s around you, because at the end of the day, yeah. It comes and goes.
CHAPTER SIX
DISCUSSION

Introduction

The experience of livebirth after a stillbirth is a life-altering event. The women in this study described this experience of a pregnancy subsequent to a stillbirth over the continuum of pre-pregnancy to postpartum following delivery of a healthy baby. Their experience in many ways echoed those in other studies, particularly in terms of anxiety in pregnancy (Armstrong & Hutti, 1998; Caelli et al., 2002; Côté-Arsenault, 2003a; Côté-Arsenault et al., 2001; Crowther, 1995; Franche & Mikhail, 1999; Hunfeld et al., 1996; Lever-Hense, 1994; Melender, 2002; Phipps, 1985-86; Theut et al., 1988; Turton et al., 2001), the influence of milestones and anniversaries (Armstrong, 2001; Côté-Arsenault & Mahlangu, 1999; Côté-Arsenault & Marshall, 2000; Phipps, 1985; Robertson & Kavanaugh, 1998), and the need for caregiving staff to know a woman's history and provide extra time for reassurance and questions (Brost & Kenney, 1992; Caelli et al., 1999; Phipps; Warland, 2000). However, their stories also contribute some new perspectives on these elements, and, in some instances, present information that conflicts with what has been reported in previous research. These elements warrant further discussion in the light of existing literature.

The findings of this study challenge what has previously been reported about the timing of a pregnancy following stillbirth, and about the importance of labour and birth in the continuum of the experience, which distinguishes the early and late pregnancy loss experiences. The study uncovered new information, including participants' inherent (but often hidden) need to protect other pregnant women, and participants' perspectives on the
helpfulness/unhelpfulness of caregiver responses, which may or may not support current caregiver practice or facilitate effective streamlining of care provision. Considering each of these issues in the context of other authors, I examine the potential meaning of the findings arising from this study.

Timing of the Next Pregnancy: Is there a “right” time?

In the past, women were told by both their care providers and society to put a stillbirth behind them and get pregnant again quickly (Davis et al., 1989). Over time, our developing psychological awareness of grieving and of the time needed to address the grief of perinatal loss has resulted in a shift towards recommending an interval of time between pregnancies (Phipps, 1985-6; Turton, et al., 2001).

There is evidence that pregnancy occurring within the first year after loss increases the incidence of complications such as complicated mourning (Lewis & Page, 1978), morbid grief (Rowe et al., 1978), depression and anxiety (Hughes et al., 1999), and post traumatic stress disorder (Turton et al., 2001). The women in my study responded instinctually to the timing of pregnancy rather than intellectually. They were “obsessed” with the need to become pregnant, and this tended to override their need for emotional healing, even when they knew that waiting would likely be beneficial. Phipps (1985-6) found that women indicated that their desire to get pregnant again quickly was related to a feeling that time was slipping away or to concerns about fertility. The participants in my study, however, experienced an “irrational” need to become pregnant again that did not seem to be related to either time or fertility.

Although the potential for complicated grieving is commonly described in the literature, some authors recommend that women should get pregnant when they feel that
they are ready (de Montigny, 1999; Griffiths, 1999), indicating that the pregnancy itself is not a significant factor in the grieving process for women who become pregnant quickly following loss. Griffiths suggests that increased depression and anxiety in pregnancies occurring in the first year post loss are related to the short time interval following the loss and constitute a normal grieving process. My own findings suggest that, whether the increased anxiety and depression in the pregnancy subsequent to stillbirth are identified as normal or abnormal grieving, they remain inconsequential in terms of their impact on women’s decision to quickly pursue another pregnancy.

In addition to the potential for complicated grieving, the obsession about becoming pregnant again quickly could also put the women at risk for having what has been reported in the literature as a “replacement child” (Lewis & Page, 1978; Pozanski, 1972; Robertson & Kavanaugh, 1998), or developing “vulnerable child syndrome” (Green & Solnit, 1964). Both these concepts express concern around the need to either replace the dead child with a live one or to idealize the dead child, and the consequent potential for separation difficulties between the live and dead child. Although these concepts represent older ideas and are not specifically related to perinatal loss, both the “replacement child” and “vulnerable child” are continually referred to in the perinatal loss literature, and their usefulness as constructs in contemporary perinatal loss literature continues to be debated (Lamb, 2002; Robertson & Kavanaugh, 1998). My study supports the findings of Davis et al. (1989), which discovered no relationship between time and feelings of overprotectiveness or replacement. The women in my study recognized the potential danger of needing to “replace” their dead child, but they considered this danger with a cognitive awareness, and they were accordingly cautious in
approaching their new baby. Interviews following the birth, some up to 14 to 18 months later, suggested no obvious confusion or inability to separate the live child from an idealized stillbirth. However, some of the women admitted to connecting the replacement issue with the baby’s sex.

The women who considered the potential for replacement wished to know the sex of the baby in order to deal with the resulting emotions prior to the birth. Their cognitive assessment of the potential for replacement and their attempts to deal with such thoughts are similar to the findings of Davis et al. (1989), in which they report that most mothers talk about feelings of overprotectiveness and replacement regardless of the amount of time between the loss and the next livebirth. My study lends support to the contention that the “replacement child” or “vulnerable child” may not be related to perinatal loss in general or the timing of the subsequent pregnancy in particular (Robertson & Kavanaugh, 1998). The need to clarify the applicability of these concepts to current experiences of perinatal loss warrants further research.

The potential for complicated grieving, attachment issues, and replacement child syndrome all have an impact on recommendations regarding the timing of the next pregnancy. However, Davis et al.’s (1989) study of women’s perspectives on doctor advice regarding timing noted considerable levels of dissatisfaction with the advice provided. A consensus on appropriate advice has not been reached in the 15 years since Davis et al.’s study, and recommendations continue to vary between under 6 months to a full year (Davis et al., 1989; Hughes et al., 1999; Phipps, 1985-6; Turton et al., 2001). In addition to the lack of consensus on the appropriate time interval, the findings of Crowther (1995) and Davis et al. (1989) also indicate that there was little consistency
between physician advice and women’s actual timing of the next pregnancy. Despite the many instances in which the women in my study stated that they knew they were not ready for a pregnancy, they remained obsessed with becoming pregnant and pursued a pregnancy as soon as their physician told them they were physically able to do so. The physician seemed to be perceived as the guardian of physical safety (as opposed to emotional safety), and it was in this capacity that doctors had a direct impact on the women’s decision to pursue the pregnancy. Given the findings of this study and others’ regarding the desire for an immediate pregnancy, as well as Davis et al.’s findings regarding the lack of consistency between physician advice and women’s actions, it is possible that neither the recommendation of a minimal wait time nor the recommendation to “wait until they feel ready” will significantly impact the timing of the next pregnancy.

In summary, the results of my study and others’ recognize that most women become pregnant again within a year following a loss (Robertson & Kavanaugh, 1998). It appears that an interplay of several factors dictates the optimal time for pregnancy for different individuals, and calls into question whether recommending an optimal waiting time is appropriate or necessary. Simply providing women with information regarding potential risks and allowing them to make an individual but informed choice may be more appropriate. The obsessive need to become pregnant is more likely to override any recommendation and consequently the provision of information, support, and understanding of the risks is a more important contribution to meeting the women’s needs. The provision of interconceptional counselling and information as suggested by Wallerstedt et al. (2003), may assist women in making an informed choice and help to
prepare for the potential of heightened anxiety and prolonged mourning in the event that they choose, or “need” to choose, a short interpregnancy interval.

**Labour and Delivery: The importance of birth**

The experience of labour and birth sets up an interesting split in the research into perinatal loss. As explained earlier, women who have experienced a stillbirth have the unique experience of labour and birth of a dead child, quite distinct from the experience of women who suffer miscarriages or newborn deaths. My contention is that, with the specific experience of stillbirth as a history, the experience of subsequent pregnancy has the potential to be sufficiently different both physically and psychologically to warrant separate research attention.

Despite my contention that women experiencing a pregnancy subsequent to a stillbirth are in a unique situation, the majority of the literature on subsequent pregnancy after loss considers women who have experienced all kind of perinatal loss (Armstrong, 2002; Côté-Arsenault, 2003a, 2003b; Côté-Arsenault et al, 2001; Côté-Arsenault & Dombeck, 2001; Côté-Arsenault & Mahlangu, 1999; Côté-Arsenault & Marshall, 2000; Côté-Arsenault & Morrison-Beedy, 2001; Franche & Mikail, 1999; Melender, 2002; Theut et al., 1990; Wallerstedt & Higgins, 1994). The general argument across this variety of literature is that women’s experience of a subsequent pregnancy reveals similarities regardless of the gestational age of the loss. From this perspective, differentiating the time of loss scientises women’s experience of loss.

Although this study’s findings support the idea that there may be considerable similarities in terms of responses to the pregnancy, fears of reoccurrence, and pregnancy anxiety, the participant accounts also suggest that significant differences may arise
farther along the continuum. Studies that do not distinguish between different types of perinatal loss appear to focus on the experience of the pregnancy as a separate part of the continuum of pregnancy - - postpartum, highlighting the psychological effect of loss on the pregnancy itself. Such research gives little attention to the birth experience, where the differences become more pronounced.

The women in this study depicted the experience of stillbirth as distinct from any other losses they had experienced. They described the stillbirth as “real” and “something they could hold on to,” and were distressed by societal perceptions of their loss as comparable to a loss through miscarriage. This confirms Côté-Arsenault and Dombeck’s (2001) finding that the degree of personhood assigned to the fetus advances with gestational age. Of note, most of Côté-Arsenault’s work does not differentiate early pregnancy losses from late losses, although it acknowledges that the higher degree of personhood assigned to a first pregnancy loss translates into higher levels of anxiety in the subsequent pregnancy. Although they are careful to caution that this finding should not be interpreted as indicating that the degree of personhood is dictated by gestational age, they acknowledge that as a beginning construct, it requires further refinement.

Further research into the construct of personhood through the continuum of pregnancy - postpartum may shed more light on the potential impact of gestational age on assignment of personhood. Examining the continuum of the subsequent pregnancy following stillbirth, as this study has begun to do in a preliminary manner, allows us to begin to appreciate the potential impact of the degree of assigned personhood of the stillbirth on the experience of subsequent birth, and the ways in which this differentiates the stillbirth from earlier losses.
A few studies explicitly focus on subsequent pregnancy following late pregnancy loss (Armstrong & Hutti, 1998; Caelli et al., 1999, 2002; Hughes et al., 1998; Hunfeld et al., 1996; Lever-Hense, 1994; Phipps, 1985-86; Turton et al., 2001). Participants in these studies who suffered a stillbirth described a fear of reoccurrence; this fear of reoccurrence appears not to be unique to women experiencing stillbirth, however, as women experiencing early pregnancy losses report similar fears. Women with late losses additionally reported a dread of labour and delivery (Caelli et al., 1999, 2002; Lever-Hense, 1994; Phipps, 1985-86; Wallerstedt et al., 2003; Warland, 2000). The body of research considering pregnancy loss in a more general manner does not focus on the anxiety around labour and delivery. My study findings suggest that women with a history of stillbirth experience a considerable depth of fear regarding labour and birth, and that this fear may have a major impact on their experience of labour and birth.

Although it is not a research-based report, Warland's (2000) published recollections of such experiences as numbness, flashbacks, and disorientation in labour resonate with the depth of women's fear in labour as reported by the participants in the present study. The women in my study appeared to "forget" the details of labour and birth in the subsequent pregnancy although their memory of the stillbirth was vivid and detailed. This suggests that the focus of the subsequent birth was the outcome and, in the context of this primary focus, the process itself was largely ignored or forgotten. I interpreted this phenomenon as a prohibiting factor in my attempt to obtain specific data regarding the physical and psychological experience of labour and birth. However, there were some instances in which participants were able to describe such experiences as flashbacks or panic moments, or reported that their husbands had later told them about
reactions in labour that they themselves did not recall. The feelings of disorientation and numbness described by these women, and echoed in Warland’s (2000) and others’ reports, may account for this lapse. To my knowledge, the only data-based study that specifically reported subjective findings in labour is Phipps’s (1985-86) study of 15 couples in a subsequent pregnancy following neonatal death. Phipps noted an increased urgency in the need for evidence of fetal well-being during labour, and reported in particular on the stress-provoking/relieving effect of fetal monitoring in labour. Beyond these few studies, this phenomenon has not been widely reported. Although the current finding may be an artifact of my particular study sample, it may also be the result of the difficulties inherent in research which attempts to obtain findings related to subjective experiences that individuals may not be able to acknowledge, recall, or report.

It is interesting to note that authors writing from a professional practice and clinical scholarship perspective report a more clear and consistent portrait of labour in a pregnancy subsequent to stillbirth than either the women in my study or the available research literature. My own professional experience, which seems consistent with that of other practitioners with whom I have discussed the phenomenon of women’s experience of labour in a subsequent pregnancy, suggests clinical knowledge of a labour and birth that is qualitatively different from the “norm.” For example, I have repeatedly observed delay in the onset of active second stage, crying and verbalization of past experience, inability or refusal to push, “apparent” accelerated progress through the stages of grief and loss (Kubler -Ross, 1969), and enhanced need for emotional support and reassurance. Resolution of the process appears to result in physiological resumption of progress in labour. Similar observations are alluded to in the clinical opinions of
Wallerstedt et al. (2003), Robertson and Kavanaugh (1998) and Caelli et al. (1999), which describe flashbacks, delayed pushing, and the need for continual reassurance. Although it is difficult to be entirely confident of this conclusion because of the complex nature of women's recall following the happy resolution of a livebirth, it would seem that these kind of labour experiences are not shared by women whose prior fetal loss was in relation to miscarriage.

**Labour and Delivery: Altered perceptions on mode of birth**

It is important to recognize the impact of stillbirth on expected norms of labour and birth. Whereas women with no history of stillbirth may commonly anticipate the norm of vaginal birth with as few interventions as possible, women experiencing pregnancy subsequent to stillbirth tend to have a different outlook. Many of the women in this study acknowledged that their expectations with regard to analgesia and their level of comfort about “allowing nature to run its course” had changed, and consequently they felt the need to plan as many details as possible in order to handle labour and birth. This often included interventions they had not considered prior to the stillbirth, such as induction of labour, Caesarean section, and epidurals for pain management.

Participants described an undercurrent of powerlessness in their inability to control the labour and birth of their stillbirth. Although all of these women requested a Caesarean section upon finding out that their baby had died, none were able to successfully negotiate this intervention. In the subsequent pregnancy, increased anxiety levels caused most of the women to demand delivery as soon as possible after the fetus was mature. Interestingly, care providers seemed more willing to intervene with induction or elective Caesarean section in pregnancies following the stillbirth than in the
pregnancy that resulted in stillbirth. Participants in this study reported a high rate of
induction of labour and a small number of elective Caesarean sections; other studies have
similarly noted this increased rate of intervention (including induction of labour and
Caesarean section) for maternal indicators in pregnancies following stillbirth (Freeman et
al., 1985; Heinonen & Kirkinen, 2000; Robson et al., 2001). These quantitative studies
acknowledge the increased intervention rates but do not advocate for increased
intervention based on a history of stillbirth alone; rather, they report that outcomes are
generally favourable in pregnancies following stillbirth. However, women's specific need
for control and increased intervention, as identified in qualitative studies such as this one
and others (Melender, 2002; Phipps, 1985-86), adds a dimension that is likely to have an
impact on intervention rates regardless of clinical need.

The decision about whether or not to intervene sets up an interesting ethical
dilemma regarding the role of women's choice in mode of birth. The women's request for
a Caesarean section upon diagnosis of a stillbirth may be a response to shock, but it may
also be an instinctive desire to choose the method of birth. Current beliefs that physical
and emotional healing following a stillbirth is enhanced by proceeding with vaginal birth
perpetuate a paternalistic approach to the management of stillbirth by medical personnel.
Although it might be argued that women's initial demand for a quick resolution by C/S is
based on psychological distress and therefore not a rational choice, the readiness of
medical personnel to intervene in the pregnancy subsequent to stillbirth calls into
question the rationale for mode of birth decisions for stillbirth and pregnancy subsequent
to stillbirth. The possibility exists that the high intervention rate in a subsequent
pregnancy may be related to practitioner anxiety rather than patient anxiety. This may
further explain the contrast between decisions made around mode of birth in the pregnancies that resulted in stillbirth and livebirth, and highlights the fact that women’s choice had little or no role to play in the process. The new debate regarding “Caesarean section on demand” is a recent extension of this argument that may be effectively extrapolated when considering the appropriateness of maternal choice regarding mode of birth in pregnancies surrounding loss. It may be that women instinctively understand the mode of birth that is best for them, regardless of the circumstances.

Protecting Pregnant Women: Social safeguard or perpetuating the silence?

The women in my study described an altered perspective on life, in which simple things were appreciated, more time was spent in reflection, and the focus was kept on what was really important. They also placed a higher value on childbearing. These findings echo Côté-Arsenault and Morrison-Beedy’s (2001) findings, in which women reflected on their changed expectations for pregnancy after perinatal loss, describing pregnancy as being tainted, and themselves as having lost the sense of naïveté that was evident during the pregnancy prior to the diagnosis of the stillbirth. A similar loss of joy has been expressed in other studies of pregnancies subsequent to perinatal loss (Brost & Kenney, 1992; Caelli et al., 2002; Côté-Arsenault & Mahlangu, 1999; Côté-Arsenault & Marshall, 2000; Lever-Hense, 1994; Phipps, 1985-86). The loss of joy and naïveté in pregnancy was common to early and late pregnancy losses alike, although comparative studies of early and late loss suggest that the late loss group had a greater potential for unresolved grief (Theut et al., 1990), and that grief increased in relation to the length of the gestation (Janssen, Cuisinier, Hoogduin, & de Graauw, 1996; Robertson & Kavanaugh, 1998). The women in my study seemed to support the finding that the greater
the gestation, the greater the anxiety and fear during subsequent pregnancy. It should be noted that the question of degree is probably not critical to the concept that the naïve and joyous expectations commonly associated with the experience of pregnancy tend to be modified following loss. The experience of a tragic outcome of pregnancy seems to be related to the women’s subsequent placement of more value on childbearing.

It seems possible that the theme of protecting other pregnant women described by participants in this study is an extension of the perception that pregnancy is forever tainted following a stillbirth. It may also be related to the increased value placed on childbearing. The women in my study never equated pregnancy with livebirth for themselves or others. They described “saying a little prayer” for pregnant women they saw on the street that all would go well for them. In addition, they reported feeling sorry for their friends because they believed that their friends’ experience of pregnancy would be tainted by the fact that they knew them and their story. During interviews participants shared specific examples of “protecting pregnant women” such as not returning to a perinatal loss support group when they became pregnant again, not referring to their stillbirth with a pregnant obstetrician, and ensuring that they were not overheard talking about the stillbirth in hospital wards where other pregnant women were present. Although I have not seen this particular concept identified in the current literature to date, it seems possible that trying to protect the experience of pregnancy for other women is a social safeguard that transforms the individual’s altered perception of pregnancy into social action.

Although protection is usually interpreted as a positive action, it is possible that the maintenance of a cloak of silence around stillbirth and loss helps to perpetuate
society's continuing inability to effectively handle grief and loss. The women in my study felt additionally powerless in their experience of stillbirth because they had no societal frame of reference to draw upon. The experience of stillbirth is uncomfortable for society at large and generally avoided as a topic of conversation. Furthermore, the women in my study described themselves as becoming members of a "secret club" once the stillbirth had occurred. They reported that women with similar experiences "came out of the woodwork" and shared their stories only when they knew someone shared their history. Participants noted that prenatal classes did not educate about the potential for stillbirth, and felt that the curriculum should include some information about this crucial issue. Lamb's (2002) clinical description of the impact of perinatal loss on subsequent pregnancy also mentions the need for prenatal education about potential loss.

Although they perceived the lack of both education about and preparation for the possibility of stillbirth as contributing to their sense of powerlessness in the stillbirth experience, once the women had embarked on a subsequent pregnancy they themselves appeared to contribute to the societal silence around loss. They described never knowing whether or not to count the stillbirth when asked how many children they had. They further noted that this decision was more difficult if the person asking was a pregnant woman, and stated that they usually chose to lie and not disclose the stillbirth.

Interestingly, I also tried to safeguard pregnant women in my recruitment strategy for this study: I chose not to circulate information about the study in places such as ultrasound clinics and prenatal classes where pregnant women were likely to gather and for whom such information might be upsetting. I now question this strategy as it appears to contribute to the perpetuation of a secrecy that places women in an additionally
vulnerable position if and when they experience stillbirth. It also perpetuates the social avoidance of open communication about death.

The women in my study wanted more information about the potential for loss and the kinds of decisions that would need to be made in the event of a loss. They appreciated the opportunity to share their stories with me because this constituted a rare opportunity to discuss a fundamental experience. However, it should be noted that their thoughts and experiences are narrated in retrospect. It would be interesting to consider what pregnant women without this type of history might consider necessary or unnecessary components of prenatal education. The potential exists for these women to respond as members of a society in which death is not openly discussed, who might prefer to be protected from information regarding potential loss. Participants' behaviour following the onset of a subsequent pregnancy seemed to support this notion, in that they tended to avoid sharing their stories, particularly with other pregnant women.

It is difficult to determine whether attempting to protect pregnant women is a social safeguard or a social action that inappropriately perpetuates the silence around stillbirth. It is possible that further discussion of the meaning and implications of this new concept and its relationship to the childbearing experiences of women as individuals and as part of society at large may increase our understanding of the tradition of silence around stillbirth and also help to identify how best to assist pregnant women.
Caregiver Response: A critical catalyst

The women in my study described several examples of positive and negative caregiver responses during both their experience of stillbirth and their pregnancy subsequent to the stillbirth. In the pregnancy that resulted in stillbirth, negative experiences were mostly related to insensitivity of ancillary medical personnel such as ultrasonographers, inappropriate communication regarding the death of the baby, lack of choice regarding contact with the baby, and insensitivity on the part of family and friends. Where described, these themes were mostly consistent with those found in other studies (Côté-Arsenault & Morrison-Beedy, 2001; Turton et al., 2001). The women in my study reflected that caregivers were most likely insensitive because they rarely had to care for a woman with a stillbirth, and because they felt personally uncomfortable around this issue. Although there is no easy way to tell a woman that her baby has died, as caregivers, we need to be conscious of our own potential discomfort around death and dying, and the way in which it impacts our ability to convey knowledge about death in a sensitive way.

Another potential rationale for poor communication regarding death is that the incorporation of the unexpected (discovering the death of a fetus) into what is a daily task for caregivers (such as listening to the fetal heart or performing an ultrasound) has a particular impact within the more clinical social environment of the hospital, which differs from society at large. In other words, some caregivers may not stop to consider a baby's death an unusual and shocking tragedy, but rather a simple diagnostic outcome of the task they routinely perform; consequently, they announce the event in the simplest, most direct, and potentially highly insensitive way, without pausing to consider the
impact of hearing “your baby has died.” Those caregivers who display sensitivity may be
cetter able to move away from the routine of the hospital environment and successfully
tap into an accepted societal role (displaying normative social behaviour). Although it
could be argued that normative social behaviour tends towards avoidance of talk about
death, the expectation of human compassion in the experience of loss is a common one.
The continuum of responses reflects the varying degree to which caregivers are able to
connect with the patient’s personal experience from a social competence perspective,
rather than from a medical competence perspective.

The women in this study perceived sensitivity and/or lack thereof as central to the
memory of the stillbirth experience. Consequently, it is paramount that caregivers
carefully consider their approach when communicating with women experiencing a loss.
The women in this study indicated that memories of good or bad practice around the way
in which the stillbirth was handled seemed to have a major impact on the resolution of
grief and on their concerns regarding the subsequent pregnancy. Caregivers who
displayed compassion, considered the women’s individual needs, and provided mementos
of the birth were seen as most helpful. The women in this study most often credited
nurses and midwives with being the professional(s) that displayed these helpful caregiver
responses. Ancillary medical personnel were reported as most likely to be insensitive and
unhelpful; other studies have also found that medical personnel were not always seen as
supportive (Côté-Arsenault & Mahlangu, 1999; Crowther, 1995;).

Negative experiences in pregnancies following a stillbirth were commonly related
to health care providers lacking the knowledge of the history of stillbirth. In addition to
the importance of knowing the history, the women in my study also emphasized the need
for control, reassurance, flexibility, continuity of care, and the need to be treated as an individual as the predominant themes in effectively managing the pregnancy subsequent to the stillbirth. One participant described the continuity of care and informed choice components inherent in the midwifery model as ensuring knowledge of the history, providing reassurance, flexibility, control, and compassion which she found particularly helpful. The benefits of midwifery care in supporting a pregnancy subsequent to loss have similarly been described by Caelli et al. (2002) and Warland, (2000). Of course, these benefits are not the exclusive preserve of midwives – other types of caregiver could also adopt them. Different models of care may require more attention in order to meet the needs of women carrying a pregnancy subsequent to stillbirth.

The ability of caregivers to mitigate a tragic (e.g., stillbirth) or frightening (e.g., subsequent pregnancy) experience has the potential to make a significant difference to women (Côté-Arsenault, 2003a; Lever-Hense, 1994; Robertson & Kavanaugh, 1998; Wallerstedt et al., 2003; Warland, 2000). The women in my study and others’ interpret psychological and emotional support as compassion, and suggest that the need for compassion is considerable. Discussions that address only the medical aspects of loss are not helpful to women (Brost & Kenney, 1992; Melender, 2002). Caregiver responses appear to have the potential to significantly influence the ways in which the experience of stillbirth is later remembered, as well as the experience of subsequent pregnancy. It seems clear that the experience of subsequent pregnancy after stillbirth is fraught with anxiety and the needs of women are many and complex. The results of the present study and others’ identify and report many caregiver interventions that are particularly helpful to women. However, the vulnerability of those women with a history of stillbirth appears
to create additional potential for caregivers to add significantly to the level of distress.

Caregivers are well placed to moderate the impact of stillbirth in a subsequent pregnancy and to facilitate the pregnancy, labour, and birth and postpartum experience for women.

**Summary**

A review of the existing literature shows that this study echoes the results of other studies in some areas, but also uncovers some new information and contributes to continuing debates. Four themes were discussed which seem to be especially relevant to the findings of my study: the timing of the next pregnancy, the importance of labour and birth, protecting other pregnant women, and the caregiver as catalyst for future recollection and reintegration of grief.

In terms of the timing of the next pregnancy, this study and others have shown that women usually become pregnant again within the first year after loss. Despite physician advice to the contrary, women in my study were obsessed with becoming pregnant again as soon as possible. This finding is supported in the studies that refer to women's dissatisfaction with advice given regarding timing of the next pregnancy. Therefore, the identification of a “right” period of time to wait, regardless of the reason for recommending it, seems moot. As an alternative to recommendations regarding a wait period, women may benefit from information and education that support them in making an informed choice.

The concept of informed choice was also discussed in terms of women’s decisions regarding mode of birth. The experience of stillbirth altered these women’s perception of labour and birth. They experienced a high rate of intervention in their subsequent birth consistent with that found in other studies. The potential for consideration of women’s
choice as an elective alternative to clinical indication as a rationale for intervention is an interesting contribution to the current ethical debate regarding elective Caesarean section.

The women’s experience of labour and birth was better described in the published descriptions of clinicians than in the accounts of the women themselves. The importance of addressing labour and birth as a part of the continuum of subsequent pregnancy after stillbirth was discussed in the context of the available literature. Despite the paucity of current literature on women’s experience of labour, the findings in my and other studies make reference to the numbness, disorientation, and flashbacks experienced by the women. The experience of labour and birth differentiates the experience of late perinatal loss (stillbirth) from early perinatal loss (miscarriage) and merits further attention.

The concept of protecting other pregnant women, which emerged from my study, has not been seen in the literature to date. The loss of joy and naivété of pregnancy experienced by the women in this study extended to other pregnant women and resulted in attempts to safeguard them. The potential for this phenomenon to actually protect other pregnant women or perpetuate the silence around discussion of stillbirth was discussed.

Last, this study, like others, found continuing reference to the themes of women’s need for control, reassurance, flexibility, continuity of care, and caregiver awareness of their history. The participants identified the role of the caregiver as critical with regard to both their recollection of the stillbirth and their experience of subsequent pregnancy.
CHAPTER SEVEN
CONCLUSIONS AND IMPLICATIONS

Summary of the Study

This study of women’s experience of livebirth after stillbirth was undertaken to gain an understanding of that experience in order to consider a potential explanation of the processes involved and to develop recommendations to inform practice. As a nurse and a midwife, my interest in this research was piqued by my observations of the process of pregnancy, labour, birth, and postpartum of women experiencing a livebirth following a stillbirth, which appeared to be different from that of women without such a history.

Although both the lay and professional literature regarding stillbirth are extensive, much less is known about the pregnancy that follows stillbirth. The available literature pays considerable attention to the experiences of women during the antenatal and postpartum periods. The literature regarding anxiety, depression, and prenatal attachment issues in subsequent pregnancy is increasing. However, the experiences of labour and birth appear to represent a significant gap in the literature. In addition, literature that addresses livebirth after stillbirth and considers the experience throughout the full continuum of pregnancy, labour, birth and postpartum is very limited.

Using an interpretive description design, I interviewed 14 women who had a history of stillbirth and who subsequently delivered a healthy baby. A few of these women were currently pregnant at the time of the initial interview and were again interviewed after the birth of their baby. With the assistance of a semi-structured interview guide, I asked the women to tell me about their physical and psychological experience of stillbirth and
livebirth after stillbirth. The interviews were transcribed verbatim and field notes were written immediately following each interview. The findings were generated from a constant comparative analysis of the data, in which common themes and patterns were identified as well as variations in the women's accounts.

Similar to the findings that have been reported by other authors, the findings of this study illuminated the manner in which women’s experience of the subsequent pregnancy is fraught with anxiety, fear, and depression. The women’s need for reassurance, control, and choice throughout the continuum of the subsequent pregnancy was a strong emerging theme throughout the findings of my study. This observation raises the potential that analysis of the experiences of such women may be applied in the practice context in such a manner as to have an impact on how care is delivered. Interpreting these women’s accounts allow us to challenge some current beliefs and practices, such as the preferred mode of delivery for both the stillbirth and the subsequent livebirth. In addition, the women’s diverse experiences of interactions with the health care system and the health care professionals within it reflected patterns and themes within both positive and negative interactions. This aspect of the findings creates a context within which we can examine and improve our practices regarding care of women experiencing stillbirth and livebirth after stillbirth.

Conclusions

The goal of this research was to begin to understand women’s experience of livebirth after stillbirth in order to improve care to this subset of women. As a result of this study’s findings, as well as an examination of those findings within the context of the available empirical literature, we can draw the following conclusions.
1. Women tend not to approach childbirth well informed about the possibility of stillbirth. Their lack of knowledge, especially regarding the decisions they might be called upon to make in a short time, contributes to a sense of powerlessness and fear when a stillbirth occurs. Women who have experienced a stillbirth describe a highly distressing sequence of events that has had a major impact on their lives.

2. Women seem to experience a powerful urgency to become pregnant again quickly following the birth of their stillborn. This is of particular importance because it may place them at increased risk for unresolved grieving and increased anxiety and depression in the subsequent pregnancy.

3. Women who experience a livebirth following a stillbirth describe an emotionally laden experience characterized by increased fear and intense and constant need for reassurance.

4. Women describe the most critical elements of care for women in a pregnancy following stillbirth as sensitivity to the women’s emotional context, knowing the important details of the history, giving women control and choice (e.g. regarding the mode of birth), providing flexibility within the care options, ensuring continuity of care, and providing sufficient time for questions.

5. Women undergoing livebirth after stillbirth may experience such psychological or emotional phenomena as flashbacks, numbness, or dissociation during labour and birth. They describe themselves as being focused on the outcome of achieving a healthy baby, but may later display a lack of recall around the specifics of labour and birth.
6. The postpartum experience of women experiencing livebirth subsequent to stillbirth can be described as an emotional continuum of joy over their new baby and resumption of (or continuation of) grief over their lost baby. In this context they may demonstrate apparent disregard for the physical discomforts of the postpartum period.

7. The sex of the baby may be an important factor in women’s experience of livebirth after stillbirth. The reasons for which the baby’s sex was considered so important varied considerably within this study, but there may be common factors underlying this phenomenon that are not yet understood.

**Implications**

Although this study is small and the findings are not generalizable to all women experiencing livebirth after stillbirth, the findings themselves reflect patterns and themes that resonate with clinical observations to the extent that it seems reasonable to suggest implications for practice. The current direction within the perinatal field is to question common wisdom and incorporate consumer perspectives into clinical policy formation; this provides a background against which to integrate the differing needs of women undergoing childbirth under difficult circumstances. Although this study is not in and of itself a basis upon which to support changes in practice, the findings generated from the voices of its participants can contribute to providing confidence for a practice perspective that is consistent with current trends.

**Implications for Clinical Practice**

The findings of this study will be particularly relevant for sensitizing practitioners to the complexities inherent in the experience of livebirth subsequent to stillbirth, as well
as the nuances of individual variations that may be observed in the clinical context.

Certain aspects of these observations may be applicable to supporting and developing practice contexts conducive to creating optimal experiences when women who have experienced stillbirths approach a subsequent labour and birth experience.

The women in this study reported considerable urgency in their desire to get pregnant again following stillbirth and also reported a high level of anxiety and depression in the subsequent pregnancy. The findings of my study, like those of other authors who have examined the post-stillbirth, preconception period, and antepartum period of the livebirth, indicate that interventions may be required to reduce the anxiety in a pregnancy subsequent to stillbirth and provide support to assist the resolution or reintegration of grief. Programs of interconceptional counseling and ongoing support should be developed and implemented to provide an information source and encourage a preventive approach to health care for this population given the strong impetus to become pregnant again quickly and the increased risk for anxiety and depression with a short interpregnancy interval.

According to the women in this study, the need for control and choice during the experience of livebirth after stillbirth has implications for clinical care that may challenge both the common wisdom of caregivers and the practical systematic organization of office and hospital ward practices. Women's reported need for constant reassurance may manifest itself in various ways, including wanting additional (possibly frequent) unscheduled medical visits, additional tests, and counseling, and may require a reorganization of nursing staff to accommodate continuity of care. In addition, the current debate around "Caesarean section on demand" highlights the complex ethical issue of
choice regarding mode of delivery for all women, as well as the particular tension concerning stillbirth or previous stillbirth as an indication for operative delivery, as distinct from operative delivery by choice.

According to the women in this study, many of the difficulties associated with their interactions with the medical community during a livebirth following stillbirth resulted from a lack of knowledge of their history among both caregivers and ancillary medical personnel, which gave rise to inappropriate and insensitive interactions. Their accounts emphasize the importance of both attending to information management within the clinical care context, and ensuring effective communication skills among practitioners. A possible concrete way to assist in improving communication within the health care system and between providers may be the development of a chart flagging system that alerts care providers to stillbirth histories throughout the continuum of care, regardless of the location of care, similar to the system used by some health care facilities to alert all care providers to histories of intimate partner violence. Another approach is to represent the qualitative findings of women’s experiences within education programs, and address the need for appropriate and sensitive care in the basic and ongoing physician, nursing, and midwifery curricula. My study and some of the available literature seem to indicate that nurses and midwives are better able to meet the psychological needs of these women. The integration of interdisciplinary approaches to health care and education may assist in the facilitation of a shared approach to care by physicians, nurses, and midwives for this subset of women.

The majority of women in this study reported the second postpartum experience as occurring within the context of the continuing process of the resolution of grief for
their stillborn. The psychological and emotional work in the postpartum period reported by the women in this study appeared to override their physical discomforts. This understanding has the potential to suggest that a shift is required in caregivers’ expectations regarding the emotional responses of women having a livebirth following a stillbirth, as well as regarding the additional attention that may be necessary in the monitoring and assessment of physiological healing for these women. In addition, potential concerns regarding postnatal attachment and parenting issues around the care of a baby subsequent to stillbirth may have implications for observation in the postnatal period, and more specifically with follow-up care in the community. The continuing trend of earlier and earlier discharges from hospital following childbirth is likely to contribute to the potential of overlooking red flags and impede caregivers’ ability to implement a program of support and follow-up for this subset of women in the community.

The findings in this study also reinforced the importance of observations that have been made by other researchers about the way in which women experience stillbirth. In the course of explaining their current experience of livebirth after stillbirth, many of the women in this study described having felt very alone and unsupported during their original stillbirth experience. Their experience was characterized by an interminable wait to hear the news that their baby had died, an apparent confusion or insensitivity associated with how the news should be delivered, the horrifying reality of labour and birth, and a postpartum period with no baby. Complicating all of these was the perception that they were alone within an experience that others could not understand. These findings emphasize the importance of ensuring adequate supports for women undergoing stillbirth so as to ameliorate and prevent some of the lingering effects that inadequate
support may produce. Such strategies as the development of a common approach for communicating bad news to women, developing support groups for women sharing similar experiences of loss, and establishing a network of volunteer mothers who have experienced a stillbirth and who are willing to visit newly bereaved women immediately after birth and provide support throughout the postpartum period might be indicated as part of a comprehensive standard care system for such patients.

Several of the women in my study indicated that they wished they had more awareness about the possibility of stillbirth and the decisions that would need to be made in the event of a stillbirth. From the perspective of the childbirth educator, educating women regarding potentially difficult outcomes might be incorporated into the knowledge provided during routine prenatal classes. The knowledge imparted during these classes regarding warning signs and areas to look out for may be identified as an indirect form of support by women. As most prenatal classes have libraries of resources, it may be an option to direct women towards resources addressing the experience of stillbirth for those women who may desire (or require) additional information. This approach addresses the direct concerns of the women as expressed in my study without introducing unnecessary fear for those who choose to focus their attention on an anticipated healthy outcome.

Implications for Future Research

Although this study has added to the understanding of women’s experience of livebirth following stillbirth, it seems apparent that the strategy of extending our

53 An example of a part of routine care for women during pregnancy that can frighten women but support their role in their care includes fetal movement assessment which if decreased can lead to a poor outcome. Women are aware of this possibility and appear to accept the concern as part of appropriate care and pay attention to the movement of the baby throughout pregnancy.
knowledge to include the women’s voices is insufficient to effectively understand the phenomenon, or to explain the observations of labour and birth among this subset of women that have been reported by clinicians. In order to develop a better understanding of this phenomenon and to generate evidence-based knowledge upon which interventions can be effectively grounded, we will require alternative perspectives from which to generate a more comprehensive empirical description. One potentially promising direction for future research might include systematic documentation of patterns within the observations and insights from two distinct perspectives — those of partners who were present during labour and delivery, and those of caregivers, particularly nurses and midwives, who are present providing active care throughout the experience.

Documentation of patterns and themes among their accounts may well provide a more confident base upon which we can articulate claims about commonalities and variations within this experience.

The beginning literature that addresses the experiences of both mothers and fathers regarding the understanding of stillbirth and livebirth after stillbirth has shown that the experience of fathers is different from that of mothers (Armstrong, 2001; Phipps, 1985-86; Robertson & Kavanaugh, 1998). This finding seems to emerge regardless whether the fathers are studied individually or as part of a couple. The women in my study also recognized that their husband’s own grieving was different from their own and was complicated by responses to their female partner’s intense grief and anxiety. Further research on the specific experience and needs of men in the loss of a baby and in their support of a partner during a subsequent pregnancy, as well as their experience of
attendance at the birth and in parenting would assist in developing a comprehensive picture of this phenomenon, particularly as it is experienced by a couple.

As has been the pattern among others who have written on the experience of livebirth after perinatal loss, the findings of this study have represented the experience as it is reported among a relatively homogenous sample of Caucasian, middle class, married, and reasonably well-educated women. It may be that the commonality among the samples reported in the literature reflects an increased interest among women of this description to participate in research of this kind, or that recruiting strategies are more likely to target a particular kind of sample. However, in order to generate a more complete understanding of the phenomenon of livebirth after stillbirth, it will be important for future researchers to include in their samples many of the variations that will be seen in the clinical context so that our knowledge can begin to address the impact of ethnic variation, poverty, single status, and adolescence on the experience of livebirth after stillbirth.

Many of the women in my study indicated a conviction that their perception of the experience of stillbirth was distinctly different from their perception of pregnancies that end in miscarriage. For example, they represented the experience of stillbirth as more “real” than that of miscarriage. Although it is clear that we cannot generalize from these women to represent the majority of women, the research that addresses perinatal loss is divergent regarding whether stillbirth is different or comparable to women’s experience of livebirth following all forms of perinatal loss. This study has attempted to make the argument that the experience of livebirth after stillbirth should not be taken out of context of the full continuum of pregnancy, labour, birth, and postpartum and that the experience of labour and delivery in particular separates the women with late pregnancy losses from
those with early losses. Women's experiences of livebirth following miscarriage may reveal both similarities and differences informative for sensitizing clinical practitioners. Further research is needed that examines the impact of gestational age at the time of loss on women's experience throughout the continuum of pregnancy, labour and birth, and postpartum in order to generate a more accurate picture of the experience of pregnancy following loss of all types. In addition, the relationship of gestational age of loss to the concept of the "replacement" or "vulnerable" child requires clarification in regards to the appropriateness of the concept for a perinatal population in general and the timing of the loss as either early or late in particular.

The experience of the women in my study who had delivered additional children following the livebirth subsequent to the stillbirth suggested that the nature of ongoing grief and the ways in which the stillbirth is incorporated into their lives changes over time. This introduction to the nature of the ongoing process of interpretation and reintegration of grief as it relates to future pregnancies may reflect a longitudinal process that does not end with the livebirth after stillbirth. The potential for the physical, psychological, emotional, and social impact of stillbirth to display shifting foci with each additional pregnancy is an avenue for future researchers to consider.

An analysis of the findings of the women's experiences of livebirth after stillbirth in this study, when compared to those of other authors who studied a similar population, reflects several commonalities in the experience, which could indicate the occurrence of an overriding social process. Further research that builds on these findings would be useful to theoretically extend the exploratory findings of this study and further clarify this difficult phenomenon. Clearly, there is still much work to be done if we are to develop
the knowledge and competencies that will best serve this small but vulnerable population of women.
REFERENCES


Appendix A

Letter of Introduction
Appendix B

Letter of Invitation
Appendix C

Participant's Information and Consent Form
Appendix D

Transcriber’s Consent Form
Appendix E

Interview Guide
Sample Interview Questions:
Women's Experience of Livebirth After Stillbirth

Preamble: Thank you very much for agreeing to talk with me about your childbirth experiences. I know you have been through a great deal over the past few years. I hope we can talk about what having a stillbirth was like for you, then about the experience of having a healthy baby. Where would you like to start?

The following questions will be used to guide the discussion as it evolves.

1. Tell me about you.

2. What was having a stillbirth like for you?
   - Tell me about your experience physically?
   - What did you experience emotionally?
   - What was your experience of finding out the baby had died?
   - Tell me about the labour and delivery.
   - What things did the caregiver do that you found helpful?
   - What things did the caregiver do that you found difficult or unhelpful?
   - Tell me about how you coped with the loss.

For women who have already given birth to a healthy baby following stillbirth:

1. Tell me what the experience of having a healthy baby is like after having experienced a stillbirth?
   - How did your experience of stillbirth impact the time interval between pregnancies?
   - How did you feel when you found out about the pregnancy?
   - Would you describe it as an uneventful pregnancy?
   - What differences, if any, did you experience in antenatal care?
   - How did the pregnancy differ from your previous pregnancy physically and emotionally?
   - Tell me about the labour and birth.
   - What things did the caregiver do that you found helpful?
   - What things did the caregiver do that you found difficult or unhelpful?
   - Tell me about your experience of pushing.
   - What was it like to see the baby?

2. Some women have said that they were scared to push the baby out as the baby might not be alive again. Can you tell me about this?
3. What was your postpartum experience like after a healthy baby?
   - How did you feel physically?
   - How did you feel emotionally?
   - What was your support network like?

4. What advice would you give to caregivers when caring for women like yourself who are currently experiencing a healthy pregnancy after a stillbirth?

5. Is there anything else you would like to share with me about your experience?

For women who are anticipating a healthy baby following a stillbirth:

1. Tell me about what it is like being pregnant after having lost a baby.
   - How are you feeling during this pregnancy?
   - How did your experience of stillbirth impact the time interval between pregnancies?
   - How did you feel when you found out about the pregnancy?
   - Would you describe it as an uneventful pregnancy?
   - What differences, if any, are you experiencing in antenatal care?
   - How is the pregnancy differing from your previous pregnancy physically and emotionally?
   - Have you experienced thoughts about your last pregnancy during this one?
   - Do you have any specific fears or anxieties?
   - What are your expectations for labour and birth?
   - What things do you hope the caregiver will do that you think would help you?
   - What things are you worried the caregiver will do?
   - What do you think it will be like to have a healthy baby?

2. Is there anything else you would like to share with me about your experience?
Appendix F

Participant Profile Form
PARTICIPANT PROFILE

Subject_________ Age_______ Occupation__________________________

Date of Form Completion____________________

G __ T __ P __ A __ L __

Stillbirth Occurred:

Year_________ Month_________

Gestational Age _______

Sex _______

Livebirth (s):

Prior to Stillbirth:  #________

Years(s)____________________

Following Stillbirth:  #_______

Years(s)____________________

Currently Pregnant? _________

Gestational Age _________

Comments: ____________________________

____________________________________

____________________________________

____________________________________
Appendix G

Sample Descriptive Summary
### Sample Descriptive Summary

<table>
<thead>
<tr>
<th>Participant</th>
<th>Age</th>
<th>Gestational Age of Stillbirth</th>
<th>Time elapsed since Stillbirth</th>
<th>Prenatal or Intrapartum notification of Stillbirth</th>
<th>Time between Stillbirth and Livebirth</th>
<th>Mode of delivery of Livebirth</th>
<th>Outcome of Livebirth</th>
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<td>43</td>
<td>28 weeks</td>
<td>11 years</td>
<td>Prenatal</td>
<td>1 year</td>
<td>SVD</td>
<td>Healthy</td>
</tr>
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<td>38</td>
<td>40 weeks</td>
<td>9 years</td>
<td>Intrapartum</td>
<td>1 year</td>
<td>Induction-SVD</td>
<td>Healthy</td>
</tr>
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<td>41 weeks</td>
<td>1 year</td>
<td>Intrapartum</td>
<td>15 months</td>
<td>Booked C/S</td>
<td>Healthy</td>
</tr>
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<td>4 years</td>
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<td>4 ½ years</td>
<td>Induction-SVD</td>
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<td>2 years</td>
<td>Prenatal</td>
<td>14 months</td>
<td>Booked C/S</td>
<td>Healthy</td>
</tr>
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<td>Intrapartum</td>
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<td>Induction-SVD</td>
<td>Healthy</td>
</tr>
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<td>34 weeks</td>
<td>5 ½ years</td>
<td>Postnatal (1 week later)</td>
<td>2 years</td>
<td>Induction-C/S</td>
<td>Healthy</td>
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<td>4 years</td>
<td>Induction-SVD</td>
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</tr>
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<td>Healthy</td>
</tr>
<tr>
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<td>Prenatal</td>
<td>14 months</td>
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<td>Induction-SVD</td>
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